"IT'S IMPORTANT TO TAKE YOUR MEDICATION EVERYDAY OKAY?" AN EVALUATION OF COUNSELLING FOR ARV ADHERENCE SUPPORT IN THE WESTERN CAPE

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INTRODUCTION

Adherence support is a critical component of antiretroviral (ARV) treatment programmes. Within the primary health care service in the Western Cape, individual counselling for adherence support is delivered by lay counsellors trained according to Egan's "Skilled Helper" model. The extent to which counsellors adhere to Egan's model is unclear however, and anecdotal evidence suggests that ARV adherence counselling consists mainly of information-giving. To date there has been no evaluation of ARV adherence counselling practice in the Western Cape (or other South African provinces). This study aimed to evaluate the counselling being delivered by lay ARV adherence counsellors in Cape Town in terms of the extent to which counsellors adhere to Egan's model, and counselling skills used.

Counselling Training for ARV Adherence Support in the Western Cape Province

Counsellors employed within the public healthcare system in the Western Cape are currently trained by ATICC using a micro-skills approach. This method of training divides the counsellor-client interaction into small, meaningful skills [1]. Basic (verbal) micro-skills trained by ATICC are presented and defined in Table 1.

Table 1: Micro-counselling skills trained by ATICC

Skill	Definition
Open question	Questions encouraging explanation or expansion upon thoughts, feelings, experiences. May start with the following stems: how, tell me, in what way.
Closed question	Questions that can be answered with yes, no or one word phrases.
Simple reflection	Repetition of clients words used to check (or convey) understanding of what has been said. May reflect content or emotions.
Complex reflection	Adds substantial (inferred) meaning or emphasis to what the client has said.

The intention is that trainees integrate these skills into the counselling framework (Egan's model). The three stages of Egan's model are each described in Tables 3, 4 and 5. For Egan [2] the relationship between counsellor and client is one of collaboration; clients are equal contributors in the counselling process, and the counsellors' task is to help the client to feel competent to solve their own problems.

METHODS

Data collection

Thirty-nine adherence counsellors from 21 clinics agreed to take part in this sub-study. Fieldworkers attended study sites during May 2009 with the aim of collecting up to 3 voice-recordings of counselling sessions from each counsellor.

Data Analysis

Recordings were transcribed and translated in to English where necessary. Analysis was based on the methods of content analysis [3]. Codes were predetermined based on the ATICC training and represented counselling micro-skills (e.g. "open question") and activities associated with Egan's model (e.g. "giving information", "brainstorming"). Other codes were added on the basis of a first review of the transcripts. Micro-skills and activities were grouped according to the stage of Egan's model they could be associated with.

RESULTS

Sixty-four usable recordings were collected from 30 of the 39 counsellors. Originally all transcripts were intended to be analysed but a restriction of resources early on in the analysis necessitated a revision of the sampling strategy. As such, 7 counsellors had one or two transcripts analysed each while the remaining 23 had one randomly selected transcript analysed each: a total of 38 transcripts were analysed.

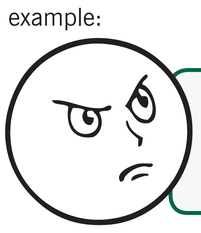
Participant Demographics

The majority of the 30 counsellors were female (n=26) and Xhosa-speaking (n=24). In terms of education, most (n=23) had achieved a Grade 12 (Matric) certificate. Counsellors had up to 5 years of counselling experience in the field of HIV, and up to 2 years of experience in ARV adherence counselling specifically.

Egan's Model Stage One: Exploration

Table 2: Required activities and skills associated with stage 1	
Counsellors' task:	To assist the client to ventilate the problem.
Goal:	In assisting the client to ventilate the problem is defined and client feels listened to.
Skills required:	Attending, listening, showing empathy, asking questions.

