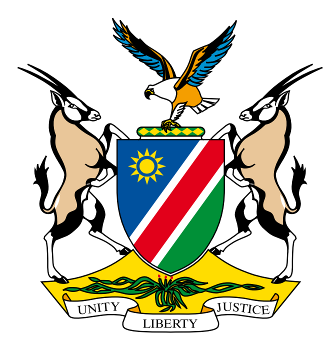


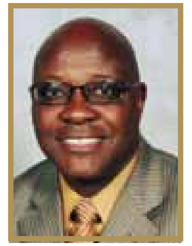
Ministry of Health and Social Services

National Community Home-Based Care Standards

DIRECTORATE OF PRIMARY HEALTH CARE SERVICES
DIVISION: FAMILY HEALTH
SUB-DIVISION: COMMUNITY-BASED HEALTH CARE AND SCHOOL HEALTH
Private Bag 13198
Windhoek
Namibia
Tel: (061) 203-2804
Fax: (061) 234968
Email:docentre@mhss.com
March 2010

NCHBCS

Preface



These standards serve as a guide for organizations that give and support community home based care to ensure quality service delivery across the country. Community Home Based Care (CHBC) facilitates the continuity of the client care between the health facility, the home and community. It is available for persons living with Human ImmunoVirus/ Acquired Immuno-deficiency Syndrome (HIV/AIDS) whether on antiretroviral (ARV) or not, people on tuberculosis (TB) treatment, and other clients with life–threatening illnesses such as cancer etc. In addition there are estimated 200,000 orphans, many of whom may also need care and support provided within family and community structures.

The standards are based on a number of previous recommendations made in documents such as the report on the National Conference on Volunteers 2006, the National HIV/AIDS Policy 2007, the National OVC Policy 2005, the National Plan of Action for Children 2007 and the Community Based Health Care Policy 2008, as well as other sources from World Health Organization (WHO).

The components of an integrated home based care are described and standards for each component are provided. The standards were developed during a national stakeholders' workshop in February 2008, to ensure that they are practical, essential and comprehensive and also provides a minimum package of services. A series of consultations to finalize the standard were conducted with the Technical Reference Group and other experts.

The process and final document has benefited greatly from ideas, inputs and critical review from a broad range of participants from the Primary Health Care Directorate in the Ministry, Regional Health Directorates, the World Health Organization, Non Governmental Organizations, Faith Based Organizations, development partners and training institutions in Namibia.

The Ministry of Health and Social Services wishes to sincerely thank each person for their contribution, co-operation and assistance. MOHSS would also like to thank USAID through PACT Namibia, WHO, and the Global Fund through the Programme Management Unit for providing funding and technical assistance during the development process.

Lastly, I would like to urge all health professionals, coordinators, managers and donors of community home based care programme, supervisors and trainers of CHBC providers and people in leadership to acquaint themselves with the content of these standards in order to provide quality health care to all Namibians.

MR. S.M. KAHIJORO KAHUURE
PERMANENT SECRETARY

Abbreviations and Acronyms

ADL	Activities of Daily Living
AIDS	Acquired Immuno-deficiency Syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral medicine
BCC	Behaviour Change Communication
CACOC	Constituency AIDS Coordinating Committee
CBO	Community-based Organization
CBHC	Community Based Health Care
CBV	Community-Based Volunteer
CD4	Cluster Differentiation 4.
CHBC	Community and Home-Based Care provider
DNA	Deoxyribonucleic acid
DOTS	Directly Observed Treatment Support
DPR	Disability Prevention and Rehabilitation
FBO	Faith-Based Organisations
FHD	Family Health Division
GMP	Growth Monitoring and Promotion
HAART	Highly Active Antiretroviral Therapy
HBC	Home based care
HEW	Health Extension Worker
HIV	Human Immuno-Deficiency Virus
IEC	Information Education and Communication
IGA	Income Generating Activities
IMAI	Integrated Management of Adolescent and Adult Illnesses
IMCI	Integrated Management of Childhood Illnesses
LAC	Legal Assistance Centre
M&E	Monitoring and Evaluation
MGECW	Ministry of Gender Equality and Child Welfare
MoHSS	Ministry of Health and Social Services
MTP III	Third Medium Term Plan [2004-2009]
NFPDN	National Federation of People with Disabilities in Namibia
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PC	Palliative Care
PCR	Polymerase chain reaction
PEP	Post exposure prophylaxis
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PWD	People with Disabilities
RACOC	Regional Aids Coordinating Committee
STI	Sexually Transmitted Infections
TB	Pulmonary Tuberculosis
ToT	Training of Trainers
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
WHO	World Health Organization

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Chapter 1
Introduction

1.1 Background and Rationale

The Ministry of Health and Social Services recognises the key role that Community Home Based Care (CHBC) can provide for people with HIV (Human Immuno-deficiency Virus) and AIDS (Acquired Immuno-deficiency Syndrome) and other chronic and life–threatening illnesses and affected family members, particularly children. Home-Based Care is simply defined as any care which is provided to ill individuals and orphans and vulnerable children in the community setting and in the home setting and focuses on the provision of prevention, promotion services, treatment adherence, palliative care, home nursing care and other support services.

It is estimated that 230,000 people are infected with HIV[1], and according to 2008 HIV Sentinel Survey, 17.8% of pregnant women tested positive for HIV. It was estimated that by 2007 more than 55,000 people would have been placed on Anti-Retroviral Therapy (ARV). It is predicted that there will be an increasing need for quality community home based care to support people on Tuberculosis (TB) treatment, people living with HIV/AIDS and other clients with life–threatening illnesses. In addition there are estimated 200,000 orphans[2], many of whom may also need care and support provided beyond the family structures.

Community Home Based Care (CHBC) for chronically or terminally ill clients and their families is currently primarily available from trained or untrained care providers supported by various faith-based organisations (FBOs) and their health facilities, community based organisations (CBOs), non-governmental organisations (NGOs) and the Ministry of Health and Social Services. In 2006, community based volunteers reached a total of 39,330 people living with HIV/AIDS, equivalent to 69% of those eligible, providing mostly HIV/AIDS related care. However coverage was not uniform and 29 of the 107 constituencies in Namibia were not covered at all by CHBC programmes. (MTPIII Progress Report 2006).

These standards have been developed in response to the implementation of the CBHC Policy. The frameworks for these standards are the National HIV/AIDS Policy 2007, the National Policy on Disability, the National Community-Based Care and Rehabilitation Programme 2006, the National OVC Policy 2005, the National Plan of Action for Children 2007 and the National Community Based Health Care Policy 2008.

1.2 Objectives of the standards

The goal of the Community Based Health Care Standards is to provide standards for the provision of quality home based care for the chronically and terminally ill including at risk groups and other vulnerable persons in the home and community. Many services are provided by a large number of organisations in Namibian communities and homes in order to improve the capacity of households

[1] MoHSS MTPIII progress Report 2006

[2] NPCS/CBS 2001 Population census

to manage chronic and terminal illness and to be more self-sustaining. Services may include home nursing, treatment adherence, basic rehabilitation, psychological, emotional, and spiritual care & social and environmental support. However, it is critical that services are delivered in a coordinated and structured manner and that quality services are comprehensive in order to address the holistic needs of the client and the family. This document outlines minimum requirements which may be necessary in order to meet these needs.

- To provide a framework to organizations involved in CBHC on standardized and harmonized approaches important for equitable access to quality services according to national guidelines.
- To promote quality HBC through the application of standards;
- To strengthen the capacity of individuals, families, communities and institutions to deliver safe and quality community and home based care services;
- To strengthen coordination and collaboration amongst CBHC implementing institutions.

1.3 Intended Users

The users of the standards are key stakeholders in Government and in organisations that are involved in community and home based care. They include:

- Health professionals serving people living with chronic and terminal illnesses, disabilities and their families; Coordinators and managers of CBHC programmes;
- Donors who support CBHC programmes
- Supervisors and trainers of Community and home based care (CHBC) providers
- Health Extension Workers (HEWs), Community Health Care Providers and Social workers
- Other people in leadership positions involved in the strategic direction and planning of health care in Namibia.

These Standards focus on care for those affected by all chronic/terminal illnesses and their families with an emphasis on HIV/AIDS, other STIs, TB, and cancers etc.

Chapter 2
The Community Based Health Care Delivery System

Over the last ten years, there has been an increasing number of community based organisations and larger NGOs and FBOs that have become involved in delivering CBHC at the household level. This has been largely in response to the increasing number of people infected and affected by HIV/AIDS and TB but some programmes focus on broader public health issues. In 2007, NANGOF registered more than 290 civil society organisations that jointly support more than 20,000 volunteers, most of whom provide health care and support.

2.1 Team Approach

Community based health care ***delivery*** is done at many levels and by different people. At the centre of the service delivery lays the client. Community home based care shall be provided by:

- The clients themselves as self-care is central to one's health promotion and dignity;
- Family members who receive skills and support from CHBC providers;
- Community members involved in support groups, treatment support, faith-based initiatives, or other local responses;
- Trained CBHC providers (Volunteers) and Health Professionals who screen clients, share skills with family members, provide the service and contact local health facility for referrals and other assistance;
- Health professionals, especially nurses and rehabilitation staff who are based in community settings who are the key link between the CBHC providers and the health system;

Community based health care is ***supported, monitored and sustained*** by:

- Service provider organisations who train, manage, support, supervise and monitor CHBC providers;
- Health Centres, Clinics, and outreach points that act as the referral centres for HBC providers; and has a focal person for CHBC and will adequately refill home based care kits on a regular basis, and keep records of this in line with the guidelines on CBHC.
- District team/constituencies' councilors
- The MOHSS Regional Management Team will coordinate all CBHC activities and facilitate HBC networks and training. Wherever possible, NGOs, FBOs, CBOs and community support groups shall have separate catchment areas for service delivery to avoid duplication of services and to ensure coverage within the operational region;
- The Sub-Division of Community Based Health Care within the Division of Family Health, in the Directorate of PHC will develop policies and guidelines, standardised training manuals and workbooks on aspects of CBHC, ensuring civil society and community participation; and provides training for regional trainers so they can act as regional training resource persons and training other trainers in Community Home-Based Care in the regions.

More detail on the roles of different stakeholders can be found in the Policy and in the Guidelines for Community Based Health Care (2008)

2.2 Eligibility criteria and levels for Community Home Based Care.

2.2.1. Eligibility criteria

People eligible for Home-Based Care include:

- Any chronically/terminally ill adult or child, male or female;
- Frail older people
- People with moderate to severe functional disabilities
- People recovering from an illness in need of assistance
- People living with a debilitating disease or condition
- Children , particularly with HIV, orphans and who are vulnerable as well as children in child headed households
- Children with disabilities
- HIV positive lactating mothers

Examples of people who are eligible include:

- An adult/child who has been diagnosed with an illness, such as HIV or cancer, but as yet has no or few symptoms and is not ill;
- An adult/child who is ill and awaiting medication/treatment such as ARV;
- An adult/child with HIV or TB or cancer who is receiving treatment;
- An adult/child who is terminally ill and who requires end of life care;
- All family members of those who are chronically and terminally ill, especially children living with a chronically ill parent, guardian or other care giver;
- A person born or afflicted with disabilities due to neuromuscular diseases like cardiovascular accident, cerebral palsy etc.

2.2.2. Levels of care for community home based care.

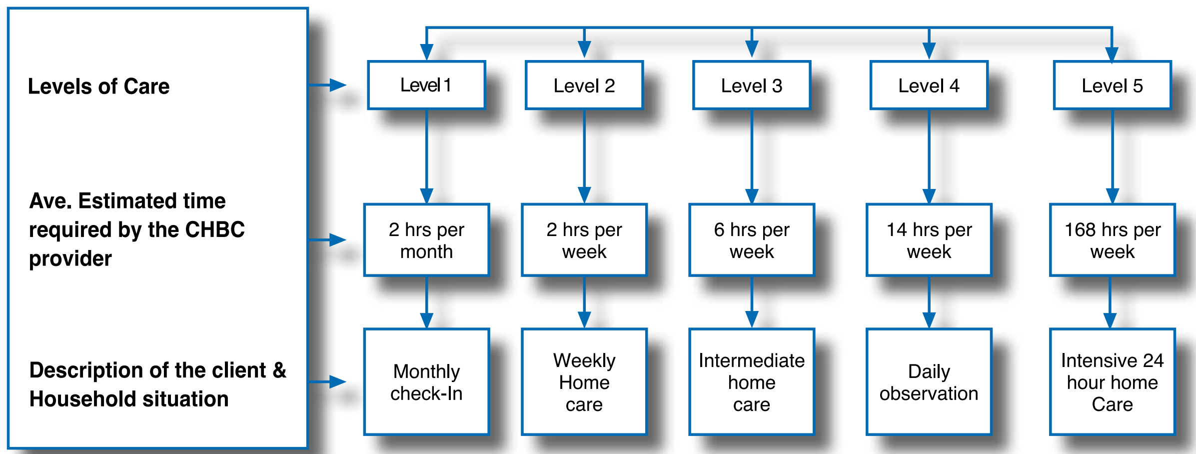
Each of the above examples will require different specific services from community or home-based care. The different services are outlined in Chapter 3. The degree to which these services are required will depend on an assessment of the client. An assessment of the client will include his/her:

- Social, physical, emotional and spiritual situation
- Family situation and personal history
- Knowledge, beliefs and behaviours
- Functional level in activities of daily living (ADL)
- Any concerns

This should be identified when a client is being enrolled into a community home-based care programme and should form part of the on-going assessment of the client. This assessment will determine the level of care for the client. The levels ranges from self-management to Level 5 care (the most intensive/restrictive) see figure 1 below. All clients need ongoing access to a broad range of additional treatment and rehabilitation services and supports (e.g, crisis, acute inpatient, vocational, family support), regardless of the level of care they are receiving.

