Options for Health: Western Cape

Preliminary Findings on the Feasibility of Incorporating Options in to Routine Adherence Counselling Practice

Report prepared for feedback meeting between the Options research team and stakeholders

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Feedback Report

Purpose of the report: To present findings relating to the implementation of *Options for Health: Western Cape* that will inform the decision on how to proceed with the roll-out of the intervention.

Introduction

In response to a recent finding that 44.7% of people initiating ARV treatment in public health clinics in Cape Town had had unprotected sex at last sex (Eisele et al., 2009), we conducted a process evaluation of *Options for Health: Western Cape*, an intervention delivered by ARV adherence counsellors and aimed at reducing sexual risk behaviour and optimising ARV adherence among people on ARV treatment in Cape Town[1]. Based on Motivational Interviewing and the Information, Motivation and Behavioural (IMB) skills model of behaviour change, *Options* is a model for counselling that is different to the model in which lay counsellors are currently trained by the AIDS Training, Information and Counselling Center (ATICC[2]).

Since counsellors from 4 randomly selected NGOs (Non-Governmental Organisations) were trained in *Options* in June 2009, we have observed that the intervention has not been implemented to the extent that was expected by the *Options* research team. In order to encourage implementation, the research team:

- Supplied counsellors (before they left the training course) with the following guidelines on when to use *Options* with their patients:

In <u>All</u> Treatment Workup sessions:	**For clients who are being prepared to start ART:** ▪ I should use *Options* to talk about practising safer sexual behaviour. ▪ I can also use *Options* to help patients to identify barriers that might prevent them from taking their ARVs and from getting to the clinic on their appointment dates.
In <u>All</u> ARV Follow-up sessions	**For clients who are already on ART:** ▪ I should use *Options* to talk about improving their adherence to their ARVs ▪ I can use *Options* to help the client to problem solve around things that prevent them from coming to the clinic on their appointment dates. ▪ I can also use *Options* to talk about sexual risk if I think this would be good and I have the time.

[1] A pilot study was conducted in the second half of 2008; results from this study have been published and the journal article is included at the back of this report.

[2] ATICC is contracted by the Department of Health to provide training to all lay counsellors working within the public healthcare system.

- Presented the *Options* intervention to members of the antiretroviral (ARV) treatment team at each facility involved in the project. These presentations were intended to create a more supportive environment for counsellors implementing *Options*, and took place during January and February 2010. A brief report on these presentations is attached as appendix A;

- Strengthened support for counsellors involved in the project by implementing monthly supervision sessions of 1 hour during which time counsellors have the opportunity to discuss difficult cases and improve their skills. These monthly sessions were facilitated by the two *Options* trainers (Ms Joanne Croome and Ms Michelle Wanless), commencing in March 2010 and were run until June 2010. To the extent that it was possible the *Options* supervision sessions were included within the monthly mentoring sessions already run by counsellors' NGOs. Where this was not possible new groups had to be created outside of the NGOs' mentoring schedule;

In order to understand the reasons why *Options* has not been implemented as intended we conducted individual, in-depth interviews with counsellors involved in the implementation of the intervention. This document first provides a description of current counselling practice and the *Options* model as background to the findings in this report before presenting data regarding the coverage of the intervention and then findings from the qualitative interviews.

Background: An Overview of the Two Counselling Models

Counsellors employed within the public healthcare system are currently trained in counselling skills using Egan's model of helping behaviour. Like *Options*, Egan's model is a stage-based, problem-management approach to counselling, but it is looser in structure and scope. Egan's model consists of 3 stages which provide the framework for the helping process (or counselling session) and is applicable to a diverse range of client issues (for e.g. "I'm feeling a bit down" or "I can't decide if I should quit my job") (Egan, 2002). The model is designed to help people explore their situation and to gain insight in to their problem so that they can take appropriate action. An overview of the model as trained by ATICC is provided below.

Stage 1: Exploration	**Stage 2: Understanding**	**Stage 3: Action**
The client explores the problem with the counsellor	The client gains insight into the problem	The client decides on an action plan
Counsellor's task To assist the client to ventilate the problem {tell his/ her story}	**Counsellor's task** To assist the client in exploring issues related to the onset and the maintenance of the problem	**Counsellor's task** To help client set goals and brainstorm strategies to achieve goals. To help clients to decide on action plan
Goal In assisting the client to ventilate the problem is defined and client feels listened to. Clients who are helped to tell their stories will learn about themselves.	**Goal** To help the client to achieve deeper level of understanding of the problem.	**Goal** To help the client to translate his/her goal to action plan.
Skills required Attending, listening, showing empathy, asking questions	**Skills required** Probing, offering information, setting goals	**Skills required** Brainstorming, Sorting pros & cons, monitoring progress, ending the session

Table 1: An overview of Egan's Model as trained by ATICC

The understanding among trainers for (and counsellors trained at) ATICC is that a counselling session conducted according to Egan's model should take around 30 minutes. Egan (2002) acknowledges the trend towards to brief therapy and reports that a colleague of his experimented successfully with shortening the counselling "hour" to 5 minutes, however the ability to do this successfully is likely to require considerable skill and is not something that lay counsellors are taught how to do.

Options is based on the counselling technique of Motivational Interviewing and the IMB model of behaviour change which states that people, in order to change their behaviour, require information as to why they should be doing something differently, the motivation to make a change and the behavioural skills necessary to effect that change. In contrast to the above model, *Options* consists of 8 steps and provides a tighter structure to the counselling session. In addition, *Options* has been designed specifically for use within busy clinic settings (a first session should take 10 -15 minutes) and is targeted at changing a particular health-related behaviour. In following the 8 steps of the *Options* counselling protocol, the provider:

1) introduces the discussion of safer sex or ARV adherence (and asks permission to talk about one of these issues),
2) assesses the patient's sexual risk or non-adherent behaviour(s),
3) determines how important it is to the patient to change their behaviour,
4) determines how confident the patient is that they can change their behaviour,
5) elicits information-, motivation- and behavioural skills-based strategies from the patient for overcoming barriers and moving towards (or maintaining) change,
6) negotiates an individually-tailored risk reduction behaviour change goal or plan of action,
7) documents details of the counselling session on a standardized patient record form (PRF) for use in follow-up counselling sessions and
8) documents the agreed upon plan on the *Options* action plan form.

Follow-up *Options* sessions, in which the provider follows-up on the clients' progress with their action plan and either renegotiates a plan of action or encourages the maintenance of the achieved goal, should take no more than 5 minutes.

Being similar in general approach, *Options* does not represent a complete departure from Egan's model but does introduce some (more advanced) concepts associated with the technique of Motivational Interviewing such as 'readiness to change' (steps 3 and 4), as well as an emphasis on client autonomy that is by no means absent from Egan's model, but is not emphasised to the same extent. A table providing a more detailed comparison of the two models is attached as appendix B.

While no formal evaluation of counselling conducted according to Egan's model has been done, *Options* has been shown to be effective in reducing sexual-risk behaviour among people attending HIV clinical care in South Africa as well as the United States. Two papers reporting positive results from Kwa-Zulu Natal and Mpumalanga are included at the back of this report. This report presents information regarding the feasibility of incorporating *Options* in to current counselling practice within the Western Cape context.

The Coverage of Options for Health: Western Cape

In this section we look at how many patients on ARV treatment referred for counselling received *Options* for the period June 2009 through May 2010. This data represents 10 of 12 months worth of the data that is being collected.

Background

Four of the 11 NGOs employing lay ARV adherence counsellors in the Cape Town metropolitan area were randomly selected and agreed to take part in this phase of the *Options* roll-out. Adherence counsellors from these NGOs took part in a 5-day training course in June 2009 and a follow-up 2-day training course in October 2009. Participating NGOs and their associated facilities are presented below.

NGO	Facility	Number of adherence counsellors trained in June 2009
Living Hope	Masiphumelele Clinic	2
	DP Marais Hospital	2
	False Bay Hospital	2
Leadership South	Albow Gardens Clinic	2
	Retreat Community Health Center	2
	Victoria Hospital	2
	Hout Bay Main Road Clinic	2
	Du Noon Clinic	2
	Somerset Hospital	1
Philippi Trust	Eerste Rivier Hospital	2
	Ikwezi Community Health Center	2
	Mfuleni Community Health Center	2
	Dr Ivan Toms Clinic	2
	Helderberg Hospital	2
Touching Nations	Tygerberg Hospital	3
	Kraaifontein Community Health Center	2
	Bloekombos Clinic	2
	Wallacedene Clinic	2
	Durbanville Clinic	1
	Karl Bremmer Hospital	1
	Delft South Clinic	1
TOTAL NUMBER OF COUNSELLORS TRAINED		**39**

Table 2: Participating NGOs, their associated facilities and number of counsellors trained in Options (per facility)

Expectations of Counsellors during Implementation

In implementing *Options* we expected counsellors to use the 8-step protocol with all patients referred to them for poor adherence or for having defaulted from the treatment programme for a period of time. In addition, we expected counsellors to use the protocol in their treatment work-up sessions to help patients about to initiate treatment to problem-solve any sexual risk behaviours that they may be engaging in.

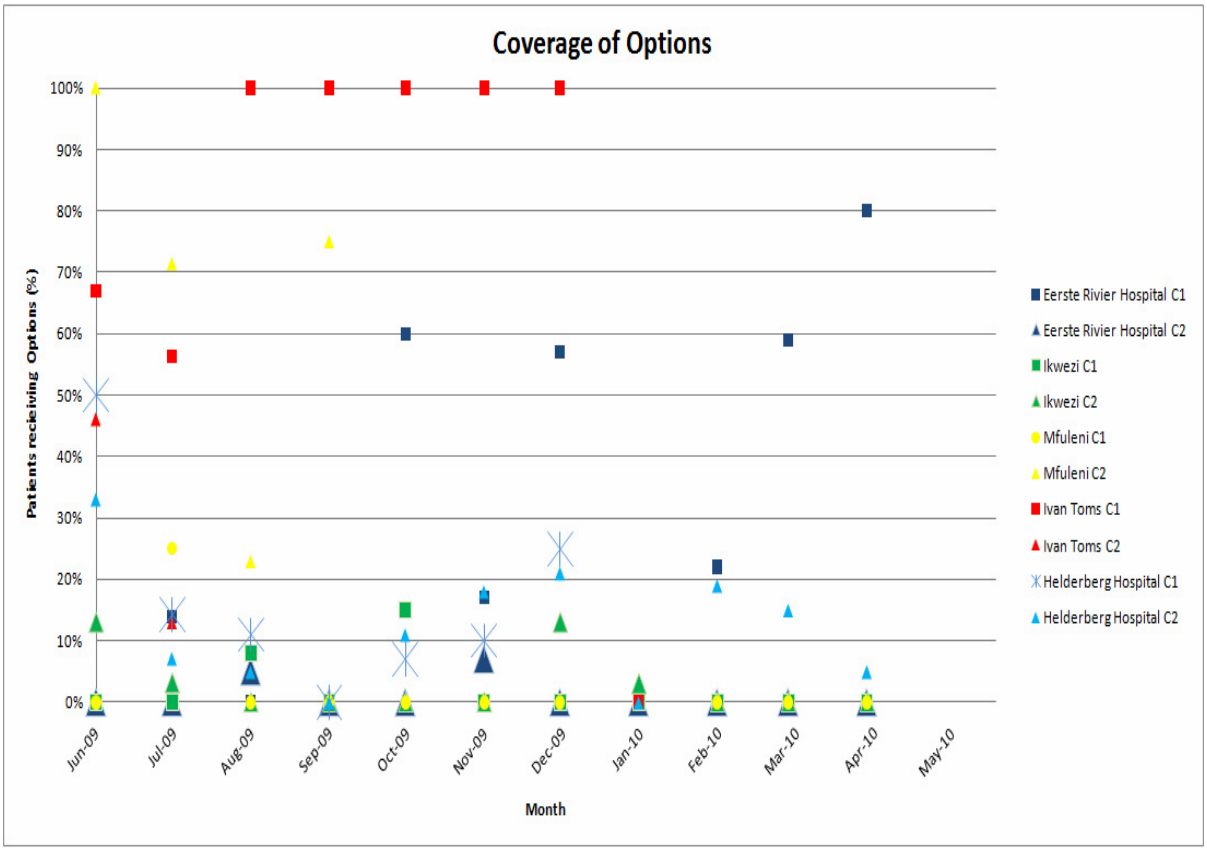
Method of assessment

A Patient Record Form (PRF) is completed as a part of the protocol for each *Options* counselling session. This form records the content of the session for the counsellors' future reference (and use in follow-up counselling sessions). Counsellors were provided with pads of PRFs printed in carbon-copy; since counsellors were trained in June 2009, we have collected copies of their PRFs from them on a monthly basis. Counsellors were also asked at each visit how many PRFs they lost or had not completed during the month.

