



HIV TESTING SERVICES NACOSA MODEL CASE STUDY

To raise an AIDS-free generation, both primary and secondary HIV prevention were adopted during the second phase of the Global Fund Grant. The OVC programme therefore focused on the provision of HIV prevention information and HIV Testing Services (HTS). This was an important new component to the programme that also aimed to provide organisations with information on the HIV status of their beneficiaries, which would in turn shape their future programming.

NACOSA sub-recipients aimed to ensure that at least 80% of OVC in their programme (or 41 120 individuals) had received an HIV test and knew their status by 31 March 2016. A review of the quantitative monitoring data found that despite a slow start, overall target numbers for OVC testing were met and a large number of OVC (8,440) were tested for HIV in NACOSA programmes by the end of the reporting period.

The aim of this case study is to draw out some of the achievements and challenges and key lessons learned from the implementation of HTS and HIV prevention programmes in organisations within NACOSA's network.

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BACKGROUND

NACOSA is a national civil society network of organisations working in the HIV/AIDS, TB and related social development fields. It consists of more than 1500 members, most of whom are community-based organisation, who are working to collectively turn the tide on HIV/AIDS and TB and build healthier communities. Under the Global Fund programme, NACOSA directly funded 29 provincially based CBOs to implement the OVC programme, called sub-recipients (SRs), and has larger contractual relationships with Childline South Africa and the National Association of Child Care Workers (NACCW) (both of whom were included in the evaluation as additional case studies).

The organisations they fund work in the coastal provinces of South Africa, namely Eastern Cape, Kwazulu-Natal, Northern Cape and Western Cape.

To achieve its aims, NACOSA employs a model it calls Community Systems Strengthening that aims to improve the well-being of OVC within a strong family/household and community context and to strengthen community-based systems that support young people and families. Through their network of sub-recipients, NACOSA aims to build capacity across three levels:

- **Community Level:** SRs participate in or initiate community Child Care Forums as platforms for custodians of children to come together to address issues facing children in their local community.
- **Household Level:** Through the Circles of Support programme, CYCW facilitate weekly meetings with caregivers for six weeks to discuss key issues relating to the welfare of the OVC for whom they are caring.
- **Individual Level (OVC and caregivers):** Psychosocial support, material support (school uniforms), emergency nutritional support for malnourished children and HTS. Trained CYCW also ensure appropriate referral to other services, including specialised community resources.

Engaging across all three of these levels was often necessary to ensure effective delivery of HTS and prevention information.

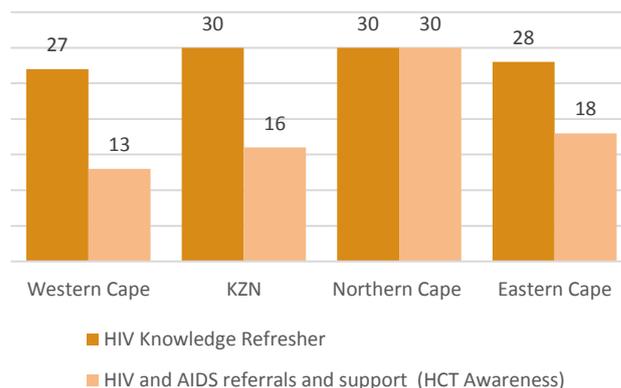
HTS training provided by NACOSA

Each of the NACOSA's SR's implementing testing and prevention services somewhat differently, depending on the organisational structure and history. However, through the GF programme, all received addition training and support from NACOSA focused on the delivery of:

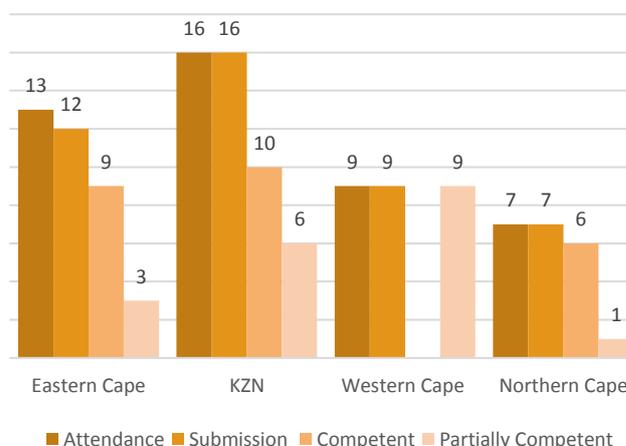
- HIV Testing Services (HTS)
- HIV Prevention / Refresher
- Procurement and Supply Management (PSM)