2.2.3 Levels of Care Continuum for Chronically Ill Households in Namibian Communities

Figure 1



Levels of continuum of Care

Level	Average Estimated Time Required by CHBC Provider	Brief Description of the Client and Household Situation
Level 1	Two hours per month	**Self Management/Monthly Check-In.** Includes either of the following: ▪ Chronically ill or elderly individual is capable of self-management, able to access health care services as needed. Client is adherent with medications, compliant with treatments and free of physical and psychological problems/symptoms at least 90% of the time. Monthly visit focused on ongoing screening for symptoms and problems and provision of emotional and spiritual support (note: can include someone who is on ARVs if they fit the above description); or ▪ Children or adolescents in the household of someone who is chronically ill or elderly who experience no emotional and/or behavioural management problems that interfere with their ability to function in the family, school and/or community setting. Monthly visit focused on ongoing screening for symptoms and problems and provision of emotional and spiritual support.

Level 2	**Two hours per week**	**Weekly Home Care.** Includes either of the following: ▪ Chronically ill or elderly individual is capable of self-management, able to access health care services as needed but is either not adherent with medications or treatments 90% of the time OR is experiencing some physical and psychological problems/symptoms which can be managed in the home. This may include a client who is recovering from an acute illness but is able to manage their symptoms by themselves and/or with some family support. Weekly visit focused on treatment support, basic management of physical problems, ongoing screening for symptoms and problems and provision of emotional and spiritual support; or ▪ Children or adolescents in the household of someone who is chronically ill or elderly who experience mild emotional and/or behavioural management problems that interfere with their ability to function in the family, school and/or community setting. Monthly visit focused on ongoing screening for symptoms. May include anxiety, hyperactivity, withdrawal, but no violent or destructive behaviours.
Level 3	**Six hours per week (two hours, 3 times a week)**	**Intermediate Home Care.** Includes either of the following: ▪ Chronically ill or elderly individual is not capable of self-management and cannot access health care services as needed. Client not adherent with medications or treatments OR is experiencing some physical and psychological problems/symptoms. This may include a client who is recovering from an acute illness but still requires frequent visits. Client has support from a primary caregiver other than the CHBC provider. Visits focused on treatment support, basic management of physical problems, ongoing screening for symptoms and problems and provision of emotional and spiritual support. Client may also require home nursing procedures or supervision which is prescribed by a professional or health care facility such as a routine dressing changes, etc. However, care is provided intermittently, or periodically, but do not need daily continuous care or daily therapeutic services; OR ▪ Children or adolescents in the household of someone who is chronically ill or elderly who experience moderate emotional and/or behavioural management problems that interfere with their ability to function in the family, school and/or community setting. May exhibit frequent anxiety, hyperactivity, withdrawal outbursts but able to form relationships within the family and perform in school.

Level 4	**Fourteen hours per week (daily visits for an average of 2 hours per day)**	**Daily Observation Care.** Includes any of the following: ▪ Chronically ill or elderly individual needs daily support and assistance with treatment or rehabilitation services. Client is not capable of self-management and cannot access health care services as needed. Client is either (1) not adherent with medications or treatments without available support from a family member/primary caregiver; OR (2) client experiences physical and psychological problems/symptoms without the support of a primary caregiver; OR (3) is a chronically ill young child who has no reliable primary caregiver (e.g. child on ARVs without adequate family support). This may include a client who is under the care of the professional/clinic but client is ill, losing weight, not doing well, needs daily assistance with activities of daily living (e.g. bathing, dressing, toileting, and eating). Visits focused on treatment support, basic management of physical problems, ongoing screening for symptoms and problems and provision of emotional and spiritual support. Client may also require home nursing procedures or supervision which is prescribed by a professional or health care facility such as routine dressing changes, etc. However, care is required /provided daily; OR ▪ Suicidal client/danger to self—presents some risk of self-destructiveness; OR ▪ Violent client/danger to others—presents some risk of threat to others; OR ▪ Client nearing their end of life stage who has no other supports by others; OR Children or adolescents in the household of someone who is chronically ill or elderly with serious to severe emotional and/or behavioral management problems that interfere with the client's ability to function in the family, school and community setting outside of a therapeutic environment (e. g. evidence of poor school performance, outburst or odd behavior which may result in safety concerns) ▪ Defaulters Tracing

Level 5	**Up to 168 hours/week, more than a daily 1-2 hour visit.**	**Intensive 24-Hour Care.** Includes any of the following: ▪ Care for a chronically ill young child who has no reliable primary caregiver(s) and needs continuous assistance with treatment and rehabilitation throughout the day (whose medical treatments are under the supervision of a health care professional/clinic) and needs continuous support with activities of daily living; OR ▪ Care for a client who is under the care of the clinic but is at home and severely ill needing continuous 24-hour assistance with activities of daily living (e.g. bathing, dressing, toileting, and eating). Client has no reliable primary caregiver and needs continuous support with activities of daily living (e.g. bathing, dressing, toileting, and eating); OR ▪ Suicide/danger to self—presents serious risk of self-destructiveness; OR ▪ Violent/danger to others—presents serious risk of threat to others; OR ▪ Client in their final end of life stage who has no other supports by others; OR ▪ Children or adolescents in the household of someone who is chronically ill or elderly with severe emotional and/or behavioural management problems that interfere with the client's ability to function in the family, school and community setting out side of a therapeutic environment (e. g. unable to attend school due to condition, frequent odd behaviour which result in safety concerns to self & others)

2.2.4 General provisions that apply to all levels of care.

- All levels of care provide individualized treatment and support services based upon an individual plan that identifies for each client and family their care goals and needed services and resources.
- Some minimum services and interventions are required for each level of care an organization provides. In addition, many organizations may provide supplemental or additional services, based on the resources and philosophies of their programs and surrounding community supports.
- Within the levels of care there is a variety of service delivery options and settings to meet each client's own unique needs for treatment and support no matter where the client resides.
- At all levels there are clients for whom medications are prescribed for their conditions. Medication management is more frequent and complex at the higher levels of care.

- Each client is to be served in the least restrictive, most family-centered and community-based setting that meets his or her treatment needs and ensures the safety of the client, the family and the community.
- Clients who are stable may be maintained at a higher level of care if evidence exists that moving them to a lower level of care would directly result in destabilization.

2.3 Enrolment in Community Home-Based Care Services

Clients may enroll in Community HBC programmes at different stages of an illness. They are usually referred to Community HBC in the following ways, depending on existing capacity and services in each region, district or community:

- Referral from a health facility, testing facility or other organization to a support group or a existing home-based care service provider
- Referral from a support group to a home-based care service provider
- Personal contact with the HEW and Community HBC provider
- Referral by a traditional or community leader

2.4 Discharge of Clients from Community Home-Based Care Services

A client may be discharged from Home-Based Care programmes under the following conditions:

- If the client and family together with the CBHP are in agreement and satisfied that the client and family does not need care and able to care and support themselves.
- If the client is on ARV and have got a treatment supporter and no longer in need of periodic assistance.
- If a client moves away from his/her area of residence, such client with his/her permission can be transferred to another CBHP in another catchment area and ceases to be a client of the transferring CBHP.

2.5 Planning and Undertaking a Home Visit

2.5.1 Planning

Most home-based care is carried out by family members or primary caregiver in the home. Therefore home visits by a secondary CHBC provider must be well planned and respectful of the commitment of the primary CHBC provider, even if the care that is being provided needs improvement. The secondary CHBC provider should remember the range of roles they have, including motivation and encouragements, as well as teaching how to care and support the sick and disabled and providing direct care to clients themselves. Planning steps include:

- Assess how an individual needing care and their family would feel about a home visit
- Assess whether an individual needing care and their family are open about HIV status
- Prepare (emotionally, physically) to address the concerns of the individual and family members
- Ensuring clarity of what would take place:
  - Note taking
  - No Gifts
  - Communication – verbal and non-verbal; demonstration of empathy
  - Entering the home, operating in the home
- Appropriately planning for which community and households to visit & number of clients that can realistically be visited

- Giving advance notification & obtaining permission from community leaders, CHBC providers and family members involved
- Ensure access to sufficient and reliable transportation

It is important for CHBC providers to be well prepared when they make a home visit. Being prepared includes attention to your own appearance and well-being. Make sure you are physically and mentally well and dressed appropriately for the visit. You also need to take universal precautions in order to protect yourself, the client and family. It is advisable to have a meal before you leave home or carry food or tea with you if the visit will involve long hours away from home. Carry along resources you may need from your kit, as well as a way to remember and record the number of clients and family members you helped and how you helped them.

2.5.2 Undertaking the Initial Visit

On arrival at the home, greet the family and introduce yourself, stating your name, organization and purpose of your visit. Wait to be offered a seat. Then:

1. Identify the head of household and ask permission to visit the ill individual and their family. Outline how you can assist them. Assure them about confidentiality.
2. Respect the family's culture.
3. Avoid making assumptions about anything, such as that they welcome your assistance.
4. Be professional in your approach, appearance, manner and use of language.
5. If the family and individual agree to let you proceed, conduct an assessment (see standard page number). Assess the family's capacity to provide adequate care at home. Document your findings.
6. Spend time with the ill or disabled individual and family members to identify their needs (physical, emotional, spiritual, social, education, etc).
7. Conduct an assessment about their symptoms, how they are feeling, feeding, sleeping, waste elimination patterns, mobility (urine and faeces).
8. Use culturally appropriate verbal/non-verbal communication.
9. Limit the size of the team/those who visit the home.
10. Assist the primary caregiver and individual to find solutions to care-related problems.
11. Make referrals as appropriate.
12. Always ensure the individual/client is at the center of all care-related decisions.
13. Involve the family and client on care issues and demonstrate new skills. Take care not to take over the care responsibilities from the primary caregiver.
14. Encourage the individual to talk and aim to promote communication amongst the family.
15. Thank the individual and family and find out if they would like you to visit again.
16. Before you leave, make an agreement with the individual and family where you again explain your role (supporting the family to provide care), when you are available, how many days during the week, duration of each visit. Advise them on where/how to get assistance when you are not available.
17. Do not make promises about time and date of next visit which you cannot keep.
18. Document your visit and make a report of problems and issues of concern.

2.6 Coordination

It shall be the responsibility of the Ministry of Health and Social Services at all levels to register and coordinate the activities of all organizations providing community home based care services in the country. The MoHSS shall cooperate and collaborate with interested individuals, organizations and agencies or bodies in promoting community home based for people living with HIV/AIDS/TB and other chronically or terminally ill clients and their families.

All organizations providing community home based care would be expected to submit the quarterly and annual reports of their performances to the MOHSS as well as to their respective Regional Council offices using the agreed standards reporting format.

Chapter 3
Components Of Community Home Based Care

Community Home Based Care in Namibia should include the following four components of care (also see table 1 below) for clients and their families, including those with disabilities and children in the household:

1. Preventative Care and Health Promotion
2. Home Nursing and Treatment Adherence
3. Emotional, Psychological and Spiritual Care
4. Social Legal and Household Livelihood Support

Quality care is provided when the needs of a client are met and his/her outcome improves as far as is possible. How far those needs are being met is assessed as part of monitoring. Another method of measuring quality could be that every CHBC implementing institution should provide a minimum package of community home based care services to clients which include at least two of the care components listed above.

CHBC providers shall, at each visit to the client, implement the standards (minimum standards) as determined by individual client's needs. The level of care for clients will be determined by the needs or condition of a client as well as availability of materials at home. Care is not required to be provided to every client by every provider all the time.

