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# Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case study of the City of Johannesburg, Gauteng

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**Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case study of the City of Johannesburg, Gauteng**




A dissertation on a research study presented to
the Department of Social Work
School of Human and Community Development
Faculty of Humanities
University of the Witwatersrand

In fulfilling of the requirements
for the degree Master of Arts (Social Work)

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March 2020

**CANDIDATE'S DECLARATION**

University of the Witwatersrand, Johannesburg

School of Human and Community Development

I, Jeffries Zwelithini Khosa (Student number: 2237859), am a student registered for Master of Arts (Social Work) in the year 2019. I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that ALL the work submitted for assessment for the above course is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.



Signature: Date: 16.03.2020

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**ABSTRACT**

The primary goal of the Joint United Nations Programme on HIV/AIDS (UNAIDS) is to bring an end to the HIV/AIDS epidemic as a public health threat by 2030. To achieve this goal, UNAIDS introduced the 90-90-90 HIV target, in which 30 million people worldwide would be on treatment, 90% of people living with HIV would know their status, 90% who know their status would be on antiretroviral (ARV) therapy, and 90% on ARVs would attain viral suppression. South Africa adopted the strategy by engaging with various stakeholders, including non-profit organisations (NPOs). Drop-in centres (DICs) are among the NPOs funded by the Department of Social Development (DSD) and supported by USAID/PEPFAR funded organisations. The aim of the study was to explore the strategies employed by DICs in contributing to the 90-90-90 HIV target realisation. The study employed a qualitative case study design. Using a non-probability purposive sampling technique, five DICs were sampled from which four employees were selected per DIC and totalling 20 participants. Semi-structured interviews using an interview schedule were conducted to collect data. Data was analysed using thematic analysis. The study's findings demonstrate that DICs have established strategies that facilitate their contribution to the 90-90-90-HIV target. While the implementation of these strategies has been enhanced by the presence of policy, the findings also indicate that four DICs do not have an HIV policy or rollout strategy. The study recommends that DICs have a policy document to help streamline the implementation of strategies in a more structured manner. The study also recommends that DSD support the sustainability of structured programmes introduced by USAID-funded organisations in DICs.

**Keywords: 90-90-90 HIV target, Drop-in centres, Strategies, HIV/AIDS, Contribution**

**TABLE OF CONTENTS**

CANDIDATE'S DECLARATION ..... i

ACKNOWLEDGEMENTS ..... ii

ABSTRACT ..... iii

LIST OF TABLES ..... viii

LIST OF FIGURES ..... viii

ABBREVIATIONS ..... ix

CHAPTER 1: INTRODUCTION ..... 1

1.1 Background to the Study ..... 1

1.2 Statement of the Problem and Rationale for the Study ..... 2

1.3 Research Question ..... 5

1.4 Aim of the Study ..... 5

1.5 Objectives of the Study ..... 6

1.6 Definition of Concepts ..... 6

1.6.1 Drop-in centre ..... 6

1.6.2 90-90-90 HIV target ..... 6

1.6.3 HIV ..... 6

1.6.4 AIDS ..... 7

1.6.5 Strategy ..... 7

1.6.6 Contribution ..... 7

1.7 Organisation of Report ..... 7

CHAPTER 2: THEORETICAL FRAMEWORK & LITERATURE REVIEW ..... 9

2.1 Theoretical Framework ..... 9

2.1.1 Organisational theory ..... 9

2.2 Literature Review ..... 11

2.2.1 Introduction ..... 11
2.2.2 Statistics ..... 12
2.3 Drop-in centres-South African perspective ..... 15
2.4 90-90-90 ..... 17
2.4.2 HIV services management plan as a strategy to reach 90-90-90 HIV target ..... 24
2.4.3 Role players in 90-90-90 HIV target ..... 28
2.4.4 Importance of partnerships and support in HIV services ..... 31
2.4.5 Support ..... 35
2.4.6 Programmatic services to enhance children's development ..... 38
2.4.7 HIV counselling and testing (HCT) as a strategy for 90-90-90 target ..... 38
2.4.8 Supervision as a strategic approach to improve HIV service delivery ..... 40
2.4.9 Confidentiality as a strategy to avoid isolation and stigmatisation ..... 41
2.4.10 Communication as a strategy for HIV services ..... 43
2.4.11 Possible obstacles to reaching the 90-90-90 HIV target ..... 45
2.4.12 Countries' success in reaching the 90-90-90 HIV target ..... 48
2.4.13 Conclusion ..... 52
CHAPTER 3: RESEARCH METHODOLOGY ..... 54
3.1 Approach of the Study ..... 54
3.2 Research Design ..... 54
3.3 Study Population ..... 54
3.3.1 Sampling ..... 55
3.4 Research Instrument ..... 56
3.5 Pre-Testing ..... 57
3.6 Method of Data Collection ..... 57
3.7 Data Analysis ..... 58

3.8 Trustworthiness of the Study ..... 60
3.8.1 Credibility ..... 60
3.8.2 Transferability ..... 60
3.8.3 Dependability ..... 60
3.8.4 Conformability ..... 61
3.9 Ethical Considerations ..... 61
3.9.1 Respect and autonomy ..... 61
3.9.2 Informed consent ..... 62
3.9.3 Anonymity and confidentiality ..... 62
3.9.4 Voluntary participation ..... 62
3.10 Limitations and Delimitations of the Study ..... 63
3.11 Conclusion ..... 63
CHAPTER 4: PRESENTATION AND DISCUSSION OF THE FINDINGS ..... 64
4.1 Introduction ..... 64
4.2 Demographic Information ..... 65
4.3 Role Played by Organisational Governance in DIC Service Provision ..... 66
4.4 Importance and Role of Collaboration ..... 72
4.5 Driving Factors Behind Community Members Using Services ..... 78
4.6 Readiness to Provide Services to Community Members ..... 85
4.7 Inadequate Resources and Support ..... 91
4.8 Conclusion ..... 95
CHAPTER 5: MAIN FINDINGS, CONCLUSION & RECOMMENDATIONS ..... 96
5.1 Introduction ..... 96
5.2 Main Findings ..... 96
5.2.1 Objective 1: Facets of implementation plan ..... 96

5.2.2 Objective 2: Contribution of partnerships and support ..... 99
5.2.3 Objective 3: Contribution of structured programme ..... 102
5.2.4 Objective 4: DIC employees' knowledge and understanding ..... 105
5.2.5 Objective 5: Challenges for DIC employees ..... 110
5.3 Conclusion ..... 112
5.4 Recommendations from the study ..... 112
5.5 Recommendations for further research ..... 113
REFERENCES ..... 115
APPENDICES ..... 128
Appendix A: Participant Information Sheet ..... 128
Appendix B: Consent Form for Participation in the Study ..... 130
Appendix C: Consent Form for Audiotaping the Interview ..... 131
Appendix D: Research Instrument ..... 132
Appendices E to H: CO3 Forms ..... 133
Appendix I: Ethics Approval ..... 137
Appendix J: Certificate of Competence in Research Ethics ..... 138
Appendix K: Letter of Request to Conduct the Study in DICs ..... 139
Appendix L: Approval Letter from Khayalethu Crisis Centre ..... 140
Appendix M: Approval Letter from Clean Touch ..... 141
Appendix N: Approval Letter to Conduct Study from PUSH ..... 142
Appendix O: Approval Letter to Conduct Study from Siyabonga DIC ..... 143
Appendix P: Approval letter from Zenzele Counselling Project ..... 144

## LIST OF TABLES

Table 2.1: Buildings blocks for HIV testing services .....26
Table 4.1: Themes .....64
Table 4.2: Demographic profile of participants (N=20) .....65

## LIST OF FIGURES

Figure 2.1: South Africa HIV/AIDS data .....13
Figure 2.2: South Africa UNAIDS data, 2019 .....15
Figure 2.3: Communication techniques for HIV services .....44

**ABBREVIATIONS**

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| ART | Antiretroviral therapy |
| ARVs | Antiretrovirals |
| CCG | Community caregiver |
| DIC | Drop-in centre |
| DOH | Department of Health |
| DREAMS | Determined, Resilient, Empowered, AIDS-free, Mentored and Safe |
| DSD | Department of Social Development |
| HBHCT | Home-based HIV counselling and testing |
| HCT | HIV counselling and testing |
| HIV | Human immunodeficiency virus |
| NGO | Non-governmental organisation |
| NPO | Non-profit organisation |
| OVC | Orphans and vulnerable children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of mother-to-child transmission |
| PrEP | Pre-exposure prophylaxis |
| SAW | Social auxiliary worker |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |

| | |
|---|---|
| USAID | US Agency for International Development |
| YOLO | You Only Live Once |

# CHAPTER 1: INTRODUCTION

## 1.1 Background to the Study

Three decades into the HIV epidemic and the disease remains a global challenge, as demonstrated by research which has revealed HIV global statistics to be 1.7 million new infections each year and 37·9 million people living with HIV (Granich, Williams, Montaner, & Zuniga, 2017). South Africa has the largest number of HIV infections globally, with over 6 million people estimated to be living with HIV by the end of 2012 (Shisana, et al., 2014; Takuva, Brown, Pillay, Delpech, & Puren, 2017), increasing to 7.5 million in 2019 (UNAIDS, 2019).

To address this problem, in December 2014, the South African government adopted the 90-90-90 HIV target, launched by UNAIDS to help end the AIDS epidemic. Should this target be realised, 90% of individuals living with HIV will be diagnosed, and thereafter 90% of those diagnosed will be initiated to antiretroviral therapy (ART), ultimately 90% viral load suppression must be attained from those on ART. “It is suggested that if the 90-90-90 target can be achieved in 2020 it may have potential to transform and possibly end the AIDS epidemic in 2030” (Abrams & Strasser, 2015, p. 1).

The National Strategic Plan (2017–2022) adopted 90-90-90, to be achieved before 2022 (South African National AIDS Council, 2017). While achieving these ambitious targets had been made chiefly the responsibility of the Department of Health, doing so alone was practical challenging; hence assistance was needed from other stakeholders including other government departments, provincial governments, non-governmental organisations (NGOs), non-profit organisations (NPOs), communities and individual citizens.

The Department of Social Development (DSD), assisted by other partners such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the President’s Emergency Plan for AIDS Relief (PEPFAR), fulfils its mandate of contributing to the 90-90-90 HIV target by providing support to NPOs offering services to orphans and vulnerable children (OVC) and their families. According to Abrams and Strasser (2015), by focusing on children, the global community is in a better position to achieve an end to the paediatric HIV epidemic. UNAIDS/PEPFAR-funded organisations such as HIVSA, Pact South Africa and Anova, provide

HIV services focusing on reaching the 2020 UNAIDS 90-90-90 HIV target. According to section 213 of the Children's Act 38 of 2005, a DIC is a facility providing basic services aimed at meeting the emotional, physical and social development needs of vulnerable children. In line with HIV services, DICs being supported by these organisations and monitored by the HIV directorate from DSD are expected to provide HIV services to their beneficiaries. Some have trained personnel conducting on-site testing and some prepare their clients and refer them to clinics or other partners for testing.

This research examined DICs, focusing on the strategies they employ in addressing South Africa's 90-90-90 HIV target. This report detailed how the study unfolded according to the scientific process of research in the social sciences. It discusses the motivation for the study, presents a statement of the problem, and underlines the aims and objectives of the study. It defines the concepts and outlines the theoretical framework underpinning the study. The research report includes a review of the literature explored, the research methodology, the ethical considerations, and the limitations and delimitations of the study.

### 1.2 Statement of the Problem and Rationale for the Study

According to global estimates, at least 178 million children, 85% of whom live in sub-Saharan Africa, have lost at least one parent to HIV. These numbers include a sizeable group of older HIV-infected children (Pegurri, Konings, Crandall, & HaileSelassie, 2015). The figures provided indicate that orphans are at high risk of being infected by HIV compared with other children, with more than double the number of HIV infections occurring among orphaned youth in sub-Saharan Africa. Study conducted by Chae (2013) argues that orphaned children are at heightened risk of early sexual debut, so as a result they are classified high risk for HIV infection and other sexual transmitted diseases. Therefore, OVC are an important target for HIV testing in line with the 90-90-90 HIV target. DICs can act as an entry point in providing multiple health and social services for OVC, including facilitating access to HIV services (Patel, Matyanga, Nyamundaya, Chimedza, Webb, & Engelsmann, 2012). OVC are easily accessed through DICs as they visit the centre daily for a meal and homework assistance. They also attend different educational programmes, including HIV/AIDS-related programmes, depending on their needs and age group.

The 90-90-90 HIV target is a vehicle for achieving an HIV/AIDS-free generation by 2030 (Abrams & Strasser, 2015; Granich, Williams, et al., 2017). According to UNAIDS data (2019), in South Africa, 90% of people living with HIV know their status, 62% are on treatment and 54% are virally load-supressed. However, the statistics among children aged 0–14 years was reported to be 76%, 63% and 46%, respectively. The DICs' contribution to the 90-90-90 HIV target is included in these figures, which shows that, in order to fast-track the country's target, there is still a lot of work to be done in the testing of children. It raises questions about the strategies the DICs employ to encourage HIV testing, treatment and adherence. Therefore, establishing the availability and effectiveness of strategies employed by DICs was vital in ensuring HIV services that would help to achieve these targets. It is hoped that this information would boost their contribution, thus helping South Africa to realise its 2030 vision of an HIV-free generation.

The study focus was in investigating strategies used by DICs in region G of the City of Johannesburg, Gauteng province. The DICs funded by the DSD's HIV/AIDS directorate have standardised needs assessment tools for beneficiaries, including a form with child beneficiary information, which is referred to as CO3 (Appendices E to H). The CO3 form is completed by the community caregiver and submitted to the social auxiliary worker, and together they plan interventions based on the assessment outcomes. In Appendices E–H under the question of HIV status, there are two options. First, is known status and second is unknown status. If status is known, it is either reactive (R) (see Appendix E), or not-reactive (NR) (see Appendix F); this will be indicated in the comment space (see Appendices E, F,G and H). Consequently, the outcomes of the assessment would guide the intervention that the social auxiliary worker and the community caregiver would provide to the beneficiaries.

For example, if the outcome shows that status is known and is R, it means that the beneficiary will need adherence support to ensure that their viral load is supressed. Nansseu and Bigna (2017) stated that people who receive home visits are more likely to adhere to treatment given that the community caregiver would conduct home visits to provide adherence support and report the progress to the social auxiliary worker. Therefore, if the results are known and reported to be NR, it means that the beneficiary is HIV-negative. In this case, the service would only involve them in programmes that educate about HIV: how to maintain their HIV-negative status and the

importance of testing to ensure that they remain aware of their HIV status.

Unknown status (see Appendices G and H) may occur either because beneficiaries refused to disclose their status, or because they did not know their status. The services to this group would be to encourage disclosure or testing so that their status could become known.

The whole process of HIV services provided to children by DICs and the accurate record of such services is monitored by USAID-funded organisations, through their social workers (DSD-social worker from HIV directorate). In addition, DSD monitors social workers regarding their progress on the services appearing in the family care plan. As the CO3 form does not necessarily assist the organisation with a clear plan for HIV services, DICs should have tailored programmes to promote testing. DICs should have a strategy to support beneficiaries who are HIV positive to ensure that they adhere to the treatment protocol, thereby ensuring that their viral load is suppressed.

Another motivation for the study was that the researcher works with NPOs, including community home-based care and DICs that provide services to OVC. The researcher provides capacity building and support to these NPOs, focusing on case management and other deliverables required of DSD from the NPOs, based on the NPOs' individual needs. For example, if the NPO identifies a gap in its referral system, the researcher organises a workshop to educate it members about referral and supports them throughout the process of implementing the newly learned referral system.

The study was conducted due to lack of literature on the strategies employed by DICs in contributing to the 90-90-90 HIV target. The DICs give priority to children who are orphans and who have been made vulnerable through HIV or poverty in their households. The reason for focusing specifically on DICs was that many previous studies had focused on NGOs in general, and that relatively little research has investigated the contribution of DICs in addressing the 90-90-90 HIV target.

The study investigated the strategy employed by DICs to fast track HIV testing, treatment and adherence. The researcher was of the view that if the country could obtain support from all stakeholders, the 90-90-90 HIV target could be achieved. Therefore, DICs as stakeholders could contribute to accelerating the country's progress in reaching the 90-90-90 HIV target. The

researcher was inspired by the research outcome indicating that the 90-90-90 target would be achievable with proper planning, political will and funding (Levi, Raymond, Pozniak, Vernazza, Kohler, & Hill, 2016). UNAID data in 2018 denoted that Sweden had already achieved these targets. Sweden was the first country reported to have met all the UNAIDS 90-90-90 goals (Gisslén, Svedhem, Lindborg, Flamholc, Norrgren,Wendahl, Axelsson, Sönnerborg, 2017), this was positive remark which suggests that it is possible to reach these targets. Furthermore, inspiration was drawn from an African country, Botswana, a sub-Saharan country, which had made remarkable progress (86%-84%-81%), indicating that it was possible for African countries to succeed in achieving these targets, as suggested by Levi et al. (2016).

As these targets were yet to be achieved in South Africa, the findings from this research would benefit the organisations participating in the study as well as other individuals and organisations. It is hoped that, through this research, they may be able to address the gaps identified and move forward in assisting the government to realise its 90-90-90 HIV target. In the process, the organisations will be able to evaluate their services and it will create a room to improve HIV services provided to children and their families. Services by DICs are not limited to child beneficiaries, but take a holistic approach which extends to the entire household.

### 1.3 Research Question

What are the strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target?

### 1.4 Aim of the Study

The study aimed to explore the strategies employed by drop-in centres in contributing to the 90-90-90 HIV target that the South African government had adopted from UNAIDS.

## 1.5 Objectives of the Study

The objectives of the study were:

- To explore facets of the implementation plan for HIV testing and management for DICs
- To determine the views of DIC employees regarding the contribution of partnerships and support from different stakeholders on HIV services
- To explore the views of employees about structured programmes' contribution to promoting HIV testing, treatment and adherence
- To explore DIC employees' current knowledge and understanding of the strategies for reaching the 90-90-90 HIV target
- To explore the challenges faced by DIC employees in contributing to the 90-90-90 HIV target.

## 1.6 Definition of Concepts

### 1.6.1 Drop-in centre

According to section 213 of the Children's Act 38 of 2005, a drop-in centre is defined a formation which should provide basic services which are primarily aimed at meeting the emotional, physical and social development needs of vulnerable children.

### 1.6.2 90-90-90 HIV target

The 90-90-90 target refers to the UNAIDS target adopted by the South African government in 2014, which suggest that by 2020 indicating that by 2020, 90% of individuals living with HIV will be diagnosed, and thereafter 90% of those diagnosed will be initiated to antiretroviral therapy (ART), ultimately 90% viral load suppression must be attained from those on ART (Davies, Pinto, & Bras, 2015).

### 1.6.3 HIV

The human immunodeficiency virus (HIV) is an aggressive virus that attack a person immune system, precisely the CD4 cells, which primarily functions to help the immune system by defending a body against any infections. When untreated, the virus compromises the CD4 cells

(T cells) in the body which makes a person to be vulnerable to any other infections in their body, like cancer. Ultimately, the virus destroy so many cells in the body such that the person becomes weak and unable to function normal (Van Vuren & Von Der Marwitz, 2012).

### 1.6.4 AIDS

Acquired immune deficiency syndrome (AIDS) is the developed stage of HIV. In this stage a person's immune system is extremely compromised which make it easy for them to be attacked by any type of sickness since their body cannot defend against any sickness attacking the body. The sickness that attacks the body is referred to as opportunistic infections (Van Vuren & Von Der Marwitz, 2012).

### 1.6.5 Strategy

Strategy involve developing a doctrine such that when is properly followed will yield success in a long run (Kvint, 2010). Freedman (2015) stated that a strategy labels the way end results (goals) should be realised by certain means (resources).

### 1.6.6 Contribution

The contribution is the part played by a person or thing in bringing about a result or helping something to advance (Roberts, 2016). Any HIV service addressing HIV testing, treatment and adherence, whose data is reported, contributes to the HIV 90-90-90 target. DICs' data is reported to UNAIDS by DSD and USAID-funded organisations supporting them, which means they contribute in some form to HIV 90-90-90 target, whether towards the first 90 or all three 90s.

## 1.7 Organisation of Report

This dissertation report comprises five chapters.

**Chapter 1: Introduction**

This chapter is introduces and provides a background to the study, discussing its relevance, motivation and rationale its aims and objectives, definitions of concepts and the study outline.

**Chapter 2: Theoretical framework and literature review**

This chapter outlines the theoretical framework of the study and the literature review. Included in

the literature review is a historic overview of HIV/AIDS and various views on issues in relation to OVC and the 90-90-90 target. The literature review examines previous research in terms of strategies, services, role players and obstacles. The chapter concludes with a discussion of other countries' success in reaching the target.

**Chapter 3: Research design and methodology**

This chapter presents the nature of the study, research design, population and location of the study, sampling procedure, data collection methods and instruments, pilot testing, ethical considerations, data analysis and limitations of the study.

**Chapter 4: Presentation of study data**

This chapter focuses on the presentation of the data gathered in the study. The findings are presented according to themes and sub-themes.

**Chapter 5: CHAPTER 5: Main findings, conclusion & recommendations**

The study findings as they relate to the literature review are discussed in this chapter. The main findings are presented in line with the objectives of the study, and guided by the main theme and sub-theme.

# CHAPTER 2: THEORETICAL FRAMEWORK & LITERATURE REVIEW

## 2.1 Theoretical Framework

### 2.1.1 Organisational theory

Organisational theory emerged during the late 1800s and into the early 1900s. It was initiated by sociologist Max Weber's idealised view of organisational structure, which saw responsibilities for workers as clearly defined and behaviour as tightly controlled by the rules, policies and procedures of the organisation (Hatch & Cunliffe, 1997).

Henri Fayol is regarded as one of the fundamental contributor to organisational theory in the early 1900s. His strong contribution was on his theory which was focusing on good management as a way of ensuring a success of organisation, he cited strategic planning, staff recruitment, employee motivation and employee guidance as good management approach for success of the organisation (Hatch & Cunliffe, 1997; Nickerson & Zenger, 2002).

Douglas McGregor differentiated the organisational theory which was considered around the mid1900s. He emerged again in 1950s, he introduced Theory X and Theory Y aimed in explaining the various ways of ensuring good management and motivation of employees at the work place (McGregor, 2006). Theory X suggests that employees who want to be directed by their managers are more likely to avoid responsibilities and instead they just want to benefit financially than anything else. McGregor, in contrary to Theory X, suggest that Theory Y employees are productive. This theory incorporated a range of views: that humans could learn to accept and seek responsibility; that most people possessed a high degree of imaginative and problem-solving ability; that employees were capable of effective self-direction; and that self-actualisation was one of the most important rewards that organisations could give their workers.

Organisational theory is the study of organisational design, relationships and structures. It focuses on such dimensions as level of organisation formalisation, specialisation, standardisation, hierarchy of authority, complexity, size, goals and strategy. These dimensions provide a way of measuring and analysing organisations (Daft, 1997). The term 'organisation' refers to a group of individuals who come together to perform a set of tasks with the intent of accomplishing common objectives (Mazur, 2010). King, Felin and Whetten (2010) defined organisational theory as an assembly of people working together to achieve common objectives

through the division of labour. King, et al. (2010) determined that the organisation provided a means to use individual strengths within a group to achieve more than could be accomplished by the aggregate efforts of group members working individually.

Organisational considers organisations to be complex social actors, and investigates how the structures they adopt affect their behaviour. This theory addresses the broad questions of how and why organisations come to be, take the forms they do, behave as they do, and survive or fail. King, et al. (2010) stated that organisations were actors that could exert their influence on individuals, shape communities and transform their environments, and that they were legitimate mechanisms for societal change.

Organisational theory provides a detailed explanation of organisations, the importance of management style, the significance of policies within organisations, and the implementers of these policies and strategic plans, which are the employees. Consequently, the theory best suited for the study since the DICs are organisations and all aspects mentioned in the previous sentence applies to DICs. As part of the process, the researcher used the theory to explain what the organisations participating in the study had done in relation to HIV services. The HIV epidemic is responsible for the high number of orphans in South Africa, which prompted the government to adopt the HIV 90-90-90 target as an approach to bringing about social change (Abrams & Strasser, 2015; Granich, Williams, et al., 2017). Organisational theory was relevant to the study as it was aimed at exploring the contribution of drop-in centres (DICs) to the country's 90-90-90 HIV target. It was also relevant as it relates to organisations, which, in the case of this study were the DICs, the unit of analysis for the study.

The focus on human influences in organisations was observed and it was most noticeably with the integration of Abraham Maslow's hierarchy of human needs into organisational theory, indicating that people had different needs and were motivated by different incentives to achieve organisational objectives (Hatch & Cunliffe, 1997). Organisational theory looks at how the organisation brings together resources for its success, such as human resources, policies and procedures. The achievement of the 90-90-90 HIV target would determine the success of the organisation, which may require policies and human resources, again making organisational theory relevant to this study. Applying McGregor's approach of organisational theory through his X and Y explanation (McGregor, 2006), the researcher was able to explain the commitment

of the 11 organisation (employees) towards their objectives. This assisted in terms of exploring each organisation's strategies regarding their contribution to the 90-90-90 HIV target and the commitment of its employees.

## 2.2 Literature Review

### 2.2.1 Introduction

This literature review focuses on previous researchers' insights into the 90-90-90 HIV target in relation to orphans and vulnerable children (OVC) and their families, as well as the contribution of non-governmental organisations (NGOs), drop-in centres (DICs) and other non-profit organisations (NPOs). This section provides an overview of HIV/AIDS statistics in South Africa and explores the country's progress in reaching the 90-90-90 target. Reference to other literature was guided by the main objectives of the study. According to Gottlieb, Schroff, Schanker, Weisman, Fan, Wolf et al. (1981) and Siegal, Lopez, Hammer, Brown, Kornfeld, Gold . . . et al. (1981)., AIDS was identified as a new disease among homosexual men in the United States. They stated that it had been determined that the disease was transmitted through blood, drug injection, blood transfusion and sexual intercourse. Abdool Karim and Abdool Karim (2003) maintained that heterosexual sex contact was the dominant mode of transmission of HIV in Africa, adding that the first case of HIV in South Africa was reported in 1981. They confirmed that HIV prevalence was increasing annually and that around the year 2000, HIV had reached epidemic proportions in South Africa. In 2014, South Africa adopted the UNAIDS 90-90-90 HIV strategy towards the goal of an HIV free generation in 2030 (Abrams & Strasser, 2015). "The road to an AIDS-free generation will require bridging the gaps in HIV services and addressing the particular needs of children across the developmental spectrum from infancy through adolescence." (Abrams & Strasser, 2015, p. 2).

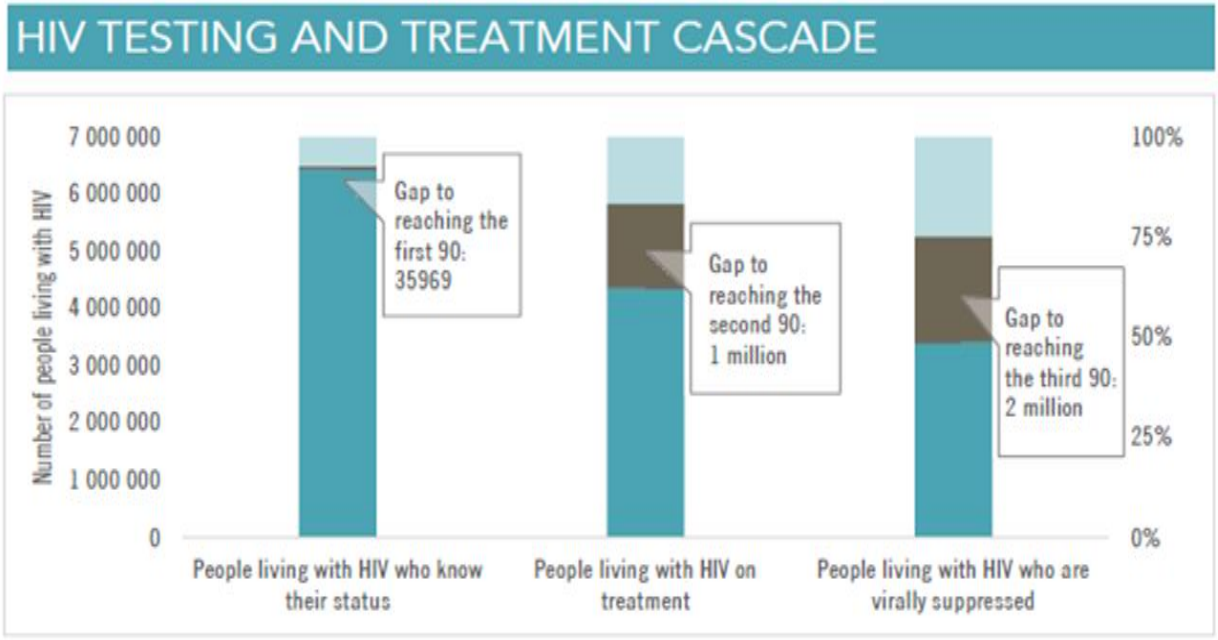
This literature review focuses on previous researchers' insights into the 90-90-90 HIV target in relation to orphans and vulnerable children (OVC) and their families, as well as the contribution of non-governmental organisations (NGOs), drop-in centres (DICs) and other non-profit organisations (NPOs). This section provides an overview of HIV/AIDS statistics in South Africa and explores the country's progress in reaching the 90-90-90 target. Reference to other literature was guided by the main objectives of the study.