The HTS training provided by NACOSA was provided over 10 days with a two month workplace general practical. The training programme was

Number of carers attending HTS refresher training



Number of carers receiving HTS training in 2014



aligned to the Further Education and Training Certificate (FETC) in Counselling at NQF Level 4. The HTS training covered basic counselling skills, how to conduct pre and post HIV/AIDS test counselling and how to provide support and counselling to those already infected and affected. Overall, 67 care workers were trained as part of NACOSA's HTS programme. The figure below shows the numbers trained per province and those that were deemed competent in 2014.

In addition to those trained in 2014, 23 additional care workers received training in 2015. As displayed in the figure below, this brought the total number of care workers trained to 67; 35 were deemed competent, 26 partially competent and 6 deemed not competent.

An additional HIV 3-day refresher course was also offered to OVC carers focused on General HIV Knowledge (this was offered in 2013) and Testing

Children for HIV (this was offered in 2014). This was provided to 192 attendees from NACOSA SRs.

With regards to the training on PSM, the training covered a number of different topics including policies and legal framework, staff management, health product management, data management and programme management. This provided SRs with a broad understanding of the key elements for the procurement, supply and/or distribution of HIV testing and condoms. It included, for example, how to monitor HTS and condom distributions, how to deal with stock and waste management, and how to incorporate HTS and condom distribution into the larger organisational strategy.

Nature of HTS provided

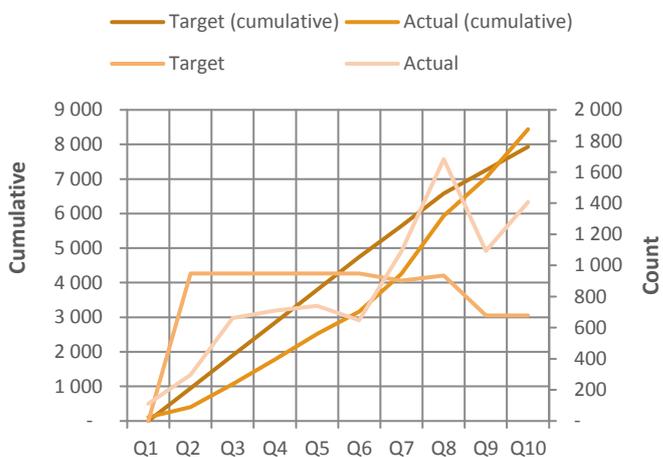
A central element of the NACOSA model, as described above, is the involvement of the household and community, as well as the OVC, in the provision of services. This was evident in the multi-stage strategies organisations used to ensure community and family buy-in to the testing programme:

“Besides the care workers of Global Fund, we have a peer educator who will sit with the carers and briefs them. They will then go and debrief the children...the educational talk is assisting us a lot. After we have done this within the community, the parents will come and say ‘this child is in the programme, but this one is not, and we want them to be tested.’ We brief the family within the house because this is where the stigma is, so that if they do find out that a child in the house is . We start with the family...we don’t force them to be in the programme but only if they agree that the children can be part of the programme.” – Programme Manager, NACOSA SR, Northern Cape

