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ASSESSMENT OF VOLUNTARY COUNSELING AND TESTING (VCT) SERVICES IN EKURHULENI METROPOLITAN MUNICIPALITY

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A RESEARCH REPORT SUBMITTED TO THE FACULTY OF HEALTH SCIENCES, UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PUBLIC HEALTH (MPH)

OCTOBER, 2010

DECLARATION

I, Teboho Douglas Moji, declare that this research report is my own work. It is being submitted for the degree of Master of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signature:

Date:

DEDICATION

To my children, Thato, Mpholo, Lindelwa and Nelisiwe

ABSTRACT

Introduction: VCT services are a meaningful entry point to a continuum of care, in treatment and prevention of HIV/AIDS and related illnesses. Although VCT has been available at some sites across the country even before 2000, there have been very few studies conducted to evaluate its implementation at local municipality level. This study describes the status of VCT implementation in the Ekurhuleni Metropolitan Municipality between January 2004 and March 2007.

Methods: Using a questionnaire, checklist and data collection sheet, data was collected between April - May 2007 in a sample of 14 VCT sites. These were government funded sites that included three hospitals, three community health centres, three clinics, three non governmental organisations and two hospices and were selected from all three service delivery regions in Ekurhuleni. Areas assessed were demographics of facility managers, staff and training, referral system, guidelines, supervision and support and VCT registers.

Results: Over ninety percent of the VCT sites had closed areas for HIV counseling and testing. Majority of the VCT service providers were lay counselors (52.9%) and others were nurses, doctors, dieticians, social workers and health promoters. Most of the counselors had received both formal and in-service training. Almost all sites (92.8%, N=13) had the relevant guidelines in place and in-service training and use of checklist were methods used to ensure adherence to guidelines. The majority of the sites (71.4%, N=10) regularly evaluated the quality of counseling offered to clients through direct observation (50.0%), exit interviews (20.0%), self evaluation (10.0%) and combination of direct observation and interviews (20.0%). Close to two thirds of the sites (64.3%, N=9) were satisfied with supervision received from the district office. All the sites used a formal letter to refer clients to other outside facilities. There was no uniformity in the data elements of VCT registers across sites and the registers had many gaps.

Conclusions: The VCT sites in this study had the necessary set up for the implementation of basic VCT services. However, because of the small sample size, this conclusion may not be true for the whole of Ekurhuleni. There needs to be improvement in VCT record keeping and data management in the sites. Further studies are needed to evaluate factors influencing uptake of VCT services.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community Based Organisation
CHC	Community Health Centre
DOH	Department of Health
ELISA	Enzyme Linked Immunosorbent Assay
FBO	Faith Based Organisation
HAART	Highly Active Antiretroviral Therapy
HAST	HIV/AIDS/STI/ TB Unit
HBC	Home Based Care
HIV	Human Immune Virus
IPPF	International Planned Parenthood Federation
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NHASP	National HIV/AIDS Support Project
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
SDR	Service Delivery Region
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

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CHAPTER ONE INTRODUCTION

1.1 Background

The human immunodeficiency virus (HIV/AIDS) pandemic has already caused immeasurable devastation to many individuals, families and communities (Gayle and Hill 2001). HIV/AIDS has already claimed millions of lives. The pandemic continues to inflict pain and grief and to cause fear and uncertainty in many communities. In some countries the HIV/AIDS pandemic is threatening economic devastation (Department of Health 2000, Gayle and Hill 2001). HIV/AIDS is the leading cause of death in Africa and the fourth overall leading cause of death worldwide (Kumaranayake and Watts 2000).

Estimates are that by the end of 2008, there were about 33.4 million people living with HIV globally. Seventy two percent of all HIV-related deaths were in sub-Saharan Africa and about 1.9 million were new infections. More than 95% of these new infections were in developing countries and over 45% were in young people (UNAIDS 2009).

Sub-Saharan Africa, especially Southern Africa appears to be the hardest hit region in the world. Of all people living with HIV, six out of every ten males, eight out of every ten females and nine out of every ten children are in sub-Saharan Africa (Jackson 2002). Although countries such as Botswana and Zimbabwe have shown remarkable declines in the prevalence of HIV, nine Southern African countries - including South Africa – still had a prevalence of over 10% in 2007 (UNAIDS 2009). Estimates are that by 2015 the total cost of HIV/AIDS treatment and care will consume up to two-thirds of health spending by governments in sub-Saharan Africa (Gayle and Hill 2001). The World Bank forecasts that a country like South Africa could face economic collapse within several generations, unless it prevents the rapid spread of HIV/AIDS more urgently (World Bank 2005).

Although data from the Antenatal survey suggest that over the past 3 years (2006-2008) South Africa's epidemic might be stabilizing, latest UNAIDS estimations are that there

are about 5.7 million people living with HIV in South Africa (DOH 2009; UNAIDS 2009). This constitutes the largest HIV epidemic in the world (UNAIDS 2009). In 1991 less than 2% of women attending government antenatal services were HIV positive but by 1998 the figure had increased to 22.4% (Johnson, Modiba, Monnakgotla et al. 2001). The South African national HIV prevalence stands at 11.0% (Shisana, Rehle, Simbayi et al. 2009). Currently HIV prevalence among pregnant women attending public sector antenatal clinics stands at 29.3% with Kwazulu-Natal having the highest prevalence in the country at 38.7%. Gauteng province is estimated to be having an antenatal prevalence of 29.3% (DOH 2009).

The 2001-2002 annual report of the Health and Social Development department – in Ekurhuleni – found that of the people tested in public health facilities, during this period, 52% were HIV positive. Presently, Ekurhuleni at 31.5% has the second highest antennal prevalence in Gauteng (DOH 2009).

There has been a significant increase in global funding for HIV/AIDS, from US$ 1.6 billion in 2001 to US$ 8.9 billion in 2006 (World Bank 2008). According to the World Bank (2008) US$18 billion was needed in 2007 for treatment, prevention and care, and the majority of this money would have been needed in sub-Saharan Africa. By expanding initiatives for prevention, treatment and care almost one million deaths will be averted annually by 2011 (World Bank 2008). Unless the incidence of HIV is sharply reduced, HIV treatment will not be able to keep pace with all those who will need therapy (Lamptey and Wilson 2005). Although VCT is a relatively costly activity, there is a belief that it is a cost effective intervention for behavioral change and has been shown in some cases to lead to a decrease in unprotected sex, reduction in multiple sexual partnerships, increase in condom use and an increase in sexual abstinence (IPPF 2004). HIV prevention- of which VCT is an integral part- has to been seen therefore, as a capital investment for the future and not as an item of expenditure. With proper prevention 29 million (63%) of the 45 million new infections expected to occur between 2002 and 2010 would be averted (UNAIDS 2005b).

