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40

Lessons Learned

Integrated Training for Health Care Providers in South Africa

Integrated Training for Health Care Providers in South Africa

'Considering the law in Zimbabwe, I will not disclose my sexual orientation to a health-care worker because I am afraid they will call the police and I will be charged for practicing homosexuality.'

Gay man, Zimbabwe

Key populations in Southern Africa are amongst the most socially and economically marginalised. Many are not insured and cannot afford private health-care and their needs and issues are not high on the political agenda. They are often negatively affected by the perceptions, attitudes and practices of health-care providers towards sex workers, people who use drugs, LGBT people including MSM. Fear of stigma and discrimination results in delays amongst these groups in seeking HIV tests and testing for other STIs. In turn, this results in the late initiation of treatment and many times poorer health outcomes[1]. Young members of these key population groups are particularly vulnerable, as they often delay or fail to seek health services due to their fear of stigma and their concerns about the confidentiality of medical consultations, especially in close-knit communal societies.

Recent South African studies, consultations and analyses have shown[2, 3]:

- High HIV prevalence and low health-seeking behaviours amongst key populations;
- Low access and quality of health-service provision for key populations;
- Discrimination by service providers towards key populations presenting a major barrier to accessing health services.

In 2012, community-led key population organisations that are partners of COC assessed the health needs within their respective communities[4]. Several factors that may result in delay or failure to seek health-care were identified. These included:

- Lack of knowledge of health issues;
- Perceived need for HIV prevention or treatment and general attitude towards health-care services;
- Experienced or anticipated negativity, stigma and discrimination in facilities.

1 UNAIDS (2014) "The Gap Report" JC2656, Geneva.
2 Cloete, A., et al. (2014) The South African Marang Men's Project. Cape Town: HSRC Press. www.hsrcpress.ac.za/product.php?productid=2328
3 Department of Health of the Republic of South Africa. (2012) Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa. Tech. Pretoria. www.academia.edu/8097294/Operational_guidelines_for_HIV_STIs_and_TB_programmes_for_key_populations_in_South_Africa
4 Bartholomew, L. K., G. S. Parcel, G. Kok, M. E, Fernandez, and N. H. Gottlieb. (2011) Planning Health Promotion Programs: An Intervention Mapping Approach. San Francisco, CA: Jossey-Bass.

ANALYSIS AND STRATEGY

'I don't want to be perceived as someone fuelling bad behaviour, if I work with them [transgender clients]. The church might also perceive me as promoting unacceptable behaviour. '

Health-care worker, South Africa

COC and country partners jointly implemented a context analysis for South Africa and Southern Africa[5 6]. COC also strengthened country partners' capacity to develop and implement knowledge, attitudes and practice (KAP) studies and disseminate results.

The KAP studies amongst health-care professionals indicated unfamiliarity with key populations, stigma, personal beliefs, negative attitudes and gaps in knowledge about key populations as obstacles to delivery of responsive health services. Results showed that health professionals lacked knowledge of the prevalence of HIV among key populations, their practices and needs. They also lacked knowledge on national health guidelines and had incorrect understanding of legal consequences when it comes to providing services to members of key populations[7].

The attitudes and practices of health-care providers are often negatively influenced by the (religious) communities to which they belong. These are then imported into the professional environment. Some health care professionals realise that key populations feel unable to reveal their sexual orientation, gender identity, sex work or drug use to their clinician[8]. However, healthcare workers who are more willing to provide non-judgemental services to key populations face ridicule from colleagues, stigma by association and unsupportive health systems. This is made worse by the fact that they often perform their duties in a highly stressed and under-resourced environment.