In 2014, South Africa adopted the UNAIDS 90-90-90 HIV strategy towards the goal of an HIV-free generation in 2030 (Abrams & Strasser, 2015). “The road to an AIDS-free generation will require bridging the gaps in HIV services and addressing the particular needs of children across the developmental spectrum from infancy through adolescence.” (Abrams & Strasser, 2015, p. 2).

### 2.2.2 Statistics

UNAIDS data (2019) revealed that, globally, children were being overlooked in terms of HIV testing, treatment and adherence. Although 1.4 million new HIV infections had been averted since 2010, 180 000 children had become infected with HIV some born with it, some because of unprotected sex, far from the 2018 target of eliminating new HIV infections among children UNAIDS (2019). The other concern raised by the UNAIDS data (2019) was that, while the overall level of HIV treatment was high, a huge injustice was being perpetrated against children, and that only about half of the under-15s living with HIV were being treated.

Figure 2.1 illustrates that, by 2018, South Africa had reached the first '90', which was good progress for the country. However, the challenge was with the second 90, reported to be at 61%, meaning that about 39% of people who were HIV-positive were not on treatment. The other challenge was that, of the people on treatment, only 47% were adhering to treatment in that their viral load had been suppressed. Consequently, South Africa still had a long way go to realise the




| | | | |
|---|---|---|---|
| All ages | 90% [82– >95%] | 61% [56–66%] | 47% [43–52%] |
| Children (0–14) | 78% [60– >95%] | 58% [45–77%] | 45% [35–60%] |
| Women (15+) | 92% [85– >95%] | 66% [61–72%] | 51% [47–56%] |
| Men (15+) | 86% [78– >95%] | 53% [48–58%] | 41% [37–45%] |
| Is antiretroviral therapy provided in community settings (such as outside health facilities) for people who are stable on antiretroviral therapy? | | | Yes |

last two 90s.

**Figure 2.1: South Africa HIV/AIDS data**

**Source:** UNAIDS data **(2019)**

The results in Figure 2.1 illustrate that testing for children from 0–14 was at about 78%, which was

below the country's average of 90%. For the second and third 90s, children were below average, at 58% and 45%, respectively. These figures confirm the global concern by UNAIDS about children being left behind on HIV testing, treatment and adherence. Therefore, targeting children had become critical and the role of DICs was more important than ever before, as they were working with OVC who were more likely to be at high risk of HIV infection (Pegurri, et al., 2015).

Recently, UNAIDS published another data report for 2019 which highlighted that the time line for realising the target which was set by UNAIDS for 2020 is very close. They further denoted that determinations to reduce HIV infections were certainly not productive, and while AIDS-related deaths had been reduced, they fear that mortality target may not be achieved (UNAIDS, 2019). The 2019 report revealed that South Africa had increased its HIV spending by US$ 650 million among 2010 and 2018, and moreover 78% of total HIV resources in the country were domestic.

Figure 2.2 illustrates that South Africa had maintained its standing in having reached the first 90, as highlighted in the 2018 data (the country is at 90%), and that it had made some progress in the second 90, from 61% in 2018 to 62% in 2019, representing a 1% increase.

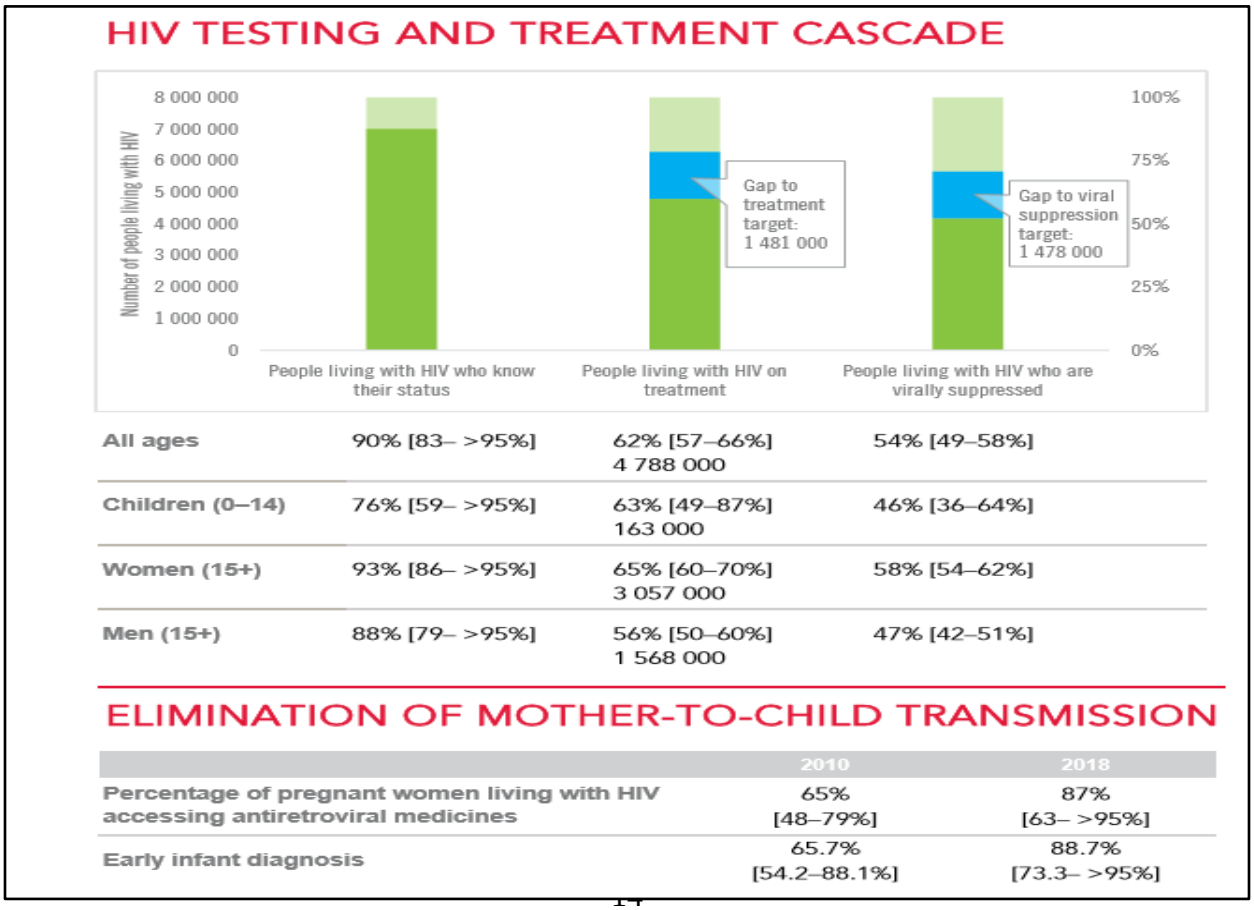


**Figure 2.2: South Africa UNAIDS data, 2019**

**Source**: UNAIDS (2019)

South Africa had also demonstrated progress with the last 90, having reported 54% in 2019, a 7% increase on the 2018 data (47%). In 2019, data for South Africa was at 90-62-54, indicating positive progress considering the country's track record with HIV for all age group. However, South Africa appears unlikely to be able to reach the actual target of 90-90-90 by 2020. For children aged 0–14, the 2019 data revealed a decline in the first 90 from the 2018 figures – in 2018, South Africa's progress for children was reported at 78-58-45, but in 2019 the figures stood at 76-63-46. Clearly, much still needs to be done regarding HIV services to children, which are lagging behind the rest of the population in achieving the 90-90-90 target. These figures confirm this study's relevance as the children were clients of DICs, most of whom could be accessed easily by community caregivers.

## 2.3 Drop-in centres-South African perspective

The authorities of South Africa has made the needs of all vulnerable children a precedence with the aid of mounting a multi-sectoral response involving most government agencies, civil society and international donors, ensuring that the required mechanisms and offerings are in place to provide noticeable assistance. These method goals to be wonderful in addressing modern-day and potential inclined children need (Department of Social Development, 2016). DICs in South Africa do so with support of DSD, USAID/PEPFAR funded organisations that provide financial support, capacity building support and structural support to implement HIV related programs aimed at ending AIDS by 2030.

History of carrying for orphans in South Africa shows that relatives and/or neighbours took orphaned children to take care of them before they were old enough to care for themselves. However, the growing increase in orphanage numbers and the spiralling poverty have made the continuation of this operation impossible for families and communities (Clarke, 2004). This is supported by Mahlase (2008), who argues that traditional extended family care services have now reached a point where they can no longer support more orphaned children because of financial difficulties. Similarly, DICs became an alternative care as a support system to these families. Furthermore, the introduction of foster care grant reduced financial strains to families

who are carrying for orphans and vulnerable children (Mahlase & Ntombela, 2011). According to section 213 of the Children's Act 38 of 2005, a drop-in centre is a facility providing basic services aimed at meeting the emotional, physical and social development needs of vulnerable children. DICs become very important formation to in addressing the diverse needs of vulnerable children. HIV/AIDS become one of the aspects.

According to children's Act 38 of 2005, the idea of drop-in centre is to provide the following services:

- counselling and psychological support;
- social and life skills;
- school holiday and educational programmes;
- primary health care in collaboration with local health clinics;
- outreach services;
- reporting and referral of children to social workers or other social service professionals; and
- prevention and early intervention programmes.

DICs may provide prevention and early intervention activities in addition to offering one of the basic services. Prevention services are aimed at improving and assisting families with children and helping them solve and prevent problems (Department of Social Development, 2016). For example, establishing relationships in a child's life with significant people, such as a school teacher, may help a child with scholastic issues and avoid a worsening of the issue. Early intervention services are offered to families who have defined children as vulnerable or at risk of harm (or removal) from their family environment. Besides offering one of the basic services, a drop-in centre may provide any of the approved programs that are suitable for the children attending the centre's developmental needs (Department of Social Development, 2016).

Prevention and early intervention activities include:

- assisting families to meet their basic needs;
- empowering families to meet their basic needs for themselves;
- providing families with information to enable them to access services;

- supporting and assisting families with a chronically ill or terminally ill family member;
- and promoting the well-being of children and the realisation of their full potential.

## 2.4 90-90-90

UUNAID data, 2018 mentioned that focusing on children is the key to realising an end to the HIV epidemic. Therefore, the role of DICs should not be underestimated since their special focus is vulnerable children.

#### 2.4.1.1 *Testing*

Testing is the only way for people to know their HIV status. A study conducted by Flowers, Duncan and Knussen (2003) asserted that HIV testing reduced the uncertainty of an unknown status. They added that fear of test results, and particularly fear of a positive result, was a central factor in people's testing decisions and influenced their decision to delay testing. While fear of positive results may present a problem in reaching the first 90, the pressure of living with uncertainty about one's status may embolden people to get tested (Flowers, et al., 2003). Research has shown that fear of stigmatisation, poor treatment from clinics (e.g. long queues and bad attitude by health care workers), or fears over HIV testing confidentiality were major barriers to people agreeing to be tested (WHO, 2014).

Research shows that in 2018 publication of diagnostic list was issued by WHO. This list provided details of test needed for priority medical conditions, among the list HIV test was mentioned, 15 which covers test like oral fluid rapid diagnostic tests and self-testing (Dave, et al., 2019).

The global drive to reach the 90-90-90 HIV goal had led to the implementation of a modern method of HIV testing (Dave, et al., 2019) – HIV self-tests that could be conducted by people at risk of infection, a procedure that was confirmed as accurate and simple to use. Granich, Gupta, Hall, Aberle-Grasse, Hader & Mermin, (2017) argued that the latest HIV self-tests were highly reliable, quick, could be performed in private without assistance, and could be read within a minute in some cases.

According to Dave, et al. (2019), self-test is vital since it will increase accessibility of testing amongst the population which is ready to take the test. Opinions have differed around the

introduction of self-testing for HIV, with some stakeholders expressing concern about the absence of pre-test and post-test counselling, particularly in the event that a test reveals a positive result (Granich, Gupta, et al., 2017). Proponents of the test have compared it with pregnancy self-tests, which were introduced nearly 40 years ago. They argued that this new technology, which seeks to democratize HIV testing, allows people who want to take the test in private rather than in a conventional health service environment access to testing. They contended that therapy was poorly performed both in a typical health environment, pre-testing and post-testing, and could not have been done at all. The hope was that care should be given to all those who tested negative for access to preventive services and to those who were diagnosed with HIV, preferably on the same results or testing day (Singh, Lee, Fenton & Preiksaitis, 2013).

WHO (2016) suggested that HIV testing and therapy should be provided in the sense of community mobilisation around the importance of knowing one's HIV status if a patient shows signs or symptoms of HIV infection or AIDS.

Improving the consistency and reliability of HIV testing services by programming good practices, some of which are discussed below, may be accomplished.

*Integration*

WHO (2016) indicated that if HIV testing can be incorporated with other health services, particularly people with tuberculosis (TB) and sexually transmitted infections (STIs), it will be more proactive. A reasoning was that this would increase the willingness of people to access HIV testing and carry it on. Research indicates that it would be easy for people to test for HIV when they enter a health facility for other services or tests, e.g. most patients testing positive for TB also test for HIV (WHO, 2012).

*Task sharing*

Another point described as good practice in HIV research was the sharing of tasks within the health sector, where tasks were spread among health-care workers ' cadres (Dave, et al., 2019). Community health workers, or qualified lay providers, were people from within a community who received much less training than physicians but who were willing to provide healthcare services where other human resources were limited. Considerable evidence has shown that

community health workers have improved the take-up of healthcare services and decreased inequality.

*Decentralisation*

Decentralization, considered one of the most successful approaches, means that HIV testing may be moved away from government facilities and health care services to locations where people routinely meet, such as home-based service agencies, drop-in centres, offices, schools, and places of worship. The advantages of decentralisation were decreased travel time to clinics and reduced overcrowding, thereby increasing the uptake of HIV testing (Aggleton, Yankah, & Crewe, 2011).

#### 2.4.1.2 *Adherence*

Adherence to ART is described as adhering to ART for viral suppression (Petersen, et al., 2016). Upon initiation of treatment, the aim was for patients to adhere to treatment to ensure viral suppression, which would prohibit them from spreading the infection to their partners, and to reap full health benefits from early initiation of treatment (Dutta, Barker & Kallarakal 2015). The UNAIDS 90-90-90 target required countries to have at least three lines of drug therapy (WHO, 2016). It was reported in 2016 that just five countries in sub-Saharan Africa are said to be implementing three line regimen (WHO, 2016).

Research conducted four countries Kenya, Mozambique, Peru and South Africa – which was observation therapy study, using ground workers like lay workers community care workers, peers, family members and so on, who helped patients take ARTs – confirmed sustained viral suppression (Garrett, et al., 2018). Several approaches used for this goal were CD4 counts, viral suppression, pill counts or self-reported adherence, as these consistent behavioural improvements will result in viral suppression clinical outcome (Dave, et al., 2019). These studies indicate that people who had help, especially from community workers, were more likely to adhere to treatment and were suppressed by their viral load. A high number of HIV-positive people usually receive help from their followers to care (Plax, Garbutt, & Kaushik, 2015).

The studies – all of which were performed in middle- or low-income countries – confirmed that certain community health workers, lay employees or others (e.g. friends or family) sent reminders to their loved ones who were HIV-positive to take their medication (Dave, et al., 2019). The studies

were focused in different activities like the issues of food security as it relate to taking of treatment, other provision of incentive to community workers and its impact on support to patient taking ART. Others focused on the alternative use of things like alarm, adherence diaries, counselling etc. to ensure adherence. (Petersen, et al., 2016).

According to a study conducted by Dave, et al. (2019) entitled "Which community-based HIV initiatives are effective in achieving UNAIDS 90-90-90 targets? A systematic review and meta-analysis of evidence (2007–2018)", community-based approaches have shown success in tailoring their application to the context of a country or culture. In a community setting where multiple concurrent partners have been popular, voluntary HIV therapy and testing by couples has not been an alternative to increased HIV testing. Kilembe, et al. (2015) suggested that a better strategy to enhance uptake on HIV testing would be an integrated or combined test or treat strategy, which meant the organisation that provided testing should be able to initiate treatment and possibly provide support for adherence. The study by Dave, et al. (2019) found that HIV campaigns were often used to promote testing and treatment; reach out to community by health service providers and educational programmes; and digital strategies (technology interventions) were deployed for viral suppression.

The study suggested that localized outreach programs such as mobile outreach and home-based HIV testing and therapy services were recognized for the first 90 as a way of targeting marginalized communities who may not have exposed themselves to testing facilities in the health care sector (Dave, et al. 2019). Research has shown that community health workers or lay people have been most effective in initiating care relationships, which is the second 90 (September & Meehan, 2016). For example, integrated testing and evaluation with innovative antenatal care integration programs have been effective in achieving the second target (Bassett, et al., 2014). The success of these linkages can be attributed to its nature which took into account the needs of the population (Bigna, Plottel & Koulla-Shiro, 2016). One significant contributor to the success of the second 90 was the availability at the same time and location of both CD4 count checking and ART initiation services (Bigna, et al., 2016). Similarly, same-day HIV testing and initiation of ART had been demonstrated to enhance treatment retention and subsequent virological suppression (Dave, et al., 2019).

With respect to the last 90, the integration of linkage to care services with micro-clinics and informal social networks, which were normally used for the management and prevention of chronic disease, could increase linkages and subsequent viral suppression (Bassett, et al., 2014). Dave, et al. (2019)

argued that changing tasks was effective in minimizing the workload in hospitals or clinics, and could benefit broader populations. Although the inconsistent timing of home visits may have adversely affected the adherence of patients; more frequent visits have had the ability to close the distance. Shifting activities in all areas of the continuum of care was not only cost-effective, but community-based HIV programs could also help meet UNAIDS 90 90 90 goals (Bigna, et al., 2016). Enhancing ART adherence and viral suppression technology was a successful alternative, as regular text messages promoted adherence (Daher, et al., 2017).

In addition to patients who had received an HIV-positive diagnosis and been linked to a clinic for the initiation of treatment, home-based care service workers for HIV services were likely to encounter people who were not willing to start with treatment (Fehr, Nicca, Goffard, Haerry, Diazaraque & Lederberger, 2013). Fehr, et al. (2013) suggested several reasons why people may wish to delay starting treatment, based on surveys of HIV-positive people. Barriers to starting treatment included:

- fear of side effects
- reluctance to take many pills several times a day
- difficulty integrating pill-taking into their lives.

Nearly 20 years after the initial release of ART, therapy has become much easier (often requiring treatment only once a day; full regimens are available in one pill), healthier and more effective. Nonetheless, given the many advantages of beginning early (McNairy & El-, 2014), there were still HIV- people who did not want to start treatment. Prompt introduction of ART co- at an individual level. Evidence has shown that a decline in HIV has helped ease ongoing damage to the immune system, brain, heart, lungs, kidneys and other essential organs and systems (Fehr, et al., 2013; McNairy & El-, 2014). Taking ART every day, as directed, and frequent check-ups for sexually transmitted infections have significantly reduced the potential risk of HIV spread (McNairy & El-Sadr, 2014), which has benefited the population as a whole. In the 90 90 90 goal, people who were reluctant to take care directly affected the second and last 90s as their numbers had been reported in the first 90 studies.

European Union and Australian researchers conducted a survey of HIV-positive patients and their physicians about perceived obstacles to beginning ART (McNairy & El-Sadr, 2014). Review of this study showed that there were still obstacles to starting therapy but were distinct from those of the late

1990s. McNairy and El-Sadr (2014) suggested that a primary obstacle among HIV-positive people was that they may not have felt sufficiently unwell or may have missed significant symptoms that would facilitate their entrance into care (McNairy & El-Sadr, 2014).

The development of ART had turned what was once an almost always-fatal infection into a manageable chronic condition. However, this was only possible when infected people maintained taking daily antiretroviral therapy, which could reduce the amount of HIV in their blood to undetectable levels (Mussini, Lorenzini, Cozzi-Lepri, Lapadula, Marchetti, Nicastri, . . . Manfrin, 2015). Remaining on treatment was crucial to keeping the virus suppressed (McNairy & El-Sadr, 2014).

Research has determined that antiretroviral therapy prevented HIV from making copies of itself (McNairy & El-Sadr, 2014; Mussini, et al., 2015). Mussini, et al. (2015) explained that when a person living with HIV began an antiretroviral treatment regimen, their viral load decreased. McNairy & El-Sadr (2014) maintained that for everyone who started taking their HIV medication daily as prescribed; their viral load would drop to an undetectable level in six months or less. Mugavero, et al. (2012) claimed that continuing to take HIV medication as directed was imperative so that the virus may remain undetectable. A person was considered to have a durably undetectable viral load if their viral load remained undetectable for at least six months after their first undetectable test result (McNairy & El-Sadr, 2014; Mussini, et al., 2015). Subsequently, promoting adherence is of clinical importance and DICs are well positioned to promote adherence through home visits and accompanying client in clinics to take their medications.

However, even when a viral load was undetectable, HIV was still present in the body (McNairy & El-Sadr, 2014; Mussini, et al., 2015). The virus lay dormant inside a small number of cells in the body called viral reservoirs. When therapy was halted by missing doses, taking a treatment holiday or stopping treatment, the virus emerged and began to multiply, becoming detectable in the blood again (McNairy & El-Sadr, 2014; Mussini, et al., 2015). This newly reproducing virus was infectious. Therefore, continuing with treatment every day, as directed, was critical to achieving and maintaining a durably undetectable status (McNairy & El-Sadr, 2014; Mussini, et al., 2015).

One benefit of adhering to treatment was that there was effectively no risk of sexual transmission of HIV when the partner living with HIV had achieved an undetectable viral load and then maintained it for at least six months (Mussini, et al., 2015). Most people living with HIV who started taking antiretroviral therapy daily as prescribed achieved an undetectable viral load within one to six months after beginning treatment.

Research showed that when therapy was stopped, the viral load rebounded, and the risk of transmitting HIV to a sexual partner in the absence of other prevention methods returned (Mussini, et al., 2015). Taking antiretroviral treatment daily, as directed, to achieve and maintain durably undetectable status stopped HIV infections from progressing, helping people living with HIV to stay healthy and live longer, while also preventing sexual transmission. Stopping and restarting treatment could give rise to drug resistance, making that treatment regimen ineffective and limiting future treatment options (McNairy & El-Sadr, 2014; Mussini, et al., 2015).

Corless, Hoyt, Tyer-Viola, Sefcik, Kemppainen, Holzemer . . . Nicholas, (2017) and Denning (2016) acknowledged the effectiveness of ART, when taken appropriately, in preventing transmission to uninfected partners. This has raised the hopes of scientists, clinicians and, more particularly, those infected with HIV that transmission could be prevented. Corless et al. (2017) stated that previous research conducted in United States of America had found that about 22% of those who were prescribed ART globally were not virally suppressed owing to a lack of adherence to treatment. Consequently, we learn that the country may succeed with the first two 90s. However, if the last 90 (adherence) were not followed, the ultimate goal of ending HIV as a public health threat by 2030 may not be attainable and the percentage of AIDS-related deaths would eventually increase.

DICs became a vehicle for adherence to OVC and their families as they offered home visits to ensure that the infected member of a family who was on ART adhered to the treatment. A research by Nansseu and Bigna (2017), in sub-Saharan Africa, stated that after home-based HIV therapy and testing, 12 per cent of diagnosed people were put on HIV / AIDS treatment. The research of Corless et al. (2017), which used a quantitative approach and administered questionnaires to people who had been on treatment but had stopped taking it, suggested that most people defaulted on their treatment for the following reasons: self-efficacy, depression, stressful life events and stigma. These challenges could be addressed by DICs through their support programmes to children and their families, and through home visits.

The availability of medication played a vital role in meeting the 90-90-90 HIV target. This was inclusive of all medications for women, children and adults, and included medication prescribed for pregnant women. According to UNAIDS (2018), there was a gap in the provision of HIV medicine for children. Despite technological progress in research and development for new adult HIV drugs, the children's choices lagged considerably behind. The demand for HIV pharmaceutical drugs for children had almost vanished in high-income countries as new HIV infections among children were largely eliminated. This had since created a gap in HIV medication for children in low- and middle-income countries and had consequently affected the last 90, which was retaining HIV children on treatment or adherence.

One problem with adherence was children who were unable to be identified after HIV positive testing. Children were more vulnerable than adults to lack of follow-up because they relied on their parents or carers to obtain access to healthcare services (Jobson, et al., 2017). A lack of caregiver contact information, stigma and therapy barriers, the pressure on families to return for outcomes, and poor follow-up in clinics were some of the reasons children failed to follow-up (Jobson, et al., 2017). The services of DICs became important in assisting clinics with tracing patients lost to follow-up. It would be difficult for a country to realise the 90-90-90 HIV target if patients were not tracked down, as they would only be classified under the first 90 which would negatively affect outcomes for the last 90.

### 2.4.2 HIV services management plan as a strategy to reach 90-90-90 HIV target

The effective execution of HIV services relies on proper planning, focusing on the best way to manage the services, and tailoring them to the service provider’s setting and the needs of recipients (WHO, 2016). The purpose of the strategic strategy for health services was to recognize HIV in individuals who were not symptomatic, and who were not seeking treatment. This included getting HIV testing out of hospitals and into the community, reaching out to the most vulnerable who could find access to hospitals challenging (Dutta, et al., 2015). This required new and innovative ways to get people tested for HIV. For this plan to be successful, HIV testing had to be easily available, even in the most remote communities, which meant the cooperation of numerous role players (Hill & Pozniak, 2015; Grimsrud, Bygrave, & Wilkinson, 2018) argued that differentiated service delivery, or differentiated care was the best approach for HIV services as it was client-centred. Differentiated service delivery supported shifting resources

to clients who were most in need and, in the context of HIV testing, was aimed at developing HIV testing strategies targeted at identifying those people living with HIV (PLHIV) who did not yet know their status, with the aim of linking them to HIV care (Grimsrud, et al., 2016).

A differentiated service delivery approach would support programme managers to think through how to mobilise, test and link to care and prevention differently (Grimsrud, et al., 2018). Grimsrud, et al. (2018) cited a six-step approach to developing a strategic mix of HIV testing service delivery models, which would address missed opportunities and neglected populations. The strategic mix would be driven by the context, including HIV prevalence and current coverage of the first 90 target, in combination with assessing how available resources could be utilised most efficiently.

#### 2.4.2.1 *Conduct a situation analysis*

According to Grimsrud, et al. (2018), it was vital to conduct a situation analysis before deciding on the strategic mix of differentiated HIV testing services. Ideally, the situation analysis should identify gaps in achieving the first 90. The analysis should be comprehensive enough to include both gaps in geographical coverage and coverage by specific populations, and assess how existing testing strategies were addressing those gaps (Ndlovu, Ronan, Ngoato, Mark, & Hatane, 2019). This analysis should consider the three core components (mobilising, testing and linking) that composed a successful model of HIV testing. Harichund, Abdool Karim, Kunene, Simelane, and Moshabela (2019) stated that an HIV testing service delivery model should include three core components: mobilising; testing; and linking (see Table 2.1). The details of the components provided in the table help to specify the HIV rollout plan and may help fast-track the UNAIDS 90-90-90 target. Grimsrud, et al. (2018) argued that the analysis should include:

- Data related to the epidemiologic context
- Data on access and coverage of HTS for general and specific populations
- The existing policies (including HTS algorithm, quality control procedures and task sharing)
- The current service delivery models in place
- The perspectives of healthcare workers and clients.

**Table 2.1: Buildings blocks for HIV testing services**

| | **Mobilising** | **Testing** | **Linking** |
|---|---|---|---|
| **When?** | Time of day and frequency. | Time of day and frequency | Time period for linking and frequency of tracing. |
| **Where?** | Location of mobilisation activities. | Health facility<br>Non-health facility<br>Community. | Location of linkage activities. |
| **Who?** | Location of mobilisation activities. | Who does the HIV testing? | Who supports linkage to prevention? Who supports linkage to ART initiation? |
| **What?** | For HIV testing alone or with other services. | For HIV testing alone or with other services. | Prevention: SMS/phone Community-based tracing.<br>ART initiation: SMS/phone Community-based tracing. |

#### 2.4.2.2 *Define challenges*

After proper analysis of the situation, the outcome of the analysis must help in identifying challenges (Grimsrud, et al., 2018). Grimsrud, et al. (2016) argued that at this stage, it was vital to host meetings with different stakeholders to sensitise HIV testing coordinators and implementing partners on the background and core principles of differentiated HIV testing service delivery. They indicated that it was equally important to provide opportunities for other stakeholders to bring on board differentiated HTS, implemented for adults and specific populations in their settings, taking forward local/district situation analyses and planning local implementation strategies.

#### 2.4.2.3 *Define for whom HIV testing services will be differentiated*

With a clear understanding of the current service delivery programme and current challenges, it should be possible to identify which differentiated HTS models required prioritising, and it should be clear which population needed to be selected (WHO, 2016). Grimsrud, et al. (2016) stated that they were encouraged to map, process and evaluate viewpoints across the cascade and across specific vulnerable populations, such as children and adolescents, pregnant and breastfeeding women, or specific key populations, and tailor the services to their specific needs as per their geographical areas and other special needs.

