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4Children Coordinating Comprehensive Care for Children

Case Study on Strengthening Referral Systems for Children Orphaned or Made Vulnerable by HIV (OVC)

WORKING IN PARTNERSHIP TO IMPROVE CHILDREN'S SAFETY AND WELL-BEING

The May'khethele Programme in South Africa

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASPIRES	Accelerating Strategies for Practical Innovation and Research in Economic Strengthening
ART	Antiretroviral Therapy
CBO	Community-based Organization
CCG	Community Caregiver
CCP	Community Care Project
CHW	Community Health Worker
CINDI	Children in Distress Network
CSO	Civil Society Organization
DBE	Department of Basic Education
DHA	Department of Home Affairs
DSD	Department of Social Development
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Women
FGD	Focus Group Discussion
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
HTS	HIV Testing and Services
IP	Implementing Partner
KII	Key Informant Interview
KZN	KwaZulu-Natal Province
LL	LifeLine
LO	Life Orientation
MIS	Management Information System
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
QI	Quality Improvement
SOP	Standard of Practice
USAID	United States Agency for International Development
YFC	Youth for Christ (here referring to YFC of Kwazulu-Natal)

Glossary[1]

Community caregiver: In the South African context this community actor may be volunteer, paid or receiving a stipend. Their role is to provide home- and community-based care, particularly for families and individuals impacted by HIV. They usually have no formal healthcare qualifications, but provide support and outreach for healthcare delivery and act as liaison with the health clinic.[2]

Facilitator: Someone who conducts HIV education in schools and runs other school-based programs around life skills education, as well as provides psychosocial support to the learners at school. The facilitator is from one of the partner organizations, and also has a key role of referring the learners to other programs of the organization or community. The facilitator may also do home visits to families and/or work closely with community caregivers (volunteers within the community).

Outreach Coordinator: Position in the implementing organizations that coordinates all project activities being implemented out of schools, especially those in very remote and hard-to-reach locations. The outreach team provides or further refers to social services identified by the facilitators in the schools.

Life Orientation Teacher: Schoolteacher who conducts school lessons on health and social topics with a purpose to prepare students for life in all areas, including physical, intellectual, emotional, spiritual, social and personal. In program schools these teachers work closely with facilitators and have been trained by the implementing partners in HIV and other topics.

Lay Counselor: Provides basic, general counseling. These counselors are trained in a ten-day course by Lifeline. Lay counselors have a key role in providing basic support to students and identifying issues that need to be referred further.

War Room: Started by the government of KZN Province, the *Operation Sukuma Sakhe* (OSS or War Room) is a ward-level (community), intersectoral body providing comprehensive, integrated and transversal services to communities through partnerships.[3] The partnership includes government, civil society and community members. War Rooms meet monthly to discuss issues related to HIV/AIDS and other community issues, and in some communities, to identify OVC or vulnerable families and refer among War Room members to provide services to those identified.

1 Definitions provided by implementing partner organizations

2 Caregivers Action Network (2013). Community Caregivers: The Backbone for Accessible Care and Support, South Africa Report. Retrieved from https://www.cordaid.org/media/publications/SA_CAN_Report_26_July2013.pdf

3 Summarized from Government of KZN, Operation Sukuma Sakhe: KZN Service Delivery Model. Retrieved from http://bit.ly/2FwgnkC and also from notes taken during a War Room meeting attended (February 2016)

