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# Assessment of voluntary counseling and testing (VCT) services in Ekurhuleni Metropolitan Municipality

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**2011-02-01**
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# CHAPTER FOUR RESULTS

## 4.1 Introduction

This chapter presents the findings of the study focusing mainly on the operational aspects of VCT services.

## 4.2 Description of VCT sites

A total of 14 sites were included in the study: Three hospitals, 3 Community Health Centres, 3 clinics, 3 NGOs and 2 hospices. Twelve sites (85.7%) were located in the township. Of the 14 sites, seven (50.0%) were located within the main facility and the others were situated outside the main facility but within the same premises. Just over half of the sites were clearly marked and identified as VCT areas. About two thirds (64.3%, N=9), based on researchers observation and discussions with site managers regarding average volume of clients seen, had adequate space in the waiting area and almost all of the sites (92.8%, N=13) had a closed area for counseling and testing. However, two of the sites (CHCs 2 and 3) with closed areas did not provide the necessary privacy.

Table 4.1 shows the types of HIV tests offered in the sites. PCR was done in only 50.0% of the sites as it was in the process of being rolled out. Viral load was done in four sites which also offered ART services.

**Table 4.1 Types of HIV tests conducted by facilities**

| Test | Number of facility | Type of facility |
|---|---|---|
| HIV rapid + Elisa | 14 | All sites |
| Rapid + Elisa + Cd4 | 12 | All sites; except 1 hospice + 1 NGO |
| Rapid +Elisa +Cd4 + Viral load | 4 | 3 hospitals + 1 hospice |
| PCR | 7 | 2 hospitals + 3 clinics + 2 CHCs |

Table 4.2 shows the other services that run concurrently with VCT. All the clinics, CHCs, hospitals and NGO 1 also offered other services such as TB, STI and PMTCT. Two CHCs (1 and 2) were the only sites that offered youth friendly services.

**Table 4.2 Number of sites offering other health services that promote VCT**

| Service | Number of facility | Type of facility |
|---|---|---|
| PMTCT | 10 | All sites except 2 hospices and 2 NGOs |
| TB | 11 | All sites except 1 hospice and 2 NGOs |
| STI | 11 | All sites except 1 hospice and 2 NGOs |
| ART | 4 | 3 hospitals + 1 hospice |
| Youth Friendly | 2 | 2 CHCs |

## 4.3 Demographics of site managers

The majority of site managers (85.7%, N=12) interviewed were females. The heads of the sites were either designated as project managers (57.1%) or clinic heads (42.9%). Of the 8 project managers, two (25.0%) were males and six (75.0%) were females. When ART services were introduced in hospitals, specific posts with the designation of "project manager" were created. Similarly NGOs and hospices preferred the designation of project manager for people running their VCT services. However, in most CHCs and clinics VCT services were integrated into existing services and overseen by the clinic head. Site managers reported being in their position for periods ranging from 1 to 10 years, with a mean of 3.7 years. Site managers designated as clinic heads had been in their positions (mean = 4 years) slightly longer than those of project managers (mean = 3.6 years), but this difference was not statistically significant (p-value = 0.768).

