


# Moving Beyond Debate to Implementation

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Social science that makes a difference

HSRC
Human Sciences Research Council

# Preamble

- The dynamics of a rapidly changing epidemic requires review of current and new strategies
- The primary aim of the NSP is to reduce the number of new HIV infections by 50% by 2011.
- Not enough people know their status
- Time for debate and artificial polarisation is over!
- Require dramatic expansion in the accessibility, availability and utilization of counselling and testing services
- Expanded response needs to include client and provider initiated models (both medical bias)

# Preamble (2)

- One size doesn't fit all: Let's think of a continuum of testing strategies or approaches
- Each with different outcomes but with similar protections
- All C and T should be voluntary, informed and confidential
- Let's collect the evidence as we proceed

# Preamble (3)

- NSP acknowledges that HIV and AIDS is a human rights issue:
  - … seeks to create a social environment that encourages many more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support (p**)
  - Promotion of compulsory or involuntary testing is dangerous and undermines our efforts
  - VCT studies: conscious, voluntary decision to test likely to change behaviour.
  - Coercion and little preparation: less likely to change behaviour and more likely to fuel stigma

# Expanded Response (1)

- Requires consideration of various factors:
  - The range of behavioural, socio economic factors that shape testing behaviour utilisation and uptake
  - Real and perceived stigma remains biggest barrier
    - Individual fears: testing positive, consequences of positive diagnosis, stigmatisation, disease and death
    - Systemic factors: breaches of confidentiality, lack of trust in health system, fear of discrimination

# Expanded Response (2)

- Create and promote a culture of testing
- How do we make testing normative? What beliefs undermine the testing message?
- How do we reach those who are asymptomatic and choose not to know?

# Improve delivery of Testing in Medical Settings

- How
- How

# Implement Provider Initiated Approaches

1. Review and adapt current draft SA policy that spells out what this means in practice
2. Routine offer individuals at increased risk (STI, TB, Family Planning and RH, ANC)
3. Asymptomatic, but in at-risk categories

- Find innovative and creative ways for increasing CT uptake in the general population, with particular emphasis on youth, men and non-reproductive health services

1. Pre-test information as part of these models if acceptable, but should not replace IC for a test

# Move Beyond Medical Settings

- Need to reduce the costs and inconvenience factors…make it easy for people to test
- Expand **CT services** in community- based and non-medical settings, including work place settings
  - Youth centres
  - Higher education centres
  - Outreach services e.g. mobile centres, facilities to reach SWs, MSM, truck drivers, etc
- Find innovative and creative ways for attracting men, and couples and families to testing
- Need to integrated, linkages with treatment, care and support
- Start piloting a few models in some provinces

# Training

- Consider the readiness and implications for RT roll out for health system provisions:
  - Human resources
  - and health systems
- Recognise and expand successful models where lay counsellors and volunteers conduct testing
- Need to formalise the status of HCW as recognised cadre
- All those involved in testing need to be trained in relevant testing models
- Broaden the range of trained personnel  who are permitted to deliver appropriate C and T services
  - Address the scope of practice
  - Remuneration and career pathing of lay counsellors
- A protocol that allows for qualified persons (other than professional nurses) to conduct rapid HIV testing is urgently required
- All need to be trained in relevant models of HIV testing

# Counselling and testing Considerations

- Promote and implement evidence-based counselling and testing models taking into account context and target groups and the additional risks faced by vulnerable groups

- Improve and maintain the quality of counselling
  - Standards for C and related care services to be determined and monitored
  - Minimum standards for counselling, yet flexible to take account of individual needs
  - Counselling to be done in a way that encourages testing
  - C and T at all times to be done in a non-coersive way

- Address the system factors that limit VCT uptake in medical settings

# Conclusion

- More plans?!
  - Urgently re-draft the current VCT policy that it is in line with NSP and WHO policy
  - Government does need to drive this
  - We need an operational plan that spells out drivers, costs, and where implementation will occur
  - We need to start now!