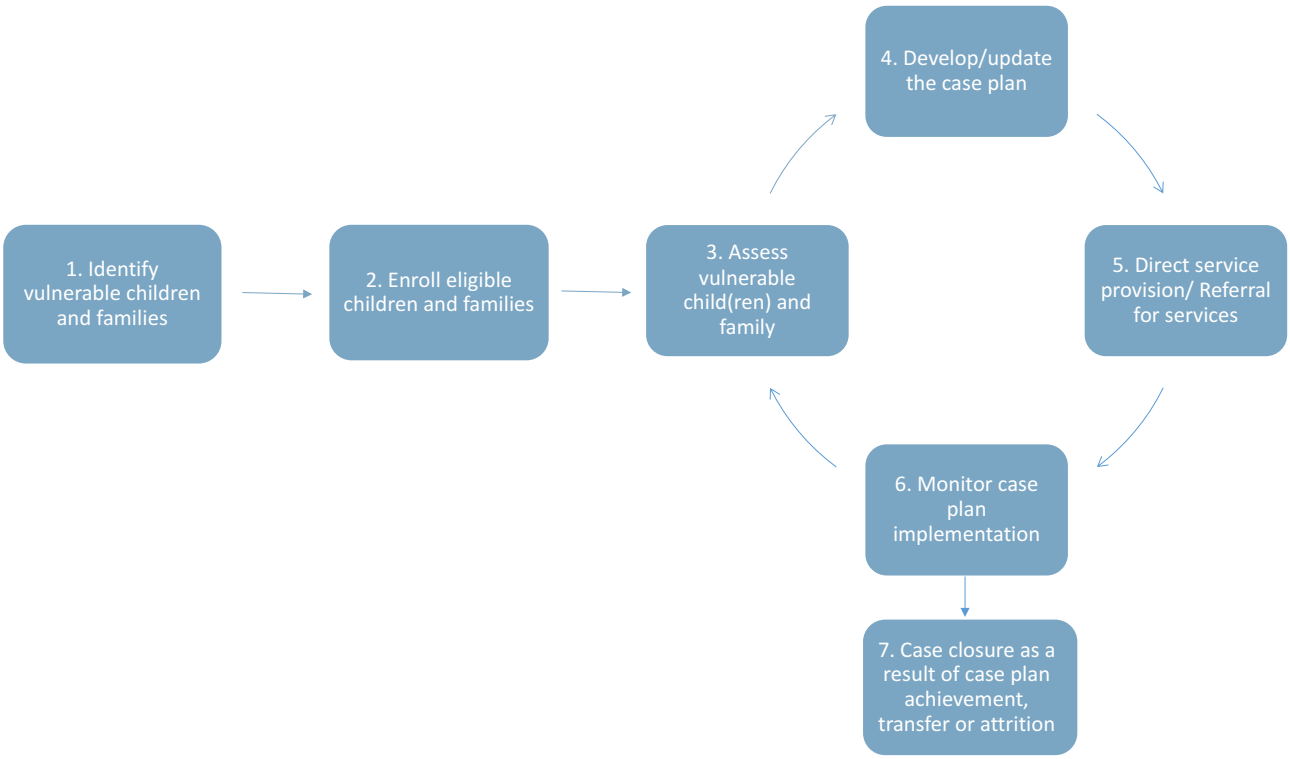
Objectives of the case study

Robust case management systems that effectively prevent and respond to the multiple vulnerabilities faced by children and families affected by HIV and other adversities include the key component of timely referral of children to critical services within and between different sectors (e.g., health, education, social services) and ensuring referral completion. Linkages between health and social service systems are especially relevant given that children and families affected by HIV and other adversities tend to have multiple vulnerabilities that require services provided by both sectors in order to improve well-being. To date, some government systems and civil society organizations have developed tools and approaches that support effective referrals mechanisms.[4] However, this is an area within orphans and vulnerable children (OVC) programming that remains a challenge. Highlighting promising practices, including relevant tools and approaches for a functional bidirectional referral system, is critical to strengthening the continuum of care among OVC.

The overall objective of the case study is to highlight and help promote good practice related to referral mechanisms within OVC programming. The case study delineates what is involved in the process of developing and implementing one type of referral mechanism, the positive results of effective referrals and some of the challenges faced when developing and implementing such a mechanism within an OVC program. The information presented should be understood as just one example of a referral mechanism in practice. Any case management system and referral mechanism should be adapted to best reflect the context in which it is utilized, the target population it serves, and the programmatic needs of the implementer. The case study is one in a series of case studies highlighting different aspects of a case management system and referral mechanisms utilized by OVC programs. The case studies aim to provide useful information that can inform the work of policymakers and practitioners engaged in programs serving vulnerable children and families. In particular, the case studies on referral mechanisms are targeted to government, especially Ministries of Health and Social Welfare, and OVC implementing partners to highlight ways of improving referrals among and between sectors, especially between the health and social service sectors.

The case study was informed by a rapid desk review of relevant project, country, regional and topic specific documentation, tools and research. Key informant interviews (KII) and focus group discussions (FGD) were conducted during a field visit to the program of the Children in Distress Network (CINDI) in the uMgungundlovu District of KwaZulu-Natal Province (KZN) of South Africa in February 2016. The KII and FGDs provided in-depth information about how the model works from those responsible for implementing the referral mechanism, as well as those who receive the referrals. The field visit was completed over one week, and included discussions with stakeholders from the district down to the village level. In total, 17 documents were included in the desk review, and discussions were held with 60 people. Stakeholders included youth and caregivers, teachers and school administrators, health officers, program outreach workers and facilitators, district level government officials, representatives from community organizations and community leaders, and CINDI and implementing partner (IP) management staff. The work was not an assessment

Figure 1: Case management process within OVC programming



4 MEASURE Evaluation (2013). Referral Systems Assessment and Monitoring Toolkit; Roelen, Long and Edstrom (2012). Pathways to protection-referral mechanisms and case management for vulnerable children in Eastern and Southern Africa. Lessons learned and ways forward.

or evaluation of the *May'khethele* (My Life, My Future) Programme but rather an opportunity to see the model of referral in action and to speak with those using and benefitting from its existence.

Context Overview

VULNERABILITY IN KWAZULU-NATAL PROVINCE, SOUTH AFRICA

KwaZulu-Natal Province (KZN) has 11 district municipalities, of which the *May'khethele* Programme focuses in uMgungundlovu District. It is the second most populous district in the province with an estimated population of just over one million people.[5] The district is ranked first in the province and fifth in the country for HIV prevalence rate (39.8% compared to 29.5% nationally).[6] KZN as a province has an estimated 1.7 million people living with HIV (16.9% prevalence rate).[7] There is an unprecedented high incidence rate among young people ages 15–24 years (15%), with a disproportionate risk to young women.[8] A high HIV/tuberculosis co-infection rate of 67% is reported.[9] The district has the third highest number of children under 15 who remained on antiretroviral therapy (ART) in the country (7,959 youth in 2012–13).[10] The leadership of uMgungundlovu District municipality identified HIV/AIDS as one of the most critical challenges facing the district and its people.

