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Understanding the relationship between the public sector healthcare workers and NGO-based HIV counsellors while providing HIV counselling and testing services to pregnant women: A Qualitative Study in Suva, Fiji

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ABSTRACT

Human immunodeficiency virus (HIV) counselling and testing plays a significant role in the prevention of mother-to-child transmission of HIV. HIV counselling and testing during pregnancy is an essential gateway for HIV prevention, timely treatment, and care services. Lack of proper counselling could jeopardise the quality of services. This paper aims to understand the relationship between the government employed hospital healthcare workers and the Non-Governmental Organisation based counsellors while providing HIV counselling and testing services to pregnant women attending antenatal clinic in one of the main hospitals in Suva, Fiji. Data were collected via individual, in-depth, interviews held in a single hospital and an associated reproductive health centre in Suva in April-May 2013. A total of 15 healthcare providers including doctors ($n = 4$), midwives ($n = 5$), nurses ($n = 4$), and counsellors ($n = 2$) were interviewed. The data were analysed using thematic analysis. Ethical approvals were obtained.

We found that there was tension between the government employed hospital healthcare workers and the Non-Governmental Organisation based counsellors involved in the provision of HIV counselling and testing services to pregnant women. The predominant causes of tension were poor referral for HIV test counselling, long counselling time, lack of cooperation and conflict due to the differences in counselling approaches.

Tension between the government employed hospital healthcare workers and the Non- Governmental Organisation based HIV counsellors appear to be the main challenge to effective provision of HIV test counselling services in the hospital. Ongoing tension between both groups could restrict healthcare workers abilities to provide quality HIV counselling services. Our findings would be useful in developing strategies to overcome tension amongst healthcare workers as it would be an imperative step in providing streamlined HIV counselling services to women attending antenatal clinic in Fiji.

Introduction

HIV counselling and testing provides an essential gateway to HIV treatment and preventive services amongst pregnant women attending antenatal care (ANC) clinics (UNAIDS 2002; WHO 2003). This is particularly important for the effective prevention of mother-to-child transmission (PMTCT) of HIV. It also ensures the timely detection of infection, meaning early access to treatment and care can be achieved.

Voluntary counselling and HIV testing (VCT) and provider-initiated HIV testing and counselling (PITC) are the two main approaches used in PMTCT programs (Sarker et al., 2007). The VCT approach (also referred to as a client-initiated or opt-in approach) focuses on promoting informed consent, by providing the individual with the right to choose whether to be tested for HIV. Informed consent is also sought prior to testing. Conversely, the PITC approach is used to expand HIV testing by offering it as part of standard ANC. In PITC, healthcare workers usually recommend

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and promote HIV testing to patients attending ANC (WHO and UNAIDS 2007), with written or verbal consent considered sufficient for testing (WHO 2012; WHO 2003; Oberzaucher and Baggaley 2002; Leon et al., 2010; Leon et al., 2014). Regardless of which HIV counselling and testing approach is taken, global policies recommend that HIV counselling should always be voluntary, based on informed consent and confidential, and include pre- and post-test counselling (UNAIDS 2000; WHO and UNAIDS 2007). Despite this, in practice, it is not always possible for voluntary consent to be obtained under the PITC approach, especially in low-income countries, due to the limited availability of pre- and post-test counselling (Rujumba et al., 2013; Meursing and Sibindi 2000).

Previous studies have shown that the PITC approach has increased the proportion of pregnant women opting for HIV testing in a number of countries, including Botswana (Creek et al., 2007), Malawi (Manzi et al., 2005; Moses et al., 2008), and Zimbabwe (Chandisarewa et al., 2007). In Botswana, PITC led to a significant increase in HIV testing compared to the VCT approach, with the number of pregnant women undergoing HIV testing rising from 47% (2003) to 78% (2005). In addition, the uptake of PMTCT amongst HIV positive pregnant women attending ANC in Botswana substantially increased from 29% in 2003 to 56% in 2005 (Creek et al., 2007).

