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Challenges for the Provision of voluntary Counseling and Testing Services in Registered Counseling and Testing Centres of Lilongwe

By

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CERTIFICATE OF APPROVAL

The thesis of **Milika Kuphanga Mdala** is approved by the Thesis Examination Committee.

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DECLARATION

I **Milika Kuphanga Mdala** hereby declare that this thesis is my original work and has not been presented for any other awards at the University of Malawi or any other University.

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Date 20th June 2008

DEDICATION

To my husband Samuel and my lovely children Upile, Thokozani and Victory, many thanks for the untiring financial, technical, moral support and prayers throughout my course work and research paper.

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ABSTRACT

This study explored the challenges of HIV Testing and Counseling (HTC) faced by Voluntary Counseling and Testing (VCT) centres in Lilongwe District. The aim of the study was to find out if there are any institutional and human resources related obstacles to low turn up of clients for VCT in Malawi. National AIDS Commission report for 2005 states that there is low turn up of clients at VCT centres in Malawi. This concurs with the 2001 NAC survey that revealed that up to 80% of sexually active population in Malawi has not gone for VCT. The rationale was to find out ways of improving the noble service of HIV Testing and Counseling. The study employed both quantitative and qualitative research methods to complement each other in order to get more comprehensive and insightful understanding.

Results of the assessment suggest that access to the HTC service plays a big role in people accepting and utilizing the service better, with the urban areas being at a greater advantage than the rural areas. It also suggested that counselors' attitude, availability and empathy during both pre and post counseling services was also commendable. Therefore the study recommends the government to resolve the issue of equity to access and consider constructing more permanent structure preferably free standing structures with a minimum of 4 qualified Counselors per centre both in the rural and urban areas.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune-deficiency Syndrome
ARVs	Anti Retrovirals
CHAM	Christian Association of Malawi
FBOs	Faith Based Organization
FHI	Family Health International
HIV	Human Immune Virus
HTC	HIV Testing and Counseling
MDHS	Malawi Demographic Health Survey
MOH	Ministry of Health
MSH	Management Sciences for Health
M&E	Monitoring and Evaluation
NAC	National AIDS Commission
NGOs	Non governmental Organization
NSF	National Strategic Framework
NSO	National Statistical Offices
NUD*IST	Non numerical Unstructured Data Indexing Searching and theorizing
OPD	Out patient Department
SPSS	Statistical Package for Social Sciences
PMTCT	Prevention of Mother to Child Transmission
UNAIDS	United Nations Joint Programme on HIV and AIDS
WHO	World Health Organization
VCT	Voluntary Counseling and Testing

CHAPTER 1: INTRODUCTION

1.1 Introduction

Malawi is a developing country in the southern Africa region with an estimated population of 11.5 million people by the year 2006.This is according to the National Statistical Office Census of 1998. [1] Just as many sub-Saharan countries, HIV/AIDS remains the greatest development threat and challenge Malawi is facing today. More than half million Malawians have since died of AIDS, and many more are getting infected on daily basis since the first case of AIDS was diagnosed in 1985. [2] The epidemic has spread very rapidly with 760,000 Malawian adults living with HIV/AIDS by the year 2003 representing a national prevalence of 14.4% among 15-49 year olds. [3] The urban areas are the hardly hit areas with the epidemic almost twice as many adults in the urban areas (23.0%) as in rural areas (12.4%) are HIV positive and it is estimated that 900,000 Malawians are living with the Virus in Malawi today. [4]

This was a cross-sectional study aiming at exploring obstacles and challenges for the provision of HTC Services in HIV Testing and Counseling Centres of Lilongwe District to find out if this leads to low uptake for the Service by clients. The study was designed so that its results should help in developing improved strategies for the provision of VCT services in order to increase HIV status awareness in Malawi through recommendations from respondents.

1.2 Background and problem statement

HIV Testing and Counseling (HTC) is a pivotal strategic approach to HIV and AIDS prevention. [5] The World Health Organization (WHO) defines HIV counseling and testing as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS. [6] Previously HIV testing used to be client initiated. This process was called Voluntary Counseling and Testing (VCT). A new process called HIV Testing and Counselling (HTC) replaced the old system and encompasses what initially were two services; the provider initiated HIV testing and Counseling including routine, diagnostic and mandatory testing and client initiated HIV testing and Counseling. [4]This combined process amplifies benefits of both services since it is done concurrently. According the UNAIDS report of 2006, the new approach to HIV Testing and Counselling is useful in both resource rich and poor settings explicitly urban and rural settings. [7]

HTC service provides all segments of the population an opportunity to access complete and accurate information on HIV and AIDS.[7] The World Health Organization (WHO) and the United Nations Joint Programme on HIV &AIDS (UNAIDS) describes HTC as the corner stone that enables a person to confidentially explore and understand his or her risk of HIV infection. [8] HTC provides an opportunity to fully comprehend the implications of ones sero-status and to learn about precautions for protection and prevention from further spread of

HIV infection. [7] In his address to the UNAIDS annual conference of 2006 the director of UNAIDS Piot stated that HTC is highly effective in changing people's behaviour to reduce their risk both of being infected and of infecting others because it brings about increased self-awareness.[9] The National AIDS Commission in Malawi being the coordinating body of all issues related to HIV and AIDS in Malawi adopted and highly recommended HTC as an excellent approach to preventing further spread of the HIV in Malawi. [3] There is strong evidence provided through several studies done in Kenya, Tanzania and Trinidad by Family Health International and UNAIDS that HTC is both effective and cost-effective as a strategy for facilitating behaviour change and also an important entry point for HIV and AIDS prevention, care, support and treatment.[10]

1.3 Literature Review

Different studies carried out so far have shown that despite these beneficial facts on HTC and its importance in HIV and AIDS prevention, a lot of people do not utilise the service. According to the monitoring and evaluation report from National AIDS Commission of 2004, 90% of Sexually Active Population in Malawi do not know their sero-status despite all efforts by the government of Malawi, donors and Non governmental support on VCT programs. [2] Another study done in the United Kingdom concurs with this saying that an estimated 80% of people living in middle income countries do not know their sero-status mostly because they have not gone for Testing. The study states that a recent survey in Sub Saharan Africa showed on

average 12% of men and only 10% of women have been tested for HIV and received their results. [11]

HTC is a valuable component of a comprehensive HIV and AIDS program among international organizations including the National AIDS Programs for many countries. There is a strong political will by the Malawi government in the fight of the HIV and AIDS pandemic, economic injustice and poverty. For this reason HTC services are free in Malawi with free first line antiretroviral treatment rolling at an encouraging rate for all eligible persons through all government, CHAM and selected Private Hospitals. [4] Most of these drugs are funded through the Global fund initiative, WHO and the government of Malawi through the coordination of National AIDS Commission. [3] HTC centres have the potential to provide HIV-positive people with information on how to manage their condition, avoid infecting others and plan for the future. The National AIDS Commission (NAC) in Malawi identified HTC as a strategy for containing the spread of new HIV infections and reversing the epidemic. [3] This shows that there is need for Malawians to be encouraged to go for HTC, know their status and act accordingly in order to have the epidemic halted or reduced.