Community led LGBTI organisations in the region have used a variety of strategies to change the knowledge, attitudes and the practice of health-care providers and to improve the quality and accessibility of health services for LGBT and key populations in general

5 COC, and MSMGF. (2012) South Africa: A Baseline on the Health and Human Rights Situation of LGBT and Other Key Populations. Amsterdam. DiDiRi. org. Bridging the Gaps, Sept. 2012. accessed online. 15 Apr. 2015. didiri.org/files/3613/8191/6912/Baseline_Report_South_Africa_2nd_Version_September_2012.pdf
6 Ricardo, M., Langen, B. and Odumosu, O. (2015) In the Picture; A Situational Analysis of LGBT Health and Rights in Southern Africa. Amsterdam. COC Netherlands, Mar.2015. Online accessed. 18 Mar. 2015. didiri.org/files/3914/2650/8746/COC_-_In_The_Picture_-_2015.pdf
7 Ricardo, M., Langen, B. and Odumosu, O. (2014). Proud & Healthy; An overview of community based needs assessments on sexual health of LGBTIs in Southern Africa. Amsterdam. COC Netherlands Mar. 2014. Online accessed. 19 Mar. 2015. www.coc.nl/wp-content/uploads/2014/08/Proud-Healthy-COC-2014.pdf
8 www.coc.nl/wp-content/uploads/2014/08/Proud-Healthy-COC-2014.pdf

- Advocacy. Partners advocate for normative guidance to providing quality and accessible services for LGBTI at national and global levels and inclusion of this in national strategic plans, programmes and budgets.
- Capacity strengthening. COC supports local partners in assessing and improving their capacity to implement quality health-care sensitisation programmes. Furthermore partners were supported in improving referral and peer education systems (Oosterhoff & de Kort 2014 9; Singizi 201410,). Partners share manuals, materials and tips and tricks and they document lessons learned. Manuals and trainings are improved by input from Southern and Northern experts within the Bridging the Gaps programme (Singizi 2014)
- Key population specialized services. Partners provide tailor-made HIV-prevention and SRHR services where necessary.
- Targeting private and public health services. Strengthening the competence and sensitivity of civil society mainstream and public health-care providers for key populations. This happens thro9ugh both topical ad-hoc health information sessions and more structured training sessions (Oosterhoff & de Kort 2014)

At the start of the programme the following challenges had to be addressed:

- **Continued commitment of government**

  Although the project was endorsed by national authorities, provincial staff did not automatically engage or register interest. This risk was mitigated by informal sensitisation, and building relationships, especially with management at provincial DoHs;

- **Collaboration between key population groups**

  Key population groups share a lot of struggles, but do not always have the same interests and are not always in agreement. Groups made this explicit at the start of the project and made sure that possible tensions were addressed;

- **Continued interest with funding agencies**

  COC funded the kick-off of the project without having confirmation from CDC/PEPFAR of co-funding. COC supported OUT and ICAP in the work plan and budget development.

9 Oosterhoff, P., and G. De Kort. Bridging the Gaps Health and Rights for Key Populations Mid--term Evaluation Report. Rep. University of Sussex: Institute of Development Studies, 2014.

10 Singizi Consulting (2014). Midterm Review, Dignity, Diversity and Rights (DiDiRi), Sexual and Reproductive Health Rights for LGBTI Populations in Southern Africa. Gauteng. Singizi Consulting, October. 2014. Online accessed. 20 April 2015. didiri.org/files/4114/2894/1150/DiDiRiEvalReportOct8.141.pdf

