Translation of a Behavioral Intervention to Community Health Centers in Lusaka, Zambia:

Staff Evaluation and Implementation Strategies

The Partnership Project

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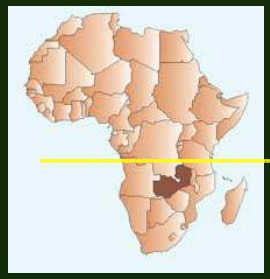


Zambia

- Zambia: 13,881,336
- Lusaka: 2,198,996 population
- 980,000 PLWA; on ART 283,900
- Adults 15 – 49: HIV prevalence rate13.5% [12.8% - 14.1%] 860,000
- Annual deaths due to AIDS 45,000
- Orphans due to AIDS: 690,000
- Life expectancy: 52.36 yrs

UNAIDS, Zambia Country Report: accessed March 21, 2012

Background

- 78% of new HIV infections occur through heterosexual sex
- Challenges in Zambia:

  - Health, economic and social impacts of a mature HIV/AIDS epidemic

Financial crisis; Continuity of funding; Financial and logistic demands WHO treatment guidelines

Reaching those who need treatment; integration of reproductive health services; reducing stigma

- High prevalence rates (incidence 1.6 per 100 PY) associated with:

early initiation of sex; unprotected sex with casual partners; concurrent sexual partnerships

Low incidence of condom use among high risk groups

Sexual violence against women; Poverty and sex exchange

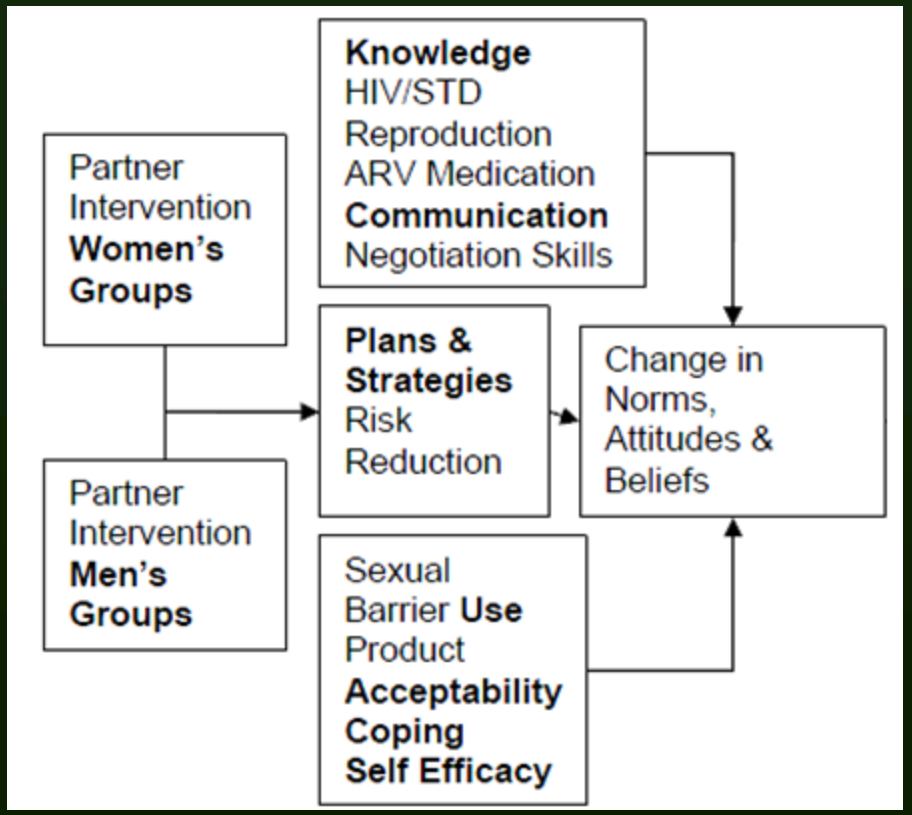
~11.8% seroconversion of negative partners, annually

- Estimated 21% of couples are sero-discordant

UNAIDS, HIV/AIDS Zambia, Developmental Challenges: accessed March 21, 2012

The Partner I Project

2001 - 2006



↑ Sexual Barrier Use
↑ Medication Adherence
↓ Alcohol Use
↓ Conflict
↑ Social Support