The standards for each of the care components that CHBC providers should follow can be found in **Standards 1, 2, 3 and 4.**

All of the above care components are sustained and improved by:
- The provision of a care kit and regular refills;
- An effective referral and networking between health and social sectors, involving government, NGOs, CBOs, private institutions, and the families and communities;
- The effective management of the community health CHBC providers;
- Monitoring, Evaluation and Reporting.

All organisations providing Community Home-Based Care should comply with the standards outlined below in **Standard 5, 6, 7 and 8**(see table 1 below)**.**

The table below show a brief summary of the CHBC Standards

Numbers	Components	Desired outcomes
Standards of Care		
1.	Preventative Care and Health promotion	Improved situation of clients/patients and their families and reduced risk of their contracting diseases and disabilities

2.	Home Nursing and Treatment Adherence	Physical problems of clients and family members are adequately screened and managed in the home and community and the necessary referrals are made
3.	Emotional, Psychological and Spiritual Care	75-100 % of clients assessed for spiritual, psychological and emotional pain and provided with or referred for appropriate care.
4.	Social Legal and Household Livelihood Support	Clients, families and OVC provided with social, legal and livelihood support required.
Standards of compliance		
5.	The provision of a care kit and regular refills;	80% of providers have continuous availability of minimum HBC contents at any time of supervision
6.	An effective referral and networking	A streamlined referral system from health institutions into the community and from the community to the health and social facilities is in place to ensure effective and efficient service to the client and family. Clients/patients and their families are informed and understand the range of services and resources available in the community and how to access them directly or indirectly.
7.	The effective management of CHBC providers;	HBC providers are knowledgeable and skilled with the right attitude to be able to provide quality, efficient, effective CHBC services in the community.
8.	Monitoring, Evaluation and Reporting.	Availability of accurate information that will guide planning, implementation, and performance assessment of the programme. Timely reports available from all service providers for quarterly national reports to Response Monitoring and Evaluation Unit of the MOHSS. Assess the quality and impact of CHBC strategies , using both quantitative and qualitative tools, to refine and improve CHBC

Component 1: Preventative Care and Health Promotion

The emphasis on preventative care and health promotion is on health education, hygiene, nutrition, immunization, Prevention of Mother to child Transmission (PMTCT) and prevention of diseases especially HIV, TB, Malaria, diarrhea and other chronic illnesses

Desired Outcome:

Improved situation of clients/patients and their families and reduced risk of their contracting diseases and disabilities.

Critical Minimum Activities based on needs assessment

1.1 Provide basic information including prevention strategies on HIV and STIs
1.2 Ensure adults and children know sign and symptoms of TB and link to TB Programme (clinic, hospital) for screening
1.3 Prevent Malaria, diarrhoea and other common diseases
1.4 Provide information on chronic diseases such as diabetes, hypertension
1.5 Provide information on how to prevent cancers
1.6 Promote behaviour change regarding smoking, alcohol and drug abuse
1.7 Provide nutrition management, support and care.
1.8 Assist with maintaining personal, household and environmental hygiene
1.9 Ensure Infection control (universal precautions)
1.10 Ensure safe waste management (moved from standard 5 on kits)
1.11 Ensure linkages to Reproductive Health Services STIs and VCT etc.
1.12 Promote PMTCT
1.13 Ensure adults and children detect signs and symptoms of disabilities such as hearing and visual impairment, neuromuscular dysfunction
1.14 Ensure all people, including people with disabilities (PWD)'s access to VCT
1.15 Promote regular and moderate physical exercise for physical and psychosocial wellbeing
1.16 Provide information on available services

Critical Minimum Activities	***Guidelines***
1.1 *Provide basic information including prevention strategies on HIV and STIs*	Provide basic facts on HIV/ AIDS and other STIs: ▪ Signs and symptoms ▪ Methods of spread ▪ Prevention methods ▪ Treatment ▪ Complications ▪ Risk assessment and behaviour counselling for risk reduction plan; ▪ Referral for confidential counselling and testing of family members and sexual partners including pregnant women; ▪ Interventions for sero-discordant couples; ▪ Correct and consistent use of male and female condoms, distribution and demonstration ▪ Referrals to support groups, Home Base Caregivers and disclosure support; ▪ Family planning counselling ▪ Explain where to access condoms
1.2 *Ensure adults and children know sign and symptoms of TB and link to TB Programme (clinic, hospital) for screening*	▪ Assess for signs and symptoms of TB ▪ Use referral system (DOTS Point) ▪ Administer / oversee TB DOTS ▪ Promote nutritional support for people with TB ▪ Assist on TB defaulter tracing ▪ Assist with treatment adherence (treatment support)
1.3 *Prevent Malaria, diarrhoea and other common diseases*	▪ Organizations should provide information on immunization for children in the household ▪ Provide Vitamin A supplementation ▪ Link to provision of Insecticide Treated Tets **(ITNs)**

1.4 Provide information on chronic diseases such as diabetes, hypertension	▪ Reduce salt and fat level in food preparation ▪ Keep active by doing minimum exercise such as walking, jogging etc. ▪ Eat more fruits and raw vegetables – do not overcook vegetables ▪ Maintain body weight ▪ Go for follow-ups every 3 months to see the doctor and every month to collect medication.
1.5 Provide information on avoidable cancers	▪ Protect skin from direct sun ▪ Avoid smoking or being near smokers ▪ Encourage women of child bearing to go for yearly pap smears ▪ Encourage women to do a monthly breast examination
1.6 Promote behaviour change regarding changing of habits such as smoking, alcohol and drug abuse.	▪ Provide information on the dangers of alcohol, cigarettes and other drugs ▪ Implement behaviour change interventions ▪ Complement ongoing behaviour change interventions.

1.7 Provide nutrition management, support and care.	▪ Ensure that clean and safe water and food is consumed.Some appropriate actions for children:
	  ▪ Provide Regular Growth Monitoring and Promotion (GMP)
	  ▪ Encourage exclusive breast feeding up to 6 months with early cessation as long as it is acceptable, feasible, affordable, safe and sustainable (AFASS)
	  ▪ Appropriate introduction of complementary foods at 6 months with continuous breast feeding to 2 years and beyond.
	▪ Assess basic nutrition (nutrition status, balanced diet, factors affecting intake)
	▪ Promote locally available foods to increase a variety (balanced) of foods (this also includes locally available vegetables and fruits)
	▪ Encourage clients to eat three or more meals per day
	▪ Recognize malnutrition for nutrition management or early referral to health facilities – in particular: weight loss
	▪ Promote maintenance of healthy body weight
	▪ Promote special dietary considerations for HIV + children and adults
	▪ Recommend foods to consume and to avoid for the chronically sick
	▪ Promote safe breast feeding options for HIV+ mothers
	▪ Counsel on nutrition management of opportunistic infections
	▪ Promote consuming energy and nutrient dense foods (such as maize or mahangu porridge with oil and milk)
	▪ Promote food preservation emphasizing hygiene and safe storage
	▪ Promote gardening methods (including composting, mulching, water re-cycling/harvesting, irrigation, intercropping, natural pest control)

1.8 Assist with maintaining personal, household and environmental hygiene : CHBC providers have a critical role to promote hygiene. Key strategies include: safe water treatment and storage, safe disposal of excrement (faeces in particular), hand washing and personal hygiene, nutrition hygiene, and support for a hygienic service delivery area (facilities, community care points and households).	

1.8.1 Personal Hygiene	Emphasize and teach the client and family on the following; **I. Hand washing** at all times with soap and water. At a minimum CHBC providers must: ▪ Wash hands before and after handling clients or infected material. ▪ Wash hands after removing the gloves because they could have gotten pierced or torn in the process of use. ▪ Wash hands before preparing or serving food. **II. Bath** – someone who is ill needs a bath or wash every day. This should be conducted with respect and privacy. Involve and demonstrate bed bath method to client and family caregivers. **III. Eye, Ears & Nose Care**. **IV. Mouth and Dental Care** twice daily **V. Hand and Nail Care** – gently wash hands with soap under running water & rinse/dry; **VI. Foot and Nail Care** –Take special precautions to care and protect the feet of clients with diabetes. **VII. Hair Care** – someone who is ill needs their hair washed enough to maintain and promote personal hygiene

1.8.2 Household and Environmental hygiene	**Basic sanitation**: People who are chronically ill will at one time or another need assistance with their toilet needs. This is an area that is commonly ignored and yet can be a major source of distress. At a minimum, CHBC providers must:
	▪ Teach clients and family members how to safely use existing latrines or other available methods If clients are mobile
	▪ Facilitate access to nappies, simple potties or commodes from some programmes to use with bed ridden clients.
	▪ Teach clients and family members by taking care when handling the soiled linen by handling the areas not contaminated, for example by using gloves or polythene paper bags.
	▪ Exercise basic disinfection principles for soiled items such as:
	  ▪ Protect hands with gloves
	  ▪ Rinse soiled items in cold water; pour water into the latrine.
	  ▪ Put soiled items into a large pot of water with some soap or detergent as though you were going to wash them. Pound vigorously with a heavy stick.
	  ▪ Boil for ten minutes. Stir with the stick.
	  ▪ Rinse items thoroughly and place in the sun to dry.
	
	Nutrition hygiene: ensure feeding and nutrition inputs are washed with clean water, hand washing at critical times and with proper techniques, and ensure a hygienic environment where the food is prepared that is free of faeces, trash, etc.
	
	Safe water: ensure households have access to safe drinking water and, support households with home-based safe drinking water treatment methods and safe storage in communities where there is not a reliable source of safe water.
	
	TB hygiene:
	▪ Encourage sufficient ventilation in the home;
	▪ Cough hygiene - Cover the mouth when coughing
	▪ Do not spit on the ground and ensure that the client has a container for sputum with a proper fitted lid and ensure that it is discarded after use (burn or bury)
	▪ Avoid over-crowding

Environmental hygiene:

- Encourage the family to keep their surrounding clean at all times.
- Trash to be properly disposed off (in a pit if possible) and no standing water to be found near the living and cooking areas.

1.9 Ensure Infection control (universal precautions)

Universal precautions are simple infection control procedures that reduce the risk of transmitting infectious agents through exposure to blood and body fluids such as pus, stool, urine, sputum, vomit, saliva, birth fluids and contaminated equipment used among client, family members and providers.

- CHBC Providers should take universal precautions with all clients, whether you know if they are HIV positive or not. These protect not only CHBC providers but also clients and families from unnecessary infection.
- Use gloves when handling contaminated
- and body fluids but if you don't have gloves use plastic bags to protect yourself.
- Cover any cuts and bruises on your skin with waterproof adhesive plasters when changing the patient's soiled linen.
- Wash hands before and after procedure.
- Dispose of soiled dressings by burning/throwing into pit latrine
- Know how to access post-exposure prophylaxis (PEP)
- Ensure basic first aid training.

- CHBC Providers who suffer from the common colds/flu, diarrhoeal diseases, skin condition such as scabies, typhoid and chest infection such a bronchitis, pneumonia, and TB should not attend to patients.

Any client, family member or CHBC provider who has been directly exposed to transmission by blood or body fluid with an HIV infected person should be:

- Immediately wash with soap under running water. A wound/ site is in contact with the infected blood, it should be washed out with household disinfectant
- Refer immediately to the health facility to obtain post-exposure prophylaxis or PEP. It should be taken according to PEP protocol.

1.10 Ensure safe waste management	▪ Always wash hands before and after each activity.
	▪ Always ensure that before dressing the patients' wounds you have got:
	  ▪ a bag to put used dressings into.
	  ▪ dressing packs and solutions.
	  ▪ disposable gloves.
	▪ Wear gloves when you are cleaning the wound, applying new dressing and disposing of the used dressing.
	▪ Burn or bury the soiled dressings.
	▪ Safe disposal of sputum:
	  ▪ Encourage the patient to spit into a container with a lid.
	  ▪ Always keep the lid of the container closed when it contains sputum.
	  ▪ When the container needs emptying, carefully empty the contents in a pit latrine or in a hole and cover it.
	  ▪ Wash the container thoroughly with soap, detergent or clean with boiled water ready for the next use
	  ▪ When changing bed linen for an incontinent patient:
	  ▪ If possible, pad the patient with pads/pampers/ diapers and throw soiled ones in a pit latrine or in a hole and cover it. If these are not available, use clean old clothes, which should be washed thoroughly and dried before reuse.

