



KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA



17th AWACC 2025

Community Engagement to Improve Retention in Care

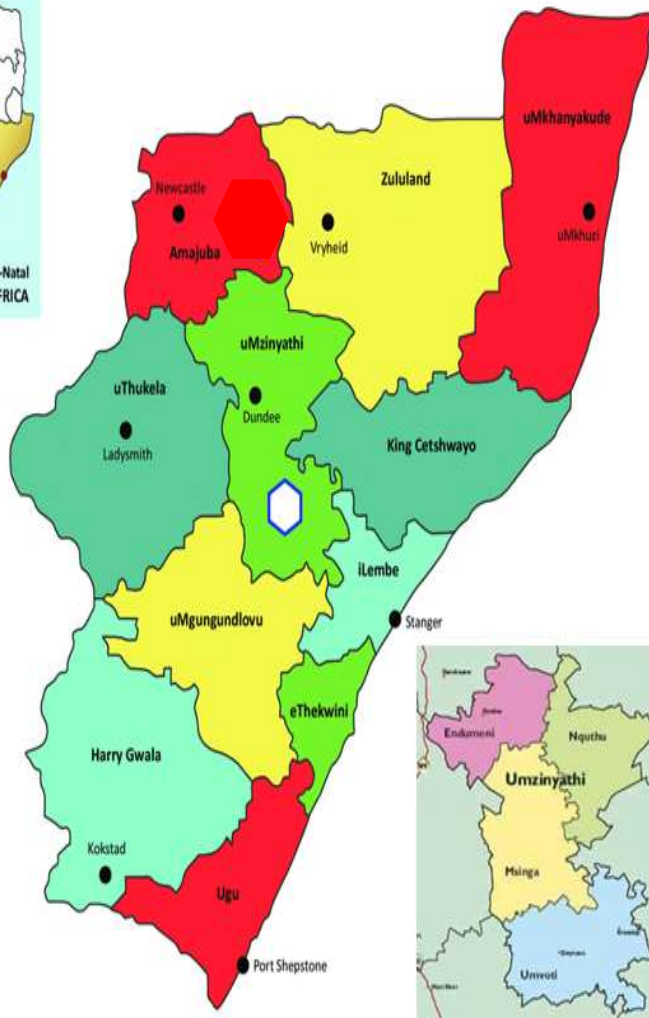
Presenter: Mrs N.S. Mange
30 October 2025
Elangeni Hotel, Durban

GROWING KWAZULU-NATAL TOGETHER

OUTLINE

- District Profile
- Background
- ART retention in care through community engagement
 - CHW's, Outreach Teams, and Household Champions' roles in HIV Community-Based Services
 - District performance
- HIV treatment cascade
- Total clients remaining on ART
- Viral load completion at 12 months
- Viral load suppression at 12 months
- Integration of Clinical Programmes – TB loss to follow-up rate
 - Interventions
 - Stakeholder/Community engagement
 - Conclusion

District Profile



- The **Umzinyathi Health District**, located in the north-central region of KwaZulu-Natal.
- The District has an estimated population of **571,650**, of which approximately **93% (531,634 individuals)** are uninsured and rely primarily on the public health system for care.
- Umzinyathi is an underdeveloped rural environment with little economic growth and sparse population growth, classified as socio-economic Quantile 1 – **Ranking among the poorest districts in the country.**
- The district has **four district hospitals, one specialized TB hospital, one community health centre, 53 fixed PHC clinics (including four gateway clinics), and 13 mobile clinics.**
- Umzinyathi comprises 4 Local Municipalities (LM) with 61 Wards :
 1. Endumeni LM – 07 Wards
 2. Nquthu LM – 19 Wards
 3. Msinga LM – 21 Wards
 4. Umvoti LM – 14 Wards

BACKGROUND

- The Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) forms part of the streams of Primary Health Care (PHC) Re-engineering and represents an important milestone in the ongoing efforts to transform healthcare nationally. These teams comprise the Outreach Team Leader (Professional Nurse) with six to twelve Community Health Care Workers who remain the health foot soldiers in the community and the first point of entry at a ward level
- Umzinyathi used this framework as the cornerstone to enhance community-based services
- Implementation of this policy framework and strategy ensured that Community Health Workers within the WBPHCOTs, supported by different categories of health professionals, formed the bridge between communities and healthcare service provision within health facilities and at a community and household level

