FACTS SHEET FOR UPSCALING COMMUNITY-BASED SERVICES ON CLOSE THE GAP CAMPAIGN IN SIX DISTRICTS (AMAJUBA, ETHEKWINI, ILEMBE, UGU, UMGUNGUNDLOVU, AND UMZINYATHI) IN KZN FROM NOVEMBER TO END MARCH 2027.

PROPOSED SCOPE OF WORK

Each organization will be expected to increase demand for health services through peer engagements to address community-based gaps to achieve 95-95-95 targets by find missing TB, HIV and NCD cases amongst men, LGBTQIA+ and children on treatment. Track and trace all people in the area who have missed their treatment follow up appointments and those who are loss to care. Markert couple year protection, especially in people living with HIV (PLWHIV). Find and screen TB PLWHIV, household contacts and People who previously had TB. Check and find children who are not immunised and link them to care. Screen and find children at risk of moderate and acute malnutrition (MAM), severe and acute malnutrition (SAM) and related mortality and refer them for further testing and treatment.

It is recommended that implementation should follow a life course approach framework for analysing how biological, behavioural, psychosocial, and environmental factors affect health and well-being. This will deliver a preventative, integrated care that optimizes health trajectories across all stages of life, from pre-conception to healthy aging, prioritizing the mentioned populations above.

Activities

- Pay stipend for the 22 contracted to the people doing the field work (abled and with matric) per NPO
- Provide comprehensive HIV prevention education, distribute condoms and demonstrate how to use them, monthly targets will be provided.
- Assist the provincial health communication unit to gather and provide feedback from the community on the developed information, educational and communication material and its impact. This will be a project pertaining to specific material.
- Track newly diagnosed individuals and ensure 100% of them are successfully referred to local clinics or hospitals for immediate treatment and care, the target will be determined by patients who tested positive.
- Follow-up with patients who have missed appointments or stopped treatment, the organization will be linked to a cluster of health care facilities where targets will be provided for weekly tracking and tracing of clients.
- On weekly basis the organization will be provided with the list of TB index patients to track and trace their contacts.
- Establish peer support groups that meet regularly for treatment pickup and counselling, for the area targets will be determined and provided to the NPO.
- Conduct patient support, adherence counselling, stigma reduction, pill counting, Social and livelihood support.
- Join the local health care facility when they provide community-based activities.
- Implement a community-based information system which will collect, analyze, and share localized health data. This will assist in verifying monthly submitted reports by the NPO.
- Work closely with local outreach teams to join forces while not duplicating services.

Implement population-based interventions and with geographic focus in targeted hotspots. Each district will allocate an area where there is a gap in community-based services and give targets for the duration of the project. The targets will be disaggregated into monthly deliverables based on activities which will be monitored through reports based on the proposed data elements, engagements and support visits.

PROPOSED MONITORING

- Reports from the funded organizations shall be submitted by the 10th working day of the following month to the nearest health care facility. These will be analyzed by designated health care facility operational manager, district and provincial officials and managers. A standard operations procedure will guide the process and timelines at each management level. Data analysis will be done against the target.
- District officials shall undertake monitoring and evaluation visits to funded organizations, at least once a quarter, and the veracity of the information submitted in monthly reports shall be ascertained.
- Incorrect and/or inaccurate information communicated through monthly reports may lead to the withholding of payments.
- Areas of non-compliance shall be communicated in writing to funded organizations and suggested corrective measures. Failure to implement corrective measures will lead to the withholding of payments.

District monthly process indicators: Health Care facilities and Districts

The monthly reports will include performance against set targets for the minimum data elements below. Where targets are met or not met, contributing factors will be specified as reasons for deviation. Challenges planned remedial actions and lessons learnt will be part of the report. The reports will be verified by the information system.

- Number of contracted people paid stipend
- Number of clients reached with health education and IEC material.
- Number of people screened for TB, HIV, STI, NCD and malnutrition
- Number of people referred for testing and treatment.
- Number of clients who had missed appointments followed up
- Number of patients who stopped treatment brought back to care
- Number of index patients 'contacts traced and brought to care.
- Number of peer support groups established
- Number of peer support groups established that meet regularly for treatment pickup and counselling.
- Number of patient support, adherence counselling, stigma reduction, pill counting, Social and livelihood support conducted.
- Number of individuals reached with a life course approach a framework for analysing how biological, behavioural, psychosocial, and environmental factors to shape health and well-being.
- Number of health promotion and wellness activities conducted
- Number of participants reached during health promotion and wellness activities
- Availability of the life course approach yields report
- Reports generated from the community-based information system