Effective interpersonal health communication for linkage to care following HIV diagnosis in South Africa

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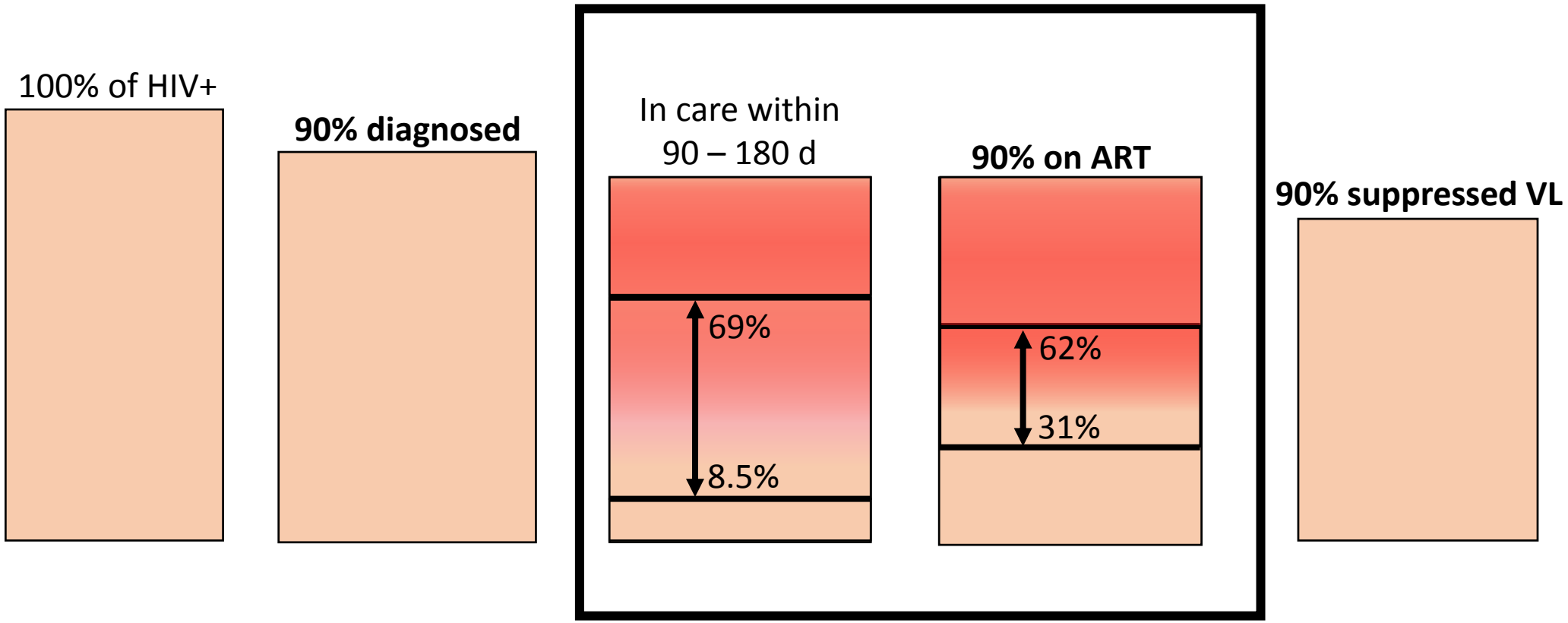
Outline

- Background
- Thol'impilo study design
- Interpersonal communication in Thol'impilo
- Thol'impilo results overview
- Analysis of interpersonal communication sessions
- Challenges to deliver precision interpersonal communication
- Place of precision communication in influencing care engagement
- Conclusions