Many countries have since realized that treatment and prevention strategies are not distinctive and competing responses to HIV/AIDS (Kelly 2002). In line with international trends, South Africa has recognized voluntary counseling and testing (VCT) for HIV as being crucial for both treatment and prevention of HIV/AIDS (DOH 2000; Kelly 2002; Magongo, Magwaza, Makhubele et al. 2002). One of the key strategies of the government's HIV/AIDS/STD strategic plan is to increase acceptability and access to VCT with special focus on youth, women and migrant workers (DOH 2000).

Access to information on ones' HIV status is a human right as well as a public health measure and VCT services are supposed to provide a supportive venue for learning this essential health information (Jackson 2002).

The Department of Health defines VCT as a process by which an individual undergoes counseling to enable them to make an informed decision about being tested for HIV, assess their personal risk for HIV and develop a risk reduction strategy. VCT requires individual choice, confidentiality, informed consent, pretest and post-test counseling, effective referral system and effective counselor support system (DOH undated).

VCT covers a variety of interventions in different settings. These may include VCT services that are mainly client initiated and completely voluntary for asymptomatic people who wish to know their status. Other services can be mainly provider initiated – with the option of opting-out – where a client has the right to refuse. These are mainly in clinical treatment setting for diagnostic purposes and in settings where specific vulnerable groups such as sex workers, drug users, men who have sex with men (MSM) and women attending ante-natal services are targeted for intervention (WHO 2005).

Both UNAIDS and WHO do not support mandatory testing for HIV of individuals on public health grounds but current debates are that HIV/AIDS should be recognized as an emergency and therefore, be addressed within a public health approach- where individual rights can be restricted- thus leading to the imposition of routine testing (UNAIDS 2003). The normalization of HIV/AIDS in a philosophical context of public health, medical

ethics and social justice should therefore, not be seen as a threat to individual human rights (De Cock, Mbori-Ngacha and Marum 2003).

1.2 Justification of the study

Although VCT has been available at some sites across the country even before 2000, there have been very few studies conducted to evaluate its implementation at a local municipality level. This study hopes to give an overview of VCT services in the Ekurhuleni Metropolitan Municipality.

1.3 Aims and objectives

a). Aim: To assess implementation of VCT services in the Ekurhuleni Metropolitan Municipality between January 2004 and March 2007.

b). Objectives:

- To describe the VCT sites included in the study.
- To describe the services offered at VCT sites.
- To determine the uptake patterns in the VCT sites.
- To describe referral systems available to VCT sites.

CHAPTER TWO LITERATURE REVIEW

2.1 Expansion of VCT services

Many countries in sub-Saharan Africa – including South Africa - and elsewhere are developing VCT services where HIV testing is done for free or for a small fee. There has been a rapid expansion of these services. In 1998, Kenya had only 4 VCT sites but by 2002 there were 49 sites (Jackson 2002). Similarly in 2003 South Africa had 1500 sites nationwide, but by 2008 these had increased to 4327 (Office of Chief Director: District Health Services, NDOH 2010). However many of these sites are still not readily accessible to people in small towns and rural areas both in SA and other countries such as Malawi (Kelly 2002; Mfutso-Bengo and Muula 2003).

There is no ideal approach towards setting up VCT services, and approaches will differ in various settings (Magongo et al. 2002). VCT services may be free standing, integrated into the public health system, workplace based, mobile, NGO based, community based, private sector based, or may be integrated into other programmes such as prevention of mother to child transmission (PMTCT) (Jackson 2002; Magongo et al. 2002). VCT sites should serve one or more purposes for HIV testing as recommended by the World Health Organisation (WHO) – namely blood donations, clinical diagnosis, research and self referred voluntary testing (Martin 2000; Mfutso-Bengo and Muula 2003).

Expansion of services places an additional burden on both infrastructure and human resources. Shortage of healthcare workers has been found to be a bottleneck in the provision of HIV/AIDS services in resource limited settings hence the need to train and place community volunteers as lay counselors in order to complement the efforts of healthcare workers (Asante 2007; Sanjana, Torpey, Schwaizwalder et al. 2009).

In order to sustain the quality of services, counselors require ongoing education and training. This does not only help maintain the knowledge and skills that they already have

but also ensures that they keep abreast with new information (Grinstead and van der Straten 2000; Nulty 2003; Sanjana et al. 2009).

The heavy demand and expectations of high performance result in counselors having to work in the face of sustained stress. It is therefore critical that counselors be regularly provided with supportive supervision and debriefings (Family Health International 2004; Grinstead and van der Straten 2000). However, supportive supervision for stress should be differentiated from supervision that is meant to ensure that policies, procedures and guidelines are adhered to (Doherty, Chopra, Nzibande et al. 2009; National HIV/AIDS Support Project (NHASP) 2006).

Lay counselors are in most cases not full time employees and are therefore always faced with the necessity of finding better paid employment elsewhere (Sanjana et al. 2009). Disputes relating to remuneration have at times led to lay counselors downing tools for extended periods of time thus compromising the provision of VCT services (Discussion with Chief Director: Ekurhuleni; Ekurhuleni District Health Plan 2008 – 2009).

2.2 HIV diagnostic methods

Since 1985, diagnostic HIV testing entailed the use of automated enzyme linked immunoassays (ELISA) for screening and the Western blot assay for repeat testing (Martin 2000; Phile and Vardas 2002). These methods of HIV testing require specially trained personnel, expensive processing equipment, reliable transportation of specimen and reliable dispatching of results (Phile and Vardas 2002). The turnaround time for results ranged from a few days to two weeks (Pronyk, Kim, Makhubele et al. 2002). This led to many people not coming back for their results. Some East African countries have reported non return rates of over 30%. The United States has reported non return rates of over 40% and South Africa has documented non return rates of well over 85% (Jackson 2002; Pronyk et al. 2002). The use of ELISA also meant that people in poor resource settings were deprived of VCT services (Martin 2000).