All adherence counsellors are required to complete a data sheet recording the numbers of different types of counselling sessions they have done every month for submission to their NGO (e.g. number of treatment work-up sessions, VCT sessions). In order to determine the coverage of the intervention we compared the number of PRFs collected (including those reported lost or incomplete) for each counsellor to statistics routinely collected by their NGOs. Data sheets differ slightly per NGO, thus they do not all collect data on the same categories of counselling (for e.g. some counted "defaulters" while others did not). In addition, some NGOs changed their reporting format during our period of data collection and so, for clarity, results are presented next by NGO.

Philippi Trust

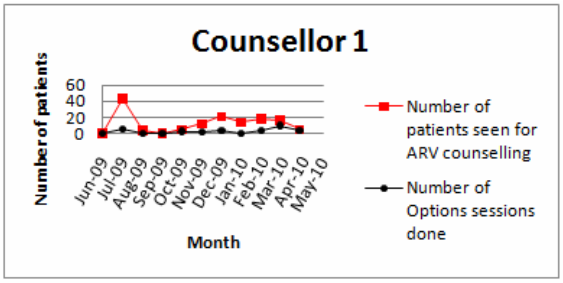
Philippi Trust routinely records the number of patients seen for "ARV follow-up counselling" by each counsellor. Using this data as compared to the number of PRFs collected, we calculated what percentage of patients seen for ARV follow-up counselling received *Options* (Graph 1). Using the patient record forms as an indicator of use, counsellors used *Options* with less than 25% of patients sent to them for 'ARV follow-up counselling' most of the time. One counsellor managed to achieve 100% coverage on a regular basis.

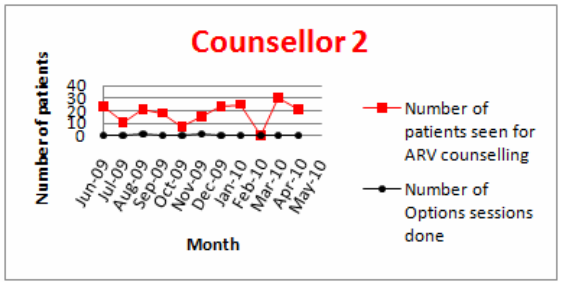


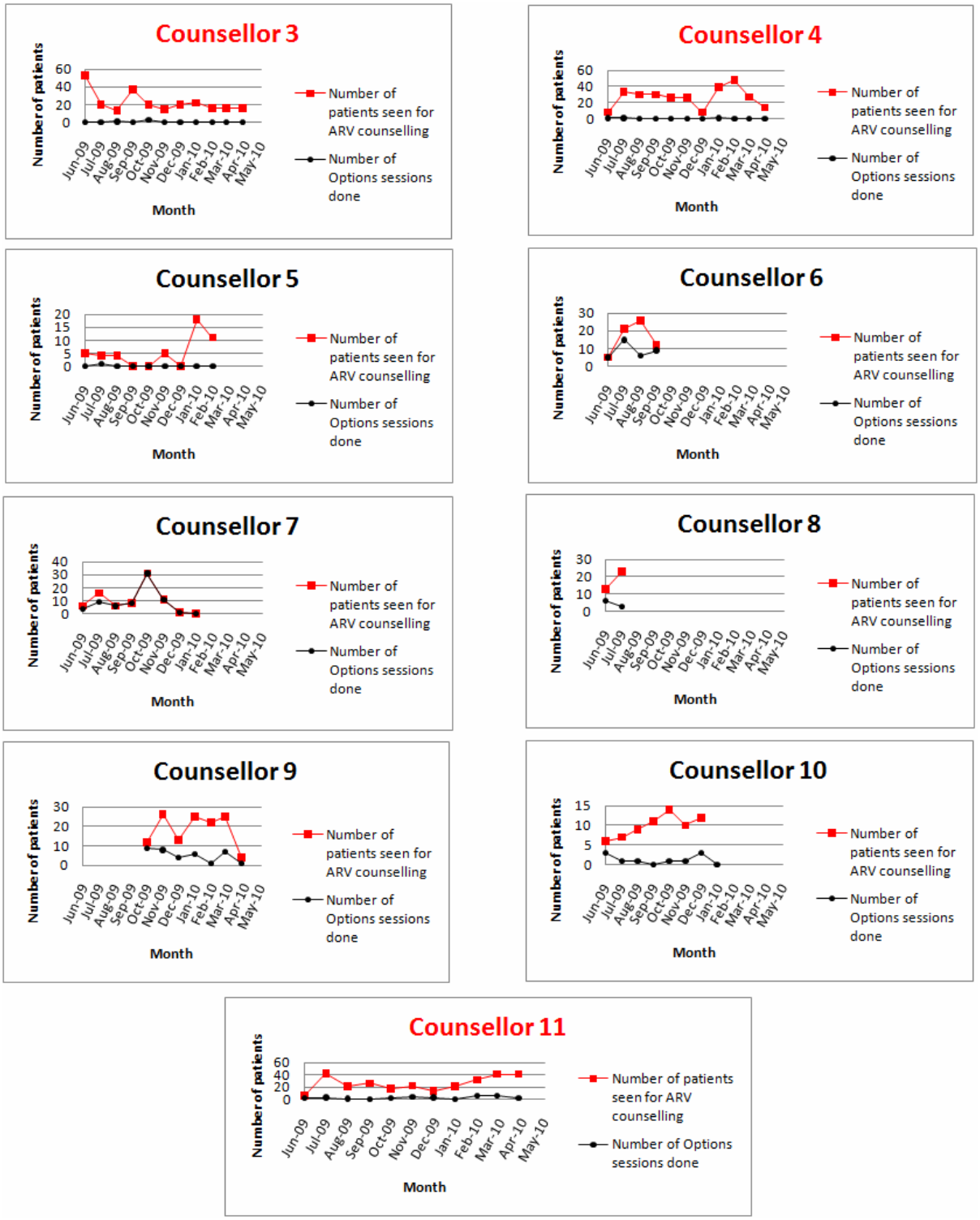
Graph 1: Percentage of Options sessions conducted by Philippi Trust counsellors

It is important to note however that the category "ARV follow-up counselling" has been reported by counsellors to include not only those patients counselled for non-adherence, but also those patients new on treatment and seen by the counsellor for routine pill counts and 'check-ins'. The implication of this limitation to the data is that it is likely that not all patients counted under the category of "ARV follow-up counselling" were eligible for *Options* counselling and, as such, our data may under-represent the number of eligible patients who did in fact receive *Options* counselling.

During implementation counsellors from all NGOs frequently reported that it was more difficult to do *Options* with patients who needed it when their clinic was busy. In order to understand the impact of patient load on the implementation of *Options* the following graphs were generated for each NGOs' counsellors.







Set 1: The number of Options counselling sessions done relative to patient load for Philippi Trust counsellors[3]

Graphs for counsellors 8 and, to some extent, counsellor 10 show more or less the relationship one would expect based on counsellors claims regarding patient load and implementation. For most counsellors (1, 2, 3, 5 and 11) however, the number of

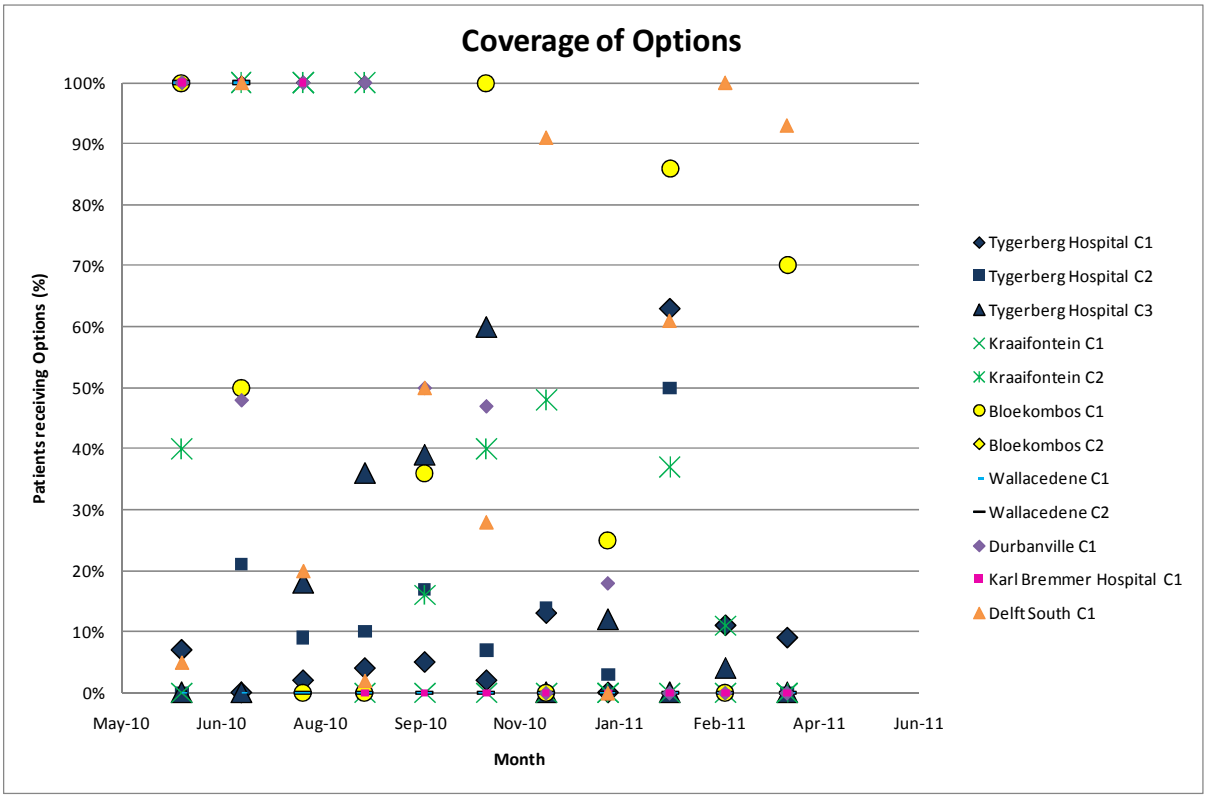
[3] Note: Counsellor 6 resigned four months following the *Options* training, while counsellor 8 resigned two months following training. Counsellor 9 moved from Touching Nations to Philippi Trust in October 2009.

Options sessions conducted was consistently low regardless of patient load. Counsellors indicated in red are those who were interviewed as a part of the qualitative aspect this research, and our analysis of these interviews revealed a number of other factors negatively influencing implementation (to be discussed in the next section of this report).

Touching Nations

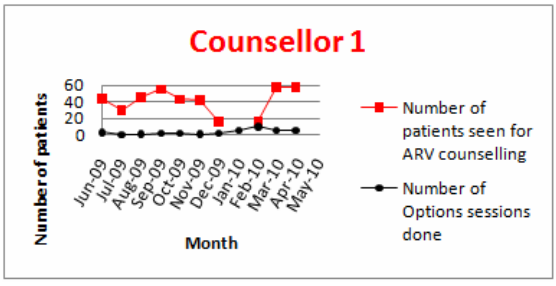
Up until September 2009 Touching Nations routinely recorded the number of patients seen for "ART Follow-up" counselling when a new category, "Defaulters", was added. The percentage of patients receiving *Options* was calculated against the number of patients seen for "ART follow-up", until October when it was calculated against "ART follow-up" combined with numbers of "Defaulters" (Graph 2). "Defaulters" would be those patients who returned to the clinic to re-start treatment after a period of absence.

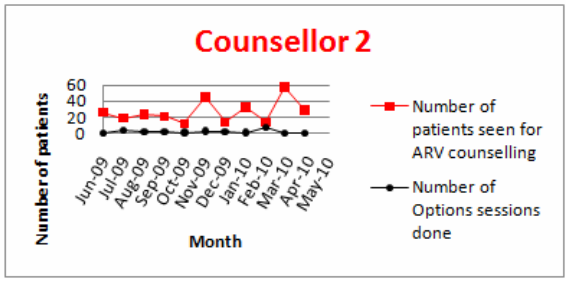
Counsellors used *Options* with less than 20% of patients most of the time, while a few used *Options* with up to 50% of their patients on a regular basis. Some counsellors managed to achieve 100% coverage for some months.