Background – care continuum

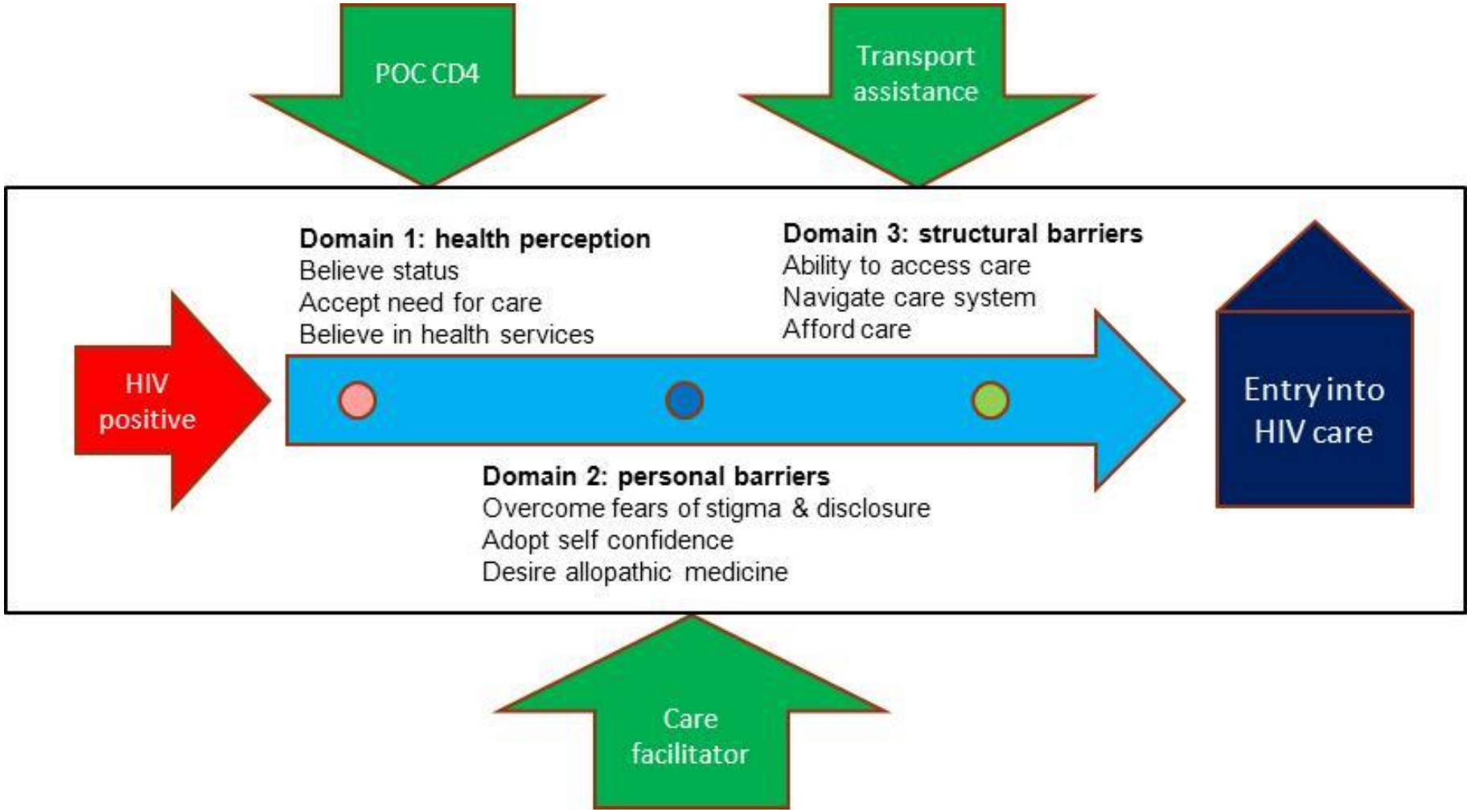


[Leon et al 2014; Genberg et al 2015; Bassett et al Rosen & Fox 2011; Govindasamy et al 2013; Barnabas et al 2014]

Background - Approaches to improve care continuum

- health system integration / co-location of services
- Home visits / home ART initiation
- POC CD4 count testing
- Strengths-based counseling
- Peer support
- Providing food / other incentives
- Assisting with transportation
- Community mobilization
- Support groups / men's groups / adherence clubs
- Mass media (TV soap operas, dramas, radio shows, etc)