Improved Health Outcomes
Decreased HIV Transmission

Participants & Intervention

- Target Population: N = 240 seroconcordant and serodiscordant adults, heterosexual couples, post-VCT from local CHCs
- Currently sexually active (past 30 days), partners for a minimum of 6 months
- Intervention: Closed, structured, gender concordant groups of 8 participants
  - 4 weekly two-hour sessions of CBT-skill training & psycho-education, emphasis on group participation and cohesion, facilitating communication and sharing
  - Topics: HIV/STDs, reproductive choice, sexual negotiation, sexual barrier products, communication, assertiveness, conflict resolution
- Control Condition: Enhanced SOC
  - Time matched health education videos

Translation & Implementation

Partner II: 2009 - 2013

- Translation model
  - Behavioral risk reduction intervention conducted at University Teaching Hospital (UTH) (P1) translated to community health clinics (CHCs) (P2)
  - Compare P2 CHC outcomes to P1 UTH site outcomes
  - Compare UTH trainer outcomes to CHC facilitator outcomes
  - Staged HIV intervention technology transfer process
    - Pre-implementation
    - Implementation
    - Maintenance
    - Evaluation
    - Dissemination

Site Selection

- **6 Community Health Centers located in urban Lusaka**

a) adequate HIV patient census

minimum of 150 HIV seropositive or serodiscordant couples seen monthly

) space for treatment and assessment activities

) available medical records to verify HIV serostatus

) willing to participate over the 5 year study

e) committed to offering the Partner Project as a CHC program using on site health care providers

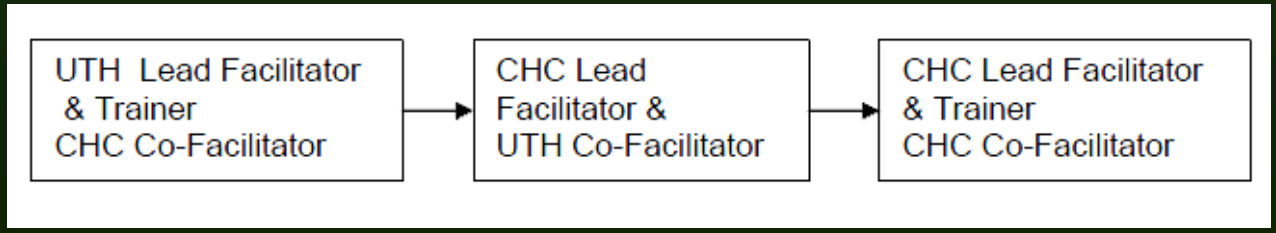
- *"…you are the only nurse on duty and you are attending to outpatients and then an emergency case comes and you put everything on hold and start attending to the emergency case... it becomes very difficult to do the two. People wait to be admitted because one person cannot manage to do everything at the same time…"*
- *"We sometimes run out of bed spaces in the inpatient ward. We put some patients on the floor and if the patient is on a drip it is very difficult."*

CHC Target Population

- **Provider Participants**:
  - Providers (N = 82) were HIV Counselors, staff & nurses from six CHCs trained in the intervention
    - Provided with in-group training & clinical supervision
      - UTH → CHC
      - CHC→ UTH
      - CHC→ CHC

- *"Most of [us] do not rest, it is like you work like a machine… there are so many patients and there is not time to take a break… There is no eating it is strictly working, even when you are hungry you just have to carry on like that and that stresses us a lot. There is not time to even go to the toilet."*

Training Model



- Staff Training: "time-lagged" by site
  - Y1: Clinic staff at the pilot site (1) and next site (2) were trained.
  - Y2: Clinic staff at the next site (3) were trained
  - Y3 - 4: Clinic staff at the final three sites (4, 5, 6) trained

"Most people believe that the moment you send them to UTH then that is the end of them."