Previous research has shown that in some countries, including Uganda, Zimbabwe (Meursing and Sibindi 2000), and South Africa, pre- and post-test counselling is often limited or entirely excluded during provider-initiated HIV testing and counselling (Bisaillon 2010; Yeatman 2007; Rujumba et al., 2013). Studies have shown that these shortcuts in counselling may undermine efforts to prepare HIV positive individuals for coping with their test results (Rujumba et al., 2013). In Uganda, pregnant women attending ANC understood HIV testing to be compulsory, due to limited counselling and a strong preference amongst health workers for HIV testing (Rujumba et al., 2013).

In Fiji, PITC is routinely offered to all pregnant women during their first antenatal visit, with the right to opt out of testing. Written consent is required from all women prior to undergoing testing. According to Fiji's National HIV counselling and testing policy, which was formulated in 2009, HIV testing should be voluntary, accompanied by pre- and post-test counselling services, and only conducted with voluntary informed consent (Fiji-MoH 2009). In 2005, the Fijian Ministry of Health has partnered with a local NGO that specialises in counselling and social support, to ensure that HIV testing is accompanied by pre- and post-test counselling, and that informed consent is obtained during ANC visits (Fiji-MoH 2012c). The NGO-based HIV counsellors are located within each of Fiji's three main hospitals. Their main role is to assist government employed hospital healthcare workers in providing pre and post-test HIV counselling services to pregnant women and their partners attending ANC (Fiji-MoH 2012b). If required, NGO-based HIV counsellors can also provide general counselling, including domestic violence counselling.

Understanding the dynamics between these two cadres of healthcare workers is essential, in order to ensure the quality of HIV test counselling services for pregnant women attending ANC. We conducted a study that explored the perspectives of healthcare workers on health system challenges related to the provision of PMTCT services in Fiji. In this paper we present the partial results of the large research project. The aim of this study was to understand the relationship between the government employed hospital healthcare workers and NGO-based HIV counsellors while providing HIV test counselling to pregnant women in ANC clinics.

Methodology

Study site

We conducted the study in the largest public hospitals in Suva, the capital city of Fiji and its associated reproductive health clinic known as Hub centre which provides follow up care to HIV positive women once they are discharged from the hospital. The hospital has less than 500 beds (Fiji- MoH 2018) and serves a catchment population of approximately 398 000 people. (Fiji-MoH 2012a). In 2017, the Maternity Unit had approximately 8500 deliveries WHO 2018. In 2012 the hospital under study had 133 doctors and 534 nurses and midwives in total (Fiji-MoH 2013) and approximately 3–4 NGO-based HIV counsellors. PMTCT services including HIV testing and counselling are currently provided to pregnant women attending the ANC clinic in this hospital.

Study design

This study took an exploratory descriptive qualitative approach that used in-depth interviews to explore the relationship between the government employed healthcare workers and NGO-based HIV counsellors while working alongside in providing HIV test counselling to pregnant women in ANC clinics in Suva. A qualitative descriptive design was considered most appropriate for generating date about healthcare workers different personal experiences while working alongside in the hospital.

Study participants

Study participants included government employed hospital healthcare workers and NGO-based HIV counsellors, both involved in the provision of PMTCT services. The NGO-based HIV counsellors were mainly responsible for assisting the government employed hospital healthcare workers by providing pre- and post-test HIV counselling services to pregnant women attending ANC. Healthcare workers were approached through the Head of the Department for Obstetrics and Gynaecology and by the midwife in charge of the antenatal clinic, both of whom arranged for written information about the study to be sent to potential participants. A total of 15 healthcare workers were invited to take part in the study. Of these, two refused to participate, with one indicating that this was due to their busy work schedule (no reason was given by the other). The healthcare workers who expressed their interest to participate were scheduled for an interview at a time convenient to them. A total of 15 healthcare providers including doctors ($n = 4$), midwives ($n = 5$), nurses ($n = 4$), and HIV counsellors ($n = 2$) were interviewed.

