Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

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Nursing Research – A Tool for Change

Overview

- Knowledge gaps
- Guiding premises
- Research questions and methods
- Preliminary findings
- Leadership hubs
- Conclusions

Scaling-up

- "Efforts to bring more quality benefits to more people over a wider geographical area more quickly, more equitably and more lastingly". (International Institute for Rural Reconstruction)

- "Efforts to increase the impact of health service innovations tested in pilot or experimental projects so as to benefit more people and to foster policy and program development" (ExpandNet)

Nurses – pivotal to successful scaling-up

"The biggest burden [of HIV and AIDS care] is shouldered by nurses and midwives, who are the first point of contact for patients, and the staff members who bear greatest responsibility for their on-going treatment. But lack of recognition or respect for their contribution is intensifying the burden and undermining countries' efforts to control the HIV and AIDS epidemic."   (Armstrong, 2003)

Literature Review – Key Findings

- Policy-to-implementation gap: national to local, "on paper" to implementation

- Research gap: nurses' participation and innovations in HIV and AIDS program

- Nurse engagement in policy gap: nursing voice largely absent from health care policy process

Capacity-building and Nursing Research
Segrott, McIvor & Green 2006

- 6 of 47 authors addressed issues of LMIC, none focused on nurses
- Key findings:
  - need for LMICs to retain autonomy and ownership when organizations from higher income countries partner with lower income countries to build research capacity,
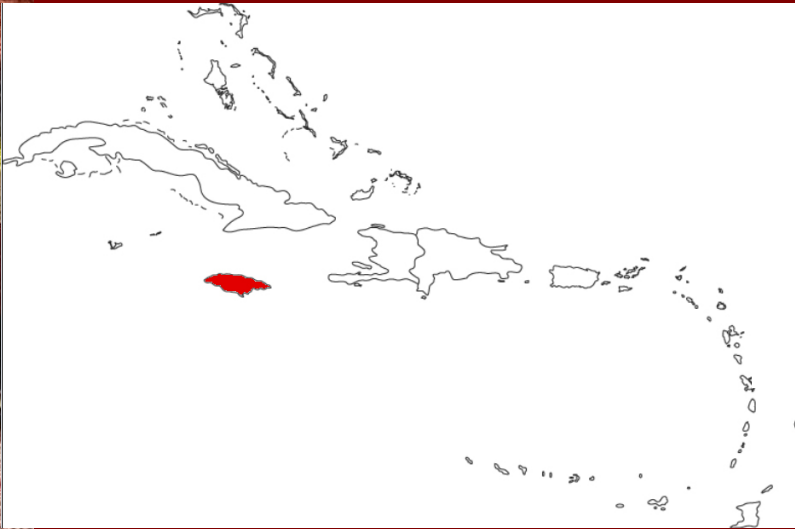 - need to develop research capacity that fits the local context.

Nurse participants in international research training
Edwards et al., INR, 2009

	WHO Tropical Diseases & Fellowships	INCLEN, AMREF, Gates, SA Reproductive health	ICN Leadership & Kellogg
Total # trainees	**15,061**	**1,808**	**500**
% nurses	**<1%**	**1.3%**	**100%**