#### 2.4.2.4 *Adapt or build models of differentiated HIV testing services*

When there was already a model for HTS roll-out and it was effective, it may be adopted (Grimsrud, et al., 2018). However, when assessing existing testing services, all three of the core components needed to be addressed (mobilising, testing and linking). Where there was no existing HTS model for a population within a given context, a new model should be built (Grimsrud, et al., 2016). The model should be based on the building blocks in Table 2.1.

#### 2.4.2.5 *Design a strategic mix of differentiated HIV testing service delivery models – adapt, build or drop*

The following factors determining this prioritisation should be included:

- The coverage of testing in specific high-risk populations (benefits of linking to both treatment and prevention)
- An accurate number of diagnoses by testing model
- Cost of specific models (cost per person diagnosed)

- Yield of specific models (Grimsrud, et al., 2018).

A strategic mix of HIV testing service delivery models at both facility and community level should be made. This prioritisation would assess the current resources available and lead to adapting, building or dropping some differentiated HIV testing service delivery models (Grimsrud, et al., 2016).

#### 2.4.2.6 *Evaluate and decide what further differentiated HIV testing service delivery models are required*

Once the differentiation had been selected and implemented, it should also be monitored through monitoring and evaluation and quality improvement initiatives to assess the feasibility of implementation (Grimsrud, et al., 2018). Analysis of the models may lead to further adaptations being suggested or, if successful, allow for the development of another model addressing different population gaps (Ndlovu, et al., 2019). The success of the strategy could be evaluated against the progress of the 90-90-90 HIV target (WHO, 2016).

### 2.4.3 Role players in 90-90-90 HIV target

Numerous role players and stakeholders were involved in meeting the 90-90-90 HIV target, both within and outside of the health service. These stakeholders included funding agencies, policy makers, researchers, implementing partners, ministries of health, industry (pharmaceutical and diagnostic), health care workers, non-profit and community-based organisations, as well as children, adolescents and caregivers (Idele, Gillespie, Porth, Suzuki, Mahy, Kasedde & Luo, 2014). The 90-90-90 HIV target gave every role player a chance to contribute their services and enforce partnerships with other stakeholders, i.e. it was not possible to realise the 90-90-90 HIV target in isolation, but institutions needed to work as a collective. The NPOs required support from different stakeholders to allow them to assist children in totality. The Department of Social Development's policy framework on orphans and other children made vulnerable by HIV/AIDS in South Africa, "Building a caring society together", gave a mandate to different government departments and NGOs in terms of their roles and responsibilities in addressing HIV/AIDS in children (Department of Social Development, 2005).

Parents plays an important role in HIV services provided to children as they had to give consent for children below the age of 12 without sufficient maturity (Children's Act No. 38 of 2005) The issue of a child giving consent at the age of 12 years or more, or less than 12 years but with sufficient maturity, was controversial in many communities in South Africa (Davies, et al., 2015). According to Davies, et al. (2015), parents were concerned about 12-year-olds giving consent for their own testing. They also expressed concern about the introduction of HIV counselling and testing (HCT) in schools, because if a child tested positive, he/she may decide to leave school, which had the potential to negatively affect the child's relationship with his/her parents. Davies, et al. (2015) pointed out that many people had argued against an initiative that encouraged children as young as 12 to have an HIV test independently. This was a challenge, as it went against societal norms, especially in black communities. Consequently, some parents would try to do everything possible to discourage their children from consenting to their own testing. To reduce this, HIV educational programs (like importance of testing, taking treatment, adhering and importance of disclosure by parents to their children) by social workers in collaboration with DICs may be imperative.

However, parents' support was required by DICs for them to reach the first 90 target, which is testing. Thereafter, parents should be encouraged to share the outcome of the testing with the DIC so that they could continually receive support from the organisation, especially when the child had a positive diagnosis. Children required an age-appropriate explanation of HIV/AIDS to broaden their understanding that if they tested positive, they would need to take medication. A higher level of adherence may come with understanding the benefits of taking the treatment.

In order to establish an efficient program, Ndimbwa, Emanuel and Mushi (2013) stated that programs should set specific targets, timetables, success metrics and reporting criteria, and assign the financial and human resources required to achieve program objectives. In order to prevent HIV spread and respond to the complex effects of HIV / AIDS on individuals, families and communities, Cabassi (2004) specified that organizations should:

- Ensure that HIV prevention, diagnosis, treatment, care and support services are incorporated into their own organizations, including successful referral mechanisms
- Ensure that they align their own initiatives with other applicable health and social services and programmes

- Promoting collaborative alliances to promote direct connections to other services and cooperative projects to meet specific needs.

Thurman, Luckett, Taylor and Carnay (2016) reported that, compared to those living in similar circumstances who did not receive program services, a home visiting program led to increasing levels of HIV testing among beneficiary children and their families who were beneficiaries of the system. The education and psychosocial support given by home visits will help child care group caregivers appreciate the benefits of HIV testing and cope with the effects of positive diagnosis, while also the HIV / AIDS-related stigma (Thurman et al., 2016).

This work will help to clarify how DIC initiatives are in place and how successful they are in reaching the 90 90 90 HIV goal. Sips, Mazanderani, Schneider, Greeff, Barten & Moshabela (2014) concluded that the design of successful strategies involved responsiveness to discrepancies in child and parent adherence experiences. They argued that adherence had to be adapted to the particular condition of each patient for programmatic measures to be strengthened and should include a thorough disclosure evaluation and the state of relationship between the child and parents. Where there was transparency, integrity and faith in a child care group caregiver (CCG) the system will be more successful (Sips, et al., 2014).

Research has shown that HIV adherence among children and their families and those participating in services funded by NGOs has increased. UNAIDS data (2018) reported on work carried out in Rwanda in 2014 where HIV-affected families focused on a locally tailored, home-based intervention. This aimed at improving the functioning of family and caregiver-child relationships, linking vulnerable families to formal and informal HIV services available, and fostering mental and behavioural wellbeing among children impacted by the HIV. The report revealed that children and adolescents (aged 7–17) from 20 separate families participated in the study. The results of the study showed that caregivers reported changes in children's behaviour six months after the intervention was carried out. The results also showed continued and enhanced family cohesion, effective parenting and social support. As a result of these measures an increase in the self-esteem of children has been identified and symptoms of depression, anxiety and irritability have decreased. This meant that having a service specific to HIV-affected families would increase the probability of acceptance and could improve the chances of children taking and adhering to their care. According to South Africa's national strategic plan for HIV, TB

and STIs 2017-2022, NGOs with assistance of the Department of Health and Department of Social Development are ground forces for programmatic interventions through home visits and the services they provided to both children and their families in their centres.

According to the World Health Organization (WHO, 2012), the program should have goals or objectives that are time-bound and must produce concrete results. WHO (2012) affirmed that the program needed to clearly define the positions and obligations of the different stakeholders involved in the roll-out. "Factored to the 90-90-90 rollout program, AIDS deaths could fall to 426 000 annually by 2020, with further reductions with expanded coverage possible" (Denning, 2016, p. 1). The best way to enforce the first goal of 90-90-90 was to ensure a regular test in the group, according to Abrams and Strasser (2015) and Nyberg et al. (2012). This study will also be administered to the NPOs functional group that includes OVC and their families. Abrams and Strasser (2015) added that this would be possible if employees (social auxiliary workers and community caregivers) were trained on the importance of, and proper approaches to, testing of children and educating parents about the importance of giving their consent to test their children.

The second 90 could be achieved by placing children who tested positive under HIV care and collecting data disaggregated by age to ensure better programme monitoring (Abrams & Strasser, 2015). The last 90 could be realised when ART was made universally available to all infants, children and adolescents, which would mean removing CD4 and clinical criteria for ART initiation and improving drug regimens and formulations (Abrams & Strasser, 2015). It was vital to research this aspect, as the challenge of DICs may be on their roll-out strategy for HIV. Consequently, to implement the plan, employees should understand its content. As most beneficiaries of DICs were children, employees must understand HIV/AIDS as it relates to children, as clarified in the Children's Act No. 38 of 2005.

### 2.4.4 Importance of partnerships and support in HIV services

Partnerships refer to cooperative and collaborative partnerships between various parties, both public and non-public, in which all members agreed to work together to achieve a shared goal or to perform a particular mission and share risks and obligations, resources and benefits as mutually agreed (WHO, 2014). Partnerships may be handled in several ways: either by a formal memorandum of understanding or a less formal agreement. Partnerships may be created to

achieve a range of results, e.g. service delivery, policy change, capacity development and resource mobilisation, as well as to develop and implement approaches aimed to achieve such results (e.g. guidance setting, awareness raising and knowledge sharing) (WHO, 2014). Regardless of the aims or priorities, collaborations with civil society need to be pragmatic, results-oriented and focused on sharing shared interests (WHO, 2014; Williamson, Wondergem, & Amenyah, 2014).

An example of the type of partnership that DICs could establish for HIV services may be found in Zambia, where people living with HIV had established a novel partnership with UNAIDS. In this scenario, networks of people living with HIV had implemented a process of capacity strengthening, empowerment and evidence gathering that had then been converted into joint evidence-informed advocacy (WHO, 2012). UNAIDS supported the establishment of a civil society engagement framework that sought to strengthen self-coordination among civil society organisations and provide a platform for advocacy with government and other partners (WHO, 2012).

Community mobilisation could facilitate larger structural changes that worked to empower communities to continually improve their lives (WHO, 2014). In the context of this study, this would be the DICs. As one of the motivations for mobilisation is living with HIV, knowledge of HIV status could be an important lever in community mobilisation, and could be accompanied by HIV testing in various settings. Community mobilisation was a critical enabler and could be divided into three categories:

*Outreach and engagement activities*

This was where the mobilising organisation went out to the communities and educated them or engaged with them about HIV/ AIDS ((Williamson, Wondergem & Amenyah, 2014).

*Support activities*

This occurred when the organisation took part in broader community activities that may not have been organised by them, but they participate because of good relationships with other community institutions or organisations (Williamson, et al., 2014).

*Advocacy*

The mobilising organisation became an advocate for people living with HIV, and ensured that they received treatment from clinics and other services from any institution of government or private institutions (Williamson, et al., 2014). Through community caregivers, DICs are advocating for the vulnerable population in communities. The study conducted by Mahlase & Ntombela (2011), shows that community caregivers are able to walk with their clients to clinics and depending on their condition, they may make arrangements with the clinics to collect medication of the clients on their behalf without the clients having to come to clinic. So, this level of advocacy promote adherence on HIV treatment, consequently, contribute to the last two 90s.

*Transparency*

Mobilising organisations such as DICs should be transparent to the community, which may be made possible by hosting an annual general meeting with community members (Williamson, et al., 2014).

*Accountability*

The organisation must be accountable for all the services it provided and also with respect to the financial aspects. This could be realised by ensuring that they provided audited annual financial statements. As per the researcher working experience with NGOs in South Africa are monitored by DSD social workers and the monitoring tool covers numerous aspects which financial aspect is one of them. It requires the audited financial statement and a policy on how they manage their finances. Subsequently, this promotes accountability.

According to Williamson, et al. (2014), community mobilisation could be strengthened through a community system, which was a systematic approach to promote the development of informed, capable and coordinated communities and community-based organisations. Hallmarks of effective community system strengthening included the involvement of a broad range of community actors who were allowed to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at a community level. Community system strengthening aimed to improve health outcomes by developing the role of key affected populations, communities and community-based organisations in the design, delivery, monitoring and evaluation of services, activities and programmes (Williamson, et al., 2014).

The research by Williamson, et al. (2014) was conducted in collaboration with NGOs, specifically churches. These churches, in partnership and collaboration with HIV organisations and the health sector, were reported to have increased organisational capacity organisational empowerment, to organise more effective and novel HIV/AIDS prevention activities (Coleman, Lindley, Annang, Saunders, & Gaddist, 2012).

Other outcomes included the organisational ability to establish new collaborations and partnerships with various HIV/AIDS agencies and churches with similar HIV/AIDS prevention goals (Coleman et al. 2012). Within the beneficiaries and community, increased HIV/AIDS-related knowledge and attitudes, and changes in HIV/AIDS-related stigma were reported (Coleman et al.2012). The churches' role in HIV/AIDS prevention intervention initiated open discussions about HIV/AIDS, willingness to get tested for HIV, increased overall knowledge about HIV/AIDS, and dispelled myths about its transmission. Also, many of the churches that received funding, especially category three funding, were able to engage and partner with other local and smaller churches to provide guidance and technical assistance to them as they implemented similar HIV/AIDS intervention models.

This research elucidated the importance of partnerships and collaboration in the South African context. NGOs that were in partnership with USAID and PEPFAR were equipped to receive training, resources and whatever else they may need to enhance their HIV services (Jobson, et al., 2017). Organisations were funded by USAID with different mandates: some to empower smaller individuals and organisations such as home-based caregivers and DICs; some were providing direct services such as testing children; were providing indirect services such as capacity building which focused on training caregivers and other staff to enhance the quality of HIV services provided to children and their families.

DICs were in partnership with the Department of Social Development (DSD), and DSD was working in collaboration with the Department of Health (DOH). Organisations such as Anova (USAID-funded) were in partnership with DOH, especially in Gauteng province, and were visible in most hospitals and clinics in the City of Johannesburg. They provided HIV services that included testing, initiating ART, monitoring adherence and conducting follow-ups (Jobson, et al., 2017). Therefore, partnerships and collaboration became vital in HIV services. NPOs that were not testing sites would need clinics, and other organisations funded by USAID or DOH to

provide such services to their clients. On the other hand, the clinics may need NPOs' assistance to trace some of the lost to follow-up patients who were linked with such NPOs as beneficiaries. This suggests that partnerships and collaboration enhanced HIV services and helped parties involved to realise their goals and targets. Consequently, this contributed positively to the country's 90-90-90 HIV target. The following were services that may be enhanced through partnership and collaboration:

### 2.4.5 Support

Testing children, according to the Children's Act 38 of 2005, required consent from parents when a child was below the age of 12. Support from the parents or caregivers of OVC who are beneficiaries of the DICs is critical. The DIC may have the best strategy, but it may not be attainable if parents are not supportive as their consent may be required. Yeap, et al. (2010) stated that parents sometimes fear seeking help for their children because they feel guilty that they had infected them. They argued that most parents had incorrect perceptions of ART, believing that it would make children sickly.

Another challenge cited by Yeap, Chubb, Flicker, Mccaul, Ebeling, Beilby & Norman (2010) was that, in some cases, the fathers were not aware of the mother's or child's status and that disclosure may be life-threatening or mean economic exclusion to both the mother and the child, as the father could blame the mother for the outcome of the HIV-positive status. Baxter and Abdool Karim (2016) suggested that educational programmes may help in dealing with such challenges. DICs accessed parents or caregivers of their beneficiary children more often and some were part of a different support group, so they could integrate HIV education into their programme to address this challenge and encourage parents' support for HIV services to children.

#### 2.4.5.1 *Strengthening families*

It was vital to have programmes that would strengthen families affected by HIV and AIDS especially that they are a support system to those infected by HIV/AIDS. This became a challenge if they were less informed about the virus about how best to support affected family members, including children (Richter, Sherr, Adato, Belsey, Chandan, Desmond . . . Wakhweya, 2009). A comprehensive review of the impacts of HIV and AIDS on children and families

alluded to direct efforts to three avenues for providing support to families: economic strengthening, family orientation to the provision of HIV/AIDS services, and providing specific services to enhance children's development. Each of these approaches is discussed in more detail below.

Research conducted by Vaz at al. (2011) reported that HIV-infected children were given limited information about their health. It suggested that health care providers may serve as important sources of support to parents who decided when and how to talk openly with their children about their health. This support may address a global concern by UNAIDS about children being left behind on HIV testing, treatment and adherence. Children's adherence to HIV treatment could be obtained when making disclosure at an age appropriate level (Vaz, Maman, Eng, Barbarin, Tshikandu, & Behets, 2011). Disclosure was categorised as full disclosure, non-disclosure and partial disclosure:

#### 2.4.5.2 *Full disclosure*

Complete disclosure applies to a case where the caregiver and the child were on the same page, where the primary caregiver had told the child about his / her HIV status, and the medications that would help avoid opportunistic infections and prolong life Vaz at al. (2011). Research by Sips et al. (2014) indicates that most of the children who have received full parental disclosure have never missed care. The caregivers have characterized these children as self-motivated to adhere to treatment. Their motivation was to know their HIV status and understand why the drug was needed.

#### 2.4.5.3 *Non-disclosure*

Non-disclosure applies to a case where the child was unaware of his / her infection (Vreeman, Gramelspacher, Gisore, Scanlon, & Nyandiko, 2013). Evidence has indicated that most parents have not revealed their HIV status to their children, suggesting that disclosure may not be appropriate for young children because they may not even understand what it entails. Research by Sips et al. (2014) revealed that most children interpreted their incentive to stick to care as wanting to impress others or cure their chronic illnesses. Parents who participated reported that their caregivers combined direct monitoring of medication taking with strong means, including threats, verbal harassment, physical violence and/or rewards, to ensure their children were taking

the medications as prescribed. Popular food products, such as sweetened fruit juice, ripe bananas, cakes and sweets, have been used as an adherence reward (Sips, et al., 2014).

#### 2.4.5.4 *Partial disclosure*

During this stage, the child was not fully aware of his/her HIV disease, but had started asking questions about the drug. The parent/caregivers used age-appropriate examples to educate children about the virus in their body and the importance of taking treatment as a way of fighting this virus. The difference between partial disclosure and full disclosure was the language and phrases used. In partial disclosure HIV was not referred to as such, but a parent would find a suitable name such as 'monster', and ARVs as a 'defender' of the body against this monster. Research indicates that full disclosure to children who had received partial disclosure was easier than to those who had never received any information.

#### 2.4.5.5 *Economic strengthening*

Richter et al. (2009) argued that poor families had fewer resources, which limited their capacity to deal with morbidity and mortality, mainly because they had less income and food security and few, if any, assets or savings. It was therefore important for NPOs providing services to these families to focus on programmes such as economic strengthening. These programmes may include creating food gardens, helping people use their potential to make a living, and establishing of any income generating project. Research shows that HIV-affected households everywhere experienced a decline in their socioeconomic status, which had a knock-on effect on children.

#### 2.4.5.6 *Family orientation to the provision of HIV and AIDS services*

Children everywhere should be connected to adults and other children, through family, kin and clan networks. This was ideal as HIV may bring stress, illness or challenges. Family care was a human species-specific cultural adaptation to ensure children's growth, learning and socialisation Richter et al. (2009). As family was the primary source of support for children or any individuals affected by HIV, it was important that they had a basic knowledge of how to care for HIV-positive children and adults (Dave, et al., 2019). This would increase the likelihood of adherence to treatment and consequently contribute to the last two 90s in the HIV 90-90-90 target.

### 2.4.6 Programmatic services to enhance children's development

Psychosocial support was an important element in the health development of children living with HIV (WHO, 2012). Several studies report that age appropriate psychosocial support increased the adherence of ART (WHO, 2013). The promotion of positive living and the use of support groups were considered an effective approach to providing psychosocial programmes. Dave, et al. (2019) maintained that the programme should address HIV disclosure, stigma, discrimination and bereavement and promote resilience among children participating. A psychosocial approach was appropriate in helping to meet age-appropriate and relevant emotional, spiritual, cognitive, social and physical needs.

### 2.4.7 HIV counselling and testing (HCT) as a strategy for 90-90-90 target

Knowledge of HIV status was a crucial component of every care or preventive plan and would be provided as part of packages for HIV preventive (Baxter & Abdool Karim, 2016). By 2020, meeting the 90-90-90 goals will entail rapid scale-up of HIV testing and creative ways of targeting communities that do not yet know their HIV status (Coates, Kavanaugh, & Ritchlin, 2014). Strategies such as community-based collaborative therapy and research through provider-initiated research (Coates et al., 2014) and home-based testing (Gardner, McLees, Steiner, del Rio, & Burman, 2011) have been introduced to increase HCT adoption.

#### 2.4.7.1 *Linkage to care*

One of the most important aspects of the 90-90-90 HIV strategy was linkages to those who were HIV positive (Baxter & Abdool Karim, 2016). Active linkages, such as taking a person who had tested positive by the hand to a clinic for ART initiation, would be an effective linkage to ensure that they start with treatment (Baxter & Abdool Karim, 2016; Baxter, et al., 2011). This approach required good partnerships and support from other stakeholders. DICs needed to have a contact person at other health facilities so that they would be able to ensure active referral through strong partnerships and support.

Studies showed that through these approaches, a home-based HIV therapy and testing (HBHCT) program targeted at families of HIV-positive patients in South Africa produced 93.7 per cent of those diagnosed with HIV positive (Dave, et al. 2019). Another research, which also examined HBHCT in South Africa, found that 76 per cent were linked to treatment (Manjezi, et al., 2016).

A community-based health and social service centre in the U.S. that offered HIV and other STI support to youth estimated that 80% of youth diagnosed with HIV met with a case manager to facilitate treatment (Naik, et al., 2015). One research compared the linkage to treatment between two groups of people who were recruited for HIV testing by alternative venue-based testing versus social and sexual reference networks. The study demonstrated the significance of network-based research in the subsequent treatment linkage (Boyer, et al., 2014). Therefore, there was significant evidence that the second 90, which is medication, was attainable when linkage to care was effective (Dave, et al., 2019; Manjezi, et al., 2016; Garrett, et al., 2018).

Community caregivers can only fulfil their task of connecting clients to formal health care if they are well integrated into a country's health care system and embraced by it. The partnership between community caregivers (CCGs) and health care providers should be defined by mutual respect and understanding in order for such linkages to be meaningful and efficient (Sips, et al., 2014). Professional health workers need to embrace the position of CCGs and understand that CCG programs would enable practitioners to concentrate on the more complex tasks they were qualified to perform. If the partnership with DICs is strong, they will be able to offer a decent service because they will refer their clients who are ready for testing and help those reported defaulting by the clinic (Sips, et al., 2014).

#### 2.4.7.2 *Retention in care*

Successful HIV treatment required sustained engagement in HIV care (Gardner, et al., 2011). People who received antiretroviral therapy sporadically were at increased risk of viral resistance (Baxter & Abdool Karim, 2016; Gardner, et al., 2011). For these reasons, poor engagement in care was associated with poor health outcomes, including increased mortality. In addition, these individuals contributed to ongoing HIV transmission in the community (Gardner, et al., 2011). When community caregivers visited for adherence support to their beneficiaries, the beneficiaries could lie by indicating that they were taking the treatment regularly, but because the community caregivers were unable to check their viral load or CD4 count, they may not be able to identify if there was a problem. However, a good partnership with clinics may assist in ensuring that beneficiaries took the medication they had received from the clinics and in tracking whether their viral load was being suppressed.

### 2.4.8 Supervision as a strategic approach to improve HIV service delivery

According to WHO (2006), the following areas are important for the supportive supervision of HIV services:

- The supervisors should ensure incorporation of HIV/AIDS training and activities in the short, medium and long-term to ensure that the supervisee has knowledge that is relevant for HIV services.
- Resources should be mobilised for the successful implementation of planned activities.
- Availability of and adherence to HIV/AIDS-related policies, guidelines, standard operating procedures and training materials is vital.
- Overall capacity (technical skills, financial and other resources) should be provided to support training institutions in their zones.
- Reporting forms and registers should be made available.
- There should be an adherence assessment of all ART clients at every visit.
- Adherence counselling and support services should be provided to patients on ART and for adherence to medication.
- Patients' adherence to programme schedules in the NGOs should be monitored.
- Processes to monitor the effectiveness of referral systems, i.e. referral of PLHIV to the clinic and family planning should be established.
- Social and legal services should be accessible.
- Recording and reporting tools should be made available for the checking of registers/forms for completion and accuracy.

Reaching the 90-90-90 target may require more than just client services, but should also entail supporting those who were providing services, such as community caregivers (Ellis & McKeown, 2017) Supervision was a tool that would help service providers to identify gaps among their employees regarding HIV services provided to service users (Judice, 2009).

A study conducted by Ellis and McKeown (2017) in United States of America examined developing a routine schedule for supportive oversight meetings or advising a supervisor at least

24 hours in advance of a supportive oversight meeting. This study found that unannounced meetings put increased stress on managers and contributed to a lack of preparedness. Scheduled, frequent meetings will result in less time spent to search for forms or reports, and improved data validation efficiency. This will also allow supervisors more flexibility to discuss the facets of supporting supervision as regards mentoring and teaching.

Some of the most important factors found was the development of a more collaborative data validation environment, enabling supervisors to provide ways to correct their own errors (Ellis & McKeown, 2017). It would boost supervisor trust in the skills of HIV services. A study conducted by Judice (2009) stated that during data validation supervisors chose to fix their own mistakes, rather than having them corrected by a supervisor. Allowing managers to come up with their own ideas will improve their problem solving capacity. Hence supervisors will be taught with their subordinates how to promote problem-solving and innovative brainstorming. WHO (2008) proposed emphasizing the supporting aspects of support supervision, such as mentoring and addressing trust, encouragement and problem-solving among staff.

Another factor found in oversight was the coordination with supervisors of information from positive monitoring activities. Ellis and McKeown (2017) and Judice (2009) agreed that 40 supervisory reports would be exchanged with managers to monitor their progress and changes. This will make the process more open, promote the growth of staff capacity and hopefully reduce some of the tension surrounding constructive supervisory meetings. It was clear that careful monitoring could be a tool for the provision by community caregivers of appropriate HIV services and progress in optimizing the contribution of the DICs to the HIV 90 90 90 goal.

### 2.4.9 Confidentiality as a strategy to avoid isolation and stigmatisation

One of the most frequently used words in the world of HIV was confidentiality. Understanding of confidentiality by community caregivers was vital to educating clients in matters of confidentiality (Rachels, 2017). Confidentiality was often used when community caregivers wanted clients to disclose their statuses so that they could link and retain them in care. In multiple cases secrecy was perceived in different ways. This is perceived in some cases as never telling someone about one's HIV status, but that is in fact secrecy, which is not the same as

confidentiality. Secrecy may fuel the impression that HIV is a topic of taboo (Tolich, 2004). While it was important not to disclose the HIV status of a person without their permission, overemphasis on individual confidentiality may make it difficult for the person to obtain adequate care (Rachels, 2017).

Rachel (2017) and Tolich (2004) suggested that if a person did not tell anyone that they had HIV, they could feel more anxious and isolated. The challenge was that people were often more concerned about the social consequences of a positive diagnosis, e.g. about what would happen to their children, than about the medical implications (Rachels, 2017). Social support played an important role in helping to keep people healthy and in reducing stress. In many cases, the only source of social support an HIV-positive person had was their family and community (Nansseu & Bigna, 2017).

A strategy that would help realise the 90-90-90 target was to tackle the issue of secrecy about HIV through, for example, better public information about HIV, encouraging people to share their serostatus with others whom they trusted, encouraging openness about the cause of death. At the same time, it meant respecting people's rights and preventing stigma and discrimination (Nansseu & Bigna, 2017; Rachels, 2017). In some cases, there was the danger of people who knew their HIV status infecting partners because they refused to use condoms, and in such cases, health workers sometimes felt frustrated by the need to maintain strict confidentiality.

Therefore, the services encouraged more historically accepted forms of secrecy in certain African 41 and Asian countries. This included mutual anonymity, using lay counsellors (who had already been educated in therapy) instead of licensed counsellors, therapy and testing couples, group counselling and community awareness to eliminate the stigma of HIV and AIDS (Rachels, 2017).

Shared confidentiality means allowing others to choose a trustworthy person and inform them about their HIV status, such as their doctor or health provider, partner, close friend or family member, or traditional healer. Shared confidentiality did not mean confidentiality was not important; the decision to reveal HIV status must always be under the control of the HIV-positive individual (Rachels, 2017; Tolich, 2004).

To certain people it may be really difficult to determine whether to tell a partner. They would choose to tell a close friend or family member, or share their HIV status news with their partner through an intermediary like a friend or relative. Reasons for not wanting to tell partners can involve fear or taboos about sexual issues. If a person was in a healthy relationship, during pre-test therapy, the psychologist might introduce the concept of mutual confidentiality. (2017 by Rachels).

Some people were hesitant to tell their family they were HIV-positive, generally due to fear of rejection. This was frequently overestimated, however, and therapy could help them more objectively evaluate the situation. If someone was still hesitant to tell a family member, he / she could be motivated to think about someone else they might trust (Nansseu & Bigna, 2017; Rachels, 2017).

Many health workers said they found it difficult to embrace the idea of confidentiality if, for example, a person who tested positive and was told did not use condoms or did not tell their sexual partner that they were HIV-positive. In one group, nurses were aware that people with HIV do not practice safe sex, and worried that by protecting the confidentiality of these people they are certainly undermining the wellbeing of their partners, so they are caught in dilemma of confidentiality (Nansseu & Bigna, 2017; Rachels, 2017).

### 2.4.10 Communication as a strategy for HIV services

Figure 2.3 shows how community caregivers should handle their clients when conducting a home visit in order to establish a good professional relationship with the client and enhance the quality of HIV services through good communication (Colton, Dunnington, Hainsworth, & Israel, 2006). Research suggests if this were done correctly, a good relationship would be established which would increase the likelihood of clients trusting the community caregiver Idele et al. (2014). When trust was well established, the client may be more willing to disclose their HIV status and continue to work with the caregiver in good faith. Subsequently, this would help in the realising the 90-90-90 target, because when a trust was established, the client would be able to give their consent for HIV testing, and may also be able to disclose their status

**Demonstrating good communication and showing a caring attitude entails:**

- Using simple words
- Talking and listening
- Letting people ask questions
- Using pictures or flipcharts
- Asking open-ended questions
- Listening carefully and repeating what was said to ensure the client has been understood correctly
- Never giving wrong information
- Finding out answers to questions one does not know.