Thol'impilo – conceptual framework



[Faal et al 2011; Gardner et al 2005; Craw et al. 2008; Nsigaye et al. 2009]

Thol'impilo Strategy combinations

- Standard of care 
- POC CD4 (plus information regarding the results)  
- POC CD4 + care facilitation (CF) (precision health communication) 
- POC CD4 + transport reimbursement 

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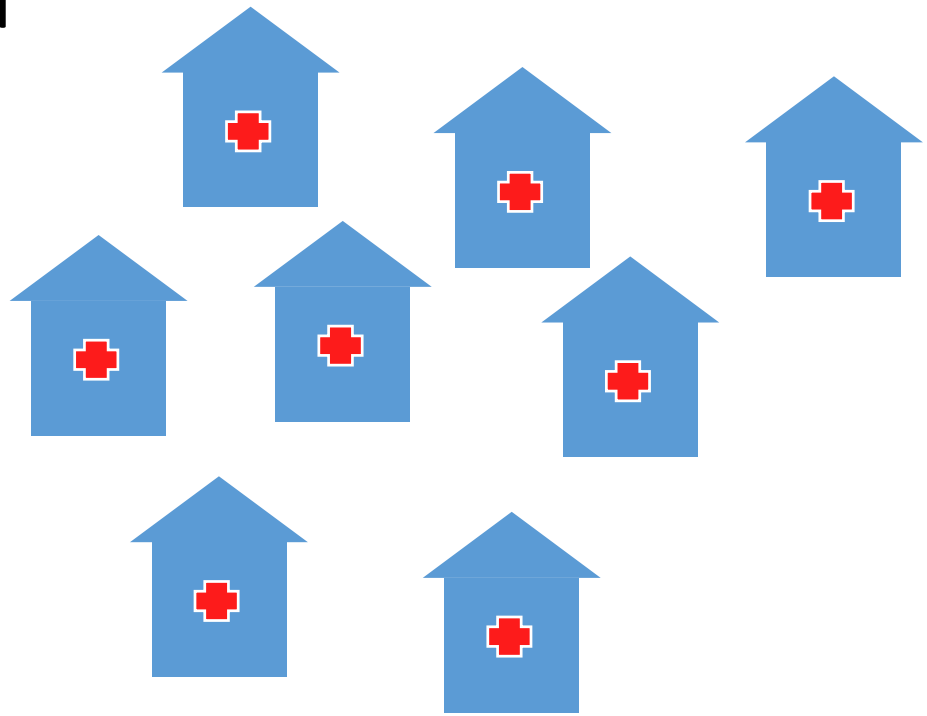
Setting & Inclusion criteria

7 mobile HCT units in urban & rural regions of South Africa

Entry-into-care



- Inclusion criteria:
  - ≥18 years of age
  - HIV-positive
  - reporting not being in HIV care

Care facilitation: IPC component

- Strengths-based, motivational interviewing approach
- Up to 5 counseling sessions within 90 days from enrollment
- Each session designed to follow a structured and progressive curriculum
  - Identify client goals
  - Determine client strengths
  - Develop plans
  - Follow-up on action
- Care facilitators were trained and had regular debriefing and quality review of sessions

[Garner et al AIDS 2005]