1.11 Ensure linkages to Reproductive Health Services STIs and VCT	▪ Birth control vs infection control ▪ Explain how to prevent unwanted pregnancy ▪ Explain about dual and barrier protection ▪ Counsel about child spacing and contraception ▪ Link with ARV, STIs, Family Planning clinics ▪ Advise on PMTCT ▪ Promote VCT if HIV status is not known ▪ Advise on importance of getting tested ▪ Arrange and direct to testing sites ▪ Support CT which may be happening in homes and communities ▪ Follow-up counselling, disclosure support
1.12 Promote PMTCT	▪ Explain the risks that HIV positive mothers may transmit the infection to their babies ▪ Explain how HIV/AIDS medicines given to the mother and the baby can help reduce those risks ▪ Explain how the medicines will help to preserve and improve the mother's health HIV-positive pregnant women should receive medical care and extended social support, ▪ Nutritional supplementation should be provided to pregnant women ▪ Encourage mother to regularly attend Ante Natal Care (ANC) in the 1st trimester and Post Natal Care (PNC) ▪ Provide information on infant feeding options ▪ Support and provide guidance at all stages of breastfeeding ▪ Support good breast attachment to prevent breast problems such as sores etc. ▪ Encourage the family to take the baby for PMTCT follow up at 6 weeks and beyond.

1.13. Ensure adults and children detect signs and symptoms of disabilities such as hearing and visual impairments, neuromuscular dysfunction	▪ Raise awareness on disability, prevention and rehabilitation ▪ Assess signs and symptoms of disabilities ▪ Use referral system
1.14. Ensure all people including persons with disabilities (PWD) have also access to VCT	▪ Identify PWD ▪ Run awareness campaign on HIV and AIDS directed to PWD ▪ Link with VCT and ARV providers ▪ Encourage pregnant mothers to bring their partner for VCT ▪ Encourage partners involvement in all aspects of care
1.15. Promote regular and moderate physical exercise for physical and psychosocial wellbeing	▪ Work in a vegetable garden (field) ▪ Sing and dance traditional songs ▪ Play with children or arrange for friend visitations ▪ Exercise for bed ridden clients, energy conservation techniques ▪ Walking, yoga, simple home adaptations and meditation
1.16. Provide information on available services	▪ Have list of all service delivery points ▪ Distribute information materials on available service delivery points.

Component 2: Home Nursing and Treatment Adherence

Special attention is given to the client with an aim of making him/her comfortable and improving their condition and immune status. This care can be given by CHBC Providers and not necessarily by medical personnel. It also includes things that people do to care for themselves. It includes screening, basic management, treatment support for adherence, follow-up and referrals.

Desired outcome:

Physical problems of clients and family members are adequately screened and managed in the home and community and the necessary referrals are made

Critical minimum activities based on needs assessment

1.1 Assessment, Communication and Counselling
1.2 Identify Common Conditions and Symptoms and refer
1.3 Mobility and Wound Care
1.4 Make a referral
1.5 Understand the special needs of sick children
1.6 Promote immunisation and other child survival interventions (e.g. growth & development monitoring, etc)
1.7 Promote regular check-ups
1.8 Treatment literacy and support

NCHBCS

2.1 Assessment, Communication and Counselling	Involves asking a series of questions to find out more about what the client is feeling and the nature of their physical condition. ▪ Knowledge of basic anatomy and physiology: ▪ Skin for protection ▪ Circulatory system ▪ Respiratory system for breathing ▪ Gastro intestinal system ▪ Central Nervous System ▪ Genito-Urinary System ▪ Listen and demonstrate empathy ▪ Perform a head to toe assessment ▪ Document each assessment of client and proposed Plan of Care
2.2 Identify Common Conditions and Symptoms and refer	CHBC providers should be on the lookout for the following conditions and **refer clients and family members to the health facility:** ▪ **Loss of appetite** is a common symptom among people who are unwell or depressed. Loss of appetite is best treated by understanding the causes. ▪ **Nausea and vomiting** are sometimes common in people living with chronic illnesses, especially HIV/AIDS and cancer. Provide nutrition counselling to clients who experiences this. ▪ **Constipation** -It is important to assess whether a client is having normal bowel movements or habits. ▪ **Diarrhoea** is a concern because it causes dehydration and malnutrition. Diarrhoea is often preventable with good hygiene, drinking safe water and ensuring the home is free from faeces and other wastes. ▪ **Sore Mouth and Throat** -Soreness in the mouth are common in people living with HIV/AIDS ▪ **Fever** is indicated when the body temperature is too high. It is a sign that something is wrong in the body and may indicate one of many illnesses. It is especially dangerous in small children. ▪ **Cough or difficulty breathing** -Screen all individuals with a cough lasting for 3 weeks or more for tuberculosis (TB). ▪ **Incontinence of urine or faeces** -Ensure that clients who are incontinent with urine or faeces are supported to protect their skin, sheets, clothing and mattress from becoming soiled with faeces. Strategies such as placing and regularly changing a plastic sheet and piece of cloth or paper under the client's buttocks are very simple and cost-effective measures which can ease the care giving burden. ▪ **Fatigue (tiredness lethargy, weakness),** identify possible causes and refer. ▪ **Weakness of upper and lower limbs** indicatesSensory problems ▪ **Physical Pain** One of the most important aspects of maintaining quality of life and dignity of clients is managing pain. Home based CHBC providers play an essential role in assessing and managing pain. If child cries continuously, it may indicate pain. Caregivers must understand and apply the following principles - remember that pain is what clients say it is (or demonstrated in small children), not what caregivers or others think it should be; pain affects quality of life; pain should be controlled in a way that helps clients stay as alert and active as possible; if medications to relieve pain are not available then there are other methods to help the client. ▪ **Genital Problems** -Opportunistic infections of the genital area and sexually transmitted infections (STIs) are common.

	CHBC providers play an important role in detecting STIs which increase the risk of acquiring or passing on HIV infection during sex, makes transmission of HIV easier and increase the amount of the virus in the body, may be transmitted to an unborn child during pregnancy, and may cause pelvic inflammatory disease. ▪ **Skin Problems** (particularly in the presence of HIV) - about 90% of people with HIV infection will develop at least on skin problem in the course of the disease. Knowing these conditions will assist in early case detection and treatment. CHBC providers must be able to assess skin to determine the type of skin condition such as scabies, herpes zoster, fungal, bacterial and viral infections, and which need to be referred immediately (e.g. caused by drug interactions) ▪ **Pain and bleeding during pregnancy**
2.3 Mobility, Wound care and Activities of Daily Living [(ADL) Self Care and Instrumental]	▪ CHBC should teach family how to prevent, manage and care for pressure sores and wounds. ▪ Regularly provide physical /occupational therapy to prevent pain and stiffness in joints especially for people who are in bed. Physical/ occupational therapy helps ensure that bedridden clients get enough exercise to maintain muscle tone, flexibility and prevent bedsores. ▪ Massage to prevent the contractures from getting worse and can make the joints a little less stiff and keep the muscles strong. ▪ Received trainings on how to use walking Aids/wheelchair
2.4 Make a Referral	Ensure that client reports to the nearest health facility so they can be seen by a health professional for any new or ongoing problems which cannot be managed in the home or community. CHBC providers must: ▪ Use appropriate referral forms ▪ Arrange transportation or taking the client to the facility ▪ Provide support to the client and family (as needed), even if the client is away from the home and at the facility ▪ Follow-up to ensure the client received care and for any follow-up needed after their visit to the facility (See Standard 6 on page 33 below)

2.5 Understand the special needs of sick & disabled children	▪ Assist parents and guardians to confirm cause of illness through referral to health services;
	  ▪ Prepare parents for the range of tests that child would undergo to gain their support e.g. DNA PCR, chest X-ray
	▪ Assist parents to explain condition to the sick child and siblings;
	▪ Guide parents to provide love and support rather than discrimination
	▪ Assist parents to prepare nutritious food to sick child and emphasise frequency of meals;
	▪ Demonstrate to the care taker the feeding techniques for children with disabilities/oral motor problems
	▪ Show how to stimulate for "at risk children", children with stunted growths or delayed milestones
	▪ Guide parents and siblings on signs of opportunistic infections
	  ▪ Diarrhoea
	  ▪ Skin infection
	  ▪ Cough and difficulty in breathing
	▪ Emphasize adherence to treatment prescribed especially TB medicines and ARVs
	  ▪ Frequency
	  ▪ Potential side effects

2.6 Promote immunisation and other routine child survival interventions (e.g. growth and development monitoring, etc)	▪ Check health passports for immunization status for both mother and child ▪ Advice parents to take children for routine/ follow up immunizations and growth monitoring. ▪ Advice parents to take children to health facility if presenting symptoms such as skin rash, fever and sudden lameness/ paralysis of the arms and legs ▪ Advice parents whose child is born at home to take the child for immunization ▪ Advice women 15 to 49 years to go for TT vaccination.

2.7 Promote regular check-ups	▪ Undertake Pain assessment regularly
	▪ Promote routine screening of of CD4 count according to national policy (currently every 6 months)
	▪ Monitor TB clients:
	    ▪ Sputum collection
	    ▪ Clinical condition
	    ▪ Weight gain
	    ▪ Dot charts
	    ▪ Self reporting
	    ▪ Pill counting
	    ▪ Side effects screening
	    ▪ Supply of medicines
	▪ Check for hearing loss as it is common during and after TB or Malaria treatment

2.8 Treatment literacy and support	Educate clients and the family on the following ▪ storage of medications ▪ Dosage, timing, frequency ▪ Importance of adherence ▪ Administration ▪ Supply ▪ Side effects Discuss importance of support ▪ Help identify treatment supporter ▪ Train the treatment supporter ▪ Importance of adherence ▪ Need for self-management of treatment ▪ Explain methods for promoting adherence e.g. support groups, community/ family/ clients, etc.
2.9 TB and HIV Co-Management	▪ Inform clients, family and treatment supporters about TB or TB-HIV and its treatment ▪ Identify clients with suspected TB and link these clients with health facilities ▪ Encourage clients with TB to make use of HIV Testing and Counselling Services ▪ Assist clients to take their TB and HIV (ARV) medications as prescribed by health professionals

Component 3: Emotional, Psychological, Spiritual Care and Well Being

Emotional, psychological, spiritual care and well being includes reducing stress and anxiety and developing coping mechanisms that promote well being for both chronically and terminally ill clients and families, and

especially children. This also includes spiritual support, bereavement counselling, and the emotional aspects of end-of-life care

Desired Outcome:

75-100 % of clients assessed for spiritual, psychological and emotional pain and provided with or referred for appropriate care.

Critical Minimum Activities based on needs assessment

1.1 Routinely assess and promote spiritual and emotional well-being
1.2 Facilitate access to and/or provide desired spiritual support, services, sacraments and rituals
1.3 Provide counselling related to meaning of life; forgiveness; reconciliation and life completion tasks.
1.4 Provide counselling and training on positive living including responsibility for own care.
1.5 Address stigma and discrimination in the family and community
1.6 Identify and address the need for psycho-social support among orphans and vulnerable children.

Critical Minimum Activities	***Guidelines***
3.1 Routinely assess and promote spiritual and emotional well-being	▪ Practice active listening; empathy; caring attitude; non-judgmental attitude ▪ Establish relationships ▪ Assess whether client has understanding of his/her condition and whether client has shared information with family ▪ Assess physical well-being visually ▪ Assess spiritual and emotional well-being through guided conversations – training in assessment of spiritual and emotional pain. Use pain scale (1 – 10) ▪ Validate feelings of client by repeating what the client said.
3.2 Facilitate access to and/or provide desired spiritual support, services, sacraments and rituals	▪ Establish what rituals and beliefs are important for client. ▪ Discuss mechanisms appropriate for client's condition ▪ Discuss the process of death and dying with family and client; discuss client's preferences around death and respect their wishes about where they want to die; it is not comfortable to take end stage clients to hospital; involve religious leaders when preferred by client/ family. Suggest items such as the following: ▪ Visitation or access to spiritual leaders, mentors, pastors, etc ▪ Participation in religious events and ceremonies ▪ Participation in traditional healer groups, ceremonies and encourage registration for traditional healers. ▪ Provision of prayer ▪ Provision of spiritual counselling – life review and assessment, counselling of hopes, meaning/purpose, guilt, forgiveness ▪ Consider how to work with registered traditional healers –
3.3 Provide counselling related to meaning of life, forgiveness; reconciliation and life completion tasks.	All actions must be client-driven - don't give advice but always present options: ▪ Provide counselling on self and life acceptance; Discuss mending relationships. ▪ Provide anticipatory grief counselling ▪ Provide bereavement counselling for client ▪ Provide bereavement counselling for family and children throughout illness and after death ▪ Refer for further counselling if necessary.