## 4.4 Profile of counselors and training

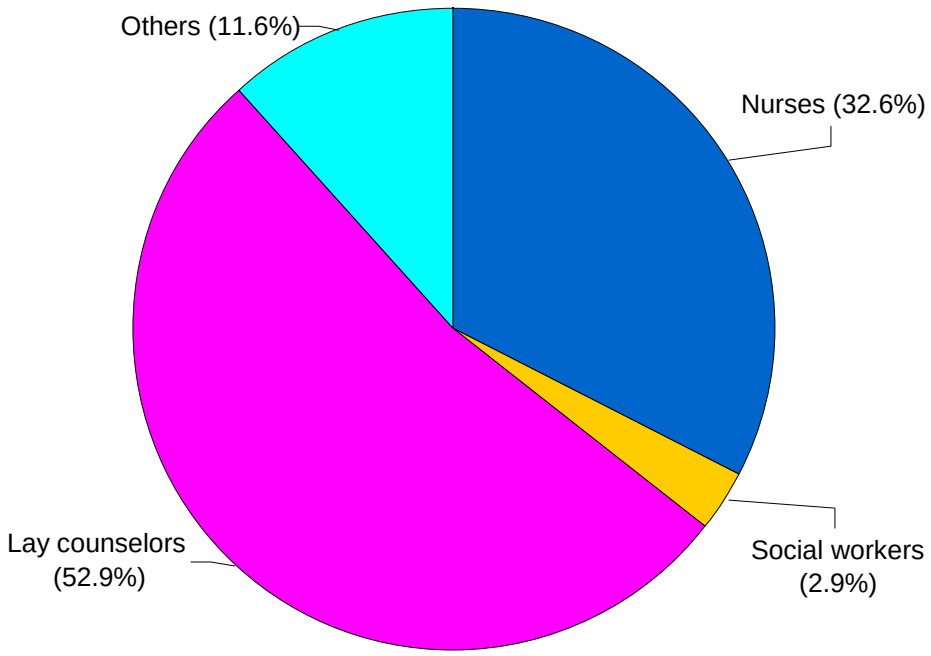


**Figure 1. A pie chart of the profile of counselors**

The fourteen sites collectively had a total of 138 trained counselors, the majority of whom were lay counselors (52.9%) and nurses (32.6%) as shown in figure 1. Others (11.6%) included doctors, dieticians and health promoters.

In eleven of the facilities (78.5%), counselors had received both formal and in-service training and in the remaining three facilities (21.5%) counselors had received formal training only. Less than half (42.9%, N=6) of the facilities reported that their counselors had received training in the past year.

## 4.5 Organisation of VCT services

Thirteen sites (92.8%) offered VCT services on a daily basis (Monday – Friday) and operated during normal office hours. Most of the sites (78.5%, N=11) did not have an appointment system and served patients on a first come first serve basis. Almost all of the sites (85.7%, N=12) had a dedicated nurse for VCT, and with the exception of two sites- hospice 2 and NGO 3-, all other sites were able to allocate a substitute nurse as and when required.

## 4.6 Management of services

*a). Guidelines:* Almost all the sites (92.8%, N=13) had the relevant guidelines (on counseling, testing, confidentiality, use of informed consent and quality assurance of test kits) in place and these guidelines were available for inspection at the time of data collection. Various methods were used to ensure that the guidelines were adhered to. Figure 2 shows the proportion of facility managers that reported the method(s) used to ensure adherence to these guidelines. In- service training is where no formal certificates were issued and checklists were the same in all facilities.

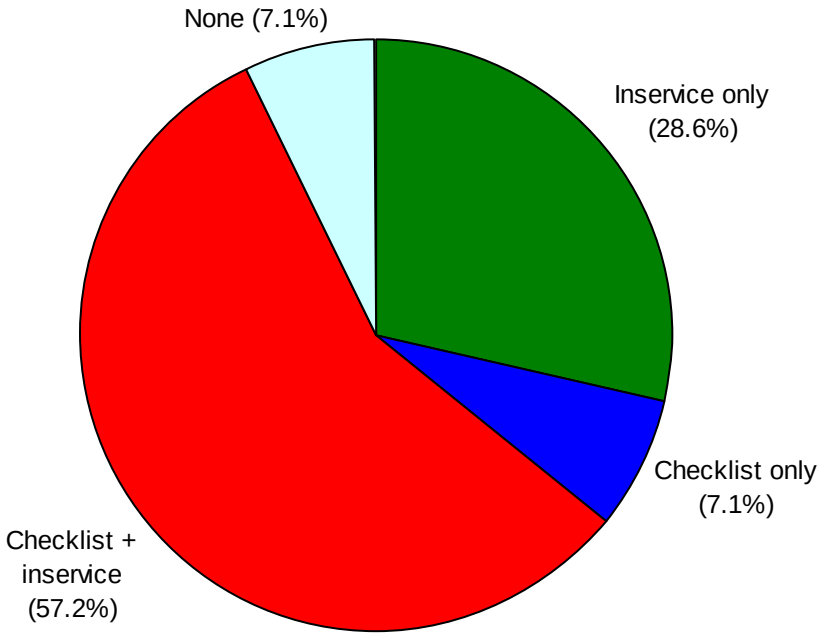


**Figure 2. A pie chart showing distribution of methods for ensuring adherence to guidelines**

*b). Quality assurance:* In thirteen of the sites (92.8%) the nurse in charge of VCT was responsible for quality testing of kits, where a confirmatory test was done on the first ten tests of every new batch.