BACKGROUND

- The implementation of the Community-Based Model has proven to be key in achieving retention in care, 2nd 95 targets
- Seeing the mountainous topography of Umzinyathi District, the poor basic infrastructure leading to inaccessibility to communities, health facilities, and numerous areas which cannot be serviced by mobile clinics, Umzinyathi remained reliant on the existing health foot soldiers and community engagement
- In August 2014 the concept of the Household Champions was implemented at Umzinyathi Health District. This Champion was a family member, interested in their family's wellbeing and nominated by family members in each household. The Champions were then orientated on health matters.
- The Household Champion Concept where members of households actively participate in keeping their families healthy, ensuring that health appointments are honoured, and further caring for those in need within a household, contributing enormously in building a sense of ownership in health matters at a household level



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ART RETENTION IN CARE THROUGH COMMUNITY ENGAGEMENT

ART RETENTION IN CARE THROUGH COMMUNITY ENGAGEMENT

WARD-BASED PRIMARY HEALTHCARE OUTREACH TEAMS

OUTREACH TEAM LEADERS (OTLs)- (27)

Professional nurse

Enrolled nurse

Community Health workers (453)

Endumeni= 04

Nqutu= 06

Msinga= 01

Pomeroy cluster= 06

Umvoti= 10

EN led teams 05

Endumeni= 02

Msinga= 03

Total number of OTLs inclusive of EN led teams = 32

ROLES AND RESPONSIBILITIES

- Action line lists by tracing all missed appointments, and facilitate referral back to care, Have weekly tracing targets
- Offer comprehensive PHC package at household level
- Appointed as TROA indicator champions in huddle meetings at facility level
- Outreach campaigns – Operation Mbo : Conducted by Sub-Districts ensuring that services are rendered to achieve the poor performing indicators
- Conduct community viral load management
- CCMDD – Pick Up Point, collection of treatment in the community thus ensuring adherence to treatment, 2775 clients collecting ART in WBOT
- Operation Sukuma Sakhe – War Rooms: Engagement with different departments, emphasizing the importance of testing and adherence to treatment
- Community Dialogues: Communities are engaged on the importance of testing and treatment and to remain in care.

ART RETENTION IN CARE THROUGH COMMUNITY ENGAGEMENT

WARD-BASED PRIMARY HEALTHCARE OUTREACH TEAMS	ROLES AND RESPONSIBILITIES
<p><u>SCHOOL HEATH TEAMS (26)</u> Professional nurse Enrolled nurse</p> <p>Endumeni= 04 Nqutu= 03 Msinga= 08 Pomeroy cluster = 01 Umvoti= 10</p>	<ul style="list-style-type: none"> - School Health Teams provide health education, HIV screening and refer students for testing in facility. - During school holidays they join WBPHCOT and conduct door-to-door campaigns. - School Health Teams are linked with High Transmission Areas (HTA) Teams in TVET's.

ART RETENTION IN CARE THROUGH COMMUNITY ENGAGEMENT

WARD-BASED PRIMARY HEALTHCARE OUTREACH TEAMS	ROLES AND RESPONSIBILITIES
<p><u>MDR OUTREACH TEAMS (17)</u> Enrolled nurse Assistant support officer (ASO)</p> <p>Endumeni= 03 Nqutu= 04 Msinga= 05 Pomeroy cluster= 01 Umvoti= 04</p>	<ul style="list-style-type: none"> - Household visit to monitor treatment adherence and side effects - Community TPT initiation under direct and indirect supervision of a Professional nurse - Assist OTLs with tracing of initial defaulters - Tracing of HAST defaulters, integrating with NCDs - Transportation of mobile patients to the centre of excellence (MDR- unit) for assessments and reviews, when shuttles are not available

ART RETENTION IN CARE THROUGH COMMUNITY ENGAGEMENT

WARD-BASED PRIMARY HEALTHCARE OUTREACH TEAMS

HOUSEHOLD CHAMPIONS (1500)

- 15 facilities are implementing the integrated Household champion and Family MUAC intervention within the district

