



Qualitative evaluation of a Positive Prevention training for health care providers in Mozambique[☆]



Sarah A. Gutin^{a,*}, Beverley Cummings^b, Prafula Jaiantilal^b, Kelly Johnson^c, Francisco Mbofana^d, Carol Dawson Rose^a

^a UCSF, Department of Community Health Systems, School of Nursing, United States

^b Global AIDS Program, Centers for Disease Control and Prevention, Mozambique

^c UCSF, Prevention and Public Health Group, Global Health Sciences, United States

^d National Institute of Health, Ministry of Health, Mozambique

ARTICLE INFO

Article history:

Received 27 April 2013

Received in revised form 19 October 2013

Accepted 29 October 2013

Keywords:

Positive Prevention
Prevention with Positives
HIV prevention
Training intervention
Mozambique
Qualitative evaluation

ABSTRACT

The rapid scale-up of HIV care and treatment in Mozambique has provided an opportunity to reach people living with HIV (PLHIV) with prevention interventions in HIV care and treatment settings. A three-day Positive Prevention (PP) training intervention for health care providers that focused on pressing issues for PLHIV in Mozambique was adapted and delivered at sites in three provinces. In-depth interviews were conducted with 31 providers trained in the PP curriculum. Qualitative data were used to assess the appropriateness of the training materials and approach, which lessons providers learned and were able to implement and which PP messages were still difficult to deliver. Providers reported gaining numerous insights from the training, including how to conduct a risk assessment and client-centered counseling, negotiating disclosure, partner testing, condom use, PMTCT, treatment adherence and approaches for positive living. Training topics not commonly mentioned included discordance counseling, STIs, family planning, alcohol and drug use, and frank sexual risk discussions. While areas for improvement exist, the PP training was useful in transferring skills to providers and is a viable component of HIV care. This evaluation helps identify areas where future PP trainings and specific strategies and messages can be refined for the Mozambican context.

© 2013 Elsevier Ltd. All rights reserved.

1. Introduction

Each year, approximately 2.5 million people worldwide become newly infected with HIV, 69% of whom are in sub-Saharan Africa (UNAIDS, 2012). In Mozambique, one of the most affected countries in the world, approximately 130,000 people are newly infected annually (UNAIDS, 2012). The national HIV prevalence is estimated at 11.5% among adults aged 15–49 years. In some of the hardest hit provinces, prevalence is as high as 25.1% (Instituto Nacional de Saúde, Instituto Nacional de Estatística, & ICF Macro, 2010). This situation is expected to continue unless effective prevention interventions are rapidly brought to scale (UNAIDS, 2008). In many countries, including Mozambique, the main HIV prevention goal has been to reduce HIV acquisition through

consistent condom use, partner reduction and increased HIV testing to increase sero-status awareness. The Government of Mozambique Ministry of Health (MOH) has done much to stem the epidemic including implementing a Prevention-of-Mother-to-Child Transmission (PMTCT) program and providing free antiretroviral therapy (ART). Still, continued high prevalence rates demonstrate the need for additional prevention strategies to effectively reduce HIV transmission.

Given that HIV is transmitted from someone who is positive to someone who is uninfected, a change in the risk behavior of a person living with HIV/AIDS (PLHIV) may have a greater impact on the spread of HIV than a similar change in the behavior of an uninfected person (King-Spooner, 1999). In order to build on this concept, prevention interventions designed specifically for people who are aware of their HIV-positive sero-status have been developed. Programmatic guidance from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (PEPFAR, August 2011) and the World Health Organization (WHO) (World Health Organization, 2008) now include such interventions – known as Positive Prevention (PP), Prevention with Positives (PwP), or as Positive Health, Dignity and Prevention (PHDP) – as cornerstones of HIV prevention efforts (Bunnell, Mermin, & De Cock, 2006;

[☆] The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

* Corresponding author at: School of Nursing, University of California-San Francisco, 50 Beale Street, Suite 1300, San Francisco, CA 94105, United States. Tel.: +1 415 597 9308; fax: +1 415 597 9386.

E-mail addresses: Sarah.Gutin@ucsf.edu, sarahagutin@gmail.com (S.A. Gutin).

Global Network of People Living with HIV, April 2009; Kennedy, Medley, Sweat, & O'Reilly, 2010; PEPFAR, August 2011; World Health Organization, 2008). The focus of PP is on building skills to meet the needs of those who are HIV-infected, including skills to help with disclosing to partners and family members, preventing transmission to partners or unborn children, negotiating sexual relationships, and addressing the stigma of HIV infection. To this end, PP was endorsed by the Mozambique MOH as an HIV prevention strategy and is included as a priority in Mozambique's 2010–2014 National Strategic Plan for HIV/AIDS (PEN III) (CNCS, 2009; Government of Mozambique, 2008).