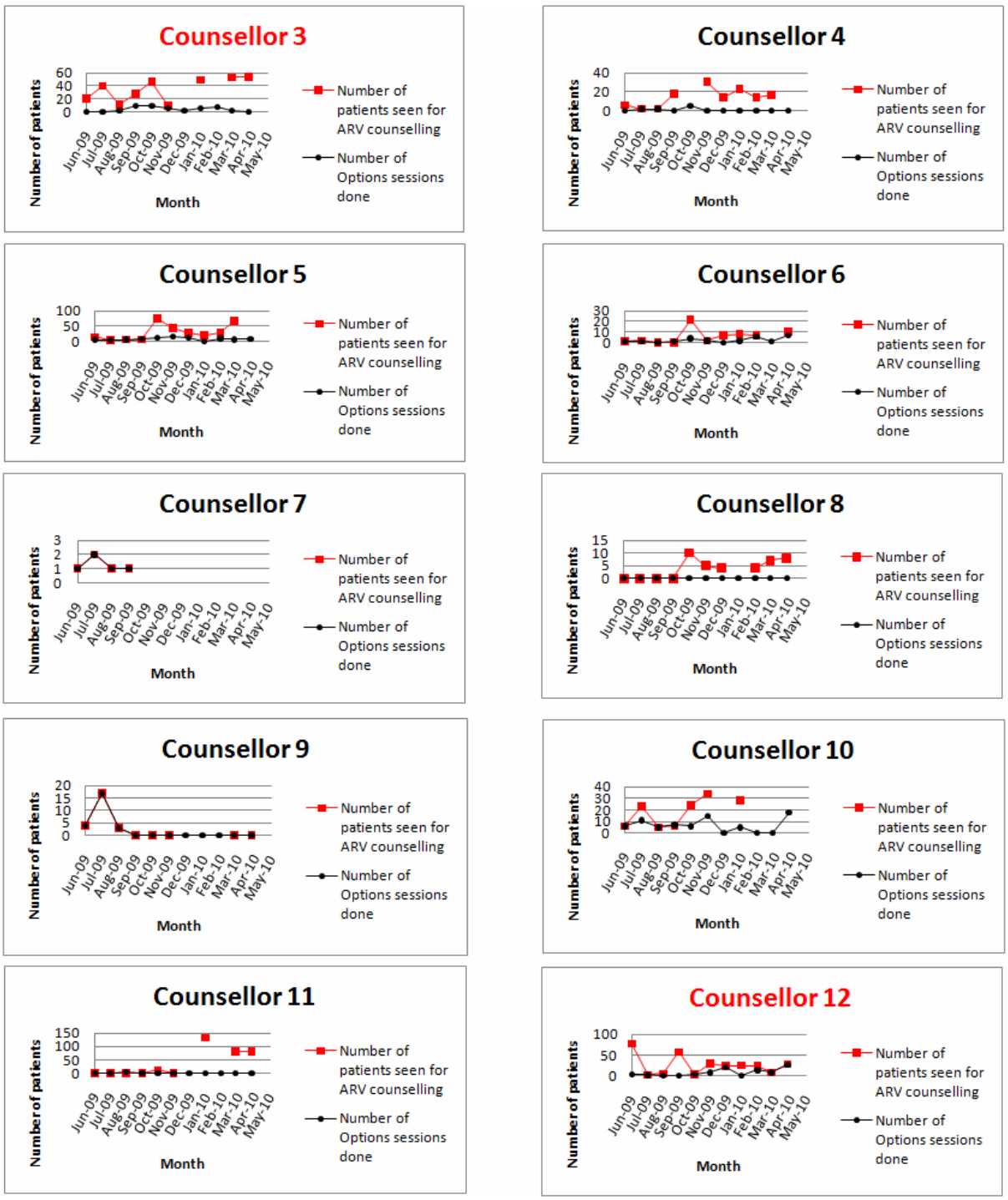


Graph 2: Percentage of Options sessions conducted by Touching Nations counsellors

Again, the category "ARV follow-up counselling" was reported by counsellors to include not only those patients counselled for non-adherence, but also those patients new on treatment and seen by the counsellor for routine pill counts and 'check-ins'. Thus it is possible that the percentage of eligible patients receiving *Options* is under-represented. What is not shown on the above graph is how many patients were being seen when counsellors managed to achieve high coverage. As for the previous NGO, the following graphs were generated to illustrate this relationship.







Set 2: The number of Options counselling sessions done relative to patient load for Touching Nations counsellors[4]

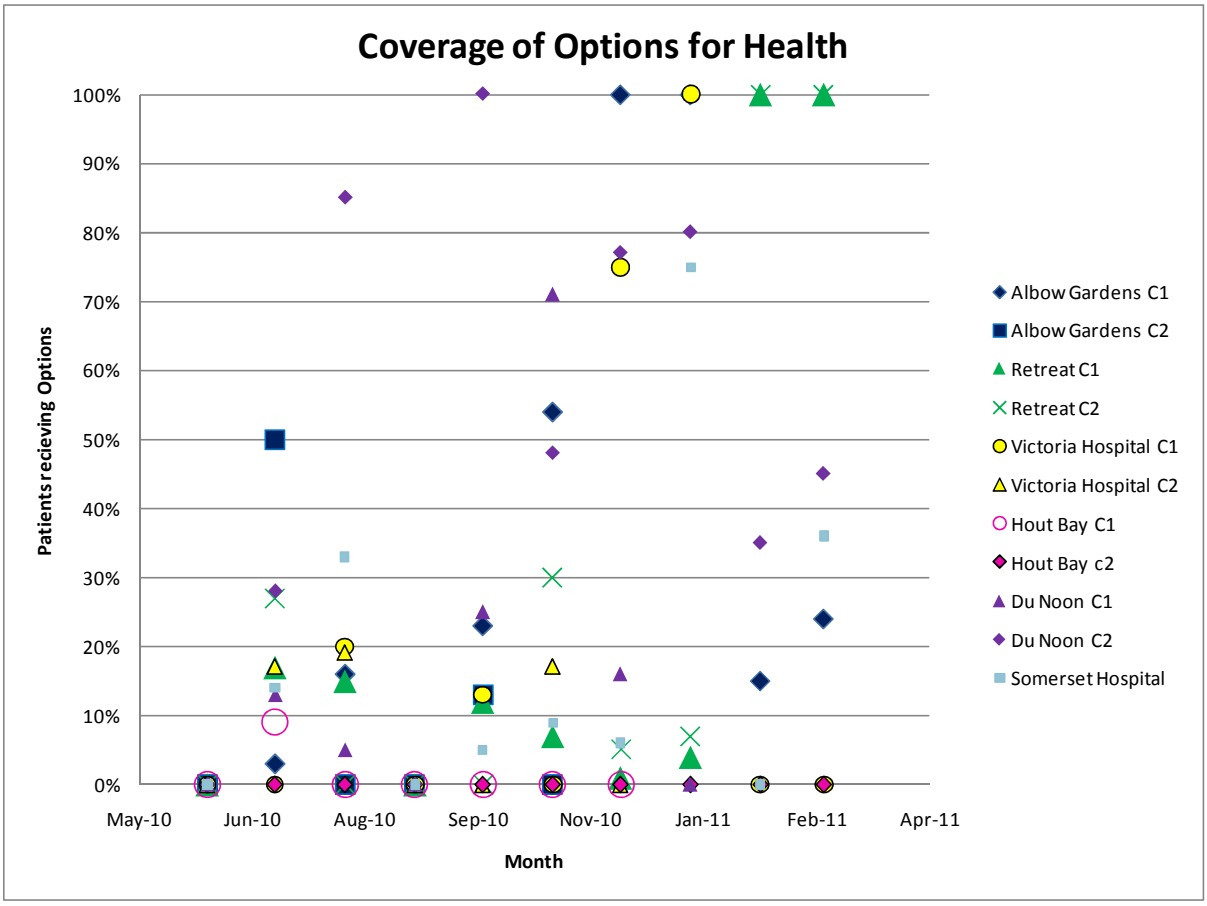
These graphs show that those counsellors who achieved 100% coverage more often than others (counsellors 5, 9, 10 and 11) did so when few (generally less than 8) patients were seen, supporting the claim that it is easier to do *Options* when the clinic is less busy. Counsellor 8 consistently used *Options* with very few of his/her patients regardless of a low patient load. These graphs also indicate the large variation in the patient loads of different counsellors, with some doing up to 60 (counsellors 1,2,3) and sometimes 80

[4] Note: Gaps in lines are indicative of data not sent through by counsellors to the NGO. Counsellor 7 resigned 4 months following training and moved to Philippi Trust.

(counsellors 5 and 11) 'ARV follow-up' sessions per month, while others do up to 10 per month (counsellors 7 and 8).

Leadership South

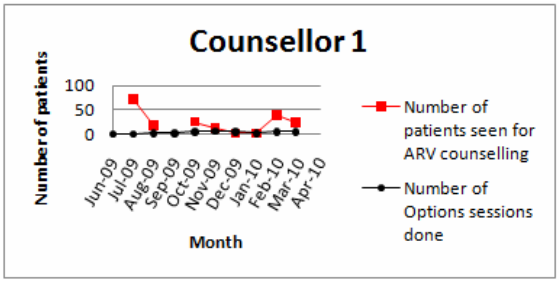
Up until December 2009 Leadership South collected data on the number of patients seen for "ART Follow-up" counselling as well as the number of "defaulters recalled". From January 2010 the category "defaulters recalled" was dropped and only the number of patients seen for "ART Follow-up" counselling was recorded. The percentage of patients receiving *Options* was calculated against the two categories combined until January when it had to be calculated using "ART Follow-up" only (Graph 3).

