CHAPTER FIVE DISCUSSIONS

5.1 Introduction

In this Chapter the results of the study are discussed and compared to findings in other similar studies. Also, the limitations of the study are highlighted.

5.2 Description of VCT sites

Although the majority of sites had adequate space in the waiting area, there was a concern for those that did not have adequate space. Lack of seating and comfort were recognized as some of the critical issues that needed to be addressed if VCT services were to operate with sensitivity and efficiency (Magongo et al. 2002). Also, TB is the most common infectious disease associated with HIV infection in sub-Saharan Africa. In Southern Africa between fifty and eighty percent of TB patients are HIV positive (National Strategic Plan 2007-2011). The primary risk factor for TB infection is overcrowding, hence the expectation for VCT sites to have adequate space in the waiting area.

The choice of whether the VCT site was located within the main facility or as a stand alone appeared to be dictated by the availability of space in the main facility. Although half of the sites (7) were stand alone, all of them were still located within the perimeter of the main facility thus reinforcing the belief that basing VCT in or close to health centres can facilitate a useful one- stop shop approach to HIV care and prevention (Gilly et al. 2005; Magongo et al. 2002). However, it should be borne in mind that some clients will always feel that a health setting with separate wings / site for VCT easily exposes to others the purpose and outcomes of clients' visits and therefore acts as a deterrent (Angotti et al. 2009).

All three CHCs had stand alone facilities in the form of 3 roomed park homes. While the rooms were fully partitioned and had doors there was consensus in all 3 sites that normal

conversation could be overheard across the rooms thus compromising confidentiality. CHC 1 overcame this problem by using only the rooms at the extremities and not using the middle room as a waiting area. Although it has to be appreciated that space is at a premium in sites like the CHCs, it may be advisable for the other CHCs that also use park homes to sacrifice the usage of the middle room in order to ensure privacy.

5.3 Profile of counselors and training

Shortages of health care workers have been recognized as a bottle neck in the provision of comprehensive HIV/AIDS services especially in resource limited settings hence the reliance on lay counselors (Asante 2007; Sanjana et al. 2009)

Lay counselors constituted the largest category (52%) of counselors; similarly in the study by Magongo et al. (2002) lay counselors were the largest group at 50% and in the study by Sanjana et al. (2009) just over 70% of clients were counseled by lay counselors. It is therefore evident that lay counselors form an important component of the VCT workforce. However, many of them are not full time employees and often leave for permanent employment (Sanjana et al. 2009). In Ekurhuleni, as is the case with the rest of Gauteng province, lay counselors are paid a stipend through NGOs and Ekurhuleni has over the past years had recurrent problems relating to remuneration of counselors which have compromised service delivery (Ekurhuleni District Health Plan 2008 - 2009). At times these problems have extended over a period of months, in some cases bringing VCT services to a complete shutdown (Discussion with Chief Director: Ekurhuleni). As an important component in the provision of VCT services a balance needs to be found which will make it possible to retain lay counselors while paying them at levels which are far lower than those of permanent employees thus making them an affordable workforce option. Because lay counselors are paid through NGOs they do not acquire a 'persal number' like permanent employees, and can therefore not apply for internally advertised posts in the government sector. As is the case with people in learnership programmes the allocation of a 'persal number' would carry the promise of possible future permanent employment. Some form of career pathing with improved remuneration within the lay counselor category may also ensure that counselors are retained for longer periods.

In contrast to the findings of Magongo et al. (2002), where only 2.0% of the counselors had attended both formal and in-service training it is worth noting that the proportion was considerably high (78.5%) in this study. Nulty (2003) in her study of the experiences and needs of counselors at Settlers Hospital also found that counselors did not receive regular in service training even though this would empower them with skills required in their job which were not provided in the formal training. The high percentage (78.5) in this study may therefore be an indication that attention is lately being paid to counselor training with more of them now attending both formal and in-service training. In this study almost half of the site managers (42.9%, N=6) indicated that counselors in their facilities had attended training in the past year. This is encouraging taking into consideration that the need for refresher courses for HIV/AIDS counselors and ongoing training has long been widely recognized (UNAIDS 2000; Magongo et al. 2002; Sanjana et al. 2009). Ongoing training ensures that counselors keep abreast with new developments in their field of work and thus contributing to improvement in the overall quality VCT services (Family Health International 2004).

5.4 Organisation of VCT services

Many of the sites (78.5%, N=11) did not have an appointment system, thus ensuring that clients are seen whenever they come. Even in those sites where an appointment was required, clients who came without one would still be attended to with preference being given to those with appointments. This is in keeping with the findings of Magongo et al. (2002) where 45.0% of counselors would routinely see clients with no appointment and a further 41.0% would attend to clients with no appointments if their schedule permitted. Similarly, in most sites in Papua New Guinea clients were seen on the same day they came even if they did not have an appointment (NHASP 2006).The convenience of being seen without an appointment mean that clients who have to travel do not incur the additional cost and those who are employed do not have to miss more days at work as a result of having to come on an appointed day.