Data collection

The lead investigator (AR) conducted the individual face-to-face, in-depth interviews between April and May 2013. The healthcare workers recruited via purposive sampling. During the interviews, participants were asked questions relating to pre and post HIV test counselling service provision in the ANC, including timeliness and availability of HIV counselling and testing service, duration of counselling, staffing and PMTCT training. The questions were used as a guide only, with participants encouraged to freely explore all issues to enable a deeper and richer understanding of the topics under study.

The interview schedules of previously published qualitative studies of HIV-related health services were reviewed to inform the development of the interview guide (Washington et al., 2008;

Nguyen et al., 2009). An interview guide from a study conducted in a similar setting was also used as a basis for this Tynan et al. (2018). All interviews were conducted in English and audio recorded, with permission to do this sought at the beginning of each interview. The duration of each interview varied between 30 min to an hour.

Data analysis

A thematic analysis approach was employed to analyse the data. The interviews were transcribed verbatim (by AR). During transcription, the data was de-identified, by using pseudonyms instead of actual names. All transcripts were double-checked against the audio recordings to ensure no errors occurred during transcription.

A draft code list was prepared by carefully checking the first five interview transcripts to derive codes by hand (by AR). The draft code list was independently checked by the study's co-author (JT). Subsequently, the final code list was developed (AR and JT). All interview transcripts were coded using NVivo 10 data management software (AR).

An inductive coding technique was employed, where themes were derived from the interview data that were relevant to the study's objective. The selection of codes was discussed between the authors (AR and JT) prior to their integration into themes. Codes describing similar types of data were grouped to identify a theme. The emerging themes were validated after discussion amongst authors (Creswell 2014).

Ethical consideration

Ethical approval was obtained from the University of New South Wales Human Research Ethics Committee (Ref: HCHC12460) and the Fiji National Research Ethics Committee (Ref: HC12460). To ensure transparency in communication, each participant was given a detailed participant information sheet. Written consent was also obtained from all participants, prior to their participation in the study.

Results

Characteristic of the study participants

All of the healthcare workers that participated in the study identified as female and had over five years of experience (with an average of seven years' experience) working in ANC and PMTCT service provision (Table 1). Only a few of the government employed healthcare workers had received training on PMTCT in the previous two years. All healthcare workers in this study expressed an interest in attending training in PMTCT.

The main theme identified in this study was the tension between the government employed hospital healthcare workers and NGO-based HIV counsellors in relation to providing HIV testing and counselling to pregnant women attending ANC. The three main contributing factors were poor referral rates for HIV test counselling, lack of cooperation, and differences in counselling approaches (Fig. 1).

Referral

Poor referral rates for HIV test counselling (from the government employed hospital healthcare workers to the NGO-based HIV counsellors) was one issue identified by the NGO-based HIV counsellors who participated in the study.

> The referral here is not good, some staff follows [the protocols] and send mothers to us and some hardly send mum's [pregnant women] to us – then we have to go in the wards to get hold of them to give their HIV test results.
>
> (Interview_14, NGO-based HIV counsellor).

> We should be actually doing 100% [counselling] under our MoH [protocols] but then it comes down to these people level – they are not referring [pregnant women] back to us for post-test counselling.
>
> (Interview_10, NGO-based HIV counsellor).

NGO-based HIV counsellors considered poor referrals as a major challenge to the provision of quality ANC. The NGO-based HIV counsellors emphasised the need to improve the referral process from the government employed hospital healthcare workers to ensure quality counselling is provided to pregnant women.

> They [the hospital staff] don't refer the mothers back to us and we miss on their post-test. I feel it's not good. Because mothers should know their result– but a challenge is we can't get hold of them, and we can't reemphasize about the preventive measures and window period.
>
> (Interview_14, NGO-based HIV counsellor).

Most of the government employed hospital healthcare workers in this study stated that hospital staff mainly used the NGO-based HIV counsellors for pre-HIV test counselling, as well as for general counselling (such as for issues related to domestic violence). NGO-based counsellors were rarely used to provide post-test counselling for HIV negative cases. Rather, the government employed midwives or doctors informed pregnant women about their negative test results, without the women undergoing post-test counselling. All the NGO-based counsellors considered that post-test counselling for negative cases was vital, as counsellors could reinforce HIV preventive measures and risk reduction behaviours. Despite this, the NGO-based counsellors felt they were not given adequate opportunities to provide post-test counselling for negative cases, as pregnant women were seldom referred to them for this purpose.

