WHO Regional Office for Africa

WHO Regional Guidance Kit for Planning and Implementing HIV/AIDS & Tuberculosis Community and Home-Based Care Activities

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FOREWORD

The mounting HIV/AIDS and Tuberculosis (TB) crisis that has devastated the international community has its biggest impact felt in Africa. As a matter of urgency, the crisis must be addressed by all countries in the Region. Many of the current changes in health care practices are in response to the HIV/AIDS epidemic and TB. There is now increasing evidence that African countries are vigorously attempting to implement efficient and effective Community and Home Based Care (CHBC) programmes. The primary concern of Member States is the quality of care and services that are provided, not only in health care institutions, but also in CHBC. This new development has been pivotal in assisting countries to provide care to patients with TB and HIV/AIDS in their homes. In spite of the efforts of Member States to overcome the related challenges in providing integrated services for HIV/AIDS and TB, many gaps still exist.

African Political leaders attest to have recognised the problem posed with providing quality integrated services for TB and HIV/AIDS.

Home Based Care (HBC) calls upon the resources, skills, time, energy and funds of communities and governments. Therefore, no single entity is able to meet the total requirements and challenges of HBC. A collaborative effort is fundamental to success. Care in the community must become care by the community.

In an attempt to mobilise resources for improving the quality of services, the World Health Organisation Regional Office for Africa (WHO/AFRO) was requested by Member States to play a leading role in providing technical assistance to countries.

This Guidance Kit is part of WHO/AFRO's efforts to assist Member States to forge a viable and effective community and home based care response to HIV/AIDS and TB along the continuum of care services. The recommendations in the Guidance Kit are based on documented experiences of health care providers and partners in different countries. Each chapter outlines approaches that have been found to be effective in alleviating the suffering of affected populations.

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ABBREVIATIONS

AIDS	-	**Acquired Immune Deficiency Syndrome**
ARV	-	**Anti-Retroviral**
CHBC	-	**Community and Home-Based Care**
CBC	-	**Community Based Care**
CBO	-	**Community Based Organisation**
DOTS	-	**Directly Observed Therapy, Short Course**
HCW	-	**Health Care Worker**
HCP	-	**Health Care Provider**
HIV	-	**Human Immunodeficiency Virus**
IEC	-	**Information, Education & Communication**
IMCI	-	**Integrated Management of Childhood Illnesses**
IPT	-	**Isoniazid Preventive therapy**
KABP	-	**Knowledge, Attitude, Behaviour & Practice**
MCH	-	**Maternal and Child Health**
NACP	-	**National AIDS Control Programme**
NGO	-	**Non-Governmental Organisation**
NHS	-	**National Health Services**
NTP	-	**National Tuberculosis Control programme**
PLWHA	-	**People Living with HIV/AIDS**
PMTCT	-	**Prevention of Mother To Child Transmission**
PHC	-	**Primary Health Care**
RH	-	**Reproductive Health**
STI	-	**Sexually Transmitted Infections**
TBA	-	**Traditional Birth Attendant**
TB	-	**Tuberculosis**
VCT	-	**Voluntary Counselling and Testing**
VTCT	-	**Voluntary Testing and Counselling for Testing**
WHO/AFRO	-	**World Health Organisation Regional Office for Africa**

1. INTRODUCTION

Overview

The close relationship between HIV/AIDS and TB has made it necessary to move towards an integrated approach to management of the dual epidemic. HIV is the most known risk factor for reactivation of latent TB. Evidently, countries severely affected by HIV are witnessing a substantial increase in the incidence of HIV related tuberculosis. The result has been an overstretching of the already scarce resources available to institutional health care facilities. This situation has therefore created a demand for improving and promoting an integrated approach to Community and Home Based Care services. Responding to this demand, countries in the WHO African Region have requested AFRO's guidance on improving CHBC services. The development of this Guidance Kit is in response to those requests.

The Guidance Kit

The Guidance Kit is a Generic Kit developed by WHO/AFRO to guide countries within the Africa region on the planning, implementation and monitoring of CHBC. While it focuses on HIV/AIDS and TB integrated services and programmes, it may be used in other related community based services. It contains suggestions on strategies and activities and outlines broad concepts essential for the implementation of integrated HIV/AIDS and TB CHBC programmes.