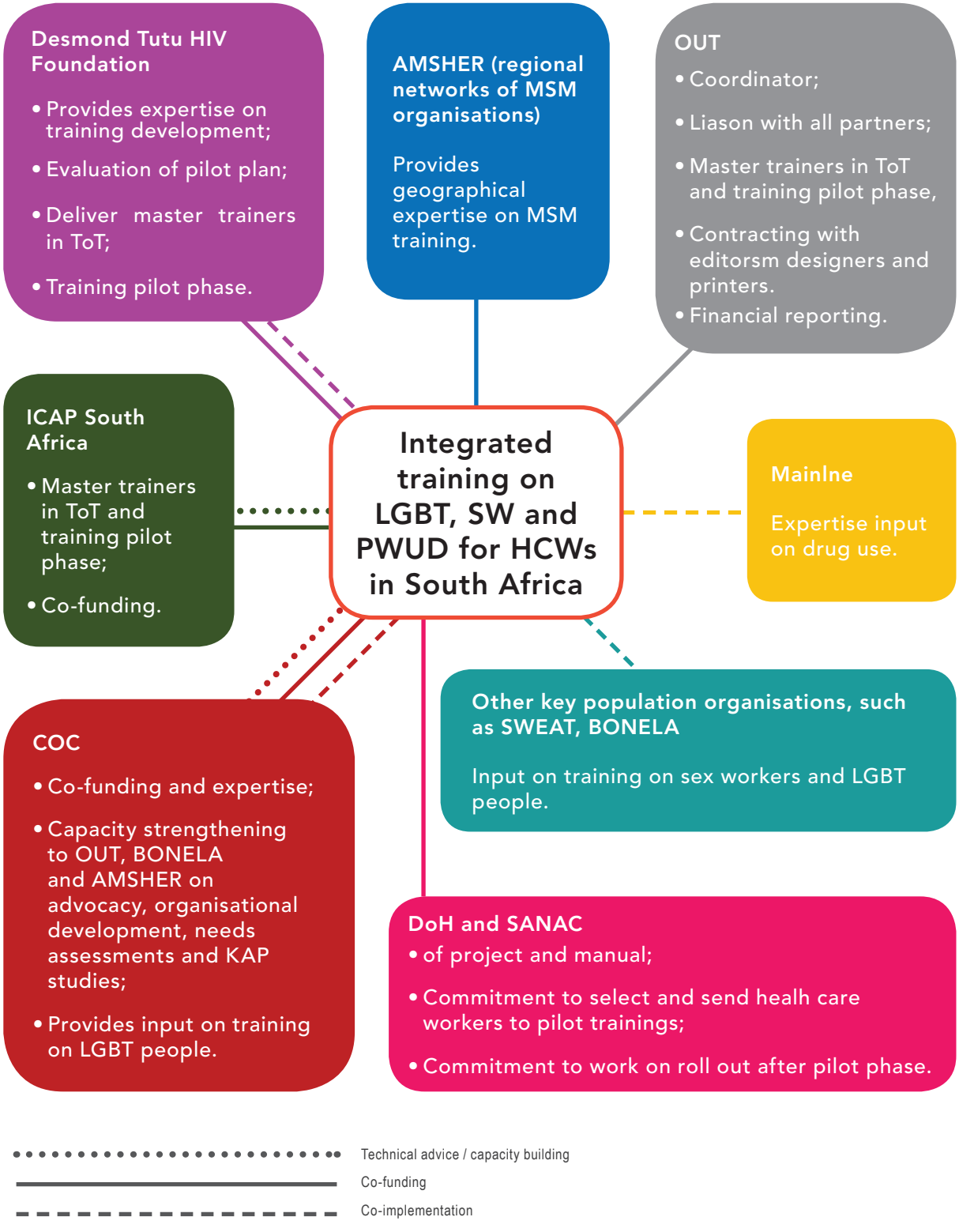
OUR INTERVENTIONS

"Given available capacity within the South African Health System, it makes sense to sensitise and train health-care workers in an integrated manner. It will save time and enable commonalties to be addressed".

Dr Abdullah, Chief Executive Officer of SANAC

In South Africa and elsewhere, the sensitisation of health-care workers towards key populations has been largely community driven: mostly promoted by key population organisations and aimed at mainstream non-governmental health facilities.

Interest and involvement of public health services and national governments in this area was limited. To change this situation, country partners invested a lot of effort and energy in relationship building, advocacy and lobbying with the South African National AIDS Council (SANAC) and national and provincial Departments of Health (DoH). COC has for many years supported LGBT partners' with advocacy capacity, practical advice and funding at the start of the project, the organisations signed a Memorandum of Understanding, which also clarified roles and positions. Throughout the implementation, roles were adjusted where necessary and agreed upon.