**Trust is built with a client by:**

- Giving the client time to become acquainted
- Demonstrating understanding
- Being willing to help
- Admitting when one does not know the answer
- Supporting the client's decisions
- Not judging the client
- Showing skill and confidence in one's work.

**Keeping client's information confidential:**

Privacy and confidentiality are vital to the relationship between community health workers (CHWs) and their clients. CHWs and clients should have a confidential relationship. The CHW should use a private space to talk to clients, and should be away from other people who may hear or see the conversation. Discussions, conversations or concerns of a client must never be shared with anyone else unless at the behest of the client.

**Figure 2.3: Communication techniques for HIV services**

According to Colton, et al. (2006), an important part of caring for PLWHA was communicating. Good communication could help people to understand and solve their problems, because good communication skills:

- Gave information that the client needed
- Provided emotional and psychological support
- Helped reduce fear and anxiety
- Promoted positive living
- Helped clients to make informed decisions (e.g. about getting tested).
- Help resolve family conflicts that may be related to stigma, planning for death, or inheritance.

### 2.4.11 Possible obstacles to reaching the 90-90-90 HIV target

Many obstacles stood in the way of reaching the 90-90-90 HIV targets. Some of the identified key role players, including NPOs such as the DICs, may lack the structural and financial capacity to fund and implement programmes on their own. Part of the challenge was that NPOs typically relied on funding from donors, national and/or international funding agencies, government grants and fundraising events (Meehan, et al., 2017). Nyberg, et al. (2012) observed that the fundamental challenge, however, was a lack of certified training, meagre stipends and unrealistic expectations, which often led to burnout and high turnover among volunteers. Furthermore, community support may be a challenge since HIV was still stigmatised in South Africa's communities.

#### 2.4.11.1 *Lack of training*

Haffejee, Ports and Mosavel (2016) reported that health care volunteers had limited knowledge of HIV services, often due to a lack of training in a health-related field. This concern needed to be addressed as community volunteers should be the custodians of general HIV information for their communities. Although not sufficient to change behaviour and reduce risk, an important component of HIV prevention was a basic understanding of HIV and how it spread, which was lacking among many general volunteers (Idele, et al., 2014).

#### 2.4.11.2 *Meagre stipends*

The World Health Organization (2002) indicated that one of the most serious challenges facing community-based organisations was how to fund and sustain their programmes over the long term. Community-based organisations received funding and technical support, mainly from international non-governmental organisations and development agencies. However, very few donor agencies funded caregiver stipends or salaries (Department of Health, 2004). This created instability within the organisation which risked losing their experienced staff because of the low stipend or lack of stipend. This was especially concerning for beneficiary families that had developed a trust relationship with a particular caregiver. If the organisation changed, the family may feel that their confidentiality had been compromised, and they may stop cooperating with the organisation regarding HIV-related services. Nyberg, et al. (2012) indicated that a lack of stipend may discourage volunteers from working with energy and commitment, which may compromise the quality of services. This can be reduced by outsourcing other local business operating within the jurisdiction of the NGOs to lobby financial support to boost the stipend of CCGs.

#### 2.4.11.3 *Expectations by volunteers*

Idele et al. (2014) explained that when volunteers joined a community-based organisation, they did so with different expectations, but for many it was for financial gain. However, when over time they realised that funds were limited, they lost interest in their job and may experience burnout and leave. When turnover of volunteers was high, it compromised the stability of the organisation and ultimately affected service delivery. Neufeld and Harrison (2003) indicated that community caregivers may experience negative interactions with the parents or carers of beneficiary children, such as disparaging comments that undermined a caregiver's experience, conflict on the appraisal of the care recipient's health status, or criticism of the caregiver's decisions. Such conflicts may contribute to burnout when a community caregiver felt the strain of the job was too severe and the income too low.

#### 2.4.11.4 *Stigma*

According to Saki, Kermanshahi, Mohammadi and Mohraz (2015), stigma was associated with delays in HIV testing. Flowers, et al. (2003) argued that HIV testing was the only way for a person to know his/her status. HIV/AIDS stigma has been cited as a major barrier to accessing

prevention, care, and treatment services (Saki, et al. 2015). Research conducted by Wattradul and Sriyaporn (2014) reported that caregivers did not disclose their children's HIV status when they went to school. This was because they perceived that there would be difficulty in accessing basic education and a lack of support for their children in terms of social stigma and suffering. The other reason cited was a fear of discrimination and social rejection, which made caregivers resentful of issues concerning the HIV status of their children (Wattradul & Sriyaporn, 2014). The research conducted by Krause and May (2016), identified the issue of trust as a problem in HIV disclosure. However, their findings concluded that through educating people living with HIV, a number of people were gaining trust and were able to disclose their HIV status.

A study conducted by Mahajan, et al. (2008) asserted that addressing stigmatisation in HIV/AIDS included teaching people about HIV/AIDS, which would increase tolerance and understanding of the virus and reduce stigmatisation. The story of HIV activist Nkosi Johnson, who made an enormous contribution internationally to the HIV/AIDS community, suggested that a child at the age 12 may be able to understand HIV. In the Nineties, at only 11 years of age, Nkosi Johnson addressed international conferences about his AIDS status (Van Dyk, 2010; Ndimbwa, et al., 2013).

#### 2.4.11.5 *Stigma reduction strategies*

Approaches to reducing stigma must be multifaceted to account for the range of stigmatising conditions that tracked with HIV/AIDS stigma, and multileveled to account for individual and structural levels of stigma and discrimination (Mahajan, et al., 2008)

**Table: 2.2 Structural level of stigma and strategy to reduce stigma**

| Level | Strategy |
|---|---|
| Intra-personal | Treatment<br>Empowerment<br>Care and support<br>Counselling<br>Cognitive-conduct therapy<br>Self-help and support groups<br>Home care teams |

| | |
|---|---|
| | Rehabilitation in the Family |
| Rate inside the Society | Pedagogy<br>Connection with HIV / AIDS sufferers |
| Establishment level | Training programmes<br>Policy development |
| Regional /<br>systemic standard | Legal interventions<br>Approaches according to rights |

### 2.4.12 Countries' success in reaching the 90-90-90 HIV target

#### 2.4.12.1 *Sweden*

Sweden was the first country to reach the UNAIDS 90-90-90 HIV target (Gisslén, M; Svedhem, V; Lindborg, L; Flamholc, L; Norrgren, H; Wendahl, S; Axelsson, M; Sönnerborg, A, 2017). Several factors contributed to the country's favourable results. Sweden was an HIV low-endemic country with fewer than 8 000 individuals estimated to be living with HIV (Hill & Pozniak, 2015). Moreover, the Swedish Communicable Diseases Act obliged laboratories and clinics to report cases, and patients had to keep appointments and submit to tests that health care providers considered necessary. Sweden's linkage system was effective in that all patients who tested HIV-positive were immediately linked with dedicated multidisciplinary teams of physicians, nurses, and social workers (Hill & Pozniak, 2015). Since 2017, Swedes testing positive for HIV had received ART free, irrespective of their CD4 count (Hill & Pozniak, 2015). Notwithstanding these factors, although Sweden's HIV challenges were on a much smaller scale than those in South Africa, South Africa could still learn from certain strategies such as Sweden's Communicable Diseases Act, linkage system, and the commitment and obligation of staff working with HIV.

#### 2.4.12.2 *Botswana*

In Southern Africa, Botswana may not yet have reached the 90-90-90 HIV target, but it had made remarkable progress. UNAIDS data (2019) indicated that Botswana was sitting at 86-84-81 and appeared well set to achieve the 90-90-90 target by 2020. Botswana's strategies included high HIV testing coverage, which was free, as well as making community-based HIV testing available (Marukutira, et al., 2018). In terms of HIV treatment and monitoring, Botswana provided free ART for its citizens, had government-funded HIV treatment programmes, and had adopted universal treatment for all (people living with HIV). In addition, the country had high

ART coverage, routine viral load monitoring available, and high viral suppression among people on ART. Botswana focused on reducing HIV-related mortality and a decentralised healthcare system, with even the lowest level facilities offering HIV care (Marukutira, et al., 2018).As part of its HIV prevention strategy, the country had introduced pre-exposure prophylaxis (PrEP) implementation, which was available but limited to a few sites or facilities (Marukutira, et al., 2018). As a country with similar problems to South Africa's, it had much to teach South Africa.

#### 2.4.12.3 *Cambodia*

Cambodia has been a regional pioneer in tackling HIV / AIDS for the past 25 years, amongst other nations. According to a 2017 census estimate (UNAIDS, 2018), Cambodia had a population of about 16.01 million. Although the population of South Africa was higher, figures according to 2017 statistics were 56.72 million (UNAIDS, 2018) it could draw on some lessons from Cambodia. Cambodia announced in 2013 its plan to eradicate new HIV infections by meeting the 90 90 90 goals by 2020. Furthermore, Cambodia showed its determination to achieve 95 95 95 95 (and fewer than 300 new HIV infections per year) which meant that by 2025 it would be close to becoming an AIDS-free nation (Pal, et al., 2016). The delivery of care and treatment facilities has been revamped and updated to effectively eradicate new HIV infections by 2025 as a strategy towards achieving this goal. Cambodia ensured that top priority was provided to human resources and logistical support, in particular ART, to facilitate the implementation and expansion of boosted integrated active case management across the world. It has been reported that Cambodia had diagnosed approximately 85 per cent of the estimated population of PLHIV in December 2017, put all diagnosed PLHIV on ART, and recorded substantial suppression of PLHIV viral load on ART (UNAIDS, 2018).

To achieve the 90-90-90 target Cambodia developed a strategy based on seven pillars as outlined by UNAIDS (2019), which are discussed below:

i. *Eliminate new HIV infections among children by 2020*

   UNAIDS data (2019) reported that children had been left behind globally with regard to HIV services. However, Cambodia had ensured that 1.6 million children had received access to HIV treatment by 2018. Cambodia's HIV response had progressed significantly with

coverage of prevention of mother-to-child transmission (PMTCT) services standing at 81% at the end of 2017, and had markedly reduced mother-to-child transmission of HIV. In 2017, an assessment of the PMTCT programme was undertaken, and a road map with a plan of action was being finalised to strengthen the PMTCT programme towards the elimination of mother-to-child transmission national targets and global requirement.

ii. *Access to combination prevention options*

These included access to pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020. This pillar was aimed especially at young women and adolescent girls, gay men and other men who had sex with men, transgender people, sex workers and their clients, people who injected drugs, and prisoners. In 2017, under the overall framework of the community action approach, which included involvement of NGOs, Cambodia succeeded in championing the prevention, treatment and care services delivery model, and at the same time ensured equitable access to prevention and treatment services in an enabling environment (UNAIDS, 2019).

iii. *Eliminate gender inequalities*

This remained a global problem, and Cambodia engaged in the process to eliminate these inequalities (Pal, et al., 2016), by ending all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020 (Khan, Meghani, Liverani, Roychowdhury, & Parkhurst, 2018).

iv. *Provide knowledge of HIV and access to sexual reproductive health services*

This involved ensuring that 90% of young people had the skills, knowledge and capacity to protect themselves from HIV and to have access to sexual and reproductive health services by 2020. This was done to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year (UNAIDS, 2018). As Cambodia's approach in this regard was very specific, the strategy was measurable and the country was able to evaluate its progress accurately. In this way, Cambodia had significantly reduced new HIV infections to less than 1 000 countrywide (between 2017 and 2018) and the epidemic was concentrated mainly among the key population. One of the benefits to this approach was that prevention efforts had focused on the youth to empower them with knowledge and skills, and the ability to access HIV prevention and sexual and reproductive health services, which

helped in preventing new infections (Khan, et al., 2018).

v. *Sensitive social protection*

The UNAIDS 90-90-90 target included ensuring that 75% of people living with, at risk of and affected by HIV were benefiting from HIV-sensitive social protection by 2020. Cambodia's progress summary indicated that efforts had been made to ensure that people living with, at risk of and affected by HIV benefited from HIV-sensitive social protection, which included grants and funds for the affected population to access health services (UNAIDS, 2019).

vi. *Ensure that at least 30% of all service delivery is community-led by 2020*

Cambodia's success in its achievement of the 90-90-90 HIV target was based on support of community-based NGOs that provided HIV services. This pillar supported research by Mahlase (2008), who indicated that DICs were owned by the community. According to this pillar, the focus would be on strengthening community-based NGOs. In Cambodia, national NGOs had spent 37% of total AIDS funding in 2014 and 38% in 2015. This approach was being expanded and implemented under the overall community action approach developed in 2017 (Khan, et al., 2018). There were clear indications that NGOs were actively involved in HIV services and were receiving government support, and that the government had allowed other partners such as USAID to support them for HIV services. Therefore, South Africa should draw on the experiences of Cambodia in terms of its investment in NGOs to reach the 90-90-90 HIV target.

vii. *Financing the HIV/AIDS response*

UNAIDS (2018) planned to increase global HIV contributions to US$ 26 billion by 2020, including a quarter for HIV prevention and 6 per cent for social enablers. As a result of strong political involvement, community participation and high rates of funding from donors for more than two decades, Cambodia had achieved its goal, according to its progress overview report (UNAIDS, 2019). The problem, however, was that HIV response funds were dwindling, and there was concern that the the economy in Cambodia, reflected in its new lower-middle-income status, would make it increasingly less qualified for funding (Mburu, et al., 2017). To avoid this, the country had committed to a more strategic use of available resources while planning to different response in financial burden (Mburu, et al., 2017). In addition, Cambodia had identified strategic

investment goals to achieve this goal, while strengthening the foundations for a transition to-domestic financing of a sustainable response to funding for HIV services. The Royal Government of Cambodia donated 3.7 million USD to ART drugs from October 2015 until December 2017. Cambodia also contributed $0.47 million to contract workers for the 2018–2020 period, and $1.5 million per annum for ARV procurement processes (Khan, et al. 2018)

These seven pillars provided a clear indication that the success of Cambodia in HIV services involved political will and strong support of the government to the country's HIV programmes. This supported the views of Levi et al. (2016) who indicated that South Africa could reach the target if it had the political will to do so.

### 2.4.13 Conclusion

The literature has demonstrated a massive gap in HIV services to children. UNAIDS data (Figure 2.1 and Figure 2.2) showed that South Africa had reached the first 90 of the target overall, but was still some way off with respect to children. Therefore, this study is important in that it wanted to explore the strategies employed by DICs in their contribution to South Africa's 90-90-90 HIV target. The literature demonstrated that communities recognised DICs as trusted providers of alternative care for vulnerable children, offering a comprehensive suite of services including HIV services. However, no specific literature had looked at strategies employed by DICs regarding their contributions to the 90-90-90 HIV target.

The literature verified the importance of partnerships and support from different stakeholders as a key factor in maximising the contributions of NPOs and NGOs to the 90-90-90 HIV target. The study wanted to establish whether the DICs enjoyed this kind of support from these stakeholders, as a lack of support or poor partnerships may have a negative impact in optimising their contribution or achievement of the 90-90-90 HIV target.

Research has shown that parents and some organisations were still not comfortable about children as young as 12 years granting consent for their own HIV tests. The literature revealed the importance of having a management plan in place for HIV programmes, which included how best to implement them, and suggested educating employees about their role in offering HIV services.

In conclusion, as no literature had specifically looked at the role of DICs in relation to the 90-90-90 HIV target, the study would be addressing a relatively new area, and the findings would contribute to new knowledge in the academic space.

# CHAPTER 3: RESEARCH METHODOLOGY

## 3.1 Approach of the Study

The study was qualitative in nature which, according to Creswell (2014), provide a means for exploring and understanding the meaning individuals or groups ascribed to a social or human problem. Babbie and Mouton (2011) defined qualitative research as the approach research takes, at its departure point, as the insider perspective on social action. Since the study was exploratory in nature, the researcher decided on a qualitative approach.

## 3.2 Research Design

According to De Vos, Strydom, Fouché and Delport (2011), research design is a plan or blueprint for conducting research. "Research design is a plan or a structured framework of how you intend conducting the research process in order to solve the research problem" (Babbie & Mouton, 2011, p. 72). The researcher used a case study design, which Creswell (2014) defined as an intensive, holistic description and analysis of a single instance, phenomenon, or social unit. The case study design is exploratory in nature as it is used to explore those situations in which the intervention being evaluated had no clear, single set of outcomes (Baxter & Jack, 2008). The unit of analysis in the study was five drop-in centres (DICs), focusing on employees who worked directly with beneficiaries. As previous studies had not considered the 90-90-90 HIV target with respect to DICs, the subject matter of this study was relatively new.

Kumar (2011) argued that qualitative study designs are not as specific, precise or well defined as designs in quantitative research. He maintained that there is a degree of overlap between study designs and methods of data collection. Some designs were considered to be methods of data collection, which is a disadvantage of the qualitative approach. The researcher was cognisant of these shortcomings, and endeavoured to ensure that levels of trustworthiness were maximised.

## 3.3 Study Population

Engel and Schutt (2013) defined the population of a study as the entire set of individuals or other entities to which study findings are to be generalised. "Target population consists of people who have some characteristics in common." (Monette, Sullivan, Dejong, & Hilton, 2014, p. 132). The

population of the study comprised community caregivers and social auxiliary workers from drop-in centres. The DICs were located in Eldorado Park (Khayalethu Crisis Centre), Kliptown (PUSH DIC), Orange Farm Extension 6A (Clean Touch DIC), Orange farm Extension 3 (Siyabonga DIC) and Fine-Town (Zenzele DIC). The reach of these organisations, including adult beneficiaries, ranged from ± 500 to ±600 per DIC. The researcher's role was to provide support in case management and other deliverables expected from DICs by DSD. As a way of addressing dual relationship in the study, from the DICs constituting the study population, the social worker (researcher) was working with only one DIC (Orange Farm Extension 6A) prior to conducting the research. Furthermore, the participants were educated about the importance of being honest about their views and that the research interviews will be confidential. Lastly, interviews took place in their homes whereby they were confortable and free to share their experiences.

### 3.3.1 Sampling

Gray (2013) described sampling as the process of selecting a set of objects, occurrences, or individuals from the parent population for a research study. Kumar (2011) asserted that sampling is the process of selecting a few (a sample) from a bigger group (the sampling population) to become the basis for estimating or predicting the prevalence of an unknown piece of information, situation or outcome regarding the bigger group. The sample for this study was drawn from a population comprising five DICs from the City of Johannesburg's region G. The researcher used purposive non-probability sampling.

According to De Vos, et al. (2011), Engel and Schutt (2013), and Kumar (2011), non-probability sampling is a method used when the number of elements in a population is either unknown or cannot be individually identified. Among the types of non-probability sampling available, the researcher elected to use purposive sampling.

"Purposive sampling is a technique based on the judgment of the researcher regarding subjects or objects that are typical or representative of the phenomenon or who are knowledgeable about the question at hand." (Brink, van der Walt, & van Rensburg, 2006, p. 133). Kumar (2019) explained that the primary consideration in purposive sampling is the researcher's judgement as to who can provide the best information to achieve the study's objectives. The researcher approached only

those people who, in his opinion, were likely to have the required information and who were willing to share it. The researcher identified DICs that were working with children and their families in the City of Johannesburg, region G and that were funded by the DSD. Funded DICs were monitored by the DSD's social workers from the HIV directorate. Monthly deliverables are expected of them regarding HIV services. After having gained entry to a DIC, the researcher recruited four participants per DIC: one social auxiliary worker and three community caregivers, as they were working together in providing services to the communities. Therefore, the study had 20 participants in total. The criteria of inclusion were: the employees were social auxiliary workers and community caregivers; they must have had at least three years' working experience with a DIC, they had to be between 23 and 45 years of age and working directly with beneficiaries.

The participants were selected as follows: The meeting was arranged with individual DIC in their respective centres with social auxiliary workers and community caregivers. The researcher explained the purpose of the study and the importance of attendees' participation in the study. Everyone was given a paper to indicate if they are interested or not, so the papers were collected from everyone whether interested or not. The difference was that those who were interested were requested to put their phone numbers so that they would be contacted for further arrangements of face to face interviews. Majority of the people were interested but participants were short-listed as per criteria of inclusion.

### 3.4 Research Instrument

Gray (2013) defined a research instrument as a tool such as a questionnaire, survey, or observation that was used to gather data as part of a research project. Creswell and Creswell (2017) stated that an instrument referred to a method or means by which data was collected. The researcher used an interview schedule as an instrument for data collection, which helped him to collect primary data from the participants. Primary data referred to information or raw data gathered from the source (Kumar, 2011).

The advantage of an interview was that it gave the researcher the freedom to decide on the format and content of the questions to be asked, and to select the wording of the questions, decide how to ask them and choose the order in which they were to be asked (Creswell, 2014;

Kumar, 2019). The researcher used a semi-structured interview schedule to collect data. De Vos, et al. (2011) explained that a semi-structured interview is used when the researcher want to gain a detailed picture of participants' beliefs or perceptions, or their account of a particular topic. The researcher wanted to explore the strategies employed by the DICs in their contribution towards South Africa's 90-90-90 HIV target.

## 3.5 Pre-Testing

De Vos, et al. (2011) defined pre-testing as piloting, a method that entailed administering the research tool before data is collected with individual/s who will not be included in the sample. Creswell and Creswell (2017), and Kumar (2011) observed that in pre-testing, the research instrument undergoes a critical examination to determine the understanding of each question and its meaning by participants. The purpose of pre-testing was to identify problems that the potential respondents may encounter in either understanding or interpreting the questions. For the purposes of this study, the researcher pre-tested the research instrument with two respondents with the same or similar attributes as the participants in the study; however, this data was not included in the data analysis. In the process of pre-test interviews, it was apparent that the participants fairly understood the questions and the instrument was then adopted as an actual tool of data collection. This assisted in validating the instrument and ensured that it was reliable.

## 3.6 Method of Data Collection

The researcher used semi-structured face-to-face interviews. De Vos, et al. (2011) stated that the advantage of using a semi-structured interview is that research participants are not limited when giving their responses and it gives the researcher an opportunity to follow up on responses that may not be clear. Interviews took place in a location that was convenient to the participants, and were conducted either at the participants' homes or at a venue outside the DIC. The participants were advised to use language that they would be comfortable to express themselves, 18 participants used English and two used Sotho and Zulu. Each interview was about 30–40 minutes long, and the researcher used audio recording to collect data as well as note taking.

## 3.7 Data Analysis

Data analysis refers to the researcher's goal to summarise what he/she had seen or heard in terms of common words, phrases, themes or patterns that would help his/her understanding and interpretation of what has emerged (Maree, 2007, p. 101). The researcher used five steps of data analysis as detailed by O'Connor and Gibson (2003). Data was analysed using thematic analysis.

*Step 1: Organising data*

The researcher listened to the recorded interviews and read the notes recorded through the process of the interview. O'Connor and Gibson (2003) advised that it was important to consider other ideas and themes that had emerged from the data in terms of how they related to the study, or how they may be useful for future research. The researcher organised the data into a table, which allowed him to examine the responses to each question individually, and helped in ensuring that themes and topics were identified.

*Step 2: Finding and organising ideas and concepts*

The researcher looked for phrases used frequently by the respondents. Taylor-Powell and Renner (2003) described organising ideas and concepts as involving looking for similar words or phrases used by respondents and categorising them. The researcher decided to also explore meaning in language, which meant preserving the data in its original form, and not cleaning up grammar during transcription and translation. The researcher took note of unexpected responses. Finally, the researcher coded and categorised ideas and concepts in tabular form.

*Step 3: Build over-arching themes in the data*

O'Connor and Gibson (2003) stated that each response categorised had one or more associated themes that gave deeper meaning to the data. Themes were identified and then the categories of such themes were discussed.

*Step 4: Ensuring reliability and validity in the data analysis and findings*

The researcher ensured that there was validity at all stages of the data collection process by confirming that the method measured what it was intended to measure and yielded data that represented reality. The researcher ensured reliability by being consistent throughout interviewing, transcribing and analysing the findings.

To ensure validity during data analysis the following were considered:

- ***Testing emergent findings***

The researcher had went through the data carefully and identified negative instances of patterns, which were discarded as they did not fit into the patterns and themes of the data.

- ***Checking for research effect***

The researcher checked all dynamics when doing analysis, such as age, gender, education, background and language as they may have affected the outcome of the interview.

- ***Validating findings***

Different members of the organisation were interviewed and provided different perspectives of specific questions or topics (Creswell, 2014; O'Connor & Gibson, 2003).

- ***Acknowledging factors that may have influenced the participants' responses***

The researcher took into account the time and date each interview was conducted and avoided elements such as the presence of other people during the interview (co-workers, family members and friends) who could have been within earshot while the interview was being conducted, as this would have affected the validity of the findings. The social worker (researcher) acknowledged that being a social worker and interviewing social auxiliary workers and community caregivers, they may feel inferior and affects outcomes of interviews, so the participants were clearly educated about the importance of being honest throughout the process of data collection during recruiting face, and it was cleared that those who feel they may have challenge of being honest they can't accept to participate in the study. They were also given a time to ask questions, so all their concerns were cleared.

*Step 5: Finding possible and plausible explanations of the findings*

The researcher started by summarising the findings, also indicating whether the findings matched the researcher's expectations. Creswell (2014) indicated that this final stage involved expressing the lessons learned by the researcher. The researcher indicated whether there were any surprises in the findings. The findings were then compared with the literature from other similar studies. The researcher also explained the implications of the findings and provided recommendations.

## 3.8 Trustworthiness of the Study

Trustworthiness refers to the availability of the following four elements: credibility, which corresponded somewhat with the positivist concept of internal validity; dependability, which related to reliability; transferability, which was a form of external validity; and conformability (Rolfe, 2006). The researcher considered each of these four elements to enhance trustworthiness in the study:

### 3.8.1 Credibility

Credibility refers to the truth of the data or the participant's views and their interpretation and type of internal validity, which implies the correct use of research methods and ensuring that the data is a true representation of the matter under consideration without any bias. The researcher allowed voluntary participation and ensured that he established rapport with the participants and created an environment in which the participants were free to contribute and to share their views without fear of prejudice. The researcher captured the data from the participants in its original form, without any language clean-up.

### 3.8.2 Transferability

Transferability refers to the extent to which the findings of one study could be applied to other situations (Shenton, 2004). According to Shenton (2004), transferability addresses the extent to which the findings of the sample can be applied to the entire population. To enhance the transferability of findings by other organisations, the researcher defined the following: number of organisations that participated in the study; type of people who participated; number of participants; data collection method; number and length of data collection sessions; the time or period over which data was collected. Furthermore, the data was collected in a place where the participant felt comfortable and in their convenient time. The researcher observed the facial expression as it could mean something different from the actual words and probe guided by the body language of the participant.

### 3.8.3 Dependability

Dependability refers to the constancy of the data under similar conditions (Polit & Beck, 2012). A study would be deemed dependable if the study findings could be replicated with similar

participants in similar conditions deploying the same processes of research methodology (Polit & Beck, 2012; Shenton, 2004). The research was supervised and the process of pre-test of instrument was done by the supervisor. This helped by guiding the direction of interview and ensuring that instrument produces the data it intended to produce.

### 3.8.4 Conformability

Conformability ensures a degree of neutrality in the study without the potential for bias (Cope, 2014; Shenton, 2004). The researcher ensured that he remained objective throughout the process of data collection through the use of reflective journal and observed the reliability and validity of the study as discussed in the process of data collection.

## 3.9 Ethical Considerations

De Vos, et al. (2011) stated that ethics are a set of widely accepted moral principles that offered rules for, and behavioural expectations of, the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students. To ensure that the study fell within the parameters of ethical considerations, the researcher obtained ethical clearance from the School of Human and Community Development Departmental Ethics Committee of the University of the Witwatersrand, clearance certificate protocol number H19/10/14. Permission to conduct the study from the DICs, following their channels of communication, was obtained from Siyabonga DIC, Clean-Touch DIC, Zenzele DIC, Khayalethu Crisis DIC and PUSH DIC, (Appendices J to O). The following ethical considerations were applicable to this study:

### 3.9.1 Respect and autonomy

Royse (2011) emphasised respect and autonomy as fundamental social work principles. The researcher ensured that research participants were treated with dignity and courtesy. Similarly, participants were not subject to any form of prejudice and their views and opinions were taken into consideration in a respectful manner.

### 3.9.2 Informed consent

Informed consent is more than obtaining a signed form from a participant. When conducting research that involves people, obtaining of informed consent is required and information has to be presented to potential participants to enable them to decide voluntarily whether to participate as a research subject (Sonne, et al., 2013). Informed consent involves, but is not limited to: informing the subject about his/her rights, the purpose of the study, the procedures to be followed, and the potential risks and benefits of participation, duration of storage of personal data, and their right to withdraw from the study at any time without consequences (Manti & Licari, 2018). The researcher informed all the participants about the importance of participating in the study and they were reassured that participating was not mandatory. The participants were provided with written participant information sheets which contained the details of the study, consent forms to participate in the study and a consent form for audio recording. Forms were completed and signed by all participants who agreed to participate in the study.