The Guide complements other WHO recommended Guides and Tools for strengthening CHBC services and programmes such as the WHO " Community Home Based Care in a Resource Limited Setting – A Framework for Action" and the "Strategy and Guidelines for Implementing collaborative TB and HIV programme activities and The Guidelines". These and other documents related to management of the dual HIV/TB epidemic are useful references and can be used in synergy with the Guidance Kit.

Objective of the Kit

The major objective of the Kit is to provide guidance to programme planners and implementers on the development, implementation and monitoring of comprehensive integrated CHBC programmes and services in support of People Living with HIV/AIDS and TB.

Scope of the Kit

The Kit provides guidance on programmatic, logistical and technical issues required for an effective response to HIV/AIDS and TB within the context of an integrated approach to CHBC.

Contents of the Kit

- Establishing Quality CHBC programmes and services.
- Establishing IEC strategies in support of CHBC
- Providing Counselling and Psychosocial support.
- Providing comprehensive support to HIV infected mothers and affected families providing ARV therapy within the continuum of care.
- Providing care for the terminally ill.
- Mobilising Community Resources
- Strengthening Multisectoral Collaboration.
- Strengthening Human Resource Development.

Chapters in the Guidance Kit can be used as separate modules. Each chapter contains objectives, proposed activities, suggestions for monitoring and evaluation, programme indicators and suggested areas for research. The apparent overlap of topics is a result of the inevitable interrelationship between the approaches and interventions in the integrated management of HIV/AIDS and TB. To avoid repetition, the basic information on suggested areas, steps for the establishment of integrated CHBC programmes, target groups and beneficiaries are outlined in the introduction, as these are applicable to all chapters.

Who is this document for?

The Kit has been developed for managers and supervisors from Government, NGO partners and Community Based Organisations (CBOs) responsible for developing comprehensive CHBC programmes and services for people with HIV/AIDS and TB. This includes a broad scope of planners and implementers of both HIV/AIDS and TB programme activities.

a) **Programme Planner**

Sectors responsible for providing CHBC services – Government, NGO partners and Training institutions.

- Organisations, agencies and institutions participating and collaborating in providing educational materials, financial support, patient-care, social and spiritual support to HIV/AIDS and TB patients, families and community groups.
- Health providers and agencies at district, provincial/regional and national levels providing IMCI, MCH, PMTCT and TB-DOTS services.
- Special interest groups/voluntary groups providing support e.g. counsellors to infected and affected persons.
- Medical and paramedical students.
- Non-health sectors which can incorporate into their existing programmes, IEC material, financial, nutritional and other psychosocial support services in CHBC for HIV/AIDS and TB.

b) **Community groups:**

- Religious groups
- Midwives
- Family groups
- Traditional birth attendants and healers
- DOTS supporters

Who are the Beneficiaries in the document?

- PLWHA/TB
- The spouses, family, friends and relatives of PLWHA and TB patients.
- Mothers infected with HIV and their children
- Orphans
- Caregivers

What is the goal of integrating HIV/AIDS & TB into CHBC programmes?

The goal of TB/HIV/AIDS integration is to reduce the burden of TB and HIV/AIDS on families and people living with HIV/AIDS and improve the quality of life of PLWHA. This integrated approach seeks to:

- Reduce:
  - Transmission of tuberculosis by improving case finding and treatment among the PLWHA as well as the general population.
  - Reactivation of latent TB infection by establishing preventive and

supportive services.

- Transmission of HIV by strengthening family and community IEC, counselling, HIV testing services and follow-up psychosocial support.
- Conditions that reduce access to prevention, care and support services for HIV/AIDS and TB.

What are the pre-requisites for HIV/AIDS/TB integrated strategies?

In light of the above, the following pre-requisites for integrating strategies and programmes at CHBC level are proposed:

- Comprehensive care policies, monitoring and reporting systems, guidelines/protocols on management and referral for integrated HIV/AIDS & TB CHBC services.
- Training of health care workers and community care providers on the integrated approach to the management of TB and HIV/AIDS such as:
  - the provision of facilities and services for the early identification of HIV/AIDS patients with TB infection and screening for active TB among management.
  - provision of preventive and other supportive services. These include education, counselling, and HIV testing as well as early referral for management.
- Joint planning for TB and HIV/AIDS control and management.
- Multisectoral collaboration and resource mobilisation across the continuum of care

What are the suggested areas for planning and implementing HIV/AIDS/TB integrated programmes?