According to CINDI, the uMgungundlovu District appealed to all non-governmental organization (NGO) partners to assist in reaching targets for reducing infection rates among youth in particular. In addition, the district has a high unemployment rate (30.4%); the youth unemployment rate is even higher

Figure 2: KwaZulu-Natal Province, South Africa

CINDI is a network of 248 South African civil society and governmental organizations working in partnership to *champion the rights of vulnerable children and their families by bringing together a strong, diverse network to implement a wide range of effective and sustainable programs for vulnerable children, in particular those affected by HIV/AIDS in the province of KwaZulu-Natal (KZN).*

CINDI creates opportunities for networking, collaboration, research and advocacy by mobilizing resources and providing access to information, and by building the capacity of its members to advance the rights of vulnerable children and their families.

at 39.5%,[11] and thus youth economic empowerment is also a district priority. CINDI also notes a high rate of teenage pregnancy, poor access to family planning services, late antenatal clinic access and high maternal mortality rate among girls less than 18 years.[12]

The KZN province leads in the country with the highest number of orphans (226,759), of which 37% are single orphans and 50% are double orphans.[13] Most are cared for by older grandparents and some live-in child-headed households. Additionally, the uMgungundlovu District ranks second in the nation for its high rate of severe acute malnutrition among children under five years.[14]

Informed by the identified vulnerabilities and the recognized need for a comprehensive, integrated and child/family-centered approach, CINDI and partners developed the *May'khethele* Programme beginning in 2007. Interestingly, and likely due to the efforts of the government, many NGOs and others, the uMgungundlovu District AIDS Council notes that the number of OVC receiving care and support has been steadily increasing. For example, the number of OVC receiving services increased from 22,534 in Q2 of 2014/15 to 25,168 in Q3.[15] They also note a steady increase in the number of newly registered OVC, a slow decrease in teenage pregnancy, and steady increases in HIV counseling and testing (HCT) targets, noting the work of NGOs within schools and the *May'khethele* awareness campaigns as important contributors to the increased numbers of children reached.

CINDI AND THE MAY'KHETHELE PROGRAMME

The CINDI *May'khethele* Programme is funded by the United States President's Emergency Plan for AIDS Relief (PEPFAR), and aims to address the vulnerabilities and challenges identified in the uMgungundlovu District and respond to the government's call for support from NGOs to mitigate the impact of HIV/AIDS. The goal is to build an expanded

5 CINDI (2015). May'khethele OVC Children Project Description and Implementation Plan (2014-2015).
6 *Ibid* citing the NDOH (2011) National Antenatal Sentinel HIV and Syphilis prevalence survey.
7 CINDI (February, 2016). PowerPoint presentation to Maestral International, quoting the HSRC 2012.
8 *Ibid*
9 *Ibid*
10 *Ibid*
11 Ibid CINDI (2015) citing the uMgungundlovu District AIDS Council (2013).
12 *Ibid*
13 *Ibid*
14 *Ibid* CINDI PowerPoint
15 uMgungundlovu District AIDS Council (2015) uMgungundlovu District Presentation Quarter 3 2014/15 to the KZN PCA meeting. Retrieved from http://www.kznonline.gov.za/hivaids/councils/Provincial-Councils-on-AIDS/2015/uMgungundlovu%20PCA%20Report%2011%20March%202015.pdf

partnership framework for enhancing access to quality services among OVC. It is implemented by three of CINDI's members and implementing partners (IP): Community Care Project (CCP), LifeLine Pietermaritzburg (LL) and Youth for Christ Kwazulu-Natal (YFC).

The *May'khethele Programme* is school-based, targeting schools with high teenage pregnancy rates, alcohol and drug abuse and school absenteeism — all issues resulting in increased vulnerability to child protection and HIV risk. The target schools are spread over seven sub-districts of uMgungundlovu. The program reaches approximately 36% of public high and secondary schools in the district (there are 274 public high and secondary schools at present) with one of the three partners implementing services and activities in each school.[16] The program objectives include those highlighted by the visual below:

Figure 3: May'khethele Programme primary objectives

A major program objective is to **strengthen and sustain an effective referral system** in order to increase OVC access to comprehensive services provided by government departments, NGOs, community-based organizations (CBO) and private businesses, as well as to improve the quality of service delivery. The program aims to strengthen the capacity of government, namely the Department of Basic Education (DBE) and Department of Social Development (DSD), through provision of training and mentorship of teachers and community caregivers (CCG). CINDI has a Memorandum of Agreement with the DBE and service-level agreements with the DSD and Department of Health. In 2015, through the PEPFAR-supported FHI 360 program *Accelerating Strategies for Practical Innovation and Research in Economic Strengthening* (ASPIRES),[17] CINDI added an objective and activities aimed at improving long-term economic security. Most recently under the new PEPFAR initiative to reduce HIV

The May'khethele program uses schools as the entry point to improve the well-being of OVC and their access to essential services.

Credit: CINDI

infection among girls and young women, the *Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) Adolescent Girls and Young Women's Initiative*,[18] CINDI has focused activities aimed at reducing incidence of HIV and violence among girls and young women.

Overall, the program's goal is to improve the health and psychosocial well-being, access to education, and economic status of OVC in uMgungundlovu District through provision of comprehensive services using schools as the entry point for the referral process. The services that are provided by IPs include provision of HIV prevention and sexual reproductive health education; psychological care, either direct or referral to HIV testing and services (HTS) (depending on the IP); healthcare support for ART; HIV-related palliative care, household economic strengthening (HES); educational support (school uniforms and supplies); general healthcare referrals; child protection interventions; nutritional support; and access to birth registration and identity documents, access to social grants, home visiting, and parenting skills training. An evaluation by Impact Evaluation in 2012 found that the program was successful at both improving OVC access to food and HIV care and support, and increasing HIV knowledge and technical information levels of people working with youth.[19]

The same evaluation found areas for improvement and ongoing challenges that CINDI has been working on.