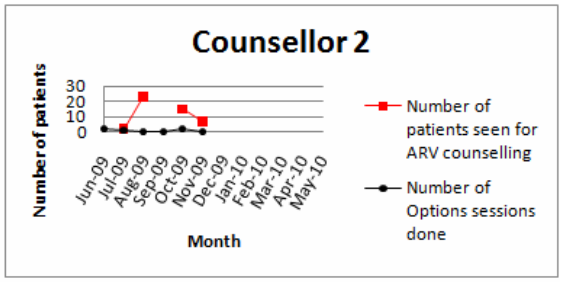


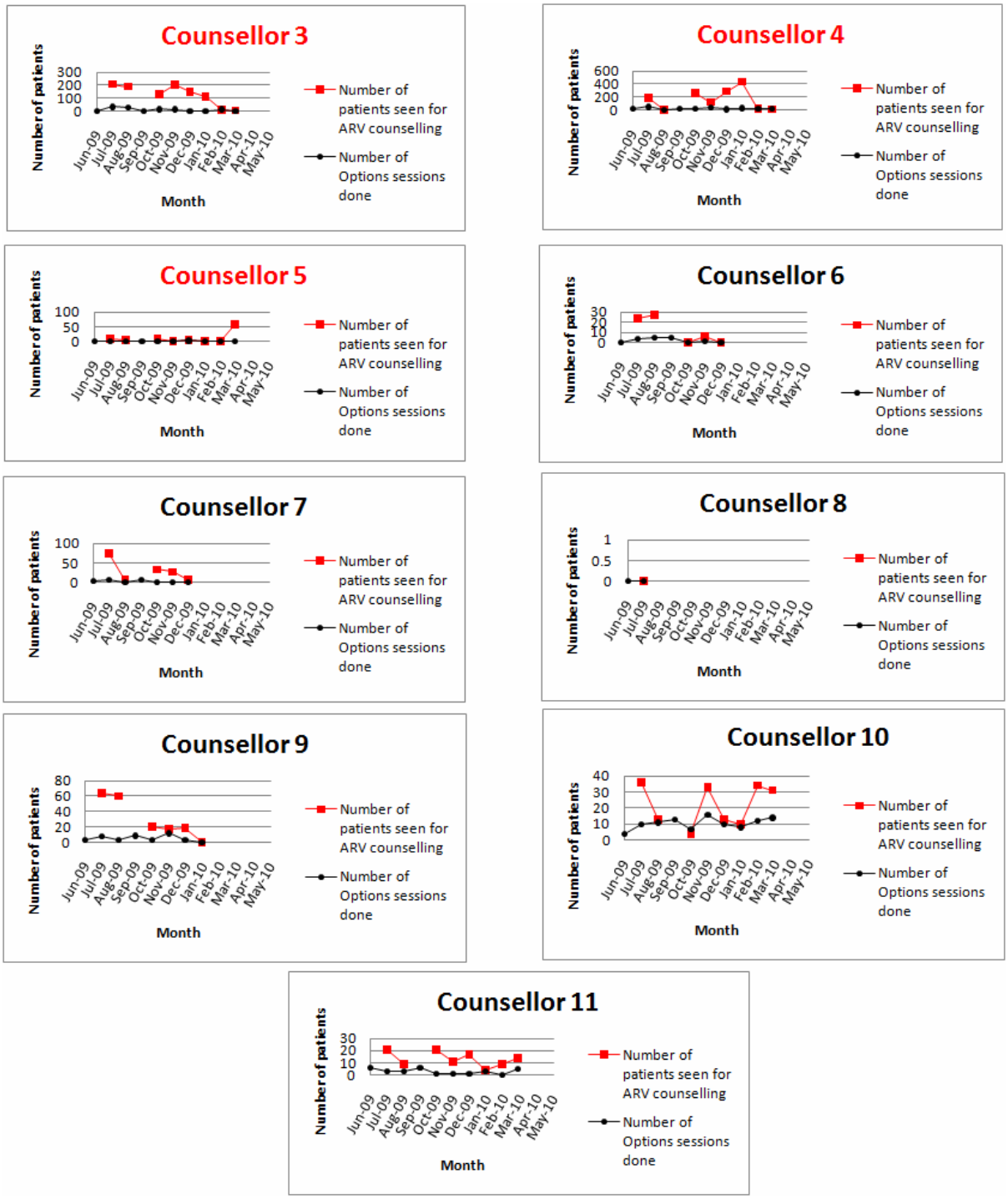
Graph 3: Percentage of Options sessions conducted by Leadership South counsellors

Here it can be seen that most counsellors were using *Options* with less than 30% of patients. Again the category of "ARV follow-up counselling" was reported by counsellors to include not only those patients counselled for non-adherence, but also those patients new on treatment and seen by the counsellor for routine pill counts and 'check-ins'.

Graphs representing the relationship between patient load and the coverage of *Options* for Leadership South counsellors are presented below.







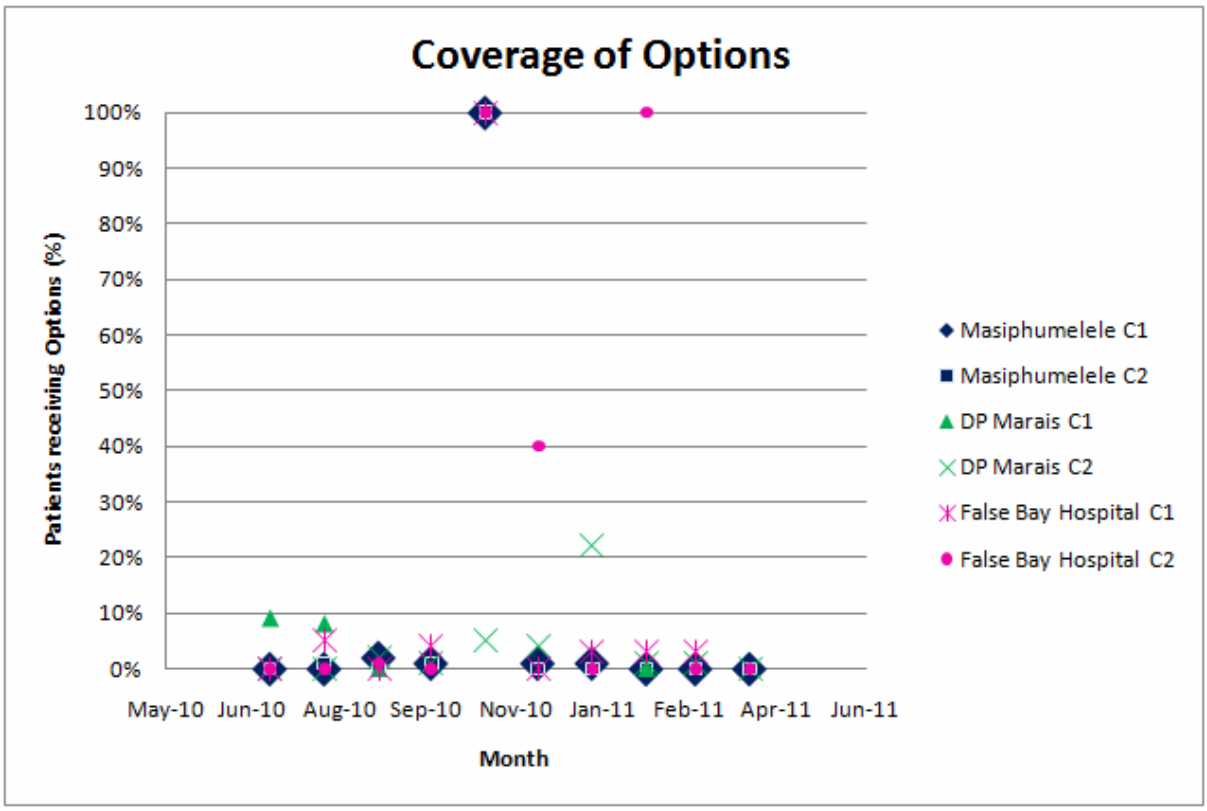
Set 3: The number of Options counselling sessions done relative to patient load for Leadership South counsellors[5]

Again this data shows the variation in the patient loads of different counsellors. Counsellors 3 and 4 appear to have been seeing extremely high numbers of patients for "ART follow-up" counselling, with counsellor 4 seeing 436 patients for January 2010, however when questioned by a member of the research team these 2 counsellors reported having included other types of counselling within this category such as VCT.

[5] Note: NGO statistics not available from April as a result of dissolution of NGO. Gaps in lines are indicative of data not sent through to the NGO by counsellors. Counsellors 2 and 7 resigned 6 and 7 months following training respectively. Counsellors 6, 8 and 9 were moved to a non-study site 7, 2 and 8 months following training respectively.

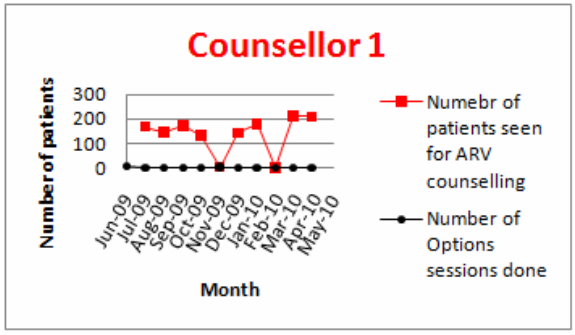
Living Hope

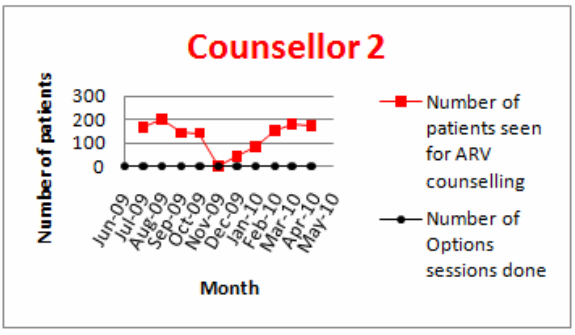
Up until November 2009 Living Hope routinely collected data on the number of patients seen as "returned defaulters" and "existing clients". From December 2009 the format of the data collection sheet submitted by counsellors changed; the new sheet omitted these two categories and included the category "ARV Follow-up" instead. Until December, percentage of patients receiving *Options* was calculated against "returned defaulters" combined with "existing clients".

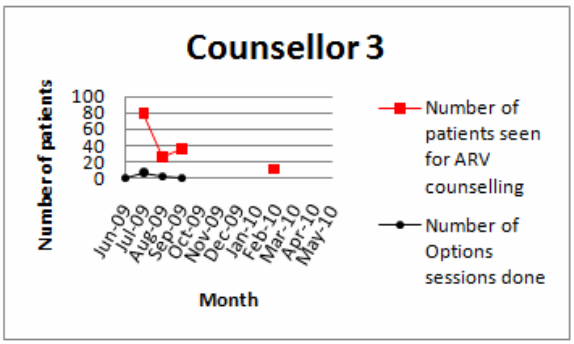


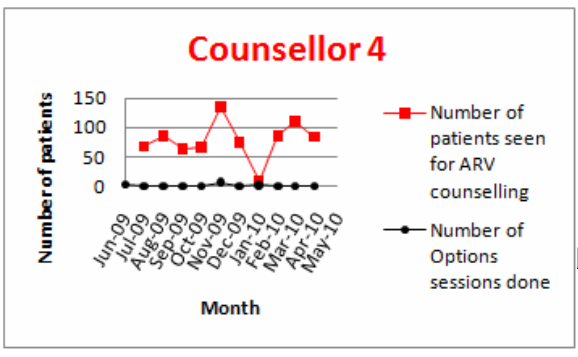
Graph 4: Percentage of Options sessions conducted by Living Hope counsellors

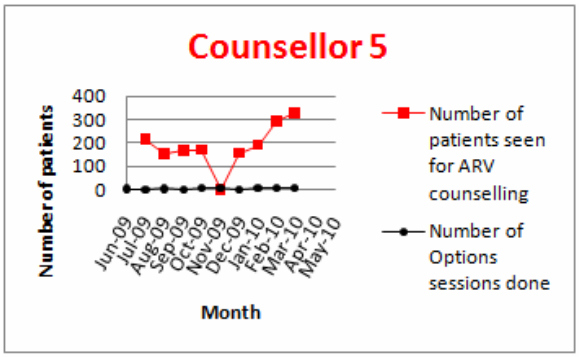
As can be seen the majority of counsellors used *Options* with less than 10% of their patients throughout most of implementation.

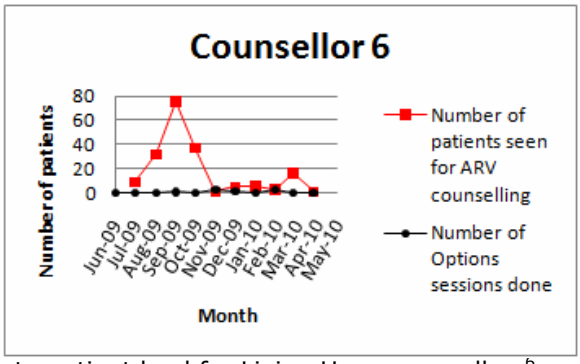












Set 4: The number of Options sessions done relative to patient load for Living Hope counsellors[6]

These graphs reflect what was shown in graph 4 above; that these counsellors used *Options* with very few of their patients, however the y-axes indicate that most of these counsellors are all seeing high numbers of patients. Counsellors 1 and 2 can be seen to have achieved 100% coverage in November when their patient loads dropped down to 4 and 3 respectively. Counsellors 1 and 2 are known to play a large role in conducting pill-counts for the ARV sisters at this site, and the inclusion of these types of 'meetings' between counsellors and patients within the category of "ARV follow-up" is likely to explain the high numbers reported. The same is possible for other counsellors represented here.

From the graphs illustrating the number of sessions done in comparison to patient load it is clear that high numbers of patients and clinic 'busyness' do have an impact on the number of sessions done for some counsellors but that other factors must be having an impact where the relationship does not appear that direct. Our qualitative interviews revealed a number of factors influencing counsellors' use of *Options* with clients, and results from these interviews are presented next.

[6] NGO statistics are not available for June 2009. Counsellor 6 was known to work primarily VCT during the 10 months of implementation, occasionally helping out with adherence counselling. Counsellor 3 was promoted to the position of coordinator in October 2009 and helps with adherence counselling only when necessary.

Results from Qualitative Interviews with Counsellors: "I Want To Use This Thing of Options but it's Difficult"

This section presents the factors affecting the implementation of Options as reported by counsellors.

Sample

Of the 39 counsellors who took part in the initial *Options* training in June last year, 31 were still involved in the project as of May 2010. 15 of these counsellors were approached and agreed to be interviewed. For the most part, counsellors who appeared to be using *Options* with few of their patients were randomly selected for the interviews as our primary interest was in the barriers to implementation. Two of the few counsellors who appeared to be using *Options* to a greater extent than others were purposely included in an attempt to determine whether there were any distinct differences that allowed them greater success in implementation.