While the low uptake of HTC Services can be explained by people's attitudes towards testing, the other factors could be related to the HTC Counseling Centres, the Counseling procedure and the Counselors leading to institutional challenges of the Service. The 2004 Global report on HIV and AIDS in Malawi says one of the

reasons for this low uptake of HTC service at the centres is shortage of health worker staff. Some clients fail to access the required service due to lack of health personnel to attend to them. [12] This concurs with the results of a survey conducted by the Management Sciences for Health (MSH) in 2004 where it was identified that, 40 percent of the Ministry of Health and population (MOH) positions were vacant. [13] Inadequate compensation, benefits and incentives, a shortage of qualified instructors in teaching institutions, and an exodus of skilled workers to other countries have all contributed to the shortage of health workers. VCT providers and Counselors are equally affected by this shortage. [13]

In response, MOH/MSH Malawi recruited and trained 16 full-time VCT Counselors (two for each participating focus district). Equipment and furniture was provided to the VCT centres in all the eight focus districts, enabling Counselors to perform rapid HIV testing and Counseling in the same room. The waiting time for HIV/AIDS test results decreased from several days to less than 15minutes by using the rapid test kits. This strategy led to the number of clients increasing rapidly from about 6,000 in the last quarter of 2004, to more than 13,000 during the first quarter of 2005 following the re-organization and strengthening of VCT services. [5, 13] Although this increase seemed impressive, the reported data indicate that only 6.9% of males and females aged over 15 years have undergone HIV Counseling and testing since 2001 yet the HIV prevalence rate ranges from 14 % to 23.5 % in the rural and urban respectively. [3] With an average prevalence of 14.4% according to 2004 sentinel surveys. [2] Even considering that some women undergo VCT as part

of Prevention of Mother to Child Transmission (PMTCT) and that some people might have undergone VCT prior to 2001, the proportion of people who have undergone VCT is still considered very low. This is an enormous obstacle that Malawi has to overcome over the next few years recognizing that VCT is an entry point for HIV and AIDS care and support, and a crucial undertaking that has a strong bearing on HIV prevention. [5, 13]

No document is currently available on perceived obstacles faced by VCT centres under Non Governmental Organizations (NGOs).

CHAPTER TWO: OBJECTIVES

4.1 Broad Objective

The aim of the study was to assess challenges faced by registered HTC Centres in Lilongwe District in the provision of HIV Testing and Counselling services.

4.2 Specific objectives.

1. To survey the situation of HTC Centres in Lilongwe
2. To explore human resource challenges in the provision of HTC services in Lilongwe
3. To explore institutional and governance challenges in the provision of HTC services in Lilongwe
4. To explore the perceptions of community leaders on HTC services in their areas in Lilongwe
5. To make recommendations basing on findings of the survey.

CHAPTER THREE: METHODOLOGY

3.1 Study Design

The study used both quantitative and qualitative methods to capture complimentary data on the topic. The quantitative method deployed a structured questionnaire designed by the researcher to assess infrastructures, staffing, resource mobilization and Centre patronage. Quota sampling was used during the quantitative data collection. The study deployed quota sampling because proper sampling framework was not easy as staff patronage differed from centre to centre. Quota sampling was therefore the most convenient bearing in mind that results from quota sampling are always within the 95% Confident intervals just as many sampling methods.[14]

Qualitative data was captured through Focus Group Discussions. The study developed a checklist of some questions that were used to entice the free flow of the discussion on the topic of interest. Four Focus Group Discussions were conducted in selected areas where the HTC Centres are located.

3.2 Sampling and data collection

Ten HTC Centres were randomly selected from the Lilongwe list of registered HTC centres. Six questionnaires were administered to staff members of each of the selected HTC Centres with a priority given to Counselors, then other staff including Clinical Officers and Nurses at the Centres.

The study administered half a day training session to explain and clarify the questionnaires to participants at each centre. This training served as a data quality and clarity measure tool since the questionnaires were self administered by the participants.

The Focus Group Discussion participants comprised of traditional leaders, political leaders, chiefs and other influential community leaders that included bottle store owners in one of the conducted Focus Groups. Anticipated limitation for the quantitative method was that the questionnaires were self administered and this could have created subjectivity in the responses. This was provided by the half day training that the study conducted for all participants in their centres for data quality and clarity. The study also deliberately adopted the qualitative component so that it could compliment and improve the quantitative data results.

The quantitative data was analyzed using Statistical Package for Social Sciences (SPSS).The data was entered and cleaned with assistance form a social scientist and statistician. Analysis was done by cross tabulation of relevant data to make sense of the findings. The qualitative data was analyzed using N6 Package, QSR 6th Version and content analysis. QSR N6 was earlier known as NUD*IST, an acronym for the accurate description of Non-numerical Unstructured Data Indexing Searching and Theorizing. It was designed in early 1980's by Tom Richards a qualitative data scientist. It is a way of coding data using three complimentary sets of coders, text and node searchers. [15]

For purposes of analysis the qualitative data was transcribed and coded into themes according to emerging information. The results revealed from both the qualitative data and the quantitative data were concurrently reported in the study.

3.3 Place of study

The following Table 1 is a representation of name, area and type of HTC/VCT Centre where the study was conducted.

Name of HTC/VCT Centre	**AREA**	**Type of Centre**
Area 18	Urban	Governmental
Area 25	Urban	Governmental
Chitedze	Rural	Governmental
Kawale	Urban	Governmental
Kamphata Youth Centre	Rural	Non-governmental
Lumbadzi	Rural	Governmental
Malawi AIDS Counseling and Resource Organization	Urban	Non governmental
Mlale Mission	Rural	CHAM
Save Our Souls	Urban	Non-governmental
Word Alive Ministries	Rural	Faith based

3.4 Ethical considerations

Data for the study was collected quantitatively through the health workers and qualitatively through community influential leaders. The District Health officer for Lilongwe approved the study and gave a letter of authorization to all parties involved in the study.

A consent form was also designed by the researcher and read to all respondents for their consent to take part in the study. All participants were assured of anonymous reporting for the survey.

CHAPTER FOUR: FINDINGS

4.1 Introduction

The quantitative component of the study which was collected using a structured questionnaire was analyzed using cross tabulations and frequency tables. Narrative descriptions were also attached to the analysis.

The qualitative component was collected through focus group discussions using a checklist of questions to entice free flow of discussion. The checklist was initially designed by the researcher and some input came from the quantitative component. This was done so that gaps observed from the quantitative component could be captured from the qualitative component. Analysis for the qualitative data was done using QSR N6 package and content analysis.

The qualitative data was collected through Focus Group discussions and observation. A total of four focus group discussions were convened. These focus groups were derived from both the rural and urban setting with two groups convened respectively. The Focus groups were composed of leaders mainly chiefs, area political leaders and village health committee members. Each of the four focus groups was attended by twelve leaders disaggregated by gender. The aim of the FGDs was to find out in-depth knowledge of the community leaders on challenges of HIV testing and Counseling Centres in their areas. The data was collected through a moderator who guided the Focus group, a transcriber who collected hand written notes. An observer captured non verbal communication and recorded back

up verbal communication through a tape recorder. This chapter will discuss the results from both the quantitative and qualitative components.

4.2 Knowledge Of HIV Testing And Counseling

A majority of the respondents in the focus groups responded that their first information on HIV testing and counseling was through health facility and the radio. A few respondents commended religious gatherings and community sensitization as being their first and more applaud method of getting information. Dramas and traditional dances with HIV and AIDS related messages were ranked third by the respondents. Such activities had direct links to organizations that are involved including the health education band and Family Planning Association of Malawi.

