FACTORS INFLUENCING THE IMPLEMENTATION OF PROVIDER -INITIATED TESTING AND COUSELLING SERVICES AT THE PROVINCIAL GENERAL HOSPITAL NYERI, CENTRAL PROVINCE, KENYA.

BY

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DECLARATION

This research project is my original work and has not been submitted for academic purposes in any other university.

Signed ..... **Date**..6/8/2011

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This research project has been submitted for examination with my approval as the university supervisor.

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DEDICATION

To Julius Muthama my husband, Barnabas and Steven my sons. Your love and support is always a great inspiration in whatever I do.

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ABREVIATIONS AND ACRONYMS

AIDS -	Acquired Immunodeficiency Syndrome
ARV -	Antiretroviral drugs
ARV -	Antiretroviral therapy/drugs.
CDC -	Centre for Disease Control
HIV -	Human Immunodeficiency Virus
HPC -	Health care provider.
HTC -	HIV testing and counseling
HTC -	HIV testing and counseling.
ICAP -	International Centre for Aids Care and Treatment Programs
IRN -	Integrated Regional Information Network
MDG's -	Millennium Development Goals
OI's -	Opportunistic Infections
PEPFAR -	President's emergency program for AIDS relief
PGH -	Provincial general hospital.
PITC -	Provider initiated testing and counseling.
UNAIDS -	Joint United Nations Program on Aids
USAID -	United States Agency for International Development
VCT -	Voluntary counseling and testing.
WHO -	World health organization

ABSTRACT

Much effort has been put by Nations world wide to curb the spread of HIV/AIDS. Most of these efforts have been geared towards providing opportunities for people to know their HIV status, and for a good reason. It has been established through studies done that people who know their HIV status tend to change their sexual behavior, to prevent themselves from being infected or if already infected, to avoid infecting their partners or even increasing their viral load. Voluntary counseling and Testing (VCT) has been one initiative where by people voluntarily visit the VCT sites to request for an HIV test. But even with all these efforts, only about 22% of the people living in Sub-Saharan Africa for example know their HIV status. The implication of this is that 78% of the population in this region is not aware of their HIV status.

PITC is one such effort aimed at providing an early entry point to HIV prevention care and support to the infected and affected people. The government of Kenya targets for PITC coverage at the outpatient is 50% and 80% for the inpatient in each facility. At the Provincial Hospital Nyeri, outpatient uptake for PITC stands at 2.6% while that of the inpatient is at 11.2% with gaps of 47.4% and 68.2% respectively. The study undertaken investigated the influence of staff levels, training, staff attitude towards HIV and availability of resources on implementation of PITC at the Provincial General Hospital Nyeri. The study adopted a cross sectional descriptive study design and stratified simple random sampling method was used to draw the sample from a population of 266 health care providers. Out of 169 respondents targeted in the sample 119 accepted to be included in the study and questionnaires administered to them.114 returned the filled questionnaires out of the 119 questionnaires administered. Documents from the hospital on staffing levels were reviewed to determine the staffing levels at the facility. Data was analyzed by use of the statistical package for social sciences (SPSS) programme and presented by use of frequency table and bar graghs.Staffing levels emerged the number one factor that affects the implementation of PITC at the hospital in that the inadequate number of staff translates to high workload making it difficult to provide PITC services to a large number (76%) of patients/clients who visit the hospital each day. Provider training and consistency in availability of material resources were other important factors affecting implementation of PITC to a great extent.

Inadequate staffing, inadequate provider training and update affect implementation of IPTC services at the Provincial General Hospital Nyeri to a great extent and as a result many patients miss the opportunity of knowing their HIV status increasing the overall percentage of missed opportunities. The staff is willing to provide the services and appreciate the importance of PITC. Provider related stigma needs to be investigated further.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Globally, the role of HIV counseling and testing (CT) has long been recognized as an important entry point to HIV prevention, care and support in resource-limited settings, yet, while appreciating these efforts being made by countries to expand HIV testing and counseling services, much remains to be done to reach satisfactory coverage in most of these countries. For over 20 years, client-initiated HIV counseling and testing also referred to as voluntary counseling and testing (VCT) has helped millions of people learn their HIV status. That notwithstanding, global coverage of HIV testing and counseling programs remain low as only 22 percent of the population in sub Saharan Africa know their HIV status.

In their study on theories and practice of HIV Counseling and testing, Claudes and G.Sangiwa state that, while appreciable efforts have been made in many countries to expand counseling and testing services, much remains to be done to reach satisfactory coverage in most countries. They continue to state that the current availability and use of HIV voluntary counseling and testing (VCT) are far from optimal, (Claudes M. Kamenga and sangiwa 2004).

The WHO and major international public health organizations have drawn urgent attention to the need to rapidly increase access to knowing one's HIV status. They have advocated the requirement to implement innovative strategies to delivering HIV counseling and testing in more settings and on a much larger scale so that more individuals can make use of the benefits of

knowing one's sero status. The need to urgently access treatment for HIV patients in resource-limited settings and the subsequent antiretroviral (ARV) treatment programs e.g. WHO "3" by "5" initiative, U.S. President's Emergency plan for AIDS Relief [PEPFAR] revealed the inability of VCT model to identify most people living with HIV who would benefit from treatment programs. The discovery led to a radical shift in the global testing policy, from a predominantly client –initiated model to one in which providers aggressively and routinely promoted HIV testing in health care settings . That shift in policy also called for modification of terminology from what had been historically called voluntary counseling and testing (VCT) to HIV counseling and testing in the broader sense. . (WHO/HIV/2003/08Vol 2).

In 2007 WHO and UNAIDS issued guidance on provider initiated testing and counseling (PITC) in health facilities to increase uptake and improve access to HIV health services. In PITC, it is the healthcare provider who offers an HIV test to a client or patient regardless of their reason for attending the facility and not the client who seeks the service as it is with VCT. HIV testing and counseling. PITC is a critical entry point to life sustaining care for people living with HIV and service delivery models need to be expanded to testing in antenatal care, inpatient wards together with other already existing testing options. Kenya adopted the provider initiated testing and counseling for HIV 2008 to provide back up to the already existing VCT services. One study done reveals that, inadequate training, stigma associated with HIV, right training as well as inadequate tools are some of the challenges facing implementation of PITC in Kenya's antenatal and STI clinics. (Dr Tanui-CDC 2005).The aim of this study was to assess the health care provider factors influencing the implementation of PITC at the PGH Nyeri.

1.2 Statement of the Problem.

In developing countries, only a small portion of people know their HIV status. It is estimated in sub Saharan Africa, the region of the world most affected by HIV, only 12% of men and 10% of women know their HIV status. Several studies have been done exploring the client factors that have continued to influence the implementation of PITC in health facilities. However, the literature reviewed reveals few studies that have explored the health care provider factors influencing implementation of PITC both globally and locally yet it is the providers of health care who are the key determinants of the success or failure of the implementation of PITC.

The government of Kenya has set targets to provide 80% of all eligible in patients with HIV testing and counseling and receive their results: at least 50% of all eligible persons at the out-patient are provided with HIV testing and counseling services and receive their results in every health facility. At the Nyeri Provincial General Hospital, the PITC testing is at 11.2% for the inpatient and 2.6% for the outpatients. From this data it is evident that a gap of 68.2% of inpatients and 47.4% of patients who are not able to access PITC services.

The study therefore sought to explore the influence of staffing levels, training, health care provider related HIV stigma and recourses on the implementation of PITC.

1.3 Objectives of the Study

In order to address the above stated problem, the study was guided by the following objectives;

1. To establish how staffing levels influence the implementation of provider initiated testing and counseling at the PGH Nyeri.

2. To investigate the influence of training levels on the implementation of provider initiated testing and counseling at the PGH Nyeri.
3. To assess how the health care provider HIV related stigma influences the implementation of PITC at PGH Nyeri.
4. To establish the extent to which resource related factors affect the implementation of provider initiated testing and counseling services at the PGH Nyeri.

1.4 Research Questions

The questions the study sought to answer were as follows;

1. How do staffing levels influence the implementation of provider-initiated testing and counseling services at the PGH Nyeri?
2. To what extent does PITC training influence the implementation of provider initiated testing and counseling at the PGH Nyeri?
3. How does HIVstigma among health care providers influence the implementation of PITC at the PGH Nyeri?
4. How do resources influence the implementation of the PITC at the PGH Nyeri?

1.5 Purpose of the study

The recommendations made in this report will facilitate formulation of strategies that will enhance implementation of PITC at the Provincial General Hospital Nyeri.

1.6 Significance of the study

HIV is an expensive disease both to treat and to live with and takes toll on every aspect of a person's life. A large number of people visit hospitals and other health care facilities daily in search of treatment as well as other health care services. If the patients are availed a chance to know their HIV status, then this would go a long way in preventing the spread of the virus.

Studies have established that, people who know their HIV status tend to change their sexual behavior. (Kais surveillance survey 2007)

In providing and understanding of the factors that are influencing implementation of provider initiated testing and counseling and addressing negative factors many people will know their HIV status and curb the spread and contribute to the attainment of MDG goal no 6 (combat hiv/aids, malaria and other diseases). A healthy nation is a wealthy nation. Saving the lives productive age- group (15-49yrs) will be a great contribution to the overall wealth of the nation.

The government spends huge amounts of money in purchasing ARVs and drugs to manage opportunistic infections, (OIS). This money with less people being infected with HIV will be redirected to other areas of need in the country.

1.7 Limitations of the study

Common inhibitors to the successful completion of any research project are time and financial resource which in this case, may hinder an extensive investigation including comparison of implementation with other large (level 5) health facilities within the country.

