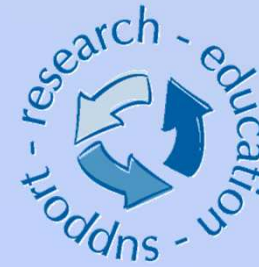


16th Annual Conference of the
National HIV Nurses Association (NHIVNA)



National HIV Nurses Association

Dr Catrin Evans

University of Nottingham

26-27 June 2014- City Hall, Cardiff



Scaling Up Testing for HIV: A Qualitative Meta-Synthesis of Nurse/Midwives' Views and Experiences of the Provision and Management of Routine 'Provider Initiated HIV Testing and Counselling' (PITC)

Principal Investigator: Dr. Catrin Evans

Team: Sylvia Nalubega, John McLuskey, Michelle Croston, Nicola Darlington, Professor Fiona Bath-Hextall

Provider Initiated HIV Testing and Counselling (PITC)

Globally: WHO Guidance (2007, 2012)

- Routine PITC in all clinical areas in high prevalence settings

UK: BHIVA Guidelines (2008)

- PITC in settings where prevalence is >0.2 per 1,000 (new registrations with GPs & acute medical admissions), as well in key clinical areas (e.g. GUM, antenatal & several others)



What is the Problem with PITC?

Globally: (Roura et al 2013, Kennedy et al 2013)

- PITC is effective (& cost-effective) in diagnosing large numbers of previously undiagnosed individuals
- But....there is a problem with implementation
 - In many settings & countries, the **proportion of patients offered an HIV test is disappointingly low**
 - Challenges include: logistics, data systems, human resources, ineffective management.....

In the UK: (Elmahdi et al 2014)

- Only 29.5% test coverage in settings where routine testing is recommended
- Provider test offer was found to be lower (40.4%) than patient acceptance of testing (71.5%).
- *“Adherence to 2008 national guidelines for HIV testing in the UK is poor outside of GUM/SH and antenatal clinics. **Low levels of provider test offer** appear to be a major contributor to this”.*



Focus on Nurses/Midwives (NMs)

What are the hurdles and how can they be overcome?

- NMs are the major group doing HIV testing in most countries
- Very little research has explored NMs' particular needs and experiences around implementation of PITC
- NMs may experience the implementation of HIV care differently to other professional groups (Vitiello & Willard, 2010, Holzemer, 2013)



Systematic Review

Aim

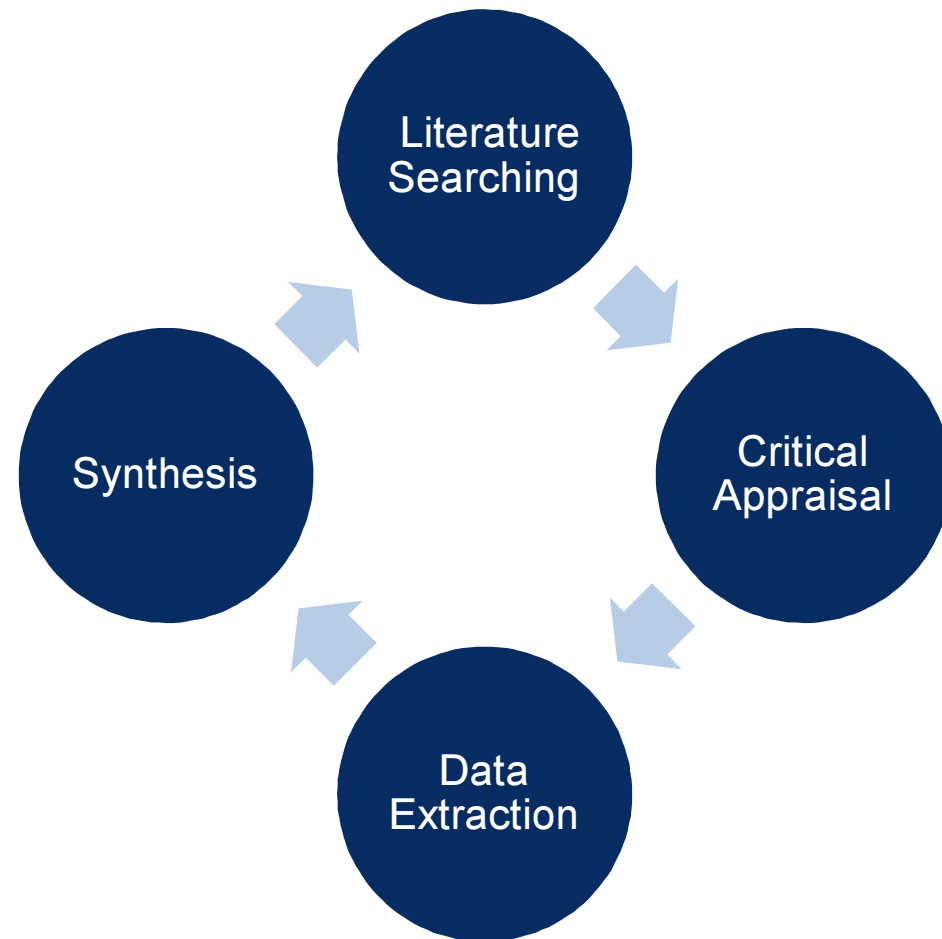
To explore
Nurse/Midwives' views
and experiences of the
provision and
management of PITC
in healthcare settings.