Participant contact and follow-up

Contact sessions to **verify contact** details

- Telephonic
- At 30 and 60 days post-enrollment

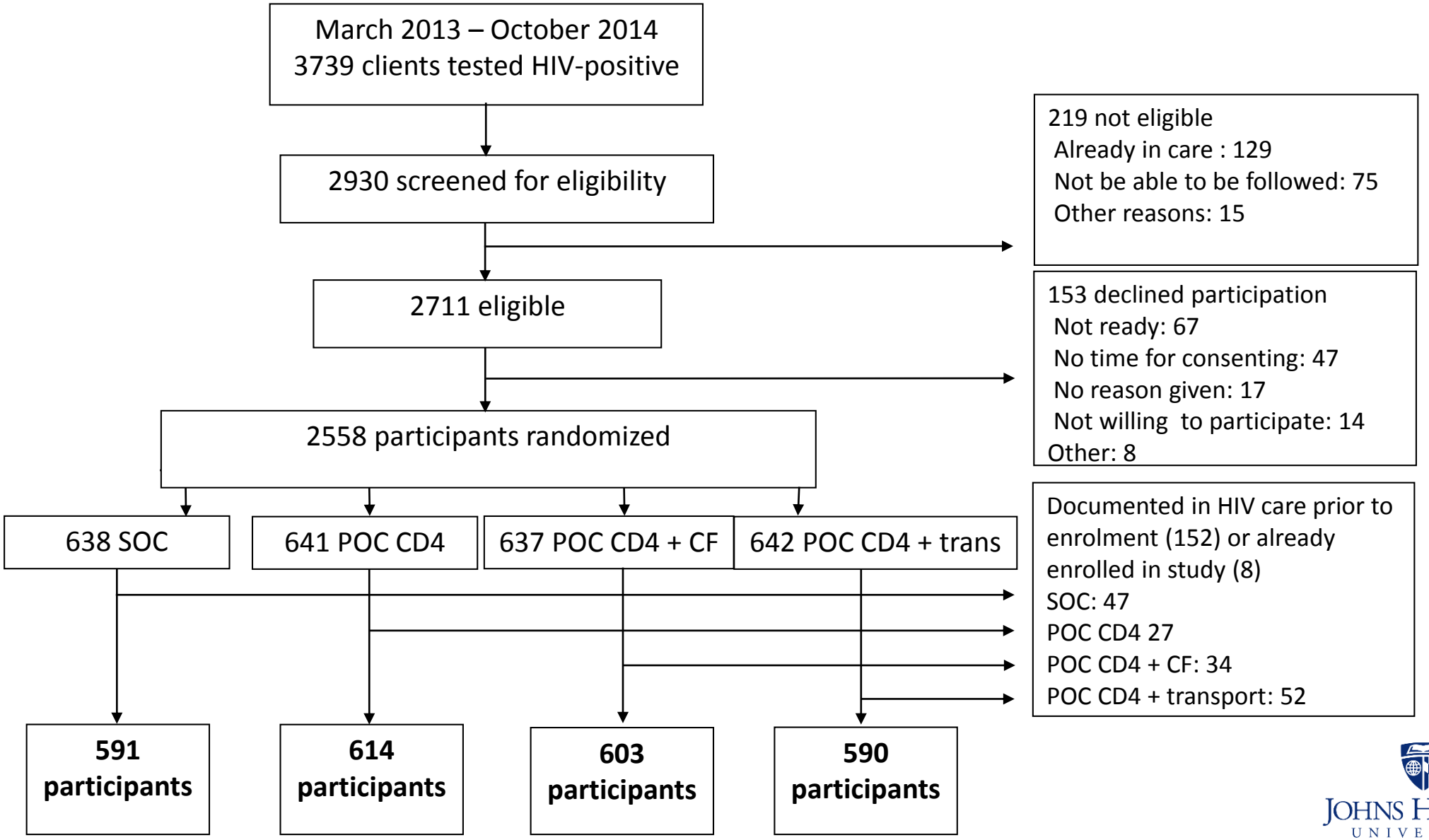
Contact sessions to **ascertain self-reported care status**

- Telephonic (if telephonic unsuccessful, home visits)
- At 90 and 180 days post-enrollment