Method

Semi-structured interviews were conducted by two members of the *Options* research team. The interview schedule included questions around how counsellors felt about *Options*, how their clients responded to *Options* and whether there were times or things about the clinic environment that made it difficult for them to use *Options*. In addition, counsellors were asked about factors in the clinic environment that made it easy for them to use *Options* and whether there were some kinds of patients with whom they found it easy to use *Options*. Based on a review of the PRFs collected we knew that few sessions focusing on sexual risk behaviour were being conducted, thus counsellors were also asked about why they were not using *Options* to talk about sexual risk behaviour with clients.

The interviews took place between January and April 2010. Interviews were conducted at the counsellors' clinics and lasted between 30 and 90 minutes. Interviews were conducted (and audio-recorded) in either English or Xhosa and, where necessary, transcripts were translated in to English.

Analysis

Thematic analysis was used to understand what the key factors affecting the use of *Options* by counsellors are. Participants' phrases (explanations and justifications) were categorised and coded, indicating the presence of recurrent themes in the data. Elements of the coding scheme were predetermined by the interview schedule (for example, reasons why *Options* was not being used in treatment sessions) and the research question, but others arose from the data. Five members of the implementation team analysed 3 transcripts each, while the 6th member analysed across these 15 in order to ensure the reliability of the analysis. A summary of findings is followed by a more detailed presentation.

Summary of Findings: Barriers To The Implementation Of *Options For Health: Western Cape*

Reasons for the limited coverage of *Options for Health: Western Cape*

Individual level barriers

- One counsellor expressed confusion about when to use *Options*, and this was related to the perception that *Options* is something different and in addition to the adherence counselling which she was trained to do by ATICC;
- Three counsellors expressed difficulty in adopting (and remembering to use) a new model of counselling;
- Patient resistance to (any) counselling: counsellors experienced time-pressure from patients who were in a hurry, and some of these patients took the opportunity to opt out of *Options* counselling sessions;
- Counsellors felt that *Options* is not appropriate for use with some patients, specifically those who are elderly or uneducated and perceived as unlikely to understand;
- Counsellors missed opportunities to use *Options* with some patients because of a limited understanding of scenarios for which *Options* can be used;
- Counsellors reported sometimes using bits and pieces of *Options* as they saw fit, in which case they would not complete the patient record forms. Thus coverage may be underestimated;
- *Options* is not being used to address sexual risk behaviour in treatment work-up sessions because of the amount of information that counsellors need to impart in these sessions;
- While not assessed directly, it can be assumed that *Options* is not being used to address sexual risk behaviour in ARV follow-up sessions as a result of the barriers to using *Options* for non-adherence expressed above.

Structural barriers

- Counsellors reported a lack/shortage of dedicated counselling space as a barrier to (any) counselling. This decreased the amount of time they had to spend with patients when they did find a room to use to the extent that they did not feel they had time to use *Options*;
- High patient loads: at times when the clinics are busy counsellors reported falling back on 'what they know' – time pressure was one of the main reported reasons why *Options* was not done with all eligible patients;
- Counsellors listed an unsupportive clinic environment as a barrier to implementation;
- "There are few defaulters": NGO statistics used by the *Options* research team to assess the coverage of *the* intervention are not a true representation of eligible patients. Thus coverage may be underestimated.

Results

The Good Stuff First: What Counsellors Like About *Options for Health*

Many of the 15 counsellors interviewed expressed positive feelings about the intervention in terms of how *Options* had both improved the quality of their engagement with clients and their own practice. For example, counsellors talked about the frustration they felt with some of their patients who returned to the clinic with the same problems related to their adherence:

> *"It feels like I'm trying my best... it's not that I'm not doing my work and then I see the patients still doing this same stuff" (counsellor A).*

Another counsellor described how having to repeat information with patients at every visit in order to encourage adherence resulted in her having *"a bad tone and attitude when I am seeing (them) again" (counsellor C).* In such instances, the *Options* model has alleviated some of this frustration because of its emphasis on collaboration between counsellor and client and the recognition that different people are at different places in terms of how ready they are to change their behaviour:

> *"(Options) took a burden from my shoulder because now it is not about me...it is about a patient and the patient has to say all the options, all the plans...if they don't want ARVs, they just say they don't want ARVs, if they feel like they can try again. So it's not about me, it's about them" (counsellor B).*

Some other counsellors spoke about how the language and approach associated with Motivational Interviewing has had a positive impact on their counselling experience:

> *"Ever since we came from Options, because the counselling we were doing at first we feel shame, if you remember we were using (words like) "must", things like that and you know, we were harsh" (counsellor D).*
>
> *"For me it has benefitted me in terms of my skills, it enhances the way I also do talk...it's very professional" (counsellor E).*
>
> *"In sessions my clients were happy and feeling open to telling me everything...because they see that Options is not shouting at them the way we did, a person feel free to tell you everything" (counsellor F).*

In turn, some counsellors were encouraged by the positive response that some clients have had to *Options* and how this has made their work "easier" for them:

> *"They are responding in a way that really even if they...maybe make the same mistake again, they are able to acknowledge that...they will tell you exactly what happened and they will tell you that they have the solution they just ask to be given another chance" (counsellor C).*

Some counsellors spoke about having had clients return after making some progress on action plans developed in previous sessions, and expressed the belief that *Options* works *("we need to do that (Options) because it helps" (counsellor G*). However, despite these good experiences and their belief in the efficacy of the model, many of these counsellors appear to have been using *Options* with few of their patients. Analysis of the interviews conducted revealed a variety of factors influencing whether (and when) counsellors used

Options with their patients or not. In addition, more information on why using the number of patient record forms collected in comparison to NGO statistics may under-represent the extent to which *Options* is being used was gained.

"We don't have defaulters"

During our monthly collections of the patient record forms we have heard the statement that "there are no/few defaulters here" from counsellors who have consistently not handed in many of the patient record forms. Hospital-based ARV clinics generally aim to stabilise patients on treatment and then refer them down to the ARV sites (clinics and community health centres) nearest to where they live. In our interviews, counsellors from 2 hospital sites reported that defaulters were uncommon in their setting as a result of this system:

> *"When you find (a client) that is defaulting you need to transfer to the nearest clinic to him or her. We left with people who are sure that they want to ... take ARVs, so that is why this thing of Options is lacking, we don't have defaulter" (counsellor H).*

> *"Here in (Hospital x), people who are coming here are staying from Khayelitsha...but they forge the address you see, because they from stigma in those places...then people who always comes here are those who do right, if a person saw that he or she defaults it's either go back to her or his clinic where she stays or else just sit down totally and not coming" (counsellor D).*

Counsellor D also explained how they do not have patient advocates to go in to the community to find and recall defaulting patients. This information is supported by the counselling statistics submitted by these counsellors to their NGOs, which show that few patients seen were categorised as "returned defaulters". While more of their patients were categorised as "ARV Follow-up" we do not know how many of these were seen for non-adherence and thus were not eligible for *Options*.

After reporting the absence of defaulting patients however, counsellor H went on to describe how she deals with situations in which patients have not been taking their treatment doses correctly. While this seems to be a contradiction to her assertion that they have no defaulters, it can be explained by our experience of different counsellors/facilities understandings and use of the word "defaulter". While some will refer to those patients who miss/take extra treatment doses as defaulters, others reserve the use of this word for those who drop out of the programme for weeks/months, referring to those who take doses incorrectly as "poorly-" or "non-" compliant or non-adherent.

While this explains why using the record of patients seen for "ARV follow-up" to assess coverage may give a misleading impression of the extent to which *Options* was implemented, this information does not yet explain why more patients who *are* seen for counselling do not get *Options*.

The Integration Of *Options* into Counselling Practice: "Must I Do The *Options* Now Or The Adherence Now?"

A noticeable difference between two counsellors interviewed, one who consistently handed in a good number of *Options* record forms and the other who consistently did almost no *Options* sessions, was the way in which they seemed to have integrated the model in to their current practice. In response to a question about how she thought the

two counselling models (*Options* and Egan) compared, the counsellor who routinely used *Options* replied:

> *"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, "what else can I use"? So all of these tools that you have, you must use them" (counsellor C).*

Counsellor C appears to have incorporated the *Options* protocol into her counselling (and her understanding of counselling) as one method that she can draw on as the situation calls for it. 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).*

None of the other counsellors interviewed mentioned not knowing exactly when to use *Options,* but the distinction between *Options* and "adherence" or "normal" counselling (based on Egan's model) is one that was made by some of the other counsellors. The perception of the *Options* counselling protocol as something that needs to be done *in addition* to 'normal' work (and perhaps even as something that is only part of a study) is a barrier to implementation and could explain why some counsellors have done few *Options* sessions with their patients.

Changing Practice: Options vs. "Normal" Counselling

Some resistance to change is to be expected when implementing new practice in any setting and, in the case of *Options*, could be another reason why relatively few patients seem to have been receiving the intervention. One counsellor (not interviewed), admitted shortly after training that she did not like to use *Options* with her patients because she did not like "*having to be nice*"; she stopped implementing *Options* around this time. She described using a directive and confrontational approach to adherence counselling, reprimanding non-adherent patients for not doing what they knew to be important.

One counsellor spoke candidly of the difficulty in adopting *Options* as the main method for counselling patients with adherence difficulties:

> *"Change is very painful because you have to change from the old style that you use...it was not easy to do Options, sometimes I forget it... it's not easy to let it go, what you have" (counsellor E).*

However others commented that they did not feel that *Options* was very different to Egan's model in which they were previously trained and one counsellor explained that, while it had been quite difficult to use *Options* in the beginning, "*as time goes on you get used to it*" (counsellor G). Interestingly, one counsellor who described *Options* as being quite similar to Egan's model later went on to describe the change in models as follows:

> *"It's like we changing the left hand writer to be a right hand writer" (counsellor I).*

This suggests that while some counsellors can see the similarity in approach between the two models, there are aspects of *Options* which some counsellors may have experienced as more difficult. For example the assessment of how ready a person is to change that is

made using the 'Importance' and 'Confidence' ladders proved to be one aspect of *Options* with which some counsellors struggled even after the follow-up training course.

Another counsellor reported having found it difficult to adopt the model because of the time that lapsed in between the training and when she saw her first patient:

> *"It's nice by that time you are train, there you understand, when you come to the clinic you don't get people, defaulters, you forget again everything...sometimes I forget to use that thing of ladders...instead I found myself doing my first adherence" (counsellor H).*

In general, the 15 interviews did not leave us with the impression that resistance to change was a major barrier to the implementation of *Options for Health: Western Cape*, but rather that there are a variety of other structural and individual level factors impacting the ability of counsellors to use *Options* with all of their non-adherent clients and resulting in their reversion back to previous practice.

"The Problem Is That We Don't Have Space"

> *"At first I did start doing Options for Health and I, I saw that it is very useful for the clients, that I did but I didn't continue doing it because it was difficult because of the time and the space for me to continue doing Options, but I saw it is working" (counsellor J).*

Of the 15 counsellors interviewed, 5 were from facilities in which space was limited and there were no/too few dedicated counselling rooms. All 5 of these counsellors listed this as one of the main reasons why they did not do *Options* with all of the patients referred to them with adherence problems. For two counsellors the lack of a dedicated counselling room meant that they did not always have their intervention materials with them:

> *"We never have a room...and then once you get a room and then you only take the patients' file, then when you are there you thought, "oh, my Options tools are down there"...then I think that "oh, I see this person needs Options but I can't go and fetch the tools now, I'm gonna see this patient and then let this patient go...because you've been struggling looking around for the room already" (counsellor K).*

For all of these counsellors however, it was the limited amount of time that they had to spend with each patient as a result of not having a dedicated counselling space that was the main problem:

> *"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).*

One counsellor who shared one room with two other counsellors explained that they used that room to do patients' pill counts as well as adherence counselling. As with the above counsellor, she described having to be quick when using someone else's room to do counselling:

"You get someone's place ... and (then) someone want her space to work, so you think Options is 8 steps, you need to have time with a person and you need to have time for recording down in those folders (patient record forms), sometimes I do Options and do not record it down" (counsellor O).

