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THE FEASIBILITY OF IMPLEMENTING A SEXUAL RISK REDUCTION INTERVENTION IN ROUTINE CLINICAL PRACTICE AT AN ARV CLINIC IN CAPE TOWN: RESULTS OF A PILOT STUDY

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INTRODUCTION

In South Africa where approximately 5 million people are living with HIV (UNAIDS, 2006), it is estimated that 400 000 HIV-positive people are receiving antiretroviral treatment (ART), including 23 000 in the Cape Town metropolitan area (Department of Health, 2008). A recent study has revealed that, of HIV-positive people initiating antiretroviral (ARV) treatment in public health clinics in Cape Town, 44.7% had had unprotected sex at last sex (Elsele et al., 2008). In collaboration with the Provincial and City Departments of Health, we intend to implement a sexual-risk reduction intervention called *Options for Health* in ARV clinics across the Cape Town metropolitan area.

The *Options for Health* Intervention

Options for Health is an HIV risk reduction intervention that has been designed specifically for people living with HIV (PLHIV) attending clinical care. This counselling intervention is based on the Information, Motivation and Behavioural (IMB) Skills model of behaviour change and uses Motivational Interviewing (MI) techniques to deliver HIV risk-reduction information, motivation and behavioural skills content (Fisher et al., 2006).

The *Options for Health* Counselling Protocol

The *Options for Health* counselling protocol for a first *Options* meeting consists of 8 steps in which the counselor:

- assesses the patients' sexual risk behaviour,
- assesses the patients' readiness to change,
- identifies barriers to consistently practicing safer behaviours,
- elicits strategies from the patient for overcoming these barriers and
- negotiates an individually tailored risk reduction goal or "action plan".

Details of each session are recorded by the counselor on a patient record form.

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OBJECTIVE OF THE PILOT STUDY

Our objective was to investigate the feasibility of incorporating Options into routine clinical care at an ARV clinic with a high patient load in the Western Cape.

FINDINGS

Implementing ***Options***: Facilitating Factors

- **Clinic Staff were Supportive of the Idea of a Sexual Risk Reduction Intervention.**
- ***Options* Did Not Interfere with Other ARV Clinic Staff Members' Daily Work.**
- ***Options* was Implemented with Fidelity to the Counselling Protocol** - the Options counselor implemented at least 7 of the 8 protocol steps in all but two Options counselling sessions.

Implementing ***Options***: Barriers

Barrier: *Options* Increased Counselling Time

Observational data was collected over 6 days. The time spent counselling patients who received Options (n=6) and those who didn't (n=28) is compared below

Table 1: Time Spent Doing Standard of Care (SOC) Adherence Counselling vs *Options* Counselling

	Counselling Time with ARV Follow-up Patients		
	Minimum	**Maximum**	**Average**
SOC Adherence Counselling	**3 minutes**	**20 minutes**	**11 minutes**
Options Counselling	**10 minutes**	**27 minutes**	**18 minutes**

Barrier: Regular On-Site Support was Required

During the study the counselor benefited from the on-site support of two members of the research team

- Initially the counselor required guidance around how to complete the patient record forms appropriately
- After the first month of implementation, when our counselor was expecting to start seeing patients for follow-up visits, he expressed uncertainty about the counselling protocol for follow-up visits and so we provided him with a brief "booster" training session on this
- He valued the opportunity to discuss cases that he had found difficult to handle, he reported that he had not known how to handle the issues that arose in two particular cases and had not completed these two counselling sessions

Barrier: Not All of the Intended Recipients Received *Options*

A comparison of the number of patient record forms collected from the counsellor with the number of ARV follow-up patients having received counselling (as recorded in the counsellors' diary) revealed that a total of 31% of the intended recipients received Options over the 15 weeks of implementation

Table 2: The Coverage of *Options* as determined by Patient Record Forms (PRFs) collected vs the number of ARV Follow-up (ARV FU) patients seen for counselling

July		August		September		October	
PRFs collected	**ARV FU**	**PRFs collected**	**ARV FU**	**PRFs collected**	**ARV FU**	**PRFs collected**	**ARV FU**
31	**35**	**20**	**33**	**18**	**75**	**9**	**105**
Coverage		**Coverage**		**Coverage**		**Coverage**	
88%		**60%**		**24%**		**8%**	

Reasons given by the *Options* counsellor for not having conducted *Options* counselling sessions were that:

- He forgot to do *Options* with some patients
- He did not feel he had the time to do *Options* in addition to adherence counselling
- He did not know how to deal with the issues that arose in the session and thus did not complete the session

Barrier: The Counsellor was Not Always Able to Implement Options Effectively

...or in such a way that a patient could attempt to reduce their sexual risk behaviour with the possibility of success

Many of the action plans aimed at reducing sexual risk behaviour that were developed appeared to be unrealistic and unachievable, for example one patient reported that he did not use condoms when he was drunk. The action plan as recorded on the patient record form was:

"To stop drinking and use condoms every time he has sex"

CONCLUSION

The barriers to implementation as identified in this study are not insurmountable and we are confident that the implementation of *Options for Health* in local ARV clinics is indeed feasible. We have revised the *Options* training programme so that the *Options* protocol is presented as a generic counselling tool that can be applied to a variety of health behaviour problems including ARV non-adherence and sexual risk behaviour. In this way, counsellors should adopt *Options* as a counselling style, instead of using the 8 step protocol for dealing with specific issues where it is likely to be 'forgotten' or ignored due to lack of time. A process evaluation will be conducted in the next phase of the roll-out in order to determine the best way in which to train adherence counselors to the level of skill required to implement *Options* effectively, what kind of support they require after their initial training, and what change occurs in their level of skill as they actually implement *Options* over a period of time.

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