Despite having the knowledge, the study revealed that people do not take the *"know your status"* message seriously. A few respondents commented that they do not look at HTC as a dire need since HIV Infection is not an emergency. One of the respondents said, "*I do not think someone can just wake up one day and look for transport or a bicycle just to go for HIV testing in town; there must be a good reason. However I have seen a lot of people borrowing transport money or bicycles to seek medical care at the hospitals in town. Looking at this I guess HIV testing is not looked at as an emergency by many people. In my area people actually wait for the mobile VCT service that comes every 3 months to test."*

4.3 Type And Proximity Of Infrastructure.

A majority of the respondents agreed they have at least one HIV testing and counseling Centres at a maximum of 5 km radius as expected by the essential health package standards of the Ministry of Health. However there was a concern from many respondents on attitude problems of some health workers/ counselors at their nearest HIV Testing Centres. The respondents expressed concern in issues that included lack of privacy and confidentiality as they have ever heard from friends of their proximal counselors talking about their sero positive status when they have not revealed their status. On this issue a majority of the respondents said they prefer to use HIV testing Centres that are far and with counselors that are not familiar to them for increased confidentiality.

On a positive note few respondents said they prefer to use other centres despite distance due to availability of more services on HIV. This was further attributed to the presence of services like Prevention of Mother to Child Transmission (PMTCT), CD4 count and provision of Antiretroviral Therapy that are not available at the nearest centres.

Many respondents also expressed concern on type of infrastructure present at their nearest HIV testing Centres. This includes but was not limited to the use of temporary buildings by some VCT centres. The respondents said permanent building motivate clients to test that the temporary ones.

The findings also revealed different percentages on the type of infrastructures for the VCT centres using SPSS and cross tabulation of type of HTC Centre vs. type of infrastructure. The results showed that the government had the highest permanent VCT centres with a representation of 47.8% from all the sampled centres. This was seconded by the non governmental centres that scored 34.8 %. CHAM and the faith based facilities were the lowest with 8.7 % each. The results also revealed that the government centres were the highest on semi-permanent VCT centres with 76.9%. The Non governmental centres revealed 11.5% while CHAM revealed 7.7 %.The faith based centres scored the lowest with a 3.8%.

Table 2 shows the type of infrastructure versus type of facility and the percentages according to sample size of the survey and counts of responses.

Type of infrastructure is the VCT centre * Type of VCT facility Crosstabulation

			Type of VCT facility				
			Goverment	Non-Governmental	CHAM	Faith Based Organisation	Total
Type of infrastructure is the VCT centre	Permanent	Count	11	8	2	2	23
		% within Type of infrastructure is the VCT centre	47.8%	34.8%	8.7%	8.7%	100.0%
		% within Type of VCT facility	35.5%	61.5%	50.0%	66.7%	45.1%
	Sei-permanent	Count	20	3	2	1	26
		% within Type of infrastructure is the VCT centre	76.9%	11.5%	7.7%	3.8%	100.0%
		% within Type of VCT facility	64.5%	23.1%	50.0%	33.3%	51.0%
	Temporary	Count		2			2
		% within Type of infrastructure is the VCT centre		100.0%			100.0%
		% within Type of VCT facility		15.4%			3.9%
Total		Count	31	13	4	3	51
		% within Type of infrastructure is the VCT centre	60.8%	25.5%	7.8%	5.9%	100.0%
		% within Type of VCT facility	100.0%	100.0%	100.0%	100.0%	100.0%

The study also looked at the infrastructures in terms current situation existence. The results revealed that 80.4% of the sampled centres were integrated into existing health facility that included hospitals in many cases. The study also found 11.8%free standing centres and at least 7.8 % of the sampled centres were considered mobile.

Tables 3 and 4 below show the Service Structures of the Centres and their conduciveness in percentages and cumulative percentages. Table 5 shows a Cross tabulation of the service Structures and conduciveness of the Centres according to total counts of the respondents.

TABLE 3 CURRENT SITUATION OF EXISTENCE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Integrated	41	80.4	80.4	80.4
	Free standing	6	11.8	11.8	92.2
	Mobile or outreach	4	7.8	7.8	100.0
	Total	51	100.0	100.0	

Table 4: How conducive are the VCT rooms

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very conducive	11	21.6	21.6	21.6
	Conducive	28	54.9	54.9	76.5
	Non conducive	12	23.5	23.5	100.0
	Total	51	100.0	100.0	

Table 5: The current service structure * How conducive are the VCT rooms Cross tabulation

Count

		How conducive are the VCT rooms			Total
		Very conducive	Conducive	Non conducive	
What is the current service structure	Integrated	6	23	12	41
	Free standing	5	1	0	6
	Mobile or outreach	0	4	0	4
Total		11	28	12	51

The study explored on conduciveness of the VCT centres. Many reasons were revealed on non- conduciveness rather than the conduciveness component. These reasons ranged from problems with the institution to the counseling procedure itself. The highly evident reason with 50 % was perceived lack of privacy and confidentiality due to integration. The qualitative data supported this idea by a majority of the respondent saying they would really appreciate if the VCT centres were stand alone instead of being integrated. The majority explained that they believed their VCT centres were very good in terms of service provision. However their greatest concern was that in most cases the entrance and exit foyers are the same for VCT and OPD services in the integrated centres. On this a concern was raised that even if the service provider are confidential in their provision, other clients cry when coming out of the VCT rooms. This therefore breaks sense of privacy since people at the OPD foyers will suspect HIV positive result for him/her.

The study also revealed lack of enough counseling space was a concern on non conduciveness with a 30% representation. This was reiterated to the same integration of the VCT centres according to the qualitative data.

The final 20% was due to lack of equipment including reagents and test kits. This was also revealed by the qualitative component when a few clients claimed that they had not yet tested for HIV since they were returned on the day they wanted to test. One of the clients said, *"one day I and my spouse left for the VCT centre to get an HIV test. We were received well and had a group counseling session completed within the next one hour. However we were really disappointed after waiting for*

another hour that the reagents were not available and we had to come back the next day to find out if reagents had come. We never returned till today."

This shows that lack of equipment including reagents makes some centres non-conducive and it is an inconvenience to clients

The frequencies of responses on reasons for non conduciveness are pasted in Figure 1 below showing the frequency of responses on non conduciveness of the Centres.

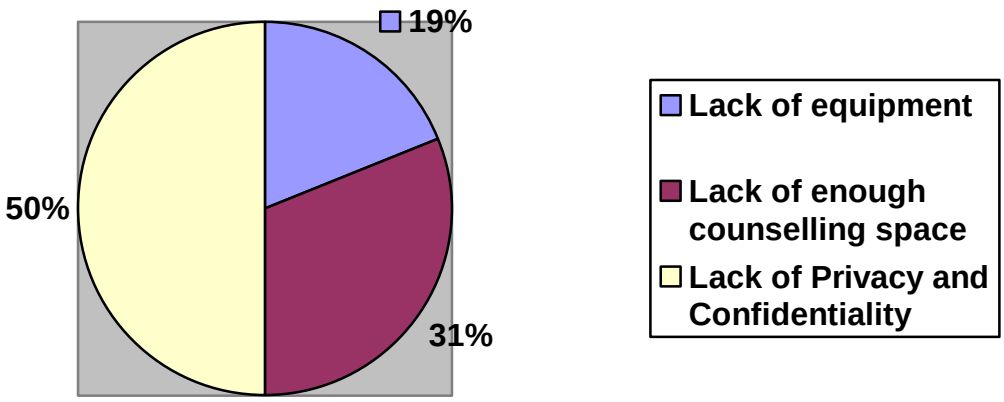

Figure 1: Frequencies of reasons for Non Conduciveness.