3.4 Provide counselling and training on positive living including responsibility for own care	▪ Promote use of treatment buddies and support groups ▪ Discuss issues on safe sexual practices ▪ Assist with parent-child disclosure ▪ Encourages client to face life with confidence and assurance
3.5 Address stigma and discrimination in the family and community	▪ Give support for disclosure ▪ Always be cognizant of client's human rights ▪ Always be respectful and non-judgmental ▪ Listen and address fears and concerns ▪ Address practices that reinforce stigma and discrimination among health care professionals and community leaders ▪ Educate the general public and public service providers concerning how and where children experience stigma
3.6 Identify and assess needs for psycho-social support for orphans and vulnerable children	▪ Involve children in communication/counselling from the beginning. Silence does not protect a child ▪ First determine what a child understands already – where they are ▪ Help child to lead a normal life as possible (carry outside/ sing/stories if bedridden)- allow to interact with other children- encourage visits ▪ Liaise with child-focused organizations (community-based and otherwise) for additional expertise ▪ REFER out when appropriate in a timely manner ▪ Use developmentally appropriate communication tools – music; stories, make believe; dance; play, memory book ▪ Ensure providers are equipped with practical ways to communicate with children that are effective for young clients. ▪ Raise awareness in the community around child development & child rights ▪ Provide Life skills education for children based on knowledge of child development ▪ Help children access opportunities for skills and knowledge development such as Experiential Learning Camps; Expeditions; Kids/youth Clubs; Counselling.

Component 4: Social, Legal and Livelihoods Support

Social, legal and livelihoods support: Includes information on and referrals to support groups, welfare services such as social grants, educational support, legal advice, help on succession planning, inheritance and wills, and where feasible provision of material assistance such as food plus increase advocacy and awareness on addressing stigma and discrimination.

Desired Outcome:

Clients, families and OVC provided with social, legal and livelihood support required.

Critical minimum activities based on needs assessment

1.1 Assist with activities of daily living including child care
1.2 Provision of assistive devices and appropriate wheelchairs (occupational therapists/medical rehabilitation workers)
1.3 Provide information about and referrals to support groups and other agencies.
1.4 Assist access to welfare services such as social grants for children and people with disabilities
1.5 Educational support and protection of children
1.6 Legal services to assist with succession planning, inheritance rights, will writing and other legal documentation.

1.7 Address stigma and discrimination by being good role models and through advocacy and awareness raising
1.8 Livelihoods and income generation activities; and where feasible provision of material assistance
1.9 Assist with transportation support through community mobilization

Guidelines	*Tips/Specifications*
4.1 Assist with activities of daily living including child care	Assistance with Activities of Daily Living (ADLs): bathing, eating, dressing, walking. Including: ▪ Assisting with toilet needs ▪ Making the bed ▪ Washing and dressing ▪ Preparing food, eating and drinking ▪ Assisting with any communication needs ▪ Keeping the environment clean and safe ▪ Helping with children (stimulate, adequate nutrition, play)
4.2 Provide information about and referrals to support groups and other agencies, e.g. church groups	▪ All referrals should use the template referral forms ▪ Distribute forms to ALL community based health care service providers ▪ All HBC groups and support groups for PLWHA to be registered with the local health facility ▪ Raise awareness among private Doctors regarding support available in the community
4.3 Assist access to welfare services such as social grants for children and people with disabilities	▪ Increase advocacy around accessing social grants ▪ Assist with registering vulnerable children with MGECW and MOHSS (children with disabilities) ▪ Assist with registering people with disabilities with MOHSS to access care and disability grant ▪ Advocate for social and disability grant forms and information to be translated including Braille ▪ Assist with all necessary documentation needed to access social grants, including transport to centres to get legal documents such as birth and death certificates
4.4 Educational support and protection of children	▪ Promote the rights of the child among community leaders ▪ Know appropriate referrals e.g. local Women and Child Protection Unit ▪ Establish contacts with local schools to promote the rights of the child ▪ Monitor school attendance of all children in the household ▪ Arrange and or assist with homework ▪ Refer for assistance with school support (fees and uniform)
4.5 Legal services to assist with succession planning, inheritance rights, will writing and other legal documentation.	▪ Provide information on local legal services e.g. LAC, paralegals ▪ HBC providers to be trained in will writing ▪ Use media to advocate secession planning, will writing and inheritance rights ▪ Traditional leaders to be sensitised and to encourage succession planning ▪ Sensitization of community on domestic violence and where support can be found

4.6 Address stigma and discrimination by being good role mdels and through advocacy and awareness raising	▪ Sensitize households and communities on stigma and discrimination in relation to gender, race, disability and HIV ▪ Personalise HIV among community ▪ Use media and local events to address stigma and discrimination (choir, drama groups, radio) ▪ CACOC, RACOC and NFPDN (and other community groups) to rollout awareness raising session on stigma and discrimination in conjunction with PLWHA
4.7 Livelihoods and income generation activities; and where feasible provision of material assistance	▪ Promote community donations of second hand clothing as income generating activity (IGA) for support groups ▪ Introduce recycling and energy and labour saving devices for IGA activities ▪ Establish links with micro-finance organisations (Project HOPE; RISE) and with IGA grant makers (MGECW; UNAIDS etc.) ▪ Promote IGA models through community groups ▪ Link with traditional authorities, clinics, MAWF and schools for use of land for gardens and to access seed and other inputs ▪ Promote household kitchen and community gardens (diversify staple and leguminous crops, fruits and vegetables) ▪ Promote use of indigenous plants, fruits and nutritious leguminous trees ▪ Promote sustainable gardening methods (composting, mulching, water re-cycling/harvesting, irrigation, intercropping, natural pest control)
4.8 Assistance with transportation support through community mobilization	▪ Encourage family commitment to plan for transportation costs ▪ Advocate for the MOHSS to include ARV refill in outreach services ▪ Advocate for decentralization of ARV to all local clinics ▪ Encourage savings schemes for families and community groups ▪ Solicit funds/donations for bicycles or other forms of transportation for community use ▪ Use of in-kind resources to barter in exchange for transportation (baskets, mahangu)

Component 5: Provision of Home-Based Care Kits

The government is responsible for a nationally standardized HBC kit and its replenishment to ensure continuous, quality care and proper standards of infection control (National HIV/AIDS policy). These tools will enable the HBC providers to give health education, provide care and manage clients with minor and common illnesses and record and report data on their activities. The providing a HBC kit is considered to be an investment in the capacity of the health care system (CBHC policy).

Content of Kits

- The home based care kit comprises the basic requirements for nursing chronically and terminally ill clients and orphans and vulnerable children outside of the health facility. The use of the kit in the monitoring tool is meant to provide direction towards a systematic approach to rendering patient care in a holistic manner. The care items and medicines in the Kit act as a checklist for comprehensive patient management.

- The kit is divided into two parts:
  - The first part consists of the materials routinely needed by the client, such as soap, a washing cloth and towels. These should be available at home for use by the family when looking after the client. These items can be provided by the family if they have the means or can be requested from the local CHBC provider organisation by the volunteer for the family.
  - The second part of the kit is what is provided to the CHBC provider. This will contain necessary consumable nursing supplies such as soap, dressing materials, and basic medication such as Paracetamol tablets. It will also contain some non-consumables and reference materials and notebook or diary for record keeping.

Replenishment and review of Kits

Replenishing the kits is a collaborative effort between the health institution, volunteer organisation and the community. The MOHSS clinics, health centres and hospitals where the CBHC providers are registered will replenish the HBC kit on a monthly basis or as necessary after the nurse in charge is satisfied with the report provided by the HBC provider that the kit is being utilized in the rightful manner.

Items such as soap, antiseptic powder, and the like which cannot be replenished in the kit by the health institutions will be the responsibility of HBC provider organisations. It is therefore necessary that all parties should budget accordingly for these. The Pharmaceutical Services and Family Health Division in Regional Health Directorates should ensure that medical contents of the HBC kits are budgeted for.
The required content of the kit will be reviewed regularly by MoHSS in conjunction with its partners and kit users according to the needs of the clients.

Use of Kit and Waste Management

Trained Home Based Care providers at different levels of the health system, community and family members in the home, use the kit to undertake the day to day care activities. The HBC provider can use any suitable and affordable items at household levels necessary to ensure the basic standard of hygiene and infection control. A Trained Coordinator can administer non-prescriptive medicines and perform simple care related procedures during supervisory and support home visits.

The safe disposal of used items, particularly those contaminated with body wastes, needs to be emphasized during training and supervision. Sound waste management systems need to be practiced by all Carers.

Desired Outcome:
80% of providers have continuous availability of minimum HBC contents at any time of supervision.

Critical Minimum Activities

5.1 Standard list for kits
5.2 Supplements in the home or from NGOs/FBOs
5.3 Distribution of HBC kits
5.4 Replenishment of HBC Kit contents
5.5 Proper maintenance, use and storage of Kit
5.6 Safe Waste Management

[3] ***Indicates items that will be replenished by the health facitlity.*

5.1 Standard list for kits

Consumable Supplies:

Item description:	Quantity	Size	Indication
▪ Box of Latex Examination Gloves (Non-sterile) **[3]	1 Box	L or M	to protect the client, CHW, and caregiver
▪ Anti-bacterial soap	2	100g	for general hygiene
▪ Conforming bandage **	12	75mm	to keep sores and cuts clean
▪ Rolled cotton wool 50g (100% pure cotton)**	1	50g	Clean the wound, disinfection
▪ Latex Lubricated condoms**	72	1 Pack	Barrier protection
▪ Antiseptic powder	1	200g	Protection of bacteria
▪ Gauze swabs**	10	75mm x 77mm	Wound dressing
▪ Adhesive plaster **	2	75cm x 77cm	Dressing
▪ Disposable aprons plastic**	10	L or M	Protective
▪ Antiseptic solution	1	125ml	For disinfection
▪ Petroleum jelly	1	200ml	Moisturising, to give massages or keep wetness away from the skin to prevent rashes.
▪ Linen savers**	10	L or M	for bed baths to keep the client's bed clean and dry
▪ Spatula (wood)**	1 box (100)	6" Length	For dispensing ointments

Non-consumables

Item	Quantity	Size	Indication
▪ Pair of scissors	1	130mm	to cut gauze during dressing
▪ Clinical thermometer (Celsius)	1	N/A	to check the client's temperature for fever

Medications:

Item description:	Quantity	Size	Indication	Dosage
▪ Paracetamol tablets **	40	500g	Pain and fever relief	2 tablets x 3 times or when necessary
▪ Paracetamol syrup**	3	100 ml	Pain and fever relief	10mls 3x day
▪ Oral Rehydration salts – sachets**	12	20.5g	Dehydration	0-1 years; 1litre of 24hrs 1-15 years; 1-3 litres Adults; drink freely
▪ Betadine ointment**	2	25g	Wound dressing	
▪ Calamine lotion**	2	100ml	to ease itchy skin and sores	Apply liberally 3-4 times a day
▪ Gentian violet**	2	20ml	to rinse the mouth and keep skin clean.	Apply twice a day

Reference materials

Item	Quantity	Size	Indication
▪ Identification tag	1		
▪ Handbook	1		
▪ Portable flip chart	1		
▪ Register/Diary	1	A5	
▪ Notebook	2	A5	
▪ Pencil/ballpoint pen	2		

▪ Carrying bag	1			
▪ Referral forms	30	A4		
▪ Monthly record sheets	15	A4		

Critical Minimum Activities	*Guidelines*
5.2 Supplements in the home or from NGOs/FBOs	In the home or through the NGO/FBO: **Consumables:** ▪ Gloves (latex, non sterile) ▪ Soap ▪ Toilet paper ▪ Vaseline/Petroleum Jelly ▪ Waste disposal bags ▪ Cotton wool ▪ Disinfectant ▪ Antiseptic powder ▪ Unrefined salt ▪ Linen savers ▪ Spatula ▪ Adult diapers ▪ Zinc cream **Non-consumables** ▪ Clean Bed sheets ▪ Bucket with lid ▪ Washing Basin ▪ Mosquito net (impregnated) ▪ Nail cutter (small) ▪ Scissors (small, steel) ▪ Washing towel ▪ 1 litre plastic jug ▪ 25 litre water container ▪ Waste disposal pan **Prescribed Medication** ▪ Any medicine prescribed by the doctor or nurse
5.3 Distribution of HBC kits	▪ Home based care kits will be distributed from National level through the Central Medical Stores to Regional Medical Stores or Regional Pharmacies where they will be distributed to the nearest health facility where care providers can obtain them.
5.4 Replenishment of HBC Kit contents	▪ Medicines and supplies will be stored at nearest health care facility ▪ A contact person (nurse or supervisor of CHBC Provider) will be designated as responsible for obtaining medications and supplies from the pharmacy and providing the medicines and supplies to the HBC provider group. ▪ The medicines and supplies will be maintained according to a replenishment plan. ▪ HBC organisations will obtain replenishments on a monthly basis on certain items from the contact person according to the replenishment plan level. ▪ The contents of the kit will be reviewed regularly by MOHSS in conjunction with its partners and CHBC providers.