Canada & Four Partner Countries

The Caribbean

Sub-Saharan Africa

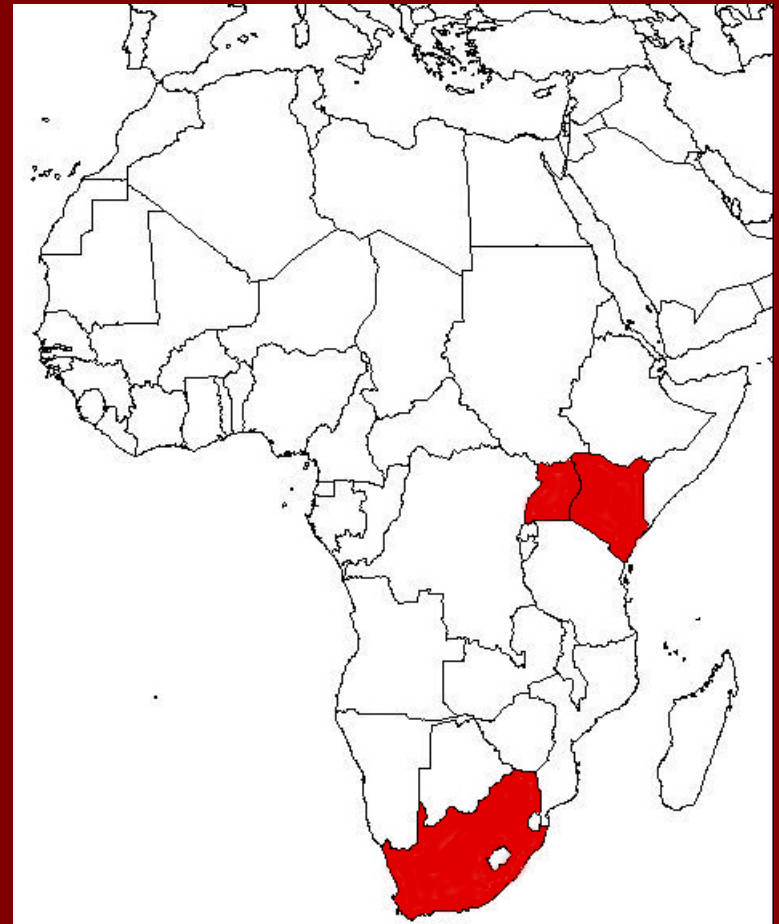Jamaica

Kenya
Uganda
South Africa

Program Goals

- Situate nurses in leadership roles to improve health system equity, quality and efficiency

- Improve the quality of HIV and AIDS nursing care

- Support scaling-up of innovative HIV and AIDS programs and practices

- Foster dynamic, sustained, and collaborative engagement of researchers and research users in HIV and AIDS policy development

Guiding Premises

1. The magnitude and dynamic nature of the HIV epidemic provides unique opportunities for nurses to exercise leadership in decision making and policy development.

2. Social injustices, including historical factors and gender oppression, are root causes for the under engagement of nurses in health systems strengthening.

3. Externally designed and imposed HIV and AIDS interventions threaten to displace local innovation and knowledge, thereby reducing local ownership and program sustainability.

Research Projects

1. Nursing practice in HIV prevention and AIDS care

2. The interface among health system priorities, capacity-building, and policy innovation

3. Dynamic collaborations to strengthen health care systems for HIV and AIDS

4. International comparative case studies

Methodology

- Participatory action research

- Mixed methods data collection

- Quasi-experimental study design

Project #2 - Research Questions

1. From the perspectives of nurse managers, front line nurses, and decision-makers, how has the HIV and AIDS epidemic affected the nursing workforce?

2. How do international funding agendas and national HIV and AIDS management strategies influence workplace policies and nursing practices?

3. What is the influence of top-down HIV and AIDS program innovations on the provision of health care services by nurses?

Realities from the frontlines

- "You run the capacity of 30 patients in the ward, three quarters of them being HIV +ve. Very ill, very emaciated, they need strictly basic nursing care to wash them, feed them, change them, position them, everything, and you have to give medications and injections with 4 staff. You don't even know how to allocate the jobs because it's 4 people against 30 very ill, helpless patients. So it is very, very difficult. When you go off, you know it [makes] every part of you painful."

- (Nurse, South Africa)

Social Repercussions

- "And remember that you are not just nursing people with HIV. You are nursing people living with HIV who are gay, sex workers, men who have had multiple girlfriends and boyfriends or a combination. So the whole stigma, the whole what is it that you are siding with and what are you promoting is what started to come down on some of these health workers." (Chairman of NGO, Jamaica)

The burden of reporting

- "We need to recognize that HIV is one programme of 30 priority programmes of the Ministry of Health…HIV tends to be very time consuming because it has projects attached to it and reports…we were told you are going to need twenty-five reports a month per parish for HIV…Can you imagine the capacity of the parish to be able to do other work than write reports?" (Technical Director, Regional Health Authority, Jamaica)

The Central Role of Nurses in HIV Programs

- "I just want to say that it is the nurses who have been the custodians [of the PMTCI Program] and without them the program would have collapsed." (Focus group participant, Kenya)