The study itself touches on a sensitive matter, HIV/AIDS, thus the respondents may be reserved when it comes to giving information.

1.8 Delimitations of the study

The study was limited to the Provincial Hospital Nyeri in the areas where PITC services are offered. The respondents were also assured of strict confidentiality about every information they gave and were not required to provide any information that would lead to their identity.

1.9 Assumptions of the study

The study assumed that the respondents would be willing to provide accurate data, useful to make meaningful conclusions. It was also the assumptions of the study that all the questionnaires would be correctly filled and returned on time for analysis.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter will discuss what is already known through previous studies on the factors influencing Provider Initiated Testing and Counseling (PITC).The review will provide a deeper understanding of how these factors have influenced implementation of PITC elsewhere. The review will also provide the information on how much is already known and therefore assist the researcher to concretize the problem identified

2.1.1 History of Provider initiated testing and counseling (PITC).

More than two decades into the AIDS epidemic, the majority of people living with HIV are unaware of their status. In 2005 surveys showed that in Sub Saharan Africa, (the epicenter of the epidemic), only 8 – 25% of people living with the HIV virus knew their status, (Christopher Spencer 2010). Low testing rates have been limited to a reliance on VCT as the sole approach to HIV testing. Barriers to VCT include low perceived risk of HIV infection, negative perception of testing services, lengthy pre and post test counseling as well as shortage of counselors (Leon et al 2010).

PITC or op -out is a streamlined model promoted by the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) to increase the opportunities for diagnosing HIV in health facilities, especially in high prevalence countries. In the PITC

approach all patients are offered HIV testing routinely by the clinicians as part of standard medical care, regardless of their presentation. (Leon et al. Implementation Science 2010, 5:8).

Testing is voluntary and the patient is given the opt-out option (or option to opt out of testing.) PITC's aim is to decrease barriers to testing in order to increase testing rates therefore facilitating earlier access to HIV treatment and prevention, (Leon et al 2010). Available evidence also shows that knowledge of HIV positive status can reduce risk behavior and transmission rates especially among sero-discondant couples. Available findings also indicate that feasibility of PITC in resource constrained countries may be of concern as it is difficult to add to the already high work load in under resourced health services.

Globally, the role of HIV counseling and testing (CT) has long been recognized as an important entry point to HIV prevention, care and support in resource-limited settings; while appreciating these efforts being made by countries to expand HIV testing and counseling services, much remains to be done to reach satisfactory coverage in most of these countries. In developing countries, only a small portion of people know their HIV status. It is estimated in sub Saharan Africa, the region of the world most affected by HIV, only 12% of men and 10% of women know their HIV status, (UNAIDS 2010). For over 20 years, client-initiated HIV counseling and testing also referred to as voluntary counseling and testing (VCT) has helped millions of people learn their HIV status. That notwithstanding, global coverage of HIV testing and counseling programs remain low. An urgent need to increase the provision of HIV testing through a wider range of effective and safe options remains.

In 2007 WHO and UNAIDS issued guidance on provider initiated testing and counseling (PITC) in health facilities to increase uptake and improve access to HIV health services. HIV testing and

counseling is a critical entry point to life sustaining care for people living with HIV and service delivery models need to be expanded to testing in antenatal care, inpatient wards together with other already existing testing options.(WHO/UNAIDS 2007).

The first six years of the 21st century witnessed a dramatic expansion in HIV counseling and testing programs in several countries and a shift in approach in HIV testing, (Claudes M. Kamenga et al, 2004)

The push for access to treatment in resource- limited settings and the subsequent antiretroviral (ARV) treatment programs (WHO) "3" by "5" initiative, U.S. president 's Emergency plan for AIDS Relief[PEPFAR]revealed the inability of VCT model to identify most people living with HIV who would benefit from treatment programs. The discovery led to a radical shift in the global testing policy, from a predominantly client –initiated model to one in which providers aggressively and routinely promoted HIV testing in health facilities to boost access to treatment and prevention.That shift in policy also called for modification of terminology from what had been historically called voluntary counseling and testing to HIV counseling and testing in the broader sense. UNAIDS, (2004).

The need to increase coverage and uptake of antiretroviral therapy and boost access to treatment and prevention services makes it critically important to expand and broaden HIV testing entry point, allowing more venues to routinely offer HIV testing (while preserving the client's right to refuse).Counseling and testing programs therefore must move from client initiated-approach to a combined approach where provider –initiated testing and counseling is offered in various clinical settings in addition to client-initiated testing. Kamenga, (2004).

Approaches to HIV testing and counseling in Kenya have shifted over the years from primary client initiated models (VCT) broad scope of approaches that are in place currently. By end of 2007, there were at least 900 VCT site in Kenya which were situated in health facilities (integrated sites) and in community settings (stand alone sites).Other models of HTC have been introduced in recent years, include; Mobile, Moonlight, Door to door HTC to mention but a few. Hospitals and health centers in Kenya have begun incorporating provider-initiated HIV. Testing and counseling (PITC) as part of routine health care to all patients and clients. More than two decades into the AIDS epidemic, the majority of people living with HIV are unaware of their status. In 2005 surveys showed that in Sub Saharan Africa, the epicenter of the epidemic, only 8 – 25% of people living with the HIV virus knew their status. Low testing rates have been limited to a reliance on VCT as the sole approach to HIV testing. Barriers to VCT include low perceived risk of HIV infection, negative perception of testing services, lengthy pre and post test counseling as well as shortage of counselors, Leon et al (2010).

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In the PITC approach all patients are offered HIV testing routinely by the clinicians as part of standard medical care, regardless of their presentation. Testing is voluntary and the patient is given the opt-out option (or option to opt out of testing).

PITC's aim is to decrease barriers to testing in order to increase testing rates therefore facilitating earlier access to HIV treatment and prevention. Available evidence also shows that knowledge of HIV positive status can reduce risk behavior and transmission rates especially among sero-

discondant couples. Available findings also indicate that feasibility of PITC in resource constrained countries may be of concern as it is difficult to add to the already high work load in under resourced health services.

2.2 Health Provider related Stigma of HIV.

According to Winrose (2007) the Encarta dictionary describes it as any situation in which a group or individual is treated differently based on something other than individual reasons, usually their membership in a socially distinct group or category; such categories include sex, ethnicity, religion, age or disability. Discrimination can be favorable or unfavorable depending on whether a person receives favor/opportunity or is denied them. In modern usage discrimination is usually considered unfavorable. (Encarta dictionary, Microsoft Corporation, 2009).

In the words of Winston Seseral 2007, "the problem with stigma and discrimination is that it is often a derivative of our instinct to live and protect life. Our tendency to survive has made us filter out the dangers that can cause us not to survive. Sadly enough, this sort of instinctive behavior leads us to stigmatize and discriminate against those that we perceive as causing danger to our existence. In the case of HIV/AIDS, this tendency is prolonged because of the fact that we know the detriment resulting from this disease and the shame and taboo that surround it in our small Caribbean state where social controls prevail. Stigma and discrimination are often seen as being derived from a lack of knowledge and understanding of a person's situation, characteristics, personality trait and even the cultural beliefs of the individual as well as the community.

In doing so it is often dismissed as a subtle sense of bias, which can be dispelled as soon as more information is availed to us about the given situation. Since the 80's we have come to realize that stigma and discrimination for HIV/AIDS is as common as the mutation of the human immunodeficiency virus, often leaving us with the sense of helplessness, anger and frustration when we encounter it. The progression of AIDS as a medical disease is similar to the havoc caused by societal stigma and discrimination of HIV and AIDS". (R. Interam, Priscal, 41(1), 2007).

To quote the words of UN Secretary General, Ban KI Moon "stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make aids the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."

2.2.1 Stigma related to government policies.

A countries laws, rules and policies regarding HIV can have significant effects on the lives of people living with the virus. Though some studies show that 71% of the countries now have some form of legislation to protect people living with HIV from discrimination, "almost all permit at least some forms of discrimination" (UN Secretary Ban Ki moon, 2008). Examples include President Meseveni's support of the national policy of dismissing or not promoting members of the armed forces who test HIV positive; the Chinese government advocates compulsory HIV testing for any Chinese citizen who has been living outside of the country for more than one year. (UNAIDS 2010).

According to Nyblade et al (2009), stigma and discrimination in the health care settings and elsewhere contribute to keeping people including health care workers from accessing HIV prevention, care and treatment services as well as adopting preventive behaviors. Studies from different parts of the world reveal that there are three main causes of HIV related stigma in Health facilities; A lack of awareness among health workers of what stigma looks like and why it is damaging, Fear of casual contact stemming from incomplete knowledge about HIV transmission and association of HIV with improper immoral behavior. Therefore, reducing HIV-related stigma in health settings should be a leading priority for health care managers. Still, little attention has been paid to this issue, particularly in low resource countries which are still grappling with burgeoning HIV epidemic. Studies done in Tanzania and Ethiopia revealed that common forms of stigma in health facilities included amongst others: Designating patients as being HIV positive in charts; Gossiping about the patients' status; Verbal harassment of patients, avoiding and isolating HIV-positive patients and referring for HIV testing without counseling, (Mbwambo 2004).