- A key issue identified was the need for increased acceptance for and uptake of HIV testing through strengthening of the referral process. In response, CINDI has continued to increase accompaniment of children, youth and family members to clinics, follow up on referrals, improvements to MIS for tracking referrals, as well as introducing home-based HTS in order to improve coverage;

16 CINDI (2015). May'khethele OVC Children Project Description and Implementation Plan (2014-2015)
17 More information at http://www.fhi360.org/projects/accelerating-strategies-practical-innovation-and-research-economic-strengthening-aspires
18 More information at http://www.pepfar.gov/partnerships/ppp/dreams/
19 CINDI (2012). Fact Sheet 5: May'khethele Programme Evaluation – Creating a Safety Net for Children.

- The evaluation recommended greater availability of support groups, peer support (such as mentoring) and home visits as important complements to the successful model of young, caring and trained school facilitators. CINDI has included peer groups and outside of school activities as part of ASPIRES and increased training to facilitators and CCGs making routine home visits; and
- The evaluation highlighted the availability of lay counselors in schools that are approachable, knowledgeable and also young as a key success factor. The evaluation recommended the provision of such counselors in all of CINDI's OVC school-based programs. This support position has proved an important link in the referral mechanism when professional psychosocial support is needed.

The referral process

Fundamental to service delivery within the *May'khethele Programme* is a strong referral mechanism that functions intra partners, inter partners, and externally to actors outside of the program. During the evaluation, one recommendation was that HIV testing and follow-up for OVC would be greatly improved by strengthening a referral process among the relevant service providers.[20] CINDI has learned that building relationships at all levels between the partners and with organizations and government agencies (e.g. CINDI managers with district officials and partner facilitators with community health workers) greatly improves the bi-directional referral aspect of the process. For example, CINDI partners have raised awareness with both the Department of Health and with community medical clinics and now receive increasing referrals of school-aged OVC that may be assisted through CINDI partners' services. Under the current program cycle, the program provides OVC and their families with referrals using a standardized procedure developed and refined by CINDI since the program began.

> *"Without effective referral systems for care and support of OVC their needs are not fully addressed. The mechanism is critical to improving the lives of children."*
>
> —CINDI Program Coordinator

DEFINING REFERRAL AND STANDARDS OF PRACTICE

Within the *May'khethele Programme* partnership there are common definitions for referral and the processes involved. All IPs use the same standard operating procedures (SOP) for case management and related forms. The program SOPs include forms for client identification, referral within or outside of the primary agency and referral monitoring. These SOPs are accepted by other agencies and government offices, and are based on the requirements of the policy framework. Recently CINDI was requested by the DBE to share the SOPs with all NGOs working in schools within the district (e.g., the DREAMS partners). CINDI is now coordinating with all of these NGOs, and managing the database of referral information across organizations based on their SOPs. This is greatly aiding the district to avoid duplication and serve OVC efficiently.

When a referral is made, it is input into the CINDI management information system (MIS) system at the level of each primary partner; specifically, the manager captures referrals on remote sites and supervisors verify small samples to ensure accuracy. Data then flows to the MIS managers at CINDI. Within the MIS, the case is followed by the case team lead until it is clear that the service has been provided (see Annex). The case team is made up of a social worker, child/youth care worker, facilitator/home visitor and/or CCG, dependent on the case and also the coordinating organization. SOPs for case team definition are not standardized across CINDI partners, and this is one area of the process that CINDI has identified for a quality improvement (QI) plan this year.

> Common definitions within the referral mechanism mean that partners can easily and rapidly make referrals to each other, and assist one another with follow-up. CINDI partners agree that the definition of a successful referral is *"…when the referred child or household member is known to have been provided with the service, and the provision of the service can be verified."*
>
> —CINDI Monitoring and Evaluation Manager

YFC, LL and CCP all have contractual agreements with CINDI, which outlines their collaborative work. The ease of their long-standing collaboration with each other facilitates easy and regular communication and streamlined referrals across partners. Each organization may be providing a slightly different service; for example, LL coordinates a rape crisis center, and both LL and CCP are accredited by the Department of Health to do home-based HTS. Regular partnership meetings organized and facilitated by CINDI program managers allow for discussion about referrals and service provision. CINDI also facilitates cross referrals to its other 200+ member organizations when necessary. CINDI is home to an inter-agency management information system (MIS) that also uses the common definitions, and allows backstopping to ensure that all referrals are followed up. *"What is really making it work is the collaborative decision-making. People have their specialties; it's a team,"* says the senior project coordinator at CINDI. The LL director adds, *"We recognize each other's strengths, and know that we need all of us to have an impact."* The common definitions across the program also assist partners in using consistent referral mechanisms outside of the partnership, to government services, other NGOs, CBOs and private sector businesses.

Stakeholders felt that the national policy framework and existing national SOPs significantly influence the understanding of referral mechanisms; however, there are recognized challenges in the consistent implementation of

20 Msunduzi Evaluation Consortium (2014). An evaluation of the CINDI May'khethele OVC Program: Evaluation report.

the policy framework. For example, even within CINDI, SOPs have been developed specifically for their project. While they may reflect the government models, they are not one and the same. The government framework does include SOPs for referral in statutory cases. The policies recognized by stakeholders as important in terms of protecting vulnerable children include:

- The South African Children's Act No. 38 of 2005 amended in 2007 and its implementation guidance, which provide the framework and SOPs for statutory child protection work.
- The health system case management guidance and SOPs provided for all health workers, including community health workers (CHW) with whom the CINDI program facilitators work closely. This framework provides the structure and instruction for all HIV testing and treatment, including for children and youth.
- The South African Child Justice Act No. 75 of 2008 provides guidance on managing cases of children moving through the justice system.
- The New Sexual Offences Act No. 32 of 2007 provides guidance on cross-sector work as it relates to cases of violence against women and girls.