Although a small proportion of the sites did not have a dedicated nurse, they managed to assign a nurse to VCT services on a daily basis. This lack of a dedicated nurse was the direct result of staff shortage. In two of the sites with a dedicated nurse, clients were turned away when the dedicated VCT nurse was not available. These were sites, one NGO and one hospice, that as a result of limited resources could not afford the services of a substitute nurse. However clients were encouraged to go to other nearby sites.

5.5 Management of VCT services

Almost all the sites (92.8%, N=13) had the relevant guidelines on counseling, testing, informed consent, confidentiality and quality assurance procedures. Doherty et al. (2009) in their study of PMTCT in clinics in rural Kwazulu-Natal also found that all clinics surveyed had guidelines for HIV management / care. Similarly, in the study by Magongo et al. (2002), more than 70.0% of managers confirmed the availability of the above-mentioned guidelines. However, confirmation of the availability of guidelines by managers does not necessarily mean that counselors have access to them, as was the case in Magongo et al. (2002) where between a third and half of the counselors had not seen some of the guidelines. However, a review of the coverage and quality of VCT services in Papua New Guinea found that all counselors had copies of pre and post counseling guidelines and that all centers (except one) knew of the existence of the policy and procedure manual (NHASP 2006).

This study found that in all the sites, there were ongoing efforts such as usage of check list and in-service training to ensure that counselors were not only familiar with but also continued to adhere to the guidelines.

WHO recognizes a variety of methods which can be used to evaluate the quality of counseling. Each of these methods has its perceived strengths or weaknesses. These methods include 1) audio recordings (where non verbal communication cannot be observed), 2) one way mirrors (which may prove costly in many settings), 3) use of dummy patients (where counselors need to be informed beforehand), 4) role playing

(which has been found to be very useful), 5) video recordings (which are expensive and do not guarantee confidentiality) and 6) observational assessments (which have been found to be less intrusive than originally thought and acceptable to both clients and counselors) (UNAIDS 2000). This study also found that observational assessment was the most common form of evaluation, used in half of the ten sites that did evaluation. A small number of sites (20%) used exit interviews, as was the case in the study by Magongo et al. (2002). None of the sites in this study utilized mock / dummy clients as was the case in the study by Pronyk et al. (2002). Less than a third of the sites (28.5%, N=5) did not evaluate the quality of their counseling, with one manager declaring: "I have never had a client coming to complain about the quality of our service and therefore never saw the need to evaluate". Exit interviews of clients regarding quality of services should not depend on whether clients complain or not.

5.6 Promotion of VCT services

All the sites that participated in the study relied primarily on health promotion as means of advancing VCT services. In contrast to the findings of Magongo et al. (2002) where sites indicated that they used other forms of communication such as print and electronic media to promote VCT services. Also, in Papua New Guinea the use of media spots and outreach activities were some of the methods used to promote VCT (NHASP 2006). Health promotion is convenient in resource limited settings and the use of other forms of promotion which may come at a cost may have to be explored at district rather than at a facility level. The disadvantage of relying mainly on health promotion is that in many health care settings, health promotion is used to cover a vast range of health topics and does not focus on VCT on daily basis. Also, health promotion talks are largely targeting out-patients to the exclusion of in-patients. Posters and reading materials should be in a language that the predominant population in that area can understand. It is worth noting that less than a quarter (21.5%, N=3) of the sites had posters in languages other than English, even though with the exception of two sites, (one clinic and one hospice), the rest of the sites were located in or near a township.

Although all sites allowed clients to take reading materials away, many of the sites (64.2%, N=9) did not have any reading material at the time of the study. The explanation given by site managers was that the contract between government and the suppliers of reading material had expired and sites had been without materials for weeks and some in some case for months. In their national assessment of VCT programme, Magongo et al. (2002) had also found Gauteng to be among the provinces that fared poorly on the availability of posters and educational material. It is worth noting that 5 years after their initial findings the same problem still exists. While contractual issues between the government and its suppliers are not the competence of individual facilities, there was no evidence that facilities were exploring other avenues (such as the use of photocopies) to ensure that reading materials were available at all times.

5.7 Support and supervision

The majority of sites (85.7%, N=12) in this study had regular meetings with the district coordinators and close to two thirds of the managers felt that they received adequate support from the coordinators. However, there were exceptions as was the case with hospice 1 which had never received a visit from the district coordinator for more than a year. In contrast, Doherty et al. (2009) in their evaluation of PMTCT services in Kwazulu-Natal found that clinic support by the district was lacking, with less than half of the facilities having been visited by a supervisor in the preceding 6 months. Magongo et al. (2002) also had a similar finding where less than half of the managers (48.0%) in their study thought the support received from district coordinators was insufficient. The findings of this study therefore suggest that there may well be an improvement in the support that districts are offering to sites. People involved in full time counseling for HIV experience considerable stress and therefore require regular support to minimise burnout and maintain motivation. (Grinstead and van der Straten 2000; Miller 2000). While counselors in all but one of the study sites had debriefings, albeit on an irregular basis, there was a concern raised by managers that these services – conducted through a private provider – were focusing on lay counselors, at the exclusion of other categories of counselors.