2.2.2 Stigma in health care settings

In health care settings people with HIV can experience stigma and discrimination such as being refused medicine or access to facilities, receiving HIV testing without consent and lack of confidentiality. Studies done in South Africa, Indonesia, Tanzania, Botswana, Ethiopia, Ghana, India, Uganda, Thailand and Zimbabwe indicate that even in healthcare settings, health workers may stigmatize patients by treating them differently; by using excessive precautions or withholding appropriate care, Makhlout (2007). Like in this example, "…..they covered the chair, the light; the doctors were wearing three pairs of gloves…." These were the words of one

HIV positive patient's experience with stigma in one health care facility. It is therefore unlikely that this kind of attitude (often fuelled by ignorance of HIV transmission routes among doctors, midwives, nurses and hospital staff) would facilitate PITC implementation. Doctors and nurses in health care settings in resource poor facilities may fear exposure to HIV as a result of lack of protective equipment, fuelling discrimination which in turn, pose a challenge to the implementation of PITC.

2.2.3 Stigma at the community level.

To quote the words of the united Nations secretary general, Ban Ki Moon, "We can fight stigma. Enlightened laws and policies are key, but it begins with openness and the courage to speak out. Schools should teach understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change, from securing legal protections to ensure access to health care". (Ban Ki Moon, Secretary-General of the United Nations 2008).Health care providers are not spared when it comes to stigmatizing HIV/AIDS themselves being members of the communities being affected and infected by the HIV virus.It is therefore possible that there is provider related HIV stigma which in turn affects the implementation of PITC.

2.3 Government policies on implementation of PITC and the involvement of core providers

Following issuance of new guidance on informed voluntary HIV testing and counseling in the world's health facilities with a view to significantly increase access to needed HIV treatment, care, support, and preventive services by the WHO and UNAIDS in May 2007. Countries around the world have been implementing PITC. (MOH National guidelines for HIV, 2008).

Today approximately 80% of people living with HIV in low and middle-income countries do not know they are HIV positive. Recent surveys in Sub-Saharan Africa showed on average about 12% of men and 10% of women have been tested for HIV and received their test results. Some clients are tested and never go back for their results as a result of the fear of a positive HIV test result. Increased access to HIV testing and counseling is essential to promote early diagnosis of HIV infection, which in turn can maximize the potential al benefits of life-extending treatment and care and allow people with HIV to receive information and tools to preventive HIV transmission to others, (WHO/UNAIDS, 2007).

The new WHO/UNAIDS guidance (from which governments have formulated policies on PITC) was prepared in light of increasing evidence that provider initiated testing and counseling can increase uptake of HIV testing, improve access to health services. Provider initiated testing and counseling involves the health care provider specifically recommending a HIV test to the patients attending health facilities after specific pretest information (not pretest counseling as in VCT) has been provided.

The test is then done unless the patient declines. PITC has been adopted by a few countries around the world dating back to 2004, either as stand-alone guidelines for counseling and testing or as part of the national policy on HIV/AIDS. In Latin America and Eastern Europe there is no PITC. In Asia only Cambodia, India and Thailand have the PITC policy. In Thailand, the PITC was introduced in the late 1990's with the prevention of mother to child transmission program (PMTCT) and later for Tuberculosis (TB) Programs as well as sexually transmitted infections (STI) settings. The services provided opt out depending on the type of service provided.

In India, the PITC policy was adopted as part of operational guidelines for Integrated Counseling and Testing centers in 2007. It was offered to; patients with symptoms suggesting HIV infection (pneumonia, TB), patients with conditions that would be associated with HIV, in settings with large numbers of clients e.g. pregnant mothers who register at the antenatal clinics (ANCs) and STT settings. The service provided is opt-out depending on the health service. In Africa, Botswana was the first country to adapt to the PITC policy in 2004 and it was adopted as part of the national policy on HIV/AIDS. Routine HIV testing (RHT) was implemented in January 2004 following a presidential announcement introducing the policy.

In Cote'd'Ivore, Democratic Republic of Congo (DRC) and Ethiopia, the PITC policy was adopted in 2007 as part of the national policy, while in Kenya, it was adopted in 2008 still as part of the national testing guidelines. The guidelines were adopted in all models and settings of CT. Guidelines exist for PITC in clinical settings but standardization is lacking leading to different interpretation of application. This could present a challenge in the implementation process. (www.aidstar-one.com).

In Kenya, it is the government policy through NASCOP to: strengthen health systems- relation to PITC through training, strengthen health systems through data management and community mobilization, orient scores of health workers at all levels on PITC, disseminate data capture tools for PITC and integrate indicators into the general health systems.

Key recommendations for provider initiated testing and counseling in health facilities by were made by WHO/UNAIDS as follows; all HIV testing must be voluntary confidential, and undertaken with patients consent; patients have a right to decline the test hence should not be tested against their will; pretest information and post test counseling remains an integral

component of testing and counseling process; implementation of provider initiated testing and counseling should be undertaken in consultation with key stake holders, including civil society groups, acknowledging that what works and is ethical will definitely differ across countries; when implementing PITC, equal efforts must be made to ensure the supportive social, political and legal framework is in place to maximize positive outcomes and minimize potential harm to patients.The WHO/UNAIDS together with their partners have pledged to continue to support countries in expanding access to the full range of HIV testing and counseling services in health facilities (winter, WHO – 2008).

The policy of 2007 WHO/UNAIDS on provider initiated testing and counseling (PITC), suggests that HIV testing and counseling 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 underlying HIV infection or the patient's reason for presenting themselves to the health facility.The policy complements the existing Voluntary Counseling and Testing (VCT) programs that rely on individuals to self refer for testing. The expansion of PITC has a potentially massive impact on Nursing roles and workloads yet little nursing involvement in HIV policy development and likewise, little research on nurses experiences of conducting the HIV testing. This is in spite of the fact that nurses in sub Saharan Africa are at the fore front of HIV care (USAID, 2003).

2.4 PITC Training and Implementation.

The PITC course is designed to expand entry point to HIV testing AND to promote testing as a more routine practice.

The course is aimed at; equipping service providers with skills and knowledge to offer quality and effective PITC services to patients/clients at health facilities, by giving clients sufficient information to have an informed and voluntary decision to be tested or decline; equip participants with skills, knowledge and attitudes requisite for provision of appropriate HIV information including counseling and testing while facilitating the clients access to prevention, care and treatment; to influence participants positively on the need to maintain accurate and detailed records of PITC.

In one study, nurses noted that they needed more and ongoing training, access to up-to-date counseling tools/aids and more mentoring and support from peers and managers. Nurses in two studies for example, complained that the senior staffs were primarily interested in gathering statistics than doing forward service improvement in PITC. Catrin Evans, (2008)

Participants should be health care providers (physicians, clinical officials, nurses and laboratory technicians), people who are involved in any aspect of HIV management interested and available in providing counseling and testing (CT) to clients with the support of their supervisors. (Schilsky A. 2008).

Though training in PITC has well defined objectives aimed at preparing the provider to offer skillful services to clients, available studies have not addressed the issue of how far this training has achieved its intended goals of equipping the health provider with skills that enable to confidently offer PITC services to clients in health facilities. There is no data documenting health facility attendance after PITC roll out and very little documentation of actual patients and community perception of particular PITC progress or their willingness to present for general medical care.

2.5 Providers Perception about PITC

Very limited data exists describing the perception of providers regarding the feasibility and appropriateness to routine testing and counseling in the facilities and their willingness to participate in those programs. However, in countries like Botswana (the first country to introduce widespread systematic PITC), data from the first two years of implementation of the program revealed a dramatic increase in testing from 60,846 to 87,894 in one year.

Similarly in Western Kenya an emergency-based routine PITC program demonstrated a 97% testing acceptance rate. In central Haiti, partners in health instituted PITC and a total of 85% of the HIV-infected patients who were identified and were referred for care and support counseling (pretest).

Unlike the voluntary counseling and testing approach, VCT, where clients are counseled before the test is done (pretest counseling) the PITC model emphasis on provision of pretest information and post test counseling with obvious consequences. Cases in Uganda of murder following HIV-positive results have been reported among spouses angry at their partners for infecting them with HIV. This is an evidence of inadequate counseling as recommended in PITC (Irin Plus 2008).

A case in point is that of Paulo Olobo(Uganda).Paul olobo was counseled for just 10 minutes at Gulu hospital, "your test results show that you are HIV positive, it's not the end of the world and you should learn to accept it" the counselor told him and sat quietly waiting for the next patient in line. With that the patient was left to decide what to do next. Was the training adequate?

(Irin Plus 2008).

2.6 PITC and Staffing Levels.

How do staffing levels influence PITC Implementation? PITC has a strong public health rationale but its introduction has been accompanied by vigorous debates about whether this is the right approach given the context of HIV-related lack of human and physical resources in the Sub Saharan African context, (UNAIDS, 2003).

Existing evidence (though not representative of the range of nursing practice in different Sub Saharan setting) gives cause for optimism on the one hand and concern on the other. It appears to show that, in spite of the constraints, nurses are willing to embrace the patient-centered philosophy of care that under pins HIV/AIDS policy. On the other hand, it indicates that the emotional labor of caring for HIV-positive patients is high and that ways must be found to give nurses appropriate support .(Phaladze. N. 2003)

2.6.1 Workload and implementation of PITC.

In Sub-Saharan Africa, nurses are at the fore front of HIV care. The expansion of PITC has a potentially massive impact on nursing roles and workloads yet there has been surprisingly little nursing involvement in HIV policy development and surprisingly little research on nurses' experiences of conducting HIV testing. Available literature has limited evidence of the challenges and opportunities that PITC raises for nurses in the Sub-Saharan region.

(Catrin E & Eunice N 2008)

2 6.2 Clients' Knowledge of Own HIV Status on Provider Work Load.