These intense advocacy efforts have paid off as the South African National Strategic Plan on HIV, STIs and TB 2012–2016 (NSP) now states that health-care services must be responsive towards the needs of key populations. The 2012 Operational Guidelines for HIV, STI, and TB Programmes for Key Populations in South Africa were based on the NSP and global normative guidance as developed by WHO[11]. Both identified sensitisation training for health-care workers as an essential intervention to address these barriers.

11 Department of Health of the Republic of South Africa. (2012) Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa. Tech. Pretoria. www.academia.edu/8097294/Operational_guidelines_for_HIV_STIs_and_TB_programmes_for_key_populations_in_South_Africa

With the Operational Guidelines and the NSP in place in 2012, key population led-organisations saw a window of opportunity to fast-track change and to hold government to its commitments in the NSP and operational guidelines. Country partners proposed the idea of an integrated training manual for health-care workers to sensitise them to the needs of three key populations. This process was strongly supported and endorsed by South African authorities. OUT Wellbeing and COC called a meeting with the National Department of Health, SANAC, several key-population organisations in South Africa, BONELA (Botswana), AMSHeR, Desmond Tutu HIV Foundation, Mainline, CDC-South Africa and ICAP-South Africa. South African key population organisations were in the driver's seat throughout the process to make sure that the manual would be locally relevant and context specific.

The integrated aspect of the manual is innovative. It is the first manual developed for health-care workers that addressed issues around sex workers, LGBT people and people who use drugs in one training package. COC and country partners had previous experience with sensitisation trainings on LGBT people. Training health-care workers on aspects of service provision to different and sometimes overlapping key populations creates efficiency gains.

The draft manual was developed by a team of technical experts coordinated by OUT. The position of women is explicitly addressed in the manual. The manual includes reference and case studies on lesbian and bisexual women and transgender and gender non-conforming people. The needs of marginalised groups like male and transgender sex workers and female drug users are emphasised.

Hard copies of manual readily available and downloadable at www.coc.nl/integratedmanual. In total 2.000 manuals have been published and shared among beneficiaries;

We developed a plan, implement and evaluate integrated training. The training was aimed at providing health-care workers in the public healthcare system with the necessary information to provide effective and appropriate care and support for key populations within South African health-care settings. The alternative to focus on pre-service training was considered, but deemed less feasible and effective at this stage.

Thirty trainers participated in an initial training of trainers (ToT). These master trainers aimed to support the training of at least 400 health-care workers in the pilot phase. The initial approach was to build capacity of Regional Training Centres (RTCs) to co-facilitate pilot training. This failed partially. As the training competence and the confidence of most trainers in the RTCs turned out to be insufficient, they were not able to run the trainings independently. Instead, master trainers from the collective completed all of the pilot trainings.

Based on the results of the ToT phase, the participants' and facilitators' manuals were adjusted and a final version was produced and endorsed by the National DoH and SANAC.

During 2013 and 2014, one-day pilot trainings were implemented in six provinces. In total, 587 health-care workers were trained during this pilot phase. Public health participants were selected and sent by Provincial DoH. Trainees held a variety of positions: nurses, counsellors, nurse practitioners, outreach workers and managers. 90% of them were women. Most participants were government employees and most had already provided health-care services for about ten years on average. Almost none of them had received any previous sensitisation training on key populations.

RESULTS

"Yes, I noticed that since I went for the course in Bloemfontein, I found that we [health care workers] stigmatise key populations. We don't treat them well. I learned a lot from the training… So I have learned a lot about key populations."

