

Providers' and patients' perceptions on task shifting as a model for improving uptake of Provider Initiated HIV - Testing and Counselling services in Kenya

Ann Ikahu^{*}, Susan Njuguna^{*}, Maureen Adoyo^{*}, Joseph Gatimu^{**}, Dr Lilian Otiso^{**}

^{*}Department of Health Systems Management, Kenya Methodist University & Correspondent
^{**}LVCT Health

Abstract- The HIV policy in Kenya recommends routine HIV testing and counselling to all clients attending public health facilities to facilitate early diagnosis and enrolment to care and treatment. The World Health Organization (WHO) recommends task shifting in HIV testing and counselling to ease the burden on medical health workers. There is limited evidence on implementation of task shifting in a public health facilities in Kenya.

The study aimed 1) to establish the perspectives of health care providers on taskshifting in the public health facilities in Kenya, and 2) assess client's satisfaction with the services offered through the task shifting model. A mixed method approach was used; a cross sectional descriptive design was adopted with qualitative and quantitative approaches.

Results indicated positive response among medical health providers with regard to the task shifting; 83% of the medical health providers described the relationship between medical and non-medical health providers as excellent. Levels of clients' satisfaction improved significantly with introduction of task shifting from 50% to 70% respectively. There was also a correlation between the number of non-medical providers who were engaged and the annual uptake of the PITC services that increased from 122,442 in 2010 to 209,022 in 2014. Task shifting strategy in HIV testing and counselling was therefore found to be feasible for scaling-up of HIV testing and counselling in the public health facilities.

Index Terms- Community Health Volunteers, HIV, Provider Initiated Testing and Counselling, Task shifting,

were formally launched and adopted by member countries, Kenya included in (WHO, 2006).

In Kenya in Lower Eastern, task shifting strategy where community health volunteers were involved, had been implemented before but with no clear guidelines on engaging the volunteers on a more permanent basis (Munga, M.A, et al, 2012). Despite the duration of the implementation, the perspectives of health workforce involved in the task shifting to community health volunteers, and the level of patient satisfaction has not been documented in the context of HIV/AIDS management. Studies evaluating clients satisfaction in services delivered through task shifting have largely ignored the patient perspective, focusing on health outcomes and acceptability to health care providers and regulatory bodies; studies worldwide have shown the significance of patient satisfaction as an indicator of quality (Elias et.al, 2014).

The community health volunteers are attached to the health facilities for supervision under Professional health care providers mainly nurses and clinical officers. The community health volunteers are involved in initiating testing, Counselling and follow up of clients referred to the facilities for HIV services. The objectives of the study were 1) to establish the perspectives of health care providers on task shifting and 2) to assess the patient satisfaction levels with the services provided using the task shifting model. The study employed a descriptive cross sectional design with both quantitative and qualitative approaches on Providers' and patients' perceptions on task shifting as a model for improving uptake of Provider Initiated HIV - Testing and Counselling services in Kenya

I. INTRODUCTION

Sub-Saharan Africa is facing a crisis in human health resources due to a critical shortage of health workers which is negatively affecting the delivery of health services (Zachariah, et al, 2009). The continent reports the estimated 25.8 million people living with HIV by 2014 who require health services (UNAIDS reports). The concept of task shifting has been promoted as a way of rapidly expanding human resource capacity to improve access of health services by clients and especially towards improving the care of those suffering from HIV and AIDS. Task shifting refers to the delegation of medical and health service responsibilities from higher to lower cadres of health staff, in some cases non-professionals (WHO, 2007). The WHO Global recommendations and guidelines for task shifting

II. RESEARCH ELABORATIONS

The study was implemented in 65 facilities in 3 counties of Makueni, Kitui and Machakos in Eastern region of Kenya. These were selected because of their experience of implementing provider initiated testing and counselling 2009. The three counties had a sparse population density of 66 persons per Sq. Km with a rough geographical terrain with limited health services and lower health indicators compared to the national levels. The health facilities in the region were understaffed with a ratio of 1:1,809 for nurses and 1: 90,000 for the population (Kenya Country Fact Sheet, 2011).

A cross sectional descriptive design that employed both qualitative and quantitative approaches was used. For clients' satisfaction, a review of biannual reports over a period of five

years on quality assessment from clients feedback was done. Purposive sampling was used to select health facilities and study participants. Purposive sampling of health providers and managers who had been involved in delivery of PITC services was carried out to establish their perspectives on the task shifting model as implemented in their facilities. Seventeen managers and workers were identified and interviewed in the 3 counties. For patient satisfaction, records on quality assurance and client exit interviews from 40 facilities in the 3 counties were sampled and analysed.