A similar practice was observed in relation to post-test counselling for HIV positive cases. At the time of data collection, the NGO-based HIV counsellors were not part of the core PMTCT hospital staff in Suva, meaning post-test HIV counselling for HIV positive pregnant women was instead provided by government employed hospital staff or the specialised PMTCT team, which in-

Table 1
Characteristics of Healthcare Workers.

Characteristics of healthcare workers	N
Sex	
Male [1]	0
Female	15
Ethnicity	
Fijian	11
Indo-Fijian	4
Profession/occupation	
Medical Doctors/specialists	4
Midwives	5
Nurses	4
NGO-based HIV counsellors	2
Years of Experience	
Under 5 years	6
5 years and over	9
Attended training in the last two years	
Yes	3
No	12
Would like to attend a PMTCT training/ refresher course	
Yes	15
No	0

[1] The majority of the HCWs were female, however there were only one male, and he was unable to participate in this study due to his busy schedule.

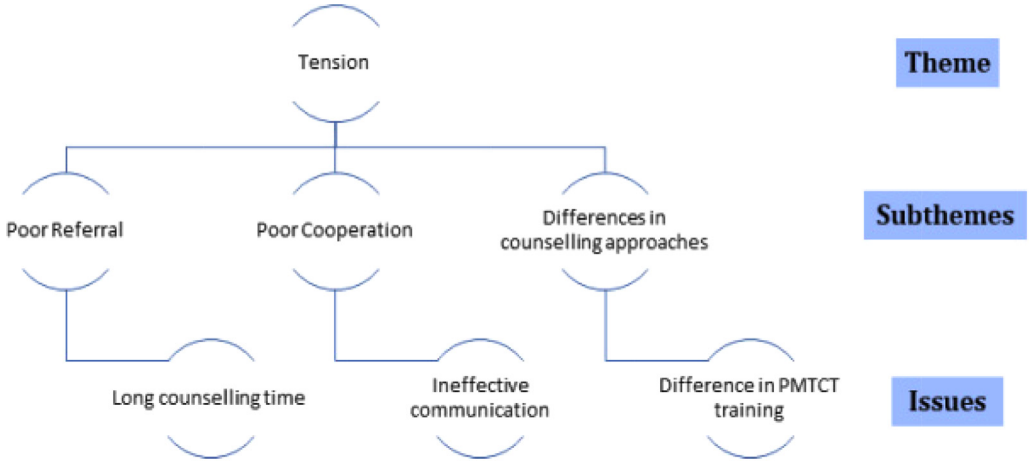

Fig. 1. Summary of the themes, subthemes, and issues.

cluded a trained PMTCT doctor, paediatrician, and a senior PMTCT midwife.

In addition, ANC was provided at different stations within the hospital. For instance, when a pregnant woman attends an initial booking appointment, she is attended to by a nurse or midwife at the registration desk. After her file is prepared, she is then sent for HIV pre-test counselling. After the counselling session, she is sent for blood testing, followed by a routine check-up with a midwife. Lastly, the woman is seen by a doctor. Disruptions or delays in the flow of women through the stations were reported to cause administrative problems, including long wait times for pregnant women. Hospital employed healthcare workers expressed their concerns about NGO-based HIV counsellors taking a "long time" (approximately 40 min) to counsel a woman, causing disruptions to patient flow across hospital stations:

> Well, my only problem with counselling group is their counselling time, it's too long. You know, if there are 40 new bookings a day, there are so many stations, this pregnant woman needs to visit in this booking day … so if counsellors are taking long, we'll pull in women who have come late [from counselling]. So, this women will be offended that she is now late in the queue because of long counselling time.
>
> (Interview_5, Midwife)

Cooperation

Poor cooperation between the different cadres was repeatedly mentioned as a major barrier to service provision. The need to improve cooperation between government employed healthcare workers was raised by the NGO-based HIV counsellors, as well as a few of the government employed hospital healthcare workers. Both NGO counsellors participating in this study expressed concerns that they found it difficult to perform their work due to a lack of cooperation from the government employed hospital healthcare workers. One NGO-based HIV counsellor also expressed some frustration towards the government employed hospital healthcare workers, as they felt they did not support the NGO-based HIV counsellors.