*c). Quality of counseling:* The majority of the sites (71.4%, N=10) regularly evaluated the quality of counseling offered to clients. The sites evaluated the quality of counseling using four methods: direct observation only (50.0%), exit interviews (20.0%), self evaluation (10.0%), and twenty percent through a combination of direct observation and exit interviews.

*d). VCT register:* All fourteen sites kept a register which fed data into the overall data management system. However, there was no uniformity in the data elements contained in the registers across all sites. Age, gender and date of attendance were the only data elements that were common to all sites. Only three sites (21.5%) indicated the type of HIV test done. All sites indicated that only programme staff had access to VCT registers. Programme staff included health professionals, counselors, data capturers and district coordinators. Monthly statistics were compiled mainly by nurses (42.8%) and data captures / clerks (35.7%). Almost all of the sites (92.8%, N=13) indicated that they analysed the statistics for purposes of informing their operational needs.

*e). Comparison of district and facility data:* As illustrated in Figure 3, the totals recorded at facilities and at the district for the number for VCT clients seen in the first quarter of 2007, were different for all facilities, with district totals being consistently higher than those of the facilities.

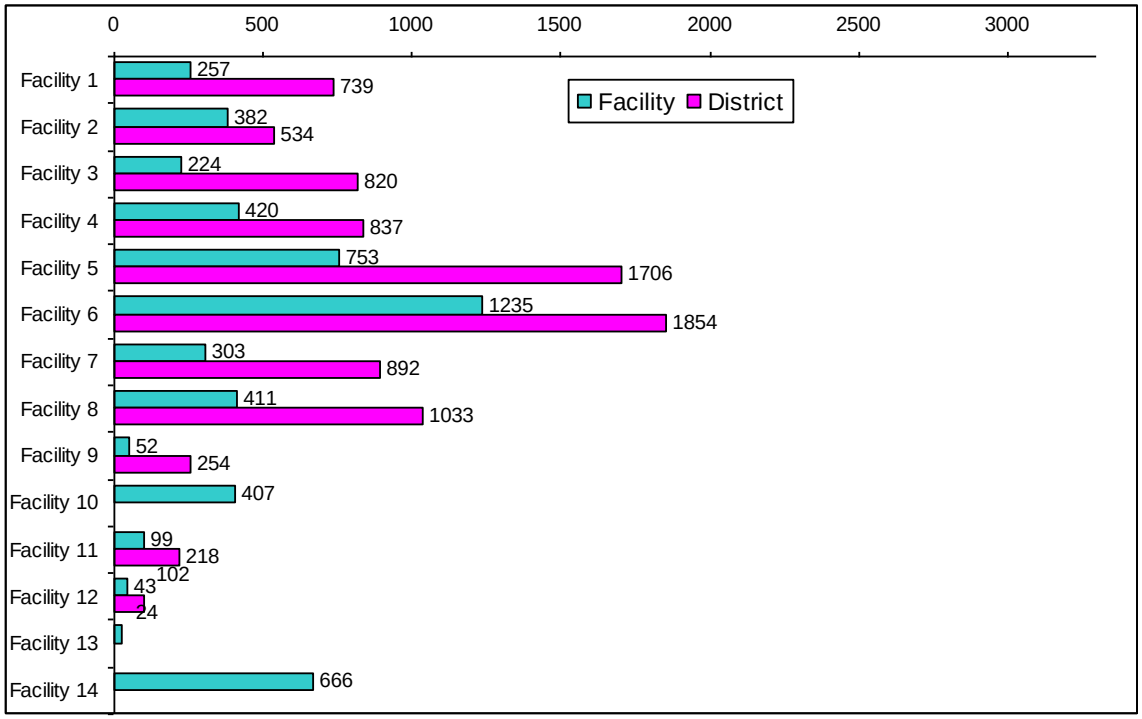


**Figure 3. Comparison of absolute number of VCT clients in facility vs. district registers in the first quarter of 2007**

## 4.7 Promotion of VCT services

All 14 sites relied on health promotion as a method for marketing VCT services. In addition, a little over a third (35.7%, N=5) relied on the collaboration of other services such as PMTCT, TB and STI to advance the promotion of VCT. Although many of the sites (78.6%, N=11) had posters, very few (21.5%, N=3) had posters in languages other than English (Zulu and Xhosa ). Almost two-thirds of the sites (64.3%, N=9) did not have any reading materials.