Studies have shown that rapid HIV tests – which provide results within 10-30 minutes – when used in combinations of two or more assays can provide results that are as reliable as those from the ELISA-Western blot combination (DOH undated; Phile and Vardas 2002). Rapid tests can be performed easily with minimal training (Phile and Vardas 2002). With rapid testing, the practical reasons for not returning are eliminated, the psychological stress of waiting for results is reduced and time and money are saved (Jackson 2002; Phile and Vardas 2002). This makes rapid testing a simple cost-effective tool that facilitates the introduction of VCT services at Primary Health Care (PHC) level even in remote rural areas and poor settings, including mobile services (Phile and Vardas 2002; Pronyk et al. 2002). However rapid tests put extra pressure on counselors to ensure that clients are really ready when they do take the test (Jackson 2002).

2.3 VCT and other services

More than 90% of paediatric HIV infections are caused by mother to child transmission (Wilkinson and Wilkinson 2001). A 1998 survey of women attending ANC services in Kwazulu-Natal found that all of them were prepared to undergo VCT, take drugs and modify their feeding patterns if it meant reducing mother to child transmission (Wilkinson and Wilkinson 2001). This means that VCT is a key factor in PMTCT. Other similar programmes such as post exposure prophylaxis (PEP) – for rape survivors and workplace needle stick injuries – have also helped to create a sense that it is worthwhile to know one's status (Kelly 2002). It is therefore important that VCT services work in close relation with other services such as PMTCT, PEP, TB, STI, and HAART. However, VCT services should not only be linked to other medical services but should also have close relations with palliative, home based care, faith based and other community based services in order to expand the support base for those who test positive (Baggaley, Kelly, Weinreich et al. 1998; National Strategic Plan 2007-2011). While the majority of VCT clients may be self referred, there is a need for a referral system between VCT sites and the other services (Gilly, Ngatia, Rachier et al. 2005; NHASP 2006).

2.4 Factors that influence VCT uptake

The rationale for VCT is that it will help reduce stigma, fear and anxiety around HIV/AIDS and lead to increased openness in communities. However, Kalichman and Simbayi (2003) in a study carried out in a black township in Cape Town, found that although most South Africans were aware of VCT, only 1 in 5 people who know about VCT were tested for HIV. The reason for this was fear of discrimination and stigmatization by their communities. Other studies in SA and other countries such as Mali have also identified fear of stigmatization as a major barrier for utilizing VCT services (Castle 2003; Kelly 2002; Day, Miyamura, Grant et al. 2003; Gilly et al. 2005; Mfundisi, Chiranjan, Rodrigues et al. 2005; NHASP 2006). Other factors that have been found to discourage people from accessing VCT services include inadequate health workforce and infrastructure (Asante 2007), long distances from the service centres (Angotti, Bula, Gaydosh et al. 2009), fear of testing positive and equating that to death (Day et al. 2003; Gilly et al. 2005) and poor quality of services (Mfundisi et al. 2005).

One of the benefits of VCT is the change of behavior that comes with knowing one's status (Castle 2003; DOH undated; Kelly 2002). Those who test negative may resort to condom use in order to remain so, while those who test positive are expected to take steps not to infect others (Castle 2003). However, VCT uptake is likely to be poor when offered without treatment or social support (Castle 2003; Kelly 2002). Up until 2002, Brazil was the only developing country to guarantee universal access – beyond a privileged few - to antiretroviral (ARV) therapy. Botswana was the first country in Africa to offer ARVs through the public health system and South Africa has followed (Fleischman 2004).While the impact of these developments on VCT services is yet to be evaluated, some have suggested that the availability of Antiretroviral Therapy (ART) is one of the factors that lead to increased uptake of VCT (Day et al. 2003; Gilly et al. 2005; Mfundisi et al. 2005). Availability of healthcare workers and counselors (Sanjana et al. 2009), knowing someone who is on ART (Dickson and Mundy 2004; Mfundisi et al. 2005) and ensuring that the services are convenient, confidential and credible (Angotti et

al. 2009; Day et al. 2003) are some of the factors that also lead to an increase in the uptake of VCT.

In high HIV prevalence settings, sickness or death of a friend, family member, colleague etc serve to convince people of the reality of the disease and may therefore lead to an increase in uptake of VCT, whereas in low prevalence areas disbelief in the existence of HIV/AIDS is widespread and this may lead to slow uptakes of VCT (Castle 2003). Debates that question the causal link between HIV and AIDS – raised by former South African President Thabo Mbeki, among others – have resulted in people questioning the existence of the illness. This skepticism is wide spread even in educated people and hampers the uptake of VCT (Castle 2003).

2.5 VCT evaluation tools

UNAIDS has developed guidelines to evaluate both the implementation and effectiveness of VCT in HIV prevention. It has also developed tools for assessing the acceptability and quality of services. These tools are not prescriptive, but are supposed to be generic and adaptable so as to reflect specific needs and local circumstances. The tools, mainly in the form of structured questionnaires, evaluate among others national preparedness for VCT implementation, operational aspects of sites and services, counselors' requirements and satisfaction, counseling quality and content, counseling for special interventions, group counseling, client satisfaction and the cost of VCT (UNAIDS 2000). Ginwalla, Grant, Day et al. (2002) in their evaluation of VCT services for mineworkers in Welkom found that even though some of the questionnaires were rather long, the UNAIDS evaluation tools were be both effective and acceptable. In this study, a composite questionnaire made up of parts from various questionnaires in the UNAIDS tool was used. While this enabled a wide variety issues relating to VCT services to be covered, it also compromised the depth to which these issues were interrogated.

In their assessment of the public sector's voluntary counseling and testing, Magongo et al. (2002) stratified sites into provinces and then clustered them into urban, rural and township. They then used convenient sampling to interview site managers, counselors

and VCT clients using structured questionnaires. Pronyk et al. (2002) studied the feasibility of introducing VCT in rural settings by evaluating clinic testing registers and using semi structured interviews with counselors and mock-client encounters.

CHAPTER THREE STUDY METHODS

3.1 Study design

A cross-sectional study of VCT services in 14 facilities distributed within the Ekurhuleni Metropolitan Municipality in Gauteng, South Africa.

3.2 Study population

All Government funded VCT sites and their managers – including hospitals, clinics, community health centers and NGO facilities – in the Ekurhuleni Metropolitan Municipality. Private hospitals and private practices run by general practitioners were not part of the study population.

3.3 Study sample

Ekurhuleni Metropolitan Municipality has been divided into three Service Delivery Regions (SDRs), the Southern, Eastern and Northern SDRs. In each SDR, VCT facilities were stratified into government hospitals, community health centers, clinics, NGOs and hospices. Because of the small sample size, random selection of facilities was done manually. Names of each facility per stratum in each SDR were written on individual pieces of paper. Each paper was folded to conceal the name. The papers were then mixed and with the assistance of the Ekurhuleni District Assistant Director for HAST, one facility was randomly selected within each stratum. Instead of a sample size of 15 sites, 14 sites were included in the study because the only hospice in one of SDRs did not offer VCT at the time of sampling. The inclusion criteria was that all sites chosen for sampling had been offering VCT services for at least one year prior to the start of the study in order for the sites to have sufficient information for data collection. Far East Rand Hospital where the researcher worked was excluded in the randomized sampling.