> Sometimes when the Ministry of Health staff doesn't cooperate with us. I think that's a big challenge, because when they don't cooperate, we, can't do our work properly … it's hard for us … I think it is mostly the barrier between us.
>
> (Interview_ 10, NGO-based HIV counsellor)

> [Due to lack of post-test counselling] we are not able to really measure whether their [pregnant women's] risky behaviour change has happened or not – Also, we are unable to produce a good result for Ministry of Health that in this hospital, we had this number of bookings, and this number of pre-test and post-test HIV counselling is given by us.
>
> (Interview_ 12, NGO-based HIV counsellor)

> We are a non-government organisation, who are working with them, so the decision to send [pregnant women] for counselling is with them. We cannot interfere because MoH is the one to decide. We have tried to address it [the issue] but… it's not working fine.
>
> (Interview_ 12, NGO-based HIV counsellor)

In addition, the NGO-based HIV counsellors and some hospital healthcare workers identified a need for improved communication. One doctor noted that clearly defined shared goals were needed to ensure effective cooperation between both groups, and that quality services are being provided to pregnant women.

> We really need to work at finding a common ground and help each other out because we're working towards the same goal … You know, because in the end the patient suffers.
>
> (Interview_2, Doctor)

Different approaches to counselling

Almost all of the government employed hospital healthcare workers were concerned that the NGO-based HIV counsellors did not consistently recommend HIV testing to pregnant women during pre-test counselling. Most of the government employed hospital healthcare workers reported that when hospital nurses and midwives counselled pregnant women, they focused on PMTCT services and recommended that they undergo HIV testing at their first ANC visit. By comparison, NGO-based HIV counsellors were reported to primarily focus on getting informed consent from the pregnant woman by providing HIV related information. During pre-test counselling, they did not recommend HIV testing or place emphasis on the importance of knowing the mother's HIV status for the benefit of her unborn child. The government employed hospital healthcare workers felt this was having a negative impact on the effectiveness of PMTCT services:

> We recommend to the mother to do [HIV] testing – NGO counsellors–They tell the mother this is your right [to go for HIV testing or not], Yes, it is the mother's right, but what about

> the right of the unborn child if the mother is refusing to be tested. We've had cases where mothers refused [HIV test] – then baby came back sick [HIV positive], so it was a missed opportunity here –so I feel it depends on how well, you advocate for the woman to be screened because if you're telling the woman you don't want to take a sick baby home, and this is an opportunity to screened.
>
> (Interview_5, Midwife)

Government employed hospital staff utilise a PITC approach by recommending HIV testing to pregnant women and encouraging them to learn their HIV status. This indicates a significant difference in the NGO-based HIV counselling approach, as the NGO-based counsellors focus on gaining informed consent without recommending HIV testing to pregnant women during pre-test counselling. The government employed hospital healthcare workers in this study argued that knowing the mother's HIV status was important, so that PMTCT services could be offered at an early stage of gestation to prevent vertical transmission. One of the doctors suggested that the NGO-based HIV counsellors needed to have a better understanding of PMTCT services, so that they recognised that ensuring pregnant women know their HIV status and allowing HIV positive women to access timely and effective treatment would benefit both the mother and her baby.