ROLES AND RESPONSIBILITIES

- The role of the Household Champions is to ensure that every household member is tested for HIV and know their status by referring them to the CHW's and in turn to the WBPHCOT's
- They constantly check when last every household member was tested and who is due for retesting or Viral Load testing.
- Household Champions know the HIV status of every household members and support all members that tested positive in treatment adherence
- Integration of health services – immunization for children, HIV and TB testing and initiation on treatment working with all relevant cadres, **family MUAC intervention**



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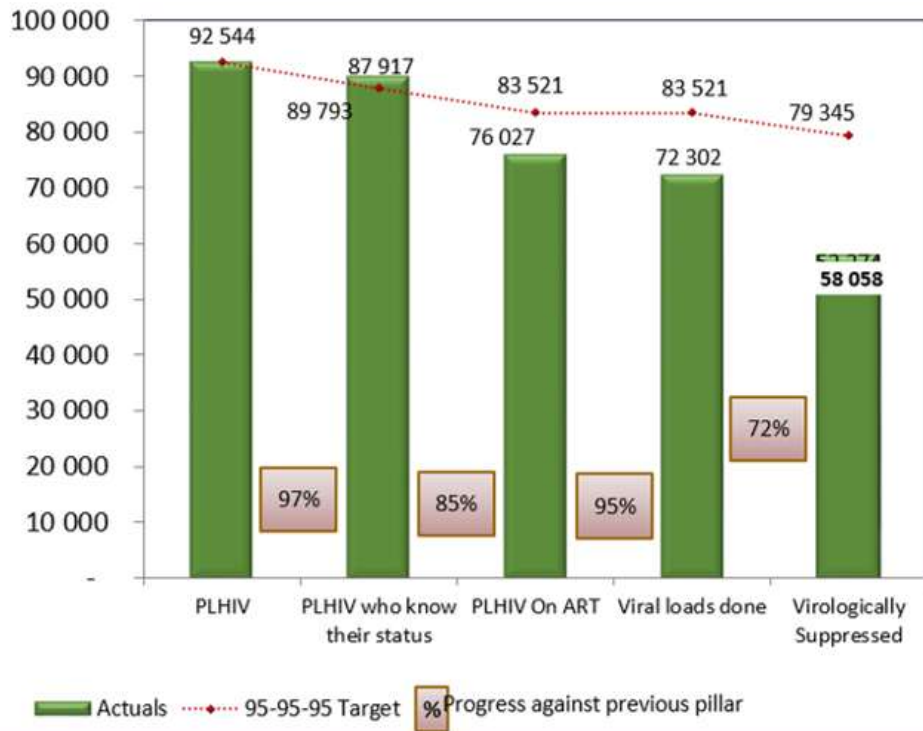
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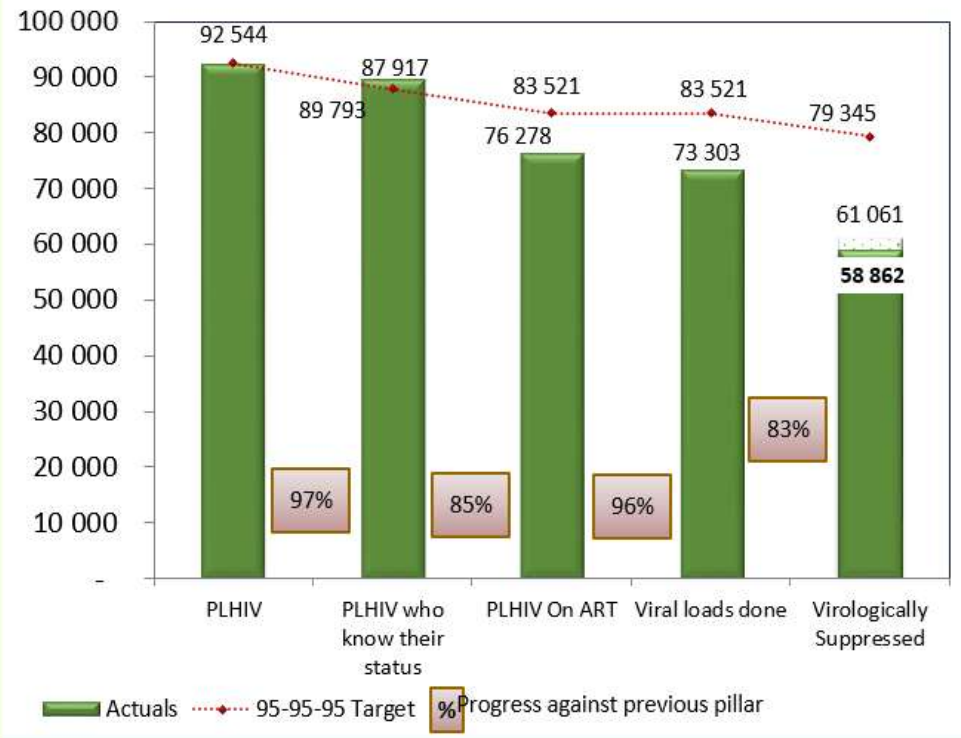
DISTRICT PERFORMANCE