In opening the session 20% of counsellors (n=6) were described as being confrontational and/or patronising, for example:

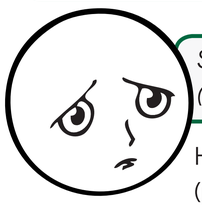


Cindy, I am of the understanding that you are now late, a month late (for your clinic visit)….and I hope that it does not happen again because this is for your health (Counsellor 20)

Asking questions: Open questions are generally considered an appropriate way to open a session because they provide the opportunity for the client to define the issue [4]. Nineteen counsellors (63%) used an open question in initiating exploration of the referral problem and this was well done in most cases. The remaining counsellors (n=11; 37%) attempted to explore with one or more closed questions. Seven counsellors (23%) engaged in bouts of closed-ended questioning that came across as interrogative. Overall, counsellors asked a ratio of 3.3 closed questions for each open question.

Simple reflections: are used to help the counsellor to understand the clients' point of view and can also be used to express empathy [5]. In total 58 simple reflections were associated with this stage. The majority of these (n=36; 62%) were well done, for example:

…and the father I am staying with, you see this also contributes to the problems in my house



So if I hear you correctly, at this minute there's a lot that is stressing you (Counsellor 15)

However the remaining 22 reflections (38%) were merely repetitions of the client's words (parroting) and did little to facilitate understanding or express empathy.

Seven counsellors (23%) did not engage in an exploration of the referral problem before going on to give information as a part of stage 2.

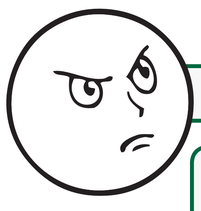
Egan's Model Stage Two: Understanding

Table 3: Required activities and skills associated with stage 2	
Counsellors' task:	To assist the client in exploring issues related to the onset and the maintenance of the problem.
Goal:	To help the client to achieve deeper level of understanding of the problem.
Skills required:	Probing, offering information, setting goals.

Probing: In total, 115 open questions were associated with this stage in comparison to 356 closed questions (a ratio of 3.1 closed to each open question).

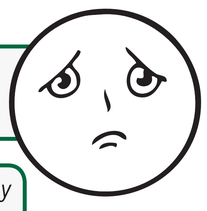
More than half (n=94; 72%) of simple reflections in this stage (n=131) were used for fact-checking and were reflections of content. Three complex reflections were observed in 3 separate sessions.

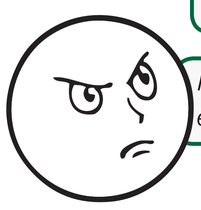
Twenty-six "missed opportunities for reflection" were coded, the majority (58%; n=15) of which were related to client statements which revealed underlying emotions such as guilt, sadness and pain:



So, and why, can you tell me why did you stop your medication?

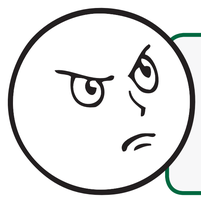
Because also the doctor here told me to leave this clinic and I should never ever come back to this clinic, she doesn't want me here.





Hmm? Okay I understand that, but remember when you first started did they explain to you how important is this medication? (Counsellor 28)

