**Impact of the COVID-19 pAndemic on health care workers and the health care system in Zimbabwe (ICAROZ)**

Principal Investigator: Katharina Kranzer [MBBS, MSC, PhD]
Phone: +263 (0)4 745583

**What you should know about this service**

- We are giving you this information sheet so that you may read about the purpose, and benefits of this study.
- After reading this information sheet you have the right to refuse to take part, or agree to take part now and change your mind later.
- We cannot promise that this research will benefit you. The main goal of research studies is to gain knowledge that may help other people in the future.
- Please review this information carefully and ask any questions before you make a decision.
- Your choice to participate is voluntary and will not affect your employment

**PURPOSE**

Health care workers are frontline workers who are employed to provide a health care service to the general population. This includes doctors, nurses, nurse aides, cleaners, clerks, lab technicians, pharmacy staff, security staff and anyone who works within the health service. Since the beginning of the COVID-19 pandemic there have been many health care workers, across the world, who have come in contact with patients who have had COVID-19. Working in a health care service can make you more exposed to COVID-19 than other service providers. In addition, health care workers require a robust occupational health service in order for them to maintain healthy lives to protect their own health and well-being.

**PROCEDURES AND DURATION:**

We are inviting you to take part in an individual in-depth interview and/or a workshop. Due to the nature of the COVID-19 pandemic, should a face to face interview not be possible, we may have the interview over the telephone. We will only begin recording the interview once you have agreed to be part of the study. We will audio record these interviews and take notes but your real name will not be recorded. We may quote what you say when reporting the results but no one will be able to link what you say back to you. If you have an email address or Whatsapp on your telephone, this information sheet and consent form can be forwarded to you for your review. You are being invited to take part in this research because you are a health care provider or work at a health care facility. We will ask you your opinions on the importance and acceptability of health screening for you and your co-workers. We would like to know what type of service you would like, where you think it should be delivered, time of day and day of the week. In addition we would like to understand how COVID-19 has impacted your work practices, the services you provide at your place of work and how you were safely able to carry out your day to day work.

If you have already accessed this service through our study team i.e. have had health screening performed by our study we wish to understand your experience of the service as well as understand how being able to use the service may have impacted on your life.
We will encourage you to talk about important health topics and also how you would like to be able to access health care and what challenges you are faced in being able to access health care. In addition, we may ask you about concerns you had around about being exposed to COVID-19 while at your place of work.

What you tell the researchers will be confidential, and no one else except members of the research team will have access to what you tell us. The researchers may record the interview, but you will not be identified by name and what you say will only be reported anonymously so that people cannot know who has said it. Afterwards, the recording will be kept in a locked cupboard, in password-protected files in the research office. It will be destroyed after a maximum of five years after the end of the study.

**RISKS AND DISCOMFORTS:**
The interviews are not designed to ask any sensitive questions. However, there is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the to[illegible]. The researchers will keep everything that you say strictly confidential and what you tell us will only be reported anonymously and in a way that stops you being identified. Please remember that you do not have to answer any question or take part in the discussion if you feel the questions are too personal or if talking about them makes you uncomfortable.

**BENEFITS AND/OR COMPENSATION:**
The results from this study will help us understand what should form part of health screening for health care providers and where such a service should be offered and how referrals for treatment can be best organized. There are no immediate benefits to you as an individual. Although taking part in the study will not cost you anything, we will also not pay you to take part in the study but we will offer you compensation for your time or reimburse your transport costs if you have had to travel specifically for this interview.

**CONFIDENTIALITY:**
If you agree to take part in this study by signing this document, all the information that you give us will be stored without using your real name. No one will be able to get hold of the information about you except for the research team. No one will be able to identify you from the information we collect about you.

We [illegible]ould like to audio record the discussion in order to make sure that we do not miss any valuable [illegible]formation. We may also take notes during the discussion. We may use some of what you say as an example of the opinions of health care workers in reports about this research, but your name will not be mentioned.

**VOLUNTARY PARTICIPATION:**
Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Biomedical Research and Training Institute working on this study or with your employer. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without penalty.

**WHO TO CONTACT WITH QUESTIONS OR PROBLEMS:**
If you would like more information or have any questions about the ICAROZ study please ask the researcher interviewing you. You may also use the following telephone numbers if you still need more information.

**Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.**



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## AUTHORIZATION

***The date you sign this document to enroll in this study, that is, today's date, MUST fall between the dates indicated on the approval stamp affixed to each page. These dates indicate that this form is valid when you enroll in the study but do not reflect how long you may participate in the study. Each page of this Informed Consent Form is stamped to indicate the form's validity as approved by the MRCZ***

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY. YOUR SIGNATURES INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL YOUR QUESTIONS ANSWERED, AND HAVE DECIDED TO PARTICIPATE.

- I have read the information sheet concerning this study and I understand what will be required of me and what will happen to me if I take part in it
  - I understand that at any time I may withdraw from this study without giving a reason and without affecting my normal care and management.

I agree to participate in this study YES☐ NO☐

I agree to take part in an in-depth interview YES☐ NO☐

I agree to take part in a workshop YES☐ NO☐

**Consent from participant:**

| Name of Participant (Print) | Signature of Participant | Date |
|---|---|---|

| Name of Research Staff (Print) | Signature of Research Staff | Date |
|---|---|---|

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## Audio Recording

**Statement of Consent to be Audio taped**

I understand that audio recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to **being audio recorded** — **Yes** ☐ **No** ☐
- I agree **to my quotes being used anonymously** — **Yes** ☐ **No** ☐

| Name of Participant (please print) | Signature | Date |
|---|---|---|
| | | |

| Name of Research Staff (Print) | Signature of Research Staff | Date |
|---|---|---|
| | | |

**YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP**

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research subject or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe on Telephone: 791792 or 791193. Cell: 0772 433 166

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