## 4.8 Supervision and support

Just over seventy percent of the sites (71.4%, N=10) had meetings with the programme staff on regular basis, the exception being one site that never had any meetings. Nearly two-thirds of the sites (64.3%, N=9) indicated that these meetings had a formal agenda that covered operational issues, case reviews and statistics. Although there were no fixed schedules, many of the sites (85.7%, N=12) had meetings with the district coordinators

and the majority of these (64.3%, N=9) reported that the support received from the district office was adequate. Counselors in all but one (hospice 2) of the sites had attended debriefing sessions.

## 4.9 Impact of VCT on other services

Many of the site managers (71.4%, N=10) reported that the introduction of VCT services did not have a negative impact on how other services were rendered. However, the remaining (28.6%, N=4) felt that the introduction of VCT had increased the workload of staff that were already overburdened. There was consensus among all sites managers that the introduction of VCT services had increased awareness about HIV/AIDS, assisted with integration of services and was in general a good development.

## 4.10 Uptake of VCT

In general, eight out of the fourteen sites (57.1%) showed an increase in uptake over the period 2004/5 to 2007

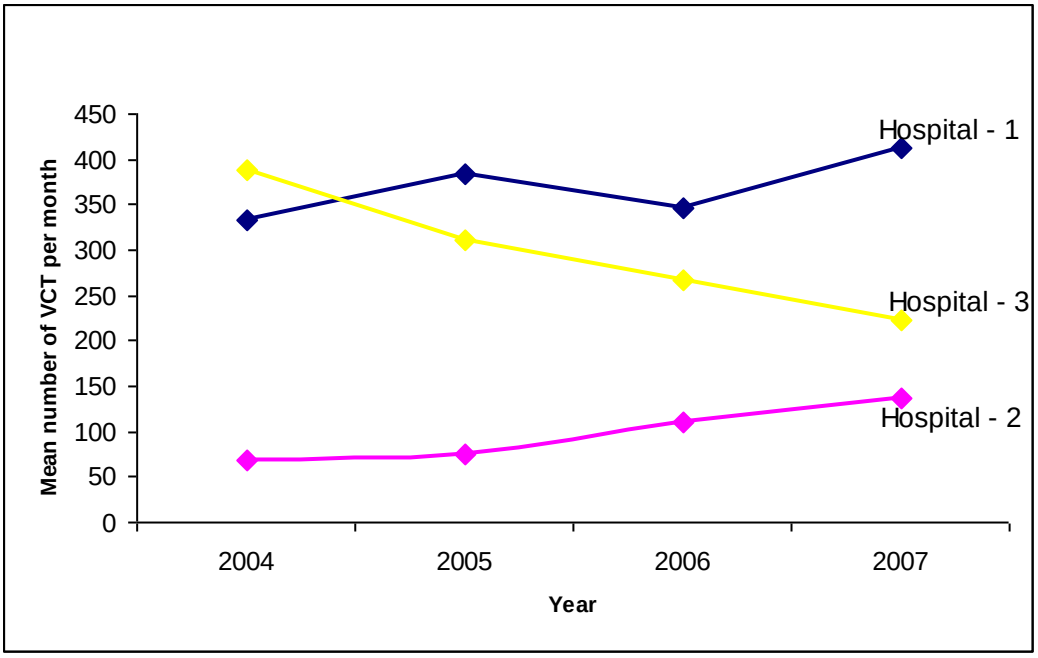


**Figure 4. VCT trend in hospitals from 2004 to 2007**

Hospital 3, showed a decline in uptake while the other two hospitals (1 and 2) showed an increase (figure 4). At the time of sampling, hospital 1 had twenty six counselors, hospital 2 had twenty five and hospital 3 had the lowest number at fifteen. Hospitals 1and 2 started offering ARVs in 2004 and hospital 3 started in 2005.