5.8 Impact of VCT on other services

Although the majority of managers (71.4%, N=10) expressed a feeling similar to one found by Pronyk et al. (2000) that the additional responsibilities of VCT did not adversely affect the rendering of other clinical services, a fair number of managers felt that the introduction of VCT had increased the workload thus echoing a sentiment expressed by two thirds of managers in the study by Magongo et al. (2002).

5.9 Uptake of VCT

More than half of the sites (57.1%, N=8) showed an increase in uptake over the period 2004/5 to 2007. Less than a quarter (21.4%, N=3) showed a decline in uptake over the corresponding period. The sites that showed an increase in uptake included two hospitals, two CHCs, three clinics and one NGO and those that showed a decline included one hospital, one NGO and one hospice. Many of the factors that may affect uptake of VCT were not specifically looked at in this study and no clear cut pattern can be discerned on the available data.

A clear illustration of this point is that all three hospitals offered ART services – two started in 2004 and one in 2005. Hospital 1, had 26 counselors, which constituted the highest number of counselors per facility, saw on average the most number of clients per month (over 400) while hospital 2, which had 25 counselors ,on average saw just a little over 100 clients per month. This difference in number of clients seen cannot be only explained by the difference in the number of counselors, which in this case is just one. Similarly, CHC 1 saw on average twice the number of clients seen in hospital 2, even though hospital 2 had three times more counselors. This shows that there may be other factors other than number of counselors, which were not explored that are influencing uptake.

Hospice 1 showed a marked decrease in uptake following an initial period of increased uptake. One of the contributory factors may be the fact that there was a decline in the funding they depended on leading to the time of the study and they were already in the

process of scaling down their operations. Also, only one site indicated that they referred clients to hospices which may indicate that their services were not widely utilized. Of the two NGOs that showed no increase in uptake, one (NGO 2) mainly served the workers of a single factory (with a stable work force) which meant the number of people requiring testing declined over a period of time and the other (NGO 3) depended on one nurse for testing and had no relief for the periods when she was not available.

Magongo et al. (2002) in their national assessment of the VCT programme found the routine data collected "lacked consistency, with most of the necessary information missing and therefore not useful". This made it difficult to calculate uptake of VCT by site. In Papua New Guinea they also found that data collection was mainly statistical, with very little narrative and the content of reports was not clear (NHSAP 2006).

Sadly, this was a similar finding in this study. There were big differences between the statistics obtained at the sites and those obtained at the district office. There is a standard "daily register" which is supposed to be used in all health care facilities in the province. The register contains a variety of data elements including elements relating to VCT services and is meant to be the document that informs the statistics received by the district. However, in all the sites visited the daily register was used in other sections of the facility but not in the VCT section. Instead each VCT section used an improvised register with elements that varied from site to site. This may partly explain the difference in the statistics obtained at the facilities and the district office. The figures obtained in the district office where higher than those obtained at VCT facilities. These differences may be as a result of the fact that totals captured in VCT site registers reflected only patients tested under the VCT programme whereas figures at the district office probably reflect all VCT patients tested including those from other programmes such as PMTCT, TB focal points, STI clinics, PEP sites and inpatients.

Despite the fact that all facilities kept a daily register, tallied statistics on a monthly basis and the majority of sites (92.8%, N=13) reported that they analysed the statistics monthly, and many (85.7%, N=12) of the sites had regular visits from the district supervisors, the

data in the daily registers had so many gaps that it could hardly be used. Some of the contributing factors may be as a result of VCT sites using registers with different data elements as well as different people being responsible for recording of statistics in different facilities. There is also no uniform expectation on how statistics should be analysed on a regular basis thus leaving it to individual facilities to decide which element they concentrate on.

5.10 Referral system

The DOH recognizes the partnership with capacitated social structures such as NGO's, FBO's, CBO's, etc as central to the effective implementation of the HIV & Aids and STI National Strategic Plan 2007 – 2011. While the referral patterns showed that VCT sites already had working relationship with some of these social structures there was no uniform policy guiding the nature of this relationship. More than half of the sites (57.1%, N=8) referred mainly to hospitals. This would have been expected as hospitals provided ART and are able to treat patients that need more than what clinics and CHCs offer. Variations in data elements of VCT registers meant that not all sites had records of where clients were referred from. However, all the sites were able to indicate where they referred clients post testing. Many of the sites used a formal referral letter to refer patients to other services as was the case in the study in Papua New Guinea (NHSAP 2006). Many of the VCT sites (85.7%, N=12) were found in and around townships. It is worth noting that in this study none of the VCT sites indicated having any relationship with traditional healers as was the case in the study by Magongo et al. (2002).

5.11 Limitations of the study

Findings of the study reflect the situation in the few sites involved and may not necessarily be true for all the VCT sites in Ekurhuleni.

Conclusions reached in this are based mainly on the information of facility managers and observations and did not take into account experiences of lay counselors and VCT clients

The lack of a common data set in VCT registers and incompleteness of the data made it difficult to evaluate uptake.