4.4 Quality of Services at the Centres

A majority of the respondents commended the VCT centres by describing them as good and organized. A few respondents claimed of bad attitude by some counselors which was attributed to personal behaviour. The group said due to other issues including cultural back ground, up bringing and life skills some people can still be rude and have uncalled for behaviour.

However a few respondents where mobile VCT services are run right in the communities were concerned. Their main problem was that in most cases the service is usually run at the chief' house or school blocks. One chief from such area said, *"I think this draws back some potential VCT clients from accessing the service by the virtue of being a house of a chief. Here the issue of culture and extreme respect for me as the chief plays a great role in people shunning the service."*

The respondents further said the mobile VCT centre usually finishes in the afternoon at 1 pm. This is also perceived as a draw back as some clients may have no access by the time the clinic has closed. During another focus group it was revealed by a majority that their counseling centre had one front desk for both welcome counseling talks as well as initial questioning of clients before they get into the counseling room. The desk is placed right at the reception where other client watch TV whilst the one that has reached the queue is being asked some pre-

counseling questions just near by. "*There isn't even a screen at this front desk."* lamented one village health committee member. A few respondents said despite the fact that privacy and confidentiality is a shred responsibility, they would prefer to get an HIV test in total privacy.

A few other respondents claimed they do not see to it as proper to get tested for HIV from a person who is popular to them. One respondent said "*Imagine if you met your counselor at the market or somewhere around wont he reveals your status to friends or partners? The nature of human being is very difficult and can easily break promises. It is better if one really wants total privacy and confidentiality to get the test away from their nearest VCT Centre. Another way would be swapping the counselors or service provider from time to time."*

On a similar note a majority of respondent commended the National HTC/VCT week was better than normal/routine testing. The good news was that the counselors that came to do the testing week were all new and visiting. This gave people morale and encouragement to go for testing knowing they might never meet again even if they tested positive.

4.5 Resource availability at the Centres

A majority of the respondents explained that they always have enough resources at their centres in terms of reagents and test kits. However a few respondents claimed they were very unhappy about their VCT centres that keep running out of stock for reagents. This group said sometimes resources are not available to the extent that they have seen clients returned without getting tested to wait for new orders of reagents.

All the respondents of the focus group agreed on shortage of counseling and testing staff at their Centres. Other centres went to the point of explaining that at their centre there is only one counselor which is very irrational according to its catchments area and expected number of clients to the centre per day/month. This was also expressed considering demand for the service that varies from time to time sometimes due to community sensitization or radio messages. A few other respondents said they have 2 counselors but sometimes depend on volunteers from near by churches to assist in counseling services.

4.6 Service acceptability and clients' turn up.

The study revealed quantitatively that the stand alone centres were more acceptable than the integrated centres. This was confirmed by the number of clients attending the stand alone centres as compared to the integrated centres. Among other things, respondents commended the stand alone centres for having larger scales of post test clubs. People who test positive at stand alone centres were said to be better linked

to such clubs that in the integrated centres. The post test clubs were commended for positive living messages and also encouraging other clients to test.

Seconding the stand alone centres on acceptability were the faith based counseling centres. Some of the reasons that run together with faith based counseling centres recommendation included;

- Friendliness of their counselors
- Provision of encouraging tracks and books on positive living
- Well organized follow ups on clients who test positive.

On this point, the Word alive counseling centres even carried more weight because its front desk has a television set, a radio cassette and sometimes show dramas on HIV and AID issues. One of the respondents said "*This is some form of entertainment for clients in rural areas like us. When we go back home and tell our friends about this entertainment and more people come for the service. It's a way that has encouraged many to come and test."*

Long waiting time and decreased privacy were reasons that the respondent gave for low acceptability at the integrated centres which mostly include the government centres.

Monthly expected number of clients that patronize the HTC Centres ranged from a minimum of 100 clients in the integrated Centres up to 1600 clients in the free standing Centres. However actual numbers patronizing the Centres during the month of survey ranged from 85-1700 in the integrated and free standing Centres respectively.

4.7 Suggestions to improve on client turn up.

A majority of the respondents recommended increased sensitization as the main method to improve client turn up. Other responses were; the need to improve Counseling rooms, improve client motivation and train more Counseling staffs as illustrated in Figure 2 below.

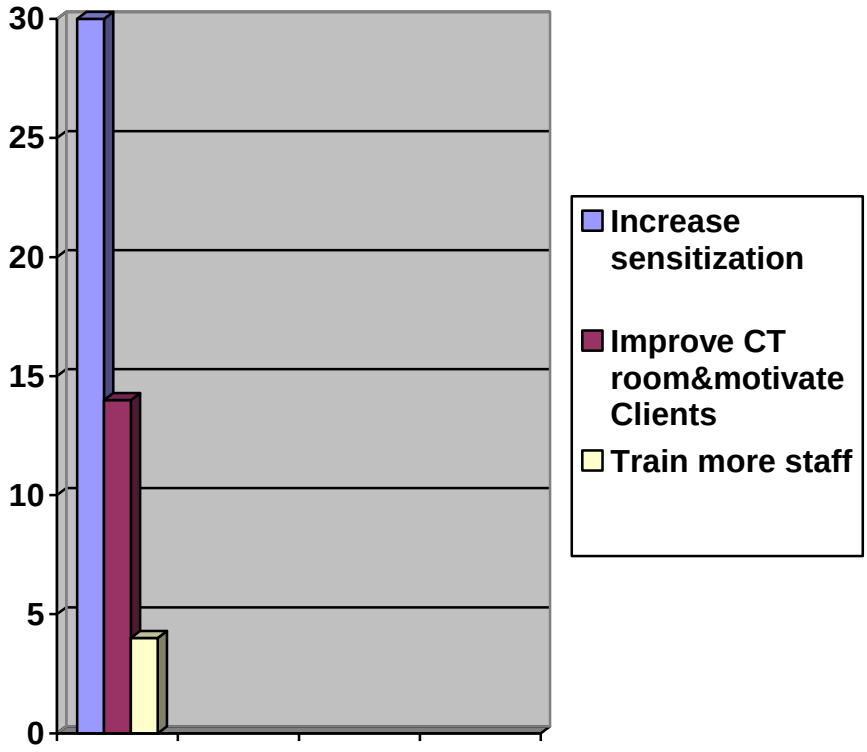

Figure 2: How to improve Client Turn up at the HTC/VCT Centres

4.8 Actual and expected number of trained counselors at each centre.

The study also explored the number of trained counselors available at each set centre versus the expected number of counselors that would provide quality service. It was revealed that the numbers ranged from 2-15 with lowest number found at the integrated Centres and the highest at the free standing Centres. The findings revealed a 30% of the centres having a maximum of two counselors. 20% had three counselors with 40% having four counselors. Only 10% of the studied centres had counselors had more than 4 counselors. The respondents were also asked on what they thought was the average required number of Counselors at each Centre to provide effective and efficient Service. On recommendation, the respondents said five trained counselors would be the most feasible number per center for effective counseling services.