Health care worker (South Africa)

The results below describe what has been achieved on an output level by integrating training for health care providers in South Africa and providing services for key populations. Most trainees completed a pre- and post-training assessment. From the analysis of these assessments it was concluded that the integrated sensitisation training resulted in:

- Awareness of how stigma affecting sex workers (SWs), LGBT people, and people who use drugs (PWUD) prevents them from getting effective health care increased from 70% (276 of 394) at pre-training to 84% (338 of 404) at post-training;
- At pre-training, 71% (286 of 399) believed that unfair treatment and discrimination by health staff towards them were barriers to health services. After the training this increased to 88%;
- The proportion of trainees who were aware of how concerns that SWs, MSM and PWUD have around the confidentiality of their engagement with health workers is a barrier to health services increased from 62% (249 of 399) to 74% (297 of 404);
- Fewer health care workers thought that having sex with someone of the same sex was immoral after the training than before – before training 48% thought it was immoral, 47% thought it not immoral. After the training these percentages changed to 40% and 70%;

- The proportion of health workers that strongly felt that they were comfortable providing health services for MSM increased from 30% (n=111) before the training to 44% (n=172) after the training;
- The proportion of health care workers that were aware that MSM may not access health services due to fear of judgement, concerns of being refused services or concerns of being abused by health workers increased from 46% to 69%;
- After the training the majority of trainees (71%, n=278) strongly agreed that this training is helpful to address stigmatising health care worker attitudes;
- After the training, 86%, 87% and 87% (N=345) of trainees felt that they were more skilled to provide services to SWs, MSM and PWUD, respectively. Six percent of trainees felt that the training did increase their skills levels to provide services to SWs, MSM and PWUD[12].

These outputs were in line with outputs anticipated at the start of the project. Implementation of the trainings was slightly delayed and the pilot phase was extended with six months.

Results on an outcome level include:

- After a rigorous selection process, WHO acknowledged the South African integrated training manual as a best practice and included it in the WHO Consolidated Guidelines for Key Populations[13];
- The Mid Term Evaluation of the Bridging the Gaps programme concluded that 'bringing together the needs of different key populations in one manual is effective[14].

Besides the pre- and post-assessment of the training results, a longer-term evaluation study on the changes in practice is underway and aims to assess:

- Long-term changes in health-care workers' knowledge, attitudes and practice with regard to key populations resulting from training;
- Changes in the level of health-care workers' stigma and discrimination towards clients from key populations;
- Changes made at the sites where HIV-related services for key populations are provided.

12 Brown, B & A. Scheibe (2015) Initial analysis, integrated sensitisation training programme – quantitative evaluation. (Forthcoming)
13 WHO (2014) Appendix V, On the ground: Programmes serving the needs of key populations (case studies) of the Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations Geneva. www.who.int/hiv/pub/guidelines/keypopulations/en/
14 Oosterhoff, P., and G. De Kort. Bridging the Gaps Health and Rights for Key Populations Midterm Evaluation Report. Rep. University of Sussex: Institute of Development Studies, 2014. Print.

The evaluation methods used included interviews with healthcare workers, key-population focus groups and onsite/facility observations. Interim, unpublished results indicate that the sensitisation workshops led to improvement in the accessibility of quality services tailored to the needs of key populations[15]. Wherever trainings had been held, people from key populations reported improvements in health-care workers' attitudes. Trust in health-care providers increased, as did the uptake of health-care facilities where the sensitisation training was linked with peer outreach by key population organisations.

During the follow-up interviews, health-care workers described how they shared their experiences from the workshop with colleagues who did not attend. They also indicated that the training programme had made them realise their own prejudices[16]. At the facility level, the observed changes were still limited. Health-care facilities generally have limited space and are often busy, noisy and crowded.

SUSTAINABILITY

The rollout of the integrated manual training is currently being implemented by ICAP in close collaboration with the Provincial Departments of Health. In the pilot phase 587 health-care workers were trained. It is envisaged that the current rollout of training will reach over 10.000 health-care workers.