The questionnaire was pre-tested in two sites (a hospital in the Westrand district and a clinic in Sedibeng district) in January 2007 before the actual study. The aim was to test

the acceptability and clarity of the questionnaires before sampling for the study. Both sites were outside the district of the study sample. No changes were made to the questionnaire following the pre-testing.

Table 3.1 Site selection per service delivery region

Service delivery region	Hospitals		CHCs		Clinics		Hospices		NGOs	
	N	selected	N	selected	N	selected	N	selected	N	Selected
North	1	1	1	1	19	1	2	1	2	1
East	2	1	3	1	29	1	0	0	5	1
South	3	1	2	1	30	1	2	1	7	1

3.4 Data collection

Data were collected between April and May 2007 using three data collection instruments.

a). Questionnaire: Prior to a self-administration of a semi structured questionnaire (Annexure 2) each facility head / manager consented and signed an informed consent form (Annexure 1) for the study. It was a composite questionnaire made up of various parts from the UNAIDS tool kit for VCT services evaluation (UNAIDS 2000). The questionnaire explored demographics of facility managers, staff and training, referral system, guidelines, supervision and support and keeping of VCT register.

b). Checklist: The investigator carried out facility observations and noted certain information using a previously developed facility assessment checklist (Annexure 3). Of importance were the physical structure and the range of services offered by each facility.

c). Data collection sheet: From the VCT register the total number of VCT clients seen in each facility during the specified period was extracted and recorded in a data collection sheet (Annexure 4). The corresponding information kept at the district office was also extracted for comparison.

d). Variables: Variables were identified to obtain the following data for analysis:

1. Facility
    a. Site description
        i. Type (hospital, hospice, community health centre, clinic or NGO)
        ii. Site location (stand alone or within main facility)

iii. Site clearly marked or not
iv. Having counseling space or not
v. Waiting area (adequate or not)
vi. Type of services

b. Number of VCT clients seen over a period of time
c. Type of HIV counselors
d. Number of counselors trained
e. How patients were referred

2. Managers
    a. Position (project manager or clinic head)
    b. Gender (male or female)
    c. Length of time as a facility manager

3.5 Data management and analysis

Each questionnaire together with its facility assessment checklist and data collection sheet was assigned a unique identification code for the purposes of records identification in this study. Names of facilities were not included in the final data analysis and this report for confidentiality reasons. Data were captured into Ms Access Database, cleaned and analysed using Stata (version 10.1). Responses to open ended questions were coded for ease of analysis.

Data analysis was carried out in two stages. The first stage involved frequency distributions of categorical variables, and determination of mean of continuous variables (e.g. number of VCT clients seen over a period of time). In the second stage of data analysis, cross tabulations and student t-test (where applicable) were used to examine differences between subpopulations and the corresponding p-values. The study had a very small sample size and this limited the use of statistical inferences. Therefore, the results of this study are descriptive and presented mainly as percentages.

3.6 Ethical considerations

All participating health care facilities and VCT sites were provided with a clear purpose of the study. They were given an opportunity to decide on whether they wanted to participate or not. Each facility head or manager consented and signed an informed consent form for the study. Anonymity and confidentiality were assured as no names of participants were reflected on the questionnaires, checklist and data collection sheet. Information extracted from VCT registers both at facilities and district did not include client names. Participants were informed of their right to withdraw from the study at any point without any consequences.

Permission to undertake the study was obtained from the Ekurhuleni Metropolitan Municipality, Health and Social Development Department. (Annexure 5).
Ethical approval was obtained from The Committee for Research on Human Subject at the University of the Witwatersrand. (Annexure 6).

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

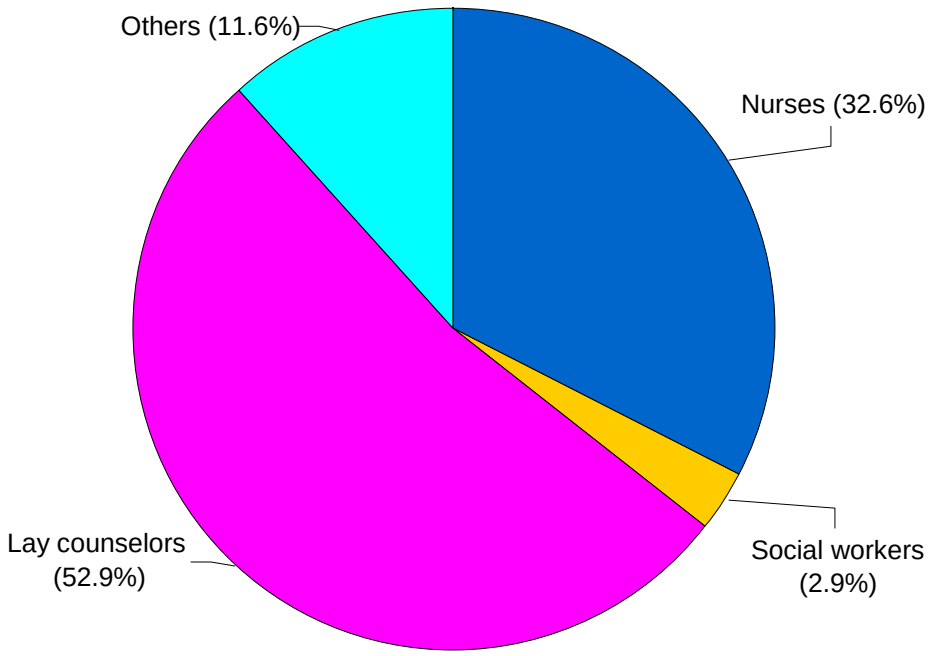


Figure 1. A pie chart of the profile of counselors

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.

