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

Stephen Moore1, Anastasia Pharris4, Maureen Muchimba3, Kashita Solo1, Christine Nalwadda2, Clare Nasuuga4, Rachel King4, Monique Oliffe4, and Philippe Mayaud5 for the Bridging Gaps Project Research Team

1London School of Hygiene and Tropical Medicine (LSHTM), University of London, London, UK. 2Institute of Economic and Social Research (INESOR), University of Zambia, Lusaka, Zambia. 3Traditional Health Practitioners Association of Zambia (THPAZ), Lusaka, Zambia. 4Makerere University Institute of Public Health (MUIPH), Kampala, Uganda. 5Traditional and Modern Health Practitioners Together Against AIDS and Other Diseases (THETA), Kampala, Uganda.

Introduction: The increasing focus on comprehensive HIV prevention and care programs requires innovative ways to provide resources in poor setting and robust tools to assess the quality of care provided. 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 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 BHP and THP illustrates methodological differences.

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 Sexually Transmitted Infection (STI), Treatment of Acquired Immunodeficiency Syndrome (AIDS), 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, demeanor with trick questions/situations, extensive role playing, data capture tools, and field safety. SCs 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 1: SCM sampling by country, district and scenario.

Half of visits were to THP and half were to BHP. Half the visits were done by men. A total of 244 visits were conducted in Zambia and 290 visits in Uganda.

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.

**SCM offers a chance to record unconscious actual practice from the point of view of a client in a first-hand and standardized fashion**

-Madden, 1997

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 consents should always be discussed. If the BHP/THP did not discuss consents then the SCs were trained to dissuade the consents at the end of the consultation. We could then assess not only what information the THP/BHP offered but also their knowledge and attitude towards consents when prompted.

Then I asked him back to HIV I said, “look I heard you talk about HIV/AIDS? 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”.

Another unexpected benefit of SCM was increased confidence of the THPs. After one round of SCM in Ndola, THPs were very suspicious of unfamiliar SCs.

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.

Health care is reflexive and SC can alter the course of the clinical encounter. SCM data from direct observations of consultations.

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 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 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. BHP may also need to be addressed that the THP 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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Sector</th>
<th>Direct Observation</th>
<th>SCM</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Welcome</td>
<td>THP</td>
<td>137/138 (99%)</td>
<td>136/138 (99%)</td>
<td>p=0.246</td>
</tr>
<tr>
<td>Quality of Privacy</td>
<td>BHP</td>
<td>486/489 (99%)</td>
<td>487/489 (99%)</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Condoms Managed</td>
<td>BHP</td>
<td>122/127 (96%)</td>
<td>113/127 (89%)</td>
<td>p=0.022</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Sector</th>
<th>Direct Observation</th>
<th>SCM</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>BHP</td>
<td>23/23 (100%)</td>
<td>23/23 (100%)</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Partner Managed</td>
<td>BHP</td>
<td>50/50 (100%)</td>
<td>41/41 (89%)</td>
<td>p=0.001</td>
</tr>
</tbody>
</table>

Acknowledgements: This work was funded by the European Union and the DFID Knowledge Program. Many research assistants made the data collection successful and fun. Thanks to all.