4.9 Counselor and client ratio and their impact

The study revealed that the counselor: client ratio was poor. This was confirmed with at total of 39.2% respondents reporting that they were once returned from their most proximal counseling centres due to in-availability of the counselors. Another high percentage of 45.1% reported that they were also once returned from their proximal counseling centres due to counselor burn out that includes issues of giving clients another date of appointment because the counselor is exhausted. The results show that a very small percentage of only 14.7% having not experienced the

problem. The finding revealed staff burn out as the main reason for client return on shortage of staff perspective due to work overload. Other reasons were;

- Misunderstanding among staffs leading to low staff morale and
- Having many responsibilities to be carried out by a single health worker on top of the counseling sessions themselves.

Table 6 below shows a cross tabulation between clients return due to shortage of staff and reagents for testing as main part of equipment.

Table 6: Have clients ever returned because of counseling staff shortage * Have clients ever returned due to lack of reagents for testing Cross tabulation

Count

		Have clients ever returned due to lack of reagents for testing		Total
		Yes	No	
Have clients ever returned because of counseling staff shortage	Yes	7	13	20
	No	16	14	30
Total		23	27	50

4.10 Impact of 2006 HTC week and recommendations for HTC services in Malawi.

The study also revealed that 100% of respondents recommended the Malawi VCT week of 2006 as having a great impact with high turn out of clients for VCT and also increased awareness of HIV & AIDS issues by people of all walks of life in Malawi.

Figure 3 below show the respondents' recommendations to improve and uphold VCT services so that HIV Testing becomes universally accepted and improved for Malawi. The reasons ranged from increasing trained Counselors to improvement of privacy and confidentiality.

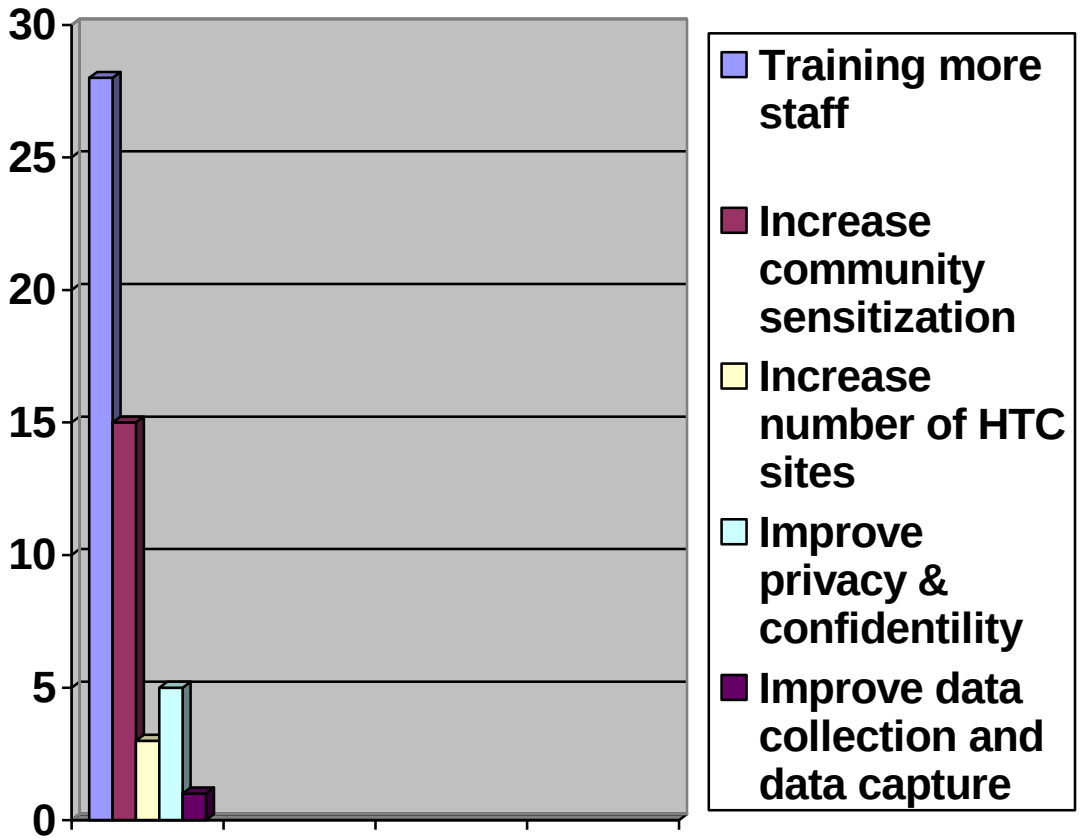

Figure 3: How to improve HTC/VCT Services in Malawi

4.11 Other barriers to HTC

There was an overwhelming agreement by a majority of the respondents that they find the greatest barrier of getting tested as fear. There is a great fear among people when it comes to HIV Testing. One respondent said; "*the greatest is fear of being found positive. I am sure every person by the time she /he is going for a test has exposed herself/himself to at least one method of contracting the virus. There is extreme fear of being found HIV positive. This is despite the hope that includes positive living after testing.*"

A few respondents said they believe that people do not really see the importance of getting tested as it takes a very long time before being put on Anti retroviral treatment (ARV). One of the respondents said *"He knew of some clients that were referred for testing by himself as a village health committee member. They tested positive and waited for a long time for CD4 count results from our VCT centre. Two of them died after 3 months of unsuccessful visits to the VCT centre for the CD4 results. This discouraged a lot of the clients in my area to test.*

Few respondents claimed they had problems with how some counselors break the news to clients. One client narrated her story that there was a time she escorted her sister for a test. Fortunately she tested negative. And the counselor just told her "*you are negative, you can go. This did not impress my sister as she expected at*

least some post counseling." If counselors can dismiss a negative case; can he encourage a positive case?" She lamented.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter presents the discussion of the findings from the study as conducted in the 10 selected VCT centres of Lilongwe. The discussion will focus on the themes identified during the data analysis of both the quantitative and qualitative components that formed the study.

There are indications from the data that VCT in Malawi is provided through four main channels. These are the government institutions, Christian health association of Malawi (CHAM), Non governmental organizations (NGOs) and Faith Based Organizations (FBOs). These VCT services are provided through the integrated, free standing (stand alone) and outreach service. The actual locations of the services were rural and urban with most of the centres present in the communities and only one centre was present in the commercial part of the city.

The study revealed that most clients and the communities got their first information through the radio and at the facility. This concurs with the results as evident in the Malawi Demographic and Health Survey that most communities rely on radio for health messages. [1]

The study also revealed lack of seriousness by the community members on getting an HIV test. People do not take the Know your status messages seriously. It was also mentioned in the findings that people priotise other health issues than going for an HIV test. This concurs with the behavioural change initiative survey by the

National AIDS Commission where it was reported that people have not yet conceived in their minds and behaviour the benefits of HIV testing.

It was very evident from the findings that type of VCT centre and proximity of these centres also plays a great role in encouraging people to go for a test. People from the urban areas commended the government for placing their VCT centres at reasonable distances of at least 5km radius. However there was a great outcry by a majority that most people prefer to use VCT centres that are not near there places of stay despite distance. It was discovered that other clients do not only consider proximity but other issues including number of services provided, type infrastructure and the nature of counselors as recommended by the communities.