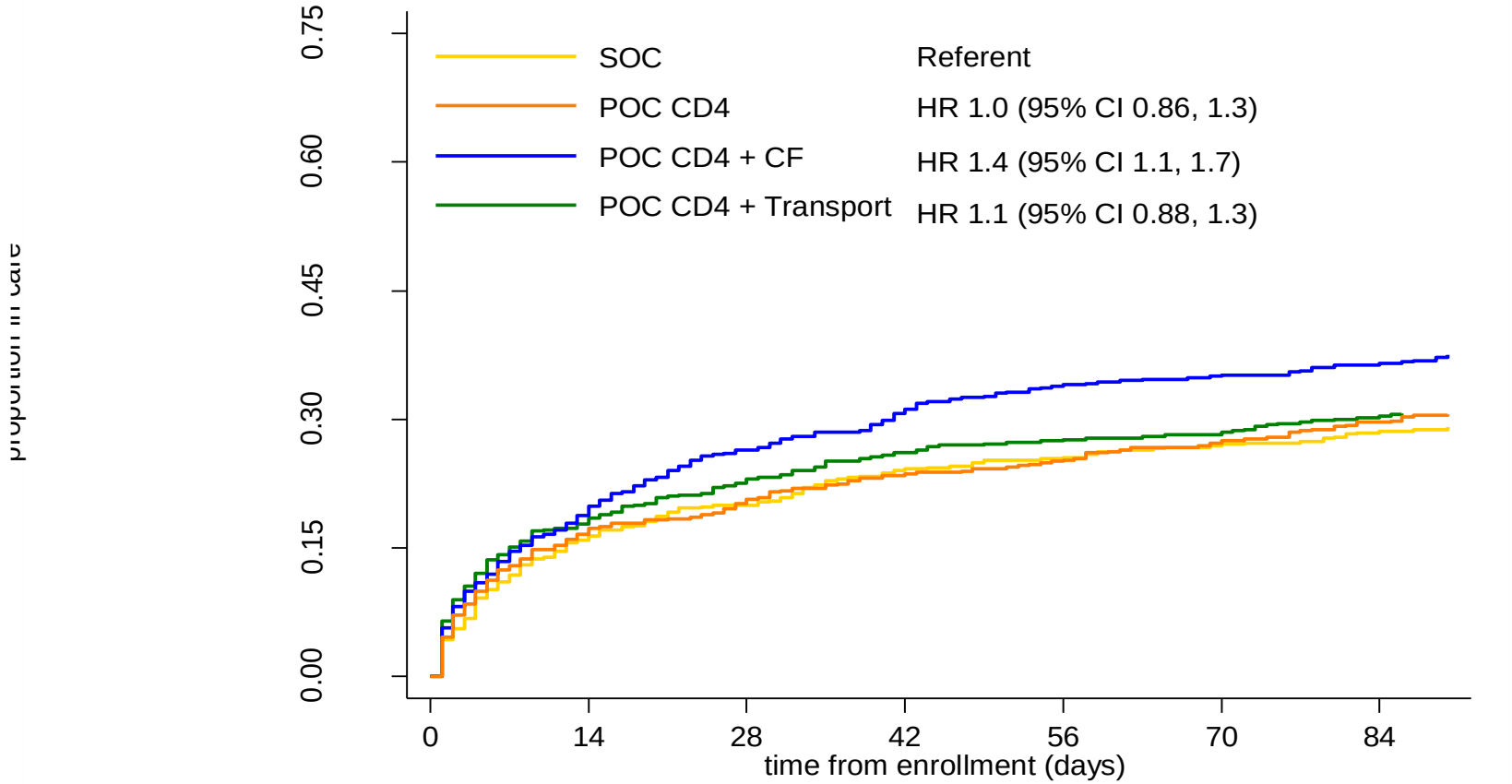
Clinical document review to **verify care status** and ART initiation

- Paper chart review at clinic reported participant reported visiting
- Electronic District HIV reporting & national laboratory data review
- National vital statistics mortality linkage

Results – Consort diagram



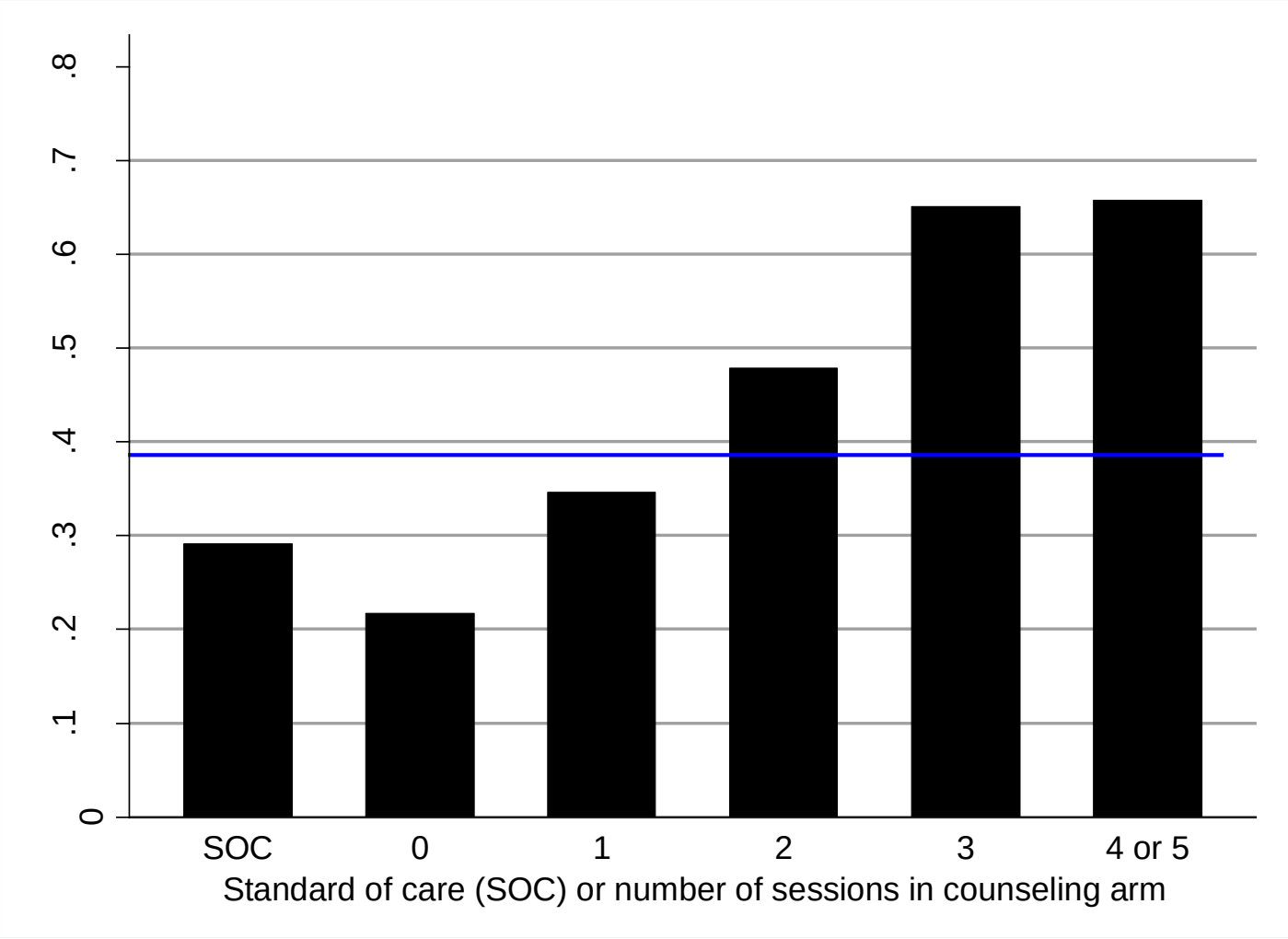
Thol'impilo primary outcomes



Number at risk

SOC	591	497	473	449	441	431	422
POC CD4	614	512	490	470	460	447	432
POC CD4 + CF	603	490	443	417	398	390	382
POC CD4 + Transport	590	485	457	435	426	422	410

Thol'impilo care facilitation



Analysis sample

- 28 participants randomly selected from 384 participants in CF arm who had attended at least 1 session
- Balance of male/female, urban/rural, and ART eligibility (CD4 <350 cells/mm^3) sought:
  - 18/28 female
  - Age 18 – 66
  - 23/28 entered care
- 50 transcripts reviewed (30 in-person, 20 telephonic)
- Thematic analysis using coding framework based on session goals

Articulate concerns & goals

- Client: I am beginning to think that my life might end any day from now. I might die any day. I will die and leave my children behind. I want to know what I need to do when things are like this. I want to know if I will get any treatment. I am stressed now because I was not sleeping around. I don't understand how I got this virus! [female, 22 years, urban].

- Client: I don't believe the results [HIV test results]. I am very confused, and I want to test again in order to prove that it is true. [female, 31 years, urban].

Stimulate reflection

- In one example, a 22-year-old female client reported being in a relationship with no children. The counselor opened a discussion on living a normal life, including safe pregnancy, while living with HIV. The client then disclosed that she was 2 months pregnant and had been harboring anxiety on future steps.

Highlight personal strengths

- Counselor: My brother as you were busy talking as I was listening to you. I saw a determined person. I see a person who doesn't lose hope in life. I also see a courageous person, because when you were met with life situations, you never turned back?
- Client: I don't know where it comes from myself [male, 30 years, urban].

Collaborative identification of approach to achieve goals

- Counselor: So, you are saying that you will not disclose to him? How do you plan to take treatment when he is around?
- Client: I don't know. It will not be easy because I want to take the treatment. I will also have a problem of having unprotected sex because I haven't told him about my status. I don't know where I'm coming from or going. I am confused. My partner and I have not been faithful to each other. I have someone else that I am dating and he also has someone else [female, 51 years, rural].

Value of longitudinal sessions – revealing barriers

- Counselor: Since you were not able to complete the task of going to the clinic, let us talk about last week's conversation when you mentioned that you had no hindrances [going to the clinic]. Today do you have any concerns of hindrances that may prevent you going to the clinic?
- Client: No, the only challenge I have is time.
- Counselor: So, the main challenge you have is time?
- Client: Yes that is the only problem. I only have time over the weekends [male, 40 years, urban].

Value of longitudinal sessions – comfort with care facilitator

- Counselors applied “focusing” techniques to direct conversational flow back to the client. For a 51-year-old male client, the client refocused the session by noting, “Earlier you said that it is important that everything should start with ‘I’ [me] because this is about you.”
- After this, it surfaced that behind the displayed levels of self-efficacy, the client had underlying challenges with accepting his status and had resorted to dissociation from the diagnosis as a form of coping.

Communication language/age barriers

P: No. I have answered you already. I told you that my problems come from people who did this [witchcraft]. You asked and I answered.

CF: Sometimes, I don't get it clearly mama.

P: You don't understand Sepedi [local language with different dialects] well do you? Where do you come from? [female, 49 years, rural].