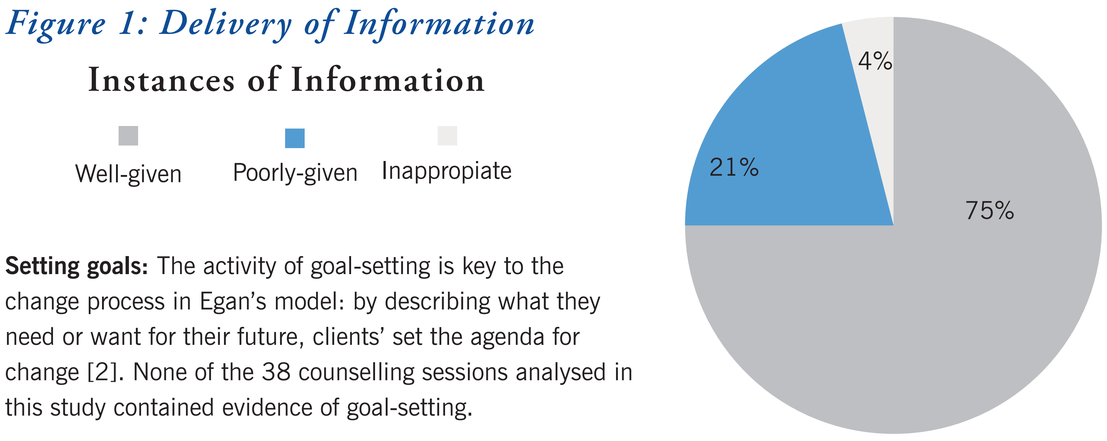
Forty-two confrontational statements were issued by 43% (n=13) of counsellors. The majority of these counsellors (n=9) were confrontational in more than one instance, with one counsellor making as many as 12 confrontational statements in one session. For example:



Okay, in all that you are saying there is nothing that satisfies me…and you must know that by not speaking the truth…I don't know if you (did) get the pills or (if) you didn't get, and I don't want to believe what you are saying…there is nothing here to convince me that you have taken your treatment. (Counsellor 16)

Offering information: In total, 378 instances of information-giving were coded. Only 16 instances were inappropriate because they did not relate to the focus of the session or were not tailored to the clients' situation (figure 2). The majority of information given was appropriate and well-given (75%; n=283), although 79 instances of information-giving (4%) were coded as appropriate but poorly-given. "Poorly given" referred to information that involved many concepts being introduced in large indigestible 'chunks', was technically incorrect, involved insensitive statements regarding illness and death, or was unclear.

Figure 1: Delivery of Information



Setting goals: The activity of goal-setting is key to the change process in Egan's model: by describing what they need or want for their future, clients' set the agenda for change [2]. None of the 38 counselling sessions analysed in this study contained evidence of goal-setting.

Egan's Model Stage Three: Action and ending the session

Table 4: Required activities and skills associated with stage 3	
Counsellors' task:	The client decides on an action plan.
Goal:	To help the client to translate his/her goal in to an action plan.
Skills required:	Brainstorming, Sorting pros & cons, monitoring progress, ending the session

Brainstorming: provides a pool of potential strategies from which the client can choose a plan of action that best fits their resources, environment and timetable [2]. Brainstorming was not evident in any of the 38 sessions. **Sorting pros and cons:** no counsellors encouraged clients to consider the pros and cons of various (or any) courses of action.

Six of 30 counsellors (20%) asked clients for their own ideas as to how they might increase their adherence before they went on to give further information; remaining counsellors (n=24; 80%) did not.

The coding structure devised for this analysis did not include information-giving as a part of the "action" stage of Egan's model, but it became clear that **information was the primary technique used by** counsellors for managing non-adherence. Instances of information-giving were also often intermingled with advice, expressions of concern, warnings and moralising. Generally advice related to strategies for overcoming barriers appeared to be appropriate to what was known about the clients' situation.

CONCLUSION

Overall counsellors displayed good knowledge and information-giving skills around HIV and ARV treatment, and instances of good counselling technique were observed.

Counsellors' practice was not consistent with a client-centred approach to counselling and conformed to the traditional patient-provider relationship. Core principles of client-centred counselling (such as the demonstration of respect and positive regard) were contravened.

Counsellors' practice did not adhere to the stages and activities associated with Egan's Skilled Helper model:

- Some counsellors did not explore the clients' non-adherence before going on to give information;
- Goal-setting around adherence and/or health and brainstorming was absent in all counselling sessions; instead counsellors relied on information-giving and advice in order to address clients' non- adherence.

In terms of basic counselling micro-skills, counsellors relied on closed questions in exploring and working to understand the referral problem. Ideally more open questions should be used. Simple reflections often took the form of parroting.

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