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Sigma Theta Tau International's 27th International Nursing Research Congress

Co-construction of consent and counselling during Provider initiated counselling and testing (PITC) in Nairobi Kenya

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Abstract

Background: The global policy focus of today's HIV efforts and strategies is to reverse the spread of HIV/AIDS and provide care, treatment and support. A key component of this strategy is to increase individual HIV status awareness through expansion of HIV testing and counselling (HTC). However, the numbers tested still remain and evidence suggests that there are significant missed opportunities for HIV testing in clinical settings. One key strategy to expand HTC in clinical settings has been to implement a policy of 'provider initiated counselling and testing' (PITC) in which all patients accessing health facilities for treatment are routinely offered a HIV test.

The introduction of PITC has brought with it a 'dilution' of the previously lengthy and stringent testing process by doing away with signed informed consent and extensive pre and post-test counselling. The previous process was recognised as a barrier to public health gains of HIV testing expansion, particularly as it differentiated an HIV test from other routine medical tests resulting in a sense of HIV exceptionalism. In its place, the PITC policy recommends an opt-out approach and replaces the extensive pre-test counselling with an information giving session placing more emphasis on post-test counselling in cases where the result is positive. This change has given rise to debates about the potential for PITC to infringe patients' rights to informed consent and counselling especially in developing countries.

Emerging evidence from the exploration of the PITC process within antenatal settings in the Sub Saharan Africa has revealed some of the complexities of implementing PITC guidelines in different cultural and healthcare contexts. These studies suggest that information giving and consent are difficult to apply in contexts characterized by healthcare worker dominance, lack of sufficient resources and time constraints. This study aims to specifically investigate how patients [and counsellors] co-construct informed consent and perform counselling during the PITC consultation. Thus it examined 'real time' patient-counselor interaction within hospital outpatient and inpatient settings in Kenya; to explore the patient's experience of a routine HIV test and to evaluate how sociocultural norms influence the PITC process in this context.

Methods: In order to explore the context of the routine testing consultation and the way the interaction played out, a qualitative research approach was adopted, utilizing multiple data collection methods (interviews, observations and audio recording of consultations). The study was carried out in two government run health facilities in Kenya's capital, Nairobi. The intention was to follow patients through the PITC process, i.e. before testing, during the HIV test and (whenever possible) after the HIV test. To get a broader picture of the events during the routine HIV testing consultation, additional interviews were conducted with 5 nurse-counsellors whose consultations had been observed. Ethical approval was obtained from the Kenya National Research Council, Kenya Medical Research Institute and the Aga

Khan University Ethics Committee. The data were analysed using Charmaz's constructivist grounded theory approach which allowed for a systematic yet flexible approach to analysis. This method facilitated immersion and engagement with the data, and provided a means of managing the different data sets in the study and undertaking a process of constant comparison within and between data sets.

Findings: Results from the study suggest that HIV remains a highly stigmatised illness in Kenyan society and is associated with death and perceived lack of morality. This is still the case in spite of years of health promotion and high profile media campaigns raising awareness about HIV and the availability and effectiveness of treatment. The context of stigma shaped the consultation so that both patients and counsellors worked together to help patients to maintain a 'moral face'. Patients tended to withhold information on risky sexual behaviour whilst the counsellors avoided inquiring into this domain. The PITC consultation was characterised by a counsellor dominated approach to communication and health promotion. Counsellor inputs were generic, highly scripted and didactic rather than patient-centred. As a result, the counsellors' style of communication allowed little space for personalised risk assessment or for patients to ask questions or to express concerns. Further on, the findings suggest that informed consent requiring explicit refusal of the test offer was difficult to achieve in an environment where the HIV test was not framed as a choice and patients came to the health facility expecting to be told what to do. Nevertheless, in spite of the obvious lack of explicit informed consent and the counsellor dominated interaction, post-test interviews revealed that patients were satisfied with the nature of the interaction.

Implications: The study concludes that there is a considerable distance between the policy recommendations and their implementation on the ground due to the complexity of real world practice. This distance does not necessarily constitute a disregard for the guideline recommendations but, rather, is an attempt to adapt to the prevailing environment. Lay constructions about HIV (HIV stigma) and the existing norms of patient-provider interaction that are characterised by a passive patient and a dominant health care provider shape the way the consultation unfolds. PITC training programs and manuals need to include skills and strategies that can support counsellors to navigate the consultation and provide quality care within this prevailing context.