The complexity of managing the dual HIV/AIDS and TB epidemics requires expert guidance, taking into account the linkages that exist in the management of the two diseases within the CHBC context. The suggested areas for the integration of HIV/AIDS and TB in CHBC are presented in Figure 1.

Figure I: Suggested Programme Areas for HIV/AIDS/TB Integration

Operational Area	TB Control Programme	AIDS Control Programme
Advocacy, IEC, Social Mobilisation	• Incorporate HIV/AIDS control messages in TB IEC materials/ campaigns • Advocate for HIV/AIDS control	• Incorporate TB control messages in HIV/AIDS IEC materials/ campaigns • Advocate for TB control
Planning	• Integrate TB/HIV/AIDS strategic and operational plans • Comprehensive TB/HIV/AIDS service delivery	• Integrate HIV/AIDS/TB strategic and operational plans • Comprehensive TB/HIV/AIDS service delivery
Human Resource Development	• Implement Integrated TB/HIV/AIDS curricula for pre and in-service training • HIV/AIDS Counselling and testing skills for TB workers	• Implement Integrated TB/HIV/AIDS curricula for pre and in-service training • TB Screening skills and management skills for HIV/AIDS workers
Case Detection	• Offer VCT services for TB patients and suspects	• Offer TB screening services for PLWHAs and VCT clients
Case Management and Case Holding	• Strengthen TB services in general and the DOTS strategy in particular • Provide PT and ARV services for PLWHAs and dually infected persons following TB treatment • Provide TB treatment and PT patient follow up • Provide for management of other opportunistic infections in PLWHAs	• Provide TB PT services to TB negative PLWHAs • Integrate DOTS for TB at PLWHA clinics • Promote community based HIV/AIDS/TB groups • TB treatment and TBPT patient follow-up • Provide for management of other opportunistic infections in PLWHAs

Disease Surveillance	• Introduce HIV surveillance in TB patients • Monitor treatment outcomes in TB patients living with HIV/AIDS	• Introduce TB screening and PT services in HIV/AIDS centres • Monitor treatment outcomes in TB patients who are living with HIV/AIDS
Community Participation/ Mobilisation	• Implement integrated community based DOTS and PT services for TB with community participation • Promote the establishment of TB and HIV/AIDS community support groups	• Implement integrated community based PT and DOTS services with community participation • Promote the establishment of TB and HIV/AIDS community support groups
Operational Research	• Assess effectiveness of DOTS in PLWHAs with TB • Assess different operational arrangements for delivery of TB treatment in PLWHAs • Determine optimum duration of TB PT in PLWHAs • Assess TB relapse rate in TB patients living with HIV/AIDS	• Assess effectiveness of DOTS in PLWHAs with TB • Assess different operational arrangements for delivery of TB treatment in PLWHAs • Determine optimum duration of TB PT in PLWHAs • Assess TB relapse rate in TB patients living with HIV/AIDS

How should the Guidance Kit be used?

This Kit can be adopted and adapted by programme planners, implementers and national teams at different health and social service levels, according to the circumstances in different countries and programmes. A particular chapter or sub-section can be selected to address specific needs.

Generally, when using the Kit one should remember that needs assessment is the most important part of programme management as it provides information for targeted interventions. The assessments should identify the needs of the client, the support needs of the caregiver, the family and also the community. The information collected should be discussed with all concerned especially the client, families, stakeholders and community leaders. It is essential to select the appropriate methods for performing a needs assessment, such as conducting rapid assessments, interviews, focus group discussions, the use of questionnaires, observation, review of records of previous mission reports, surveys and studies. The data should be analysed, reports written, and responsive action should be undertaken with the full participation of the above-mentioned people. *Though the type of information to be collected differs, the needs assessment exercise applies to every chapter, but to avoid repetition, see Annex 1 for tools that guide programme planning and implementation.*

What are the steps for planning and implementing HIV/AIDS/TB? integrated programmes?

In relation to the needs assessment, the responsive actions will differ at different levels of programme planning and implementation, but for each programme area or chapter, there are basic steps to be followed as shown in Figure 2

Figure 2: Basic steps For Planning, Implementing, Monitoring and Evaluating HIV/AIDS/TB CHBC Programme and Activities.