For the majority of counsellors interviewed, pressure in terms of time was one of the main reported reasons why they were not doing more *Options* counselling sessions with eligible patients. In the comparison between the *Options* and Egan's models on pages 3-4 x it was noted that *Options* requires considerably less time per session than Egan. If counsellors do not have 15 minutes to spend with each patient, what are they managing to do with patients in the limited time that they have?

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:

"You see because sometimes I ... got a lot of people and sometimes the pharmacist she's working half day you see, so we must push, so I don't have enough time" (counsellor L).

At such times counsellors reported falling back on what they are used to doing:

"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).

In addition, a couple of counsellors reported being tired out by the number of patients they were seeing on some days:

"Especially there are times when I'm tired then I feel no, I'll (rather) just go ahead with my counselling sessions than do Options ... say like we are seeing about over a hundred people" (counsellor G).

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, where time is limited *Options* should be the method of choice. While some counsellors felt that *Options* was quite quick, others explained how it could take a long time with particular patients:

"The patients are very difficult. They don't understand this Options thing. You will explain this and the patient will say another thing... So if they don't understand we spend a lot of time explaining what Options is and all that" (counsellor M).

During one of our site visits a counsellor explained how clients would often change their stories halfway through the session, meaning that he would then have to go back a few steps to start again and that this made the session longer than it should be. He attributed this to the fact that during the session patients would become more comfortable because of the way in which he was conducting the session, and would then feel free to tell him the 'truth' of the matter.

One of counsellors' main complaints during implementation has been that patients do not understand how to use the 'readiness to change' ladders. Having to try and explain

the ladders until patients give scores that the counsellor can work with increases the time spent on the session and could even result in the session not being completed:

> *"Sometimes there are difficult patients, where you try to make this thing easy but you find no, it's difficult him or her so I'm gonna prefer, it's better to go back ... to my (traditional) adherence (counselling), and use it then it's easy" (counsellor H).*

In response to continuous complaints about patients not understanding the ladders, we have revised them to include statements which should help patients to understand how the ladders work. The English version of this ladder is attached as appendix C; this ladder has been translated in to Afrikaans and Xhosa as well. As of yet we have not systematically collected feedback from counsellors on how well these new ladders are working.

Patient Resistance to Counselling: "Eeeeh My Time, I Wasted A Lot of Time to You"

Pressure in terms of time did not only come from other clinic staff and high patient loads but from patients themselves, and this seemed to be related to a resistance to counselling in general which made it challenging for counsellors to use *Options* with certain patients. 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).*

> *"Most of the clients they don't have time...some of them are working, some of them have children at home, some of them stay far... (and so) they want to come here just for the doctor...the pharmacy the he want to go home" (counsellor A).*

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

> *"It's what they, this (clinic) decide that because people...even 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 more then, so we say, we don't if he misses one day" (counsellor I).*

She went on to explain that not all patients who defaulted for more than one or two days were sent for counselling either (although she felt that they should be), "*because the staff they have got some favourite patients*" and they allow these patients to bypass the counsellor (they 'let them off' so to speak). 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; 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.

Counsellor H explained how she had adapted her practice in response to the reluctance of patients to attend counselling by conducting group sessions:

> *"The time you to take them in the waiting room and (say) "come", here she/he want to know, "for what?" ... they still with others, so it's not easy to explain what you are going to do ... so it end up now*

me doing like this way, if I got a problem with something from the first person, maybe when I count them as I count their pills, I find that there are three people or four who have more pills, I do education in all of them ... They start to understand a person will say, "oh, no my mistake was this...," you will hear them after you talking to each other" (counsellor H).

This would explain why, for this particular counsellor, "ARV follow-up" patients were being recorded as having been seen, but no *Options* record forms were forthcoming.

Patients experiencing problems with adherence are sent for counselling as a part of the ARV clinic system, however *Options,* in accordance with the principles of Motivational Interviewing*,* introduces an element of choice to the counselling session (and of which some patients take advantage). Counsellor K observed that when you start asking permission to do the counselling session, patients stop seeing it as a part of the clinic protocol:

"You know what, that permission thing, it's ... really making things difficult ... because once you ask the permission to the patient, and said "how long is it gonna to take?" and say 5 minutes, "oh, huh uh, I'm in a hurry no, I need to be at work, my boss already phoned me and then I can't wait for another 5 minutes" (counsellor K).

In terms of Motivational Interviewing, these patients should be allowed to leave without counselling if a few attempts to overcome their resistance are unsuccessful. However this is in contradiction to ARV clinic protocol, where patients struggling with adherence must be targeted to receive counselling assistance. One counsellor explained how some patients would agree to the session but that:

"They don't feel to do the Options, they just tell us what we want to hear...they will give me all ten (on the importance and confidence ladders)...this people just want to tell me just to get out you know" (counsellor A).

One counsellor did have experience with patients who did not want to receive *Options* counselling in particular; she appeared to be giving her clients a choice as to which 'type' of counselling they would like:

"(I) explain the procedure...everything about the Options then after you said this...when we are finish to do the counselling you are going to sign what you have said to me as a ... to confirm that it's those words are coming from you, then the patient would say, "no, not now, I'm not ready for this kind of counselling, I want the (other) counselling" (counsellor I).

Feedback from counsellors over the past 11 months of implementation has indicated that patients do not like to sign the action plan that is written up at the end of an *Options* session because they feel that their confidentiality will be compromised or that they are being tied in to something. 'Counsellor I' explained that while some patients are happy to sign the plan, "*others they will say, "sisi, this thing of signing it's more like ... I'm going to be arrested!"* When this issue arose in the follow-up training course that was held in October 2009, counsellors were informed that patients are not required to sign the action plans if they do not want to, neither are they required to take the written-down plan out of the counselling room. Counsellors expressed the feeling that unwillingness to take/sign the plan demonstrated a lack of commitment on behalf of the client, and the counsellor quoted above obviously viewed it as an important part of the protocol.

So far it has been shown that the pressure that counsellors experience in terms of time (as the result of the clinic's schedule, lack of space, high patient loads and patients with other places to be) prevents them from using *Options* with all patients who should be receiving the intervention. In addition to these barriers (which are somewhat beyond their control), counsellors expressed the belief that *Options* was not appropriate for all of their patients who were experiencing problems with adherence and clinic attendance.

"There Are Patients That You Really Don't See the Use of Using Options"

In addition to not always having time to do *Options* with patients, counsellors did not feel that *Options* was appropriate for all patients referred to them with adherence problems:

> *"Sometimes the other ones are uneducated and then you really have to use illustrations...to make the patient understand what you talking about...it's really sometimes difficult and you see, I don't see Options will work here, how am I going to explain this and that?" (counsellor K).*

> *"The Options training help me not in all my patients you see, because some of my patients ... put it like that, I got this older patients you see, now I must explain them about this Options" (counsellor L).*

One counsellor mentioned abandoning *Options* when she realised that patients had "*emotional problems*" in which case she would refer them to a psychiatrist or the ARV nursing sister. In addition to the elderly and 'uneducated', counsellors reported reverting back to their 'old style' of counselling with patients who were described as difficult. 'Difficult' patients were those who didn't understand how the ladders worked, who denied having a problem with their adherence as well as those who were non-responsive:

> *"Like 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).*

In total two counsellors reported having to counsel patients who were drunk, and these were patients they would not use *Options* with. One counsellor reported that, while waiting their turn to see the doctor, some patients would "*quickly go for one sip*" (counsellor O). This counsellor also reported finding it difficult to use *Options* who denied having any difficulty with their adherence despite having an incorrect pill count. At such time she would revert to using Egan's model:

> *"Oh like there are times when a person will say "I take my pills" ... but the percentage (adherence) is not saying that they are taking their pills ... I try Egan's model, I told her it's important to take pills and explain what shows if she takes the pills and the bloods that are taken, the virus is going to be seen like viral load is suppressed and CD4 count is going to be seen by increasing if she is taking her pills" (counsellor O).*

This counsellor seems to understand Egan's model as being synonymous with information-giving.

One counsellor complained that *Options* prevented her from being able to confront patients who denied that they were having any difficulties in taking their treatment, in response to which the interviewer related another counsellors' experience:

> *"One of the counsellors was so bored with that thing because she was asking ... and the patient was denying and then she said...straight to her "you know what your problem is? You are drinking!" ... and then (the patient) said,"oh yes, sisi ... I'm drinking" (Interviewer).*

Such anecdotes from the field reveal the belief that some patients *need* to be confronted in order to tell the 'truth'.

In describing situations and types of patients for whom they did not feel the use of *Options* was appropriate, many counsellors 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 counsellors 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).*

Patients having forgotten to take treatment doses for very particular reasons were not perceived to have a problem and one counsellor felt that doing *Options* and coming up with action plans to improve adherence was of little use to people like truck drivers because it was likely that they would not come back for a follow-up visit. The inability to get patients to return for follow-up visits was another common theme and is discussed later.

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

At every collection of patient record forms counsellors are asked how many forms they think they have forgotten to complete or may have lost during the month. Most often counsellors reported that they had not lost or not completed any forms, however a few have expressed concern during the research period that the number of patient record forms collected is not a true representation of how much *Options* they are actually doing. During the interviews counsellors reported sometimes using bits and pieces of *Options* as it suits their need:

> *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 *Options* protocol or not; one counsellor particularly liked the concept of asking for permission as a helpful way to begin a discussion on a sensitive topic.

Throughout implementation many counsellors have perceived the patient record forms as a burden (attached as appendix D). Feelings are that the forms take too much time to complete and that there is already enough paperwork that they have to do. Currently counsellors are not required to complete a record of each session for each patient by

their NGO, however recording practice differs from site to site as some clinics have developed their own forms for this. Some counsellors will also write notes on the patients they have seen in the diaries that they use to record their monthly counselling statistics.

One counsellor admitted during her interview that she did not see the point in having to write each session up like that. In terms of the *Options* implementation plan this is a problem as counsellors must review a patients' record form in preparation for a follow-up counselling session. However during the interviews counsellors mentioned that it was very rare to get a patient back for a follow-up session and this assertion is backed up by a review of the patient record forms collected:

> *"We will see that person now ... you give her a follow-up date but she won't come back to you, she will run away even if she's here at the clinic, you'll see someone hiding here, she doesn't want to come back, I don't know why" (counsellor J).*

Patients may bypass the counsellor for a variety of reasons but this difficulty explains why counsellors may not feel that it is important to always complete the record forms. While some counsellors do believe that *Options* does work, the inability to get patients back for follow-up sessions interfered with others' ability to determine the impact their work is having on their clients:

> *"I don't know (if) it's working, I just fill form and a patient go home ...it's very seldom for me to get a patients for second (session)". (counsellor N).*

Counsellors who are working under the constraints as identified in our interviews and who are then unable to get patients back for follow-up *Options* sessions may not see the point of persevering with an intervention that relies in many ways on an ongoing relationship between the counsellor and client. As was mentioned above, one counsellor did not see the point in using *Options* with truckers who not guaranteed to return. It is possible that the lack of follow-up, in combination with the other difficulties faced by counsellors, is a barrier to implementation.

Involvement of ARV clinic staff

When asked about what makes it easy to implement *Options*, some counsellors replied that having a supportive clinic environment was beneficial:

> *"We are a team, like we work together ... whenever Sister X sees someone with a high viral load or who's defaulting ... she send that person to me ... the same with Sister Y" (counsellor G).*

Although counsellors did not elaborate on exactly how other staff members enabled them to implement *Options* in their counselling sessions, having a supportive environment was obviously important as others listed an *un*supportive environment as something that made it difficult for them to implement *Options*. Counsellor E described how her team had responded to hearing about *Options* in a way that resulted in more work being required of her:

> *"It was like a competition ... immediately when we introduce Options to them, we sat with them and did feedback about our training ... immediately they task another doctor to develop a (new) form" (counsellor E).*

Counsellor E went on to say that she was not using this 'new' clinic form for her counselling sessions. Counsellors appreciatively mentioned other staff members that took an interest in their work, and some felt that clinic staff needed to be more involved in the implementation of *Options* (and sometimes even that all staff should be trained in the intervention):

> *"If there can be those ones that are in charge that understands it clearly, I think maybe they can draw the strategy that can also help the counsellor to do that Options" (counsellor K).*

> *It's difficult for us to continue Options because the nurses, it seems as if they don't understand anything about Options ... if this can start up and go down, not start down and go up ... then they can know about the forms and everything, even when they came here to introduce Options to the manager, the manager promised that he is going to look after us to see that we are doing Options (but) I never saw the manager coming in ... asking us how we are doing on Options because he ... doesn't even check what is going on, on the ARV side" (counsellor J).*

What is being expressed by counsellor J is the desire to have someone with authority at the clinic to address or at least acknowledge the difficulties she is experiencing. She went on to explain:

> *"I'm positive Options can work if they can start there (at the top) and you must also know that we are, I don't know what I can call us, we are minors from these people so anything that comes from us, they don't listen to it – even the space thing, the clinic was extended ... everybody has got a room but no one cared to give us a room" (counsellor J).*

Involving clinic staff in the implementation of *Options* by merely informing them about the *Options* counselling protocol and of what is required for Options to work (the completion of PRFs, the referral of patients to counsellors) is likely to increase the extent to which staff 'buy-in' to the intervention and to facilitate implementation.