### 3.9.3 Anonymity and confidentiality

Babbie and Mouton (2011) stressed that confidentiality is achieved when the researcher can identify a given person's response but promise not to do so publicly. For this study, the participants' confidentiality was guaranteed, as the researcher did not reveal the responses of the participants with their identifying information to anyone other than the supervisor. In this final report when presenting findings, DICs were referred to as DIC1, DIC2, DIC3, DIC4 and DIC5 randomly, thereby maintaining confidentiality and anonymity.

### 3.9.4 Voluntary participation

According to Bless, Higson-Smith and Kagee (2006), and Marlow (2010), voluntary subject participation means that all participants, as human beings, had legal and human rights, and should be willing participants in a study. This is closely related to a client's self-determination in social work practice. The participants were not pressured to participate in the study and they were assured that there would not be consequences should they refuse to participate. They were advised that they could withdraw from the study at any point should they wish to do so, without penalty, even after completing the consent forms.

## 3.10 Limitations and Delimitations of the Study

The researcher experienced challenges with some DIC managers who attempted to give directives as to who should be interviewed. The researcher believed this may have been based on who they trusted would speak well about them or the organisation. Had the researcher agreed to this, it could have negatively affected the outcome of the research; as such people would be participating through the instruction of their manager, not of their own free will or desire to contribute to the study. The researcher explained to those managers that participants should meet the criteria of the researcher as per the criteria of inclusion, and that participation was entirely voluntary, meaning that participants should have the option to participate should they so they wish. To support his explanation, the researcher clarified the purpose of the research and the importance of credibility of data. Once the managers understood, they allowed the researcher to select participants without their interference.

Another challenge was that some organisations had only a few community caregivers (CCGs) with three years' experience, limiting the pool of CCGs from which the researcher could select participants. CCGs often moved on to take advantage of other opportunities. Some of those who had left may have had relevant experience that could have contributed greatly to the study. There was the possibility that this may have limited the amount information that the researcher could gather.

## 3.11 Conclusion

Chapter 3 discussed the research methodology of the study which explained the approach and design of the research study, population and sample procedures, research instrument and pre-testing of the research instrument. This chapter also looked at the method of data collection, data analysis, and trustworthiness of the study. The chapter concluded by explaining the ethical considerations and limitations of the study.

# CHAPTER 4: PRESENTATION AND DISCUSSION OF THE FINDINGS

## 4.1 Introduction

The overall aim of this study was to explore the strategies employed by drop-in centres (DICs) in contributing to the 90-90-90 HIV target adopted by the South African government from UNAIDS.

This chapter starts by describing the demographic information of the participants. The findings of this study are organised according to five broad themes in response to the aim and objectives of the study:

- Theme 1: The role played by organisational governance DIC service provision
- Theme 2: The importance and role of collaborators
- Theme 3: Driving factors behind community members' use of services
- Theme 4: Readiness to provide services to community members
- Theme 5: Inadequate resources and support.

Several sub-themes were identified within each broad theme as illustrated in Table 4.1.

**Table 4.1: Themes**

| **Themes** | **Sub-themes** |
|---|---|
| The role played by organisational governance in DIC service provision | Policies<br>Care<br>Skills development<br>Information sharing |
| Importance and role of collaborators | Trust<br>Responsiveness<br>Relationship<br>Support |
| Driving factors behind using the services by community members | Motivation<br>Preparation<br>Reduced stigma<br>Community unity/engagement<br>Keeping informed<br>Training<br>Supervision<br>Campaigns |

| Themes | Sub-themes |
|---|---|
| Readiness to provide services to the community members | Keeping informed<br>Training<br>Supervision<br>Campaigns |
| Inadequate resources and support | Donors<br>Inadequate cooperation<br>Programmatic support |

These themes and sub-themes are discussed and illustrated in this chapter with quotes. To protect the identities of the study participants, their real names have not been used; they are referred to as Participant 1 to 20. To maintain confidentiality and anonymity in the study, the DICs have been allocated numbers randomly and are referred to as DIC1, DIC2, DIC3, DIC4 and IDC5. DIC1 represents participants 1–4, DIC2 represents 5–8, DIC3 represents 9–12, DIC4 represents 13–16 and DIC5 represents 17–20.

## 4.2 Demographic Information

Table 4.2 demonstrates the diversity in all categories of the participants' demographics.

**Table 4.2: Demographic profile of participants (N=20)**

| Demographic factor | Sub-category | No. |
|---|---|---|
| Gender: | Male | 3 |
| | Female | 17 |
| Ethnicity | Black | 18 |
| | Coloured | 2 |
| Age | 23–24 | 3 |
| | 25–29 | 9 |
| | 30–34 | 4 |
| | 35–45 | 4 |
| Years of experience | 3–5 years | 14 |
| | 6–9 years | 5 |
| | 10 years or more | 1 |
| Position | Social auxiliary workers | 6 |
| | Community caregivers | 14 |

### 4.3 Role Played by Organisational Governance in DIC Service Provision

Organisational governance specifies how a DIC is conducted, from management to community caregivers of the organisation, in terms of the policies, programme management, recruitment of beneficiaries, etc. (Mahlase & Ntombela, 2011). Organisational governance was identified as a leading theme in the study. The data confirms that the approaches the DICs took towards their HIV services reflected the governance of their individual organisations. Key components aligned to governance as per participants' responses were: policy, skills development, recruitment of beneficiaries and programme management.

Policy was a critical component identified as key to contributing to the governance of DICs. Participants indicated that, even though policy may exist in the organisation, they were not aware of it:

> *"Yes, we do have a strategic planning which duration is 5 years. In terms of the HIV policy, we do have, though the content I just saw it, but then in terms of the content, I didn't get the workshop in terms of the HIV policy as yet."* (Participant 1, 34 years old, female, social auxiliary worker, DIC1)

> *"At the moment, my answer will be I'm not sure if there is a strategy within the organisation because I haven't come across one myself in my experience. So let me answer this: I'm not sure."* (Participant 16, 31 years old, female, community caregiver, DIC4)

> *"The only policy I know of is a confidential policy, so I think it contains confidentiality of people's statuses but is not specifically HIV policy. No."* (Participant 4, 26 years old, female, community caregiver, from DIC1)

> *"I believe we do. It's just that we're not familiar with it. It is there, we know it is there but we don't have come in contact with the policy."* (Participant 15, 27 years old, female, community caregiver, DIC4)

Participants' varying answers around policy calls into question the degree of orientation they received concerning policy. The following are some examples from the findings:

> "*Mm. Yes we do have a policy*." (Participant 3, 27 years old, male, community caregiver, DIC1)

Conversely, another participant from same DIC said:

> *"So in terms of policy, there's no policy."* (Participant 2, 23 years old, male, community caregiver, DIC1)

The same comments were made in other organisations, such as DIC5:

> *"No we don't have."* (Participant 18, 34 years old, female, social auxiliary worker, DIC5)

> "*We have a strategic plan in our organisation what we do with HIV-positive patients, at our centre, since we don't do any testing, we make sure that our clients they adhere to medication, they attend clinics regularly and they take their medication. If we find someone who wants to test we refer them to our colleagues who also assist us and we also motivate them to know their status at all times."* (Participant 19, 40 years old, female, community caregiver, DIC5)

> *"Um, actually I'm not sure about it. All I know about our organisation is that we do have the policy." (*Participant 10, 25 years old, female, community caregiver, DIC3)

The findings reveal that, across five drop-in centres, only one (DIC2) had all participants agreeing that there was an HIV policy or strategic plan in their organisation. In the other four DICs, as mentioned above, participants had mixed answers about the existence of a policy.

A participant from DIC2 shared the same sentiment as three other participants from the same organisation:

> "*Yes we do. Okay, in the services, in the plan, it's stated that a client should volunteer to test for HIV, so we don't force anyone and it's stated in the policy. A client should volunteer to test for HIV. A client should also sign a consent form whereby the client will be told what's gonna be happening, will be taken through the process of testing, how long it takes, the pre- and the post-counselling sessions that take place, and if the clients decides after the pre-counselling session to say that I want to withdraw, it's within their rights to withdraw. Even in the policy it's there that no one is forced, even if the client said 'I want to test'; if they change their minds it's still fine for them."* (Participant 8, 29 years old, female, social auxiliary worker, DIC2)

While all five organisations were providing HIV services covering testing, treatment and adherence services, the only challenge was that for some, their plan had not been documented. This is confirmed in the following statements:

> *"I would say my role as a caregiver is to ensure that the clients that I'm working with, they do get tested and they have knowledge of HIV, and they take the treatment given that the results came. I guess our role is to be there, to support them with everything that they will be going through at that moment and to keep encouraging them to eat healthy, take your treatment, exercise, do everything that the doctors tell you to do because thina* [us]*, we not specifically trained for HIV so all we can do is to just support you and encourage you and give you referrals to go the clinics and whatnot, because we not really trained about HIV'. So, we just like anybody who just assisting you with relevant information that we have. Thina, it's just for us to encourage you to do the right things and to follow the protocol."* (Participant 17, 24 years old, female, community caregiver, DIC5)

> *"Okay, my responsibility would be, when the households and beneficiaries are tested and then after they tested, the person who tests doesn't give us the results, so what we do is we have this relationship with our clients. So if ever the clients discloses their HIV status, its whereby we need to support our caregivers, the caregiver that reports to me in terms of doing follow-ups, whether the client is getting some ARVS and is adhering to the treatment. So we have developed a template whereby on a monthly basis we have to check the cards, the clinic card, to find out whether the beneficiary/household or client is adhering to the treatment. So what we have done now is we have started doing the pre-group interviews in terms of having the support group for those who are taking, who are on ARVs."* (Participant 1, 34 years old, female, social auxiliary worker, DIC1)

> "*My role, what I do, is doing referrals as a caregiver. I make sure that I can take the necessary testing stations so they can come and give, offer services of testing during that period of time. And I also write referrals to the people who need the testing, because basically I'm not allowed to do any testing of some sort because I don't have any training per se. But we have other stakeholders that do deal with such things so we work hand-in-hand with them. So we organise them they come within the organisation. Me, my role is to organise clients, participants were interested in testing so that I can come and get the*

*services more."* (Participant 16, 31 years old, female, community caregiver, DIC4)

Providing the necessary care to HIV-infected and affected clients required skill, this raises the issue of skills development. Skills development is about capacitating the employees of drop-in centres, empowering them to have the necessary skills to aid in the implementation of the 90-90-90 strategy. The data shows that some DICs were doing well in developing their employees in connection with HIV services. For instance, all participants at DIC2 confirmed that that they received good support from management regarding empowering staff. Participants from other DICs acknowledged that trainings were taking place within their organisation, but that only a few people were invited to attend and, even then, it was a rare occurrence:

*"They offer us trainings where we go mainly for two weeks or a month to do trainings on what we are ... remember we are doing learn-as-you-earn here, so every time and again we go to trainings for adherence, for testing or whatsoever. So we do trainings."* (Participant 8, 31 years old, DIC2)

"*Through workshops that take place, but they don't occur regularly. It's something that happens maybe on the 1st of December; maybe we will have a workshop for campaigns or small event. They don't occur regularly*." (Participant 4, 26 years old, female, community caregiver, DIC1)

*"Organisation has helped me a lot since I've been here, like I've acquired a lot of information since our NGO opened. Other partnerships such as, like, HIVSA which are the ones you bring them and interventions that we get, we are embedding within the community and they support us by giving us workshops and trainings on HIV. Every new information that is out there, we go to workshops supervision where we talk about things such as how we're going to bring change within the community."* (*Participant 16, 31 years old, female, DIC4)*

The following comment from Participant 9 (31 years old, female, social auxiliary worker, DIC3) indicates that training may be limited to a certain number of people and that employee empowerment was moderate:

*"Okay, the organisations, they take us, they took us for trainings .... um, like yesterday there are two caregivers who went for trainings .... I went last month ..."*

DIC5 indicated that they had received no HIV training whatsoever. One participant admitted to looking up information on Google to update her knowledge on HIV:

> "*We just get the knowledge whenever we had we could but we don't get any skills from anyone about HIV/AIDS. We just randomly Google if there's more information we need but there's no training."* (Participant 18, 34 years old, female, social auxiliary worker, DIC5)

Another component identified as important under governance was recruitment of beneficiaries. The findings reveal that the DICs were focusing on orphans and vulnerable children and their families:

> *"Okay, since I'm a caregiver, neh … um, a community caregiver, I'm… okay. Our DIC partnered with HIVSA so there I work as a girl mentor, neh. And also a facilitator, so my role there is to recruit, identify and then we do sessions, neh. Ey, okay is to recruit, identify HIV affected and infected children, neh, and then those who are affected we encourage them to test and then we also link them with our testing partner, which is Mountain View Health. Testing partner, Mountain View Health something, something. It's not a clinic."* (Participant 15, 27 years old, female, community caregiver, DIC4)

The last component noted under governance was programme management. The management style in DICs matters most in relation to its contribution to the 90-90-90 HIV target. As indicated by the findings above, some DICs did not apprise all their staff of HIV policies or plans for rolling out HIV services. However, the data reveals that the management of DICs allowed social auxiliary workers (SAWs) and community caregivers to operate freely in terms of providing services to beneficiaries. Moreover, the data indicates respect in the hierarchy of communication regarding case management of HIV services in all DICs. Community caregivers mentioned that when they were doing their jobs and encountered challenges, they reported to SAWs who, if unable to successfully address a challenge, would report it to Department of Social Development (DSD) social workers:

> *"I have reported the matter to my social auxiliary worker, um … we visited the school, we visited her so it's an on-going and she then referred the case to social worker. But because there's, I think it's one social worker for I don't know how many organisations, so your case getting reached, it takes a whole long process. So that is a big problem that we have faced*

*because in these cases, we follow the protocols of reporting to the social auxiliary workers and social auxiliary worker will conduct also home visits with us. And then if there's no change, then refer to the social worker, but then you have to wait and wait and wait. So unfortunately, that is one of the challenges that we face in the organisation. Yeah"* (Participant 6, 23 years old, female, community caregiver, DIC2)

*"Mostly what I said was with testing, testing their child because, mostly you find that there's an inner case – the parent knows the status of the child, just that maybe the child doesn't. He's not aware of the medication he's taking or what is it for. So if I encounter such problems, like, I refer the parent to my supervisor which is a social auxiliary worker. Where we go, maybe we do a home visit to find out more of the ways is this parent like so, like, doesn't want a child to, to um (what's the word?) engage in our programme. So, like mostly, as time goes on, as much as we earned the trust of the parent, you might find that's where we find out the parents are not allowing their child to do so, because there's this issue of disclosure of their status. So if there's the case, we make sure their child might say to me, 'I want to test', but make sure, like, I just keep the child away from testing at all until their parents is further services so that she can be able to disclose to their child and so forth."* (Participant 16, 31 years old, female, community caregiver, DIC4)

In DIC1, which was also a testing site, a community caregiver indicated the following:

"*I speak to the woman who works with testing. I take her with to speak to the parent and then they can sometimes agree to be tested.*" (Participant 4, 26 years old, female, community caregiver, DIC1)

*"We are doing the call-in letters for them, if they allow coming and talking to us, to see the social auxiliaries and the caregiver."* (Participant 20, 44 years, female, community caregiver, DIC5)

There were clear indications that the management of DICs were not interfering with the processes of case management – a sign of good governance and management. However, the findings indicated that some DIC management communicated poorly with their staff, which affected staff morale:

*"Yes, I went to leave, and I come back, DREAMS was closed, and they didn't even explain. I was so afraid to ask. We were continuing all along and then we used to work with girl child*

*from 10–24 years. She even included boys and then it just things changed. I don't know what happened and then I was taken to grade 1 kids, and then DREAMS is from grade 3–12 and outside to 24 years. It was, it was a very good programme and now it just stopped, and we were learning too."* (Participant 20, 44 years old, female, community caregivers, DIC5)

*"You know sometimes, I feel like there are a lot of us here in the organisation who I might say are my colleagues. So we have that skill and the manager is aware of that, so I find it hard to understand why can't she take a step, you know? She's aware because there was a time whereby she came to us, one by one, asking about these kinds of skills of HIV and AIDS, information of HIV and AIDS, do you understand what HIV/AIDS is all about? Then we said 'yes'. I had to demonstrate how do I do my pre-counselling and post-counselling. Nothing happened I continued being a community caregiver and health screener, but on the HCT part, I was not part of that."* (Participant 2, 23 years old, male, community caregiver, DIC1)

### 4.4 Importance and Role of Collaboration

In the context of this study, collaboration referred to DICs working with other stakeholders to enhance their contribution to reaching the HIV 90-90-90 target. In discussing the activities at the DIC, the participants emphasised that partnerships and support contributed positively to the provision of HIV services. The collaboration and partnerships had been strengthened by existing relationships among the organisations, built on trust and support. This collaboration also raised awareness among DIC employees about HIV and current trends. The study showed that the DICs were in collaboration with more than one partner for the provision of HIV services. Partners included DSD, which was funding them, the Department of Health (through local clinics) and USAID-funded organisations. Through these collaborations and partnerships, the DICs were able to maximise their contribution to achieving South Africa's 90-90-90 HIV target.

Participants described the support from other stakeholders regarding HIV services as the way to reach the HIV target:

"*Okay, our stakeholders … I'll start by our clinics, neh, our local clinics. They do support us in many ways, because like after testing our children, our beneficiary, they make sure that if there are children who are positive, they are not on treatment, they make sure that they have to be on treatment and get their ARTs you know."* (Participant 2, 23 years, male, community

caregiver, DIC1)

*"The relationship with other stakeholders, like health facilities, it's quite well because they know that here we are also doing HIV testing and counselling and also adherence. Remember they also doing the same thing. So, if we take our clients to them, it's also a benefit to them so it's … we build a relationship by giving them our clients and then making sure that it's not about, it's about our clients. Yeah."* (Participant 5, 26 years old, female, community caregiver, DIC2)

The researcher wanted to understand whether they had established any partnerships to address the challenge of clients who were not adhering to treatment, or who had been lost to follow-up. Participant 5 stated*:*

*"We have that partnership because when I give them 15 clients they will tell me, like, maybe out of 15, maybe 12 are still doing the right thing but 3 – we can't find them. That's where they partner us with community caregivers who make sure that those clients are being traced again and then taken back to care. So, we do have that thing – the meetings whereby we arrange how we get hold of those clients and sometimes to make sure that we don't duplicate, because you know, some clients, they test at the clinic, at the same time come back to the organisation, so it's a duplication of the results."*

Participant 1 (34 years old, female, social auxiliary worker) from DIC1, a testing site, responded to the question on collaboration and partnerships as follows:

*"Okay, in terms of that I would say we have a strong relationship with our clinics. So what happens is in terms of all the testing equipment, we get them from the clinic. So what we do is they offer us all the testing kit, because we're a non-governmental organisation, on a monthly basis. But what they want in return would be, like, they want to see the target, how many did you reach a month. Yeah, we do have a strong relationship with them and even if let's say we've got someone who tested positive in our organisation, we refer that person to the clinic. So what happens, the person who does HIV testing does that, like, takes the client to the clinic and then when they get there, they retest that person just to make sure the results they correspond. So we are having this strong relationship with the clinic. They even refer clients."*

When probed further, she added:

> *"… in terms of HIV, what I remember is that we are having schools that we work closely with. We are having three schools that we work closely with, because most of our beneficiaries, they attend in those schools. So, what happens is they allow us to distribute condoms, put condoms in the toilets and even give information as awareness to the kids. So it's more like we are reaching out even to those who are not our members through the awarenesses."*

Trust was among the factors identified by participants as either present or absent. Clients were not always willing to discuss HIV-related matters with staff, which could affect issues of testing, disclosure and treatment. Mistrust between an organisation and a client could lead to clients refusing to test and to those who tested refusing to disclose their status. Trust may be compromised by clients who were concerned about the stigma associated with HIV.

The data suggests that mistrust between clients and community caregivers made it difficult for DICs to provide the necessary support, especially in terms of adherence, to families that had an HIV-positive member, but who had not disclosed their status to the DIC owing to trust issues:

> *"Mm, they do have support from parents, but in most cases disclosure is the issue.*" (Participant 12, 29 years old, male, community caregiver, DIC3)

According to the data, the issue of trust, especially pertaining to disclosure of HIV status remained a problem:

> *"Some of them don't feel comfortable with disclosing their status. Like you just hear, like in coloured area it's a bit difficult to disclose. That, like, my child is also HIV positive, because they are scared of what you might say and stuff like that so ja, that the only challenge we have – its people not going for the treatment and taking the children."* (Participant 7, 29 years old, female, social auxiliary worker, DIC2)

> "*The challenge is that people are so closed they are so stiff … like especially, that's why if you see the young child, they are, like, no why should I speak to this child (caregiver) because that she is young. Like, I'm 10 years older than her, like they are not free. But maybe if it's someone older that shows up, then they accept and they say, 'Ja, this person is*

*old; I can talk to them'."* (Participant 11, 34 years old, female, community caregiver, DIC3)

The issue of trust extended beyond clients, as the findings revealed it also came into play with other partners, as per the following example:

> *"For us to go to the clinic and request for a list of children who are HIV positive, because we are dealing with Vhutshilo 3, which is for kids that are taking treatment. So when we go the clinic, they don't understand because they are not allowed to disclose the status. So that's when we involve Anova and they then explain the programme and why the list is needed. But even with Anova involved, it is still a challenge"* (Participant 13, 41 years old, female, social auxiliary worker, DIC4)

The data indicates that community caregivers and SAWs were responsive to the HIV service needs of the families in their communities and the general community. However, the findings also reveals that some parents were less informed about HIV, which suggests a lack of awareness in the community in general, and may lead to delays in disclosing their status to their children or community caregivers.

The following examples illustrate caregivers' responsiveness to the individual needs of families. In the comment below, the participant was talking about parents with less information about HIV who may refuse to consent to the testing of their child, because of a lack of knowledge:

> *"So like, we kinda like do home visits. We intervene whereby we start by issuing out the consent form, right? Then after the parents have refused that his/her child can get tested, that's whereby we go and try to talk with the parent to give the client more information and to bring the client to this light of HIV/AIDS, the risks you know, of the child maybe not being on treatment if the child is HIV positive."* (Participant 3, 27 years old, male, community caregiver, DIC3)

Another participant affirmed the responsiveness of DICs to the needs of individual families:

> *"In that of a case, that happened last month, there was a parent who was taken to the clinic after testing with the three beneficiaries. So we were not disclosed the status, the testing partners did not tell us anything. So what we did is we conducted a home visit last week. The parent told us that no, no the child (children) are negative and we didn't even ask. What we*

*are going to do is to support the guardian."* (Participant 9, 31 year old, female, social auxiliary worker, DIC3)

The data demonstrates that community caregivers from DICs had established good relationships with most of their clients, to the extent of disclosing their statuses to them, and receiving adequate services from DICs. Consequently, they contributed to progress in reaching the 90-90-90 HIV target. Participants responded that they had a positive relationship with the local clinics:

"*Okay in terms of that I would say we have a strong relationship with our clinics. So what happens is in terms of all the testing equipment, we get them from the clinic. So what we do is they offer us all the testing kit because we're a Non-Government Organisation, on a monthly basis. But what they want in return would be like, they want to see the target, how many did you reach a month. Yeah, we do have a strong relationship with them and even if let's say we've got someone who tested positive in our organisation, we refer that person to the clinic. So what happens the person who does HIV testing does that like, takes the client to the clinic and then when they get there they retest that person just to make sure the results they correspond. So we are having this strong relationship with the clinic. They even refer clients.*" (Participant 1, 34 years old, female, social auxiliary worker, DIC1)

*"We have that partnership because when I give them 15 clients, they will tell me, like, maybe out of 15, maybe 12 are still doing the right thing, but 3 – we can't find them. That's where they partner us with community caregivers who make sure that those clients are being traced again and then taken back to care. So, we do have that thing – the meetings whereby we arrange how we get hold of those clients and sometimes to make sure that we don't duplicate, because you know some clients, they test at the clinic at the same time come back to the organisation, so it's a duplication of the results."* (Participant 5 31 years old, female, community caregiver, DIC2)

*"Not instantly or on the first day, we meet with the client. But then as time goes, we have a relationship with them and probably they are able to tell us if okay, I have HIV or someone in my family has HIV. So questions can follow after if I've known you better, but on the first day it's really inappropriate to ask someone. At first, they don't even trust you, so you need*

*to build the trust first and then all those things can follow after when they free to talk to you and they can see ukuthi* [to say] *,'Okay now, this is the person that I can talk to', cos it's a sensitive issue to deal with; it's not easy to talk about it."* (Participant 17–24years old, female, community caregiver, DIC5)

The data gathered indicates that DICs received support from some parents, but had challenges with some who refused to grant consent for the testing of their children. Some who gave consent refused to disclose after testing, especially a positive status:

*"So, the support it varies with parents. Some of them, they are there, they want to be helped, they want the best for their kids, and so it becomes easier. It's easier to help someone who needs help, so but then if it's someone who doesn't really show interest. Ay, What you coming to give them? Then it becomes difficult, but with the kids I was working with, I can say it becomes more challenging. So, the support from the parents is a challenge from the parents, from my side."* (Participant 17, 24 years old, female, community caregiver, DIC5)

*"We deal with orphan and vulnerable children so I would say the majority of the support is good because we have support groups every month. We have a granny's support group, we have a support group for HIV infected parents and caregivers and we also have single parents' support group, so that is we work with the parents. We have workshops with the parents and the guardian and improve their parenting skills, as well as maintaining that bond between the organisation as a household. For the majority, we have a good understanding."* (Participant 6, 23 years old, female, community caregiver, DIC2)

*"Um, parents are supportive, because in most cases, we have to start with knowing the parent, know the entire household. So either the child stays with the mother, or uncle or aunt or whoever. The parents are very supportive because we usually have community engagement.*" (Participant 14, 34 years old, female, community caregiver, DIC4)

The other dimension was to establish whether support was directed to DICs from stakeholders such as the Department of Health (clinics), DSD and USAID-funded organisations. Data emerged that DICs also received support from parents and stakeholders. It is apparent that one of the strategies to ensure smooth implementation of HIV services was to build a sustainable relationship with all stakeholders. An effective implementation required collaboration of all the

parties involved. The data shows that all DICs had partnerships with local clinics, which were assisting them with testing, initiating their positive clients to receive treatment and working with DICs in adherence support.

The responses regarding the question of support as provided by USAID-funded organisations demonstrated that DICs received some kind of support:

> *"I would say through the supporting organisations, as I said before. Pact, DSD but most probably it's Pact because they have been supporting us. So I would say through the organisation, Pact came through, so with them we managed to get more knowledge even in terms of how do you go about in terms of disclosure, how do you prepare the parents to disclose to their beneficiaries. So throughout my experience, I would say Pact has played a huge role."* (Participant 1, 34 years old, female, social auxiliary social worker, DIC1)

> "*It's been good, we've had a lot of positive stakeholders who are assisting us including trainings that they provide to us, programmes that they bring to the organisation like YOLO. We had a programme called BREACH, we had a programme called DREAMS whereby it's a HIV prevention programme for the youth."* (Participant 8, 26 years old, female, social auxiliary worker, DIC2)

> "*We do get support from our clinics. We work with clinic and other testing partners and other clinics. Most of the clinics we get support and the schools, because we go there to identify and recruit our children, where we can and they sometimes they give us the … wouldn't say database, but they also refer us to say within these children need your support."* (Participant 15, 27 years, DIC3)

### 4.5 Driving Factors Behind Community Members Using Services

Impelling – a prominent theme emerging from this study – means to drive, force, or urge someone to do something (Maleka, 2016). For DICs to maximise their contribution to the 90-90-90 HIV target, they needed to encourage their beneficiaries and communities to consider HIV testing and if they tested positive, to encourage them to take and adhere to ARV treatment. The data shows that the DICs were an impelling force, using different approaches such as structured and unstructured programmes to motivate clients to take an HIV test and to live

healthy lifestyles when testing positive, including adhering to treatment. The information gathered from this study reveals that DICs were involved in community engagement in that communities were urged to have HIV tests and to take medication in the event that they were positive:

> "*I would say my role as a caregiver is to ensure that the clients that I'm working with, they do get tested and they have knowledge of HIV, and they take the treatment given that the results came ... so all we can do is to just support you and encourage you and give you referrals to go the clinics and whatnot, because we not really trained about HIV. So, we just like anybody who just assisting you with relevant information that we have. Thing it's just for us to encourage you to do the right things and to follow the protocol*." (Participant 17, 24 years, female, community caregiver, DIC5)

> "*Okay, my role would be, after the beneficiary or the clients have tested, it will depend if the client is ready to disclose to me. If the client has disclosed to me, that's whereby I'll ask the client if ... I'll convince the client to go to the clinic to get some treatment."* (Participant 2, 23 years old, male, community caregiver, DIC1)

The data also demonstrates that most of the structured programmes provided by DICs motivated beneficiaries to sign HIV consent forms. DICs that provided testing on their site took clients who had completed HIV consent forms to conduct tests there. However, for those who does not provide testing on site they would refer their clients to clinic or testing partners for testing and follow-up with the clients after testing.