Step 1
Conduct a Needs Assessment / utilise existing data provided it has the information required

Step 2
Review and revise existing structures and systems, to identify gaps within the system and to link priority interventions

Step 3
Identify partners, their roles and responsibilities for implementation of HIV/AIDS/TB CHBC services

Step 4
Develop an implementation plan, set targets, indicators, time frame and budgets. Assign responsible persons, agree and establish monitoring system and indicators

Step 5
Implement CHBC activities

Step 6
Develop an on-going education and training plan and conduct training

Step 7
Establish monitoring, evaluation and reporting system

It should also be remembered that, though the principles to be followed are the same for each chapter, the application of these steps, and the amount and type of information used at each step would differ among programme planners and implementers at different levels of service delivery.

At central level, policies, protocols and guidelines for implementation are developed and disseminated to the lower levels.

At provincial level- policies are interpreted for implementation and resources mobilised.

At district level policies and guidelines are further translated into action

At community level different programmes and activities are implemented, with full participation of the community.

At all levels the multisectoral approach is adopted, where NGOs and the private sector form partnerships with the government to fight against the dual epidemics

What are the Components of Comprehensive Care for the sick?

- Provision of physical/nursing care, social, spiritual and emotional support for the patient, and also supporting the caregiver and family
- Provision of shelter, sanitation and money.
- Laboratory Diagnostic services including HIV testing (Annex 2) and TB screening (Annex 3).
- Medical back-up services for the client.
- Education and training for family, community volunteers, PLWHA, TB and health workers.
- Care for the caregivers with emphasis on infection prevention and control
- Monitoring and evaluation
- Referral system and discharge planning process

**Other accompanying documents*

The documents mentioned below can be obtained from the WHO/AFRO offices

- WHO/AFRO, Community Home Based Care Monitoring Tool for Patient Management: Supervisors Reporting Tool, 2003.
- WHO/AFRO, Community Home Based Care Monitoring Tool for Patient Management: Community Home Based Caregiver Reporting Tool.
- WHO/AFRO, Referral and Discharge Planning for both HIV/AIDS and TB Recommended Tool, 2002.
- WHO/AFRO, Manual on Infection Prevention and Control Policies and Guidelines, 2002.

- WHO/AFRO, Manual on Infection Prevention and Control Curriculum, 2002.
- WHO/AFRO, Recommended Test of Supplies and Medications for Community Home Based Care Kit, 2001.

How do we monitor the use of the Guidance Kit?

WHO/AFRO will monitor the use of the document based on the following:

- Feedback from Member States that use the document.
  Some of the issues to consider when using the document include:
  - Simplicity/clarity
  - Usefulness in planning, implementing and monitoring CHBC programmes/activities for integrated services
  - Relevance of areas/topics to prevailing conditions and situations
  - Additional information that can be included.

- Demand for the document.

CHAPTER 1

ESTABLISHING QUALITY CHBC FOR CLIENTS WITH HIV/AIDS/TB AND THEIR FAMILIES

PICTURE

1.1 INTRODUCTION

Much has been learned from existing national programmes about planning and implementing HIV/AIDS/TB institutional healthcare services, but many challenges still remain. The escalating number of clients suffering from HIV related and other chronic illnesses exceeds the capacity of institutional care, making home-based care an inevitable option for those who cannot be hospitalised. An additional challenge is the application of appropriate strategies for effective and efficient CHBC services.

The primary goal of any quality- focused CHBC service is to improve the client's quality of life and also reduce the burden of care on the family. The approach is to provide integrated HIV/AIDS/TB services at different entry points so that comprehensive care can be offered to clients, be it at HIV or TB services. This entails establishing the health status, care and support needs of clients with HIV/AIDS/TB, the support needs of the families, and the availability and adequacy of community resources for the provision of care and support to PLWHA, their families and orphans in the community. It also entails the training of various cadres of health personnel to provide essential services for the two diseases, and the coordinated provision of care by government, NGOs and community-based care providers and families.

1.2 PROPOSED BROAD ACTIVITIES:

1.2.1 Needs Assessment (See Annex 1)

Goal

Establishment of the patient load in a specific community and identifying specific physical, mental and spiritual needs for care and support.

- Client and family needs:

Determine:

- The health status of clients with HIV/AIDS/TB
- Information and education needs of the family regarding integrated HIV/AIDS/TB
- The availability of social support and human resources to support the family.