Focus Group Discussions

- Identifying organizational challenges & barriers
  - Teamwork
  - Patient Volume & Staff limitations
  - Positive attitudes
  - Insufficient compensation
  - Concerns about safety
  - Supply stock-outs

- *"…you are the only nurse on duty and you are attending to outpatients and then an emergency case comes and you put everything on hold and start attending to the emergency case... it becomes very difficult to do the two. People wait to be admitted because one person cannot manage to do everything at the same time…"*

- *"…some patients expectations are too much... They feel they are neglected when they come to the health facility, they say bad things, and some even threaten to beat us up [health workers] because they feel that we do not treat them well and we do not give them enough attention…"*

CHC Assessment

- Job Satisfaction
- Burnout
- Clinic logistics

→ Readiness for Change

- *"…patients don't appreciate when you take long they complain and start coming in the treatment room uninvited shouting and screaming so whenever we are working we are threatened by patients."*
- *The space is not enough. The treatment rooms are small and very difficult to see patients. There is need to have more working space. The maternity wing is so small and there are a lot of people who come to deliver from here [and not at the UTH hospital]."*
- *"When you report for work there are a lot of unexpected incidents but most of us are so dedicated that even when the day is rough we are willing to come back the next day and we continue to work."*

- "We write them prescriptions but we know very well that most of them do not afford to buy the medicines that we prescribe for them, but at the end of the day there is nothing we can do."

Results

- There was no difference between clinics in the level of reported job satisfaction (F = 1.90, p = .11).
- Clinics differed on overall burnout, primarily attributed to work-related rather than client-related factors (F = 2.53, p = 0.36).

- Burnout may be offset by financial rewards or perceived employee appreciation, both of which were associated with lower burnout.
- Neither job satisfaction nor burnout were related to readiness for implementation of the intervention.

The Front Lines of HIV Care in Zambia

Retention	Baseline	Midpoint (6 mo.)	Endpoint (12 mo.)
Clinic 1	N = 10	N = 10 (100%)	N = 5 (50%)
Clinic 2	N = 12	N = 10 (83%)	N = 6 (50%)
Clinic 3	N = 15	N = 10 (67%)	N = 13 (87%)
Clinic 4	N = 15	N = 12 (80%)	N = 4 (27%)
Clinic 5	N = 15	N = 11 (73%)	Pending
Clinic 6	N = 15	N = 10 (67%)	Pending

- 88% of clinics > 25 employees
- 50% overcrowding
- 70% lack of space to perform jobs
- 68% share office space
- 70% teamwork

Understaffed, high burden and high turnover

- *"Health staff turnover is a problem in the whole of Zambia… salaries are bad and most of the people have other job working in private clinics at their spare time or doing other programmes where they are paid extra money. In as much as we are providing a service we also need to look after our welfare, we have families to look after as well."*

- *"Most people leave to go and pursue further studies and others just go on transfer."*

No Cost, Low Cost, High Cost: UTH & CHC

- "We have two types of patients, those who feel attended to well at UTH and these usually have extra money to spend and they also have transport money to go to UTH. There are some that cannot afford to go to UTH because of finances, they do not have enough transport money and worst still when they are admitted they know that their relatives will not afford to be visiting them at UTH."

- "There is also a group of patients that is so ignorant. They think going to UTH is more prestigious than being treated at the local clinic. They feel they have the money to go to UTH and such…"

- "Most people prefer getting the treatment from here [CHCs] …when the case is complicated we refer them to UTH, they refuse to go there and they say that what is it that you cannot do for me here that they can do for me at UTH. Some would not want to go to UTH because they fear that they will go and die there."

- "This is a mini hospital most of the diseases are taken care of… when you need specialized treatment go to UTH and see a specialist."

Conclusions

- Importance of both qualitative and quantitative assessment of staff during the initial evaluation phase of the intervention
- Maximizing clinic "down" times
- Providing staff incentives ($)
- Offering training, certification and ongoing supervision
- Achieving Community Advisor Board support
- Obtaining Clinic-Head (Nurse In-Charge) buy-in
- Identifying dedicated space for program implementation

- *"What I can say is that to be in our field one has to have a good heart and very willing to work in any circumstance. There are times when I feel so stressed but I think about the people here and how much they need my help. This makes me get up and just so eager to come for work."*

Future Implications

- Preliminary translational study data can be used to inform implementation of intervention and community uptake
- Evidenced-based interventions to translation for HIV prevention are feasible and acceptable
- Healthcare providers are supportive of HIV prevention initiatives
- Multiple challenges exist in resource-limited settings
- Findings highlight the need for funding streams to support integration of novel strategies for HIV prevention in existing care

- Avenues to obtain sustained financial support from the Ministry of Health
- Compiling HIV Testing Surveillance Data
- Evaluating long term outcomes related to community prevention initiatives