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

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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 no – Explain

- How do you ensure adherence to these guidelines?

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

Yes	
No	

If yes – How?

If no – 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