National and provincial DoHs together with SANAC, international donors, multilateral funding agencies and key populations organisations are currently planning the long-term implementation of public health-care worker sensitisation with regard to key populations in South Africa. The results of the evaluation study provide important evidence in this process. Although sensitisation training is insufficient on its own, it is an essential first step towards fostering enabling environments for effective health-care provision for key populations.

LEARNING AND FLEXIBILITY

Country partners are scaling up the project in the region. The rollout will build on experiences in South Africa, but each country will need to take full ownership of the process and make country-specific adjustments. Both in terms of the content of the manual and the implementation.

15 Brown, B & A. Scheibe (2015) Initial analysis, integrated sensitisation training programme – quantitative evaluation. (Forthcoming)
16 Ibid.

Sensitisation of policy makers has become an important preparatory intervention in this process and is supported both by COC and OUT's joint regional training programme and ad hoc in-country sensitisation sessions during country visits by COC and OUT staff. In December 2014, the Ministry of Health in Swaziland invited national stakeholders, funders and COC to develop a localised integrated manual and an implementation plan. Funders have shown clear interest. A similar process is currently unfolding in Botswana and Malawi.

As another spin off of the integrated manual for health-care workers, COC, Aids Fonds, Mainline and country partners are developing a similar integrated sensitisation training for law enforcement officers in Southern Africa, funded by the Dutch Embassy in Maputo.

Key learning from the project included:

- The need for a **robust assessment** of the capacities of the RTCs and the selection criteria for the pilot trainers from the RTCs
- **Accreditation:** Although the manual has been endorsed by the National DoH and SANAC, the training programme has not yet received accreditation by the South African Qualifications Authority. ICAP, OUT and DoH are currently working on accreditation so that participants can receive points for continued professional development.
- **Fostering understanding:** Bringing peer educators and health workers together in trainings builds trust and contributes to understanding. Hearing the lived experiences of individuals helps to break down prejudices. Contact during training was often followed up with communication and collaboration afterwards.
- **IEC material:** Health-care providers indicated that it would beneficial, if they had access to IEC material on key populations. Health-care workers themselves, COC and partners therefore developed a leaflet on how to discuss risk reduction strategies and sexual health with LGBT people.

COLLABORATION WITH THE DUTCH MINISTRY OF FOREIGN AFFAIRS (MOFA)

MoFA plays an important progressive role in the policy development with UNAIDS, WHO and the Global Fund. Policies within these institutions have become much more in line with the needs of key populations.

This is proving extremely supportive for local key population led organisations in their lobby towards their own governments and mainstream health organisations. MoFA's flexible and pragmatic funding approach made it possible for COC to be flexible and pragmatic in its funding, especially where CDC/PEPFAR co-funding was less flexible.

The Netherlands Embassy in Pretoria attended one of COC's regional conferences. This raised the profile of the conference, making it more attractive for policy makers from Ministries of Health and health institutions to attend. The Embassies in Pretoria, Maputo, Luanda and Harare have provided

important leads to contacts with national stakeholders to COC and country partners. The Embassy in Maputo has financially supported the upscaling of health-care curriculum development beyond South Africa.

ENDING NOTES

The longstanding technical and financial support of COC has strengthened OUT's capacity to play a coordinating role in the improvement of human rights and health for key populations in Southern Africa. Through its leading advocacy role and its ability to bring civil society stakeholders together, OUT has been able to create locally relevant sensitisation training for health-care workers on different key populations. Years of building relationships and finding common ground underpinned collaboration with a wide network of stakeholders in South Africa. The evidence on its effectiveness and the WHO recognition as best practice, create opportunities for partners to contribute to improved quality of and access to HIV prevention, treatment and care for key populations in South Africa and beyond.