- "I consider nursing as having a pivotal role in this whole thing, HIV/AIDS." (CEO, Jamaica)

Nurses' Involvement in Policy-making

- "There is a misnomer by the policy making body that the bulk of information to be provided on the health care, is really from the medical profession and this error has been made many times over. We really make that error in stopping at the doctors and believing that their views are over-arching and encompass everything else. I think [nurses] need to be more vociferous as it relates to influencing policy" (CEO, Jamaica)

Nurses' Influence on Policy

- "Government policy is riding high, there is no channel to make policy. [Policies] are channeled from above, it reaches from national level through medical level and so you can't clarify these. As nurses we are told 'OK this is what is there, implement it'." (Nursing officer, Kenya)

Nurses are Implementers

- The nurses have not really been involved in program design and evaluation. CDC does the critical analysis…nurses only implement….doctors and other professors, these big people do evaluation and within no time come up with new programs.
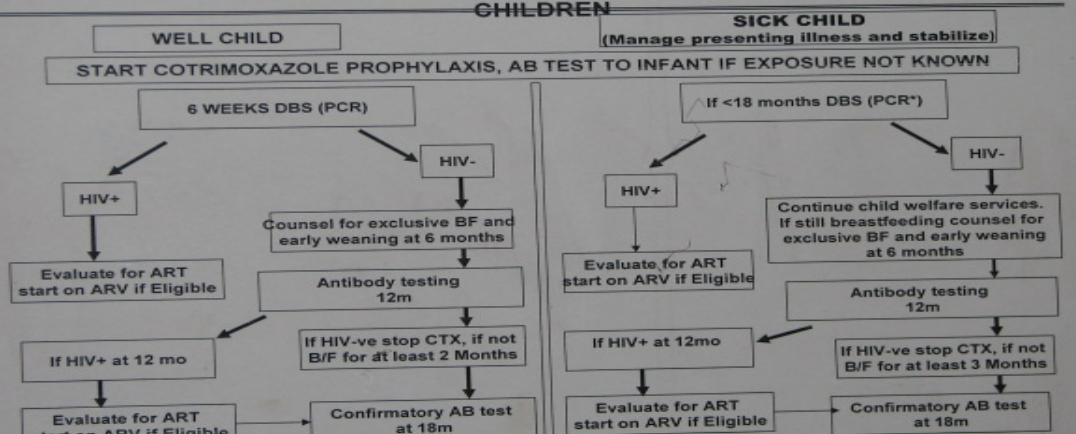- (PMTCT Program, Focus Group participants, Kenya)

Nurses' Involvement in Program Design

- PMTCT was being implemented or owned by CDC, they have their own goals, their own data collection tools, which must be filled and we are given deadlines to abide with. You find that we are narrowed down to the needs of program designers but not to our own local needs.

- (Focus Group participant, Kenya)

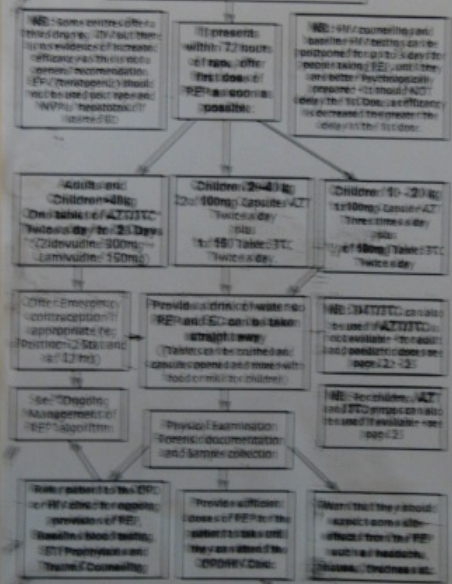# ALGORITHM FOR EARLY INFANT DIAGNOSIS FOR HIV EXPOSED CHILDREN

WELL CHILD	SICK CHILD (Manage presenting illness and stabilize)

START COTRIMOXAZOLE PROPHYLAXIS, AB TEST TO INFANT IF EXPOSURE NOT KNOWN

Well Child branch

6 WEEKS DBS (PCR)

→ HIV+ / HIV-

HIV+: Evaluate for ART start on ARV if Eligible → If HIV+ at 12 mo → Evaluate for ART start on ARV if Eligible