No data has been cited on this subject yet it is believed that patients whose status is known access treatment and support faster hence improving their chance of living a healthier life than clients who are infected and yet do not know their status. These are the patients who will overstay in the hospital, develop complications as a result of opportunistic infections, increase their cost of healthcare and increase work load for the already overstretched workforce in resource constrained countries like Kenya. Equipping providers through training will enable them take the initiative to recommend patients for HIV tests more readily.

2.7 PITC Implementation and Availability of Resources.

This will be discussed in the following context;

2.7.1 Space in relation to Confidentiality and Privacy.

According to NASCOP Kenya, in some areas there is no space for proper client flow especially in the busy hospitals that were built some time back-a category where most of the health facilities fall. WHO and UNAIDS recognizes that resources and other constraints may prevent immediate implementation of the PITC guideline and provides advice about how to prioritize implementation in different types of health facilities.

2.7.2 Inadequate drugs and equipment

Lack of drugs and equipment and working with unmanageable patient loads have been noted as factors challenging the implementation of PITC in resource constrained facilities.

2.7.3 Provider remuneration and implantation of PITC.

Research has found out that in spite of nurses taking on greatly expanded roles and responsibilities associated with HIV; these have rarely been accompanied by promotions, great remuneration or other work place incentives. This situation Saps nurses' motivation.

2.8 Leadership and implementation of PITC.

Provider initiated testing and counseling (PITC) integrates HIV testing and counseling (HTC) into overall health care services. By providing HTC where people access health care PITC allows for more people to learn their HIV status and get linked with treatment and support services.

AIDSTAR-One is actively involved in learning how PITC is implemented and how the three C's of HTC (consent,counselling and confidentiality) are being presented in countries with limited resources.AIDSTAR-One provides PITC resources including study findings review of country PITC policies and assessment tools. Leadership in health care settings is responsible for ensuring that implementation of PITC is enhanced through provision of tools and guidelines for PITC provision. Governments of countries where PITC has been rolled out through their partner CDC have provided tools like prevention of mother to child transmission of HIV (PMTCT) treatment support tools (CDC 2006).

In Cambodia AIDS STAR-One 2009 developed PITC assessment tool which is a field interview guide designed to interview health care workers about how PITC is being implemented. Other guide lines developed by this partner of Cambodian government include a pharmacy interview

guide as well as a client exit interview guide for clients attending ANC, TB, and STI clinics to determine if they were advised to take the HIV test by the health care providers.

In Tanzania the ministry of health and social welfare developed a training course for health care workers on the clinical management of TB including a module on PITC whose complete course is delivered in 6 days. In Kenya the National counseling protocol for PITC by National Aids Control Council NASCOP and JHPIEGO.2007 developed a job aid that assists health care workers to conduct PITC in a clinical setting including the steps, key messages and the interpretation of results. NASCOP also developed learning resource package for skills training in PITC in the clinical settings together with trainers guide for conducting a five day training on PITC in clinical environment and improving access to HIV and AIDS comprehensive care.

2.9 CONCEPTUAL FRAMEWORKS

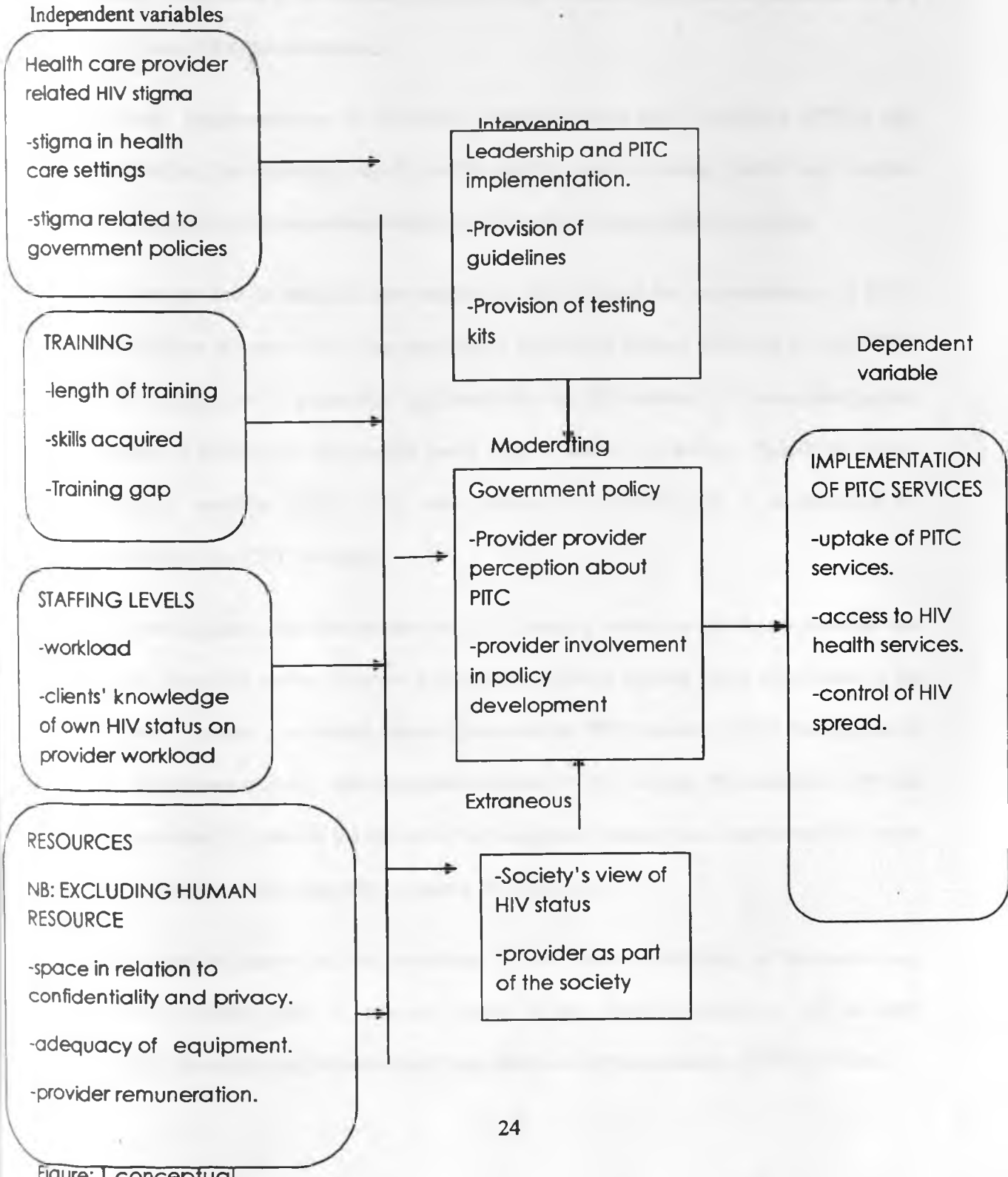


Figure: 1 conceptual

2.9.1 Conceptual framework

A conceptual framework is an abstract or general idea inferred from specific instances. It is a need to be discussed to be understood.

In the study, implementation of provider initiated testing and counseling (PITC) was conceptualized as the dependent variable while staffing levels, training, health care provider related HIV stigma, and resources availability were used as the independent variables.

The study endeavored to establish how staffing levels influence the implementation of PITC. This was looked at in terms of how the respondents viewed the existing workload to which PITC is added in relations to the number of staff available and also whether they were able provide PITC services to each client who sought health care services at the facility . Healthcare related HIV stigma is another variable that was assessed to establish how it is affecting the implementation of the PITC services.

The study also sought to establish the level of PITC training among the healthcare providers and its adequacy according to the providers themselves. Adequate training builds confidence in the providers and becomes a motivator towards provision of PITC services, while the opposite is also true. Inadequate training affects implementation of PITC in that, the healthcare provider would be unwilling to provide the service if not adequately trained since she/he will not know how to deal with the client especially a positive HIV test result.

Resource is another factor that was considered in this study. Availability of equipment e.g. testing kits, adequate space to provide privacy of the clients/ patients as well as staff remuneration. The study sought to establish their effects on implementation of PITC services.

2.10 Summary

From the literature review, it has been observed that Provider-Initiated Testing and Counseling (PITC) is indeed a very important entry point to HIV prevention, care and support in resource-limited settings. A number of countries had adopted the PITC strategy from as early as 2004. However, literature reviewed has not addressed the 'how' of the implementation of PITC especially in resource constrained countries. While the literature reviewed indicates that the three cadres of staff who form the front line providers of PITC in health facilities are the laboratory staff, nurses and clinicians, only the nursing staff seem to have been studied on (albeit in only few studies) and even in this case, it has not been clearly established how their experience with the PITC service provision influences its implementation.

Provider factors influencing PITC service provision have not been adequately addressed. This study therefore set out to assess how these factors influenced the implementation of PITC services at the PGH Nyeri.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Kombo K. and A. Tromp (2006) describe methodology as the description of the methods applied in carrying out the research study. Research methodology is organized under the following sections namely; research design, research site, population to be studied, sampling techniques and procedures, the research instruments to be used, data collection procedures and how data will be analyzed.

3.2 Research design

The study will adopt a cross-sectional descriptive survey design in the assessment of the factors influencing implementation of provider initiated testing and counseling at the provincial general hospital Nyeri, in Nyeri South district. This design was adopted because the data required on factors influencing implementation of PITC in PGH Nyeri will be collected within a limited period of time (month of May 2011) at the outpatient department and the selected sample wards. The study will use both qualitative and quantitative approaches. In qualitative research, several methods of data collection e.g. in-depth interviews focus group discussions and questionnaires among others are used. (Collins K.et al (1989).