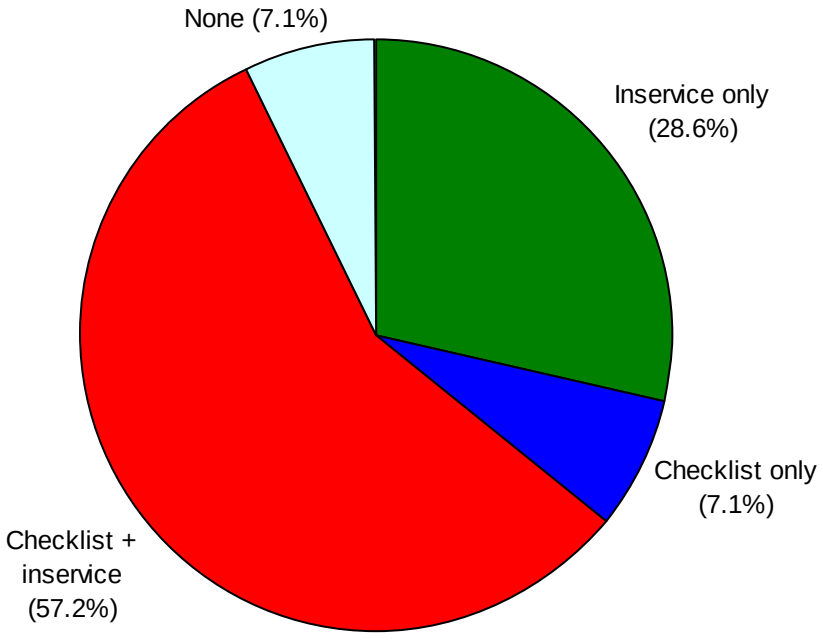


Figure 2. A pie chart showing distribution of methods for ensuring adherence to guidelines

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.

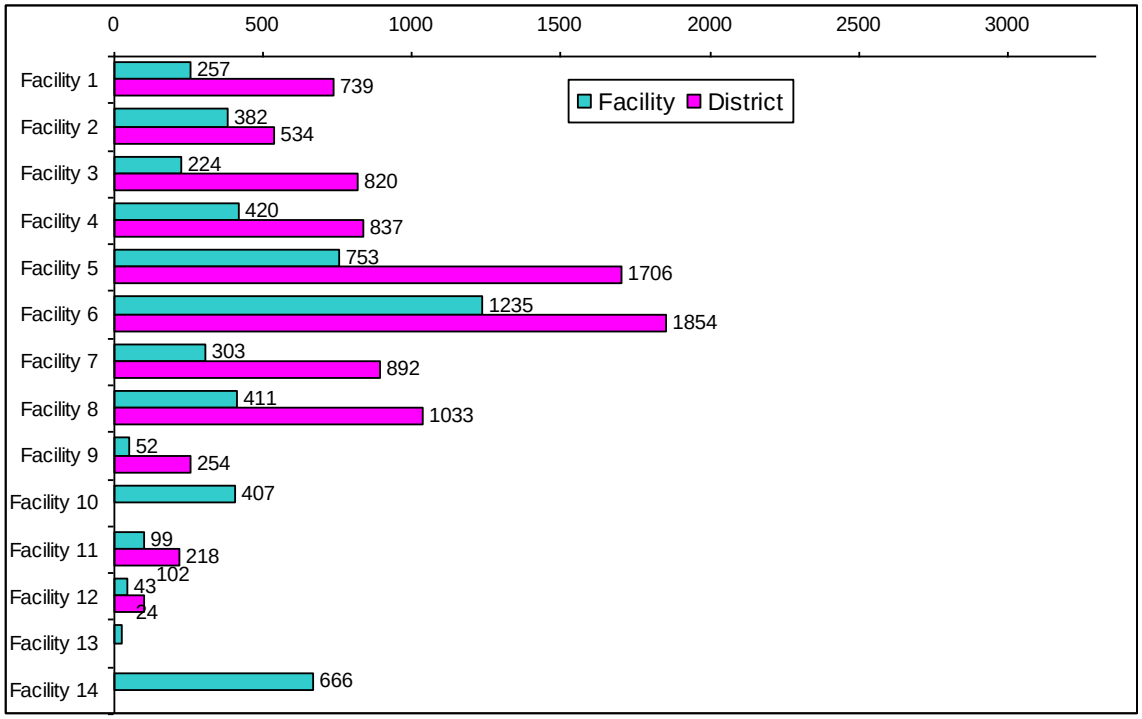


Figure 3. Comparison of absolute number of VCT clients in facility vs. district registers in the first quarter of 2007

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

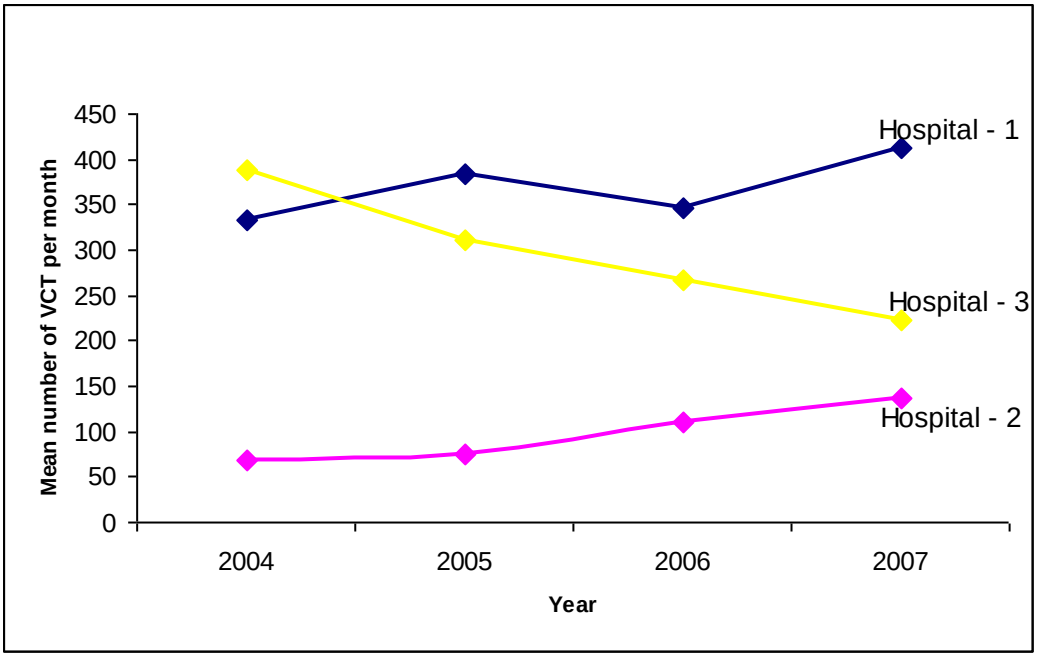


Figure 4. VCT trend in hospitals from 2004 to 2007

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.