The national legal and policy framework is especially helpful with referrals to and between key government departments, such as health clinics, DSD and the South African Social Security Agency (for social grants), and Department of Home Affairs (DHA), that has the responsibility for birth registration and legal identification. CINDI partners use referral and referral monitoring forms that are recognized by and compatible with government agencies. In the case, of CD4 counts, for example, a specific note must accompany the patient to clinic. Program partners work to ensure that paperwork is in order and often accompany people to clinic, factors that health workers say expedite health services.[21] Referrals are made outside of the CINDI network for HTS, CD4 counts, ART, school uniforms, birth registration, identification papers and other services.

Program managers from YFC said of the *May'khethele* Programme, *it's based on a primary basis about the child and improving at the community level.* This is reflected in the work with War Rooms (see key definitions) where community partners can come together to discuss cases of OVC and vulnerable families, and make direct referrals to each other to resolve issues. The War Rooms, with which CINDI partners work, use the *May'khethele Programme* mechanisms that lead to stronger referrals, such as group discussion of case needs, joint decision-making on service referrals and agreement on key follow-up actions. The War Room members hold each other accountable for ensuring referrals happen because cases are discussed at the meetings, and members are expected to come with updates. One member of the War Room commented regarding the referral mechanism, *it is an excellent tool. What we ourselves do not have others do.*

The strength of the May'khethele referral system is the collaborative process, including the use of War Rooms where community partners discuss cases and make joint decisions.

Credit: CINDI

CINDI partners see it as part of their responsibility to share case registers, and report back to the War Rooms on number of cases; however, most sharing of information is informal. There are NGOs (outside of CINDI) tasked with building the capacity of War Rooms to report back information on referrals to NCT, social grants, etc., to the District AIDS Council in a more formal manner.

FOLLOW-UP, TRACKING AND MONITORING

As mentioned earlier, for referral to be successful, the CINDI partners believe that it must be followed up, tracked and monitored. Tracking is done by the caseworker and/or the case team using the program monitoring and referral form (see Annex), which indicates when the referrals were made, to whom they were made, mode of referral and when the service was delivered. The referral system works because all partners use the same referral form, and CINDI oversees the MIS system, but there is also a critical human relational component. To ensure follow-up to the point of successful service delivery, the program:

- Always checks to make sure that the service being referred to exists, and that the person being sent will find someone to receive her/him on the other end. This is both the responsibility of the worker who referred (including outreach coordinators, facilitators, lay counselors, etc.) and the monitoring and evaluation officer at the office, who tracks referrals and follow-ups in the MIS.
- Will have the facilitator, outreach coordinator or CCG accompany children, youth, parents and caregivers to the service to ensure they get there, are well received,

21 According to February 2016 interview with a health clinic coordinator.

and understand what they may need to do next. The person closest to the child, youth or parent/caregiver will be the one to accompany. The "accompaniment" begins the moment that the lead worker builds a trusting relationship with the child/youth and family. Through this relationship the child/youth comes forward with their needs. The worker can then make clinic appointments and physically go with the client. This helps to ensure system challenges, such as long queues at health clinics, are mediated. The community workers also spend time building community relationships (e.g., with clinic workers), which leads to client-friendlier services. These are consistent approaches across CINDI partners. One family member mentioned, *it is not easy to go to the services alone, and it helps when they go together with us.* The health clinic manager said, *I had a patient that had come with the CCG. They are really getting people to the clinic – they get the job done.*

- Assists the person in completing or gathering necessary paperwork, and encourages services to come to "meet the client where they are." For example, arranging for DHA to come to the schools to complete registrations and legal identification papers, or sending in a partner licensed to do home-based HCT. Of this, one caregiver shared, *when they come to my home, the children run to them just like they are aunties.* A family member interviewed said, *they help us to access the services — like she asked to see all of my papers, and checked them to make sure that I had what I needed before I went to the DSD and then she told me what else I would need*.

- Uses follow-up email and telephone calls to outside agencies to track specific referrals. Health clinics receive regularly updated lists of the people who have been referred to their services. The referral list is received by the lead health worker depending on the issue; for example, the lead HCT worker or the lead family planning worker, or by the clinic operational manager. Facilitators responsible for the cases referred will then follow up directly with the health clinic responsible person.

- Builds community relationships through a process of mapping community assets using a mapping tool. Networking and constant learning about community assets is seen as part of the facilitator's job (e.g., with health clinics). This work helps workers to know where the services are, and builds relationships with community actors that later help clients to access what they need. Mapping is done at the start of the relationship with a new community, and then periodically as new services or community dynamics arise.

Referrals are also received by the *May'khethele Programme* from schoolteachers, DSD social workers, CCG, War Rooms, other NGOs/CBOs and directly from community members. They may be received by email, telephone, referral note or walk-in/self-referral. These referrals are entered into the system at the organization where it was received, and from there it goes into the CINDI tracking system. There are several places where backstopping (e.g., supervisor/team lead, organization manager, CINDI M&E manager) is done to ensure that the referral has been followed up, and that the client's care is being monitored. (See also **Defining referrals and standards of practice,** page 8.)

Monitoring of OVC and vulnerable families is done through regular school meetings (individual and group), as well as during home visits by facilitators. *We do the follow-up where we can see if the child is struggling,* said one YFC school facilitator. Another added, *we are here for them. They know we are here for them. The mechanism does not just start and end with the referral paper.* Case planning determines how often home visits are done. The home visiting component used to be more ad hoc, but this approach meant that the visit did not always meet clients' needs. For example, everyone might be visited at home for delivery of food parcels. Now the CINDI partners do home visits based on the case plan and therefore the client's needs. All families are visited at least monthly, but more acute cases might be visited twice a month or even weekly.

CINDI has learned many lessons over the years of working with the MIS. Initially the case management tools were very long and tedious to complete as they were based on data needs, not case or worker realities. CINDI learned that these needed to be balanced and based on feedback from social workers and facilitators; the forms were tailored for the case management system while also focusing on the needed data. Another lesson was that training combined with mentorship and supervision improved data collection and use of forms. Training alone did not result in better data collection, yet improvements were noted when the one-on-one follow-up of supervision and mentorship were added. CINDI describes itself as a *learning organization,* and this shows not only in the documentation of lessons learned, but also in incorporation into QI and subsequent program adjustments.

LINKAGES TO THE CASE MANAGEMENT SYSTEM

The *May'khethele Programme* referral mechanism, which follows from identification of the OVC and/or vulnerable family, is closely linked to the overall case management system within the project partner's programs. Identification is the starting point. The program starts from the assumption that every child may be vulnerable. Workers have been trained on a common definition of vulnerability found in the PEPFAR *South African Strategic Information Manual*. The information form (Annex) is then used to enroll and gather family information to determine interventions. *The facilitators of CINDI partners are the ones out there — the eyes and the ears,* said the health clinic manager. Regarding identification of OVC, comments from the KII and FGD included:

- Identification is the first way that the program helps. *After identification, it assists with counseling, HIV testing, food parcels, visits to families. All things the school can't do.* (School administrator)

- *As teachers, it is hard to identify children who are having difficulty with health or social problems, but*

The program works to develop all levels of the social service workforce with skills building available for social workers, facilitators, lay counselors, parents and even the youth who learn leadership skills in the school.

Credit: CINDI

they (referring to CCP) can talk to the learners in a different way. We contact CCP where we need help. (LO teacher)

- *It really helps to find cases — we need others to be out there watching for cases. Sometimes communities don't want to say, but the relationship with the community helps.* (Non-partner NGO)
- *The program is helping the learners to identify other learners who need help.* (LO teacher)

In addition to identification, the processes involved in the referral mechanism require case planning because cases often require more than one service from more than one provider. Related to planning for a case, the YFC manager said, *before we can send the person out, we have to be sure their case has been worked within.* Within this case planning, an individualized combination of interventions will link people to other systems of case management, such as the DSD management of social grants or the system of child protection for cases of child abuse and neglect.

The referrals, whether internal, external or a combination, are followed up with direct provision of services by CINDI partners and/or following up to make sure that direct services have been received by the service providers. Combinations of direct services might include one-on-one youth counseling and life orientation (LO) classes at school, home visits and home-based HTS, and community parenting groups for caregivers; HIV/AIDS education and youth empowerment programming; parenting/caregiver support groups, youth groups at school and family economic-strengthening activities. *The program is huge for our school, because it involves all the learners – those who are HIV+, those who are not, those who have HIV+ parents, and the vulnerable community,* shared a school principal.

WORKFORCE DEVELOPMENT

One of the objectives of the *May'khethele Programme* is to build capacity across different levels of the social service workforce within schools and the community, but also among youth, within families and in the community. There is a strong commitment to professional and personal growth, both internally within the CINDI network and externally. This leads to common understandings about the needs of OVC, community services and referral mechanisms and follow-up. Training helps to raise awareness of the importance of an integrated, functional referral mechanism to ensure that OVC have access to services and education. CINDI partners provide training for teachers and school administrators, lay counselors, LO teachers and health providers. For lay counselors the national training model is used, for which LL is an accredited training organization. CINDI partners all have master trainers prepared in evidence-based models by USAID South Africa. This includes topic-specific training for facilitators (e.g., "Let's Talk"), as well as training on how to be a facilitator using CINDI-established facilitator training curriculum. Annual refresher training, mentorship and supervision and specific training through case debriefing are also important parts of capacity building.

Those interviewed recognized the value of the training they received. Lay counselors trained by LL commented on how training not only impacted them professionally, but also applied to their own family and community. *You go back to your own community at the end of the day, and you notice things differently,* commented one. Training was said to positively influence career paths and the way in which many workers engage with children. Commenting that without the program she would not be working in the school, one YFC school facilitator said, *because of the organization, I am a qualified child and youth care worker, HIV counselor and facilitator.* One school administrator had the following to say about his training: *This training changed the way that I discipline the children. Before, I never knew about ways to talk to them, how to show them love, and how to be more open.*

Social workers, facilitators and lay counselors cited mentorship and supervision as important aspects of capacity building. CINDI partners hold weekly team debriefing meetings in which difficult cases may be discussed. Often a professional psychologist is brought in when the team needs additional support. Individual support supervision is provided to social workers and facilitators by their supervisor on a monthly basis, or more regularly if needed.