5.5 Proper maintenance, use and storage of Kit	▪ Supervisors will ensure that HBC providers know how to use the HBC kit and will be responsible for ensuring it is replenished by the MOHSS and the HBC Organizations. ▪ HBC providers will be trained in good storage practices to be utilized in their homes (i.e. keep away from children) ▪ Storage of kit at home level in a safe place ▪ Storage conditions should be the same for all institutions (i.e. clinic level, regional level or at home based care organizations)
5.5 Safe Waste Management (see Standard1.9)	▪ Always wash hands before and after each activity. ▪ Safe disposal of all bodily fluids ▪ Burn soiled dressings ▪ Burn incontinence pads and nappies.

Component 6: Referral and Networking Systems

Referrals are a crucial component of HBC service. Referral is an effective and efficient two-way process of linking a client from one caring service to another. Referral and networking are essential to ensure continuity of quality care for the client at all times.

Referring a CHBC client will be deemed necessary:

- For continuity of care from the health facility to other caring services/organisations within the community
- From family level back to the health facility;
- To access GRN services when a client/or family members meet criteria e.g. OVC grants
- For specialised care, treatment or support;
- When the CHBC provider has limitations in meeting certain needs of the client or is experiencing burn-out and needs to suspend care for a while.

All **home-based CHBC providers** will be trained to recognize the need for referrals, to know when a referral is required, to consult as needed to determine the source of required services and to assist the clients and their families to make the necessary contacts.

The MOHSS will work closely with local home-based care programmes to identify appropriate referral points for the range of services likely to be needed by clients and their families. Within each health facility and within each service provider a specific team member will be designated as the one responsible for ensuring that referrals are done promptly and appropriately. Should that person be absent, arrangements with the local clinic for a standby person should be made.
Examples of referral forms for the HBC provider and other service providers are attached in Appendix 2 and 3.

Desired Outcome:

A streamlined referral systems from health institutions into the community and from the community to the health and social facilities is in place to ensure effective and efficient service to the client and family. Clients/ patients and their families are informed and understand the range of services and resources available in the community and how to access them directly or indirectly.

Critical Minimum Activities based on needs assessment

1.1 Create two-way linkages to and from the health facility and the community and home based CHBC provider;

1.2 Map appropriate referral points for health, psychosocial social support; legal and economic support;

1.3 Facilitate referral according to the needs of the client and family to reduce suffering and improve quality of life;

Critical Minimum Activities	***Guidelines***
6.1 Two-way linkages to and from the health facility and the community and home based CHBC provider	▪ All health workers and HBC providers shall be trained to use the correct referral system. ▪ Home Based Care Forums should be established and strengthened under the supervision of the MOHSS. Forums should meet once a month including all HBC service providers and other relevant services. ▪ At CACOC or HBC Forum meetings, referrals should be a regular agenda item ▪ At RACOC meetings, referrals should be a regular agenda item ▪ Local health facility personnel shall meet HBC providers at least once a month; ▪ All service providers shall keep their respective health districts informed of their services; ▪ HBC providers shall be given accurate information on services to be able to refer clients; ▪ Local health facility personnel shall keep adequate stocks of all referral forms; ▪ A referral focal person would be identified by every organization or service delivery point making referral or receiving referral. The Focal person will be in charge of the register of referrals made and those received and ensure adequate follow-up and tracking. Their contact details will be available in the referral network register to be developed. ▪ Lobby and advocate for the rights of clients; ▪ Community support programmes should be involved in Health Facility Meetings e.g. ARV, TB

6.2 Mapping appropriate referral points	Referral points:
	▪ The CACOC or HBC Forum should coordinate mapping of HBC organisations and functional HBC providers including:
	  ▪ Recognized health institutions: government, private or mission hospitals
	  ▪ Social support groups; Spiritual leader and Traditional leaders
	  ▪ Legal agencies and local administration, for example, for writing wills, legal advice for surviving family members, settling property disputes, and addressing burial disputes and arrangements.
	  ▪ Other ministries for example Ministry of Agriculture and MGECW and any other relevant agencies depending on the client's needs

6.3 Facilitate referral according to the needs of the client and family to reduce suffering and improve quality of life.	▪ Client referrals shall be determined by the client's need for care or guided by aims to reduce suffering and improve quality of life. ▪ CHBC providers will be trained to recognize the need for referrals, to know when a referral is required, to consult as needed to determine the source of required services, and to assist the clients and their families to make the necessary contacts. ▪ CHBC providers will be trained to make appropriate and timely referrals for counselling and testing; TB screening; treatment of opportunistic infections; cotrimoxazole prophylaxis; palliative care medicines; PMTCT; family planning.

Component 7: Management of CHBC Providers

At the core of most community home based care programmes in Namibia is the CHBC provider – usually a volunteer. Supportive management of CHBC providers is done through training, on-going supportive supervision and appropriate recognition.

The MOHSS Guidelines for Implementing Community Based Health Care Services give considerable detail on managing HBC providers so please refer.

Desired Outcome:

HBC providers are knowledgeable and skilled with the right attitude to be able to provide quality, efficient, effective CHBC services in the community.

Critical Minimum Requirements based on needs assessment

- VII.1 Selection of CHBC providers based on agreed criteria
- VII.2 Trained trainers able to use appropriate methodology
- VII.3 HBC providers trained, awarded certification and attend annual refresher courses
- VII.4 Orientation, agreements and description of duties
- VII.5 Supportive supervision monthly: technical, emotional, spiritual and administrative
- VII.6 Case load
- VII.7 Standardised package for CHBC providers

Critical Minimum Requirements	***Minimum Guidelines***
7.1 Selection of CHBC providers based on agreed criteria	On-going community mobilisation is required to ensure community ownership and support for the CHBC programme. Local leaders should be involved in the selection of CHBC providers and follow the criteria below: ▪ Mature men or women (usually 18 years old upwards) with or without disabilities; ▪ Able to speak a local language – preferably several different languages especially in urban areas; ▪ New recruits should ideally have at least Grade 8. ▪ Existing CHBC Providers should be willing to be supported to become literate and numerate ▪ Reliable, committed and willing to undergo training; ▪ Able to maintain confidentiality ▪ Based in the community she/he is going to serve; ▪ Respected and accepted by the community; ▪ Representative of diverse members of community ▪ Be a good role model

7.2 Trained trainers able to use appropriate methodology	▪ Selection should include competent health and health related professionals, such as nurses, HBC Coordinators and rehabilitation professionals ▪ Minimum TOT training for 20 days, in blocks. ▪ Minimum 10hrs / yr refresher training for TOTs, which is the responsibility of MOHSS ▪ New trainers should be mentored for at least 8 hours when they start giving training. ▪ Participatory methods that encourage adult learners should be included in the TOT
7.3 HBC providers trained, awarded certification and attend annual refresher courses	▪ CHBC providers trained for a minimum of 120 contact hours, including theory and practice (12 weeks) followed by 20 hours of supervised practice. It is advisable to consider training in blocks or modules of one week followed by supervised practice. ▪ Supervisors will be required to conduct an ongoing needs assessment of trainees and provide onsite training ▪ Standard training manual is used, recognized by MOHSS ▪ Instructional aids in appropriate languages; pictorial aids provided; ▪ Certificates of achievement and attendance awarded ▪ CHBC providers shall be provided with a minimum of 20 hours refresher courses in CHBC on a yearly basis
7.4 Orientation, description of duties and agreements	▪ CHBC providers shall be given orientation that includes local community health care information, networking and referral points, information on the service organisation itself - its operation and its procedures. ▪ Each CHBC provider shall have a description of duties and responsibilities, reviewed at least every two years (see CBHC Guidelines for more details) ▪ Each CHBC provider shall have an agreement signed between the HBC provider and the service organisation that states the duties and responsibilities of each party shall be used. ▪ There shall be an agreement between the MOHSS and each HBC service organisation. ▪ Each CHBC provider shall have a standardised MOHSS ID Card
7.5 Supportive Supervision	▪ Each CHBC provider shall receive quality supportive supervision monthly, including: technical, emotional, spiritual and administrative components ▪ Each CHBC provider shall be managed, supported, supervised and evaluated by a permanent staff member, trained in supportive supervision. ▪ Each supervisor shall accompany each CHBC provider on a home visit at least once per year. ▪ The supervisor shall keep written records of supervision meetings. *Recommended duties of the supervisor should include to:* ▪ determine compliance with quality standards of each CHBC provider ▪ provide on the job skills transfer and learning ▪ listen to the CHBC providers

- recognise signs of burn out in self and others
- ensure groups of CHBC providers are working together and that group or peer counselling takes place
- facilitate regular support group or network meetings
- ensure groups use stress management techniques and other coping strategies
- encourage group members to stay in good health
- arrange quarterly network meetings with other local partners, if not organised by the MOHSS clinic nurse.
- adjust the case load of individual CBHC providers when a client's situation changes
- encourage success stories to be shared
- discuss challenges and give appropriate advice or take appropriate action
- monitor that HBC kits are being used properly and benefiting the clients
- reinforce the use of taking universal precautions
- collect reports and report to next level

7.6 Case Load

- The level of care required by each client and each of his/her family members is assessed on a regular basis
- The case load of each CHBC provider will be determined by the level of care required by the client's whole family and the level of family support available
- A group leader should have no more than 10 CHBC providers under him or her

7.7 Package for CHBC providers

CHBC service organisations and the government should ensure that qualified CHBC providers receive:

- the necessary tools, I.E.C. materials in local languages and supplies in a home based care kit and these should be replenished monthly, where possible.
- recognition and praise from their CHBC service organisations, government and from their community leaders. E.g. annual seminars, parties and certificates of appreciation
- an ID card and other means of identification e.g. T shirt, hat, umbrella, shoes which boosts community confidence and promotes the programme
- A contribution towards expenses incurred in carrying out their duties e.g. transporting or accompanying clients and communication costs
- Remuneration that is agreed upon with the CHBC service organisation and reflects the level of quality service provided and the hours served.
- As an alternative to remuneration, the CHBC service organisation and GRN may provide technical support to enable CHBC groups to establish income generating projects or food security projects.
- Opportunities to move along a career path
- free healthcare at GRN facilities

Component 8: Monitoring, Evaluation and Reporting

The Family Health Division of the Ministry of Health and Social Services at all levels in conjunction with the Monitoring and Evaluation Unit in the Regional Councils shall have the responsibility of supervising and monitoring the activities and functions of the various organizations providing community home based care services in the country.

Monitoring is the ongoing process of reviewing planned activities to ensure they are carried out in such a way that the goals and objectives of a particular intervention are likely to be met. Monitoring is done continuously throughout the project.

Evaluation is the process of assessing actual progress toward goals and the outcome of programmes on target groups and is usually done at regular intervals for example mid-way through and at the end of a project.

All organizations shall supervise and monitor the trained CBHC providers and other caregivers working under their umbrella. Community health nurses within the community would be providing necessary technical assistance and support as may be required by the CBHC providers.

All community home-based care programmes should include provision for monitoring and evaluation (M&E) to ensure that quality services are provided in a timely, effective, and cost-effective way. M&E of community home based care programmes is crucial to be able to gather accurate information that will guide planning, implementation, assessment of the performance and impact and documentation of best practices.