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

While the information presented above helps to explain why *Options* is not being done with all patients sent for ARV counselling, review of the patient record forms collected since June 2009 shows that not many *Options* sessions have focused on sexual risk behaviour. When questioned during site visits most counsellors claimed that they did not know that they were expected to be using *Options* to conduct the sexual risk component of treatment work-up sessions. In our 15 interviews, counsellors reported that they did indeed address the issue of sexual risk behaviour with treatment work-up patients, but that using *Options* to conduct this section was not feasible:

> *"They have to do go through three counselling sessions before they start medication. So in Counselling One you need to explain; you need to make sure that the client understands why they come to the ARV site ... you need to find out about disclosure and social circumstances, everything ... Then when they come for their for second session that is Counselling Two; that is where you tell them now how will they take their Arv's and you need to make sure that they can still remember what you said in counselling one because before you start counselling two you need to ask them if they have*

> *any questions concerning now their first counselling you did because by the end of all these three counselling sessions a client needs to know exactly how must they take their Arv's ... Explain to them about follow-up dates and everything. So it's a lot of work for us and then on top of that lot of work there is Options" (counsellor M).*

Because counsellors felt like they already had a lot to get through in these sessions, they preferred to continue giving information on sexual risk behaviour and to conduct condom demonstrations as is a part of the Provinces' treatment work-up counselling protocol. In addition, counsellors in hospital-based facilities would often do treatment work-up with patients who were to be fast-tracked for treatment, in which case treatment work-up did not proceed as normal:

> *"For me I'm not using the normal routine of ARVs, how it should be, so sometimes the case is that a person has to be fast-tracked...the doctor just put him on ARVs...then (in the) afternoon... I have to go back to the patient and explain and even there in the consulting room (it) is just roughly (to) explain that, "you are taking the ARVs now" (counsellor B).*

When asked about whether they use *Options* to talk to ARV follow-up patients about sexual risk counsellors said that they would do this particularly when a patients' viral load increased but that patients won't 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" (laughing) (counsellor K).*

This, in addition to the constraints discussed above helps to explain why *Options* is not being used to talk address sexual risk behaviour to the extent that it is being used to address problems with adherence.

Issues for Discussion

In addition to providing information on the extent to which *Options* has been applied within routine adherence counselling practice, this report has highlighted a number of barriers that have affected the smooth implementation of *Options* within the South African (and specifically Western Cape) context. Whilst these barriers are not insurmountable they do highlight the importance of conducting a process evaluation such as this in order to assess the feasibility of implementing a new intervention such as *Options* and what, if any, adaptations need to be made to its protocol and the way it is introduced into health service practice if it is to work within our context.

Interestingly, our qualitative interviews with 15 adherence counsellors highlighted a number of factors associated with their current practice that adversely affected the quality of implementation and extent of coverage of *Options.* These included the following:

- One counsellor expressed confusion about how *Options* related to her current practice and three others expressed difficulty in adopting the model in addition to the one in which they are currently trained (Egan's model). It is possible that this could be addressed by a) training counsellors' in *Options* soon after they qualify as adherence counsellors b) providing more guidance during training on how to incorporate *Options* in to their practice and c) using monthly supervision sessions

to address and problem-solve difficulties in including *Options* in their current practice.

- There appears to be no system currently in place within the ARV clinics (likely due to a lack of financial and human resources) for ensuring that patients with adherence problems and sent for counselling are ever followed up by the counsellors. The inability to conduct follow-up *Options* counselling sessions with patients was one reason why some counsellors suggested they did not conduct the first *Options* session with their clients. At this stage it is unclear what effect this limitation to implementation has on the efficacy of the *Options* intervention.

- Just as there appears to be a limited number of follow-up counselling sessions being conducted, it appears that the extent to which counsellors record even the basic details of their counselling sessions is similarly limited. We have observed that some counsellors make basic notes in their 'patient dairies' but this does not appear to be routine as others do not. Whilst some facilities have clinic-specific forms that have been developed (reflecting an attempt to capture some of the dynamics of the adherence counselling sessions[7]), the completion of the *Options* PRF was often perceived as a burden by some adherence counsellors, particularly where time was an issue or there were clinic-specific forms to be completed as well. The observation of the researchers in some cases was that the PRFs in themselves were not particularly burdensome, but rather getting into the routine of *recording* the key issues and outcomes of a session was itself a burden. Whilst acknowledging the limitations on counsellors time, this does raise the issue as to whether *not* recording (even at a very basic level) the key issues and decisions discussed in a counselling session is acceptable practice. Even if such documentation is not required for a follow-up session with a non-adherent client it could be used to inform the counsellor's supervision sessions and, where appropriate, to relay important information to the ARV clinic team.

- *Options*, like many counselling approaches, is based on a principle of respect for client autonomy. One way in which this spirit is practically demonstrated in *Options* is that the counsellor will begin the counselling session by asking the clients' permission to talk about a particular issue (sexual risk or adherence behaviour). This in effect allows a patient the opportunity to refuse counselling. This 'freedom to choose' appears at odds with current practice where the implication is that once a patient has been sent by a doctor or nurse to the adherence counsellor, they are *required* to have a counselling session.

- Whilst counsellors did not list this as a barrier to implementation, there is some evidence from the interviews conducted that this value of respect for client autonomy emphasised by *Options* is not always congruent with the perception and belief that some of the ARV clinic staff (and even some of the counsellors themselves) have about the role of counselling and how issues around non-adherence should be addressed. This difference in opinion (between a very directive approach and one that is more patient-centred) is an issue that needs to be acknowledged, discussed and in some ways resolved amongst key stakeholders if *Options* is to be delivered in accordance with the principles of Motivational Interviewing.

- Whilst not directly impacting on the implementation of the *Options* protocol itself, the way in which the adherence counselling statistics are being collected by NGOs did not enable us to assess the *true* coverage of the intervention as it is was not possible to separate out (a) the numbers of patients being counselled for

[7] For example, Masiphumelele clinic has developed a counselling form (not dissimilar to the *Options* PRF) for "red alert" patients which records issues needing to be addressed with a particular patient, the counsellors' assessment of the patients' situation as well as the 'action plan' developed to address the issues listed.

problems with their adherence, and (b) the number of patients counsellors saw purely for pill counts or routine 'check-ins'. Related to this is the fact that data (for example, for a particular month) that is not sent in by counsellors does not appear to always be followed up (as evidenced by gaps in the data in graph sets on pages 8, 10, 12 and 14).

- Finally, counsellors reported experiencing pressure in terms of the time they had available with patients for a variety of reasons (e.g. pressure from patients themselves, other staff members and sometimes merely as the result of a busy clinic environment). At such times counsellors mentioned reverting back to their previous method of counselling (based on Egan's model). In theory, *Options* should take half the amount of time (i.e. 10 – 15 minutes) a session based on Egan's model should take. The reports we received from counsellors that they were too pressured to use *Options* lead us to wonder what counsellors *are* doing with clients when they have limited time to spend.

Unfortunately the structure of treatment work-up sessions (counsellors follow set guidelines for these sessions ensuring that they cover all relevant information with patients), the limited time counsellors have to spend with both work-up and follow-up patients as well as the lack/shortage of private counselling space seems to preclude the possibility of using *Options* to address sexual risk behaviour within this context. This then begs the question: what ought to happen to this component of the intervention in moving forward?

A Preliminary Evaluation of Current Counselling Practice

In addition to assessing the coverage of *Options*, our evaluation also sought to determine the ability of counsellors to implement the *Options* counselling protocol in terms of Motivational Interviewing techniques as well as the 8 steps of the counselling protocol. In order to do this we have been collecting voice-recordings of counselling sessions conducted by counsellors with patients at their clinics. To date a total of 237 recordings of adherence counselling sessions conducted by counsellors taking part in the implementation have been collected at the following intervals:

- Before the initial 5-day *Options* training which took place in June 2009;
- Immediately following the June 2009 *Options* training;
- Following the 2-day follow-up *Options* training which took place in October 2009.

A final round of recordings is scheduled to start in July 2010, following the implementation of *Options*-specific supervision sessions over the past 4 months.

For the purposes of this report, and in order to get an idea of what counsellors are doing with the limited time that they have to spend with patients, we conducted a preliminary analysis of 10 randomly selected transcripts of counselling sessions recorded by counsellors taking part in our research before they were trained in the *Options* intervention (thus representing counselling sessions conducted according to Egan's model). The 10 transcripts represented the work of 7 counsellors. Transcripts were coded for the use of counselling techniques associated with the 3 stages of Egan's model (as listed in the table on pg 4) and notes on the overall impression of each session were made.

Findings

The 10 sessions analysed varied from 2 minutes to 13 minutes in length, with an average time of 7 minutes 35 seconds. Two transcripts exhibited none of the features of Egan's model.

Stage 1: Exploration

Skills associated with this stage include listening, showing empathy and asking questions.

Generally counsellors relied on simple reflections (where the counsellor repeats or rephrases what the client has said) and questions to move the counselling session forward. In this stage where the counsellors' task is to help the client to explore their problem, open-ended questions should be used. Five counsellors made use of open questions in order to explore their clients' situation (two did so only once), however all counsellors relied heavily on closed-ended questions in acquiring information at this stage.

Perhaps because counsellors' attempts to understand things from the client's perspective were limited, evidence of empathy for the clients' situation (with the exception of the use of reflective statements) was lacking. While most counsellors made some use of simple reflections, two counsellors' did not use this skill at all. Intended to make the client feel heard (and also to check understanding), one counsellor was seen to reflect what the client had just said *incorrectly*, while another counsellors' reflection took on what was perceived by the analyst as a confrontational spin ("*you forget them sometimes, you know what happens when you forget your pills?*").

Stage 2: Understanding

Skills associated with this stage include probing, offering information and setting goals.
Two counsellors' attempted to gain a deeper understanding of their clients' non-adherence by probing ("*what was your problem when you stopped, what was happening to you?*") but generally counsellors missed opportunities to explore the client's situation before providing information or advice.

All 10 transcripts contained instances of information-giving. While one counsellor gave information that was in-depth and appropriate to the clients' situation, others offered large amounts of information regardless of whether this would help the client to overcome their barrier or not. At times information-giving took on a paternalistic style, perhaps as the result of an attempt to engage the client in the session:

> Counsellor: *Do you still remember what they said, what is the main job of the medication?*
>
> Patient: *The main jo..job of the medication is to protect the virus*
>
> Counsellor: *Exactly it's to protect the virus...to decrease*
>
> Patient: *To decrease*
>
> Counsellor: *Not to what?*
>
> Patient: *To go forward*

Counsellor: *To increase and go forward*

Patient: *Uh*

Counsellor: *What we want to go forward is what? It's your immune system of your body...*

None of the 10 transcripts revealed any attempt by the counsellor to help the patient to set goals relating to their ARV treatment.

Stage 3: Action

Specific skills associated with this stage include brainstorming, sorting pros & cons, monitoring progress and ending the session.

Not one transcript revealed the counsellor engaging the client in brainstorming ideas for improving their treatment adherence, nor did counsellors encourage their clients to think about the pros and cons of different plans of action. One counsellor suggested ways in which his/her client could remember to take their ARVs but, because the counsellor did not explore the reasons as to exactly why the client was forgetting, it is unclear whether any of these would address the problem. In general attempts made by counsellors to change their clients' behaviour involved giving advice with no plan as to how to proceed:

"*You have a girlfriend, okay ... when you are ...having sex with your girlfriend you must wear a condom*" (counsellor).