HIV Treatment Cascade Total population

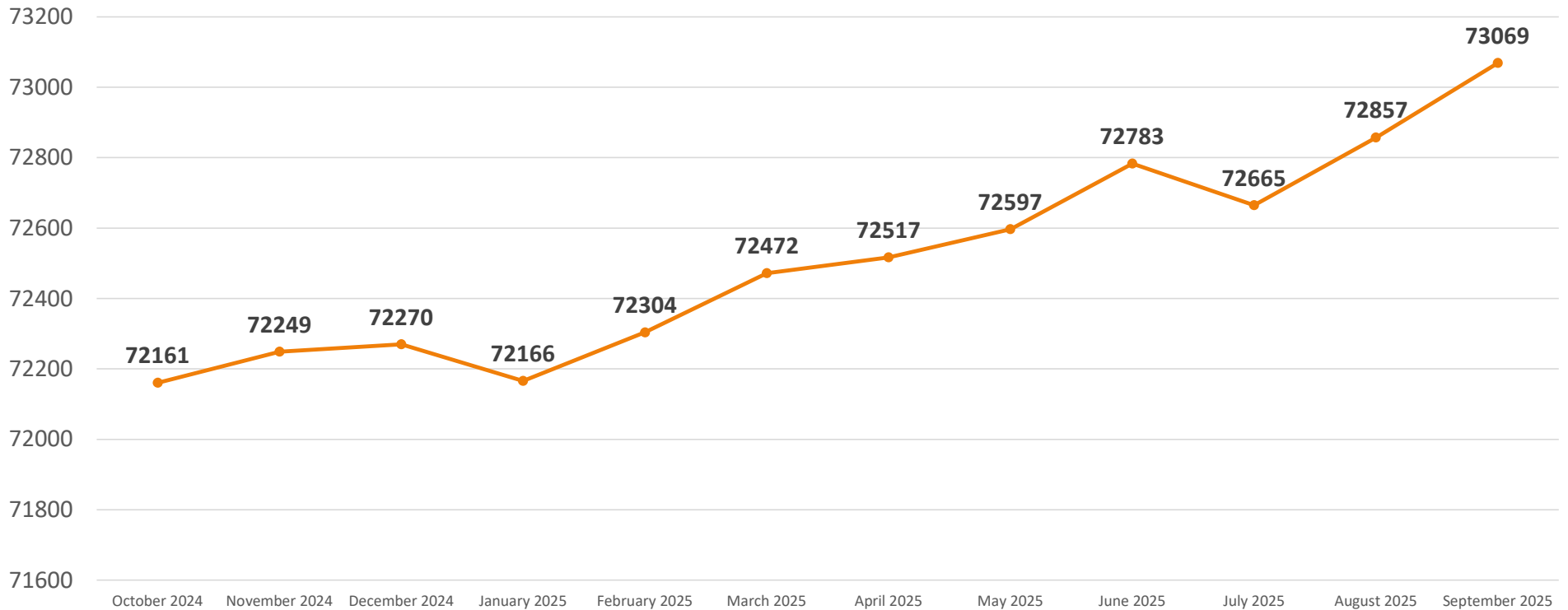
95-95-95 Cascade - Total Population
umzinyathi (Q1 (2025/26)) - Public & Private sector



95-95-95 Cascade - Total Population
Umzinyathi (Q2 (2025/26)) - Public & Private sector