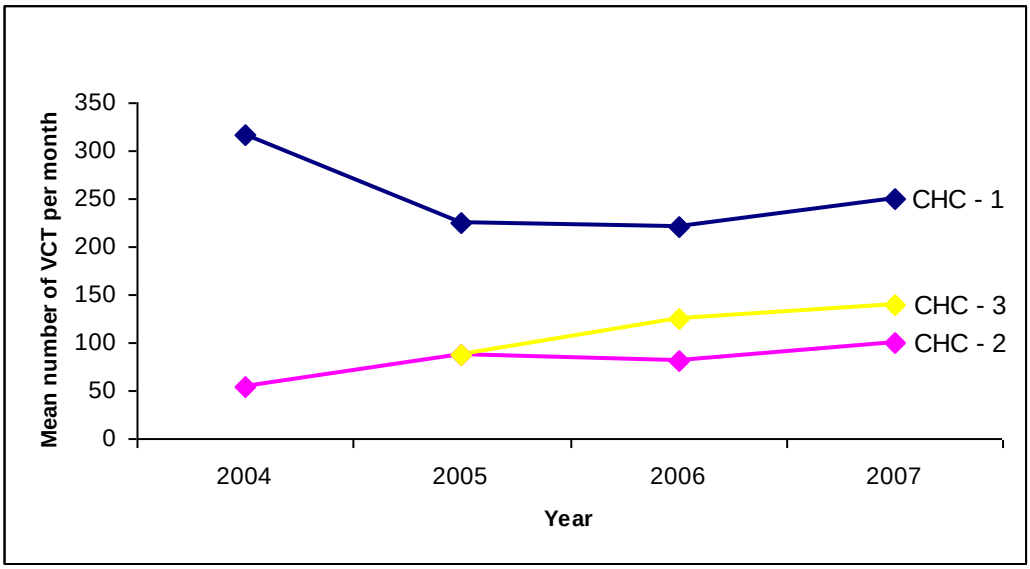


Figure 5. VCT trend in community health centres from 2004 to 2007

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.

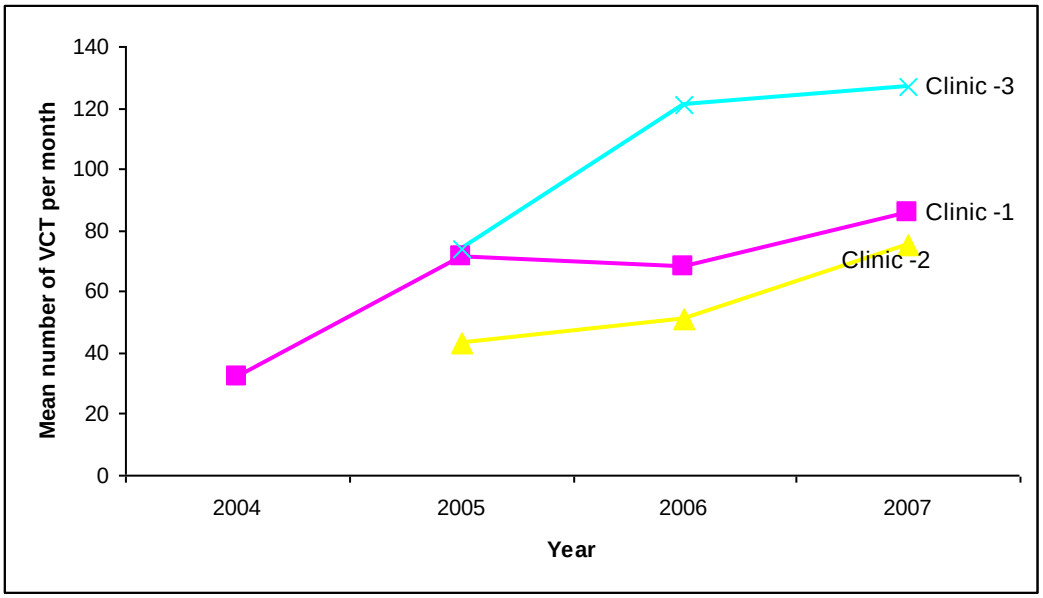


Figure 6. VCT trend in clinics from 2005 to 2007

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.

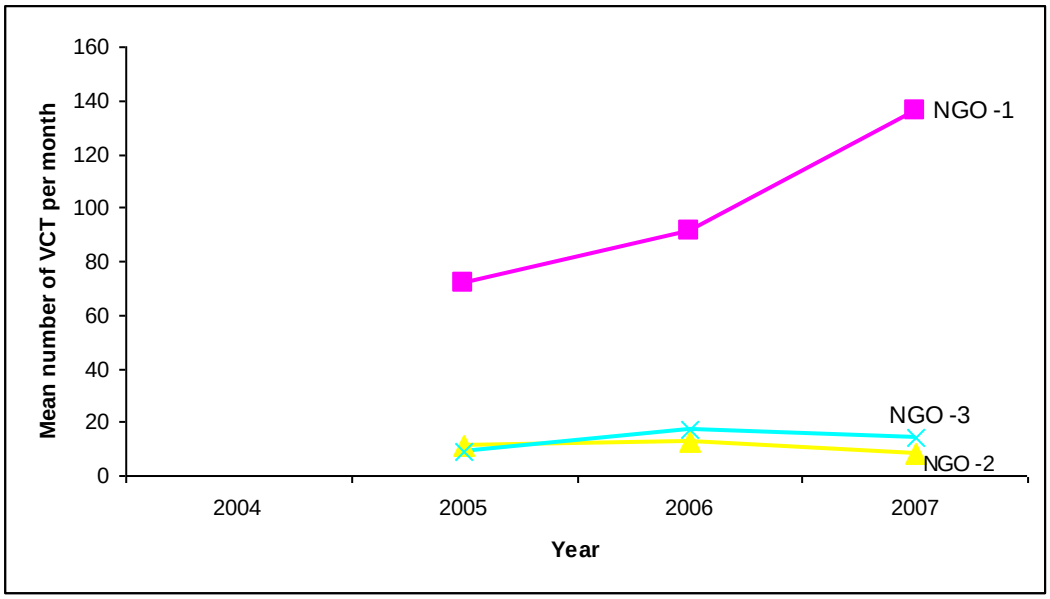


Figure 7. VCT trend in NGOs from 2005 to 2007

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.