Conclusion

The transcripts revealed variation in the counselling skills used by counsellors and in the extent to which Egan's model was adhered to. This preliminary analysis (based on the work of only 7 counsellors) thus points to the need for an evaluation of counsellors' current practice in order to determine the quality of the counselling that is being provided. While some counsellors' performed better than others, not one completed the 3rd stage of Egan's model (where clients negotiate a goal and plan of action for behaviour change) in a satisfactory way. In general the analysts' impressions of the transcripts evaluated here were not good; an assessment of all 64 pre-*Options* training transcripts is recommended in order to determine how representative these sessions are of what is being delivered in ARV clinics.

While a good model for training on basic counselling skills, the incorrect (or incomplete) use of Egan's model in practice (likely the result of the constraints on their practice as experienced by counsellors') raises the question as to whether this is the model on which ARV adherence counselling practice within the South African clinic context should be based. The question as to whether *Options* can be effectively delivered within the context of such constraints is also raised and indeed it may well be asked what counselling, if any, *can* be delivered effectively under such circumstances.

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Appendices

Appendix A: Report on facility visits to present Options for Health: Western Cape

Introduction

Facility managers were contacted by a member of the Health Systems Research Unit who explained that the ARV adherence counsellors at their clinic had been trained in an advanced counselling method that they were currently implementing with their patients. The researcher requested an appointment with all members of the ARV clinic staff in which a 10 minute presentation on the intervention would be given following which staff would have the opportunity to ask questions. The facility visits were conducted by two members of the implementation team (SD and AC). The presentation consisted of a brief background to the study before the 8 steps to the *Options* counselling protocol were explained.

Attendance

Counsellors involved in the implementation were present at 8 of 20 facilities; those not present were either absent that day or busy with clients. Facility managers sat in on the presentations at 7 facilities. ARV clinic doctors were present at all but 2 facilities, and ARV clinic Sisters were also present at all facilities but 2. At 8 facilities other members of staff such as patient advocates, data capturers, social workers and pharmacists assistants were present.

Response to the presentations

At all clinics but one the response to *Options* was positive. In this one clinic the presentation was not delivered - staff denied that an appointment (coinciding with their staff meeting) had been made and seemed annoyed by the researchers' arrival. After instructing her to wait until they were finished they adjourned the meeting and informed her that she should talk to the counsellors only; the appointment was not rescheduled. At another facility staff expressed unhappiness that they had not been informed about the implementation of the intervention at the beginning of the project but this did not appear to affect their support for the intervention.
Generally patient advocates and other members of staff were quiet during the presentation and didn't actively participate. Doctors and nurses expressed interest and support for the project and in some cases wanted to know what could be done to aid the implementation of *Options* and to increase coverage. At one facility the social worker offered to support the counsellor using *Options* by discussing cases with her and also felt that she herself could use it as she also counselled defaulters sometimes. At another facility the doctors suggested that they place patient record forms in the folders of patients whom they think should receive *Options* before sending them to the counsellor in order to encourage (and remind) the counsellor to use the *Options* protocol.

At some facilities, staff gave examples of the reasons why some of their patients were struggling with adherence and asked how *Options* could be used to help. In response the researcher would give examples of the kinds of plans that could be devised together with the patient in order to overcome the stated barrier. At one site clinic staff expressed interest in using *Options* within the adolescent clinic that was soon to be opened, and at

another site the ARV Sister expressed interest in *Options* training for the nurses at that clinic. This same Sister also felt that sometimes patients had to be 'pushed' in order to tell the truth about having had unprotected sex when presenting with STIs or raised viral loads.

While some doctors and nurses reported having seen the patient record forms before, most were not familiar with them. A doctor at one hospital-based clinic also expressed concern that *Options* was not appropriate for talking about sexual risk behaviour as patients are reluctant to deal with those issues in this particular setting.

Comment and Recommendations

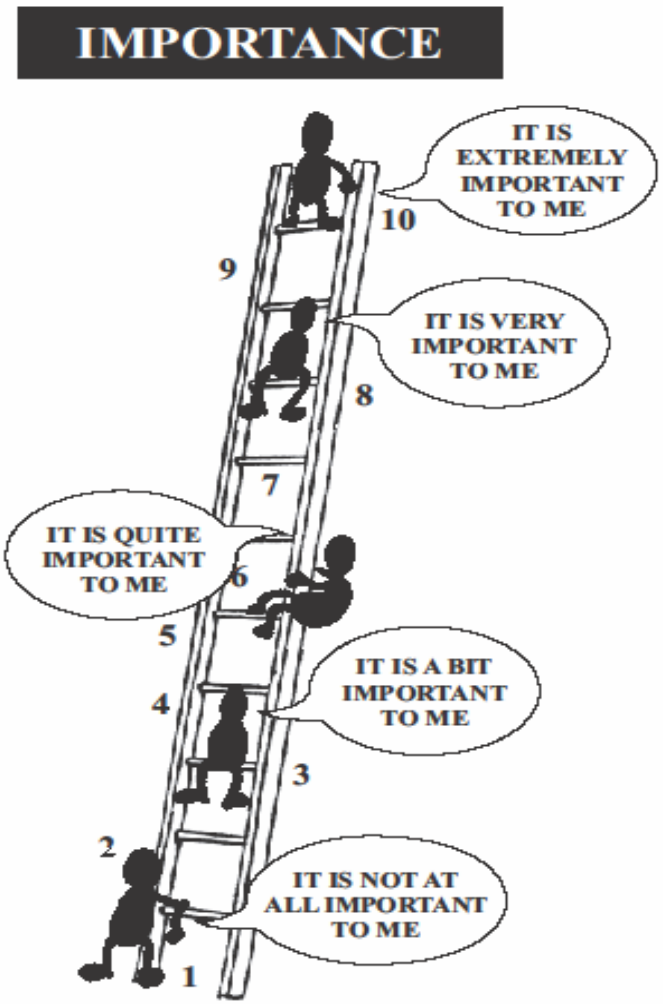
Despite one or two difficulties the facility presentations were a positive experience for the research team; ARV clinic staff were receptive to the idea of an intervention aimed at optimising their patients' ARV adherence and reducing sexual risk behaviour, and were interested to learn how they could help to improve the implementation of the intervention. In future, facilities should be briefed on the intervention prior to implementation; counsellors may be more likely to approach staff knowledgeable in the requirements of the intervention with any difficulties they are experiencing and, in turn, staff may be better able to address these.

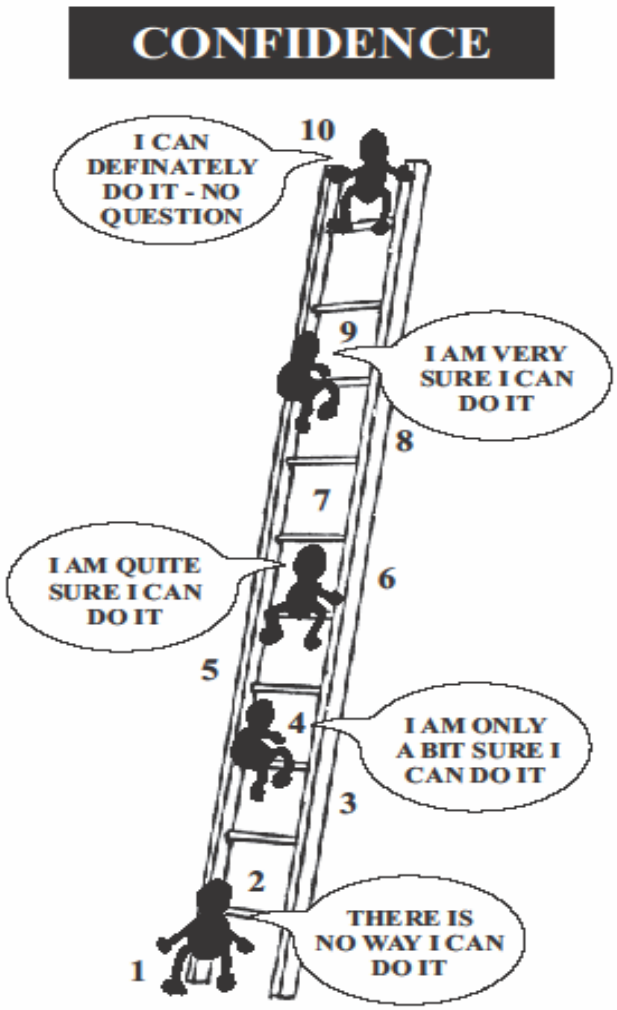
It was mentioned that staff at one facility had the idea of putting record forms in to patients' folders to encourage the counsellor to use the *Options* protocol; while this seemed to be a good idea at the time of the presentation, it was later discovered through our interviews with counsellors that the main barrier at this site was the lack of counselling space. As such, this plan does not help to overcome a barrier to implementation but instead is likely to increase the pressure on the counsellor without providing a means of alleviation. Different counsellors have been found to face a variety of different barriers to implementing *Options* with their patients. While general recommendations for improving implementation can be made, an awareness of the specific difficulties faced in each site is required so that recommendations can be tailored to address these.

Appendix B: A comparison of the Options and Egan counselling models (developed by Joanne Croome, 2009)

STAGE	EGAN'S 3 STAGE MODEL	STEP	OPTIONS 8 STEP MODEL
1	**What is the problem** • This is the client's story	1 - 2	**What is the <u>risky behaviour</u> that is a barrier to:** • Adherence • Safer sex
2	**Getting a deeper understanding of the problem** • When did the problem start • Did anything change • What keeps the problem going • What has the client tried • Is there another way of looking at the problem **Setting a goal** • How does the client want things to be in his/her life	2 - 5	**Understanding what causes this barrier** • What **<u>motivates (causes) the risky behaviour</u>** o Lack of knowledge o Lack of skills o Lifestyle o Unwillingness to change o Relationships issue **Assess <u>readiness to change</u>** • Importance and confidence **Setting a goal** • Client buy-in to some kind of **<u>behaviour change</u>** to overcome barrier o Increases adherence o Decreases unsafe sex
3	**Action** • Brainstorm options that would help the client achieve the goal and pick one • Complete counselling notes	6 -8	**Action** • Brainstorm **<u>options</u>** (menu) of things that the client could try and pick one to o Increase adherence o Practice safer sex • Write up **<u>Action Plan</u>** • Complete Options Record form
Model Structure	• Client-centred • Looser structure – can discuss many issues • 45 minutes	**Model Structure**	• Client-centred • Tighter structure – focus on changing client's behaviour • 10 – 15 minutes
Focus	• Solving the problem	**Focus**	• Can be **<u>baby steps</u>** towards solving the problem
Skills	• Attending • Listening • Questioning • Probing • Reflecting • Summarising	**Skills**	• Attending • Listening • Questioning • Probing • Reflecting • Summarising • **Motivational interviewing technique** – more advanced counselling skills to add to your Egan's model toolbox

Appendix C: Revised 'Readiness to Change' Ladders (English)





Appendix D: The Options for Health: Western Cape Patient Record Form (PRF)

Date:_____

OPTIONS FOR HEALTH
Patient Record Form

Client Name:_____ Counsellor Name:_____

A. PATIENT PROGRESS ON PREVIOUS GOAL

N/A: Today is first Options visit	No Action Plan made at last visit	No progress on Action Plan	Partially achieved Action Plan	Fully achieved Action Plan

Previous Action Plan: _____

Barriers to Achieving this Action Plan: _____
_____

FOR SEXUAL RISK BEHAVIOUR

B. RISK BEHAVIOUR: _____
_____

C. WHY IS SAFE BEHAVIOUR CHALLENGING? *(e.g. client has not disclosed to partner/ partner refuses to use condoms)*
_____
_____

FOR ARV NON-ADHERENCE

D. NON-ADHERENT BEHAVIOUR:_____
_____

E. WHY IS ADHERENCE CHALLENGING?_____
_____

FOR ALL CLIENTS

F. BEHAVIOUR FOR WHICH IMPORTANCE AND CONFIDENCE WERE RATED: *(Be specific)* _____
_____

G. IMPORTANCE SCORE

0 1 2 3 4 5 6 7 8 9 10 Didn't have client rate IMPORTANCE

Not At All Important — Somewhat Important — Extremely Important

H. CONFIDENCE SCORE

0 1 2 3 4 5 6 7 8 9 10 Didn't have client rate CONFIDENCE

Not At All Confident — Somewhat Confident — Extremely Confident

I. ACTION PLAN THAT CLIENT AGREED TO FOR NEXT VISIT:
_____
_____

J. WAS AN "ACTION PLAN" HANDED TO THE PATIENT? YES NO

K.COMMENTS:_____
_____
_____