Parents and caregivers were also enthusiastic about the awareness and skills they gained from training. One mother commented that an important change that resulted from her

parenting training was, *to not hear from the outside what the problems are, but rather to listen so that our children will tell us themselves.*

Training for youth in the school programs has also led to increased awareness about a range of topics and issues, positive changes in behavior such as HTS, and increased peer leadership. Said one student, *the program is really helping us to think about these issues and our own choices. We think more about how to make the right choices.* Youth in the ASPIRES program describe increases in self-confidence, improved supportive peer relationships and less isolation: *The program gives us something to do so we are not just being at home with nothing, and it is easier to make better choices when we have something to do.* In addition, the youth describe sharing information with their parents, caregivers and other family members, and cite positive changes in the home, including more communication in general and also specifically on HIV, sexuality, sexual health, family planning between themselves and the adults in the home.

QUALITY AND INNOVATIONS

The use of technology is one of the ways that the *May'khethele Programme* reaches high levels of quality and innovation. This includes everything from using technology for supervision and referrals, to an innovative MIS that helps to track referrals and follow-up. According to CINDI managers, the Government of South Africa has been interested in replicating the MIS system for use in other provinces and within different government departments.

The program uses electronic mail and SMS messaging for referrals and follow-up, resulting in faster tracking of referrals and timelier follow-ups. As highlighted earlier, referral is not simply providing the client with a referral to the services, but also ensuring that service is received. Using technology to communicate with clients and services provides tools to streamline the process. WhatsApp groups are used for communication between members of War Rooms, *May'khethele Programme* facilitators and groups of CCGs. This is a fast, easy and inexpensive way to communicate urgent client needs, check on referrals, and provide case-related supervision and mentoring.

Many stakeholders who participated in the KII and FGD felt that the ward-level War Rooms are really innovative. They are described as *"fighting HIV on the ground"* (this is where the name War Room comes from). The War Rooms were designed by the leaders of KZN Province to respond to the need for more community engagement in HIV awareness, prevention, testing and treatment. Their objective is to increase community-owned and implemented solutions. War Rooms exist in every district of the province, and may work on anything from community gardening to cross-agency referral for HIV services and addressing other community vulnerabilities. The War Room is a multi-disciplinary, multi-agency community protection group. Because it is a community-level mechanism attended by government agents such as DSD, health providers, CBOs, traditional leaders, and others — and all community issues are discussed — there is felt to be a faster response time to the priority needs identified and high sense of community responsibility to impact change. A War Room's success depends on the level of engagement of these different actors and their willingness to both attend meetings and assume responsibility for follow-up tasks.

There are a number of methods in place for service feedback that can lead to quality improvements. Supervisors make field visits, and look at how suggestions and lessons are being incorporated. Standards for supervision are not the same across all partners, but all organizations have trained supervisors. Supervisors help workers to set personal and professional goals (based on job descriptions), and to periodically review how the worker is doing. Coaching is provided if there are key areas for worker improvement.

Supervisors also talk to the learners informally about the facilitator's work in the school to help ensure their needs are being met. The IPs have suggestions boxes at their offices. There are also suggestion boxes at the schools. Both are checked regularly, and suggestions are discussed at the CINDI partner joint team management meetings. For example, when feedback was received that facilitators were often late in arriving, a sign-in sheet was placed in the reception office at every school. This simple requirement of signing in improved timeliness. In another example, feedback was received that newer facilitators had a hard time keeping control of their classrooms. CINDI used this feedback to bring in new training and refresher training on classroom management combined with using practice sessions that included mentorship to give new facilitators opportunities to try out different methods. Feedback from the schools about challenges with having enough transportation for children that showed up for HCT led to extending the sign-up period. It turned out that having just one day for sign-up did not give youth enough time to think about attending. Now the sign-up is open for one week. As an added method for feedback and QI, and showing a commitment to child participation, CINDI recently integrated youth representatives into the joint team management meetings. There will be two to three youth representatives rotating as participants.

DATA COLLECTION AND INFORMATION SHARING

A number of the key points on data collection and information sharing within the *May'khethele Programme* have already been touched upon. A major focus of the CINDI effort has been the development of common forms and practices that feed into the inter-agency MIS. The system not only helps clients and the IPs, but also feeds into the reporting required by government systems, for example, on how many new OVC are identified. The information can be easily accessed because data collection is uniform across partners, and collated in one system.

This seems to be aiding the entire referral mechanism process from identification to follow-through. Because the MIS requires several places for backstopping (at the worker level, at the supervisor level, at the data entry level and then at CINDI), there are assurances that a referral is actually followed through to service delivery and outcome. Workers, supervisors and the management team can easily share the data collected. This helps them to identify both successes and gaps. War Rooms can be used for information sharing at

community level, and for checking that referrals have been received and acted upon appropriately.

Ongoing challenges

The *May'khethele Programme* has not been without challenges, as is to be expected in a resource-constrained context like that found in the uMgungundlovu District, KZN Province, South Africa. Most stakeholders describe the work with government departments as the most challenging aspect. The government has limited financial and human resources. There is reliance on NGO partners to do the work on the ground, but when it comes to statutory responsibility, the government response time (particularly the DSD) is said to be very slow. In KZN province, the DSD contracts with an NGO, Child and Family Welfare Society of Pietermaritzburg, for child protection interventions, including removal of children from abusive homes and monitoring of foster care. As well, the Department of Health has a process to allow NGOs to be approved for HTS. These kinds of partnerships in response to the resource constraints are of critical importance for OVC. The government is also said to lack common forms, procedures and capacity for follow-up. There is no government MIS to track the case management process other than some systems to collect health data. Lastly, project partners find it challenging that there is very little intersectoral cooperation at the provincial level. The *May'khethele Programme* provides a referral mechanism and MIS as an example for the government. At the time of this report it was expected that the program's model would inform work at the national level to improve the government's responses and procedures at all levels.