Specific Questions

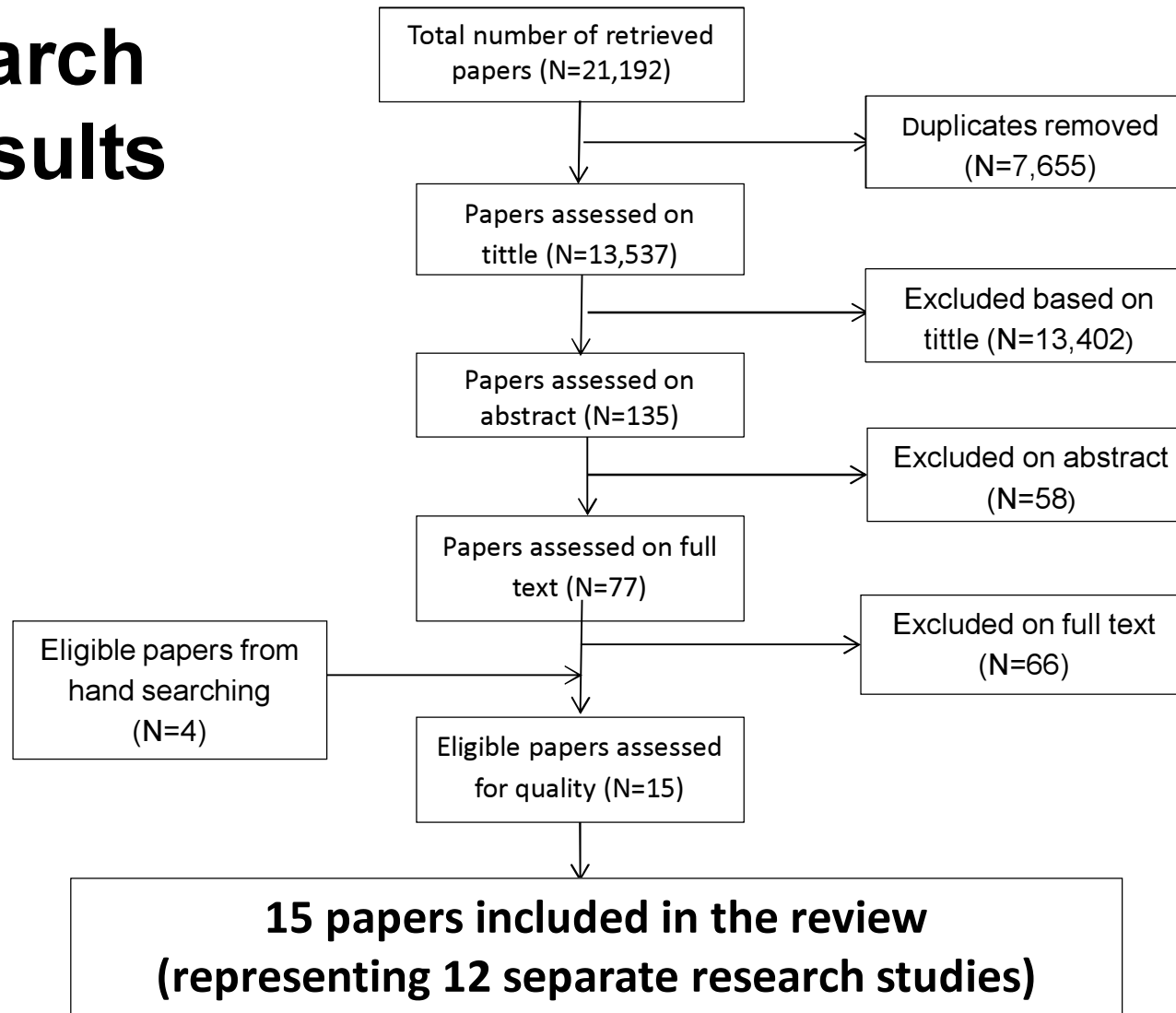
1. What are NMs' views and experiences of conducting PITC?
2. What are NMs' views and experiences of establishing and managing PITC services?
3. From a NM perspective, what personal factors, practices or contexts facilitate or hinder the implementation of PITC within their role or setting?
4. From a NM perspective, what constitutes high quality care in the provision of PITC and what factors facilitate or hinder the provision of high quality care in PITC services?