> *"Yes they do help [*structured programmes] *and they make their beneficiaries to be aware that if they engage in sexual activities without protection, there's HIV there. No matter, irrespective of your age or whatsoever, HIV is there and there's also PrEP* [pre-exposure prophylaxis]. *Our beneficiaries are aware if they're sexually active there's a way of preventing HIV as well through PrEP. We refer them straight to clinic where they access that treatment and testing and so forth.*" Participant 16, 31 years old, female, community caregiver, DIC4)

> "*… because the basic, the main reason for those programmes, in most cases it's about HIV testing, adherent. They talk about PrEP, they tell, they even educate parents and children*

*that there are many ways to prevent HIV …"* (Participant 11, 25 years old, female, community caregiver, DIC3)

(Structured programme) *"It promotes testing yes, and then treatment is a process. Treatment, sometimes it does not happen immediately; we need to go on and on speak to the person. The testing, the testing happens a lot even without us having a campaign or awareness, but you find people are coming to test. Even our children, especially the over 12, because the over 12, according to the department, we don't need the consent of the parent. So, with those ones, they would come and test every time and if the child, because we still refer to them as children that's when we will call the parent in. So, they test a lot. The problem becomes the treatment and adhering because you find that other children will be like, where did I get this so why should I take treatment for it? So the treatment and adherence is a long process. The testing is not the problem. Yeah."* (Participant 8, 31 years old, female social auxiliary worker, DIC2)

The data reveals that motivation may also apply to those people who were on treatment and who, for whatever reason, had stopped adhering to treatment. Community caregivers, through home visits and programmes, provided motivation to them to reconsider taking treatment and adhere to it. However, participants reported that community caregivers encountered challenges in most DICs when trying to motivate treatment because clients refused to listen; not all clients were happy to receive their services. The following quotes provide some evidence that community caregivers motivated clients when circumstances called for it. Participant 6 (23 years old, DIC2) explained what she had done as a community caregiver with the families she was supporting:

*"… And if you are found to be HIV positive, we encourage you to also condomise all the time and adhere to your treatment and live a balanced healthy lifestyle."* (Participant 6, 23 years old, female, community caregiver, DIC2)

*"Yes, I can say it is vocal enough but then what we do as an organisation? Sometimes we have pictures to show children, you know, that if you don't adhere to treatment this is what's going to happen. So, in that way children get, like, they become afraid, of which I don't wanna like look like this person or I don't want my private part to be like this, so yeah."* (Participant 3, 27 years old, community caregiver, DIC1)

The findings reveal how structured programmes helped community caregivers and social auxiliary workers to prepare beneficiaries for HIV testing. Some beneficiaries took time to understand or agree to either test or disclose their HIV status. Most DICs would allow them time and not force them to test, but continued to do home visits, intervening through programmes and giving information. In most cases, they ultimately won their trust.

DICs prepared for testing in different ways, through educating their beneficiaries and individual counselling. When they were ready for an HIV test, they were given a consent form and sent for testing. In this way, by the time their clients went for testing, they were well informed about the processes of testing and its implications:

> *"So like, firstly I have my client information already. If I have my client whereby this client, I knew already that this client is at risk, I'll have to intervene to advise or to convince the client to know the statuses of the children. Through the home visits, that's whereby I plan maybe in a day that okay, today I'll be having information giving with my clients. Because these HIV testing programme, it's one of the services that we render here at the organisation. Okay, my role would be, after the beneficiary or the clients have tested, it will depend if the client is ready to disclose to me. If the client has disclosed to me, that's whereby I'll ask the client if…, I'll convince the client to go to the clinic to get some treatment."* (Participant 2, 23 years old, male, community caregiver, DIC1)

Stigma reduction was another factor in encouraging the use of services. Preparation may assist people to reduce the stigma attached to HIV. The data shows that most DICs were encountering clients who were still afraid to disclose their HIV status:

> *"The challenge is that we need them to give us skills so we can have the skill to dealing with HIV-positive clients, to get information that we need about HIV. Another challenge is that there are people who want to test, but they are afraid that other people in the township will know I came to test, because black people don't believe in confidentiality*." (Participant 4, 26 years old, female, community caregiver, DIC1)

> *"Those who are infected and affected, they are stigma-stricken, to say ay, they either refuse us access to their child. Or if their child comes here, then there will be consequences for the child. But we always try to mediate such situations and there's also that, maybe the child,*

*doesn't know the disclosure, doesn't know they are positive and then the child thinks I'm drinking these pills because I've got asthma and stuff and then we you go to the clinic you find the child is positive and then maybe is defaulting or is not gaining weight or something so they ask us to intervene and the child doesn't know he's HIV positive, so we also … there's that 50:50 but overall we get good support from parents."* (Participant 15, 27 years old, female, community caregiver, DIC4)

According to the data, the DICs provided optimal care to their beneficiaries, which helped to reduce the stigma related to HIV. This care was provided mainly through home visits. The study's participants indicated that when people realised that there were people who cared about them, who understood their situation and who were willing to listen to them, they started to develop trust and learn to listen, ultimately accepting help. Having won their clients over, participants would use home visits to provide education, which helped to eliminate the stigma attached to HIV:

"*Okay, we tell people about HIV and we encourage them to test and we encourage them to take treatment, and every time they must be free to talk to us so that we can help them if they need help. So, our plan is for them to live long and reduce the stigma."* (Participant 20, 44 years old, female, community caregiver, DIC5)

*"If the child takes medication while still at the organisation screening department we will ensure that the child takes the medication every day when at the organisation. And we also educate the children from the KidzAlive programme about staying healthy, staying safe, viral load and all those things that the child might not understand. But as an organisation, that's what we ensure – that they don't feel left out or, you know, stigmatised, feel like they are sick or there's something wrong with them, something bad with them. So the KidzAlive programme allows them to be happy, live normal lives as children and just know that you just have this responsibility and how to live the best lives regardless of the HIV status.*" (Participant 6, 23 years old, female, community caregiver, DIC2)

Participant 1 (34 years old, female, social auxiliary worker, DIC1) suggested that stigma was a reality they were facing regarding testing and disclosure, regardless of how much support they gave their clients:

*"I would say, in my own opinion, it would be the issue that we stay in this same community and then people are so sensitive in terms of the HIV issue, because if ever they come to our centre and they realise the person doing HIV testing is just my neighbour, so that mentality even if you do emphasise the issue of confidentiality. I strongly believe that it becomes a barrier in terms of saying you are having one person who is doing HIV testing and this person is staying in this environment. So most people, they are not as free or open for their statuses to be known. So, it's more like they are scared or it's a stigma; I don't know how I should put it. So that's the barrier we are encountering at the present moment."*

The data reveals that some clients they were supporting were not even on ARVs. However, after their interventions, they were able to refer them to a clinic for treatment. This was considered an effective strategy for referral:

*"I cannot say it's interesting. At the same time, it's challenging should I say, because sometimes you find it, like now, sometimes you deal with difficult clients. And then sometime you test the client, you find that the client is HIV positive and then when the client is HIV positive, when you want to link the client, the client will tell you, 'No, I'm not ready to be linked to care'. And then sometimes the client will go to the clinic when you take that client to the clinic, and then from there the client doesn't go anymore. So we mostly deal with defaulters, because sometimes you take the client this month then after three months down the line, the client doesn't take treatment anymore. So you have to re-test the client and re-link the client to care again. Yeah, it's that challenge."* (Participant 5, 26 years old, female, community caregiver, DIC2)

Participant 9 (31 years old, female, social auxiliary worker, DIC3) stated that they would do the following, to avoid stigmatising the children who attended a structured HIV-positive programme for children:

"*We took these children and mix them. There are consent forms which they sign, which is Vhutshilo 1 and Vhutshilo 2 so that they cannot feel rejected or somehow and stigmatised."*

*"As I'm saying it's stigma of parents disclosing to children to say 'you are HIV positive'. We've got a lot of crisis where the parent, they do want to tell their children. The child will take medication for so long and then when you ask the child, 'What medication do you*

*take?' And then they say, 'No, my mother said it's for diabetic' or for some other illnesses. Just to disclose serious issues to our community and to tell the child, 'You are HIV positive, this is what and this is what is going to happen", it's very difficult for our communities; they don't want it. As much as children are growing and becoming teenagers, it's when the problem is starting, then the child needs to be told that you are HIV positive; the treatment you are taking is not for diabetes.* (Participant 18, 34 years old, female, social auxiliary worker, DIC5)

Participant 19 (40 years old, female, community caregiver, DIC5) responded to unstructured programmes the DICs provided to children as follows:

*"Sometimes, some of them, they don't attend the programme fully. They dropped out along the way and then others, when they hear about testing, they just scared. Even after the all the education they have learnt, they just scared because I think it's the stigma behind that today I test and when things go wrong, what then afterwards? Even if you told them about the support and everything else, but remember the support also goes a long way, it does not only end here at the centre; it also goes home where you come from. And then let's say the child tests positive, she's never had boyfriend, she's never been involved with anyone and they know her as a virgin and she comes back and test positive. For her to go home and tell parents, 'Now I'm positive and I don't understand all these things', it's going to be a shock of a lifetime and meanwhile, those kids were left with their grannies and others with their relatives. They don't even know the cause of their parents passing on. that's why I'm saying parents and guardians should be educated as well."*

*"To deal with stigma, we have a support group called KidzAlive. So that support groups is only for the children that are HIV positive, whereby they come together because you find that when you speak with them when we do the one-on-one sessions, the child will tell you 'I'm the only one who's HIV'. They don't know each other's statuses as they are here, so we thought let us form a support group for the children, because we have a support group for the parent, for the grannies. So let them also have a support group so that they can see one another to say, 'I'm not alone and this one is coping fine', because there's others who are coping fine because they are taking their treatment. And there are those who are not taking it, so when we do support groups, at least they are able to speak with one another. They are*

*able to share with one another. Even with side effects of the treatment, they speak to one another. So it becomes much better like that because we the KidzAlive programme they also go out. So we have other organisations who will fund us to say, 'Go and learn more about HIV' where, where we take the group of children maybe to Durban. There they are exposed to other environment to see it's not the end, I can still travel the world even though I'm HIV positive, so we go out a lot in that."* (Participant 8, 31 years old, female social auxiliary worker, DIC2)

### 4.6 Readiness to Provide Services to Community Members

HIV services needed to be provided by people who were informed, substantially equipped, alert and able to reach out to communities. Consistent with the findings from this study, most DICs that participated in the study were doing their best to ensure that their staff members were educated or trained in HIV services. The data shows that they received support from USAID-funded organisations in the form of workshops covering the subject of HIV, with the aim of empowering them to assist their beneficiaries and their communities in general. The study found that most DICs were aware and educated about the 90-90-90 HIV strategy. The results prove that most community caregivers and SAWs were well informed about their role and responsibilities in HIV testing, treatment and adherence. Of the five DICs, only one (DIC5) was less informed about the HIV services, as they had either never received a workshop, or they had had just one workshop very long ago.

However, these organisations were able to work together. Participant 17 (24 years old, female, community caregiver, DIC5) mentioned the following*:*

*"There's like for, example, [*DIC2*]. Because they are trained for HIV and so when probably have events and they gonna talk about HIV, we know that we can go there and ask someone because they have better information. And through that we also learn something because they are trained in HIV services."*

The organisation she referred to was DIC2, which was well trained, and was helping DIC5 with HIV information.

The data demonstrates that most participants were informed about HIV services, especially as it

related to children, as the services they provided were mostly for children. A question was asked with the purpose of examining DIC employees' knowledge of consent for testing of children. The responses from participants revealed that most were fairly aware that parents had a right to give consent. Most participants were also aware that children from the age of 12 may give their consent for HIV testing. However, a few participants believed that the parents or caregiver were the only ones who could give consent to test children. This was the same group of participants that did not know about children's rights with respect to HIV testing. Some participants were aware of children's rights as per the Children's Act (2005), but they resisted the idea of 12-year-old children granting consent. These participants either stated that their organisation attended to issues of HIV in children through their parents' consent, or their view was that children of 12 were still too young to consent to their own testing.

Participants demonstrated a clear understanding of the 90-90-90 strategy and were able to rate themselves against the target. However, some participants were not aware of the rights of children giving consent, or the age at which a child started having the right to give consent.

The response from Participant 8 (26 years old, female, social auxiliary worker, DIC2) demonstrated a clear understanding of the rights of children:

> *"So a child under the age of 12, the parent or the legal guardian of the child has the right to give consent for the child to be tested. And then child over 12, as you know that children from the age of 12, they can go for abortion on their own, meaning they can give consent to test for HIV on their own because they can also go to the clinic to get contraceptives without consent of a parent."*

Participant 18 (34 years old, female, social auxiliary worker, DIC5) had the same understanding:

> "*The child can give consent, but when they older from 12 upwards."*

The data shows that most community caregivers understood what was expected of them, the parents and the testing organisation in cases where a child had tested HIV positive:

> "*Okay, if a child is tested HIV positive, then the role as an organisation is to refer the child so that the child may receive treatment and we also have a KidzAlive programme. We facilitate and educate HIV-positive children about living the best life and not allowing the*

*status to affect them. So that is one of the programmes that I left out – the KidzAlive programme, so as an organisation if a child test positive, the child gets referred, and as the caregiver of the child we ensure that the child is adhering to treatment. And then the screening department will go with the child to get treatment, go to the clinic and so forth, make sure that the child is taking the medication. If the child takes medication while still at the organisation, screening department champion will ensure that the child takes the medication every day, when at the organisation. And we also educate the children from the KidzAlive programme about staying healthy, staying safe, viral load and all those things that the child might not understand. But as an organisation, that's what we ensure – that they don't feel left out or, you know, feel like they are sick or there's something wrong with them, something bad with them. So the KidzAlive programme allows them to be happy, live normal lives as children, and just know that you just have this responsibility and how to live the best lives regardless of the HIV status."* (Participant 8, 26 years old, female, social auxiliary worker, DIC2)

However, the data reveals that some community caregivers were not aware of the age at which a child may grant consent to be tested:

*"I think a teenager, 13, but before then it has to be a parent or a guardian to give consent."* (Participant 17. 24 years old, female, community caregiver, DIC5)

Participant 13 (41 years old, female, social auxiliary worker, DIC4) also demonstrated resistance to children's rights to consent to their own testing:

*"The reason for us doing that is also, because like mentioned before, other parents know their kid's status; it's just that they don't want to disclose it. So if we test the child without consent and he/she finds out that they are positive, they will tell their parents and there will be havoc; we are avoiding that. So if the parents know their child's status, we tell them that if you know your child's status and still refuse to test, it's okay but we do go back to them to try and show them support." … "Other children who are 12 years are not matured enough; they are not aware of what is happening."*

Participant 19 (40 years old, female, social auxiliary worker, DIC5) shared the same sentiment when responding to the question of whether the HIV programmes the organisation was offering

were helping:

> *"It helps, but at the very same time the very same child who has tested; what if they come back positive? And remember, if you do with people who are between the ages of 14, teenagers, they can consent for themselves that I want to be tested and the results, they come and then those results, when they come back, whether they are positive or negative, they have to go back home. And they when you go back home, you find a parent who's not educated as you are, who's gonna shout at you who's gonna do what? So sometimes they are good, at times they are bad, because the parent is gonna come to you and say. 'How can you test without speaking to me?' meanwhile forgetting that a 15 years old can consent for themselves. So I feel that even our older generation, they have to be … there is education but – I don't know how to say it – they have to be more open to their kids so it could be easy for them to understand about HIV/AIDS. They have to understand HIV/AIIDS is like being diabetic because of once our communities are, like, in denial and putting and labelling and give HIV/AIDS different names, that's when everything goes wrong."*

Most participants who did not know the age of consent said 13 years, but it was apparent during the interviews that they were just speculating and did not know the correct age. Most DICs had one or more participants who had no idea about the actual age at which children could give consent for their own testing. None of the participants from DIC5 knew the answer to the question, whereas all participants from DIC2 knew the answer. Some also expressed an understanding of current knowledge and were able to share the information with their beneficiaries:

> *"I think that we are getting there because whatever information we give these children , just like the information on PrEP, we now have a lot of people interested in PrEP, especially these young ladies and young men."* Participant 13, 34 years old, female, social auxiliary worker, DIC4)

The research outcomes show that most DICs participating in the study ensured that their employees received workshops on HIV services and programmes and services of other organisations. Most DIC employees who participated in the study fully understood the content of the questions. They were able to answer all questions aimed at examining their knowledge of current trends relating to HIV. Therefore, most participants proved themselves to be substantially

equipped. All participants from all the DICs confirmed that they provided HIV services to the beneficiaries in the centre through different means, e.g. at clients' homes during home visits, and some also to the community in general. However, some DIC employees acknowledged that they still needed more education about HIV as it was a broad topic involving many new developments:

> *"Um… well, firstly when I started here in 2017, I didn't really, I knew what HIV is. I learnt in school, but I didn't really know enough and there was still that stigma around HIV. So the organisation assisted me by providing training for me and the training that we have, every year it gets renewed because there's also what different and new information coming up about HIV. So the organisation assists you to know how to deal with people who are HIV positive, know how to educate and especially – we work with kids – know how to give kids correct information about HIV so that if they are negative, they stay negative and if they are positive, they live healthy and balance lifestyle. So the organisation ensures that you get training and you know the policy, and you know how to deal with HIV-positive people and not to stigmatise people, and deal well with clients who wanna come in and come to be tested. So we provide a safe space for them, we are respectful to the client and we know how to deal with different situations during testing."* (Participant 6, 23 years old, female, community caregiver, DIC2)

Most DICs' employees were trained for HIV services by their employers through workshops or short courses. Participant 1 (34 years old, female, social auxiliary worker, DIC1) agreed that they received training on HIV services:

> "*I would say through the supporting organisations as I said before. Pact, DSD but most probably it's Pact because they have been supporting us. So I would say through the organisation, Pact came through. So with them we managed to get more knowledge even in terms of how do you go about in terms of disclosure, how do you prepare the parents to disclose to their beneficiaries. So throughout my experience I would say Pact has played a huge role."*

However, one DIC (5) admitted to still having some gaps in her HIV knowledge. Participant 17 (female, 24 years, DIC5) said*:*

*"I think the challenge would be proper training and guidance in terms the issue of HIV that will just be the only challenge hindering … What you asking? I feel like that will just be the only challenge. Because with proper information and trainings and guidance, there wouldn't be any challenge. You'd know how to tackle any situation that's gonna come. You'd know how to deal with anything that's gonna come. But because we limited within that, it becomes a problem given a scenario, maybe child tested positive but cannot disclose at that moment, what do you do? What are you gonna say to them or how are you gonna help them?"*

Participant 16 (31 years, DIC4) said:

*"Organisation has helped me a lot since I've been here. Like I've acquired a lot of information since our NGO open. Other partnerships such as, like, HIVSA which are the ones you bring them and interventions that we get we are embedding within the community, and they support us by giving us workshops and trainings on HIV. Every new information that is out there, we go to workshops supervision where we talk about things such as how we're going to bring change within the community."*

In addition to training, participants identified the availability and support of supervision as enhancing their added knowledge and skills in service provision. If faced with challenges when providing services, after trying their best to intervene without success, they went to their supervisors (SAWs) and reported the matter to them. Together with their supervisors, they would then discuss and educate each other on the best way to intervene. Participant 6 (23 years old, female, community caregiver, DIC2) was asked how she solved a case of difficult clients who were not cooperating. She said:

"*I have reported the matter to my social auxiliary worker. Um … we visited the school, we visited her so it's an ongoing and she then referred the case to social worker. But because there's, I think it's one social worker for I don't know how many organisations, so your case getting reached, it takes a whole long process so that is a big problem that we have faced. Because in these cases, we follow the protocols of reporting to the social auxiliary workers and social auxiliary worker will conduct also home visits with us. And then if there's no change, then refer to the social worker, but then you have to wait and wait and wait. So unfortunately that is one of the challenges that we face in the organisation. Yeah."*

Participant 3 (27 years old, male, community caregiver, DIC1) also demonstrated the effectiveness of supervision in HIV services. Her response was based on dealing with difficult parents denying a child consent:

> "*If the child is ready, I think the child must test because the child have his/her own rights. Yes. So I don't see a problem when a child is practising her or his own rights, so that is where I will seek for guidance again yet from social auxiliary worker."*

Another community caregiver (Participant 10, 25 years, female, DIC3) indicated the following:

> *"I, I report … if there is a problem, to my supervisor that this is the problem that I encountered then they tell us how to deal with it. For example the way you communicate with them. You have to communicate in a, a sort of, like, diplomatic way. You don't just have to say what is your status and all that?"*
>
> *"Yes, because of as a community* [location concealed]*, we being aware that most of our teenagers are becoming HIV positive, they are having this disease. Which is sad, like they don't have more information about it. So when we do campaigns we make sure that the sessions are more private."* (Participant 12, 29 years old, male, community caregiver, DIC3)
>
> *"The parents come for workshops as well as all the campaigns we have for HIV/AIDS and they sign consent forms for our children before we do any testing. So I would say they give us 100% or 90%. If I were to say, 90%, because some it depends – a caregiver may go to a household and find that the parent is not within the household so in that way we'd say maybe 90%, but its good when it comes to parents because they do consent and we get children tested."* (Participant 7, 29 years old, female, social auxiliary worker, DIC2)

### 4.7 Inadequate Resources and Support

The data reveals that four DICs received some kind of support from USAID-funded organisations, usually in the form of programmatic support and capacity building through the provision of training in HIV services.

As non-profit organisations, DICs did not generate an income, but relied on support from other stakeholders. The data collected confirms that all organisations were receiving financial support

from DSD, and that four DICs were receiving support from USAID-funded organisations such as HIVSA, Pact and Anova. One organisation (DIC5) received support from DSD only but, like the other four organisations, was in partnership with local clinics for HIV services. DIC5 had not benefited from any services from USAID-funded organisations. The data clearly indicates that these USAID-funded organisations were assisting DICs with HIV education through the workshops and programmes they provided.

For example, HIVSA introduced Vhutshilo, DREAMS, KidzAlive and structured programmes, and Pact introduced YOLO, a structured programme dedicated to young people. However, the data emphasises that DICs needed more support financially as they had been providing services but had not received the necessary financial support. The data indicates that sometimes, even when these organisations left the DIC for any reason, the DIC may fail discontinue the programmes, particularly if they needed financial support to sustain them. For example, a programme may be running on a Saturday, and be facilitated by HIVSA which would bring refreshments for participants. The challenge when they left and the DICs remained with manuals, was that they may have had the content, but would have been unable to provide refreshments, which may prevent the programme from being implemented.

The data suggests that progress may be hindered by the lack of a client's cooperation, e.g. where some parents were not cooperating with the community caregiver or SAWs. It was apparent from the research that the lack of cooperation directly affected progress on HIV services and other services to these families:

> *"I don't know, they don't trust us enough on giving us information about their children. You may find that the client doesn't tell you that she is HIV positive and the child is HIV positive too. Then the client tells you that this child is HIV positive … so I can say that our clients don't trust us; they don't give us full information. You might be surprised that of information you get from another person, maybe a relative or a cousin, the client is not there but the relative is here, is telling you lot of information that there is no idea of. So sometimes if our clients can trust us, I think yeah … we can have a way forward you know, yes."* (Participant 2, 23 years old, male, community caregiver, DIC1)

> *"Some of the parents, like, they are very difficult. I think it's because they are not well*

*educated on HIV, so some when you talk about HIV, they still have that mind-set that I'm going to die and stuff so yeah that is … if the information gets through the parent you know, I think that will be better."* (Participant 3, 27years old, male, community caregiver, DIC1)

The data provides evidence that all DICs were providing HIV programmes to their beneficiaries. However, of the five DICs participating in the study, four had structured programmes and one (DIC5) did not have a structured programme that addressed issues of HIV. Some programmes mentioned, such as YOLO, were aimed at a certain age group (15–24). Views were mixed about the YOLO programme's content for HIV services. Most participants implementing the programme mentioned that it was good in terms of covering the content on HIV testing, but some said it did not include much about HIV services and felt the content for HIV could be improved. The following remarks were made about the YOLO programme:

Interviewer:*" So looking at this manual that you are using for the structural programme, do you think they are addressing enough the issue of HIV testing, taking of treatment or rather adhering to treatment, the YOLO programme in particular."*

Respondent: "*No I don't think they are talking enough about the topics of HIV/AIDS and the topics, those topics in the manual they are not strictly focusing on HIV/AIDS but I don't know why because we do put our topics, like HIV/AIDs because there are no such topics in the manual. That manual…* (Shaking the head)" (Participant 2, 23 years old, male, community caregiver, DIC1)

Another participant who shared the same sentiment indicated the following:

*"I think the manual (YOLO) don't motivate enough, but your job as the facilitator is to build a kind of relationship with the people that you are facilitating and encourage them and motivate them about the positive aspects of knowing your HIV status and what is important, yeah. So the manual won't necessarily motivate enough because it's just there, as a content that you must display as the facilitator. But as the facilitator you know what your organisation stands for so you know that you have to motivate people and encourage people to know their HIV status."* (Participant 6, 23 years old, female, community caregiver, DIC2)

Participant 6 added the following to the question of what structured programmes they had in their organisation:

*"Okay, we have a programme called Power Girls. It's a programmes designed only for girls facilitated by ladies' facilitators and the programme is funded by a big organisation from overseas, which is also HIV prevention programme to teach them about life in general. Because there's HIV as a topic, there's teenage pregnancy as a topic, there's contraceptive as a topic. So, we have a programme which is very big at the moment; it was on television, I think two weeks back. They were speaking of how the programme is helping because it's not only us. We are a group of organisations, we are five running it, funded by the same people, so it's growing. It's becoming big; soon it's going to be a national programme and it started here."*

The other programme mentioned was Vhutshilo, aimed at different ages. All participants implementing the programme believed it had good content for HIV services, and promoted issues of HIV testing, treatment and adherence. However, some DICs implementing the programme said it had been discontinued owing to contractual challenges with the organisation facilitating the programme. One DIC was continuing with the programme, but no longer received support from the partner who had brought it on board. This is what some DIC centres said about the programme*:*

*Okay, this is, um, we have Vhutshilo 1; it's 9–13 year. Vhutshilo 2, it's 14 to 17 years, it's teenagers. Then we have KidzAlive, yah the KidzAlive, it's a package of Vhutshilo 3, it's 5 to, um 5–12 years."* (Participant 9, 41 years old, female, social auxiliary worker, DIC3).

The researcher asked Participant 9 whether the content was able to assist with regard to testing, treatment and adherence, and she said:

*"Yes, they are helping because we started the sessions in June and after that, when we call parents for testing, they come in numbers."*

Participant 6 responded to the challenges that they were facing as employees of the DICs as follows:

*"Um we have some challenges, um there are beneficiaries who do not know their status, their HIV status, and parents are afraid to tell them about their status. So when they come to the centre, we take them to a programme like Vhutshilo 2; it's prevention of HIV, and Vhutshilo 3 is where you know your status. But we take them for Vhutshilo 2, because they*

*don't know their status. At the same time, we do have one-on-one session to help them disclose the status of the beneficiaries because they are failing to tell them."*

*"Yes, so it's got Victory session, which is an HIV prevention, starting from the social aspect of the child to the home aspect and then to the mother and girl or mother… usually we work with girls; our target with boys is very few. Mother to child bond to say your mother should be the first person to talk to and then we go to HIV information and stuff. And then there's that Victory which is catered for HIV positive in fact mostly, not mostly, all HIV-positive children they attend Victory and KidzAlive, and then with KidzAlive there's also parents involved there. They also have their own sessions, another one, which is called Financial Capabilities where the mother also attends. It's a financial skills programme; the mother who also attends, there's programmes. It's a four-hour session, sometimes split it to four days because you can't do it one day, 24 hours. So the parents would also attend and then we also have our … it's a structured programme, I'm not sure if the campaigns go in there also, the campaigns."* (Participant 15, 27 years old, female, community caregiver, DIC4)

## 4.8 Conclusion

Chapter 4 included results from the participants' views, which were analysed using thematic analysis by identifying different themes and codes to present their views. A demographic table of the participants' information was included. The data demonstrates that the participants were aware of their responsibilities as community caregivers and social auxiliary workers on HIV services. Consequently, their role in the 90-90-90 strategy was crucial. Chapter 5 will draw on the major findings and present conclusions and recommendations.

# CHAPTER 5: MAIN FINDINGS, CONCLUSION & RECOMMENDATIONS

## 5.1 Introduction

This chapter highlights the main findings of the study, which are discussed in line with the analysis presented in Chapter 4 and the theoretical framework underpinning the study presented in Chapter 2. They will be summarised according to the objectives of the study. The chapter will provide a conclusion and recommendations emanating from the study, and will present future research prospects.

The aim of the study was to explore the strategies employed by drop-in centres (DICs) in contributing to the 90-90-90 HIV target adopted by the South African government from UNAIDS. It was hoped that the study findings would benefit the organisations that participated in the study, as well as those who would relate to the findings. The researcher was inspired to conduct the study following the success of countries that had already realised the 90-90-90 target. Moreover, he was motivated by the statement made by UNAIDS data (2019), indicating that children had been left behind in receiving HIV services, which in South Africa could become easily accessible through non-profit organisations such as DICs.

## 5.2 Main Findings

The summary of the findings is presented according to the objectives the study sought to address.

