TRANSLATING RESEARCH INTO PRACTICE: THE IMPLEMENTATION OF OPTIONS FOR HEALTH: WESTERN CAPE

S Dewing[1], C Mathews[1,2], N Schaay[3], A Cloete[4], L Simbayi[4]

[1]Health Systems Research Unit, Medical Research Council,
[2]School of Public Health and Family Medicine, University of Cape Town,
[3]School of Public Health, University of the Western Cape,
[4]HIV/AIDS, STIs and TB (HAST) research programme, Human Sciences Research Council

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BACKGROUND

- MRC study found that 44.7% of HIV-positive people initiating anti-retroviral (ARV) treatment in Cape Town engaged in unprotected sex at last sex (Eisele et al., 2009)
- In response to this *Options for Health* was implemented across 21 ARV clinics

What is *Options for Health*?

- One of the first interventions to integrate prevention and care in South Africa, and it has been shown to be effective in reducing the HIV risk behaviour of HIV+people on ARV(Fisher et al., 2006)
- Based on the Information, Motivation and Behavioural (IMB) model of behaviour change
- Motivational Interviewing (MI) is used to deliver HIV risk reduction information, motivation and behavioural skills content
- Designed to be used in busy clinic settings, a first *Options* counselling session is designed to take 10-15 minutes, while follow up sessions take 5 minutes
- In the USA and Kwazulu-Natal *Options* has been shown to significantly reduce sexual risk behaviour among ARV patients (Cornman et al., 2008)

How was *Options* implemented in Cape Town?

- Inclusion of a ARV adherence component
- ARV adherence counsellors were trained
- Process evaluation revealed that counsellors delivered less than 20% of intended patients over a 10 month period

OBJECTIVE

- To determine the factors negatively affecting the implementation of ***Options for Health: Western Cape***.

METHODS

- Semi-structured interviews were conducted with 15 to 31 lay ARV adherence counsellors
- Interviews were recorded, conducted in English or Xhosa and translated where necessary
- Thematic analysis was used to identify the key factors affecting counsellors' use of *Options.*

RESULTS

The Integration of Options into Counselling Practice: "Must I do the Options now or the adherence now?"

A difference between two counsellors interviewed, one who used ***Options*** to a greater extent than the other, was the way in which they seemed to have integrated the model in to their current practice. Counsellor C appears to have incorporated ***Options*** into her counselling as one method that she could draw on as the situation calls for it:

> *You know there are so many challenges I do not want to lie, you need to apply the skills that you have, I am not going to say which one is... better than the other...because you sometimes find out that you are cornered [and you think] "what else can I use"? So all of these tools that you have, you must use them."* (Counsellor C)

This, in comparison to the counsellor not using ***Options***, who understood it as something completely different to her usual practice:

> *"The sister said I must give adherence counselling, that is where I said I found some of the difficulty: must I do adherence now? Must I do Options now? To choose one of the two, see?"* (Counsellor A)

This distinction between ***Options*** and "adherence" or "normal" counselling is one that was made by some of the other counsellors as well. The perception of the Options counselling protocol as something that needs to be done in addition to 'normal' adherence counselling (and perhaps even as something that is only part of a research study) was considered by the team as a barrier to implementation.

"The problem is that we don't have space"

Of the 15 counsellors interviewed, 5 were from facilities in which space was limited and there were no or too few dedicated counselling rooms. The limited time that they had to spend with each patient as a result of not having a dedicated counselling space was considered a barrier to (any) counselling:

> *"I'm in the doctors room...then the doctor opens and gets in ... "finish up I'm here to see, I want to see a few patients before I go to see the wards ... so please finish up" you know, so you, you've got maybe 6 patients that are waiting for you, so in any case you gonna try to fit those 6 patients before that time the doctor comes in."* (Counsellor K)

Work (and Specifically Time) Pressure: "When it is busy it gets really hectic for us"

Counsellors reported finding it difficult to do Options when the clinic was busy because they felt the need to rush through the pile of folders belonging to patients waiting to see them. Being pushed for time meant that they fell back on their "normal" counselling routine:

> *"The number of people we see, it's too much ... we do our...the normal counselling, we do it before we even know it."* (Counsellor M)

Theoretically, the model on which their 'normal' counselling is based requires 30-45 minutes per counselling session, while the Options model should take no longer than 15 minutes for a first session. Thus, when time is limited Options should, theoretically, have been the method of choice. Of concern to the team was that if the counsellors felt that they did not have sufficient time to do Options (10 – 15 minutes) with each patient, and their 'normal' counselling routine required double that amount of time, what was it that they were in fact managing to do in their routine practice with each client?