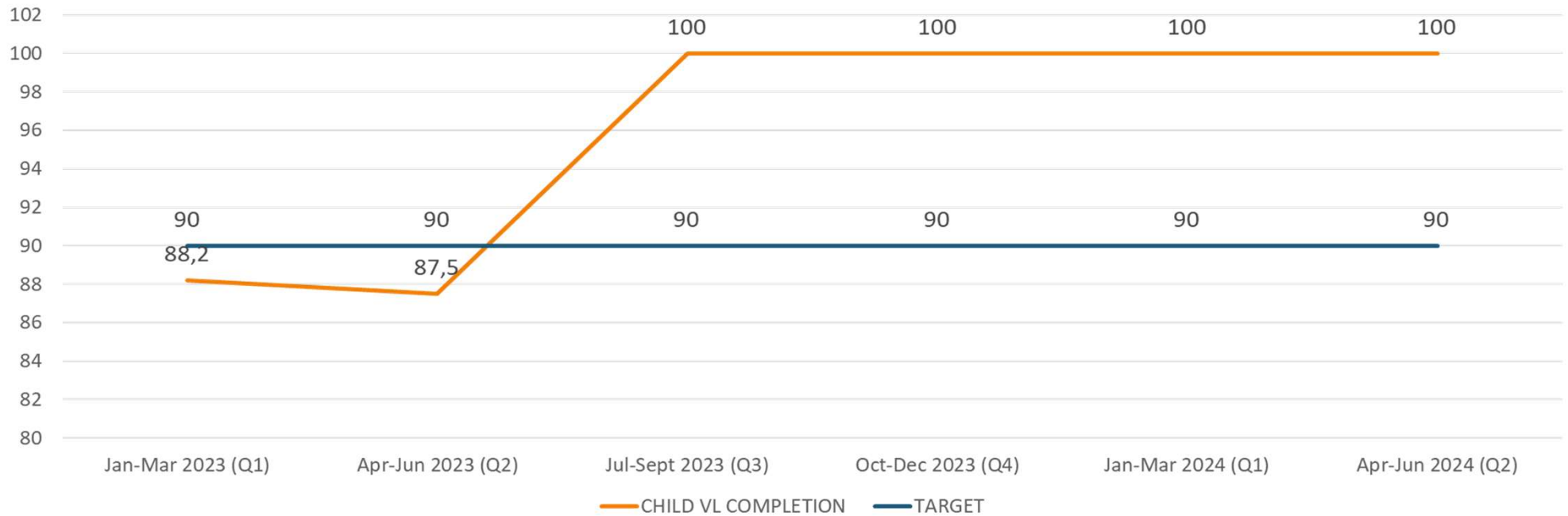
ART CLIENT REMAINING ON ART END OF MONTH – SUM (MONTHLY TREND)