- Community

Assess:

- The social and cultural environment, and structures available in the community to support the individuals and families.
- The community's capacity to accept CHBC in its area, understand the nature of the illnesses, provide care and mobilise resources.
- Facilities in the community to provide medical and supportive back up services such as mobile clinics, drop-in day-care centres etc.
- Identify social and cultural factors influencing responses to HIV/AIDS/TB. e.g. stigma, isolation, violence and abuse occurring in the home.

1.2.2 Establishment of multi-sectoral linkages for planning implementation of CHBC services

Identify:

- Partners to mobilise additional human, financial and material resources.
- Key people and partners who are to be involved in the implementation of activities.
- Systems required for implementation of CHBC activities.
- Ways of collaborating with other relevant active programmes, agencies and groups.

1.2.3 Development of integrated services

A key element in the provision of quality care is the development of a comprehensive and integrated care plan guided by national policies and guidelines on the management of PLWHA and TB at home and at community level. It should aim at activities such as:

- Identifying the programme areas for integrating TB & HIV/AIDS. Course outline and the curriculum for training CHBC caregivers found in annexes V and VI will give guidance to this process.
- Developing an implementation plan with a budget and time frames
- Formulating joint policies, guidelines and protocols for client management, referral and discharge
- Developing tools for discharge, supervision, referral, monitoring and evaluation. The WHO/AFRO recommended Monitoring Tool found in annex VII will give appropriate guidance for adaptation.
- Forming CHBC Client Care Teams within the existing PHC Team
- Relieving the client's symptoms, reducing discomfort and preventing complications through appropriate management and treatment
- Reducing the psychosocial impact of the disease on the patient and family, reducing stigma and preventing the spread of infection from within the family in the home
- Providing nutritional support

- Engaging community support groups such as traditional healers, PLWHA and TB network support groups, TB DOTS supporters etc.
- Building on available structures
- Integrating care of HIV/AIDS/TB clients and their families into different health and other community and social support programme activities at all levels of service provision.

1.2.4 Development and implementation of training plans for health and non-health professionals/ workers at all levels

Develop:

- Training programmes
- Multilevel training manuals and monitoring tools including discharge plans, supervisors check lists, referral tools for monitoring and evaluating the care provided to the PLWHA and TB client
- Conduct training for care providers based on results of needs assessment

1.2.5 Establishment of multisectoral fora and mechanisms for planning and information exchange.

- Develop a management information system for recording, reporting and feedback
- Carry out operational research and use findings to revise and re-programme activities

1.2.6 Development of a communication strategy for the community and families

- Encourage formation of support groups
- Conduct focus group discussions
- Use information obtained from focus groups to develop relevant and culturally acceptable IEC programmes for patients, families and communities

1.3 MONITORING AND EVALUATION OF CARE ACTIVITIES

Monitoring and evaluation are critical elements of any CHBC Programme. In order to ensure an efficient monitoring system, the following should be done:

1.3.1 Supervision and Support of Care Activities

- Determine monitoring systems for use at different levels.
- Develop and use a monitoring and supervision schedule and check list for assessing performance and quality of care provided.
- Monitor and respond to the training needs of health and other care partners in the provision of care.
- Review records and information collected from monitoring tools.
- Provide feedback through regular meetings and written reports to managers regarding the type of services provided by the CHBC team.

1.3.2 Monitoring indicators for integrated HIV/AIDS/TB activities

Monitoring indicators can be used to assess the process and outcomes of programme activities. Indicators should be selected according to the activities that are being implemented in the communities. Some core indicators to be monitored include:

- Proportion of health workers who have been trained in HIV/AIDS/TB programme policies and guidelines
- Proportion of patients at the facility that are appropriately diagnosed, treated and counselled
- Number of Health institutions referring clients with HIV/AIDS/TB for home care
- Satisfaction with CHBC services expressed by the clients
- Number of family and community groups who have been trained to provide the services
- Number of supervisory visits carried out in the home by care providers
- Number of PLWHA and TB clients who complete their TB treatment course
- Number of clients with positive treatment outcomes as a result of being managed under CHBC as compared to alternative services

1.4 RESEARCH

Operational research in CHBC is important to ensure high quality care, to assess the impact and cost-effectiveness of interventions and to generate information that is useful for guiding the design of new interventions. Some suggested areas for operational research include:

- Impact of HIV/AIDS/TB on health care workers.
- Research on traditional practices with respect to prevention and control of HIV/AIDS/TB.
- Studies on healthcare delivery regarding factors likely to enhance programme effectiveness and the sustainability of an integrated approach to HIV/AIDS&TB
- Cost and Quality of the integrated services
- Cost effectiveness studies looking at institutional care versus CHBC programmes
- Characteristics of care recipients and providers within the CHBC service settings

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CHAPTER 2

ESTABLISHING IEC ON CHBC FOR CLIENTS WITH HIV/AIDS/TB AND THEIR FAMILIES

Educational and counselling session with the family in the home.