The other thing that also was evident from the data both quantitative and qualitative was that those people in the urban areas are well served. They have wide range of providers to choose from depending on personal conviction. On the contrary the rural masses have their centres far apart. This puts rural people at a disadvantage of accessing the test as wished. The findings even narrated of having to wait for the only mobile VCT service that comes once in 3 months to get a test. Issues of poverty here as well ignorance plays a role in health seeking behaviour. This concurs with statements in primary health care and poverty book about the complex interrelation between poverty and AIDS. [16] Poverty, in its many and diverse aspects and with its many and diverse consequences, creates a fertile breeding ground for the expansion of HIV and AIDS. [16] In turn, HIV and AIDS,

for its mode of transmission and its epidemiological features, badly affect the livelihood of its victims, their families, their entire communities and countries. Lack of accessible testing centres for the rural mass in Lilongwe therefore puts the rural and poverty stricken communities at a higher risk of HIV Infection since people keep infecting each other due to lack of knowledge of their status. This as stated earlier combined with ignorance of their HIV status may lead to increase infection among each other unknowingly. Murru concludes by saying that the fight against HIV/AIDS is the fight against poverty and health service inequality. [16]

In pursuit of VCT service the data indicates that clients look at proximity of the centre and accessibility of services to utilize the service on an increased basis. For example there are some areas where people are situated within the proximity of at least 3 VCT centres and their choices were purely influenced by factors beyond proximity but rather the quality of service provided at the centre. This was evident by clients expressing that their choice of VCT centre also look at the number of services provided at the centre including PMTCT and ARV therapy. While on the other hand there are some areas where community members due to distance to alternative provider they have to do with the locally available service irrespective of whether it is an integrated, free standing or an outreach centre. At such point people would just access the available service without considering issues of quality of service, behaviour of counselors and other considerations. This concurs with the previously revealed consequences of being economically able or not. The

economically able people who are interested to get a test have a wide choice than the poor people.

In Malawi there is a strong reliance on Public Health Sector service provisions. This was also clearly confirmed by the findings of this study where it was quite evident that most VCT centres that were easily accessed were the government VCT centres. However the draw back lied in that all these VCT centres were usually integrated in already existing Health facilities. For this reason, although the Public Sector VCT centres are usually proximal, the worrisome situation is that there is low turn up of clients as compared to the number of clients that go to the free standing services. All the free standing VCT centres are Non governmental in nature and sometime statutory. The respondents reiterated integration of the infrastructures to lack of confidentiality due to most VCT rooms being inconveniently located. The results further claims of small counseling spaces that in turn reduce the reasonably expected privacy and confidentiality by clients.

On the other hand the issue of lack of enough equipment including reagents and test kits was also highly evident in the integrated centres. Some clients reported of ever being returned from a centre due to lack of equipment.

A majority of the respondent also expressed concerns on the attitude of some service providers. This acclaimed to clients requiring empathy from the VCT providers. This was more evident in the qualitative component of the research with

a few members saying they actually tested in other centre whilst running away from attitude problems.

It has to be acknowledged here that the likelihood of space being a problem is inevitable in the integrated HTC centres. The space problem is high considering that VCT facilities were incorporated in to these Health Centres long after the health facilities were established. Thus it would be difficult for other health centres to have a secluded place for the provision of VCT services.

Quality and quantity of the VCT providers play a great role in the issue of provider attitude. The findings from the data indicate that there are a maximum of 2 VCT providers against high expected number of clients of a maximum of 1600 per month. Considering the skill and time required for each counseling session to take place, from pre-counseling, carrying out of the test and post-counseling, there is need to increase the number of providers. The study recommended a minimum of 4 providers per centre for the integrated centres that have a lower expectation of clients and as high as 20 in the free standing centres. This then takes the issue further to looking at the counselor and client ratio and its impact on service delivery. The findings revealed 40% of the respondents saying know of clients being turned back due to unavailability of counselors at the centres. The issue was even expressed further talking the component of staff burn out. This concurs with the VCT guidelines which explains that counseling involve the entire human being in body and soul. When providers are experiencing burn out, empathy reduces and so does the skill to deliver the wholesome counseling session. The finding also found increased workload as the most evident and critical reason for the staff burn out. This concurs with Romero J. [17] in his book on commitment, walking the

extra mile to expand access to VCT. [17] In his book he said developing health care personnel commitment beyond their normal working duties to take on new responsibilities in unfavorable work environments and with no extra compensations is a challenge for an expanded response to VCT services. He continues to say little attention has been paid so far to enhance the abilities of health care workers to take on the added workload and emotional stress for HIV and AIDS issues. He continues to state that VCT services as the port of entry to comprehensive health care for PLWHA should indeed be comprehensively tackled by counselors. [18]

The findings also revealed an issue of some people who do not look at VCT as priority health issue. Surprisingly the findings further revealed that this is irrespective of wide range of sources of information and increased knowledge of HIV Prevention methods. This concurs with what the Monitoring and evaluation report of 2005 by the National AIDS Commission that knowledge do not necessarily translate to behaviour change.[3] The Behaviour Change Strategy also expresses a similar note where it says the presence of Knowledge alone does not change behaviour of clients on HIV and AIDS issues. VCT is a great component of Behavioural Change as it assists the client to make an informed choice on HIV infection prevention or further spread of the Virus hence the need to work it out through human behaviour.

A majority of the respondents also explained through the data that there is a gap between a positive result and a client being enrolled on life prolonging ARVs. This

is due to the fact that most centres that provide VCT do not do CD4 count, one most reliable criteria of starting HIV positive people on ARVs. It was revealed that most of the times clients are referred to a secondary centre usually the Lighthouse at either Lilongwe Central or the Bwaila hospitals. The ensuing worry is that community members are aware of people that died while waiting to be enrolled on the ARVs and this has drawn back some prospective VCT clients.

The other result that was strong in the data was that community members were optimistic about the strides that are made during VCT National Testing Week. This means that it is worthwhile for Programme providers to strengthen on the recommendations that come from this finding. As the findings stand, having a great number of counselors and moving counselors to areas that they are less known to the community members has increased buy in by VCT clients.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study aimed at assessing challenges faced in the Provision of Voluntary Counseling and Testing in registered Centres of Lilongwe District by surveying institutional situations, human resources challenges and explores community leaders' perceptions on HTC Centres in Lilongwe.

Voluntary Counseling and Testing is a pivotal strategic approach to HIV and AIDS prevention and is the corner stone that enables a person to confidentially explore and understand his or her risk of HIV infection. Voluntary Counselling is highly commendable because a majority of adult populations are HIV negative worldwide even in high prevalence settings. Knowing one is negative can serve as a strong motivation factor to remain negative, particularly for those who may otherwise assume its too late to adopt safer sexual practices.[18]

On the other hand by knowing one's positive status, HIV positive individuals may become more motivated to adopt a more healthy lifestyle that improves their health status and slow progression from infection to full blown AIDS.[18]

The researcher used both quantitative and qualitative methods to capture complimentary data on the topic through self administered structured questionnaire to health workers and counselors and focus group discussion with community influential leaders respectively.

The results of the study clearly indicate that access to VCT service plays a big role in people accepting and utilizing the service better. This was proved through both qualitative and quantitative data. People in urban areas have a greater advantage than

those of the rural areas in terms of both accessibility and permanency of infrastructures. Recommendations for the government are to look into permanency of infrastructure, train more counselors and sensitize communities.