A descriptive research is aimed at giving the specific details of a situation (in this case a social phenomenon), social environment or relationship Neuman, (1977: 19-20).

The design enables the researcher to generate both descriptive and numerical data which can then be used to measure the relationship of the variables of interest. The descriptive study will be aimed at determining how the identified factors affect implementation of PITC at PGH Nyeri.

3.3 The study population

A population is defined as a complete set of individuals, cases or objects with some common observable characteristics; an aggregate of all that conform to a given specification mugenda and mugenda (1999:9). The study population consisted of all health care providers at the PGH Nyeri while the target population consisted of; Nurses, Laboratory staff, Clinical officers and Doctors working at the out-patient and in the wards during the 4weeks of data collection period. The target population was N=266.

3.4 Sample and Sampling Procedures

3.4.1The sampling method

The study adopted a stratified random sampling method. The reason for the choice of this method is because the target population consists of several categories of health care providers namely, doctors, nurses, clinical officers as well as laboratory technologists all of who provide PITC services. According to Mugenda and Mugenda (1999), the role of stratified random sampling is to achieve desired representation from various subgroups in the population of the researcher's interest.

This sampling method is done by dividing the population into strata or categories and selecting proportional representatives from each strata or category.

A sample is part of a whole or a subset of measurement drawn for a population. It is then a selected group of elements from a defined population, studied in an effort to understand the population of the researcher's interest. Bless & Higson Smith (1995: 88; Brink 1996:133).

A sample is a finite part of a statistical population whose properties are studied to gain information about the 'whole' Webster, (1985). Where the study is dealing with people, the sample can be defined as a set of respondents who have been drawn from a larger population for the purpose of the study (Kombo and Tromp, 2006).

Sampling makes the scope of the study manageable because of the sampling formula and in this study, solving formula Wilcox R. & Hulsizer,(2008) was used to determine the sample size that will be used in the study as follows;

$n=N/1+N\,(e)^2$

Where N=Population size.

n= Sample size

e=Margin of error (usually use 1%, 5%)

Where margin of error is not specified 5% or 0.05 is always used.

N=266

Sample population size $n=266/1+266(0.05)^2$ =159 plus 10% because of non respondents hence n=174.

Proportion of the sample to the population= 174/266= 0.654

Number of Doctors in the population -12

Required sample from the population = 12*0.654=7

Number of Nurses in the population -221

Required sample from the population = 221*0.654=144

Number of Laboratory technologists in the population -24

Required sample from the population=24*0.654=15

Number of Clinical officers in the population =5

Required sample from the population =5*0.654=3

Total Sample =169

(Adopted from Wilcox R. & Hulsizer, 2008).

Once the sample was determined a convenient sampling technique was used to select respondents from the four strata. Convenient sampling technique is a technique involving selection of cases or units of observation as they become available to the researcher Mugenda and Mugenda (1999). In this study the technique was used to enable the researcher obtain the required sample for the study within the constrain of complicated working schedules of the potential respondents and the limited time available for the data collection.

3.5 Validity.

Validity refers to the degree to which results obtained from the analysis of the data actually represents the phenomenon under study Mugenda&Mugenda (1999). In order to improve validity, the researcher ensured that the research instruments were accurate after making the necessary adjustments after conducting a pilot study and ensuring that the questions were getting the right responses to measure what was intended. The researcher also consulted with experts i.e. the supervisor and other researchers and used the feedback to adjust the instruments accordingly.

3.6 Reliability

This is the extent to which an experiment, test or any measuring procedure yields the same results on repeated trials Mugenda&Mugenda (1999).

Testing for reliability enables the researcher to identify misunderstandings, ambiguities, and inadequate items in the research instrument and therefore provides a chance for relevant adjustments to be made before the actual data collection begins.

In this study, reliability was achieved, by subjecting the questionnaire to a pilot study at the town health centre in Nyeri Town health centre among respondents consisting of the categories of health care providers similar to the ones on whom the questionnaire would be used in the location of study. Questions that were ambiguous giving varied responses were reframed, while those questionnaires that didn't yield relevant data were deleted.

3.7 Operationalization of variables

Table 1: Operationalization of Variables

Variable	Indicators	Measurement Scale	Method of Data analysis
Influence of staffing levels on the implementation of Provider Initiated Testing and Counseling at the PGH Nyeri	1. Number of nurses in the health facility. 2. Number of Medical officer interns in the Facility. 3. Number of clinical officers in the facility. 4. Number of Laboratory technologists in the Facility	Nominal. Nominal. Nominal. Nominal.	Descriptive
Influence of training levels on the implementation of PITC at the PGH Nyeri	1. Number of service providers trained in PITC. 2. Quality of PITC training.	Nominal. Ordinal	Descriptive
Influence of health care provider HIV related stigma on implementation of PITC at the PGH Nyeri	1.Attitude of health care providers towards HIV positive patients 2. Level of confidentiality of HIV status of the patient among health care providers.	Ordinal Ordinal	Descriptive

Effects of availability of resources on implementation of PITC at the PGH Nyeri	1. Availability of all the required materials for testing. 2.Constancy of supply 3.Evidence of remuneration	Ordinal . Ordinal	Descriptive

3.8 Methods of Data collection.

The study employed two methods of data collection. A questionnaire was used to gather information from the four stratums of health care providers. The questionnaire was divided into four sections according to the study objectives namely; staffing levels, provider training, provider HIV perception and resources. Additional information on staffing levels was obtained from the existing documents on staffing Hospital staffing levels in the hospital. The two methods provided the primary data (from the questionnaires) and the secondary data from the review of documents. All the questionnaires were self administered, and hand delivered by the researcher together with the research assistant to the sampled population in the month of may and june 2011.The researcher and the respondent agreed on the time and place where to questionnaires were to be collected.

3.9 Methods of Data analysis

According to mugenda and mugenda (1999, 203) data analysis in qualitative research is the process of bringing order, structure and meaning to the mass of information collected. After

collection the filled questionnaires stored in secure place to maintain confidentiality. The researcher will then pre-process the data to eliminate unwanted and unusable data which could be contradictory or ambiguous, develop a coding scheme by creating codes and scales from the responses, summarize and store it both physically (on paper) and electronically. Analysis was done by use of the statistical package for social sciences (SPSS).

3.10 Ethical considerations

One of the responsibilities researchers have towards the people whom they research is that they must not do them any harm. In this regard therefore, permission is therefore necessary before they can be involved in any research. Permission to conduct the study was sought from the Provincial General Hospital Research board .Consent was also sought from each respondent before they could be included in the study. Any information that may lead to identification of the respondents was also not requested in order to protect their privacy and anonymity.

CHAPTER FOUR:

DATA ANALYSIS, PRESENTATION OF FINDING AND INTERPRETATION

4.1 Introduction

In this chapter the findings of the data collected from the sampled population of health care workers providing PITC services at the PGH Nyeri on factors influencing implementation PITC of central province, Kenya will be presented. Out of the 169 respondents targeted by the study, there were 119 (70.4%) respondents who consented for inclusion into the study and were given the questionnaires. Out of the 119 questionnaires distributed 114 were filled and returned a response rate of 96%. The study recorded a high response rate of 96% and according to Linder and Wingenbach (2002), surveys that have high response rates provide a measure of reassurance that the findings can be projected to the population from which the sample is drawn. The success of the high response rate can be attributed to the fact that the completion and return of the questionnaires was well supervised by trained research assistants. The data was interpreted according to the study objectives. Descriptive statistics were used in data analysis and study finding presented using frequency tables, and bar graphs.

4.2 Response rate

Out of the 114 respondents, 7 were doctors representing a 6.2 % of the overall respondents, 3 were clinical officers representing a 2.6% of the overall respondents, 7 were laboratory technologists representing a 6.2 % of the overall respondents while 97were nurses representing a 85.1 % of the overall respondents. The nurses represented the largest portion of the overall respondents in the sample therefore most of the questionnaires were administered to them.

Nurses form the greatest percentage of health care providers at almost every point where PITC service provision is done across the facility. It was therefore important that a large number of the nurses respond. The doctors' response was also very important because like the nurses they are found in all PITC provision points apart from the laboratory and therefore their responses would provide crucial information for this study. The clinical officers and the laboratory are basically in the outpatient and form part of the staff that provides PITC to patients in this department. The table below illustrates the response rate.

Table 4.1Questioneire response rate

Title of respondent	Questionnaires issued	Questionnaires returned	Percentage of the overall questionnaires administered	Response rate as per questionnaires issued
Doctors	8	7	6.3	87.5
Nurses	9	97	84.5	98.9
Clinical officers	3	3	2.4	100
Laboratory technologists	10	7	6.3	70
Total	119	114	100	

4.3 Staffing levels and the implementation of PITC

Staffing levels is critical to implementation of any new program as it will determine its failure or success. The researcher was interested to establish how staffing levels at this facility influenced implementation of PITC and therefore reviewed the existing records at the facility, for Nurses. Doctors, Clinical officers and Laboratory technologists. The table below shows the staffing levels at the PGH Nyeri.

Table 4.2 Staffing levels and implementation of PITC

Category of staff	Current numbers	Expected Number	Deficit
Nurses	258	416	158(37.98%)
Doctors	12	24	12(50%)
Clinical officers	7	15	8(53.33)
Laboratory technologists	20	25	5(20%)
Total	297	480	183

4.3.1 Work load and implementation of PITC

The researcher was also interested to find out how the staff viewed the amount of work they handle daily in relation to their numbers and PITC provision. As the table above illustrates, there is evident staff shortage in all the categories and especially in the three categories, the Nurses,

Doctors and the Clinical officers and these are the key providers of PITC. Another area looked at is the workload. The table below illustrates the respondents view on work load. Out of the total respondents, 73.6% indicated the workload was too much while 25% described their workload as sufficient for the staff allocated.