CHCs 2 and 3 showed an increase in uptake over the study period albeit small and CHC 3, showed an initial decline from 2004 to 2005 then followed with a slight an increase in VCT uptake from 2005 to 2007 (figure 5). CHCs 1 and 3 had seven trained counselors each and CHC 2 had nine.

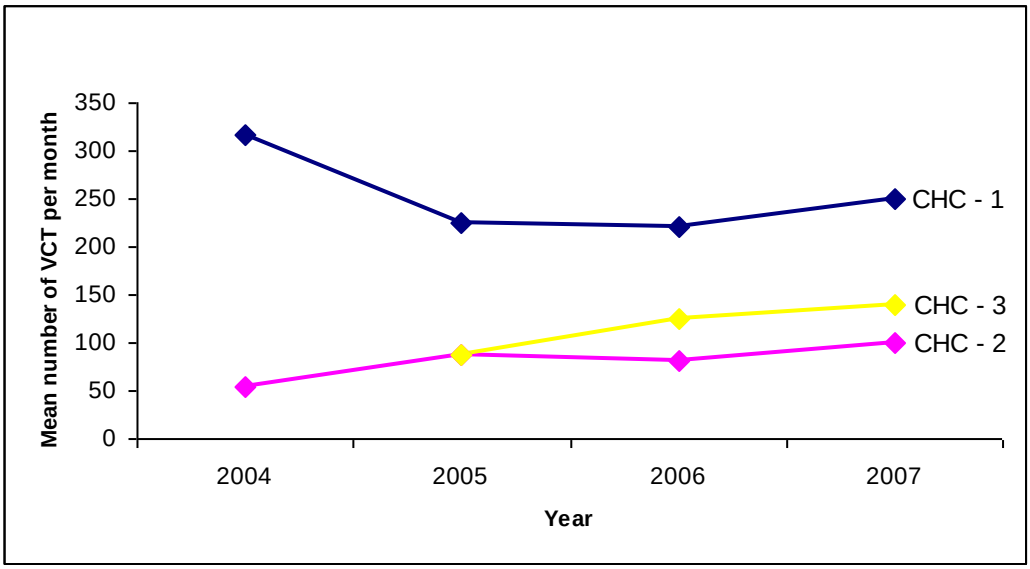


**Figure 5. VCT trend in community health centres from 2004 to 2007**

Figure 6 shows that there was an increase in VCT uptake in all 3 clinics. Clinic 1 had six counselors, clinic 2 had nine and clinic 3 had three.