The HTC week as conducted by the UNFPA was also well commended. The study suggests that it should become an annual event. This concurs with what the HIV theme group agreed in June 2007, to make the VCT/HTC week an annual event in order to meet the Millennium Development Goals targets on HIV and AIDS.

6.2 Recommendations

The government is the overall manager and custodian for all health issues. These recommendations are therefore mainly addressed to the government and all the relevant developmental partners in issues of HIV prevention in Malawi being one of the response areas. The government always involves necessary developmental partners in the fight against HIV and AIDS since it is a cross cutting issue that requires multisectoral and multitalented approach. These recommendations therefore will assist the relevant authorities in putting in place measures of tackling the surfaced obstacles through forms of policy documents and targeted Programme intervention.

The study therefore recommends the following points:

1. The government should consider constructing more permanent structures. According to respondents suggestions this would lead to improved client turn up for the service as permanent infrastructures themselves are a motivator for client turn up. The survey found out that only 47.8% of all the government centres studied were operating from permanent infrastructures.
2. The government should focus more on constructing free standing infrastructures to provide the service as the integrated structures are usually shunned by clients due to issue that include in-conduciveness. The respondents said privacy and confidentiality is compromised at most integrated centres. This came out more through the qualitative data collection where respondents complained that some VCT centres have same entry for out patient departments (OPD) and VCT which discourages clients from testing. If the infrastructures are free standing then

whosoever is going there definitely is going for a test or escorting a partner/ friend testing. The respondents said this would lead to no/reduced questioning than if some OPD patients who know you start murmuring or commenting about you visiting the VCT room.

3. The government should consider revisiting the issue of space for counseling rooms. This recommendation came because it is not possible for all areas to have free standing centres built in a short time meaning other clients would continue using the integrated but improved VCT centres.
4. The government needs to increase sensitization as it was ranked the highest need in improving client turn up. The respondents suggested that this would be done mainly through the radio and post test clubs. It was clearly picked through the focus groups that especially the youth who have gone through the test (regardless of result that whether positive or negative) should be encouraged to educate and sensitize their fellow youths in the communities to test. The respondents said this is the only way to ensure an HIV free generation. It was further requested by the respondents that the provision of kind of transport like bicycles for community education and sensitization would be even more encouraging to these post test club volunteers. Sensitization would also assist reducing the questioning and murmuring of other OPD patients in integrated centres as everyone would be in a position to clearly picture the importance of VCT.
5. The government should increase the number of trained counselors. The recommended number of trained counselor per HTC Centre as suggested by the respondents was a minimum of 4 fulltime qualified counselors per centre. This

would in turn improve the type of service rendered and offer clients greater opportunity to express themselves without being rushed through due to time. It would also improve on the issue of provider attitudes that is sometimes cause by staff burn out and exhaustion.

6. The government should also intensify on data collection and data capture skills. This would assist in meeting the expected targets of VCT better. Malawi is currently using 130,000 people tested by 2010. Improved data capture would help the government to know who the first testers are and who repeat testers are so that the target can be reached without compromise.
7. The government should ensure uninterrupted supply of VCT equipment which include reagents and test kits.
8. The government should ensure regular monitoring and evaluation of the VCT Programme to assure quality and effectiveness of the service.
9. Community participation in the VCT services should be encouraged. Communities would assist in building a new VCT centre in their area through provision of local materials like bricks. This would ensure improved accessibility to the VCT service especially in the rural areas.
10. The government should emphasize on empathy and passion as a requirement for all counselors undertaking training.

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APPENDIXES

APPENDIX 1: STRUCTURED QUESTIONNAIRE

Challenges for the Provision of Voluntary Counselling and Testing in Registered Counselling Centres of Lilongwe

Chapter 1: CENTRE IDENTIFICATION

1. Name of VCT centre…….

2. Type of VCT centre

Government ☐

Non-Governmental ☐

Other specify _____

3. Area of VCT centre

Urban ☐

Rural ☐

4. Respondent's occupation at the VCT centre

……
……
……
…….....

Chapter 2: INFRASTRUCTURE QUESTIONS

5. What type of infrastructure is the VCT centre?

a. Permanent ☐
b. Semi-permanent ☐
c. Temporary ☐

6. What is the current service structure?

a. Integrated ☐
b. Free standing ☐
c. Mobile or outreach ☐

8. How conducive are the VCT rooms

a. Very conducive ☐
b. Conducive ☐
c. Non conducive ☐

9. Explain, what makes you think your VCT centre is conducive?

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10. Explain, what makes you feel your VCT centre is non conducive?

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……

11. Do you think this VCT centre has adequate infrastructural equipment?

Yes ☐

No ☐

12. If no how would you like the situation to improve?

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……

13. In your opinion what makes adequate infrastructural equipment?

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……

14. What is your expected number of VCT visits per month?

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……
……

15. What is the actual number of people having VCT per month at this centre?

……

16. Any suggestions on improving the situation of client turn up at this centre?

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……
……

17. How many trained counselors do you have at your centre?
…….
…….
……
18. In your opinion, what is the average required number of trained counselors in order to provide adequate service to meet the demand from your population?
…….
……..
19. How many clients are seen by a single counselor per month?
……
……
……
20. How many trained counselors do you have at this centre?
……
……
21. Who trains/trained your counselors?
……
……
……

22. How long was the training?
……
……
……

23. What is the entry qualification for someone to be trained as a counselor?
……..
……..
24. Is the training in line with the National HIV policy?

Yes ☐

No ☐

Don't know ☐

25a. Have you ever had a situation where a client or clients were returned because of counseling staff shortage?

Yes ☐

No ☐

b. How often has this happened?

Very often ☐

Often ☐

Rarely ☐

Never ☐

26a.Do your counselors ever experience burn out?

Yes ☐

No ☐

Don't know ☐

b. If yes, explain the main cause of counselor burn out?

……
……
……
……
……
……

27. Who supplies the centre with testing kits and reagents?

……
……
……
……
……

28. How often does the supplier come to restore reagent stock or how often do you make reagents and test kits orders?

Very often ☐

Often ☐

Rarely ☐

29. Have you ever had a situation where a client or clients were returned due to lack of reagents for testing?

Yes ☐

No ☐

30. How often has this happened?

Very Often ☐

Often ☐

Rarely ☐

Never ☐

31. Do you always get your supplies on order?

Yes ☐

No ☐

32. The Malawi government implemented the National VCT week from 17- 22 July 2006: did this week have an impact on your service provision?

Yes ☐

No ☐

33. If yes; describe the impact made.

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……

34. If no why do you think it did not impact your service provision?
……
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……

35. What other requirements do you need to improve the VCT services at your centre?
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36. What are your suggestions on how Malawi as a country can improve its VCT services?

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Appendix 2: FOCUS GROUP DISCUSSIONS (ENGLISH)

Challenges for the Provision of Voluntary Counselling and Testing in Registered Counselling Centres of Lilongwe

QUESTION GUIDE FOR FOCUS GROUP DISCUSSIONS

INTRODUCTORY QUESTIONS

a) Have you ever heard of Voluntary Counselling and Testing (VCT)?
b) What is Voluntary Counselling and Testing (VCT)?
c) Do you have a VCT Centre(s) in your area?
   Hint: How many VCT Centres do they know?
d) What is the nearest VCT Centre in your area?