### 5.2.1 Objective 1: Facets of implementation plan for HIV testing and management

According to the data presented, some DICs demonstrated good governance in HIV services, as they had clear policies in place. They were also able to empower their employees with recent knowledge of HIV/AIDS and fairly frequent workshops on the DIC's policies. This aspect of the DIC was critical as it could determine whether the DIC would succeed or fail in its mission. This was in line with Max Weber's theory, which addressed the broad questions of how and why organisations came to be, took the forms they did, behave as they do, and survived or failed. King, et al. (2010) stated that organisations were actors that could exert their influence on individuals, shape communities and transform their environments. It was clear that this was attainable through good governance. Policy provided clear guidelines on the scope of the practice

of an organisation. Having a policy helped social auxiliary workers and community caregivers in carrying out their duties with confidence. It was, however, evident that irrespective of whether a DIC had a policy in place, or whether its staff members had been orientated in the policy, that did not hinder them from providing the service. In addition, community support, supervision and sponsors enhanced the work of these DICs.

Four DICs in the study did not have a policy or strategic plan for HIV roll-out processes. Despite this challenge, they provided comprehensive HIV services to their beneficiaries and the community in general. Policy orientation to staff members still presented a gap in DICs. Consequently, the findings reveal that four DICs provided HIV services randomly, without a proper plan in place.

The data shows that these DICs are governed differently, although some of the approaches employed were similar. For example, of the five DICs, only two (DIC1 and DIC2) were providing testing in their centres; the others referred patients to clinics and USAID testing partners. This was in line with the previous literature which maintained that the effectiveness of HIV services may be well executed through proper planning, focusing on the best way to manage it, and tailoring it to the setting of the service provider and recipients of the services (WHO, 2016).

The findings show that training was taking place in most DICs, aimed at empowering employees to provide quality HIV services to their beneficiaries and the community. The strategy in Cambodia (a country that had reached the 90-90-90 HIV target) included providing knowledge of HIV and access to sexual reproductive health services. This entailed ensuring that, by 2020, 90% of young people would have the skills, knowledge and capacity to protect themselves from HIV and would have access to sexual and reproductive health services (Pegurri, et al., 2015). In South Africa, this group was easily accessed by NPOs such as the DICs. Therefore, their ability to transfer their knowledge and empower and strengthen community caregivers and SAWs became important in realising the 90-90-90 target.

It was evident that USAID-funded organisations played a vital role in empowering these DICs with trainings. Although the participants agreed that there had been trainings, some DICs expressed their concern, indicating that some of the trainings required a specific number of

people, which meant some would be excluded. Participants from DIC5 mentioned that they had never received any HIV training as they were not in partnership with any USAID-funded organisations.

The findings show that the DICs were providing services to orphans and vulnerable children (OVC), especially those infected and affected by HIV/AIDS. This was in line with the concerns of UNAIDS, as outlined in its 2018 and 2019 data. The UNAIDS 2019 data report documented 76%-63%-46% for children from birth to 14 years, against the country's achievement of 90%-62%-54%. Therefore, the 90-90-90 HIV target as it relates to children was below the rest of the country's progress. Clearly, there is still a lot to be done regarding HIV services to children. This study suggests that DICs were doing a good job in focusing on this vulnerable and neglected population through their HIV services.

According to the study's findings, management of DICs had not been interfering with the hierarchy of case management between clients, social auxiliary workers and community caregivers, or outside stakeholders such as social workers from the Department of Social Development (DSD). This line of supervision was observed in all DICs that participated in the study, which is in line with McGregor's Theory Y (2006). Theory X encompassed the old view of workers, which held that employees preferred to be directed, wanted to avoid responsibility, and cherished financial security above all else. McGregor believed that organisations that embraced Theory Y were generally more productive. This theory incorporated a range of views: humans could learn to accept and seek responsibility; most people possessed a high degree of imaginative and problem-solving ability; employees were capable of effective self-direction; and self-actualisation was among the most important rewards that organisations could provide their workers. All the DICs that participated applied Theory Y.

Two DICs were doing excellently well in developing their employees regarding HIV services and the other two were moderate and the last one admitted that they haven't receive any training whatsoever but they empowered themselves, using Google to update their knowledge of HIV. The first two (DIC1 and DIC2) admitted that they received good support from management with regard to empowering their staff. The moderate two (DIC3 and DIC4) indicated that they received training, but only after a long time and only attended by a specific number of people. This suggests that employee empowerment was moderate.

Irrespective of the majority of participants' views that they received support from management, some expressed the concern that managers communication is poor, which badly affected employees. Some claimed that they had skills in HIV services such as HCT, but felt that management did not consider how those skills could be applied to the benefit of the organisation's HIV services.

This concern reflects what had been provided in organisational theory, which stated that the focus on human influences in organisations was observed most noticeably with the integration of Abraham Maslow's hierarchy of human needs into organisational theory. This indicates that people had different needs and, therefore, were motivated by different incentives to achieve organisational objectives (Hatch & Cunliffe, 1997). Similarly, this theory looks at how the organisation brought together resources for its success, such as human resources, policies and procedures. The results indicate that some employees' needs had been neglected by management (like adequate trainings for HIV or proper orientation in policies), which may affect their work, and consequently affect DICs' HIV services and their contribution to the country's 90-90-90 HIV target.

### 5.2.2 Objective 2: Contribution of partnerships and support from HIV services stakeholders

The study shows that the DICs were collaborating with more than one partner for the provision of HIV services. Among others, was the DSD, which was funding them, the Department of Health (through local clinics) and USAID-funded organisations. Through these collaborations and partnerships, they were able to maximise their contributions to South Africa's 90-90-90 HIV target. These findings were in agreement with previous literature conducted on partnerships and collaborations with NGOs, which were churches. Churches, in partnership and collaboration with HIV organisations and the health sector, were reported to have increased organisational capacity, defined as increased organisational empowerment, to partake in more effective and novel HIV/AIDS prevention activities (Coleman et al., 2012).

The outcomes reveal that all the DICs in partnership with USAID-funded organisations demonstrated a higher level of knowledge on HIV services. This concurs with previous research that indicated that, in the South African context, NGOs in partnership with USAID and PEPFAR were equipped through training, resources and whatever they may need to enhance their HIV services (Jobson, et al., 2017).

Trust, as one of the elements, posed a challenge between community caregivers/social auxiliary workers and service users. It was one of the most important elements emerging as an important component of collaboration in this study. The HIV services provided by DICs to households were based on trust. This was because mistrust between a DIC and a client could possibly lead to clients refusing to test, and those who tested refusing to disclose their status. Where trust prevailed, there seemed to be cooperation by the service users to take up services and adhering to HIV management. However, where mistrust existed, uptake of services was derailed. For example, some parents were not comfortable discussing issues of HIV with community caregivers or social auxiliary workers. Mistrust subsequently affected the last two 90s (taking of treatment and adherence) of the 90-90-90 HIV target. In addition, trust may have been compromised by the stigma associated with HIV. The findings around trust are supported by the study conducted by Krause and May (2016), which identified the issue of trust as an obstacle in HIV disclosure. However, the final findings of their study showed that trust between the service providers and service users was improved through information giving and educating people living with HIV. This is in line with the findings of this study which shows that trust with clients was not obtained in first encounter between community caregivers and clients, but it was developed over time. Though some families would show no interest in working with community caregivers their persistence paid off at the end because trust was established and clients would disclose their HIV statuses or those of their children.

The findings show that DIC services were able to respond to most clients' individual needs, especially in HIV services, regardless of their level of education or the number of workshops they received. The approach of DICs is supported by previous literature from Richter, et al. (2009) , which indicated that it is vital to have programmes that would strengthen families affected by HIV/AIDS, especially as a support system to those who infected by HIV/AIDS. It became a challenge if they were less informed about the virus and lacked knowledge on how best

to support affected family members, including children (Richter, et al., 2009). Research conducted by Vaz at al. (2011) revealed that HIV-infected children were given limited information about their health. They suggested that health care providers may serve as important sources of support to parents as they decided when and how to talk openly with their children about their health.

Previous studies proved that for linkages to be effective and successful, the relationship between community caregivers and providers in the health system should be characterised by mutual respect and understanding (Sips, Mazanderani, Schneider, Greeff, Barten, & Moshabela, 2014). If the relationship with clinics was good, they would be able to provide a good service, since they would refer their clients who are ready for testing and support those that the clinic would identify as defaulters (Sips et al., 2014). It is apparent as per the findings of the study that the good relationships between the local clinics and other testing partners with DICs contributed to the acceleration of HIV services, and maximise their contribution to South Africa's 90-90-90 HIV target. Other DICs who are testing on site mentioned that when they test some client's positive

Support was identified as an important element in HIV services. Some families needed support to understand the basics of HIV. Without support, they may appear to be ignorant, but with support they would be able to understand HIV and eventually do what is actually expected from them. Previous research explains why some parents may not disclose the status of their children. According to Yeap et al. (2010), parents sometimes feared seeking help for their children because they felt guilty that they had infected them. They argued that most parents had incorrect perceptions about ART, believing that it would make children sickly. Community caregivers and SAWs indicated that it was difficult for them to provide accurate services to families who were not willing to be open by disclosing their HIV status. This concern was raised by most participants from all DICs that participated in the study. Other researchers, such as Baxter and Abdool Karim (2016), suggested that educational programmes may assist in dealing with this kind of problem. However, in terms of meetings and community campaigns organised by DICs, the data confirms that most parents did attend, which afforded DICs the opportunity to educate these parents as suggested by previous research findings.

Data shows that DICs also have support from USAID-funded organisations, bringing programmes that were implemented to the beneficiaries. As their support was not permanent, most of the programmes they introduced were structured (they had manuals). Therefore, DICs were able to continue with them even though their initiating partner was no longer with them. The data reveals that these partners provided training that capacitated the DICs and assisted in fast-tracking their contribution to the 90-90-90 HIV target.

Through collaboration with clinics, parents, USAID and the community, DICs were able to respond to the HIV services needs of their clients and the community. The findings reveal that DICs were able to respond to the needs of people who were based in remote areas, some of whom were unable to go to clinic to take their treatment, by helping them to obtain the treatment. The existing relationship between organisations and local clinics encouraged linkages of HIV clients. The study shows that the partnership between USAID-funded organisations and drop-in centres fast-tracked HIV testing, treatment and adherence to treatment by DIC beneficiaries.

### 5.2.3 Objective 3: Contribution of structured programme to promoting HIV testing, treatment and adherence

As the primary root of support to children or any individuals affected by HIV, it was crucial that families had a basic knowledge of caring for HIV-positive children and adults (Dave, Peter, Fogarty, Karatzas, Belinksi, & Pai, 2019). The study findings are in line with the Dave et al. (2019)'s literature, as community caregivers were targeting families through home visits and programmes to test, treat or encourage adherence to treatment.

The data shows that motivation also applied to those people who had been on treatment, but for some reason had stopped adhering to treatment. Community caregivers, through home visits and programmes, motivated them to reconsider taking their treatment and adhere to it. Studies conducted in South Africa, Kenya, Mozambique and Peru specifically used directly observed therapy, through a community worker, lay worker, a peer or even a partner, to ensure patients took ARTs and experienced sustained viral suppression (Garrett, et al., 2018). This study demonstrates that people with support, especially from community workers, were more likely to adhere to treatment and have their viral load suppressed. Generally, those who received support from their families had shown a high percentage of adherences (Plax, Garbutt, & Kaushik, 2015).

Other studies suggested that a strategy that would help realise the 90-90-90 target was when secrecy about HIV was tackled through, e.g. better public information about HIV, encouraging people to share results with others that they trusted, encouraging openness about the cause of death, and, at the same time, respecting people's rights, and preventing stigma and discrimination (Nansseu & Bigna, 2017; Rachels, 2017)

DICs shared the same sentiments with regard to programmatic support which USAID-funded organisations were providing to them, except for one (DIC5), which indicated that they had received no support from USAID-funded organisations since terminating their relationship with one that was supporting them in 2018. DIC5 received minimal support from clinics, which only came once in a while or sometimes not at all. This research highlighted the importance of partnerships and collaboration. Previous research shows that, in the South African context, NGOs that were in partnership with USAID and PEPFAR were equipped to receive training, resources and whatever else they may need to enhance their HIV services (Jobson, et al., 2017).

Another component identified by the findings of this study was the importance of the programmes. The results of the findings show that DICs were providing different programmes, both structured and unstructured, that were able to equip beneficiaries to the extent that they were able to understand the benefit of an HIV test, the benefits of treatment when testing HIV positive, and the importance of adhering to treatment. This is in agreement with literature by Thurman, et al. (2016), who claimed that a home visiting programme contributed to increasing rates of HIV testing among beneficiary children and their relatives who were also beneficiaries of the programme, when compared with those living in similar circumstances who did not receive programme services. The education and psychosocial support that home visitors provided may help caregivers to understand the benefits of HIV testing, and cope with the implications of a positive diagnosis, while also reducing the stigma associated with HIV/AIDS (Thurman et al., 2016).

The results of the study confirm that most DICs encountered clients who were still afraid to disclose their HIV status. This is in line with previous research which says that some people who were asymptomatic may be in denial and as a result, may not feel ready to start taking treatment for life. This point to a need for adequate counselling and support, and for the health benefits of early initiation of care need to be sufficiently explained (Granich et al., 2017). Most community

caregivers and SAWs suggested that fear of stigma may contribute to non-disclosure. Community caregivers recruited these clients to become part of programmes such as support groups, to educate them more about HIV. Previous literature shows that the spacing of home visits may have influenced patients' adherence; more frequent visits may potentially close this gap (Bigna, et al., 2016). The data indicates that issues such as stigma were addressed by both community caregivers and SAWs in different ways, such as age-appropriate programmes, and support groups for HIV children and adults. The organisations also involved communities in educating them about HIV services and how to live with people affected by HIV, which addressed the issue of stigma. This is supported by studies such as a study conducted by Mahajan, et al. (2008) which asserted that addressing stigmatisation of HIV/AIDS included teaching people about HIV/AIDS, which would enhance tolerance and understanding of the virus and reduce stigmatisation. The data shows that the DICs avoided stigmatising children or other beneficiaries in the support group by preventing suspicion among others when they recruited for an HIV support group.

The results demonstrate the level of care that the DICs provided to their vulnerable clients. This is in agreement with previous studies that indicate that active linkages, such as taking a person who has tested positive by the hand to the clinic for ART initiation, would ensure that they started with treatment (Baxter & Abdool Karim, 2016; Gardner, et al., 2011).

Research shows that community health workers/lay workers were most successful in facilitating linkages to care or treatment (which represents the second 90) (September & Meehan, 2016). It illustrates the care they provide to families who need it as they are affected by HIV. Most of the data shows that the role of community caregivers and SAWs was to provide support in the form of home visits, in line with the needs of families. For example, if the family had a member who disclosed their HIV-positive status to the DIC, they provided support in terms of ensuring that they adhered to treatment which would eventually suppress the viral load.

While DICs had HIV programmes that were provided to their beneficiaries, there were some gaps suggesting that the content of these programmes for HIV could be improved. This was due to the fact most HIV programmes that the DICs were providing were not structured. The structured programmes provided by DICs were able to motivate beneficiaries to take up HIV testing and treatment. The programmes extended to those who had stopped adhering to

treatment. Community caregivers, through home visits and programmes, encouraged them to reconsider taking treatment and to adhere to it. Most community caregivers and SAWs suggested that stigma may be a problem for non-disclosure. Community caregivers recruited these kinds of people to become part of programmes such as support groups, to educate them more about HIV, and to reduce stigma.

### 5.2.4 Objective 4: DIC employees' knowledge and understanding of strategies for reaching 90-90-90 HIV target

*Lobbing for support and partnerships as strategy of addressing HIV*

The results demonstrate that DICs received support from USAID-funded organisations in the form of workshops covering the subjects of HIV, with the aim of empowering them so that they may assist their beneficiaries and communities in general, which is in agreement with literature according to Abrams and Strasser (2015) which indicated that the best way to implement the first target of 90-90-90 was to ensure that there was a routine test in the community. This would be possible if employees (social auxiliary workers and community caregivers in the context of this study) were trained in the importance of, and proper approaches to, testing of children and educating parents about the importance of giving their consent to test their children.

The data reveals that, through training and support from different stakeholders, most community caregivers were well informed about HIV services, to the extent that they were able to educate the community and their beneficiaries. However, a few participants believed that for testing of children, parents or caregivers were the only ones who could give consent. This was the group of participants who did not know about the rights of children on HIV testing. This concurred with research conducted by Haffejee, Ports & Mosavel (2016), who stated that health care volunteers had limited knowledge of HIV services, often due to a lack of training in a health-related field. Haffejee, et al. (2016) argued that this was a concern that needed to be addressed, as community volunteers should be the custodians of general HIV information for their communities. Although not sufficient to change behaviour and reduce risk, an important component of HIV prevention was a basic understanding of HIV and how it spread, which was lacking among many general volunteers (Idele, et al., 2014).

The data demonstrates that the DICs received support from the community. Participants indicated that when they called parents' meetings, the parents attended, which is a clear indication that DICs received such support. All DICs emphasised that they received maximum support from the community. The data suggests that DICs were able to bring the community together on issues of HIV services. Two DICs (DIC1 and DIC2) reported that they provided testing in their centre to accommodate clients or community members who may feel uncomfortable to go to the clinic.

*Knowledge of community caregivers about children and HIV as a strategy to provide correct education about HIV*

Some participants were aware of the rights of children as per the Children's Act 38 of (2005), but they resisted the idea of a 12-year-old child giving consent. They stated that their organisation attended to issues of HIV among children by obtaining parental consent. Their view was that at the age of 12, children were still too young to consent to their own testing. This concurred with the research of Davies, et al. (2015) who indicated that parents were concerned about 12-year-olds giving consent for their own testing They believed children were still too young to understand the implications of consenting to testing. A counter-argument was raised, highlighting the case of Nkosi Johnson, and contending that a child of 12 may be able to understand HIV, just as Nkosi Johnson had in the 1990s when he was at the age of 11, he addressed international conferences about his AIDS status. Nkosi Johnson made an enormous contribution internationally to attitudes towards HIV/AIDS (Van Dyk, 2010; Ndimbwa, et al., 2013).

An imbalance in the level of knowledge and understanding of HIV among the DICs' employees was evident. Their knowledge and understanding of HIV services was low, although they still provided HIV services to their clients. They also sought assistance from the nearest drop-in centre whose employees were well trained for HIV services. A supportive administrative and educational aspect in supervision between SAWs and community caregivers played a vital role in the implementation of HIV services, thereby maximising the contribution of DICs to South Africa's 90-90-90 HIV target. Campaigns had been organised within the DICs, which provided education about HIV, and which both their beneficiaries and community members attended.

*Supervision as a strategy to provide quality HIV services which remained focused on 90-90-90 target*

The data indicates that DIC centres used supervision as a strong element to eliminate challenges faced by community caregivers in the provision of HIV services. The community caregivers reported any problems they had, from the field, to the social auxiliary workers, and they worked together to arrive at a solution. This concurs with previous research that suggested creating a more collaborative atmosphere for data validation by allowing supervisees to offer solutions to correct their own mistakes (Ellis & McKeown, 2017). The study participants reported that a supportive, administrative and educational aspect in supervision between the SAWs and community caregivers played a vital role in the implementation of HIV services, consequently maximising the contribution of DICs to South Africa's 90-90-90 HIV target. This is in line with previous studies which suggested that the 90-90-90 target may require more than just client services, but also to support those who were providing services such as community caregivers (Ellis & McKeown, 2017).

*Trainings as a strategy to empower social auxiliary workers and community caregivers on 90-90-90 target*

Training of community caregivers and social auxiliary workers was considered an important aspect of ensuring that DICs' clients received adequate education. Working with people on a constantly-changing issue such as HIV may require continuous updating with recent information about HIV, in order to provide adequate services. The results show that, through the support of clinics and USAID-funded organisations, DICs were doing their best to ensure that their employees were educated or trained in HIV services. USAID-funded organisations were given workshops addressing topics around HIV, with the aim of empowering them so that they could assist their beneficiaries and communities in general.

Haffejee, et al. (2016) maintained that health care volunteers had a limited knowledge of HIV services, often due to a lack of training in a health-related field. This was a concern that needed to be addressed, as community volunteers should be the custodians of general HIV information for their communities. Although not sufficient to change behaviour and reduce risk, an important component of HIV prevention was a basic understanding of HIV and how it spread, which was

lacking among many general volunteers (Idele, et al., 2014).

*Awareness campaign and HCT*

A popular approach to working with communities, especially regarding HIV, was through awareness campaigns. According to the study findings, four of the DICs had campaigns providing education about HIV in their organisation, which both their beneficiaries and community members attended. Only one (DIC5) did not run campaigns for HIV as it reported having insufficient training in HIV. However, it gave educational talks on HIV during the home visits when they visited their beneficiaries. WHO (2016) recommended that, in the context of community mobilisation around the importance of learning one's HIV status, HIV testing and counselling should be offered whenever a patient showed signs or symptoms of HIV infection or AIDS. However, the researcher is of the view that counselling should be provided to anyone who is willing to test; such group should receive pre and post-counselling regardless of the outcome of the test. This will help in providing tailored educational session to individual who would have tested. For example, if one tests negative they will be encouraged and be educated on the ways or behaviours that will help them to stay negative. In the other hand, when one tests positive, they will be educated about the implications thereby, initiated on treatment and importance of adhering to treatment.

The literature indicated that strategies, such as provider-initiated testing community-based voluntary counselling and testing (Coates et al., 2014) and home-based testing (Gardner, et al., 2011), had been implemented to improve HCT uptake. HCT approach was well understood and implemented by two DICs according to the study findings. These were the organisations that provide testing on site. They are providing HIV counselling and testing to both children beneficiaries and adult beneficiaries. Furthermore, they also do home testing and provide counselling and consequently take those who test positive by hand to local clinics and makes follow-up with regard to adherence to the treatment. Otherwise the other three DICs only provide HIV counselling on site and through home visits to the beneficiaries and refer those who want to test to their testing partners, clinic or USAID funded organisations like Anova.

The DICs provided home-testing to those who felt uncomfortable to test anywhere else. The approach of these DICs concurred with previous studies which maintained that reaching the 90-90-90 targets would require a rapid scale-up of HIV testing and innovative ways to reach populations who did not yet know their HIV status (Coates et al., 2014). Strategies such as provider-initiated testing, community-based voluntary counselling and testing (Coates et al., 2014), and home-based testing (Gardner, et al., 2011) had been implemented to improve HCT uptake. This could be done in a community that had accepted the DICs and fully understood their role in the community, especially regarding HIV services. Research conducted by Dave, et al. (2019) shows that home-based HIV counselling and testing directed towards families of HIV-positive patients in South Africa yielded 93.7% of those diagnosed HIV positive using these methods. Another study, also looking at home-based HIV counselling and testing initiatives in South Africa, demonstrated that 76% were linked to care (Manjezi, Fatti, Mothibi, Shaikh, Oyebanji, & Grimwood, 2016).

To prevent the spread of the disease, community engagement was not only directed at infected individuals, but also at those who were not (Ndimbwa, et al., 2013). This is linked with the first objective of the study. The study's findings shows that some DICs shared information about HIV services with their beneficiaries and the community where their organisation was based. They did so through community engagement and some through home visits conducted with their beneficiaries. The findings suggests that this is one strategy for reaching out to the community and beneficiaries in promoting HIV services. This information sharing emerged mostly following the researcher's question about the role of community caregivers or SAWs in HIV testing, treatment and adherence services. Kilembe, et al. (2015) suggested that a better strategy to enhance uptake of HIV testing was an integrated or combined test or treat strategy. The study found that HIV campaigns were common for testing and treatment, and mobile interventions were commonly used for HIV testing and educational programmes, and for digital strategies (technology interventions) deployed for viral suppression (Dave, Peter, Fogarty, Karatzas, Belinksi, & Pai, 2019).

### 5.2.5 Objective 5: Challenges for DIC employees in contributing to 90-90-90 HIV target

The study results reveal that the majority of parents were supporting DICs regarding the HIV services they provided. However, a few parents had not supported the DICs. This became a challenge as the involvement of parents may be necessary, particularly when the service was provided to a child. Testing children, according to the Children's Act 38 of 2005, required consent from parents for children below the age of 12. According to Yeap et al. (2010), parents sometimes feared seeking help for their children because they felt guilty that they had infected them. They argued that most parents also had incorrect perceptions about ART, believing it would make their children sickly. However, the findings show that DICs did not stop trying to reach out to difficult families through education. They provided education as a way of trying to make the parents understand the benefits of HIV services. This is in line with the literature by Baxter and Abdool Karim (2016), who suggested that educational programmes may assist in dealing with difficult clients.

The DICs relies on support from the government as they are NGOs, which means they are not making any profit to sustain themselves. The findings reveal that one of the criteria for sampling the DICs was that they should be funded by DSD. Therefore, all the DICs that participated were funded by DSD. The findings confirm that all organisations were receiving financial support from DSD. The data also shows that four DICs were receiving support from USAID-funded organisations such as HIVSA, Pact and Anova. However, the support they received from most of these organisations was not in the form of cash, but capacity building and programmatic support.

The case study of Cambodia showed increased investment in tackling HIV, including 25% for HIV prevention and 6% for social enablers (UNAIDS, 2019). According to a progress summary report, Cambodia had succeeded as a result of strong political commitment, community engagement and high levels of support, over more than two decades, from donors (UNAIDS, 2019). This was a lesson that could be learned by the South African government to support NGOs such as DICs, to enhance their HIV services to the vulnerable population.

Results indicate that some organisations were unable to continue with programmes that were yielding good results in HIV services due to a lack of support from other stakeholders. Two DICs mentioned that they had terminated their contract with a USAID-funded organisation, and had stopped the programme because they could not afford to continue. This was based on the fact that when USAID funded organisations like HIVSA comes with a program in the organisation, firstly they will train specific number of caregivers (maybe four) to implement whatever HIV program they are targeting. So, as the program runs they usually provide participants with refreshments and provide stipend to trained facilitators. Consequently, when they leave the organisation, the facilitators will be discouraged to continue without stipend and children will also be discouraged to attend without refreshments. Some programmes discontinue because few caregivers were trained and when they leave the centre it compromises the continuity of the program. This could be solved by government intervention to ensure continuity in services that had been brought in by USAID-funded organisations, as they would not be available to these organisations forever.

Because the DICs were working with families, for their services to be effective, they needed family support. Despite the fact that some parents are cooperating with the DICs, there are also some who are not cooperating. It is apparent that the lack of cooperation is directly affecting their progress in HIV services and other services to these families. Ultimately, it would affect the progress of DICs in their contribution to the country's 90-90-90 HIV target.

It is ostensible that DICs were implementing programmes in their organisations, some structured and others unstructured. Structured programmes had all been brought in by USAID- or PEPFAR-funded organisations. USAID-funded support is contractual and after the end of the contract with DICs, they may choose to not extend their stay. The findings reveal state that three DICs stopped implementing the Vhutshilo programme because the contract between them and the organisation that bought the programme had ended. Surprisingly, these organisations still have the manual and some of the community caregivers who were trained to run the programme, but they are not implementing it anymore.

## 5.3 Conclusion

The study shows that the DICs are performing well through their employees, CCG and SAW in HIV services, especially in reaching out to the most vulnerable population. This is in line with the McGregor's theoretical approach, which believed that organisations that embraced Theory Y were generally more productive (McGregor, 2006). This theory held that: humans could learn to accept and seek responsibility; most people possessed a high degree of imaginative and problem-solving ability; employees were capable of effective self-direction; and self-actualisation was among the most important rewards that organisations could provide their workers. This was the case within the DICs because most caregivers were willing to go out to conduct home visits, irrespective of a lack of training in some aspects of HIV services.

The results indicate a gap in policy development for HIV programmes and the absence of a clear strategic plan for HIV roll-out. The study reveals that although DICs used their own models to roll out HIV services, it was not documented.

## 5.4 Recommendations from the study

The results demonstrate that some DICs did not have a policy or strategic plan for HIV roll-out. The DICs suggested clarifying the following facets to include in the strategic plan towards achieving the 90-90-90 HIV target: conduct a situation analysis; define challenges; define for whom HIV testing services will be differentiated; adapt or build models of differentiated HIV testing services; design a strategic mix of differentiated HIV testing service delivery models – adapt, build or drop; and evaluate and decide what additional differentiated HIV testing service delivery models are required.

It is recommended that the DSD should ensure that the DICs that they are funding are provided with support that would promote networks with other stakeholders as it is difficult for an individual organisation to function optimally in HIV services when they operated in isolation.

The results point to some challenges in programmatic sustainability, especially given that most structured programmes were introduced by USAID-funded organisations, and their relationship and partnership with DICs was not permanent. Therefore, when a contract came to an end, some organisations found it difficult to maintain the programmes. Vhutshilo was identified as one

programme that had had a positive impact in HIV services. However, some organisations had stopped implementing it since terminating their relationship with the USAID-funded organisation that bought the programme.

It is, therefore, recommended that there should be a programmatic sustainability strategy by DICs, especially for programmes brought in by USAID-funded organisations. Another way to sustain the programmes would be to have most community caregivers trained to facilitate these programmes. However, if a few are trained and left the DIC for any reason, the continuity of the programme may be compromised. Most importantly, other financial means to pay the stipends of programme facilitators will be of paramount importance since this can be a motivating factor for them to continue with the program.

The results confirm that two DICs participated in the study were implementing HCT in their DICs. It is recommended that all DICs, through the Department of Health, have some people trained to provide testing in their centres and in partnership with local clinics.

The findings reveal that supervision is needed in home-based care HIV services. It is recommended that social auxiliary workers be trained in HIV supervision, so that they may strengthen their support to community caregivers.