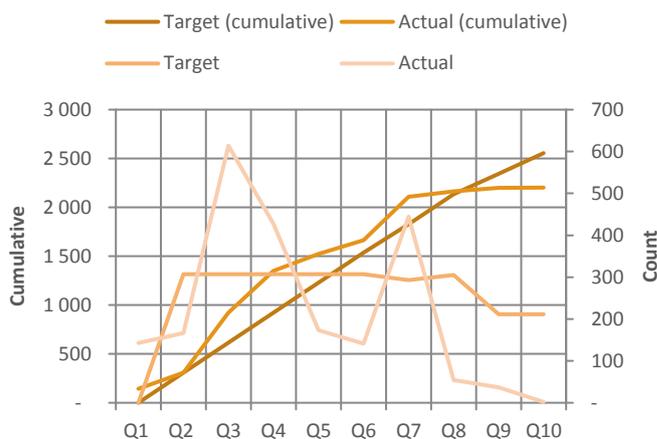
Overall, NACOSA SR’S did the majority of testing themselves (8 440 OVCs tested) rather than referring to other service providers (2202 OVC’s successfully referred). They also tried to provide these services as part of broader holistic models of care, including school work assurances, ARV adherence, parent communication and other activities. Figures 4 and 5 below show the number of OVC tested for HIV that received their results and the number of OVC referred for an HIV test

that receive their results respectively. As evident in the graphs, NACOSA SRs met and exceeded their targets in terms of the number of OVC ‘knowing their status’.

Number of OVC Tested for HIV and Received the Result



Number of OVC Referred for an HIV Test and Know Result



SUCCESSSES

Overall, managers at the SR’s reported that as a result of the GF programme, people were more informed, less afraid to test and more willing to talk about HIV.

“The stigma around testing and HIV/AIDS in general within the community is slowly decreasing. This is a result of the work of community workers who educate the community members on HIV/AIDS related issues and the support provided.” – Director, NACOSA SR, Eastern Cape

In addition to overall reductions in stigma, managers described how trust in the organisations' staff had increased over time. It was also explained that as parents became more comfortable talking about HIV/AIDS, they came to realise the benefits of knowing their status, and were more willing to test themselves and their children.

One organisation, which does not do HIV testing themselves, has developed an efficient system for engaging families through pre-test education and counselling, working with the local hospital to deliver the testing service, and then following up with post-test services for both HIV-positive and HIV-negative young people. In this process, they are careful to respect the confidentiality of all participants, offering services and counselling without forcing families to disclose should they not feel comfortable doing so.

“Over time people in the community have learned to trust us and are now coming forward to have themselves tested, very few people are afraid to come forward and test. That means our campaigns are working. We have also noticed that the number of positive people is dropping this year”. – Programme Manager, NACOSA SR, Eastern Cape



Image by Millennium Promise

For some organisations, the provision of HTS was a new service they were able to offer as a result of training and support provided through the GF programme, and was something that they felt provided an important new benefit to the children and families they worked with, especially in areas where testing services had previously been difficult

to access. They spoke of the benefits of ensuring that all the children in their programmes knew their status so that effective care could be given.

“Yes, now each and every child in the programme knows their status. Or even if we don't have that child's results, the guardian or the parent knows that child's results and status.” – OVC Coordinator, NACOSA SR, KZN

Managers also described how the availability of testing services at their organisations had made it easier for individuals to test because they did not have to wait for clinic staff to be available to provide them with HTS. Further, managers pointed out that the programme also had a positive impact on local clinic staff because it had reduced their burden of delivering all the testing services in the area, and had also improved their relationship with the Department of Health. Organisations describe the great value of the collaborative relationships they had built with local clinic staff, which enabled them to work together to achieve target numbers and test more children, as well as to procure test kits.

“The organisation has a good relationship with the clinic...if the organisation needs to reach more children to meet their target they will share this with the clinic counsellor. For example, if the target is 30, the organisation will test 10 and the clinic will test 20. They get test kits from the clinic for free.” – Programme Manager, NACOSA SR, Northern Cape

This staff member also emphasised the importance of following up after the HIV test to ensure that the test results led to better prevention and care:

“The carers know that if a child test positive, they are a priority. We know the problem within the community...what's the use of asking people to come and test...even if they test negative you need to support them to stay negative. If they are positive, we support them as there is a long road to travel.” – Programme Manager, NACOSA SR, Northern Cape

For others, who had already been providing HTS before the start of the GF programme, it was useful in providing new training and skills.