ASSESSMENT

e) You may have gone or not gone to the VCT Centre, based on what you know or have heard how do you perceive the services of your nearest VCT Centre in terms of
   - Confidentiality
   - Quality of service
   - Attitude of service providers
   - Availability of resources including reagents
   - Acceptability by clients
   - Accessibility by clients

UTILIZATION

f) What do you think is the utilization of the service in your area and why?
g) Do you think many people utilize the services? Why?

BARRIERS TO UTILIZATION

h) In your area what do you think would prevent people from utilizing these services?
i) Have you ever heard of a client being returned from the VCT Centre due to lack of

   - Staff to attend to them
   - Reagents to be used
   - Some equipment (To be used as prompts).

IMPROVING SERVICES

j) What do you think the VCT Centre can do to improve utilization of the services at the Centre?

Appendix 3: FOCUS GROUP DISCUSSION GUIDE (CHICHEWA)

Kufufuza za mavuto amene amapezeka pa nkhani yoyezetsa magazi kuti munthu adziwe ngati ali ndi kachilombo koyambitsa matenda a edzi kapena ayi mwakufuna kwake mmalo oyezetsera ovomerezeka ndi boma ku Lilongwe.

MALONJE

a. Kodi munayamba mwanvako za kuyezetsa magazi kuti munthu udziwe ngati uli ndi kachilombo koyambitsa matenda a edzi kapena ayi mwakufuna kwanu?

b. Ngati munanvako kodi kuyezetsa magazi mwakufuna kwako ndi chiyani?
c. Kodi mdera mwanu muno muli ndi malo amene mumakayezetsa magazi mwakufuna kwanu?
d. Nanga ngati alipo malowo alipo angati mdera muno?
e. Nanga ngati alipo, malo apafupi kwambiri dzina lake ndi chani?

KUFUFUZA ZA MALO

f. Mwina munapitako kapena simunapiteko kumalo oyezetsera magazi mwakufuna kwanu, koma kupyolera pazomwe munamva kapena pazomwe mukudziwa mungandiuze chiyani za malo oyezetsera magazi mwakufuna kwanu pa nkhani zokhudzana ndi
    - Kusunga chinsinsi
    - Dongosolo la kagwiridwe ka ntchito?
    - Khalidwe la ogwira ntchito
    - Kapezekedwe ka katundu ogwiritsa ntchito
    - Kavomerezedwe ka anthu ndi kulolera kwawo kuti azigwiritsa ntchito malowa.
    - Kafupikidwe ka ulendo wopita kumalo oyezetsera.

KUGWIRITSIDWE NTCHITO.

g. Mmene mukuganizira kodi kagwiritsidwe ntchito ka malo oyezetserako magazi mwakufuna kwa munthu nkotani? Kwambiri kapena pang'ono?
h. Nanga mukuganiza kuti anthu amagwiritsa ntchito malowo motero chifukwa chiyani?

ZOPINGA KAGWIRITSIDWE KA NTCHITO KA MALO OYEZETSERA MAGAZI

i. Kodi pali zopinga zilizonse zomwe zingapangitse kuti anthu asagwiritse bwino malo oyezetserako magazi a pafupi mdera lanu lino?

j. Kodi munayamba mwanvako munthu kapena anthu abwezedwa kumalo oyezetsera magazi chifukwa choti kulibe zinthu zina zoyenerera monga
    - Ogwira ntchito
    - Mankhwala ogwiritsa ntchito poyeza
    - Zida zina zoyenerera kugwiritsa ntchito poyeza magazi

KUKONZA MALO OYEZETSERA MAGAZI

k. Mmaganizo anu mukuona ngati oyang'anira malo oyezetsera magazi achite chiyani kuti ntchito yoyezetsa magazi iyende bwino?

Appendix 4: LETTER OF PERMISSION

Milika Mdala
International Labour Organisation
C/O UNDP
P.O Box 30135
Lilongwe.
18th November, 2006.

The District AIDS Coordinator
Lilongwe DHO
Through:
The District Health Officer
Lilongwe DHO

Dear Madam,

SEEKING PERMISSION TO CONDUCT A SURVEY IN REGISTERED HIV COUNSELLING AND TESTING CENTRES OF LILONGWE.

My name is Milika Mdala, a second year Masters in Public Health Student with College of Medicine in Blantyre.
I write to seek permission from your office to conduct a survey in Registered HIV Counselling and Testing Centres of Lilongwe District. The title of the survey is Challenges for the provision of Voluntary Counselling and Testing in Registered HIV Counselling and Testing Centres of Lilongwe.
The aim of the study is to find out challenges of Voluntary Counselling and Testing in relation to the institution, human resources and as perceived by community leaders in the areas where the VCT Centres exist.
The study has been approved by the College of Medicine Research centre to be conducted in partial fulfillment for the award of a Masters Degree in Public Health.

The sampled Voluntary Counselling and Testing Centres for the study are Malawi AIDS Counselling and Resource Organisation (MACRO), Save Our Souls Centre (SOS), Kawale Health Centre, Area 18 Health Centre, and Area 25 Health Centre in the Urban and Word Alive Centre, Kamphata Youth Centre, Mlare Mission Centre, Lumbadzi Health Centre and Chitedze Health Centre in the rural.
The survey will take place from Week beginning 27th November, 2006 to 8th December, 2006 and will use structured questionnaire and focus group discussions.

I will appreciate if this will be accepted.

Yours faithfully,

Milika Mdala.

Appendix 5: CONSENT FORM

Challenges for the Provision of Voluntary Counselling and Testing in Registered Counselling Centres of Lilongwe

.

CONSENT FORM.

INTRODUCTION

My name is Milika Mdala, a Masters in Public Health Student at College of Medicine in Blantyre. I am conducting a survey on challenges for the provision of Voluntary Counselling and Testing (VCT) in Registered Counselling and Testing Centers of Lilongwe.

PURPOSE AND AIM OF THE STUDY

The purpose of the study is to identify an area of the study is to identify an area of public health concern and address the problem with partnership based effort among the Universities, Government and Non-governmental organizations.

The study aims at finding out institutional and human resource challenges faced by the VCT Centres and as perceived by traditional leaders of the areas where the Counselling Centres are situated.

INSTITUTION UNDER WHICH THE STUDY IS BEING CARRIED OUT.

This study has been approved by the College of Medicine Research Committee and is being carried out in partial fulfillment for the award of a Masters Degree in Public Health. Further consent has been granted by the District AIDS Coordinator for Lilongwe DHO through the District Health Officer.

BENEFIT OF THE STUDY

The results of the study will assist in developing improved strategies for the provision of VCT services in order to increase HIV status awareness in Malawi. The results to the study will be disseminated to all participating centres, the College of Medicine, Ministry of Health and all participating Non governmental Organizations that are involved with the provision of VCT services.

PARTICIPATION

Participation in this study is voluntary upon acceptance and understanding of the consent form. All information that will be gathered from this interview will remain confidential and anonymous but will be very important as it will lead to identification of possible solutions to deal with infrastructural and human resources obstacles and improve VCT services.

STUDY TOOL

The study tool is a questionnaire that has 30 less sensitive questions related to institutional, human resource problems and VCT. The questionnaire will last about 30- 40 minutes.

CONCLUSION

If you have accepted to be part of this study, please sign or print finger below as a sign of consenting to be part of this study.

Respondent sign or finger print	Interviewer's signature
…….	……