Monitoring and evaluation of CHBC activities have the following goals:

- To ensure that guidelines in the provision of CHBC are being adhered to.
- To document programme activities and progress.
- To help identify constraints and possible solutions.
- To identify best practices with the idea of replicating them where possible;
- To enhance accountability and transparency.
- To assess the impact of the programme on the client and family.
- To guide in establishing proper organisational structures for supervision purposes.
- To assess the viability of the CHBC programme

Desired Outcome:
Availability of accurate information that will guide planning, implementation, and performance assessment of the programme. Timely reports available from all service providers for quarterly national reports to Response Monitoring and Evaluation Unit of the MOHSS. Assess the quality and impact of CHBC strategies , using both quantitative and qualitative tools, to refine and improve CHBC

Critical Minimum Activities based on needs assessment

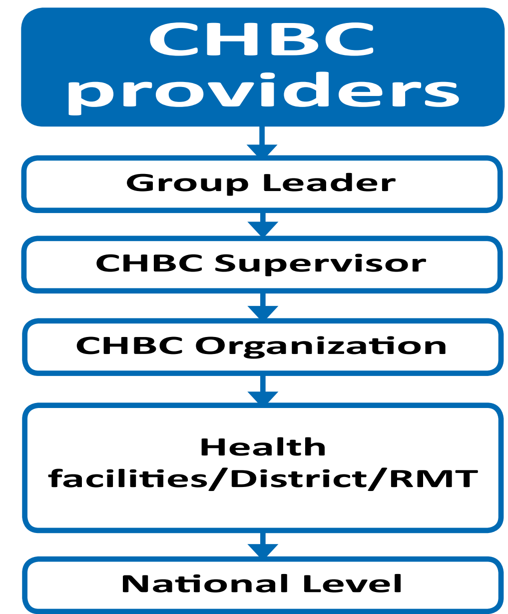
1.1 Participation
1.2 Methods
1.3 Types of data
1.4 Use of data
1.5 Reporting lines and time frames

Critical Minimum Activities	**Guidelines**
8.1 Participation	Various individuals and institutions at different levels should be involved: ▪ ***Client:*** This is based on self-assessment of the physical and emotional /spiritual / psychological / social condition, quality of life, etc. ▪ ***Family level***: Starting with the CHBC provider, relatives, and friends. These parties give each other feedback on the progress of the programme based on their assessments of how the client has been helped. ▪ ***CHBC Provider Level:*** provides regular information on numbers of clients served, and the services offered**.** ▪ ***Local NGO/FBO/CBO:*** The HBC service organisation has a central role in collating and validating data from the CHBC Provider and in providing information upwards to the health facility and across to the community and clients. This may be done with the help of a group leader. ▪ ***Health facility level***: At this level all the professionals implementing the components of home-based care are involved.

8.2 Methods	▪ All home-based care programmes should include provision for M&E
	▪ CHBC providers to be trained in simple record keeping and to keep records of individual visits and client registration forms (adult and children)
	▪ Group leaders to be responsible for summary report forms once a month.
	▪ Regular monitoring to be undertaken through supportive supervisory visits to CHBC unit. These should include:
	  ▪ Data collection through observation, interviews, home visits.
	  ▪ Collaborative meetings among stakeholders.
	  ▪ Review of existing reports/records.
	  ▪ Document good practice
	▪ CHBC organisations shall make resources available for M and E.
	▪ Technical support will be provided as needed by MOHSS to NGOs/FBOs

8.3 Types of data	**Quantitative:** ▪ # of clients receiving a HBC services at least 2 CHBC components according to the 4 components of care ▪ # of clients with physical or psychosocial (mental) disabilities ▪ # of clients referred for disability prevention and rehabilitation management ▪ # of clients enrolled in support groups and those on treatment adherence support ▪ # of clients discharged from CHBC program ▪ # of patients referred to CHBC providers from health facilities ▪ # of clients referred to clinic or health facility from CBHC providers ▪ # of clients referred for psycho social support ▪ # of CHBC providers trained and active in the past 12 months (Training).

	▪ # of kits for HBC distributed to CHBC providers. ▪ # of kits for HBC replenished. ▪ #/% of CHBC providers with no reported stock outs lasting >1 week of national recommended essential medicines/ supplies at any time during the past 3mths ▪ # of CHBC providers reporting having been visited by their supervisor. **Qualitative:** ▪ Level of progress of client physically, socially ▪ Client reporting positively on quality of care ▪ Family members reporting positively ▪ Level of community support *Monitoring of outcomes can include:* ▪ What is the level of quality, practicability, and effectiveness of the HBC services provided? ▪ How sustainable and practical are the CHBC interventions? ▪ How well do the referral and networking systems work? ▪ How is it supervised? ▪ What was the quality of the training and of the skills follow up. ▪ How effectively and efficiently have the financial resources been used, especially for funded programmes? ▪ Has the programme complied with monitoring and evaluation requirements? ▪ What are the short- and long-term effects of the programme (e.g., behaviour change)?
8.4 Use of data	▪ Results of M and E should be shared with providers, clients and community through supervisors and through CACOCs and Village Health Committees and other forums as well as with regional and national MOHSS structures ▪ Identify best practices with the idea of replicating them to the where appropriate. ▪ Use data to guide planning, implementation, assessment of the performance and impact and documentation of best practices
8.5 Reporting lines and time frame	▪ Information flow will be to and from:



- CHBC provider will provide monthly reports to group leader or supervisor; the supervisor will provide monthly summary reports to organisation and local health facility
- The Directorate of PHC in the MOHSS will provide guidance on collecting and reporting the data required for ongoing programme monitoring. This will be done to ensure that the country attains the goals it set for itself periodically such as the Millennium Development Goals.
- All organisations in the regions will provide reports to the MOHSS local facility on the standard form, which in turn will submit such reports to district, regional and national levels.
- The MOHSS reporting time frame will be quarterly submissions to National level.
- The Regional Management Team shall ensure that HBC provider organisations receive feedback on the monitoring reports at the quarterly meetings.

Annex 1.Client Needs Assessment Form

The client or the caregiver can answer the questions in this form. After filling out the form, decide what the client's needs are, how often will you have to visit the clients and what skills you will train the client or caregiver to do first, next, and so on.

Short medical history:

1. Has an HIV test been done?

   ❒ Yes ❒ No

2. HIV status: ❒ Positive ❒ Negative ❒ Don't know
   (*this may remain confidential*)

3. Is the client bed-ridden? ❒ Yes ❒ No

4. TB treatment ❒ Yes ❒ No
   For how long_________________

   ARV Treatment (❒ Yes ❒ No
   For How Long_________________

5. What Are The Regular/ Major Complaints Of The Client?

6. Are you on any kind of treatment? ❒ Yes ❒ No
   What kind:

7. What Other Illnesses Does The Client Have including Disability? _______________________________
   ____

Getting Around

8. Is it usually easy for you to leave home and get around by yourself?
   ❒ Yes ❒ No

9. Is it easy for you to get around your home on your own?
   ❒ Yes ❒ No

10. If you need help getting around, what kind of help would you like?
    ❒ Just someone nearby who can help when I need it
    ❒ A cane or a walker
    ❒ A wheelchair

11. Do you have difficulty moving any part(s) of your body? ❒ Yes ❒ No
    ❒ Arms:____ Left _____ Right _____ Both
    ❒ Legs: ____ Left _____ Right _____ Both
    ❒ Others ____

12. How much time do you spend in bed?
    ❒ All of the time
    ❒ Most of the time
    ❒ Only when I'm tired or for sleep at night

NCHBCS

13. Do you need any help with the following tasks? (Tick all that apply).
❒ Personal hygiene(bathing, mouth care, hair care, etc.)
❒ Bedsore management
❒ Getting dressed
❒ Eating
❒ Using the toilet
❒ Doing housework (cleaning, washing clothes, fetching water, etc.)
❒ Assistance with children
❒ Other: ____
____

Nutritional concerns

14. Do you need any help preparing your meals?

❒ No, I prepare them myself. ❒ No, my family prepares the food.
❒ Yes, I'd like help now. ❒Yes, I might want help later.

15. Have you noticed any changes in your appetite (wanting to eat)?

❒ Less than normal ❒ More than normal
❒ Normal ❒ Never the same

16. Do you have any problems eating or drinking? What help would you like?______________________
____
____
____

Sexual and Reproductive Health

17. Could you be pregnant?
❒ Yes ❒ No

18. Are you currently using a family planning method?
❒ Yes ❒ No

19. Are you satisfied with your current family planning method?
❒ Yes ❒ No

20. Do you use condoms?
❒ Yes ❒ No

21. Do you have any questions about using condoms?
❒ Yes ❒ No

22. Do you use condoms and another family planning method at the same time (dual protection: preventing pregnancy and STIs/HIV)?
❒ Yes ❒ No

23. Do you have any symptoms of infection in the genital area?
❒ Itching ❒ Smelly discharge ❒ None
❒ Sores ❒ Other: ____

24. Do you have any sexual concerns that you would like help with?
❒ Yes ❒ No
If yes please describe.
____

Symptoms

25. Do you have any problems with pain? ❒ Yes ❒ No,
If so, where and what makes it better?

26. Do you have any specific physical symptoms that you need help for?

Tick all that apply.

❒ Nausea	❒ Fatigue or weakness	❒ Vomiting	❒ Fever
❒ Constipation	❒ Chills	❒ Diarrhea	❒ Seizures
❒ Incontinence	❒ Night sweats	❒ Skin	❒ Joint stiffness
❒ Breathing problems	❒ Thrush or sores (mouth or throat)		
❒ Genital Problems	❒ Bad cough	❒ Other: ____________________	

____

____

Emotional and Psychosocial Support

27. Do you often feel... ? (Tick all that apply.)

❒ Confused	❒ Memory loss or forgetfulness	❒ Tired all the time
❒ Depressed	❒ Anxiety	❒ Worried

❒ Other: ____

28. Are you having trouble dealing with your emotions or feelings (e.g., trouble sleeping or eating due to worries, feeling angry most of the time, or losing hope)? ❒ Yes ❒ No
29. Would you like to have someone to talk to about how you are feeling? ❒ Yes ❒ No
30. Would you like to talk with others who are also in the same situation as yourself? ❒Yes ❒ No_____

____

Financial, Legal, and Other Concerns

31. Who is the head of the household in relation to the client? (e.g. self, husband, aunt etc.)_________
32. How many children are in this household? _______________________________________
How many are orphans? ____
33. What economic activity is the household engaged in____________________________________

34. Is the client getting a grant from GRN basic income fund or elsewhere___________________________

35. Have you prepared a will? Have you asked someone to be legally in charge of your belongings? and property?

❒ Yes.
❒ No, and I will take care of that myself.
❒ No, and I would like some help now.

36. Do you need any help arranging your financial affairs (banking, paying the rent and bills) so that things are in order once you are too sick to be responsible for them?

❒ No, I will take care of them myself.
❒ Yes, I would like help now.
❒ I have given someone power of attorney (legal responsibility) who is helping me.

37. Do you have any insurance policies that might help with your care?

❒ Yes, and I will take care of that myself.
❒ No, and I would like help now.
❒ I do not know what to do and I would like some help finding out.

38. Do you need help contacting your priest, pastor, or anyone else?

❒ No, I will take care of that myself.
❒ Yes, I would like help now.
❒ I do not know any one and I would like some help finding out.

39. Do you receive services from other organization ❒ Yes ❒ No

If yes, what organization?____

What services are provided?____

____

Annex 2: Clients Register Form

CHCP Code: ____________________

Name of CHBC Provider: ______________

Village: ________________________

Name of CBO/Organization:____________

Catchment clinic:_______________

Health District: _______________________

Constituency:___________________

Region:______________________________

Date	Client Code	Name of Client	Age	Sex	No of children in the house (0-18)	Village	Remarks

Signature of CHBC Provider: ______________________

Date:_______________________

Annex 3: Client Referral Form[4]

FOR CHBC PROVIDER TO FILL OUT AND GIVE TO CLIENT/ CAREGIVER TO TAKE TO THE SERVICE PROVIDER

Date: ________________________ Referred by:____

Address of person making referral:____

Name of Client: ____

Date of Birth:__________________________Sex:____

Does client/ caregiver consent to be referred (client signs or puts a cross):_____________________________________

Client referred to: ____

Referred for/to (tick all that apply):

_____ Medical care
_____ VCT
_____ TB screening/ treatment
_____ Legal support
_____ ARVs
_____ Psychosocial support
_____ Social grants
_____ School fee exemption application
_____ Woman and Child Protection Unit
_____ ANC/PMTCT
_____ Condoms and/or family planning
_____ Youth-friendly services
_____ Support group
_____ Nutrition support
_____ Partner and/or child follow-up
_____ Opportunistic infection (specify)___________
_____ Other (specify) ____

Signature (person referring):____

---tear or cut here---

FOR THE SERVICE PROVIDER TO FILL OUT AND GIVE BACK TO THE CLIENT, WHO CAN THEN SHARE IT WITH THE CHBC PROVIDER

Date: ______________________

Name of Facility/ Service provider: ____

Name of Client: ____

Remarks: ____

____

____

____

Service given: ____

Follow up (e.g., home care, revisits): ____

Date of Next Visit: ____

Name of Service Provider: ____

Designation of Service Provider:____

Signature: ____

[4] *Adapted from Community Home-Based Care for People and Communities Affected by HIV/AIDS: A Handbook for Community Health Workers by Pathfinder International*

Annex 4: CHBC Provider Activity Form

Name of volunteer:................................	Name of place:................................	Month Reporting on:................................
Name of Village	Name of constituency :................................	Region:................................