Table 4.2.1 workload

Work load	Frequency	Percentage
Too much	82	73.5%
Just enough for staff allocated	32	26.5%
Total	114	100

4.3.2Time taken with each client and implantation of PITC

In addition to workload, the respondents were asked to say how long it took to attend to one PITC client and 11.4% indicated that they spend 10minutes with one patient/client, 46.5% said it took 15 minutes to attend to one client/patient, with each PITC client, 28.1%of the respondents said that it took 30minutes while16% of the respondents said that it took over 40 minutes to attend to one PITC client as the table below indicates.

Table 4.2.2 Time taken to attend to one PITC client

	Frequency	Percentage
10 Minutes	13	11.4
15Minites	53	46.5
30Minuted	32	28.1
Over 40 Minutes	16	14
Total	114	100

4.3.3Respondents able to offer PITC to every new client /patient

The researcher sought to know how many of the respondents offered PITC services to every new client/patient.25.4% offered the services to each new client/patient while 74.6 % did not. The respondents who were not able provide PITC to each new client were asked to say what hindered them from doing so and some of the responses were as follows; "No enough time as i also have to perform other Nursing duties", another respondent said, "Iam not able to provide PITC to every new client/patient because there is too much work and sometimes unavailability of materials. Table4.3.2 below illustrates these responses.

T able 4.2.3 PITC to every new client.

Able to offer PITC to every new client/patient	Frequency	Percentage
Yes	29	25.4
No	84	74.6
Total	114	100

4.4 Provider training and implementation of PITC

The researcher wanted to investigate the influence of training levels on implementation of PITC and asked whether the respondents had been trained on some selected topics in the past six months and whether or not the training had an impact in their level of confidence when providing PITC services. As Table 4.3 indicates, 34% of the respondents have had training in the last six months while 69% had not attended any training in the same period. All those who had been trained also indicated that the training was beneficial to them and in the words of some of the providers; "It helped me to deal with the pretest and post test counseling", another provider had this to say, "It made me change my attitude about HIV patients" yet another said, it improved my counseling skills."

Table 4.3 Provider training and implementation of PITC

Training in the last six months	Frequency	Percentage
Trained	34	31
Not trained	80	69
Total	114	100

4.4.1Provider confidence in providing PITCand implementation of PITC.

The researcher wanted to know whether training of the health care providers contributed to their level of confidence in providing PITC services. The findings showed interesting results in that 81.6 % of the respondents were confident to offer PITC against 18.4% of the respondents who expressed lack of confidence to offer PITC services .The findings also showed that 69.5% of the respondents who said they were confident when offering PITC services they had not attended any training or updates in the preceding six months. Table 4.3 shows these results.

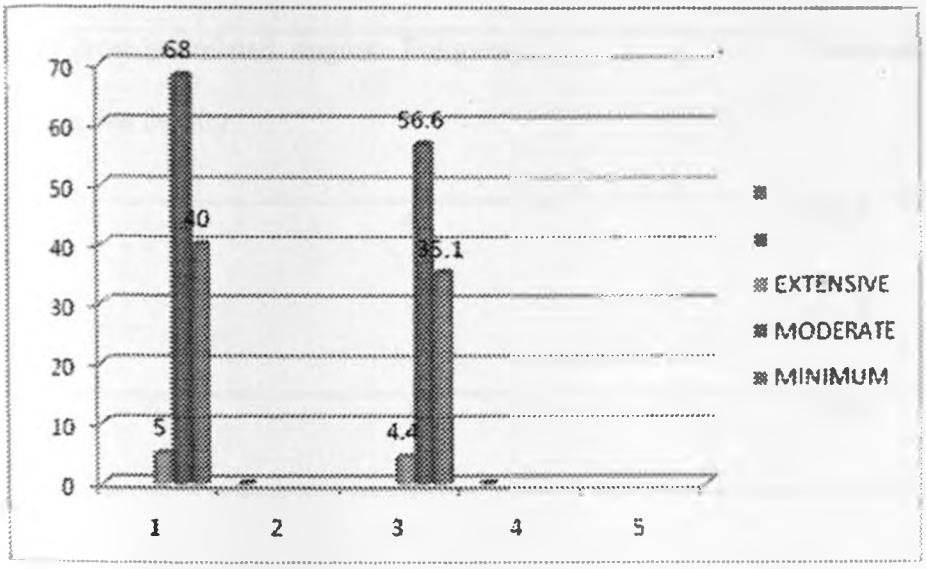
Table 4.3.1 Provider confidence in PITC provision and implementation.

Confident when providing PITC	Frequency	Percentage
Confident	93	81.6
Not confident	21	18.4
Total	114	100

4.4.1PITC knowledge and implementation of PITC.

The researcher also sought to find out how the respondents rated their level of PITC knowledge and 4.9% rated their PITC knowledge as extensive, 56.2% as moderate while 38.9% rated their knowledge as minimal. This shows that a very small number of service providers are adequately prepared through training to provide PITC. The bar graph in figure 4.1 illustrates these findings both in frequencies and percentages.

Figure 4.1 Level of knowledge on PITC and implantation.



4.5 Provider related Stigma and implementation of PITC.

The respondents were asked to indicate whether or not provider related HIV stigma existed among the healthcare providers in the facility and table below shows that the majority of the respondents 62.3% felt that provider related stigma did not exist while 37.7% of the respondents were of the opinion that provider related stigma did exist. Table 4.4 illustrates the findings on whether according to the respondents' stigma existed or not. The respondents who said that sigma existed were asked to explain how they saw it affecting the implementation of PITC and the following are some of their responses."Patients decline to be tested", another respondent said, "poor services are offered "and another respondent had this to say, "It makes it difficult to provide PITC services since patients have mistrust in healthcare providers."

Table 4.4Existence of provider related HIV stigma and implementation of PITC.

Does provider related stigma exist in this facility	Frequency	Percentage
Yes	43	37.7
No	71	62.3
Total	114	100

A Licert scale was used to examine the perceptions of the service providers on existence of provider related HIV stigma and the respondents were asked whether when taking blood pressure of an HIV positive patient they would use gloves, they would disclose a patient's HIV status to the family members without the patient's consent, whether the doctor should make the decision to do the HIV test or not where the patient/client declines to give consent, and finally whether people who get HIV through sex and use of drugs have themselves to blame. The table 4.4.1 illustrates the responses given when respondents were asked whether they would use gloves when taking blood pressure of an HIV patient.

Table4.4.1 Use gloves as evidence of health care provider stigma.

Will use gloves when taking blood pressure of an HIV patient	Frequency	Percentage
Strongly agree	4	3.5
Agree		
Agree	22	19.3
Disagree	50	43.9
Strongly disagree	38	33.3
Total	114	100

The respondents were asked to indicate on a licert scale whether they would disclose a patient's HIV status to family members without the patient's consent and the greatest number did not support the disclosure as the table 4.2.2 below indicates.

Table 4.4.2 Disclosure of patient's HIV status to family members

Would disclose patient's HIV status to family members without The patient's consent	Frequency	Percentage
Strongly agree	11	9.6
Agree		
Agree	43	37.7
Disagree	31	27.2
Strongly disagree	29	25.4
Total	114	100

The respondents were asked whether they agreed that the doctor should make the decision to do the HIV test if the patient declines to give consent and the responses given show that majority of the respondents (41% and29%) were of the opinion that, the patient was the final decision maker as far as consent for an HIV test was concerned. Table 4.4.3 illustrates these findings.

Table 4.4.3 Consent to do an HIV test.

The doctor should make the decision to do the HIV test if the patient declines to give consent	Frequency	Percentage
Strongly agree	6	5.3
Agree Agree	27	23.7
Disagree	47	41.2
Strongly disagree	34	29.8
Total	114	100

Still in an attempt to establish the presence or absence of provider related stigma the respondents were asked to indicate on a likart scale whether those who contracted HIV through sex or drugs had themselves to blame and majority disagreed that it was their fault. The table 4.4.4 illustrates these findings.

Table 4.4.4: Acquisition of HIV through sex and drugs.

People who get HIV through sex or drug use have themselves to blame	Frequency	Percentage
Strongly agree	4	3.3
Agree Agree	17	14.9
Disagree	50	43.9
Strongly disagree	42	37.7
Total	114	100

4.6 Resource related factors and implementation of PITC

Table 4.8 illustrates the responses given regarding the availability of materials required to offer PITC services. The researcher wished to establish the extent to which resource related factors affected the implementation of PITC services. According to the table,33.4% of the respondents said that materials for PITC were available all the time, majority, 65.8% of the respondents said materials were available some of the time,while0.9% of the respondents said that the materials were not available at all.

