Background

The DART trial demonstrated that antiretroviral therapy (ART) can be delivered effectively to HIV-infected adults without routine laboratory testing for toxicity; benefits for CD4-testing were small and with limited resources more lives would be saved by treating more people with clinical monitoring. The Lablite project aims to demonstrate ART roll-out to primary health care facilities, optimizing clinical management. Development of strategies for training/mentoring health care workers (HCWs) to clinically monitor patients on ART was identified as important and was proposed on a training needs assessment.

Methods

A cross-sectional survey using qualitative and quantitative methods was done at 4 Lablite sites in Uganda and 4 in Zimbabwe. Nine areas of knowledge assessed comprised: diagnosis of HIV/AIDS, HIV staging, starting ART, management of opportunistic infections, side effects of ART, ART failure criteria, monitoring of HIV patients, PMTCT and pharmacy logistics. Assessment of formal training included counseling and HIV prevention but grouped ART management and did not include logistics.

Results

In Uganda, 54 HCWs were assessed in a hospital (33 HCWs), a Health Centre IV (8 HCWs) (both sites providing ART) and 2 Health Centre IIIIs (3 HCWs, not providing ART). HCWs assessed were 5 doctors, 8 clinical officers, 35 nurses and 6 nursing assistants). In Zimbabwe, 38 HCWs were assessed in a district hospital (18 HCWs, site providing ART) and 5 primary care facilities (12 HCWs, 2 sites with outreach ART, 1 not providing ART). HCWs assessed were 2 medical officers, 24 nurses, 2 counselors and 2 pharmacy staff.

In Uganda in each of nine areas of HIV prevention/management, >33% of HCWs had received formal training, mostly pre-service rather than in-service; proportions were low in all facilities. Only 13% of HCWs had received training in ART initiation (4/5 doctors, 5/35 nurses and 3/6 nurses assisting). In contrast, in Zimbabwe, in each area 63% of HCWs had received training; 77% of HCWs had received training in ART initiation in the last 2 years (1/2 medical officers, 19/24 nurses, 1/2 counselors, 2 pharmacy staff).

In Uganda, although proportions with formal training were low, proportions with knowledge of different topics were higher; implying mentorship from trained HCWs occurred. Topics HCWs were most conversant with were diagnosis of HIV (69% HCWs conversant) and PMTCT (70%). They were least conversant with pharmacy logistics (33%), monitoring of HIV patients (33%) and clinical criteria for diagnosing treatment failure (7%). Despite more formal training, knowledge levels were generally similar in Zimbabwe; 50% of HCWs were conversant with HIV diagnosis, 63% with PMTCT and only 27% with pharmacy logistics; although 53% were conversant with monitoring and 33% with treatment failure.

Challenges reported by HCWs included: understaffing, poor/unavailable laboratory facilities and lack of confidence in making clinical decisions.

Conclusions

Due to understaffing, an onsite mentoring training approach was strongly suggested; some informal mentoring was occurring in Uganda already but clinical mentorship had not been implemented in Zimbabwe. Training should focus on building confidence of HCWs in making clinical decisions with minimal laboratory monitoring. Records/logistics management should be included.