The rapid scale-up of HIV care and treatment in resource-limited settings has provided the opportunity to reach many PLHIV when they access healthcare services. As part of the standard of care for HIV, PP services should optimally be integrated into existing HIV care, treatment, and support services, whether in a health clinic or in the community. Studies have illustrated that communicating prevention messages within the HIV care system is most effective when done by a health care worker (Cornman et al., 2008; Myers et al., 2010). While several studies conducted in the U.S. have shown the efficacy of provider-delivered HIV prevention messages for changing high risk behavior among patients attending HIV clinical care, these interventions have not been widely studied in resource limited settings (Dawson Rose et al., 2010; Crepaz et al., 2006; Fisher et al., 2006; Gardner et al., 2008; Healthy Living Project Team, 2007; Kennedy et al., 2010; Myers et al., 2010; Richardson et al., 2004). In developing countries, PP interventions have been shown to have a positive impact on condom use and a reduction in risky sexual acts (Bunnell, Ekwaru, et al., 2006; Cornman et al., 2008; Mola et al., 2006) and a reduction in multiple sexual partners (Peltzer, Tabane, Matseke, & Simbayi, 2010). Based on these various findings, trainings introducing prevention techniques into HIV care have been adopted by several U.S.-based HIV clinics as well as in many developing country contexts. Based on this prior work, a PP intervention emphasizing a tailored approach to risk reduction (Catania, Kegeles, & Coates, 1990) was adapted for the Mozambican context using strategies found to be useful with HIV-infected individuals.

In this evaluation, we have used qualitative data to assess how appropriate the training materials and approach were for providers, which lessons they learned and were able to implement in their interactions with PLHIV, which PP messages were still difficult to deliver and the applicability of the training topics to the Mozambique context.

2. Methods

2.1. Overview of the Mozambique PP intervention

In 2006, the University of California, San Francisco (UCSF), in partnership with the Mozambique MOH and the U.S. Centers for Disease Control and Prevention (CDC)-Mozambique, adapted and piloted a PP intervention that targeted health care providers in Mozambique. The first intervention step was to involve the clinic as a whole in the PP process, mirroring techniques used by Richardson and colleagues, who trained all clinic staff on behavior change theories, communication skills and how to conduct brief counseling sessions as part of the Partnership for Health intervention (Richardson et al., 2004). This model was employed because the few clinicians who are present in health care facilities in Mozambique are often seeing large numbers of patients. Thus, both clinical and non-clinical personnel are likely to see patients and are able to deliver prevention messages. Based on the HIV Intervention for Providers (HIP) approach (Dawson Rose et al., 2010), health care providers who offer services to PLHIV were trained to: (1) build their own skills to assess behavioral and

contextual risk among their patients; and (2) provide a risk reduction-based prevention intervention focused on incremental change, tailored to the patient's transmission risk behavior and prevention needs. By addressing these needs, PP aimed to increase the ability of PLHIV to protect their own health and minimize the risk of transmitting HIV to others through behavior change.

The pilot program consisted of a three-day PP training that was delivered over a two-year period at several sites in three provinces (Maputo, Sofala, and Zambézia) where ART treatment was supported by PEPFAR. The theoretical basis of the training was the AIDS risk reduction model (Catania et al., 1990). This behavioral change theory stipulates that risk behaviors can be changed incrementally with the goal of eliminating risk behaviors over time. Risk reduction was operationalized by discussing risk assessment, tailoring messages, focusing on specific behaviors and assessing what a patient can do to decrease risk or transmission. Teaching methodologies included experiential learning, didactic presentations, interactive skills-building activities, case-based discussions that highlighted opportunities for risk reduction, and role-plays of patient interactions. Key technical PP components included an overview of the PP Model, risk reduction counseling and prevention messages, discussing disclosure, family planning, PMTCT, and living positively, which is defined as taking action as it relates to one's health and well being (see Table 1 for details).

This study was conducted as part of that larger qualitative evaluation to assess the feasibility and acceptability of Mozambique's PP intervention, and utilized a descriptive, cross-sectional design to examine the success of the training in terms of provider knowledge and implementation ability.

2.2. Evaluation study design

Individual in-depth interviews were conducted with providers trained in the PP curriculum. Interviews were designed to provide a descriptive evaluation of the PP training program and to ascertain how appropriate the training materials and approach were for providers, including which lessons providers learned and were able to implement in interactions with PLHIV, which PP messages were difficult for them and the applicability of training topics.

2.3. Study population

For this study, providers were defined as clinicians (including medical technicians and nurses), counselors (including counseling and testing staff, adherence support staff, support group leaders), and other site staff (such as pharmacists, lab technicians, and project management staff) who received the PP training. Although their educational backgrounds and job functions differ, these cadres were chosen to receive PP training and to be evaluated because they represent the types of health care workers who have contact with the patient population. For example, counselors, social workers and peer educators generally provide counseling and refer for clinical services. In contrast, medical technicians and nurses provide clinical care. To be eligible, providers had to be at least 18 years old, fluent in Portuguese, have participated in a PP training, and be regularly providing care to HIV-infected patients.

2.4. Study settings

Interviews were conducted at five rural MOH clinics. These sites included: the Namaacha Health Center and Esperança-Beluluane Counseling and Testing Center in Maputo Province, Mafambisse Health Center in Sofala Province, and the Namacurra Health Center and Inhassunge Hospital in Zambézia Province. Each site was chosen because it employed health care providers who had

Download English Version:

<https://daneshyari.com/en/article/322488>

Download Persian Version:

<https://daneshyari.com/article/322488>

[Daneshyari.com](https://daneshyari.com)