Qualitative data was collected through key informant interviews while quantitative data was collected through retrospective review of facility biannual quality assurance reports. The records include data on client exit interviews of clients who received PITC services. The interviews were carried out biannually by community health volunteers who administered a structured questionnaire. The quality assurance mechanisms explored overall satisfaction, waiting time, attitude of health providers, information provided, confidentiality, whether results were received on the same day, enquiry on referrals performed. Quality assurance data was collected by analysing the past facility biannual reports on client exit interviews assessing clients' service satisfaction for the period of five years using a tool. The quantitative data was analysed using SPSS version 20.

III. RESULTS OR FINDINGS

Providers perspective; Objective 1 sought to establish the perspective of the healthcare providers on task shifting strategy for PITC service utilization. This involved non-medical providers placement in public health facilities to offer provider initiated HIV testing and counseling services.

The results are from the 65 facilities that had implemented a task shifting approach for PITC for a period of 5 years, 40 facilities implemented quality assurance mechanisms including client exit interviews in the 3 counties. Twenty one respondents participated in the in-depth interviews drawn from different departments and with different roles within the participating facilities. Among the 21 respondents, six were manager in-charges of the health facilities or departments within the hospitals. The six, included two (2) hospital managers, two (2) nurses who also played the role of OPD in-charges, one (1) clinical officer who also doubled as the health facility in-charge and one (1) medical superintendent. Fifteen (15) of the respondents were health care service providers with no managerial roles. Among them were; six (6) nurses, five (5) non-medical HTC providers, two (2), and one (1) program officer and laboratory technician respectively. The response rate was 90%.

The number of health of non-medical health providers engaged to supplement delivery of HIV testing and counselling increased over time in the three counties as shown in figure 2. At the same time, the number of the clinical staff involved in HTC service delivery reduced. This was as a result of deliberate intervention informed by the availability of the different cadres to conduct PITC. The study found that medical health providers were too busy with other clinical work though initially hired for PITC, hence could not give time to PITC and therefore they were scaled down while non-medical providers were increased.

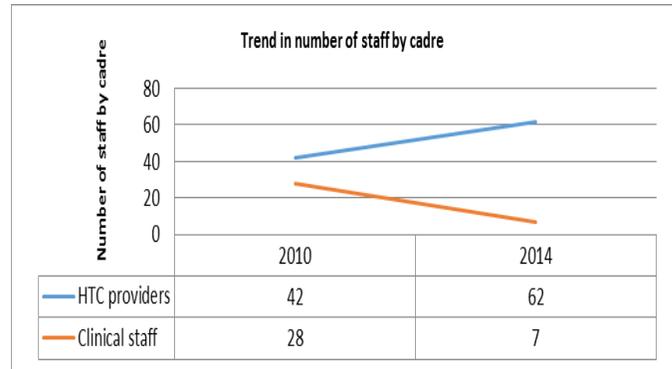


Figure 1: Number of staff engaged to deliver PITC

Figure 1 above shows a trend in the number of non-medical and medical providers engaged to provide HIV testing services in the health facilities where the study was done. The average increase in the number of non-medical providers in the 3 counties between 2010 and 2014 was 47% from 2010 to 2013. There was also a correlation between the number of non-medical providers who were engaged and the annual uptake of the PITC services that increased from 122,442 in 2010 to 209,022 in 2014.

Qualitative data from the key informant interviews conducted identified roles that the medical providers thought as tasks that could be performed by non-medical providers. Of relevant to note is the provision of HIV testing and counselling services which was mentioned by majority of the medical providers as stated in quotes below:

“They off loaded us and enabled utilization of PITC services in the facilities by more patients compared to when we did PITC and other clinical work at the same time”

They also acknowledged that the non-medical providers had the capacity to deliver PITC;

“...the non-medical providers have the capacity and offered quality PITC services and we have good mutual relationship between us based on purely team work”

The health care providers were asked about their perception on feasibility and acceptability of PITC services in the counties during the task shifting period.

“We can meet our set target for testing and counselling set by our managers, however we cannot do without the non-medical HTC providers. We need an additional number in busy health care points for service sustainability. We now feel like they belong here and they are very useful”

Five of 6 health care providers described the relationship between medical and nonmedical HTC service providers as excellent. 2 respondents noted that the relationship was affectionate and professional, 1 shared that the relationship was good since referral between the medical providers and the non-medical HTC providers was smooth. Three providers noted that initially the medical providers viewed the counsellors as unprofessional, a view that had since changed.

Patient satisfaction with PITC services

Client satisfaction surveys were conducted biannually by the facilities offering PITC services. As shown in figure 2 below shows levels of client satisfaction from the HIV testing and

counselling services increasing gradually across all the counties and through the task shifting implementation period. Prior to 2010 when the task shifting was introduced, there were no quality assurance mechanisms in the facilities to assess the levels of client satisfaction levels. At the beginning the task shifting in 2010 client satisfaction levels were below 50% across all the counties. This improved to an average of 70% by 2014.

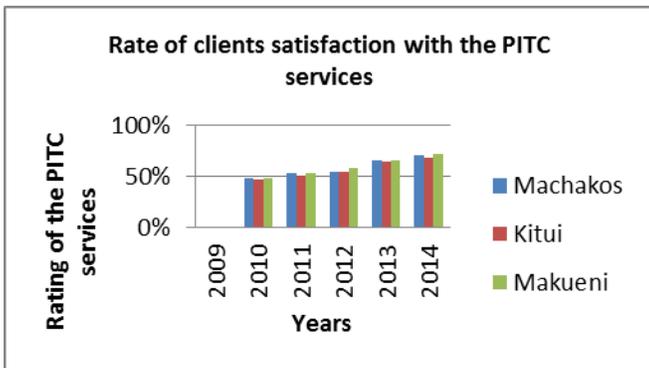


Figure 2: Levels of client satisfaction from PITC

IV. DISCUSSIONS

The objective of the study was to determine the feasibility of task shifting strategy in public health settings in delivery of PITC services in Eastern, Kenya. The two key indicators were; provider perspectives and client's satisfaction from services offered through task shifting strategy. The task shifting strategy is feasible and acceptable strategy for public health facilities to ease workload to the medical providers and should be institutionalized. Medical and non-medical providers had a good relationship and task shifting improved quality of services contrary to fears of conflict or non-acceptance of the non-medical providers. The study further recommends for development of national standards that to guide the facilities on; non-medical providers qualifications, hiring and engagement processes, remuneration package including development of a quality assurance framework for continuous quality assessment. Policy makers should consider recognition of a cadre of non-medical providers within the county public service boards for sustainability and to address the human resource shortages in Health systems.

The task shifting model was aimed at improving uptake of PITC services for general population. This is particularly critical in the Lower Eastern Kenya that is characterized by wide geographical areas, rough terrain, poor transport, long distances to health facilities, poor health indicators and understaffed facilities. The model was useful in engaging non-medical providers in public health facilities to ease work load, minimise missed opportunities and increase PITC uptake. This study showed that PITC services were tasks that could be delegated successfully to the non-medical providers to allow the medical providers focus on performing clinical duties. Other Studies done also confirms that the majority of HIV services were effectively delivered by non-medical providers. (Ledikwe, J, 2013).

Other studies done that with an aim of describing contribution of lay health care workers in supporting basic clinic

tasks and HIV adherence counselling revealed that the engagement of lay health care workers increased uptake of HIV care services from 1,176 to 39,900 patients within 3 years (Chiambe. G et al,2009). This study is in line with a study done in Cameroon where patients reported significantly better relationships with caregivers and easier access to consultations (WHO, 2008). In Zambia and Ethiopia studies recommended Task shifting to be implemented within systems that contain adequate checks and balances to protect both health workers and non-medical providers and the people receiving treatment and care, including appropriate health legislation or administrative regulation that can both enable and regulate task-shifting practice.

Other studies noted the critical role of quality assurance mechanist and setting standards if task shifting is to improve the overall quality of care. Standards should be in place including areas of recruitment and training of the lay health workers to ensure they are appropriately qualified for the tasks to be undertaken. Assurance that the appropriate standards are being met can be provided through credentialing (WHO, 2006).

V. CONCLUSIONS

The taskshifting model in public health facilities done by non-medical providers was found to be feasible and should be utilized to maximize on delivery of health services particularly in resource constrained settings.

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AUTHORS

First Author – Annrita Ikahu, M.A, Kenya Methodist University & Correspondent, Email: aikahu@lvcthealth.org
Second Author – Susan Njuguna, PhD, Kenya Methodist University & Correspondent, Email: rsmnjuguna@yahoo.com
Third Author – Maureen Adoyo, PhD, Kenya Methodist University & Correspondent, Email: maureenadoyo.kemu@gmail.com
Fourth Author – Joseph Gatimu, M.A, LVCT Health, Jgatimu@lvcthealth.org
Fourth Author – Lolian Otiso, MBA, LVCT Health, lotiso@lvcthealth.org

Correspondence Author – Annrita Ikahu, M.A, Kenya Methodist University & Correspondent, Email: aikahu@lvcthealth.org