SOURCE: Mashambadzo Community Home-Based Care Programme, Harare, Zimbabwe

2.1 INTRODUCTION

To implement sustainable IEC programmes and education services in support of CHBC activities, a communication strategy must be developed. Programmes should focus on developing messages that highlight prevention, care, counselling and support for all clients and their families. Studies have revealed that an IEC strategy targeted at community education helps to reduce the stigma attached to HIV/AIDS/TB. It further promotes responsible sexual behaviour including utilising voluntary counselling and HIV testing services.

The primary goal of IEC programmes for CHBC is to train health care and other workers to develop and disseminate culturally relevant and traditionally appropriate IEC messages in support of HIV/AIDS/TB prevention and care; and to mobilise families and communities to provide IEC on HIV/AIDS/TB to PLWHA at all levels.

For the implementation of comprehensive IEC programmes, the following key broad areas should be considered:

- The IEC needs of PLWHA and TB, their families and the community at large, regarding integrated management of HIV/AIDS/TB in CHBC.
- Opportunities for IEC on HIV/AIDS/TB in an integrated CHBC programme
- The adequacy of resources to promote and sustain IEC activities for clients and families in CHBC settings.
- The capacity of families and community groups to provide IEC services.

2.2 PROPOSED BROAD ACTIVITIES

2.2.1 Determination of IEC needs regarding HIV/AIDS and TB within a CHBC context.

- Identify the KAPB of communities and health care workers with regard to the care of HIV/AIDS/TB patients
- Compile and analyse data from the assessments on the care needs of the patient, caregiver, family and community.
- Identify training needs of health workers and IEC promoters

2.2.2 Development of an IEC implementation plan for integrated HIV/AIDS/TB services

- Collaborate with other relevant programmes, agencies and groups for the possible integration of IEC into relevant programmes.
- Plan for resources required for expansion of activities.

2.2.3 Mobilisation of material resources for the development of IEC programmes

- Develop IEC materials for health workers on HIV/AIDS/TB
- Collaborate with partners to develop culturally acceptable IEC programmes (e.g. use of participatory methods and folk media in collaboration with local media personnel and artists).

2.2.4 Mobilisation of health care and other workers to support HIV/AIDS/TB IEC activities in CHBC

- Education and training of caregivers in IEC for CHBC service provision.
- Organisation of informal community support groups (e.g. traditional healers, TBA, TB DOTS supporters) to provide IEC to clients with HIV/AIDS/TB and their families.
- Development of multimedia materials and activities, drama groups and videos for promoting CHBC care and support services.
- Conducting of IEC training workshops for CHBC caregivers on prevention, care, control and psychosocial support.
- Conducting of focus group meetings for community support teams, the PLWHA and TB, their families and communities.
- Establishing mechanisms for monitoring of behaviour and attitude change regarding HIV/AIDS/TB and CHBC.

2.3 MONITORING AND EVALUATION OF IEC ACTIVITIES

Constant monitoring of IEC activities is essential to guide adoption of the most effective strategies in influencing positive behaviour change.

To facilitate the effective supervision of IEC activities, it is useful to:

- Determine appropriate supervision, monitoring and evaluation methods for assessing the implementation of IEC activities for CHBC services at all levels.
- Develop:
  - Schedules and checklists for supervising and supporting providers of integrated HIV/AIDS/TB IEC activities.
  - Monitoring indicators for assessing the coverage, outcomes and impact of IEC programmes in the context of the CHBC programme.
- Conduct:
  - Supportive supervisory visits to care givers, family members and community groups providing CHBC IEC services.
  - Continuous evaluation through direct observation of CHBC activities.
  - Periodic KAPB studies on HIV/AIDS/TB and CHBC to determine the impact of the programme on clients, families and communities.
- Review CHBC IEC activity records and provide support as needed.
- Develop responsive IEC activities based on the findings of the periodic assessments.