“Global Fund provided us with a lot of training and learning opportunities in terms of HTS, especially around the safe keeping of our patient files, best-practice protocols, remaining up to date with HTS-related policy changes, optimal temperature and conditions for storing testing kits and so on.” – Programme Manager, NACOSA SR, KZN

Overall, the quality of training was emphasised by a number of managers at NACOSA organisations, and was suggested to be a key element in the success of the programme.

CHALLENGES IN DELIVERING HTS

One of the key challenges that managers at NACOSA SR’s recounted was related to stigma and unwillingness to test, usually on the side of parents and caregivers. In some places, organisation staff found that despite their efforts to provide additional information and education, individuals were still reticent to test, although they did identify some positive shifts:

“Because of the high stigma associated with being HIV positive we have been struggling to find out what we should really do in order to make people to come and do the testing. However, we thought we should go to schools and spread information and encourage people to test, and we also did outreach programmes but that has not really worked. However, we are starting to see some change with people coming bit by bit but it is not enough. Many people are still not coming forth.” – Programme Manager, NACOSA, Western Cape

It was also suggested that parents who know their children are HIV positive are choosing not to bring their children to the organisations to be tested because of concerns about stigma or about revealing the HIV status of other family members through the child’s test results:

“Yes. The main challenge is that parents do not like to have their children tested, although children themselves would love to test but the parents would refuse them doing it. Another thing is that you find that the children who are on treatment, their parents do not like people

discussing the status of their children.” – Programme Manager, NACOSA SR, KZN

“The problem is that we are not allowed to test children without consulting and getting permission from caregivers and when we deal with them most of them are very defensive and in denial because you would find that a child lost their parent due to HIV and the family members do not want to take the child for testing because they are afraid of the results. So we have that challenge of convincing the family members to agree to the child doing the test, and it is not always easy at all.” – Programme Manager, NACOSA SR, Western Cape

One organisation also reported practical challenges obtaining the test kits in the start of the programme, which they said had affected their testing uptake number in the start of the programme, though they had worked hard to catch up.

Because of the high target numbers, some organisations felt a great deal of pressure to ensure that they met targets, despite individuals’ resistances and practical implementation challenges. This meant that staff sometimes had to work long hours and developed different strategies for incentivising participation or increasing numbers, sometimes at the cost of quality of care. Although SRs were paid an additional amount per person tested, over and above other stipends received monthly, it seems that some care workers still struggled with the targets set:

“On the negative side, the targets for our organisation in terms of HTS were huge and have meant counsellors have to work weekends in order to meet the targets. It has meant that now our counsellors watch the clock – rather than spending as long as needed with a patient, they try to move on to the next patient in order to reach the stats.” – Programme Manager, NACOSA SR, KZN

On the other hand, the additional training and support provided by NACOSA under the GF programme also helped organisation staff to more effectively approach children and parents to provide them with sufficient information and build enough trust to encourage testing uptake.

CHANGES OVER THE COURSE OF PROGRAMME

While many staff spoke of these ongoing challenges, others identified that there had been positive changes since the start of the GF programme.

“When the testing of the children was started it was difficult to convince the client, the guardians, to test the children because they were worried about the trauma and everything but training that the councillors were given and also the capacity around HIV and benefits of knowing your status, it make it easy. It was a challenge at first but with all the support that we get it makes it to be one of the good things that we want.” – Director, NACOSA SR, Eastern Cape

More broadly, managers at a number of organisations highlighted how the GF programme had significantly shifted their attention towards the important of testing children in order to ensure that they were able to receive adequate care and had ensured that they had the training and resources to do so.

FACING THE FUTURE

Some organisations staff spoke frankly about the ways in which the funding imperatives were shaping how they understood service provision:

“We did not before think that our job was to push towards HTS but it's very much becoming the focus it's very important in our holistic approach plus it seems like future funding will be based on how much prevention work you do. So that's very much changed our focus looking into the future.” – Programme Manager, NACOSA SR, KZN

In general, most organisation managers stated that they hoped to continue to provide HTS if they are able, often by partnering with the local clinic or hospital.

This case study was compiled by Creative Consulting and Development Works (developmentworks.co.za) for NACOSA and NRASD, monitored by the Department for Social Development.



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