HIV-: Counsel for exclusive BF and early weaning at 6 months → Antibody testing 12m → If HIV-ve stop CTX, if not B/F for at least 2 Months → Confirmatory AB test at 18m

Sick Child branch

If <18 months DBS (PCR*)

→ HIV+ / HIV-

HIV+: Evaluate for ART start on ARV if Eligible → If HIV+ at 12mo → Evaluate for ART start on ARV if Eligible

HIV-: Continue child welfare services. If still breastfeeding counsel for exclusive BF and early weaning at 6 months → Antibody testing 12m → If HIV-ve stop CTX, if not B/F for at least 3 Months → Confirmatory AB test at 18m

FOR MORE INFORMATION CONTACT THE NATIONAL AIDS/STD CONTROL PROGRAMME (NASCOP)
P.O. BOX 19361-00202 NAIROBI TEL: 0202729502 FAX 020 2710518

Ongoing Management PEP in OPD or HIV clinics

Remember to offer trauma counselling to all rape survivors in addition to HIV test counselling

Was the patient started on PEP within 72hrs of the exposure?

- **No** → Offer the first dose of PEP as soon as possible, if < 72 hours from time of exposure (For Rape: offer emergency contraception if not yet given)

- **Yes** → For Rape: Offer STI Prophylaxis within 1st week after rape Norfloxacin 800mg stat + Doxycycline 100mg BD 7 days

Assess patient's current understanding of benefits of PEP and reasons for HIV Testing – give full explanation. If HIV Testing is declined after counselling, explain that PEP cannot be continued.

Request baseline bloods (within 72 hours of starting PEP) Hb, SGPT and Cr (and urine pregnancy test) Refer to VCT/DCT with blood forms Dispense enough doses of PEP until patient can return with results

HIV Positive: Explain that they have not become infected from this exposure - STOP PEP - Give post-test counselling and enrol into HIV clinic for ongoing medical care

HIV Negative: Baseline Bloods Hb<6.5 SGPT>175 Cr>3.0?
- Yes → Do not continue PEP without discussion with senior clinician
- No → Give an appointment for 1 week – provide enough Doses of PEP until then

Review side-effects-assess and encourage adherence. Give Appointment for 1 week, provide PEP and blood forms for the "2 week" blood tests (Haemogram + SGPT)

Bloods at 2 weeks Hb<6.5 (or a fall of >3 from baseline) SGPT>175
- Yes
- No → Give appointment for 1 week and dispense PEP → Review side-effects and assess and encourage adherence → Dispense enough PEP to complete a total of 28 days

Offer HIV testing at 6 weeks and 3 months from exposure. Reassure if Negative – counsel and enrol in care clinic if positive

For Rape: If pregnancy occurs as a result of the rape, inform woman that in this circumstance, termination is allowed in Kenya → Refer as appropriate

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Guidelines for the Management of Rape Survivors Attending Casualty – HIV and Pregnancy Prevention

Bottom-up innovation

- "We really make policy and plans on the basis of ideals…but we are not recognizing the constraints we have. We really have to look at how the nurses manage. How do they do this?" (CEO, Jamaica)

Nursing voices

- "[Nurses] really need to be supported and their voices heard. Because many a time they fear their dismissal and they keep it to themselves, so when you find the nurses, they don't even have a group…. The people like using them when they are hidden behind someone else.. They are used, the nurses are used…They have knowledge just waiting to be tapped." (District public health nurse, Kenya)

Waiting to be told

- "Due to non-empowerment and non-involvement of nurses at the program design level…they just wait to be told. We do not have the confidence and authority to adapt programs to our local settings."