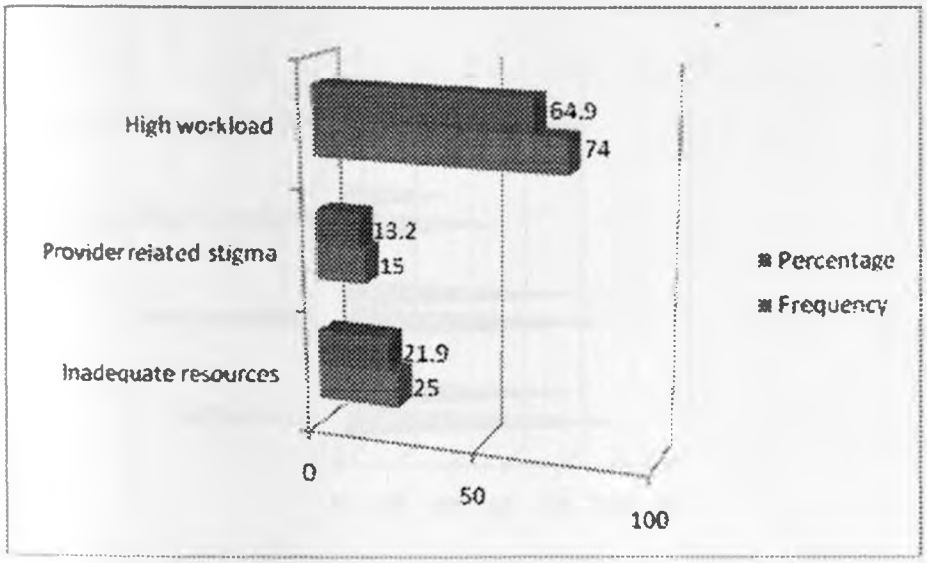
Table 4.5 Consistency of the availability of materials

Materials for PIT available	Frequency	Percentage
All the time	37	33.4
Some of the time	76	65.8
Not available at all	1	.9
Total	114	100

4.7 Greatest challenge to PITC

The researcher also sought to know what the respondents view was concerning the greatest challenge to the implementation of PITC in the facility. Out of all the respondents 64.9% described high workload as the greatest challenge to implementation of PITC,21.9%described inadequate resources as the greatest challenge while 13.2%described provider related stigma as the greatest challenge to implementation of PITC services.

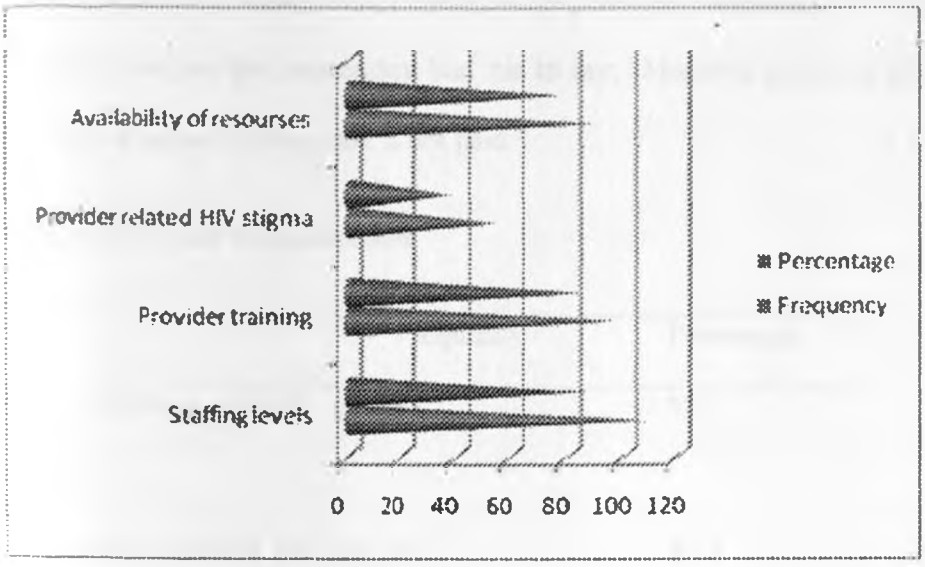
Figure 4.2 Greatest challenges to PITC implementation.



4.7.1Extent to which implementation of PITC is affected by key factors.

The respondents were asked to rate the extent to which they thought staffing levels, provider related stigma, training and availability of resources affected the implementation of PITC and 85.5% of the respondents were of the opinion that staffing levels were affecting implementation of PITC to a great extent, followed by, 85% of the respondents view that it was the provider training, 77.4% of the respondents viewed availability of resources as affecting implementation of PITC to a great extent and 37.4% of the respondents viewed provider related HIVstigma as the factor that affected implementation of PITC to a great extent. The graph in figure 4.3 illustrates these findings.

Figure 4.3 Extent to which implementation of PITC is being affected by key factors.



4.7.2 Staff remuneration and the implementation of PITC.

The researcher also sought to find out whether staff remuneration had any influence on the implementation of PITC and the respondents were almost divided down the middle.52.7% of the respondents were of the view that staff who provided PITC services should get better pay while 47.3% said that PITC services were part of all the other services provided to patients in health facilities. Some of the respondents who felt that staff that provided PITC should get better pay had this to say; "They should get better pay to motivate them". Another provider said, PITC is an added responsibility to staff that is already overworked so better pay should be provided to the staff who offer PITC services", "they are under pressure to provide large data but poorly paid hence no motivation", another respondent had this to say, "They should get better pay because HIVpatients require much attention most of the time "and another said, "they should get better pay because, it goes without saying, enough resourses-good care provision". The respondents

who held the view that staff providing PITC services should not get better pay also had their reasons."Better pay should be provided to all providers regardless of whether patients are HIV positive or not, another respondent had this to say; "Money is good but one should not refuse to care for the patient because she is not paid."

Table 4.6Provider remuneration

Pay	Frequency	Percentage
PITC providers should get better pay	62	52.7
PIT providers should not get better pay	52	47.3
Total	114	100

4.8 Summary

This chapter examined the influence of staffing level, provider training, health care provider related HIVstigma and consistency of availability on the implementation of provider initiated testing and counseling (PITC) for HIVservices and the findings confirmed the conceptual frame work that, low staffing levels slowed down the implementation of the program as it added to the workload of an already overstretched workforce. The findings also showed that training was not frequent for most of the providers and this was seen as another factor that affected the implementation of PITC to a great extent. Consistency of availability of resources was identified as a third factor that affected the implementation of PITC to a great extent slowing down the implementation process.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter, the summary of the findings, and the conclusions reached will be discussed according to the responses given by the respondents. The summary of the findings will be given in relation to staffing levels, provider related HIV stigma, provider training and availability of resources and the way these factors have been seen to influence the implementation of PITC services. The chapter also looks at the conclusions and the recommendations made from the findings. Areas requiring further research will also be highlighted.

5.2 Summary of the findings

The study undertaken was intended to; establish how staffing levels influenced implementation of PITC services. Staffing levels is critical to implementation of any new program as it will determine its failure or success. As the study findings show, there is evident staff shortage in all the categories and especially in the three categories of service providers , the Nurses (38%), Doctors (50%)and the Clinical officers(53%) and these are the key providers of PITC because they attend to patients and clients at all levels of care both in the outpatient and the inpatient . Another area looked at as an aspect of staffing levels was the workload. Out of the total respondents, 73.5% indicated the workload was too much. This means that staff who already viewed their workload as too much are unlikely to appreciate an additional service however important to the patient it might be. The long term good effects of the services i.e. eventual

reduction of work load and improved quality of life for all may be shielded by current pressure of work and affect the implementation of the PITC program. It also emerged from the finding that on average, a provider spent 25minutes with each PITC client meaning that due to the small number of staff 74.6% of the patients/clients could not receive PITC services translating to 74.6% missed opportunities. The respondents also indicated that high workload was the greatest challenge to implementation of PITC and those overall, staffing levels that affected the implementation of PITC a great extent.

Findings on training level and the influence it had on the implementation of PITC services showed that majority of the respondents (69%) had not attended any training in the last six months prior to the study and the same time inadequate training was identified as a factors that affected the implementation of PITC at the PGH Nyeri to a great extent. On assessment to establish how health care related stigma influenced the implementation of PITC, it did not come out as strongly as had been anticipated and therefore did not seem to influence the implementation of PITC significantly as majority of the respondents (62.3%) indicated that it did not exist. Concerning the extent to which resource related factors affected the implementation of PITC services it emerged that there was inconsistency in availing material resources according to 62% the respondents and this contributed to the slowing down of the implementation of PITC at this facility. It is hoped that the conclusions and recommendations made will make a difference in the implementation of PITC services at this facility as well as offering useful suggestions to policy makers on ways implementation of PITCcan be enhanced.

5.3Discussion of findings

The study findings point out that staffing levels does indeed influence implementation of PITC in that though it is an excellent approach to cub the HIV spread and improve the overall HIV care, the inadequate number of staff is not coping with the workload. The study findings concur with those of (UNAID2003) that despite PITC having a strong public health rationale, there was a concern about the approach given the lack of HIV-related human resourse in sub-Saharan African region. Other findings by Phaladz.N. (2003) indicated that there was a high emotional labour of caring for HIV positive patients and therefore ways must be found to give providers appropriate support. Unlike the voluntary counseling and testing approach, VCT, where clients are counseled before the test is done (pretest counseling) the PITC model emphasis on provision of pretest information and post test counseling with obvious consequences. Cases in Uganda of murder following HIV-positive results have been reported among spouses angry at their partners for infecting them with HIV. This is an evidence of inadequate counseling as recommended in PITC (Irin Plus 2008). Patients who's results turn positive require more time and as this study finding indicate and therefore adequate staffing is required to ensure not only the success of the implementation of the PITC program but also to ensure quality services are given to the clients. The PITC training is designed to expand entry point to HIV testing and to promote testing as a more routine practice. The course is aimed at; equipping service providers with skills and knowledge to offer quality and effective PITC services to patients/clients at health facilities, by giving clients sufficient information to have an informed and voluntary decision to be tested or decline; It is also meant to influence participants positively on the need to maintain accurate and detailed records of PITC NASCOP (2008).