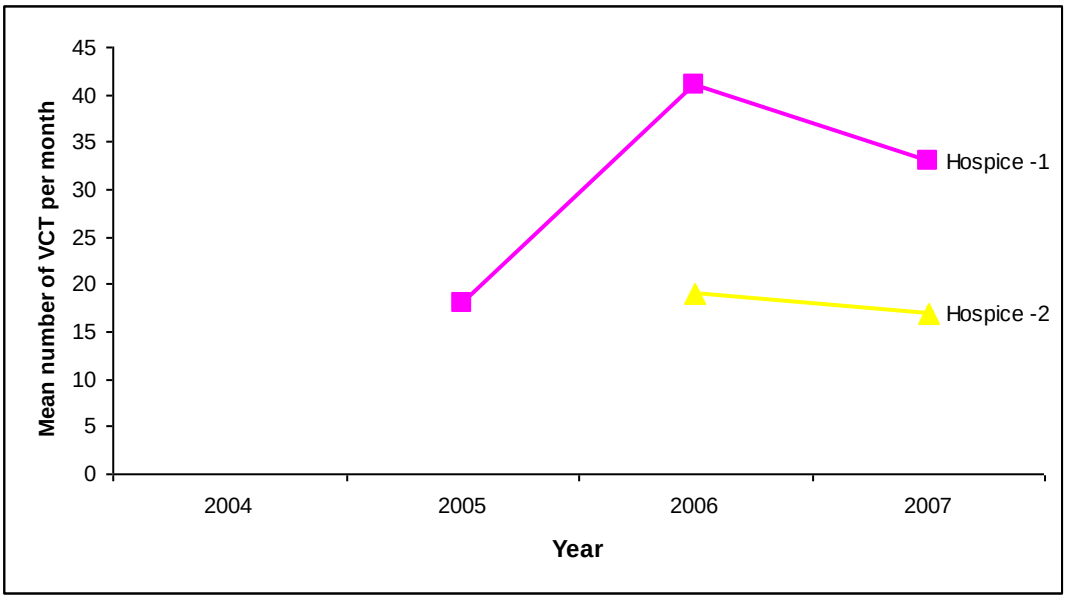


Figure 8. VCT trend in hospices from 2005 to 2007

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.

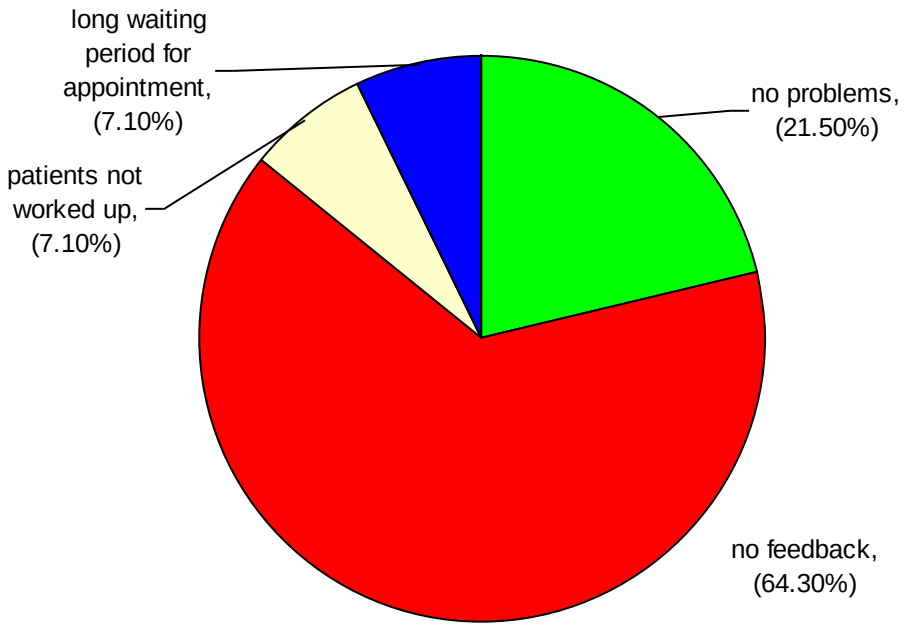


Figure 9. A pie chart showing problems associated with referrals

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.

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.

CHAPTER SIX CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

- The majority of VCT sites had a closed area for counseling and testing but not all provided the necessary privacy.
- Lay counselors constituted the majority of all trained counselors.
- Not all VCT sites evaluated the quality of counseling.
- All the VCT sites relied almost exclusively on health promotion to market VCT services.
- All sites kept VCT registers which had different data elements and a lot of gaps.
- Reading materials were lacking in many of the sites.
- Posters were mainly in English.
- The schedule for debriefings was irregular and focused mainly on lay counselors.
- No formal guidelines on relationships with community structures.

6.2 Recommendations

- Ensure that counseling and testing space provide the necessary privacy in all VCT sites.
- All sites need to regularly evaluate the quality of counseling.
- Expand VCT marketing strategies beyond health promotion.
- Standardize data elements in the VCT register and put in measures to ensure the completeness and integrity of the data.
- Studies of factors influencing VCT uptake be carried out.
- Provide posters and reading material in languages, predominantly used by nearby communities.
- Ensure that debriefings are regular and include all categories of counselors.
- Establish guidelines that regulate formal relationship between VCT sites and community based structures.

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ANNEXURE 1: CONSENT FORM

Hello

Thank you for taking a few minutes of your time to read this document. I am Teboho Moji, a public health student at the University of the Witwatersrand. As part of my studies, I am conducting an assessment of Voluntary Counseling and testing (VCT) services in Ekurhuleni. VCT services are a meaningful entry point to a continuum of care, in treatment and prevention of HIV/AIDS and related illnesses. Although VCT has been available at some sites across the country since 2000, there have been very few studies conducted to evaluate its implementation both nationally and at a local level. This study hopes to give a comprehensive evaluation of VCT services at a local level.

Your participation in this study will be appreciated. Participation is voluntary and should cause you no inconvenience other than requiring that you fill a questionnaire. This questionnaire should take approximately thirty (30) minutes of your time. All information given by participants will be kept confidential. Nobody other than the researcher shall know your identity as site/facility manager or have access to the completed questionnaires. Your name or that of your facility will not be reflected on the questionnaire. You are free to cancel your participation at any time, without consequence. A copy of the final report will be handed to the regional director of health where participating sites can access it if they so wish.

Should you have any further enquiries please contact me or the University of the Witwatersrand's Human Research Ethics Committee (Medical) at the numbers below.

Teboho Moji: 082 7837831

Ethics Committee: (011) 717 1234

If you are happy to participate please sign on the attached sheet.