- (Focus group participant, Kenya)

Leadership Hubs

- Act as a lever for change
- Six to nine members per hub:
  - Nurse researchers
  - Front-line nurses and nurse managers
  - Decision-makers
  - Community representatives
- Develop relational capital among researchers, practitioners and policy makers
- Strengthen vertical links through decision-making hierarchies

Leveraging for Change
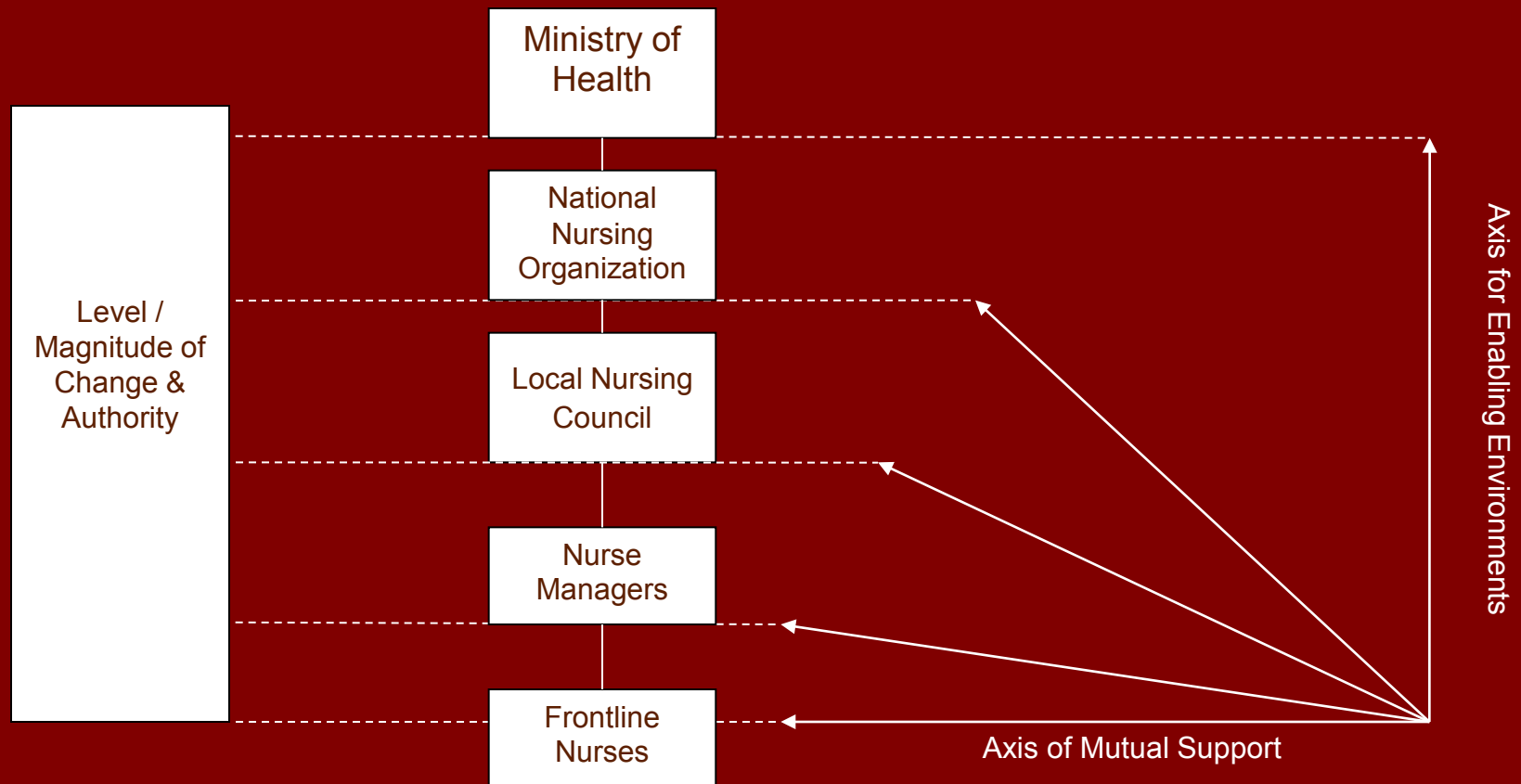
The greater the angle between someone's level in the hierarchy of change and authority, the greater the opportunity for change and creation of an enabling environment as well as knowledge translation
(Team workshop, August 2006)

Leadership Hubs
Capacity-building

– Influencing policy

– Using qualitative and quantitative research for evidence-based policies

– Evaluation

Reflections and Conclusions

- Disempowering burden of care may be exacerbated as HIV and AIDS programs are scaled-up

- Nurses as innovators, thinkers and problem-solvers

- Scaling-up requires an equity chain