> The two counselling groups have two different agendas. For them [NGO based HIV counsellors], they want to carry out the counselling you know, that consent process – because to me, their box to tick is you know, that information giving to women and all that – I don't know, to us it's different. We are driving [for HIV testing] because we are offering it for (PMTCT). So to us, we try to get the lady to consent and we try to tell her that knowing her status, is very important especially for her baby.
>
> (Interview_4, Doctor)

One of the senior doctors felt that NGO-based HIV counsellors should be involved in PMTCT training facilitated by clinicians, so they could have a better understanding of the PMTCT program and clinicians' perspectives. This indicates that both groups of healthcare workers have trained differently on providing HIV counselling and testing. As one participant described the situation:

> They're [NGO counsellors] quite territorial about counselling. But I'm hoping to get one of the counsellors in leadership to come and attend one of our PPTCT [prevention of parent to child transmission of HIV] trainings. So, that they can understand, their point of view will change, and they will see where we are coming from …. They need to be trained on PPTCT because they are such an important part of the whole process.
>
> (Inteview_2, Doctor)

Discussion

A strong tension was identified between hospital employed healthcare workers and NGO based HIV counsellors, both of whom have responsibility for delivering HIV counselling and testing services in Suva, Fiji. This tension between the groups was mainly attributed to differences in their counselling approaches. Our findings highlight that an inadequate referral process (for both pre- and post-test counselling) from the government employed hospital healthcare staff to the NGO-based HIV counsellors, a lack of effective communication, and fundamental differences in the counselling approaches of the two groups were key factors driving this tension. Similar tensions between healthcare workers have also been reported elsewhere (Ferguson et al., 2012; Winestone et al., 2012).

Poor referral rates for HIV test counselling (particularly post-test) were considered a major challenge in providing HIV test counselling to pregnant women attending ANC. This finding was supported by the Empower Pacific report (2015) published during the study period, which indicated the rates of HIV post-test counselling sessions in our study site were considerably lower than in other two divisional hospitals. In 2014, approximately 41% of pregnant women received post-test counselling at the study site, whereas 75% of pregnant women received HIV post-test counselling sessions at a main hospital in Lautoka and 73% at a hospital in Lambasa (Empower Pacific 2015). This suggests an urgent need to improve the referral processes surrounding HIV test counselling at this leading hospital in Suva.

Our findings indicated that issue of counselling, in particular, arose as a source of tension between both groups of healthcare workers providing ANC services to pregnant women. Previous research has also shown that professional hierarchy, workplace cultural differences, and differences in professional education or training could be associated with workplace tension hindering effective collaboration between healthcare workers (Fewster-Thuente and Velsor-Friefrich 2008; Baker et al., 2011).

Part of the issue is explained by differences in the counselling approach of each group of healthcare workers. As both the VCT (human rights) and PITC (biomedical) approaches have partially trickled down to the ANC level, both groups of healthcare workers were taking different sides of the international HIV testing debate (Fields and Kaplan 2011; Apanga et al., 2015; Yahaya et al., 2010; Hardon et al., 2011; De Cock et al. 2006).

The findings of this study contribute to the extensive debates that have arisen due to the shift from the VCT approach to the PITC approach and questioning the effectiveness of both testing approaches. Many public health experts consider the VCT approach to be an ineffective approach to HIV testing due to low uptake. Therefore, many advocate for the PITC approach, which is more of a biomedical approach to testing (De-Cock and Bunnell 2006; Fields and Kaplan 2011) that allows more people to be tested for HIV and commenced on treatment. However, human rights experts express concerns over the PITC approach, because it could undermine the voluntary nature of consent for HIV testing (Meursing and Sibindi 2000; Allwood et al., 1992). The literature indicates that women may find it difficult to decline HIV testing when receiving care under the PITC approach, due to the power differential between patients and healthcare workers (Evans and Ndirangu 2011; Obermeyer and Osborn 2007), and thus patients may feel compelled to accept HIV testing (Wiseman et al., 2017).

In our study, we found the government employed hospital healthcare workers employed the PITC approach and encouraged pregnant women to know their HIV status so that PMTCT services could be offered to HIV positive pregnant women to prevent transmission to their unborn child. In comparison, the NGO-based HIV counsellors employed more voluntary counselling to ensure that pregnant women could make informed choices about HIV testing, without imposing their own advice on them during pre-test counselling.

The lack of an aligned counselling services amongst healthcare workers could have a negative impact on the quality of HIV counselling services being provided to pregnant women. In this study, most of the government employed hospital healthcare workers felt that the NGO-based HIV counsellors did not focus on PMTCT services when providing HIV counselling services to pregnant women. This was considered a clinical risk, as it was thought to have an adverse impact on efforts to reduce mother-to-child HIV transmission. Therefore, resolving tension between both groups of healthcare workers is an important factor that needs to be addressed to ensure the provision of quality HIV counselling services in Fiji.