Patient resistance to counselling: "Eeeeh my time, I [have] wasted a lot of time [with] you"

Counsellors described patients as being unwilling to attend counselling sessions and reported that they would complain when called in for (any) counselling:

> *"You see some of them they will always say, "no, I don't want to go to the counsellor again because its wasting my time or I'm in a hurry and all that, you see, they don't want to come."* (Counsellor L)

In addition, some patients who 'accepted' counselling were experienced as being uninterested:

> *"They just tell us what we want to hear..people just want to tell me just to get out, you know."* (Counsellor A)

Counsellor I described how the clinic had revised its protocol around counselling because patients viewed it as a kind of 'punishment':

> *"It's what they, this (clinic) decide ... when you are sending the patient to the counsellor they fear that "what have I done wrong?" so now because we don't want to scare him [any]more then, so ...we don't [send him to counselling] if he misses one day."* (Counsellor I)

Another counsellor described how patients don't like to receive counselling on adherence because they believe that they already have all the information that they need and they already know that adherence is important. This implies that patients understand counselling sessions to involve merely the provision of information and to be of little benefit to them.

"There are patients that you really don't see the use of using Options"

Counsellors did not feel that Options was appropriate for all patients referred to them with adherence problems. These included "difficult" patients, the elderly and uneducated:

> *"We've got bergies that come in and out here taking treatment, they come drunk and whatever you say they don't care ... they come not interested, you ask them questions, they just shut up as if you are sitting with a doll."* (Counsellor J)

Many counsellors also revealed an understanding of the Options model that was limited to particular types of non-adherence. As a result it seems that counsellors are missing opportunities to deliver Options; some did not feel that Options was appropriate for what were perceived to be "once-off" problems or 'valid' reasons for poor adherence:

> *"Like most of our patients they default, they go to Eastern Cape... and it's something that happens once a year ... and the patient tells you that , "no, it was because of the death of my grandmother"... so what's the use of using Options in that case?"* (Counsellor K)

One counsellor felt that coming up with action plans to improve adherence (a part of the Options protocol) was of little use to people like truck drivers because it was likely that they would not come back for a follow-up visit. Currently ARV adherence counselling is organised on ad-hoc basis and there is no system for ensuring that patients receiving counselling are followed-up at future clinic visits. Thus, counsellors who are unable to ensure that patients return for follow-up counselling are unlikely to see the point of conducting the first Options session given that it requires a follow-up session.

"Even if I don't do Options properly ... I got tools that I'm using from Options"

Counsellors reported sometimes using bits and pieces of Options as it suited their needs:

> *"Even if I don't do Options properly ... then I will ask a person that, "yeah, tell me how important is it for you to take your treatment?" that means I'm trying to search from this client by using one of the Options tools."* (Counsellor J)

A number of counsellors seemed to have adopted particular skills associated with Motivational Interviewing and found them to be useful regardless of whether they were using the full Options protocol or not. One counsellor particularly liked the concept of asking permission as a helpful way to begin a discussion on a sensitive topic.

Why *Options* is not being used to talk about sexual risk behaviour

When asked about whether they use Options to talk to ARV follow-up patients about sexual risk, counsellors said that they would do this when a patients' viral load increased but that they found that patients rarely admit to engaging in any sexual risk behaviour:

> *"We don't really have the patients that are having the sexual problems, our patients are using condoms but all you find out after 6 months or 3 months the patient is pregnant!"* (Counsellor K)

This, in addition to the constraints that have been described above about ARV adherence counselling in general, helps to explain why Options was not used to address sexual risk behaviour in particular during the ARV adherence counselling sessions that the lay ARV adherence counsellors facilitated during the study period.

RECOMMENDATIONS

It is recommended that before proceeding with any further Options training in the metropolitan area of Cape Town that an evaluation of the 'normal' (current) practice of lay ARV adherence counsellors be conducted in order to understand what it is that counsellors are in fact doing with their clients – especially in a context where time is of the essence.

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REFERENCES

- Cornman DH, Kiene SM, Christie S, et al. Clinic-based intervention reduces unprotected sexual behaviour among HIV infected patients in Kwa-Zulu Natal, South Africa: results of a pilot study. J Acquir Immune Defic Syndr. 2008;48(5):553–60.
- Eisele, T. P., Mathews, C., Chopra, M., Lurie, M.N, Brown, L., Dewing, S. & Kendall, C. (2009). Changes in risk behavior among HIV-positive patients during their first year of antiretroviral therapy in Cape Town, South Africa. AIDS and Behaviour, 13(6): 1097-105.
- Fisher, J.D., Fisher, W.A., Cornman, D.H., Amico, K.R., Bryan, A., & Friedland, G.H. (2006). Clinician-delivered intervention during routine clinical care reduces unprotected sexual behavior among HIV-infected patients, Journal of Acquired Immune Deficiency Syndrome, 41(1):44-52.

For a full copy of this report or more information about this study please contact Ms Sarah Dewing (MRC) at sarah.dewing@mrc.ac.za

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