I understand and voluntarily agree to participate in this study

Name:…….

Signature:…….

Date:……..

Thank you

ANNEXURE 2: FACILITY/SITE MANAGER'S QUESTIONNAIRE

Facility code:…….. Date:……..

- Site description (*mark one)*====> - Public hospital
  - Hospice
  - CHC
  - Clinic
  - NGO

	1
	2
	3
	4
	5

- Position:…….
- Gender:…….

M	F

- How long have you been a facility/site manager?
- When did VCT services start?
- How do you promote your VCT services? Explain
- What other services are offered ========>

Mark all that apply

PMTCT	
TB	
STI	
ART	
Youth friendly	
Others – Specify	

- How are patients referred between services?

Explain:

♦ How are patients referred to outside services?

♦ Describe problems- if any- associated with the referral system.

♦ Does your facility have any relationship with community based HIV/AIDS organisations?

Yes	
No	

Please explain

♦ Is there an ART site nearby?

Yes	
No	

If <u>yes</u> when did it start operating?

♦ How many trained counselors do you have?

♦ How many are ====>

-	Nurses	
-	Social workers	
-	Lay counselors	
-	Others (Specify)	

Mark all that apply

♦ What type of training did they receive?===>

Formal (certified)	
In-service	
All of the above	
Others (Specify)	

♦ How many have attended training in the last year?

♦ Does the site have a dedicated nurse?

Yes	
No	

If <u>yes</u> describe their duties

If <u>no</u> - Why?

♦ What happens when the dedicated nurse is absent?

♦ Are VCT services offered daily? ===>

Yes	
No	

If <u>no</u> – Why?

♦ What are the hours of operation of the VCT site?

♦ Do you have an appointment system? ==>

Yes	
No	

If yes, what happens if someone comes without an appointment?

♦ Do you have adequate space to ensure that counseling sessions can be private?

Yes	
No	

If yes, specify type of space

Private office	
Cubicle	
Curtained-off area	
Other(describe) _____ _____ _____	

Counseling	Yes	No
Testing		

- Do you have the following policy guidelines available?

Confidentiality		
Informed consent		
Testing quality		
Assurance		
All of the above		
Non of the above		

- Are all staff involved with VCT familiar with these guidelines?

Yes	
No	

If <u>no</u> – Explain

- How do you ensure adherence to these guidelines?

- Do you evaluate the quality of counseling and content offered to clients?

Yes	
No	

If <u>yes</u> – How?

If <u>no</u> – Why?

- Who does the quality assurance of testing kits?

How often?

Explain

- How often do you meet with the programme staff?

- Is there a set agenda for these meeting?

Yes	
No	

Explain?

♦ How often does the regional VCT coordinator visit?

♦ Do you get to interact with them at every visit?

Yes	
No	

Explain?

♦ Do you get enough support from the coordinator?

Yes	
No	

Explain?

♦ Is there any debriefing programme for VCT staff?

Yes	
No	

♦ Who does the debriefing?

How often?

Explain?

♦ Who is responsible for keeping the daily register?

♦ Who has access to this register?

♦ Who compiles monthly statistics?

♦ Do you ever analyse these statistics?

Yes	
No	

Explain?

- Has VCT services affected how other services are rendered?

Yes	
No	

If <u>yes</u> – Explain

- What is your overall impression of your VCT services?

Thank you for your participation

ANNEXURE 3: FACILITY ASSESSMENT CHECKLIST

Facility code:…….. Date:……..

- Site description:
  - Public hospital
  - Hospice
  - CHC
  - Clinic
  - NGO

	1
	2
	3
	4
	5

- VCT site located within main facility or as a stand-alone?

- VCT site clearly marked or not?

Yes	
No	

- Description of waiting area

Small	
Adequate	
Enough sitting space	

- HIV/AIDS posters

Present	
Absent	
English	
Other languages	

- HIV/AIDS reading material

Present	
Absent	
English	
Other languages	
Can it be taken away	

- Counseling space

Open	
Closed	
Privacy	
No privacy	
Other	

♦ Testing space

Open	
Closed	
Privacy	
No privacy	
Other	

♦ Testing type

Rapid test only	
Rapid and confirmatory only	
Rapid and confirmatory and Elisa	
CD 4	
Viral load	

ANNEXURE 4: DATA COLLECTION SHEET

Date:……

Facility code:…….

1. Number of VCT performed over a period of time in facility + district
   a. Monthly
   b. Quarterly
   c. Annually

2. Type of register

3. Components of VCT register in facility

ANNEXURE 5: EKURHULENI METROPOLITAN MUNICIPALITY APPROVAL

Department of Health
Lefapha la Maphelo
Department van Gesondheid
Umnyango weze Mpilo
EKURHULENI HEALTH DISTRICT
Private Bag X1005, Germiston, 1400
Enquiries: Modise Makhudu
Tel: (011) 876-1817
Fax: (011) 876-1818
Email : ModiseMa@gpg.gov.za
DaleenD2@gpg.gov.za

To: Dr. T. D. Moji – CEO for Far East Rand Hospital

From: Mr. M. Makhudu – Acting CD for Ekurhuleni and Sedibeng Health Region

CC: Dr. A. Govender – Acting Director for Ekurhuleni Health District
Ms. T. Maboe – Deputy Director for HAST
Ms. P. Molepo – Deputy Director Clinical Support
Ms. N. Khambule – Assistant Director for HAST

Ref: DIR/472/1/2007

Date: 12th of January 2007

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN EKURHULENI HEALTH FACILITIES: "ASSESSMENT OF VOLUNTARY COUNSELING AND TESTING (VCT) SERVICES IN EKHURHULENI METROPOLITAN MUNICIPALITY"

1. Please refer to the above mentioned request.
2. Hereby approval is given to perform your research at the Provincial Health facilities.
3. Kindly share your findings with this office.

Regards

MODISE MAKHUDU
ACTING CD: EKURHULENI AND SEDIBENG HEALTH REGION
DATE: 12/1/2007

ANNEXURE 6: ETHICS APPROVAL

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Moji

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M060538**
PROJECT	Assessment of Voluntary Counseling and Testing (VCT) Services in Ekhurhuleni Metropolitan Municipality
INVESTIGATORS	Dr TD Moji
DEPARTMENT	School of Public Health
DATE CONSIDERED	06.05.26
DECISION OF THE COMMITTEE*	APPROVED UNCONDITIONALLY

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 06.07.13 **CHAIRPERSON** .....
(Professor A Dhai)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Dr F Akpan

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES