# Novel use of simulated client visits among traditional health practitioners:  Strengths, weaknesses, and cross tool comparisons

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**Introduction:**  The increasing focus on comprehensive HIV prevention and care programs requires innovative ways to provide services in resource poor settings and robust tools to assess the quality of care.

The Bridging Gaps Project (BG) was a 40 month intervention project. BG was designed to assess whether improved collaboration and communication between Biomedical Health Practitioners (BHP) and Traditional Health Practitioners (THP) could improve the quality of HIV and Sexually Transmitted Infection (STI) care in Zambia and Uganda.

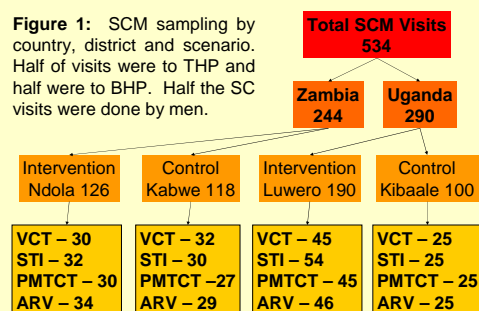The Simulated Client Method (SCM) has been widely used to assess

> "SCM offers a chance to record unselfconscious actual practice from the point of view of the client in a first-hand and standardized fashion"
>
> -Madden, 1997

quality of care in family planning and STI clinics.  SCM uses trained research assistants to act as patients with standardized disease scenarios.  These simulated clients (SC) then visit health care providers as a normal patient would.  After their consultation the SC experiences are recorded, analyzed and compared.

Here we report strengths and weaknesses of the SCM from the first known use of the SCM to assess quality of HIV/AIDS care and support among THP.  A comparison of BG data from the SCM and direct observations among both THP and BHP illustrates methodological differences.

**Figure 1:**  SCM sampling by country, district and scenario. Half of visits were to THP and half were to BHP.  Half the SC visits were done by men.



Total SCM Visits 534
- Zambia 244
- Uganda 290

Zambia:
- Intervention Ndola 126 — VCT – 30, STI – 32, PMTCT – 30, ARV – 34
- Control Kabwe 118 — VCT – 32, STI – 30, PMTCT –27, ARV – 29

Uganda:
- Intervention Luwero 190 — VCT – 45, STI – 54, PMTCT – 45, ARV – 46
- Control Kibaale 100 — VCT – 25, STI – 25, PMTCT – 25, ARV – 25

**Methods:**  534 simulated client visits were conducted among BHP and THP in urban Zambia and rural Uganda between February and November 2005 (Figure 1).  SCV followed one of four standardized care-seeking scenarios:  counseling and advice for Voluntary Counseling and Testing (VCT), Sexually Transmitted Infections (STI), ART, or Prevention of Mother to Child Transmission of HIV (PMTCT). SCs were school leavers recruited from outside the study areas. SC training included expectations of care, normalizing the THP experience, introduction & development of scenarios, colloquialisms, dress, researcher-patient balance, dealing with tricky questions/situations, extensive role playing, data capture tools, and field safety. SC were debriefed by field supervisors (Figure 2). BG also collected data from direct observations of BHP and THP consultations. Quantitative Zambian data from SCM was compared to quantitative data from direct observations of consultations.

**Figure 2:**  SCM debriefing in Ndola, Zambia.  Debriefing occurred as soon as possible after the SC visit and used both a short qualitative narrative and a quantitative questionnaire.



## Results and Discussion:

**Strengths:**  SCM has previously been described as an excellent method to assess quality of care at the first point of contact.  SCM data from THP visits was typically less predictable but was easier to analyze because THP typically operate individually.  SCM data from BHP could be much more complicated because they often involve multiple care providers with each care provider giving a different quality of care.

SC scenarios were designed so that condoms should always be discussed.  If the THP/BHP did not discuss condoms then the SCs were trained to discuss condoms at the end of the consultation.  We could then assess not only what information the THP/BHP offers but also their knowledge and attitude towards condoms when prompted:

> Then I took him back to HIV I said,  "look I heard you talk about HIV/AIDS?"  I said "how does a condom and HIV/AIDS work?"  He said, "oh yes these other diseases [STI] like I told you we give tattoos but for HIV/AIDS it is the condom that works".

Another unexpected benefit of SCM was increased confidence of the THPs.  After one round of SCM in Uganda THPs approached the intervention leaders at their next session and explained to them how excited they were about some recent STI/HIV patients whom they had referred to the clinics. The patients they described were simulated clients.

SC share some of the emotional experiences of real patients.  THP scored higher on the privacy indicator during observed consultations than they did during SCM (Table 1).  This may be due to a change in actual practice of the THP when they know they are being observed or it could be due to SC being embarrassed by their scenarios and therefore much more attentive to privacy issues than a detached observer would be.

**Weaknesses:**  BHP have Ministry of Health guidelines.  THP do not have defined standards of care and this makes it difficult to define and assess quality of care in the THP sector.  With SCM we dealt with this problem by designing the SCM scenarios to assess key aims of the BG intervention.

For the safety and privacy of the SC it is important to recruit SC from outside the study area. Occasionally rural THP were very suspicious of unfamiliar SCs.

Urban THP were less suspicious.  This could alter the course of the consultation and the quality of care provided:

> She said, "if you come, come with your wife together… What time are you coming?  I really want to see you there because I am going to the hospital tomorrow to confirm your presence…" She said she was writing that she was not so sure I am living with HIV/AIDS because she has not seen my card [VCT card].

Health care is reflexive and SC can alter the course of a consultation.  SC were told they did not have to undergo spiritual examinations since many SCs felt uncomfortable with spiritual examinations.  The following extract from a narrative demonstrates how the natural course of a consultation can be altered by the actions of the SC:

> She came back in with a gourd and went behind a curtain.  She started shaking it so I told her, "grandmother are you trying to find out what I just asked you?"  She said, "yes".  I said "no, no, no today I am not ready so perhaps you can give me medicine without consulting the spirits".  Then she came from behind the curtain and said "you don't want to consult the spirits".  I said "no just medicine".  She said, "that is fine I will give you medicine you can take to clean out your system. It will melt all the infections".

It was impossible to identify who the SC consulted when they visited a clinic.  This made it difficult to assess whether the intervention was successful among individual BHP who participated in the intervention.  This was not a major problem since the intervention was designed to influence quality of care of all clinic staff through peer influenced networks.

**Cross-Tool Comparisons:**  SCM provides a less favourable view of quality of care across most indicators (Table 1 & 2).  BHP perform particularly well during direct observation but quite poorly during SCM when they do not know they are being assessed.  This suggests they have adequate knowledge and skills but may face barriers in implementing their knowledge and skills (Table 1 & 2).  THP scored poorly on counseling indicators during both direct observations and SCM.  This suggests that THP lack the knowledge and skills to

practice good counseling.  This information can help to target interventions.  Among THP knowledge needs to be improved while among BHP issues such as motivation and work load may need to be addressed so that BHP can put their knowledge and skills into practice.  Direct observation seems to overestimate the true quality of care (Table 1 & 2).

**Table 1:**  Cross tool comparisons of interpersonal quality indicators.  Red indicates statistically significant differences between direct observation and SCM results.

| Indicator | Sector | Direct Observation[1] | SCM[2] | p-value |
|---|---|---|---|---|
| Quality of Welcome | BHP | 484/489 (99%) | 32/46 (69%) | p<0.0001 |
|  | THP | 137/138 (99%) | 46/48 (95%) | p=0.246 |
| Not Rushed | BHP | 472/489 (96%) | 28/46 (60%) | p<0.0001 |
|  | THP | 122/137 (89%) | 42/48 (87%) | p=0.779 |
| Privacy | BHP | 486/489 (99%) | 16/46 (34%) | p<0.0001 |
|  | THP | 117/137 (85%) | 20/48 (41%) | p<0.0001 |

**Table 2:**  Cross tool comparisons of counseling indicators.  Red indicates a significant difference between direct observation results and SCM.

| Indicator | Sector | Direct Observation[1] | SCM[2] | p-value |
|---|---|---|---|---|
| Condoms Discussed | BHP | 451/483 (93%) | 23/46 (50%) | p<0.0001 |
|  | THP | 41/138 (29%) | 10/48 (20%) | p=0.22 |
| Demonstrate Condoms | BHP | 323/483 (66%) | 4/46 (9%) | p<0.0001 |
|  | THP | 9/138 (6%) | 0/48 (0%) | p=0.07 |
| Condoms Provided | BHP | 429/483 (88%) | 12/46 (26%) | p<0.0001 |
|  | THP | 1/138 (1%) | 2/48 (4%) | p=0.096 |
| Partner Managed | BHP | 431/483 (89%) | 10/21 (47%) | p<0.0001 |
|  | THP | 30/138 (22%) | 9/23 (39%) | p=0.071 |

## Conclusions:
- SCM is well suited to assessing quality of care among THP.
- SCM can be used to explore specific themes such as condom counseling even when the subject is not raised by the care provider.
- Rural THP know their communities well and can be suspicious of strangers.
- SCM provides a much less optimistic view of quality of care when compared to direct observations.

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