Recommendations

Our findings suggest that to reduce this tension, both groups of healthcare workers need to have a mutual understanding and agreement on a streamlined HIV test counselling approach. One of the most effective strategies to resolve tension would be to involve both the NGO-based HIV counsellors and government employed hospital healthcare workers in the standardised PMTCT and human rights approach-based HIV counselling training. This is facilitated in partnership with the Fijian Ministry of Health (Nguyen et al., 2009) and the NGO-based HIV counselling group. It could be beneficial for both groups of healthcare workers to understand each other's perspectives, and would also bridge gaps in provider knowledge (Rujumba et al., 2013). This is critically essential in providing consistent and streamlined HIV counselling services to pregnant women attending ANC in Fiji. Additionally, Fiji's national HIV counselling policy could be modified to better reflect the global standard, to ensure that high-quality HIV screening is being provided in ANC.

Another feasible solution to overcome tension would be to improve communication about HIV test counselling by scheduling regular meetings between both groups of healthcare workers. Studies have shown that communication (Mbindyo et al., 2009; Mickan and Rodger 2005; Garcia et al., 2011) is essential in facilitating information sharing, resolving conflicts (Mickan et al., 2010; Nzinga et al., 2009), and building relationships (Mbindyo et al., 2009) amongst healthcare workers, including HIV workers. In Tanzania, effective communication amongst HIV workers was considered as one of the main facilitators of quality improvement in HIV care, resulting in increased access to antiretroviral therapy and higher rates of patient retention (Garcia et al., 2011). Several studies from low-resource countries have also linked scheduling regular meetings between different cadres of health workers (Kaboru et al., 2006; Mutemwa et al., 2013) with improved communication and maintained coordination between groups (Kaboru et al., 2006; Bergman et al., 2016). This intervention is likely to be effective in improving coordinated care in Fiji, as it will enable both groups of healthcare workers to understand each other's perspectives and provide opportunities to resolve any issues between them. Further research that encompasses in-depth interviews with pregnant women attending ANC would be beneficial in gaining a better understanding of the health system challenges facing the provision of HIV testing and counselling services. This would also provide greater insight into their implications in context of the Asia-Pacific Region.

Limitations of the study

Our study has some limitations that should be considered when interpreting the results. Firstly, due to budget constraints, the scope of the study could not explore the relationship between government employed hospital healthcare workers and NGO-based HIV counsellors across different health facilities that provide HIV testing and counselling services to pregnant women. Secondly, the study reported the experiences of healthcare workers only and not pregnant women with experience of the services. However, a strength of the study included collecting and triangulating data from healthcare workers at different levels.

Conclusion

Tensions between government employed hospital healthcare workers and NGO-based HIV counsellors providing HIV testing and counselling services to pregnant women in Suva, Fiji was a major barrier to service provision. A lack of an adequate referral system, cooperation issues, and differences in counselling approaches were the main factors identified as creating this. The difference in counselling approaches appears to be the primary challenge to effective provision of HIV counselling services in the ANC.

Simple interventions, such as scheduling regular meetings and facilitating standardised HIV testing and counselling training for all cadres of healthcare workers, should relieve some of the identified tension. There is also a need for a mutual agreement between staff to utilise a common HIV test counselling approach, as this would be an imperative step in providing streamlined HIV counselling services to women attending ANC in Fiji.

Ethical approval

Ethics approvals from the University of New South Wales Human Research Ethics Committee (Ref. HCHC12460), and the Fiji National Research Ethics committee (approval /identification code 012 67) were obtained.

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Authors' contributions

AA and JT designed the study. AR performed the analysis and interpreted the data and JT reviewed it. AR prepared the manuscript. AR, AA, NS and CRG critically reviewed all draft versions of the manuscript. All authors read and approved the final manuscript.

Declaration of Competing Interest

The authors declare that they have no conflict of interest.

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