Lastly, it is recommended that DSD increase its funding which will assist in hiring of full-time social workers for each DIC centre. This will help in fast-tracking the services in the DICs and subsequently help to maximise the contribution of DICs in reaching the 90-90-90 HIV target.

### 5.5 Recommendations for further research

It is hoped that this study will be used as a foundation for further research on drop-in centres and HIV services. Future research into the 90-90-90/95-95-95 target or an HIV-free generation should focus on:

- Investigating the linkage system between DSD statutory social workers and DICs to ensure that HIV-positive foster care children are treated as legitimate beneficiaries of drop-in centres and receive comprehensive HIV services.
- Interrogating the content of structured programmes offered by DICs and determines whether

the content promotes HIV testing, taking of treatment and adhering to treatment.

- Investigating barriers of trust between community caregivers and parents on HIV status disclosure of their children.
- Investigating the experiences of HIV-positive teenagers after disclosing their status to DICs' social auxiliary workers or community caregivers.

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**APPENDICES**

**Appendix A: Participant Information Sheet**




Faculty of Humanities

School of Human and Community Development

**Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case study of the City of Johannesburg, Gauteng**

Good day,

My name is Jeffries Khosa and I am a post graduate student for the degree of MA in Social work at the University of the Witwatersrand. As part of the requirements for the degree, I am conducting a research entitled, 'Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case study of the City of Johannesburg, Gauteng. It is hoped that the information gathered will help to identify the gaps hindering maximum contribution by DICs to country's 90-90-90 HIV target. Consequently, the outcome could inform our knowledge base and improve HIV services provided to orphans and vulnerable children and their families.

As an employee of a drop-in centre working with orphans and vulnerable children and their families, you are ideally positioned to contribute to my research. I therefore wish to invite you to participate in my study. If you accept my invitation, your participation would be entirely voluntary, and you are free to withdraw at any time without any penalty. There are no consequences or personal benefits of participating in the study.

If you agree to take part, I would arrange to interview you at a time and place that is convenient to you. The interview will last approximately one hour. If you choose to participate you may

refuse to answer questions that you feel uncomfortable with answering. You will be supplied with interview guide and questions prior to interview. If you decide to participate, I will ask your permission to tape-record the interview. No-one other than the researcher and the supervisor will have access to the tapes. The tapes will be kept in a locked cabinet for two years following any publications emanating from the study. A copy of your interview transcript without any identifying information or audio records of participants will be stored in a secured file in a computer and may be used for future research.

Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report. Furthermore, in final report DICs will be referred to as DIC A, B, C, D and E randomly, so you won't be linked with information provided since no one will know who comes from which DIC. The results of the research may also be used for academic purposes (including books, journals and conference proceedings) and a summary of findings will be made available to participants on request.

Please contact me on 0822621819 or 2237859@students.wits.ac.za, or my supervisor, Dr Busisiwe Nkala-Dlamini on (011) 717 4483 or busisiwe.nkala-dlamini@wits.ac.za if you have any questions regarding the study, and we shall answer them to the best of our ability. If you have any concerns or complaints about the study, please contact ***Human Research Ethics Committee (non-medical) contact details***: Chairperson: Jasper.Knight@wits.ac.za or the administrator: Ms Shaun Schoeman Tel: 011 717 1408 or Shaun.Schoeman@wits.ac.za

Thank you for taking the time to consider participating in the study.

Yours faithfully

Jeffries Khosa

**Appendix B: Consent Form for Participation in the Study**

**Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case study of the City of Johannesburg, Gauteng**

I hereby consent to participate in the research study. The purpose and procedures of the study have been explained to me.

I understand that:

- My participation in this study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose to not answer any specific questions asked if I do not wish to do so
- There are no foreseeable benefits or particular risks associated with participation in this study
- My identity will be kept strictly confidential, and any information that may identify me will be removed from the interview transcripts.
- A copy of my interview transcript, without any identifying information, will be stored permanently in a locked cupboard and may be used for future research.
- I understand that my responses will be used in the write-up of a masters project and may also be presented in conferences, book chapters, journal articles or books.

Name of Participant: _____

Date: _____

Signature: _____

**Appendix C: Consent Form for Audiotaping the Interview**

**Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case study of the City of Johannesburg, Gauteng**

I hereby consent to tape-recording of the interview.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password-protected computer) with restricted access to the researcher and research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- When the data analysis and write-up of the research study is complete, the audio-recording of interview will be kept for two years following any publications or for six years if no publications emanate from the study.
- The transcript with all identifying information directly linked to me removed, will be stored permanently and may be used for future research.
- Direct quotes from my interview, without any information that could identify me may be cited in the research report or other write-ups of the research.

Name of Participant: _____

Date: _____

Signature: _____

**Appendix D: Research Instrument**

1. Do you have an HIV policy/strategic plan in your organisation?
2. If you answered Yes to question 1, how does the policy/strategic plan advance the implementation of HIV services?
3. If you answered No to question 1, what governs HIV services in your organisation?
4. What is your role in HIV services in the organisation with respect to HIV testing, treatment and adherence?
5. In what ways did the organisation empower you to strengthen your skills in HIV services?
6. How would you describe the support from other stakeholders for your organisation regarding HIV services?
7. Explain the extent of support you receive from parents/carers of your child beneficiaries regarding HIV services in your organisation.
8. What structural programmes do you have in your organisation and which beneficiaries do they cover?
9. Do you think these programmes help in promoting HIV testing, treatment and adherence to beneficiaries?
10. Explain who has the right to give consent for testing of a child?
11. What is the role of a testing organisation, parents/caregivers and your organisation in case a child tests HIV-positive?

APPENDIX E

The Information is just names that are created.

## C03 CHILD Beneficiary Assessment

Completed by the CCG one per child beneficiary — CCG Form

| | | | |
|---|---|---|---|
| Organisation/ Project | | Date : | 12-05-2019 |
| CYCW/CCG Name | Mavis Bakoyi | CYCW/ CCG Signature | |
| Beneficiary ID | 2004-08-25 | | |
| Name: | Gift Malyeke | Supervisor Name | Jean Bulaitzi |
| Surname: | Malyeke | Date : | 12-05-2019 |
| HH number | 2237 | Supervisors Signature | |

| Assessment | | Tick "yes" or "no" where applicable ? | Yes | No | Comments |
|---|---|---|---|---|---|
| | Orphan status | Mother deceased ? | | | |
| | | Father deceased ? | | | |
| | Health | Road to health card updated ? | | | |
| | | HIV/AIDS status known? | X | | R |
| | | TB Adherence support needed ? | | X | |
| | | ARV Adherence support needed ? | X | | |
| | Nutrition Support | Child eats 3 meals per day? | | | |
| | | Child had meals in the last two days ? | | | |
| | | Child malnourished (saw a doctor/nurse)? | | | |
| | | Child not in need of food ? | | | |
| | | Child is overweight ? | | | |
| | | Feeding plan needed? | | | |
| | Psychosocial Support | Individual development plan (IDP) developed? | | | |
| | | Lay Counselling needed ? | | | |
| | | Caregiver support needed? | | | |
| | | Succesion planning needed ? | | | |
| | | Memory box needed ? | | | |
| | | Referral to support group needed? | | | |
| | | Stimulation needed ? | | | |
| | Reproductive assessment | Is the child beneficiary pregnant ? | | | |
| | | Information unintended pregnancies needed ? | | | |
| | | Child is on PMTCT medication? | | | |
| | | Adherence support needed ? | | | |

| Tick "yes" or "no" where applicable ? | | Yes | No | Comments |
|---|---|---|---|---|
| Educational Support | Child attend school or creche? | | | |
| | Did child missed ten days from school or creche? | | | |
| | School uniform needed ? | | | |
| | Homework supervision needed ? | | | |
| Grants received | Child support grant received ? | | | |
| | Foster child grant received ? | | | |
| | Care dependency grant received ? | | | |
| Refferd for services to: | Social Worker | | | |
| | SASSA | | | |
| | Home Affairs | | | |
| | Police station | | | |
| | Clinic / Hospital | | | |
| | Home Affairs | | | |
| Action taken as a result of referral: | Child removed from parents/ family ? | | | |
| | Court order? | | | |
| | Treatment provided ? | | | |
| | No further action necessary? | | | |
| | Other needed identify | | | |
| Child protection incidents, identified | Child succesfully placed ? | | | |
| | Sexual Abuse case open ? | | | |
| | Form 22 to be completed ? | | | |
| | Child using drugs? | | | |
| | Child drinking alcohol? | | | |

Services after this assessment : Comments: The Parent reported that a Child is HIV positive and he is in medication. She indicated that sometimes she forget to give Medication.

Page 1 of 2

APPENDIX F

## C03 CHILD Beneficiary Assessment

Completed by the CCG one per child beneficiary — CCG Form

| | | | |
|---|---|---|---|
| Organization/ Project | Ritani DIC | Date : | 12-05-2019 |
| CYCW/CCG Name | Mavis Baloyi | CYCW/ CCG Signature | [redacted] |
| Beneficiary ID | 2006-02-21 | | |
| Name: | Chanel | Supervisor Name | Titan Balojel |
| Surname: | Mashele | Date : | 12-05-2019 |
| HH number | 3321 | Supervisors Signature | [redacted] |

**Assessment**

| Tick "yes" or "no" where applicable ? | | Yes | No | Comments |
|---|---|---|---|---|
| Orphan status | Mother deceased ? | | | |
| | Father deceased ? | | | |
| Health | Road to health card updated ? | | | |
| | HIV/AIDS status known? | X | | MR |
| | TB Adherence support needed ? | | X | |
| | ARV Adherence support needed ? | | X | |
| Nutrition Support | Child eats 3 meals per day? | | | |
| | Child had meals in the last two days ? | | | |
| | Child malnourished (seen a doctor/nurse)? | | | |
| | Child not in need of food ? | | | |
| | Child is overweight ? | | | |
| | Feeding plan needed? | | | |
| Psychosocial Support | Individual development plan (IDP) developed? | | | |
| | Loy Counselling needed ? | | | |
| | Caregiver support needed? | | | |
| | Succession planning needed ? | | | |
| | Memory box needed ? | | | |
| | Referral to support group needed ? | | | |
| | Stimulation needed ? | | | |
| Reproductive assessment | Is the child beneficiary pregnant ? | | | |
| | Information on intended pregnancies needed ? | | | |
| | Child is on PMTCT medication? | | | |
| | Adherence support needed ? | | | |

| Tick "yes" or "no" where applicable ? | | Yes | No | Comments |
|---|---|---|---|---|
| Educational Support | Child attend school or creche? | | | |
| | Did child miss ten days from school or creche? | | | |
| | School uniform needed ? | | | |
| | Homework supervision needed ? | | | |
| Grants received | Child support grant received ? | | | |
| | Foster child grant received ? | | | |
| | Care dependency grant received ? | | | |
| Referred for services to: | Social Worker | | | |
| | SAPS | | | |
| | Home Affairs | | | |
| | Police station | | | |
| | Clinic / Hospital | | | |
| | Home Affairs | | | |
| Action taken as a result of referral: | Child removed from parents / family ? | | | |
| | Court order? | | | |
| | Treatment provided ? | | | |
| | No further action necessary? | | | |
| | Other needed identify | | | |
| Child protection incidents, identified | Child successfully placed ? | | | |
| | Sexual Abuse case open ? | | | |
| | Form 22 to be completed ? | | | |
| | Child using drugs? | | | |
| | Child drinking alcohol? | | | |

Services after this assessment : Comments: The parent reported that the child is HIV negative she was last tested in March 2019.

Page 1 of 2

APPENDIX G

**C03 CHILD Beneficiary Assessment** — Completed by the CCG one per child beneficiary — **CCG Form**

| | | | |
|---|---|---|---|
| Organisation/ Project | | Date: | 12-05-2017 |
| CYCW/CCG Name | Mavis Baloyi | CYCW/ CCG Signature | |
| Beneficiary ID | 2002-03-14 | Supervisor Name | Dean Baloyi |
| Name: | Felix | Date: | 12-05-2017 |
| Surname: | Phosa | Supervisors Signature | |
| HH member | 1234 | | |

| Assessment | Tick "yes" or "no" where applicable ? | | Yes | No | Comments | Tick "yes" or "no" where applicable ? | | Yes | No | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| | Orphan status | Mother deceased ? | | | | Educational Support | Child attend school or creche? | | | |
| | | Father deceased ? | | | | | Did child missed ten days from school or creche? | | | |
| | Health | Road to health card updated ? | | | | | School uniform needed ? | | | |
| | | HIV/AIDS status known? | | X | Refused to disclose | | Homework supervision needed ? | | | |
| | | TB Adherence support needed ? | | | | Grants received | Child support grant received ? | | | |
| | | ARV Adherence support needed ? | | | | | Foster child grant received ? | | | |
| | Nutrition Support | Child eats 3 meals per day? | | | | | Care dependency grant received ? | | | |
| | | Child had meals in the last two days ? | | | | Referral for services to: | Social Worker | | | |
| | | Child malnourished (seen a doctor/nurse)? | | | | | SASSA | | | |
| | | Child not in need of food ? | | | | | Home Affairs | | | |
| | | Child is overweight ? | | | | | Police station | | | |
| | | Feeding plan needed? | | | | | Clinic / Hospital | | | |
| | Psychosocial Support | Individual development plan (IDP) developed | | | | | Home Affairs | | | |
| | | Lay Counselling needed ? | | | | Action taken as a result of referral: | Child removed from parents / family ? | | | |
| | | Caregiver support needed? | | | | | Court order? | | | |
| | | Succession planning needed ? | | | | | Treatment provided ? | | | |
| | | Memory box needed ? | | | | | No further action necessary? | | | |
| | | Referral to support group needed ? | | | | | Other needed identify | | | |
| | | Stimulation needed ? | | | | Child protection incidents identified | Child successfully placed ? | | | |
| | Reproductive assessment | Is the child beneficiary pregnant ? | | | | | Sexual Abuse case open ? | | | |
| | | Information unintended pregnancies needed ? | | | | | Form 22 to be completed ? | | | |
| | | Child is on PMTCT medication? | | | | | Child using drugs? | | | |
| | | Adherence support needed ? | | | | | Child drinking alcohol? | | | |

Services after this assessment / Comments: The client is not comfortable to disclose the Status. Disclosure counseling group recommended

APPENDIX H

## C03 CHILD Beneficiary Assessment

Completed by the CCG one per child beneficiary — CCG Form

| | |
|---|---|
| Organisation/ Project | Qiyani OVC |
| CYCW/CCG Name | Mavis Bezuidenhout |
| Beneficiary ID | 2002-05-11 |
| Name: | Jimmy |
| Surname: | Human |
| HH number | 3214 |
| Date: | 12-03-2019 |
| CYCW/ CCG Signature | |
| Supervisor Name | Joan Bezuidenhout (SAW) |
| Date: | 12-03-2019 |
| Supervisors Signature | |

Assessment

| Tick "yes" or "no" where applicable ? | | Yes | No | Comments |
|---|---|---|---|---|
| Orphan status | Mother deceased ? | | | |
| | Father deceased ? | | | |
| Health | Road to health card updated ? | | | |
| | HIV/AIDS status known? | | X | Never tested |
| | TB Adherence support needed ? | | X | |
| | ARV Adherence support needed ? | | X | |
| Nutrition Support | Child eats 3 meals per day? | | | |
| | Child had meals in the last two days ? | | | |
| | Child malnourished (saw a doctor/nurse)? | | | |
| | Child not in need of food ? | | | |
| | Child is overweight ? | | | |
| | Feeding plan needed? | | | |
| Psychosocial Support | Individual development plan (IDP) developed? | | | |
| | Life Counselling needed ? | | ✓ | |
| | Caregiver support needed? | | | |
| | Succession planning needed ? | | | |
| | Memory box needed ? | | | |
| | Referral to support group needed ? | | | |
| | Stimulation needed ? | | | |
| Reproductive assessment | Is the child beneficiary pregnant ? | | | |
| | Information unintended pregnancies needed ? | | | |
| | Child is on PMTCT medication? | | | |
| | Adherence support needed ? | | | |

| Tick "yes" or "no" where applicable ? | | Yes | No | Comments |
|---|---|---|---|---|
| Educational Support | Child attend school or creche? | | | |
| | Did child attend ten days from school or creche? | | | |
| | School uniform needed ? | | | |
| | Homework supervision needed ? | | | |
| Grants received | Child support grant received ? | | | |
| | Foster child grant received ? | | | |
| | Care dependency grant received ? | | | |
| Referral for services to: | Social Worker | | | |
| | SAPS | | | |
| | Home Affairs | | | |
| | Police station | | | |
| | Clinic / Hospital | | | |
| | Home Affairs | | | |
| Action taken as a result of referrals | Child removed from parents / family ? | | | |
| | Court order? | | | |
| | Treatment provided ? | | | |
| | No further action necessary? | | | |
| | Other needed identify | | | |
| Investigations | Child successfully placed ? | | | |
| Incidents Identified | Sexual Abuse case open ? | | | |
| | Form 22 to be completed ? | | | |
| | Child using drugs? | | | |
| | Child drinking alcohol? | | | |

Services after this session Part I Comments: The client never tested for HIV, HIV education required and testing is recommended.

## Appendix I: Ethics Approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

**HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)**
R14/49 Khosa

| | |
|---|---|
| **CLEARANCE CERTIFICATE** | **PROTOCOL NUMBER: H19/10/14** |
| **PROJECT TITLE** | Strategies employed by drop-in centres in contributing to South Africa's 90-90-90 HIV target: A case of the City of Johannesburg, Gauteng |
| **INVESTIGATOR(S)** | Mr J Khosa |
| **SCHOOL/DEPARTMENT** | Human and Community Development/ |
| **DATE CONSIDERED** | 18 October 2019 |
| **DECISION OF THE COMMITTEE** | Approved |
| **EXPIRY DATE** | 12 November 2022 |

**DATE** 13 November 2019 **CHAIRPERSON** (Professor J Knight)

cc: Supervisor : Dr B Nkala-Dlamini

**DECLARATION OF INVESTIGATOR(S)**

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

Signature

15 / 11 / 2019
Date

**PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES**

**Appendix J: Certificate of Competence in Research Ethics**



# CERTIFICATE OF COMPETENCE IN RESEARCH ETHICS

**Full Name:** Khoza Jeffries Zwelithini

**Student No:** 2237859

**Date of Certification:** 15 April 2019 - 14 April 2022

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

***TRAINED BY:***
*Professor Jasper Knight (Research Ethics)*

*Signed:*

***ACKNOWLEDGED BY:***
*Dr Robin Drennan (Director: Research Office)*

*Signed:*

This certificate is confirmation of successful completion of a training course in Research Ethics for Non-Medical Human Research, based upon achieving a minimum level of competence in different assessment tasks. This certificate is valid for a period of three years from the date given above.

**Appendix K: Letter of Request to Conduct the Study in DICs**

**To: The Project Manager/Director**

**Name of organisation:_____**

**Date: _____**

**RE: Request to conduct an academic study in your organisation**

Good day

My name is Jeffries Khosa and I am an MA in Social Work student at the University of the Witwatersrand. As part of the requirements for the degree, I am conducting the study under the topic: *"The challenges experienced by drop-in centres in contributing to 90-90-90 HIV target adopted by South African Government from UNAIDS to be achieved by 2020"*. It is hoped that the information gathered will help to identify the gaps hindering maximum contribution by DICs to country's 90-90-90 HIV target. Consequently, the outcome could inform knowledge base and improve HIV service provided to Orphan and vulnerable children and their families.

I am humbly requesting you to allow me to conduct the study in your organisation. My proposed participants are social auxiliary worker and community caregivers in the organisation. If you give me go-ahead I will ask potential participants to take part in my study on a voluntary basis.

Please contact me on 0822621819 or 2237859@students.wits.ac.za, or my supervisor, Busisiwe Nkala-Dlamini on (011) 717 4483 or busisiwe.nkala-dlamini@wits.ac.za if you have any question regarding a study.

**NB: please note that, as required by the University, the response should be a formal letter with a letterhead, signed/stamped and dated, referred to me by name or title of the study and finally gives me specific permission, in this case to interview staff.**

Your assistance will be highly appreciated.

Yours sincerely

_____

Jeffries Khosa

Master of Art Student

University of the Witwatersrand

## Appendix L: Approval Letter from Khayalethu Crisis Centre

**ELDORADO PARK FAMILY CRISIS CENTRE**
CNR BUCKINGHAM AND MAIN ROAD, ELDORADO PARK
TEL NO: 011-342-2264 | E-MAIL: crisiscenter@mweb.co.za

14 May 2019

MR JEFFRIES KHOSA
MA in Social Work Student
University of the Witwatersrand

Dear sir

**RE: PERMISSION TO CONDUCT ACADEMIC STUDY AT KHAYALETHU CARE CENTRE (KLIPTOWN, JOHANNESBURG)**

Your request to conduct academic study in our organisation dated 02 May 2019 refers.

We are pleased to inform you that you are hereby granted permission to carry out the requested academic study at Khayalethu Care Centre in partial fulfilment of your Master in Social Work to address the topic "The challenges experienced by Drop-in-Centres in contributing to 90:90:90 HIV target adopted by South African Government from UNAID to be achieved by 2020". You are granted permission to interview Social Auxiliary Workers, Child and Youth Care Workers and Community Care Givers who will be requested to fully cooperate if they volunteer to participate.

Kindly note that permission to enter the DIC and interact with our staff is granted on condition that you strictly abide by our Child Protection Policy, a copy of which shall be given to you. We further request a timetable showing the days and time that you wish to conduct the interviews to allow us to adjust our weekly plans to suit your activities. Finally, the organisation will kindly request a copy of your final work, if permissible, in the hope that your findings may help us to improve service delivery.

I would like to welcome you to the organization and trust that your interaction with us will be both challenging and fulfilling. We look forward to working with you towards the achievement of your goals.

Yours sincerely,

Gloria Stewart
DIRECTOR

## Appendix M: Approval Letter from Clean Touch

REG NO: 021-150 NPO

Address: 10642 Ext 6A Orange Farm, Stretford 1841

clean touch
Administrative Services

Office Tel: (011) 850 1034/079 537 8080 Email: cleantouch8@gmail.com

Website: http://mail.cletas.org or Info@cletas.org

**Re: Permission to conduct a study in Clean Touch Administrative Services.**

Dear Mr. Khosa Jeffries

MA Student at University of the Witwatersrand

We would like to inform you that your request to conduct a study "The Challenges experienced by drop-in centers in contribution to 90:90:90 HIV target a adopted by South African Government from UNAIDS to be achieved by 2020. You are allowed to interview our employees as per your selection .

Hope you find this in order.

Kind Regards

HH Dladla (Project Manager)

HHDladla

Clean Touch Administrative Services Org
Stand No: 10642 Ext 6A
Orange Farm
Contact No: 084 644 9161
Date: 06-05-2019

**Appendix N: Approval Letter to Conduct Study from PUSH**



PERSEVERE
UNTIL
SOMETHING
HAPPENS


*Postal Address:*
*PO Box 79*
*Kliptown*
*1812*

*Physical Address:*
*1 Boundary Road, Ext. 7,*
*Eldorado Park,*
*1812*
*Johannesburg*
*Tell: (011) 945-2050*
*Fax: (011) 342-1229*
*Email:* pusha@mweb.co.za
*www.push.org.za/push.html*

NPO 015/532


People United to Save Humanity

15 March 2019

**TO: Mr Khosa Jeffries**
**MA-Social Work: Wits**

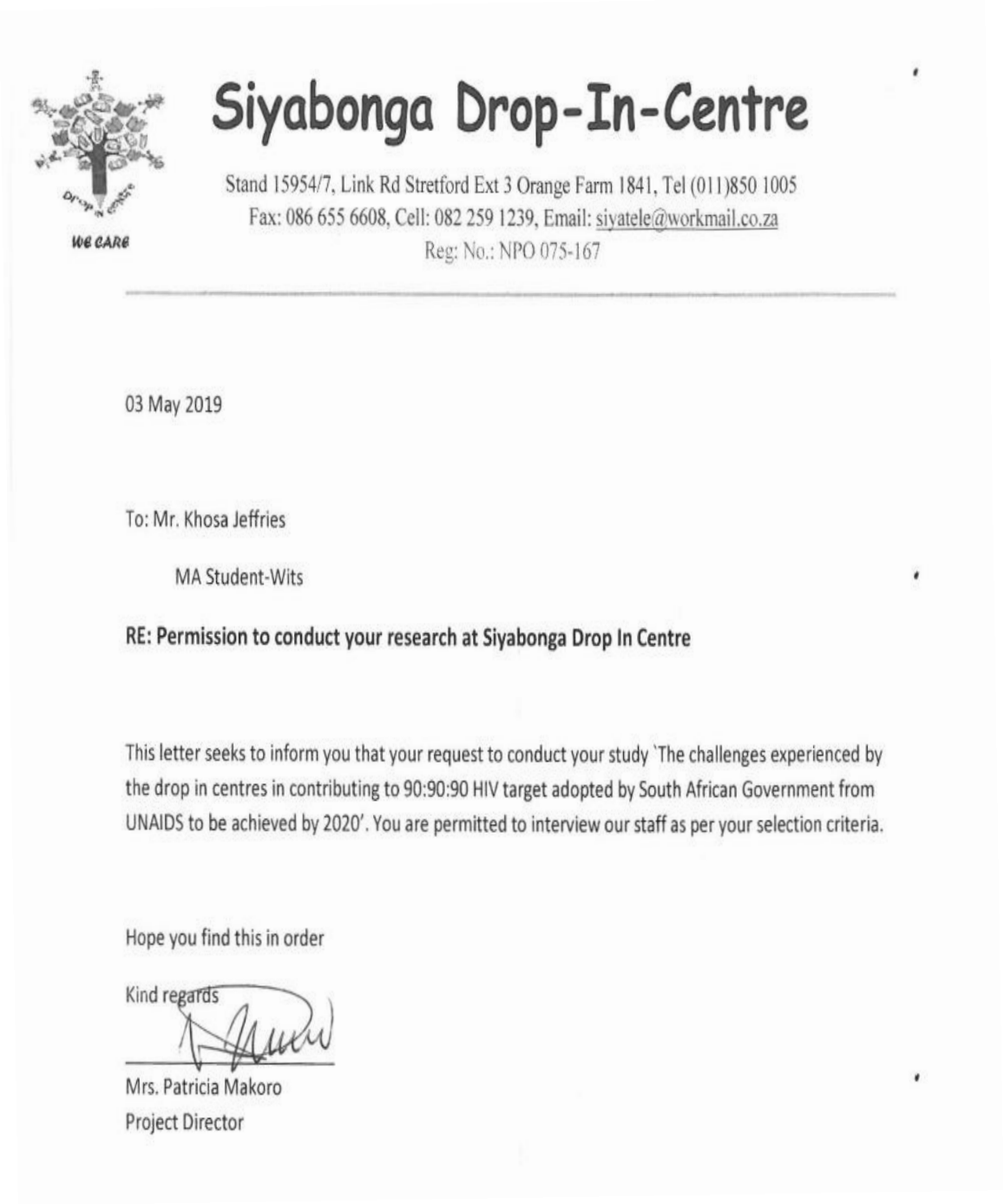
**PUSH** hereby grants you permission to conduct his study under the topic **"The challenges experienced by drop-in centres in contributing to South Africa 90:90:90 HIV target."** at our organisation. You are allowed to interview our staff as per your selection criteria

Kind Regards

Director
Lorna Fisher
+27 82 502 9844


***Board Members**: A. Rawlins, L. Laurie, M. Daniels, N. Hlatshwayo, A. Carrim and L. Stewart*

**Appendix O: Approval Letter to Conduct Study from Siyabonga DIC**



# Siyabonga Drop-In-Centre

Stand 15954/7, Link Rd Stretford Ext 3 Orange Farm 1841, Tel (011)850 1005
Fax: 086 655 6608, Cell: 082 259 1239, Email: siyatele@workmail.co.za
Reg: No.: NPO 075-167

03 May 2019

To: Mr. Khosa Jeffries

MA Student-Wits

**RE: Permission to conduct your research at Siyabonga Drop In Centre**

This letter seeks to inform you that your request to conduct your study `The challenges experienced by the drop in centres in contributing to 90:90:90 HIV target adopted by South African Government from UNAIDS to be achieved by 2020'. You are permitted to interview our staff as per your selection criteria.

Hope you find this in order

Kind regards

Mrs. Patricia Makoro
Project Director

**Appendix P: Approval letter from Zenzele Counselling Project**

# ZENZELE COUNSELLING PROJECT

[NPO: 015-524]

**PHYSICAL ADDRESS**
2173 PHILLIP STREET
FINETOWN
GRASMERE
1828
073 855 7387 / 084 03 444 31

**POSTAL ADDRESS**
PO BOX 387
KAISHA PARK
LENASIA SOUTH
1829

07 MAY 2019

To: Mr Khoza Jeffries
MA-Student-Wits

**RE: Permission to conduct your study in Zenzele DIC**

I would like to inform you that your request to conduct a study, the challenges experienced by drop-in centre in contributing to 90:90:90 Hiv target adopted by South African government from UNAIDS to be achieved by 2020, you may interview our employees as per your selection criteria. Thank you for considering our organisation.

Yours in development

ROSELINA DHLAMINI
CENTRE MANAGER

ZENZELE COUNSELLING PROJECT
P.O. BOX 387, KAISHA PARK
LENASIA SOUTH, 1829
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