TROA Net gain 908

Target = 90%

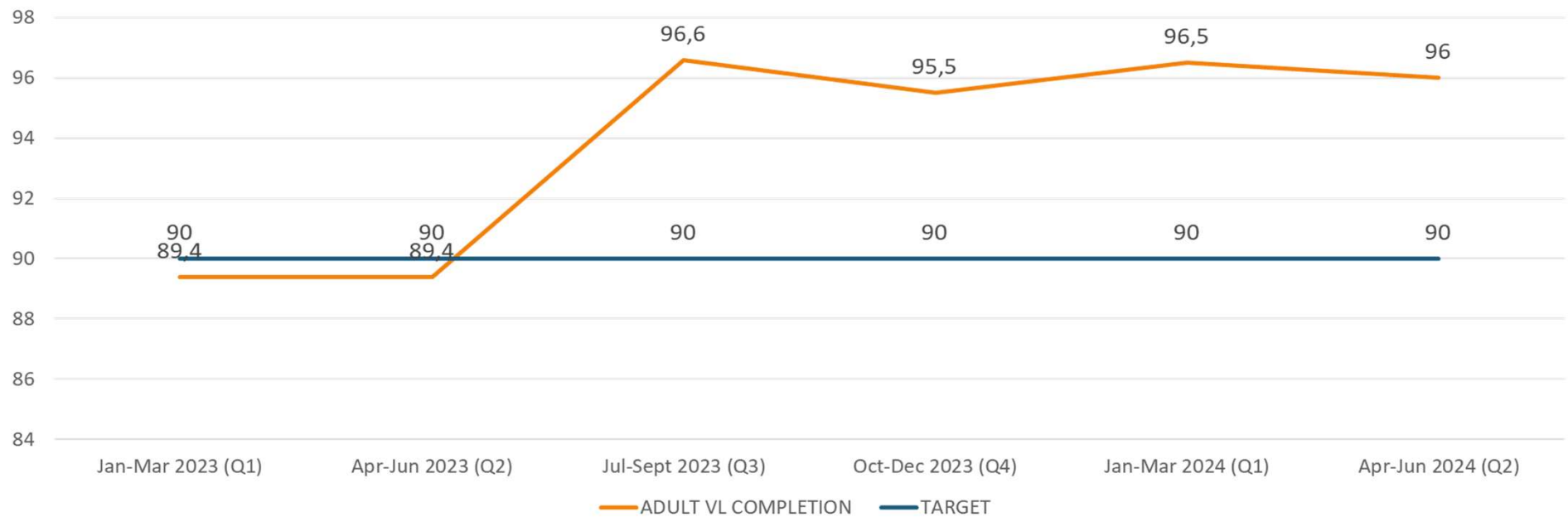
Child VL completion rate @12/12



Q1 -88,2% (15/17)	Q2- 87,6 %(14/16)	Q3- 100%(12/12)	Q4- 100% (12/12)	Q1- 100% (13/13)	Q2- 100% (11/11)
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Target = 90%

Adult VL completion rate @ 12/12



Q1-89,4% (621/695)	Q2- 89,4% (505/561)	Q3- 95,6% (498/521)	Q4- 95,5% (505/528)	Q1- 96,5% (587/608)	Q2-96% (485/505)
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INTERVENTIONS

CLINICAL SUPPORT

- Capacitation of sub-district managers on monitoring ART cohorts
- Mentorship on ART guideline implementation and VL algorithm in a specific
- Community VL management
- VL cohort monitoring, is a standing agenda item in all nerve centres
- ‘Know your child strategy’ and ‘Adopt a child strategy’
- Data for action approach