Systematic Review Methods

- Followed the approach advocated by the Joanna Briggs Institute (JBI)
- Aggregative review (meta-aggregation)



Literature Search Results



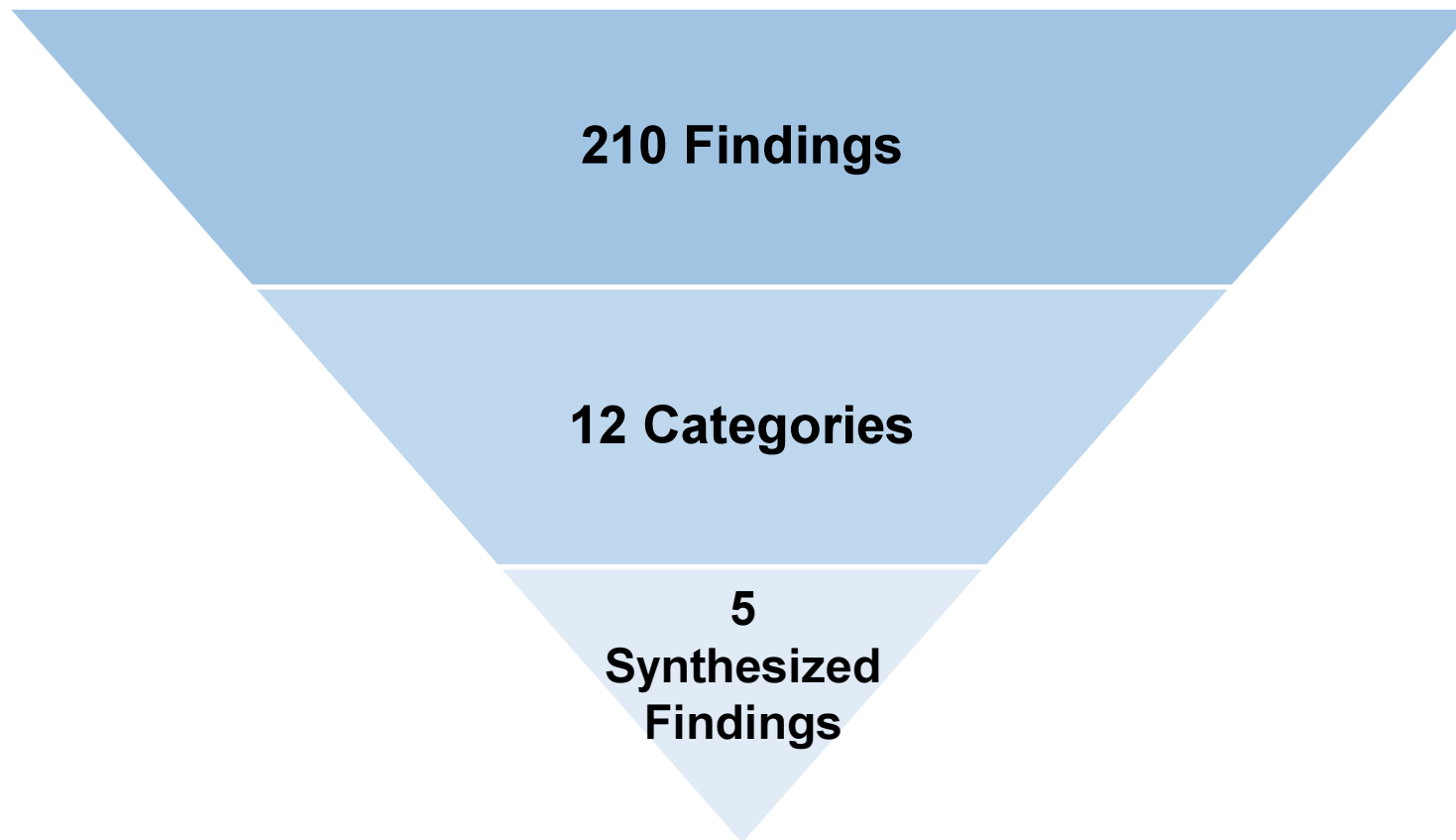


Characteristics of Included Papers

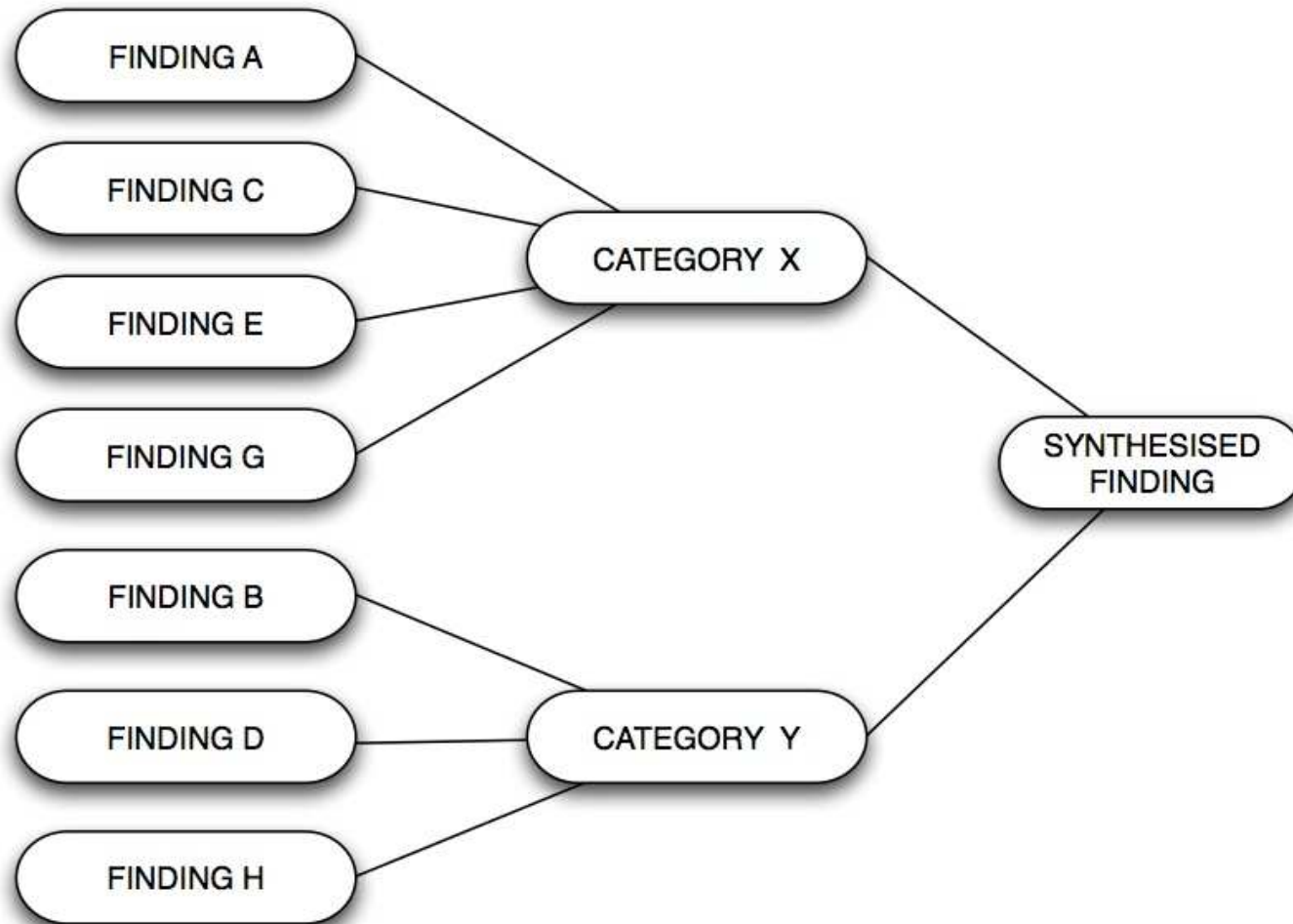
Number of Papers	12 research studies (15 papers)
Date Range	2004-2013
Geographical Settings	6 from sub-Saharan Africa; 6 from high income settings (UK, USA, Canada)
Clinical Settings (wide range)	Primary care, STI, TB, maternity, substance use, hospital in-patient, hospital out-patient, A&E