In this study training was identified as a factor that influenced the implementation of PITC to a great extent. From the findings it was evident that most providers are not able to access frequent training on HIVcare, most of the providers' knowledge of PITC is inadequate and can be described as average and therefore more frequent training s and updates are required to build on skill, competence and quality.

The study findings agree with a study done by Catrin Evans (2008) on the Nursing Implications on routine provider initiated HIV testing and Counseling in Sub Saharan Africa, nurses noted that they needed more and ongoing training, access to up-to-date counseling tools/aids. In the study respondent likewise expressed the need for regular updates when responding to the question on how they can be better equipped to offer PITC services.

HIV stigma among health care providers and however does not seem to be a challenge to the implementation of PITC in this facility. According to Mbwambo (2004), common forms of stigma in health facilities included amongst others were, Designating patients as being HIV positive in charts, Gossiping about the patients' status, Verbal harassment of patients, avoiding and isolating HIV-positive patients, testing patients for HIV without consent as breaching the confidentiality of the patient. The forms of stigma that were examined yielded negative results contradicting the studies that have shown that the above named forms of stigma are common in health facilities. However this is an area that requires further investigation where a different approach can be used to study provider attitudes in relation to HIV and how some of the attitudes translate to stigma for as UN Secretary General, Ban KI Moon says, "stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make

aids the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."(WHO/UNAIDS 2008).

Inconsistency of availability of materials was rated as the third factor that affected the implementation of PITC services to a great extent at this facility. Shortages of and inconsistent supply materials to perform tasks or render services are contributors to breaks in the flow of that service and this impedes the implementation of any programme and especially if the programme is not yet well established as it leads to demoralization of the staff. The USAID (2011) while carrying out an assessment on implementation of PITC in Cambodia found out that expansion of HIV testing and counseling from VCT to PITC would exacerbate the already existing problem of stock out of testing kits. Proper planning and budgeting is crucial in order to address this challenge. The respondents in the final analysis rated availability of resources as the third factor affecting the implementation if PITC to a great extent.

5.4 Conclusion.

The study came up with the following conclusions

Firstly inadequacy of health care providers for PITC translating to high workload at the PGH Nyeri is affecting the implementation of PITC services to a great deal and also pose the greatest challenge to the implementation of PITC esrvices. Even though the long term benefit is reduction of workload with improved quality of life to these clients/patients, these benefits will be shielded by the current pressure of work as 74.6% of the clients/patients are not receiving the services.

This in effect translates to missed opportunities for HIV testing and counseling as well as denying the clients' access to other relevant care that PITC is meant to make possible.

Secondly most of the providers are not able to access frequent training on HIV care and therefore, most of the provider's knowledge of PITC is inadequate and can be described as average.Therefore, more frequent trainings and updates are required to build on skill, competence and quality. In the overall analysis, provider training was identified as the second most important factor for successful implementation of PITC services.

Thirdly, while provider related stigma had been thought to be one factor that influenced the implementation of PITC at this facility, the study findings showed that it is not a major influence to the implementation of PITC services. This notwithstanding, further investigation is recommended to study provider attitudes in relation to HIV and how some of the attitudes translate to stigma because stigma has been identified as the single and most important challenge to the fight against HIV and PITC is one of the strategies being employed to combat the HIV disease.

Lastly, Shortages of and inconsistent availability of resources to perform tasks or render services are contributors to breaks in the flow of services and this impedes the implementation of any programme and especially if the programme is not yet well established as it leads to demoralization of the staff.

5.5 Recommendations

Based on the findings of the concluded study the following recommendations were made:

Firstly before implementation of any program, an assessment of the staffing needs for the program is an important requirement. The assessment should include, the number of staff required as well as the preparations the staff requires.

If a program is to be integrated to the already existing services, the staff on the ground needs to be involved in the planning in order to gain their support and participation.

Additional staff that is adequately prepared for that service need to be available in order to give the programme a head start and increase the chances for its success.

This will also ensure ease of the implementation of the project and the development of the right attitudes towards the program by the staff already on the ground. At the end of the day this will lead to greater acceptance of the program as well as greater success in its implementation.

Secondly, all the staff to take part in the program need to be adequately trainened on the outset so that, again the right attitudes develop and confidence required to do the job well. Adequate training also includes frequent updates that keeps the staff informed and knowledgable.Staff who are well trained are motivated and contribute to the success of the implementation of any progarmme.

Thirdly, forecasting and planning for the resources needed to implement the program need to be done. Planning includes; identifying the material resources required (types), quantities reliable sources, space required, costs of the materials to facilitate adequate budgeting as well as

efficient procedures for and transportation systems to the users in a timely manner. This will eliminate inconsistency of supply and missed opportunities for the provision of the services and ultimately lead to success in the implementation of the programme.

5.6 Areas of further research

There is need make an assessment of the existence provider related HIV stigma and how it is

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APPENDICES

Appendix 1: Letter of introduction

University of Nairobi,

College of Extramural Studies,

School of Continuing and distance education

Nyeri Centre.

The health care provider

Provincial General Hospital Nyeri

Box 27 Nyeri,

Dear sir/Madam.

RE: Academic Research

I am a student of the University of Nairobi, pursuing a Masters Degree in Project Planning and Management.

I am carrying out a research on the implementation of Provider Initiated Testing and Counseling at the PGH (Provincial General Hospital) Nyeri.

I kindly request you to fill the questionnaire as accurately and as honestly as you can. The questionnaire is in four parts namely; workload, training, stigma and staff remuneration. I hereby

also assure you that all the information you give will be treated with ultimate confidentiality and will only be used for the purpose of the research.

Yours faithfully, Faith M Muthama

Appendix 2: Questionnaire

HEALTH FACILITY PROVIDER QUESTIONAIRE.

{All the information that will be gathered shall be treated with utmost confidentiality.}

Instructions:

- Please answer these questions as honestly as you can and to the best of your knowledge.
- Write your responses in the spaces provided.
- Mark with a tick [✓] where appropriate.

Section A. Staffing levels

1. Indicate in your view, the most appropriate health care provider to offer PITC services within the health facility? (Pick one answer)

2. How do you rate your work load?

   a. □ Too much

   b. □Just enough

   c. □Sufficient for the staff allocated.

3. How long does it take to offer PITC services to one patient?

   a.□10 min. b. □15Min, c.□30Min, d. □Over 40 min.

4. Are you able to offer PITC services to every new patient who comes to you?

   a.□ Yes b.□ No

5. If no what hinders you from offering the services?.....

.....

Section B. Staff training.

6. In the last 12 months, did you receive any training in the following subjects?

a) Yes☐ No

b) If yes which among those listed below did you receive?

☐Stigma.

☐HIV treatment.

☐Infection control.

☐Policy and procedures.

☐HIV testing and counseling.

☐Preventing mother-to-child transmission.

☐Orphans and vulnerable children care.

7. Was this training helpful as far as testing and counseling patients for HIV is concerned?

☐Yes ☐No

8. If yes in, what ways was it helpful?

.....

.....

.....

9. I am confident when offering an HIV test to a patient?

☐Yes ☐No

10. If no, what in your opinion causes lack of confidence?

.....

.....

11. How do you think this can be addressed?

.....

12. How would you rate your overall PITC knowledge level?

☐ Extensive ☐ Moderate ☐ Minimum ☐ None.

Section C. Provider HIV perception.

13. In Your opinion does HIV stigma exist among health care providers in your facility?

☐Yes ☐No

a. If yes how do you see it affecting PITC Services in this facility?

.....

14. Does your health facility have a policy to protect HIV-positive patients from discrimination?

☐Yes

☐No

☐ I don't know.

15. When measuring the blood pressure of an HIV Positive patient, a health care provider should put on gloves

☐strongly agree ☐agree ☐disagree ☐Strongly disagree

16. It is OK If a health care provider discloses the HIV status of a patient to the patient's family members without his/her consent.

☐Strongly agree☐ agree ☐disagree ☐strongly disagree.

17. If a patient declines to provide consent to an HIV test, the doctor should have the right to make the final decision.

☐Strongly agree ☐Agree ☐Disagree ☐ strongly disagree.

18. People who get HIV through sex or drug use have themselves to blame.

☐Strongly agree☐ Agree ☐ Disagree ☐Strongly disagree

Section D. Resources.

19. Materials for HIV are available

☐ All the time.

☐ some of the time.

☐ Not available at all.

20. What do you consider to be the greater challenge for the health care providers in the provision of PITC services in this facility?

☐inadequate resources ☐service provider HIV related stigma ☐high work load.

21. Do healthcare providers who provide PITC services get better pay?

a.☐ Yes

b.☐ No

c.☐ don't know

If (b) do you think this has an effect on the care given to HIV positive patients?

☐ Yes ☐No

22. Please comment on your response.

.....

.....

23. The following are some of the factors affecting the implementation of PITC services in many facilities. Indicate, in your opinion, to what extent each of them affects PITC implementation in your facility/ the area in which you work (on a scale of 1-4 as shown below).

1. I don't know
2. Not at all
3. To some extent.
4. To a great extent.

	1	2	3	4
Staffing levels				
Provider related HVI stigma				
Provider training				
Availability of resources				

Thank you for your time

Appendix 3: Data collection tool from available documents on staffing levels.

Staff Category (Strata)	Current Staffing Levels	Required staffing levels	Deficit
Nurses	257	447	190
Doctor(medical officers)	12	18	6
Lab technologists	24	57	33
Clinical Officers	9	16	7