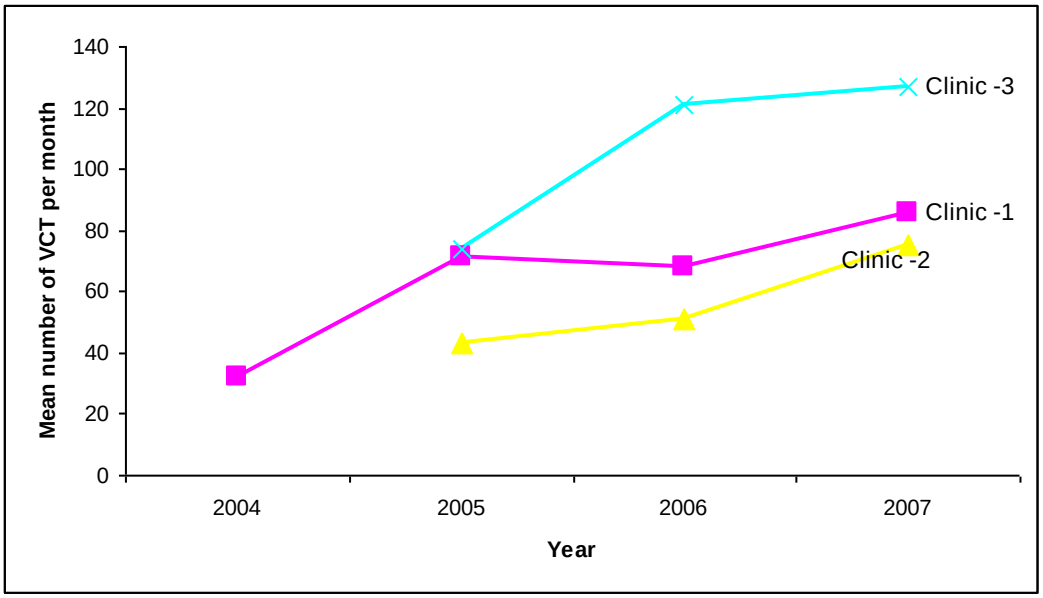


**Figure 6. VCT trend in clinics from 2005 to 2007**

NGO 1 showed an increase in uptake and NGOs 2 and 3 had no increase in uptake (figure 7). NGO 1 had nine counselors, NGO 2 had only two and NGO 3 had six.

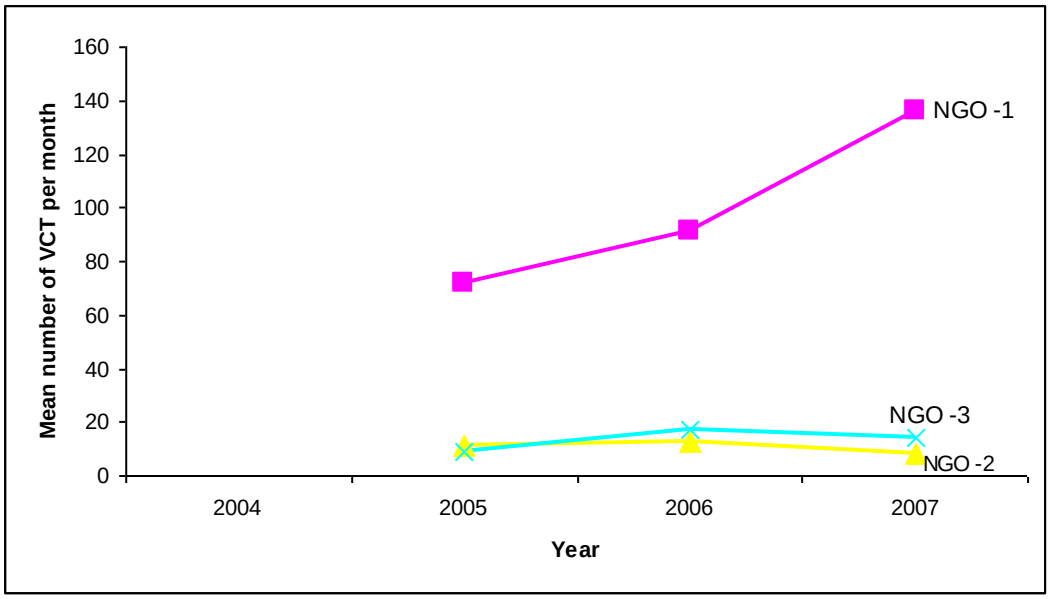


**Figure 7. VCT trend in NGOs from 2005 to 2007**

As shown in figure 8, hospice 1 had an increase in uptake from 2005 to 2006 followed by a decline from 2006 to 2007. Hospice 2 showed a decline in uptake. Hospice 1 had thirteen counselors and hospice 2 only had two.