Data Extraction & Synthesis



Data Synthesis





Synthesized Finding [1]

Acceptability

NMs are supportive of PITC if it is perceived to enhance patient care and to align with perceived professional roles

“I would be concerned about them understanding what they are being tested for, especially in the ER setting.....when you see 40 patients per day it becomes very difficult.... and I just don't know if the ER is the right place for preventive care”

(Spielberg et al 2010, USA, ER)

Synthesized Finding [2]

Resources

NM's ability to perform PITC well requires an appropriate infrastructure and adequate human and material resources

“We’re chronically short of staff and this needs a dedicated person.

.....There’s not a lot of privacy out there, and people get offended if we ask them in an open space in the waiting room”

(Schnall et al 2013, USA, ER)

Synthesized Finding [3]

Organisational Processes

At organisational level, NM's engagement with PITC is facilitated by an inclusive, management structure, alongside the provision of ongoing training and clinical supervision. PITC is hindered by difficulties with fitting the process into existing workloads and routines

“The nurse manager admitted that more involvement on her part would have increased testing and nurses in her clinics reported that when she was present it was a good motivator ”

(Conners et al 2012, USA, Veteran Substance Use Disorder Clinic)

The nurses also articulated displeasure with all the paperwork...They felt there were too many steps to go through....and found it, administratively, to be “a lot of extra work”

(Pindera et al, 2009, Canada, Primary Care)

Synthesized Finding [4]

Contradictions of PITC

NMs perceive that good care in PITC requires time and the ability to apply a patient centred approach. This can be difficult to achieve in a context when testing is routinized and where an enduring stigma is still associated with HIV

“We offer it as a test along with all the others....and don’t put too much emphasis on it because of the fact that people who get worried about it tend to say ‘no’.....

[Upon receiving a positive result]....the first thing they say is: ... “When am I going to die?”

(Pellowe, 2004, UK, Midwifery Settings)

Synthesized Finding [5]

Emotional and Moral Burden

The emotional work involved in PITC can be stressful. NMs may require support to deal with complex moral/ethical issues

One coordinator described often thinking as she entered the room to inform the woman of her diagnosis: “I’m going to ruin the rest of your life”

“One partner wanted to see me because he was worried about his relationship. I met him once but that makes it difficult - because then you feel you are in the middle - and my role is to see the woman through her pregnancy”

(Pellowe, 2004, UK, Midwifery Settings)



Implications for Practice & Policy

1. Need more initial consultation and advocacy to secure staff engagement and buy in. Frame HIV testing in terms of 'good care'.
2. More attention is required to address operational challenges (e.g. sequencing, 'fit' with existing work patterns, paperwork & work loads).
3. Need adequate resources.
4. Need sustained organisational support, including feedback on progress.
5. Need on-going training & clinical supervision. Training needs to go beyond 'HIV basics' & address the more complex ethical issues.

Conclusion



Need to Value &
Recognise NMs'
Contribution to
Implementing PITC

More Research on
Operational Success
Stories

*“You can't will the ends
without willing the means”
(Thomas Friedman, New York Times,
2006)*



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NHIVNA – for a research grant

The Research Team (especially Sylvia Nalubega)



Any Questions?





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