Client Information			*Client at home?*	*Level of client care/ Type of Client*					*Services provided to client during the visit*					*Developments at time of visit*				*Referrals*	*Length of visit*
Date	**Client Name/ Code**	**Sex**	**Yes/No**	**L1**	**L2**	**L3**	**L4**	**L5**	**Physical care incl Dis. & Rehab Management**	**Social care**	**Emotional & spiritual care**	**Health education**	**Treatment support**	**New**	**Moved/ hospital**	**Died**	**Discharged from CHBC Prog**	**Where to**	

Totals no of clients:................................	Males:................................ Females:................................		
# of times visited by Supervisor during the month		# of clients enrolled in support groups	
# of clients on TB treatment under the care of CHBC providers		# of clients on TB treatment under the care of CHBC providers who completed TB treatment	
# of clients on ARV under the care of CHBC providers		Number of children receiving ARV	
Comments by CHBC Provider:			

....
Signature

....
Date

Annex 5: CHBC Kit Use & Replenishment Form

Name of CHBC Provider :………………………………………………… Date received:………………………………………

Village/location:……………………………………………………………………………

Region:…………………………………………………………………………

	Item description	Date	Qty used	Date	Qty used	Date	Qty used	Total Qty Used
	Gloves (Non-sterile) **[2]							
	Anti-bacterial soap							
	Conforming bandage **							
	cotton wool							
	Latex Lubricated condoms**							
	Antiseptic powder							
	Gauze swabs**							
	Adhesive plaster **							
	Disposable aprons plastic**							
	Antiseptic solution							
	Vaseline/Petroleum jelly							
	Linen savers**							
	Spatula (wood)**							
	Paracetamol tablets **							
	Paracetamol syrup**							
	ORS							
	Betadine ointment**							
	Calamine lotion**							
	Gentian violet**							

_________________________________ ………………………………………………

Signature of CHBC Provider **Date**

………………………………………. ………………………………………………

Signature of Supervisor **Date**

Annex 6: CHBC supervisory checklist form , Monitoring and service delivery

Period:……………………………………………………… Name of supervisor:……………………………………………

Area:………………………………………………………… Region:…………………………………………………………

Indicators	Number	Functionality	Comments
Number of Active Health Committees			
Number of active caregivers			
Number of replenishment centres			
Number of kits replenished			
Number of clients receiving HBC services			
Number of clients on TB DOTS			
Number of clients on ARV			
Number of children receiving ARV			
Number of families supported			
Number of client deaths recorded			
Number of clients admitted to hospital recorded			
Number of clients referred to clinic or health facility			
Number of clients referred to other services			
Number of clients discharged from CHBC program			
Number of partners FBO/NGO providing HBC			
Number of volunteer meetings			
Number of clients provided with medical support			
Number of clients provided with psychosocial support			
Number of family members trained in caring for PLHA			
Number of clients provided with medical support Number of clients provided with DPR support			

Reporting Month:…………………………………………… Report prepared by:………………………………………

Name of Area:………………………………………………… Region:………………………………………………………..

Annex 7: CHBC Supervisor's Monthly Report

SERVICE INFROMATION	
Number of trained HBC providers in the community	
Number of active HBC providers in the community	
Number of clients assisted by HBC providers this month	
Number of clients on TB DOTS	
Number of clients on ARV	
Number of children receiving ARV	
Number of OVC	
Number of families benefiting from HBC this month	
Number of client deaths recorded	
Number of clients admitted to hospital recorded	
Number of referrals made	
Number of referrals received	
Number of partners FBO/NGO providing HBC	
Number of volunteer meetings	
Number of clients using assistive devices	

HBC KIT DISTRIBUTION	**Quantity**
# of kits received in current period	
# of kits distributed	
# of current stock at hand	
# losses reported during the month (expired, stolen kits)	
Requirements for next period	
HBC KIT USAGE	
Types of medicines and supplies dispensed by HBC providers this month	
Medicines/ Supplies	***Quantity***
SUMMARY AND RECOMMENDATIONS	

Annex 8: CHBC Kits Receiving Form

Date: .... Supplier:...

Order Ref:. .... Delivery Voucher No:. ....

Stock Code	Product Description	Pack Size	Quantity Received	Remarks

Store Manager.. Driver/Shipper ....

Name:.......................... .... Name ....

Signature:.. Signature...

Annex 9: MOHSS Regional Reports for CHBC Activities

Name of Region:……………………………………………………………………………………

Month Reporting on:…………………………………………………………………………………

Person Compiling Report:…………………………………………………………………………

1. COMMODITIES: HBC Kits

INSTRUCTIONS: PLEASE DO NOT WRITE IN SHADED AREAS

1.1.	***CURRENT STOCKS***		
	Opening stock		
	Received in current period		
	Total available for distribution		
	Less		
	Distributed during reporting month (to be reported to PMU)		
	Returns/Losses during reporting month		
	Closing stock as per stock sheet count (PLEASE ATTACH COPY OF SIGNED STOCK SHEET)		
1.2.	***REQUISITION***		
	Forecast as per annex (sheet B)		
	Less closing stock		
	Requirements for next period		
2.	**HBC GIVERS IN THE REGION**		
	Number of current HBC givers with region office:	Males	
		Females	
		Total	
3.	**REGIONALCOVERAGE OF HBC PROGRAMMES:**		
	1 Number of areas covered by HBC programmes:	# of Health Districts	
		# of Constituencies	
		# of Villages	
		# of Settlements	
		# of NGOs	
		# of CBOs	
4.	**2 HBC CLIENTS**		
	3 Number of clients receiving care and support:	Males	
		Females	
		Total	

Annex 10: Regional CHBC Kits Requisition Sheet (B)

Name of Region:…………………………………………………………………………….

Date:………………………………………………………………………………………………

Compiled by:……………………………………………………………………………..

Names of Areas/Groups that need HBC Kits	Quantity
Total Required	

Comments:

____
____
____
____
____
____
____
____
____
____
____
____
____

Full Name:…………………………… Signature………………… Date…………..

Annex 11: Client Treatment Adherence FORM

Client Code/Name: ____________________
Village: ______________________________
Catchment clinic:______________________
Region:________________________________

Name of CHBC Provider: _______________
Name of Organization:__________________
Health District: _________________________
Date:___________________________________

Treatment was initiated on / / Duration of treatment [ ] Months/yrs

Ask client:
Please mark the client's response to the following questions.

Question	Yes	No
Have you had difficulties to remember to take your medicine during the past week/s or month? *(depending on the frequency of the visits)*		
When you feel better, do you sometimes stop taking your medicine?		
Thinking back over the past four days, have you missed any of your doses?		
Sometimes if you feel worse when you take the medicine, do you stop talking it?		

Pill count
Ask the client to inspect each container and its contents. He or she should then tell you the name of the medication, number of pills to take per dose, the times he or she takes the medication, and whether there are any additional instructions.

Name of medicine	Knows the name *(Y/N)*	Knows the number of pills per dose *(Y/N)*	Time the medication is taken			Knows any additional instruction
			Morning (hour)	Evening (hour)	Taken correct *(Y/N)*	

Who is helping the clients to remember to take his/her medicine and to go for follow-ups?

Treatment buddy or volunteer		Reminder such as a pill box	
Wife/ Husband		Support groups	
Children		Relatives	
Other—please specify			

Any side effects

____

Adherence Improvement Plan (Include details of plan agreed on with client)

____

Annexure 12: TB Screening Questionnaire

Ask the following question	Yes	No
Are you coughing for 2 or 3 weeks?		
Are you having night sweats?		
Are you losing appetite?		
Are you losing weight?		
Are you in close contact with someone who is on TB treatment or recently treated for TB?		

If you answer yes to any of these questions please refer to the nearest health facility

Glossaries

Activities of Daily Living: Are routine activities that people tend to do every day without needing assistance. There are six basic ADLs such as: eating, bathing, dressing, toileting, transferring (walking) and continence. An individual's ability to perform ADLs is important for determining what type of long-term care (e.g. nursing-home care or home care) and coverage of the individual needs.

Basic sanitation: Is the lowest-cost technology ensuring hygienic excreta and sullage disposal and a clean and healthful living environment both at home and in the neighborhood of users.

Community: Is a group of people, with the same interests, values, norms and lifestyle, under recognized leadership. This is referring to both geographical areas and interest groups.

Community Based Health Care: Is a strategy to operationalise and ensure effective community participation in Primary Health Care. It addresses all aspects of health care (preventive, promotive, curative and rehabilitative) at community level and it may address issues such as: environmental health, reproductive health, training of community members and Income Generating Activities.

Community Home Based Care: Is the holistic, comprehensive care of clients that are extended from the health facility to the client's home through family participation and community involvement within available resources and in collaboration with health workers. It encompasses clinical care, nursing care, palliative care, counseling and psycho-spiritual care and social support.

Community Home Based Care provider: Are volunteers who make a significant contribution to CBHC within this larger group. They visit homes and support and provide palliative care to people with chronic illnesses and their families

Continuum of care: Describes the delivery of health care over a period of time. In patients with a disease, this covers all phases of illness from diagnosis to the end of life.

Coordination: Is the act of coordinating, making different people or things work together for a goal or effect.

Hospital Discharge: Discharge from the hospital is the point at which the patient leaves the hospital and either returns home or is transferred to another facility such as one for rehabilitation or to a nursing home. Discharge involves the medical instructions that the patient will need to fully recover.

Emotional support: Means having others say or do things that make you feel better, is good for your mental and physical health. Research has shown that people who get support are better able to cope with terminal illness and that their immune system is better. But it's unlikely that you'll get the support you need unless you express your emotions and what you need from others.

Evaluation: Is systematic determination of merit, worth, and significance of something or someone using criteria against a set of standards. Evaluation often is used to characterize and appraise subjects of interest

in a wide range of human enterprises, including the non-profit organizations, government, health care, and other human services.

Health District: Refers to an operational area of the Ministry of Health and Social Services which include one or many constituencies in a given region. The population in the given district is equal to the catchment population of the correspondent District hospital.

Health Facility: Are facilities that provide health care, they include hospitals, health centers, clinics, and specialized care centers, such as maternity centers and psychiatric care centers.

Heath Promotion: Is the process of enabling people to increase control over their health and its determinants, and thereby improve their health.

Home nursing: Is a care given to an individual in the home. The care may be provided by a family member or a friend. Home nursing as care by a non-professional is differentiated from home care services provided by professionals: visiting nurse, home health agencies, hospital, or other organised community group such Community HBC providers.

House Hold: Is a person or a group of persons living together and sharing a common source of food.

Immunization: Is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease.

Intensive care: Intensive care or sometime referred to as *critical care* is a type of care concerned with the provision of life support or organ support systems in patients who are *critically ill* and who usually require intensive monitoring.

Level of Care: Is a classification of health care levels by the kind of care given, the number of people served, and the people providing the care and the time spent in providing such care. The kinds of levels of continuum of care are level 1 to 5.

Medical History: The medical history or anamnesis of a patient is information gained by a physician by asking specific questions, either of the patient or of other people who know the person and can give suitable information with the aim of obtaining information useful in formulating a diagnosis and providing medical care to the patient. Medical histories vary in their depth and focus. The information obtained in this way, together witc clinical examination, enables the physician to form a diagnosis and treatment plan.

Palliative care: Is care that "improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (WHO 2002).

Replenishment: Refilling or filling again by supplying what has been used up i.e. home based! care kit refill.

Standards: Standards are an established norms or requirements. It is usually a formal document that establishes uniform criteria, methods, processes and practices Standards are usually mandatory if adopted by a government, NGOs CBO, FBOs etc.

Supportive supervision: Is a series of visits conducted to the operational staff with the aim to give them in service training, support and orientation.

Trainer of Trainers: A TOT is a person trained in communication and or facilitation skills, who conducts training and orientation at operational levels:

Treatment adherence: Also treatment compliance means the degree to which a patient correctly follows medical/treatment advice. Most commonly, it refers to medication, or drug compliance, but may also mean use of medical appliances such as compression stockings, chronic wound care, self-directed physiotherapy exercises, or attending counseling or other courses of therapy.

Treatment literacy: Is the extent to which a person is knowledgeable in order to change his/her behavior with regard to taking his/her medication, following a diet, and/or executing lifestyle changes in line with the recommendations of a health care provider.

Volunteer: Is a person who carries out unpaid activities, occasionally or regularly, to help the organization accomplish its goals. Such person should be motivated by the free will, and not by a desire for material or financial gain or by external social, economic or political pressure; intended to benefit vulnerable people and their communities.

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