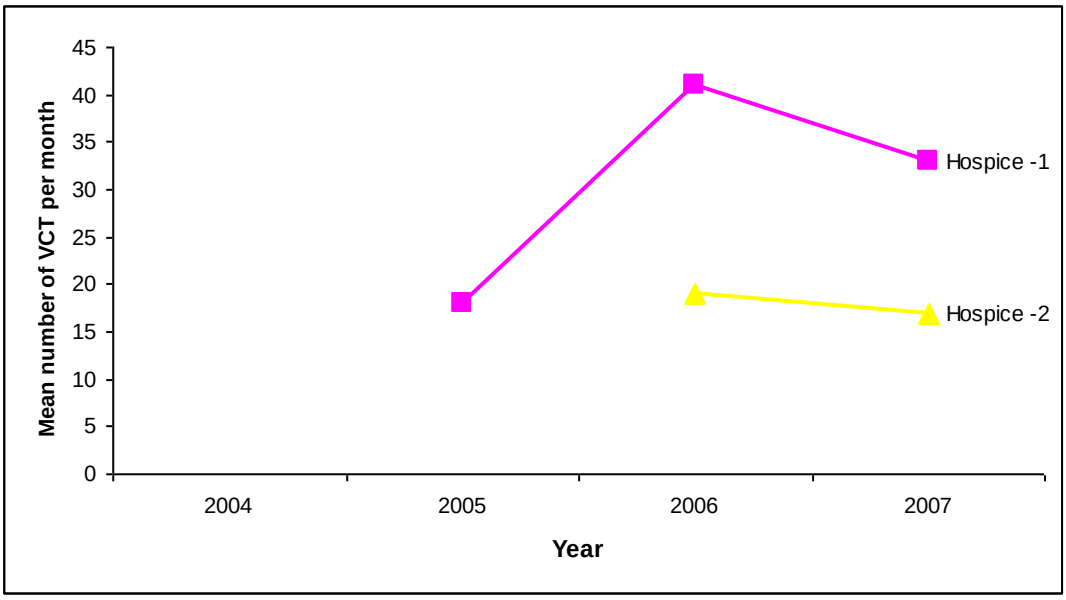


**Figure 8. VCT trend in hospices from 2005 to 2007**

## 4.11 Referral system

All sites used a formal letter when referring clients to services outside their facilities. Similarly, 57.1% (N=8) of the sites again used a written referral to other services within the same facility. Figure 9 shows the issues reported to be associated with referrals. Many of the sites (64.3%, N=9) cited lack of feedback as the major problem associated with referrals.

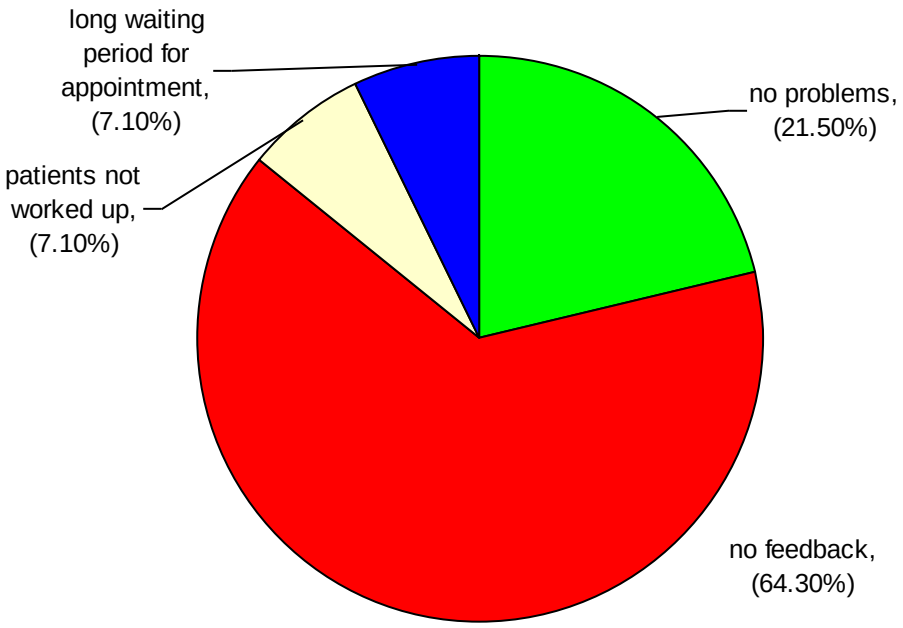


**Figure 9. A pie chart showing problems associated with referrals**

**Table 4.3 Facilities to which VCT sites refer for other services**

| Facilities | No of sites |
|---|---|
| Hospital | 8 |
| Community Based Organisation | 5 |
| Faith Based Organisation | 2 |
| Clinic | 4 |
| Home Based Care | 6 |
| Hospice | 1 |
| Non Governmental Organisation | 6 |

Table 4.3 shows the facilities to which VCT sites refer patients for other services. Hospitals, followed by NGOs and HBC were the places where clients were mostly referred to. Even though the sites indicated where they referred clients to, most of the registers did not indicate where the clients had originally been referred from. The majority of sites (78.6%, N=11) had monthly meetings with structures to which they refer.