While generally the direct on-the-ground relationships help with referrals and facilitate follow-up, there are also varying degrees of community engagement. Program partners find that it helps to have the same contact person within the government and within NGO partners. Taking the time to build relationships is important to addressing challenges with cross-agency referral. *Within the NGO sector we know that the referral is received but not always with others unless we know someone from there,* said one NGO representative. The referral mechanism of the *May'khethele Programme* impresses, in part, because of the strong partnership committed to working hand-in-hand and recognizing the importance of relationships. *What's really cool about what we do,* said one CINDI senior project coordinator, *is how we all work together, bringing our various strengths, to help children, youth, families and communities.*

Conclusion: Stronger referral mechanisms through partnership

There are a number of strong aspects of the CINDI program that can be highlighted as takeaway learning for others. First, the CINDI project places a very high value on the relational aspects of referral. Referrals themselves increase when awareness about service provision is raised and relationships of trust and mutual benefit are established. These relationships also ensure that referral does not end with the filling out of a paper. Because one can pick up the phone and reach someone on the other end, assurances are in place to bring referral to the point of a client receiving the needed services. Investing in and finding ways to allow service providers to know one another's results in successful referrals and supported children, youth and families seem to be leading to stronger client outcomes.

This idea of relationship in the referral mechanism and partnership between actors carries through to the relationships in schools. The CINDI program partners have worked to bring together different school actors so that children and youth have a variety of "safe and protective" people around them – including teachers, administrators, lay counselors, LO teachers and facilitators who can provide a linkage and protective mechanism between home, community and school. In this way schools are really used a "hubs" for a system of referrals that is leading to more confident and engaged youth, increased HIV awareness, prevention, HTS and ART adherence, and reduced stigmatization.

The issues related to high rates of HIV in the uMgungundlovu District and underlying poverty mean that multiple and acute client needs hinder sustainable impact. Many households face a multitude of challenges, including substance use or abuse, disability and complex health issues. There are many risks to child protection. Against these odds a strong NGO partnership with a functional referral system forges on building relationships and community resilience.

Annex A: Sample referral form

MAY'KHETHELE REFERRAL AND MONITORING FORM

Services Needed	Urgent	Not urgent	Organization referred to	Date referred	Mode of referral	Service delivery date	Date captured
□ **Identity document**							
□ **Birth certificates**							
□ **Social grants**							
□ **HCT**							
□ **CD4 count test**							
□ **TB Screening**							
□ **Referral for** Medical Male Circumcision							
□ **TB symptomatic screening**							
□ **Referral TB diagnosis**							
□ **ARV treatment**							
□ **Referral for PEP**							
□ **Immunizatio**n							
□ **Deworming**							
□ **Treatment of STI**							
□ **School uniforms/stationery**							
□ **School fee exemption**							
□ **Mentorship in support for Tertiary Education**							
□ **Further counseling**							
□ **Removal from abusive environment**							
Services Delivered						**Service delivery date**	**Date captured**
□ **HIV/GBV prevention** education							
□ **Sexual Reproductive Health** education							
□ **Bereavement counselling**							
□ **After school** tuition/home-work clubs							
□ **Economic Strengthening** Employability Education							
□ **Economic strengthening** (Financial Education)							
□ **Small group child protection** education workshops							
□ **Parenting skills (TALC)** workshops							
□ **Condoms Promotion and** provision							

NAME OF FACILITATOR WHO REFERRED THE CHILD: _____

SIGNATURE: _____ ORGANISATION: _____

Annex B: Sample May'khethele information form

MAY'KHETHELE

INFORMATION FORM

PERSONAL DETAILS			
FIRST NAME:		**SURNAME:**	

SA Identity Number if any_____

☐ **Male** ☐ **Female** **Date of Birth:** _____ **Age:** _____

Address: _____

My biological mother is:	Present and well		My biological father is:	Present and well	
	Present and mostly ill			Present and mostly ill	
	Absent			Absent	
	Dead/Passed away			Dead/Passed away	

PREVIOUS SCHOOL		PREVIOUS CLASS	

Name of the person who looks after me at home:

The person who looks after me is:

☐ My Mother/Father

☐ Step Mother/Step Father

☐ My Grandparent

☐ Other relative (e.g. uncle/aunt, brother/sister)

☐ Adult not related to me

☐ Shelter/Boarding House

☐ Myself

Age of the person who looks after me: _____ Cell/tel No. _____

Number of children in the house who are under 18 years of age _____

Completed by (name):		Date:	Signed:
Facilitator's name:		Date:	Organisation:

Home Tel/Cell: _____

Do you have any kind of disability? : ☐ Yes ☐ No **: If Yes Please specify type:** _____
___

CURRENT SCHOOL		CURRENT CLASS	

Optional Information for Partners

Have you done VCT? **YES** ☐ **NO** ☐

☐ If **YES**, when? _____

Have your Siblings done VCT? **YES** ☐ **NO** ☐

☐ If **YES**, when? _____

☐ Please write down your nickname/s if you have any_____

For office use only:

Data captured by: _____: date: _____

Data verified by: _____: date: _____

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Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International and Westat