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Review

The nursing implications of routine provider-initiated HIV testing and counselling in sub-Saharan Africa: A critical review of new policy guidance from WHO/UNAIDS

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ABSTRACT

Background: In 2007 WHO/UNAIDS issued new HIV testing guidelines recommending 'provider-initiated HIV testing and counselling' (PITC). In contrast to existing 'voluntary counselling and testing' guidelines (whereby individuals self refer for testing), the PITC guidance recommends that, in countries with generalised epidemics, *all* patients are routinely offered an HIV test during clinical encounters. In sub-Saharan Africa, PITC aims to dramatically increase HIV testing rates so that PITC becomes a vehicle to increase access to HIV prevention and care. Nurses in this region work on the frontlines of HIV testing but have been neglected in related policy development.
Aim: To provide an overview of the PITC policy guidance and to critically consider its implications for the nursing profession in sub-Saharan Africa.
Methods: Policy documents and published and unpublished research were identified from organisational websites, electronic databases and conference proceedings.
Results: PITC has generated widespread debate about whether it is the right approach in a context of HIV-related stigma and lack of human/material resources. Key concerns are whether/how informed consent, privacy and confidentiality will be upheld in over-stretched health care settings, and whether appropriate post-test counselling, treatment and support can be provided. Limited available evidence suggests that health systems factors and organisational/professional culture may create obstacles to effective PITC implementation. Specific findings are that:

- PITC greatly increases nurses' workload and work-related stress.
- Nurses are generally positive about PITC, but express the need for more training and managerial support.
- Health system constraints (lack of staff, lack of space) mean that nurses do not always have time to provide adequate counselling.
- A hierarchical and didactic nursing culture affects counselling quality and the boundaries between voluntary informed consent and coercion can become rather blurred.
- Nurses are particularly stressed by breaking bad news and handling ethical dilemmas.

Conclusion: Three areas are identified in which the PITC implementation process needs to be strengthened: (i) research/audit (to explore nurse and patient experiences, to identify best practice and key obstacles), (ii) greater nurse participation in policy development, (iii) strengthening of nurse training and mentoring.

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What is already known about the topic?

- There is an urgent need to increase rates of HIV testing in sub-Saharan Africa.
- WHO/UNAIDS have recently recommended that countries adopt 'provider-initiated HIV testing and counselling' policies to complement existing voluntary counselling and testing approaches. This guidance is controversial due to fears over protection of human rights in a context of stigma and human resource deficiencies.
- Nurses are at the forefront of HIV service delivery but have not been adequately involved in related policy development. There is a need to consider the implications of PITC for nurses, but there is a lack of evidence on nurses' experience with PITC.

What this paper adds

- The limited available research shows that, although nurses are generally positive about PITC, it greatly increases their workload and work-related stress. Health system factors (for example lack of staff) and organisational/professional culture (for example a didactic approach to counselling) create a number of challenges to appropriate PITC implementation.
- There is a need for more nursing research, greater policy involvement and more support/training for nurses to implement PITC.

1. Introduction

After much controversy and a lengthy process of global consultation, in 2007, WHO/UNAIDS released guidelines urging countries to adopt provider-initiated HIV testing and counselling (PITC) in health facilities (WHO/UNAIDS, 2007). This paper presents an overview of this new policy guidance and critically considers its implementation in the sub-Saharan African context, focusing specifically on its implications for the nursing profession.

2. Scaling up HIV testing in sub-Saharan Africa

2.1. The HIV epidemic in sub-Saharan Africa

Sub-Saharan Africa is the world's most severely affected region by HIV/AIDS, making up 67% of all people living with HIV/AIDS, and 72% of AIDS-related deaths in 2007 (UNAIDS, 2008). National HIV prevalence rates vary widely from 2 to 39% in this vast and diverse region comprising 47 different countries (UNAIDS, 2008). In some Western and Central African countries, average HIV prevalence is just under 2% compared with over 15% in many southern African countries and 5% in other countries in Central and East Africa. In spite of the inter-regional variation the vast majority of countries in sub-Saharan Africa are classified by UNAIDS (2008) as having a 'generalised' HIV epidemic (where HIV prevalence amongst pregnant women is consistently over 1%).

2.2. Rationale for provider-initiated HIV testing and counselling

In recent years, there has been a tremendous global push to enhance HIV/AIDS prevention and treatment efforts, with a specific focus on increasing the access of low income countries to anti-retroviral therapies (ART). As a result, generic ART has become cheaper and more widely available across sub-Saharan Africa but huge disparities still exist in access to services with only 30% of those needing treatment currently able to obtain it (UNAIDS, 2008).

In this region, the scaling up of HIV treatment and prevention is severely hindered by the fact that up to 90% of the HIV-affected population have not had an HIV test, and, therefore, do not know that they are infected (WHO/UNAIDS, 2007). From a public health perspective, it is important that awareness of one's HIV status occurs as soon after infection as possible so that individuals can be counselled to modify any risky behaviour and thus aid prevention efforts, but also because ART outcomes are significantly better if treatment is started before the onset of full blown AIDS. By accessing treatment early, individuals can be kept healthy for longer, thus minimising the impact of the epidemic on individuals, their households and society (WHO/UNAIDS, 2007).

In order to maximise the potential benefits from increased treatment availability there must, therefore, be a concomitant scale up of HIV testing services. Until recently, global HIV testing guidance has been based upon a client-initiated 'voluntary counselling and testing' (VCT) model whereby individuals self-refer to HIV testing centres based in the community or at health facilities. These VCT centres have been comparatively well resourced and are based upon an ethos of respect for the 3 'C's–consent, confidentiality and counselling (Gruskin et al., 2008). The new WHO/UNAIDS (2007) guidelines propose to supplement this approach with a *provider-initiated* testing model. In areas with generalized epidemics (encompassing most sub-Saharan African countries) it suggests that: "*HIV testing and counselling should be recommended by the health care provider as part of the normal standard of care provided to the patient, regardless of whether the patient shows signs and symptoms of underlying HIV infection or the patient's reason for presenting to the health facility*" (WHO/UNAIDS, 2007:7).

The PITC guidance is a response to a growing body of research demonstrating that many opportunities to diagnose HIV are being missed during routine medical encounters. For example, in a large Kenyan hospital, a PITC pilot project found that 11% of women coming for cervical cancer treatment were HIV positive and 84% of these were identified for the first time (Gichangi et al., 2006). A study in Uganda's largest hospital found that only 20% of patients discharged from a medical ward had received an HIV test (Wanyenze et al., 2006). The subsequent implementation of PITC in this hospital found that 98% of patients agreed to have a test, 81% of patients were tested for the first time and HIV prevalence was 25% (Wanyenze et al., 2008). Another study in the Emergency departments of two hospitals in Uganda found that 95% of patients agreed to be