Application

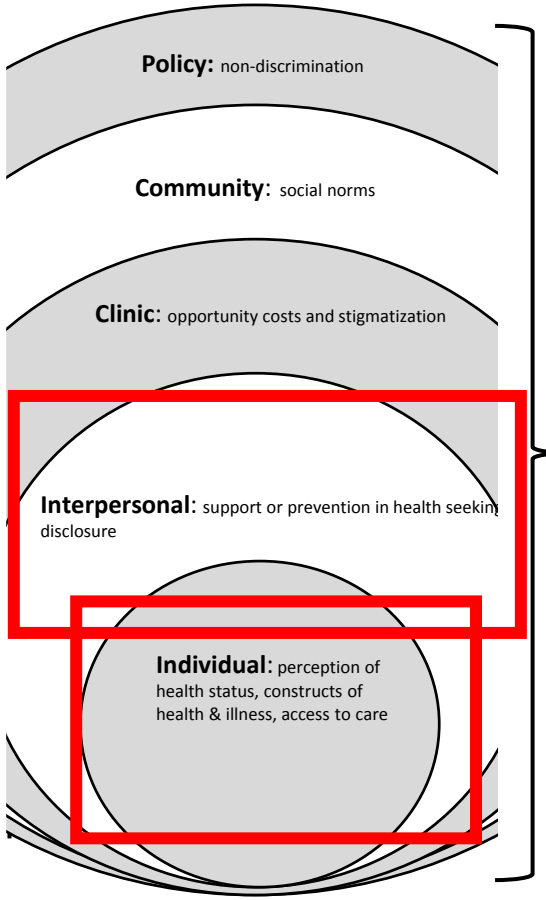
- Deliver communication that meets the immediate needs and concerns of the individual
- Guides individual toward self-efficacy
- May have an important role when action (care engagement, adherence, etc.) is desired
- May have a place for CHW (if they can be adequately trained), HCT counsellors, etc

Challenges

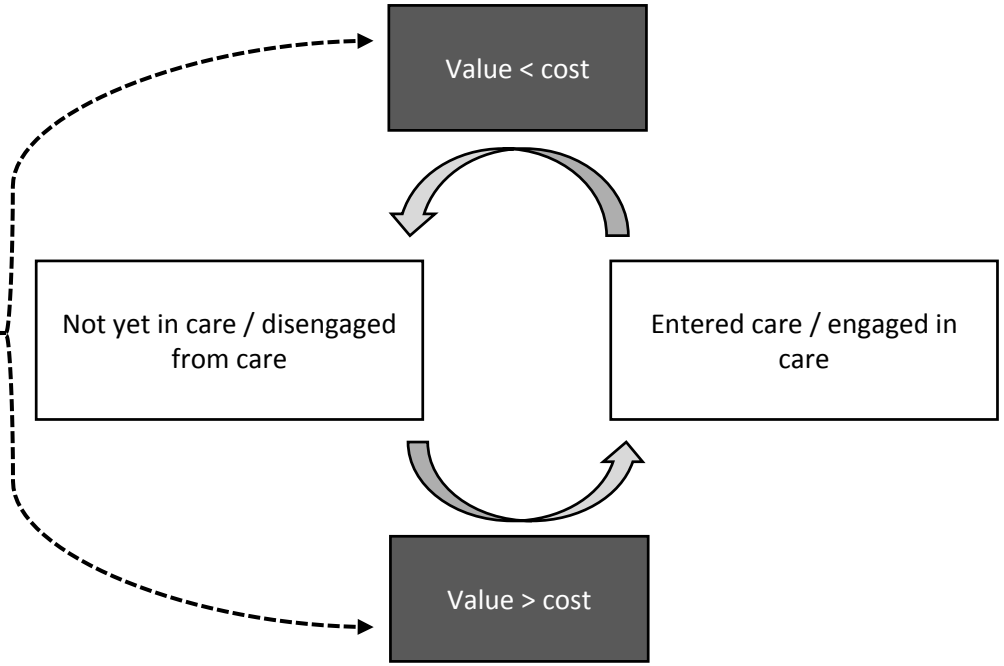
- Receptiveness of clients to counselling
- Time constraints
- Training and oversight of staff to supply this level of communication and not revert to instructions and information

Level of precision health communication

Social ecological framework of levels affective individual perceptions



Value cost model



[Hoffmann et al 2016]

Conclusions

- Effective communication is essential to multiple stages of the care continuum
- How that communication is delivered is not always assessed or prioritized
- There is little assessment of communication during key interactions such as post-test and adherence counseling.
- Use of a more precision approach in settings of interpersonal communication may improve the effectiveness

Acknowledgements

- Participants
- Team in South Africa
  - Tonderai Mabuto
  - Salome Charalambous
- London School of Hygiene & Tropical Medicine
  - Katherine Fielding

USAID: Implementation Science Cooperative Agreement A-12-00028