Lessons Learned publications in this series:

43. Raising awareness of stakeholders and mobilization of transgender and intersex communities
42. LGBTI refugee programme
41. Advocating against draft anti-LGBT legislation in Kyrgyzstan
40. Integrated Training for Health Care Providers in South Africa
39. A comparison of urban and rural LGBT support groups in Botswana
38. Identifying gaps to focus on in future work through community dialogues with law enforcement, healthcare workers, students and rural villages in Lesotho
37. Creating access to health services for LGBT Community in primary health care settings in the four regions of Swaziland.
36. Lessons learned at Equidad's HIV/STI testing centres for MSM in Ecuador
35. Raising awareness in the face of ignored deficiencies in the National Police Force of Panama
34. Safety for human rights advocates and defenders in the Central American context
33. Health Care Providers' sensitization and capacity development; and community mobilization through arts and theatre in Lusaka (Zambia)
32. Moving beyond individual counselling of LGBTI people to address central psychosocial issues on community level in Tshwane (Pretoria)
31. Bonela Challenging structural barriers through the Gender and Sexual Minority Rights Coalition in Gaborone (Botswana)
30. CEDEP Advocacy Approaches in Malawi
29. GALZ Lessons learnt amongst MSM in the uptake of Male Circumcision (Zimbabwe)
28. Uptake of Post-Exposure Prophylaxis (PEP) by Men who have Sex with Men in Tshwane (Pretoria).
27. OUT's Peer Education Programme for MSM / LGBT's in Tshwane, Pretoria
26. The Pink Ballot Agreement
25. Peer Education Programme (Malawi)
24. Schorer Monitor
23. Health, culture and network:Interventions withhomosexuals living with HIV/AIDS at Rio de Janeiro polyclinics
22. Telling a story about sex, advocating for prevention activities – informational materials about safe sex and harm reduction for gay men and MSM from 14 to 24 years.
21. Mainstreaming of LGBTI/MSM/WSW issues in all areas of service provision: Empowering Service Providers and Policy Makers in Botswana through trainings
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19. Towards a Comprehensive Health Care Service Model for Transgender People in Ecuador
18. Comparative analysis and account of the outreach process to implement a method to change behaviors of youngsters with homo/lesbo erotic feelings in Costa Rica
17. Methodology for behavioral change in teenagers with same sex feelings, from the Greater Metropolitan Area, in Costa Rica
16. Breeding Ideas: building up a young peer educators' network.
15. Prevention Images: notes about a photography workshop with young MSM and people living with HIV/AIDS in Rio de Janeiro
14. Advocacy campaign to prohibit hate lyrics targeted at men having sex with men during a dance hall concert in Suriname.
13. Interactions between young multipliers and young gays and bisexuals in internal and external activities in Rio de Janeiro (Brazil).
12. Information Stands: Prevention Project aimed at young gay men from Tegucigalpa (Honduras)
11. Ndim'lo (This is me) Photovoice with lesbian and bisexualwomen in the Western Cape, South Africa
10. Me&3 Campaign for lesbian and gay individuals in Pretoria (South Africa)
9. Sensitization of the National Policeby transgender organizations in Ecuador
8. Exercising 'Knowledges': Implementing training and prevention activities.
7. Public Incidence Activities: In search of public spaces accessible to teenagers with same sex feelings in the Greater Metropolitan area of Costa Rica. "Specific Case: Incidence with the National Institute for Women - INAMU - Costa Rica"
6. My body, your body, our sex: A Sexual Health Needs Assessment For Lesbians and Women Who Have Sex With Women, Durban, South Africa
5. Working with buddy groups in Zimbabwe
4. 'MAN TO MAN', a joint approach on sexual health of MSM in the Netherlands via the Internet
3. Lessons learned from project "Visual information on sexual health and the exercise of citizenship by the GLBTI beneficiaries of the Organization in Quito, Ecuador".
2. Coffee afternoons: Prevention Project aimed at young gay men from Tegucigalpa (Honduras)
1. Womyn2Womyn (W2W) quarterly open day, for lesbian and bisexual (LB) women at the Prism Lifestyle Centre in Hatfield, Pretoria (South Africa)

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