HIV and Nurses: A Focus Group on Task Shifting in Uganda

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The HIV prevalence rate is 7.4% in Uganda, where the HIV-related President's Emergency Plan for AIDS Relief and United Nations millennial development goals have not been met. This is partially due to a critical shortage of nurses and other health care providers. Task shifting is a World Health Organization strategy to address the shortage of human resources for health by shifting work from one cadre of health care worker to another, often less-trained, cadre. We conducted three focus groups with nurses in Uganda to better understand perceptions of their preparation for and implementation of task shifting. The focus group included nurses from diverse work settings. Data analysis revealed that nurses were proud of the work they were doing but were challenged by the lack of consistent and appropriate support. We found a need for additional policies, regulations, and consistent preparation for nurses who work in environments with task shifting.

(Journal of the Association of Nurses in AIDS Care, 27, *312-321*) *Copyright © 2016 Association of Nurses in AIDS Care*

Key words: *focus group, HIV, human resources for health, sustainable development goals, task shifting, Uganda*

Care for people living with HIV (PLWH) is more effective today than ever before. Uganda, however, is a low-to-middle-income country that continues to have an HIV prevalence rate of 7.4% (Ministry of Health, The Republic of Uganda [MOH], 2012; World Health Organization [WHO], 2014a). Globally, two million people are diagnosed with HIV each year; those diagnoses are often made too late and antiretroviral therapy is frequently not available (United Nations, 2014; WHO, 2014b). The U.S. President's Emergency Plan for AIDS Relief and the United Nations Millennium Development Goals (UNMDG) for lower prevalence and longer life expectancies have not been met in Uganda, in part due to an inadequate number of health care providers (O'Brien & Gostin, 2011; WHO, 2008, 2014a). The UNMDG program ended in 2015 and will be followed by the United Nations Sustainable Development Goals (UNSDG) with a single health-specific goal to ensure healthy lives and promote well-being for all at all ages (Alleyne, Beaglehole, & Bonita, 2015; Buse & Hawkes, 2015). Neither health care providers nor nurses were specifically mentioned in the UNMDG, but they were instrumental in the successes of the UNMDG and will be important in the realization of the UNSDG (Benton, 2015).

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http://dx.doi.org/10.1016/j.jana.2015.12.007
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The lack of nurses and other health care providers is keenly apparent in Uganda and across East Africa, where a critical shortage of human resources for health has been repeatedly documented (Baine & Kasangaki, 2014; Bryar, Kendall, & Mogotlane, 2012; Crisp & Chen, 2014; Crowley & Mayers, 2015). In Uganda, there are 1.3 nurses and midwives per 1,000 persons, while in the United Kingdom, there are 8.8 per 1,000 persons (WHO, 2014a). The human resources for health shortage extends to nurses, but in absolute numbers, more nurses than physicians are available to provide care for PLWH (McCarthy, Voss, Salmon, et al., 2013). As a result, the tasks of HIV care in many settings have been shifted to nurses.

Task shifting is a WHO strategy to ameliorate shortages by the redistribution of work to other differently prepared cadres, one of which is nurses (Bryar et al., 2012; WHO, 2008; Zachariah, Ford, & Philips, 2009). Task shifting is not new and has always been a significant part of the provision of care for PLWH in low-to-middle-income countries (Callaghan, Ford, & Schneider, 2010; Libamba et al., 2005). Nurses have the responsibility to provide care for people, including those who are living with HIV infection. The purpose of our exploratory-descriptive qualitative study was to describe Ugandan nurses' perceptions of the preparation for and implementation of task shifting.

Background

Nurses provide the majority of health care in low-to-middle-income countries; in East Africa, nurses provide care for millions of PLWH (Callaghan et al., 2010; McCarthy, Voss, Salmon, et al., 2013; Yakam & Gruénais, 2009). Numerous research studies have reported the benefits of nurses caring for PLWH, including the outcome of more people being able to access care because of task shifting (Bryar et al., 2012; Iwu & Holzemer, 2014; Sanne et al., 2010). Consequently, more people are being appropriately screened, more people are being prescribed antiretroviral therapy (Emdin, Chong, & Millson, 2013), and more PLWH are receiving nurse-delivered care that meets quality standards (Emdin et al., 2013; Fulton et al., 2011; Sanne et al., 2010; Shumbusho et al., 2009). Formal and informal task shifting are found in Uganda in the care of PLWH. Formal task shifting occurs in clinics where there are designated nurse prescribers with clear protocols and appropriate training, and the program is more likely to be evaluated. Informal task shifting occurs when the nurse takes on tasks without formal protocols or education. The outcomes of informal task shifting are rarely documented.

Professional organizations and international leaders have repeatedly recommended the development of infrastructure and policy-level support for task shifting (Baine & Kasangaki, 2014; McCarthy, Kelley, Verani, Louis, & Riley, 2014). The International Council of Nurses has provided input to the World Health Professions Assembly to develop principles for task shifting (International Centre for Human Resources in Nursing, 2010). Nurses and other human resources for health continue to be given additional tasks in settings where task shifting is an unofficial response to the human resources for health shortage (Baine & Kasangaki, 2014; Crowley & Mayers, 2015; McCarthy, Voss, Verani, et al., 2013). The lack of formally adopted policies consistent with WHO guidelines and International Council of Nurses principles is a barrier to the achievement of HIV and other patient care goals (Baine & Kasangaki, 2014; Dambisya & Matinhure, 2012; Zuber, McCarthy, Verani, Msidi, & Johnson, 2014).

While there is a plethora of literature about task shifting, few studies have been published on the effects of task shifting on nurses, rather than patients, and even those have rarely included bedside and clinic nurses as the primary sources of information (Iwu & Holzemer, 2014). Researchers have speculated that task shifting might improve work-related quality of life for providers, yet heavy workloads intrinsic to task shifting diminish nurse satisfaction (Crowley & Mayers, 2015; Iwu & Holzemer, 2014; Opollo, Gray, & Spies, 2014; Sun & Larson, 2015; Zachariah et al., 2009). The frontline providers–nurses for the majority of people in low-to-middle-income countries–can provide insight and information as programs and policies are refined and revised (Benton, 2015; Bryar et al., 2012; Iwu & Holzemer, 2014; Miles, Seitio, & McGilvray, 2006). Task shifting permeates the health care system of Uganda; it is present in hospitals, clinics,

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