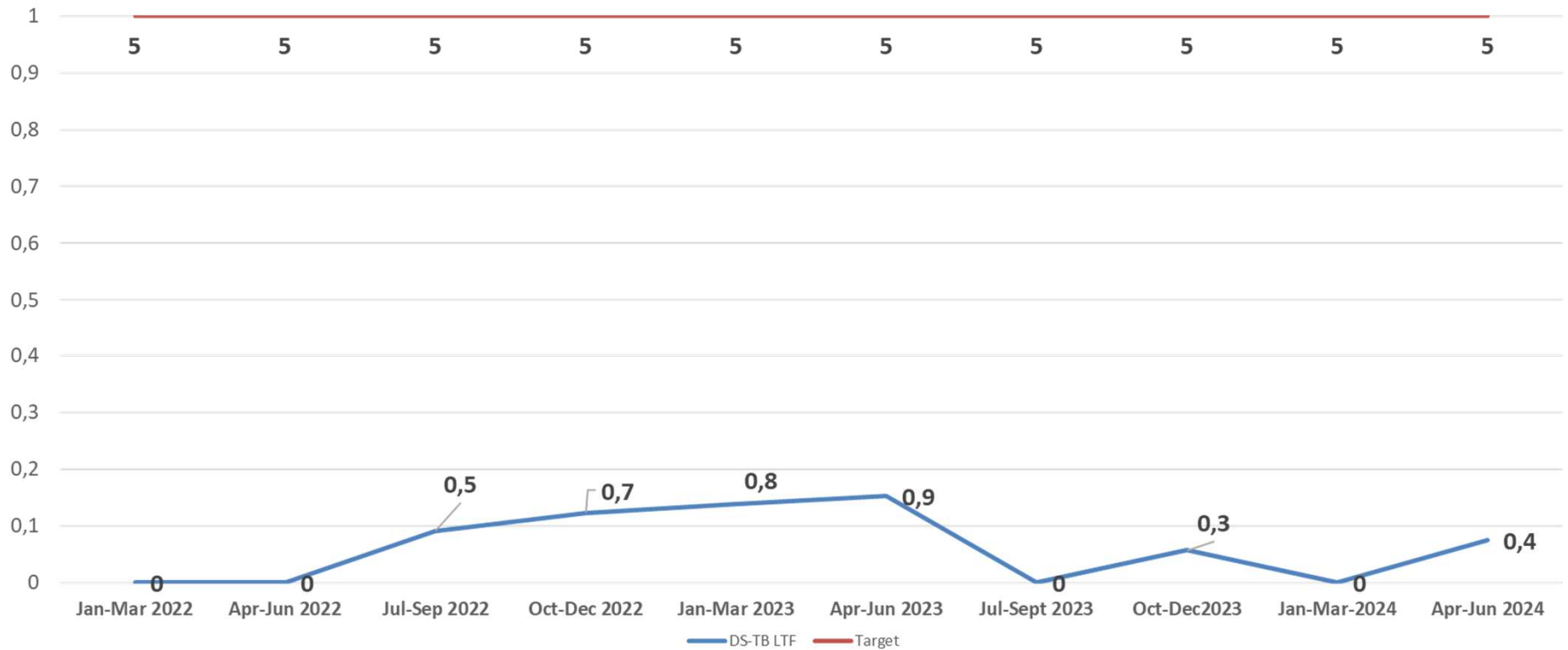
ADHERENCE SUPPORT AND MENTORSHIP

- Community Case Conference
 - The District Psycho-social Team mentor the Sub-District Psycho-social team, Programme Coordinators and facility cadres (OTL, HAST Champion, VL champions and Lay Counsellors).
 - Mentorship is conducted at the household level whereby the District Psycho-social team demonstrate community case conferencing and hand over to the Sub-District team for the continuum of care.
 - District Team monitors the progress of the Sub-District team.
- Disclosure training conducted in Jan and Feb 2025, mentorship programme commenced on the 6th of May 2025. All sub-districts represented in the training, cadres trained : 20 Lay counsellors, 4 DOH social workers, 5 DSD social workers, 1 Occupational therapist, 43 PNs and 8 EN's.

INTEGRATION OF CLINICAL PROGRAMMES

Target = <5%

DS-TB Loss to Follow-up rate



INTEGRATION OF CLINICAL PROGRAMMES- DS TB LTF

- DS-TB newly diagnosed clients are enrolled on treatment and linked to Outreach Teams for treatment support
- Support visits are conducted weekly by Surveillance Officers and TB Outreach Teams to monitor treatment adherence at household level
- At the institutional level, the Linkage Officers are visiting wards daily for notification and treatment initiation, linking patients to the nearest facility and Outreach Teams for support (Community Based Model (CBM) and integration)
- Surveillance Officers are supporting facilities on a daily basis to monitor reports captured on Tier.net for early detection of loss to follow-up
- Sub-District TB Coordinators follow up on a weekly basis and give continuous progress until the client is brought back to care

STAKEHOLDER/ COMMUNITY ENGAGEMENT



MEN'S HEALTH



Msinga sub-district
Ethembeni Clinic

Venue
Community hall

Promotion of Men's health
services

Stakeholders involved
Induna Mr Mchunu
Ward Councillor- Mr Ntuli

Activation at Institution of higher learning (Dundee Majuba TVET college)



Endumeni sub-district

Venue

Majuba sub-district

HIV/AIDS awareness
campaign

Stakeholders involved

- DOH
- DSD
- South African Traditional Health Medicine Institution
- Red Cross
- Basadi Foundation
- GCSI
- Higher Health
- Thuthuzela Care Centre

COMMUNITY DIALOGUE - DISCLOSURE



Msinga sub-district

Venue
Msinga library

Community dialogue-
Disclosure

Stakeholders involved
Civil society
PLHIV
DSD
Msinga LM representatives

TRADITIONAL HEALTH PRACTITIONERS' ORIENTATION ON DōH PROGRAMMES



Endumeni sub-district

Venue

Dundee hospital

Orientation of THPs on priority programme, Referral pathway for early diagnosis and treatment

Stakeholders involved

Traditional Health Leaders

CONCLUSION

- With the introduction of the 95-95-95 targets that need to be achieved by 2030, community-based ART management has been identified to play a vital role in increasing HIV testing and retention in care, through health foot soldiers in hard-to-reach areas and community engagement at large.



THANK YOU