2.3.1 Monitoring indicators for IEC

- Number of IEC sessions in support of CHBC held with families and community groups.
- Number of families and communities groups expressing interest and willingness to work with HIV/AIDS/TB client and their families after IEC sessions, campaigns or exposure to AIDS drama and videos.
- Knowledge about HIV/AIDS/TB infection and control in the community.
- Signs of reduced stigma and discrimination for PWLHA &TB
- Number of people seeking CHBC services.

2.4 RESEARCH

Research is an ongoing process to address new needs as they arise. Some recommended areas for research include:

- Information gaps regarding HIV/AIDS/TB.
- Appropriateness of IEC messages.
- Studies to evaluate knowledge, attitudes, and behaviour change amongst specific groups that have been targeted by IEC programmes.

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CHAPTER 3

PROVIDING COUNSELLING AND PSYCHOSOCIAL SUPPORT FOR THE IMPLEMENTATION OF CHBC

Counselling session in a youth centre.

SOURCE: Ministry Of Health, Zambia.

3.1 INTRODUCTION

Counselling and psychosocial support are integral parts of comprehensive care for clients with HIV/AIDS/TB and other chronic illnesses. Integrating counselling and psychosocial support in CHBC programmes presents service providers with many challenges. Considering how many people now associate TB with HIV/AIDS, the major challenge is to develop a trusting relationship between the client, the family and counsellors. The aim is to share information about the psychosocial support required in CHBC and to reduce the related stigma.

In order to provide counselling and psychosocial support to HIV/AIDS/TB clients and their families, counsellors and programme implementers must consider the following:

- Psychosocial impact of HIV/AIDS/TB among clients and their families
- Empowerment of the individual and family through counselling and HIV testing to accept and cope with their HIV/AIDS/TB status by living positively with HIV/AIDS/TB.
- Assisting families and communities to recognise their role in providing psychosocial support.

3.2 PROPOSED BROAD ACTIVITIES

3.2.1 Development of counselling guidelines and orientation of CHBC HIV/AIDS/TB counsellors.

- Integration of IEC messages with counselling services to de-stigmatise HIV/AIDS/TB within families and communities
- Equip DOTS treatment supporters with knowledge of HIV/AIDS and counselling skills.

3.2.2 Supporting the establishment of networks to increase coverage with VCT services.

- Establishment of referral systems between formal HIV/AIDS/TB prevention, care and support services and CHBC services.
- Collaboration with faith based organisations, traditional and other special interest groups. (Start with groups who are already involved in community support activities).
- Linking the family with support groups, to assist them to work through their fears, concerns, inadequacies and other limitations.
- Provision of education to community support groups and healthcare workers about HIV testing, (Annex 3) where to go and what to do.
- Education and training of caregivers, family members and community support groups in basic counselling skills.

- Training of health faith based organisations and other related workers in individual family and community counselling skills and techniques.
- Training of other community workers in basic counselling skills to enable them to work with families, so that HIV/AIDS/TB counselling becomes part of their activities.

3.2.3 Support and follow-up of clients

- Establish ongoing counselling and support services for the patient and family
- Counsel the family members as individuals or in groups as the situation requires.
- Visit the client and the family while in hospital and build a relationship of mutual sharing before discharging the client home.
- Counsel clients and families on the importance of good nutrition for HIV/AIDS/TB patients

3.3 MONITORING AND EVALUATION OF COUNSELLING ACTIVITIES

3.3.1 Supervision and Support of Counselling activities:

- Develop a schedule for conducting supervisory and support activities at all levels of service provision and all stages of programme development
- Involve community leaders and partners to ensure that counselling and psychosocial activities are sustained.
- Use supervisory checklists, including assessments in different areas such as utilisation of services e.g. VCT, TB, STD.
- Monitor the effectiveness of the referral system after the client is counselled and referred through the appropriate tracking systems.
- Check on the use of guidelines and monitor the counselling environment, communication skills and accuracy of information.
- Review records of counselling activities at all levels.

3.3.2 Monitoring indicators for Counselling and Psychosocial support:

- Number of clients receiving counselling and psychosocial support services as part of care in their homes.
- Number of counselling sessions that have been provided to individual families who are caring for their HIV/AIDS/TB relatives.
- Number of visits to clients for the purpose of offering spiritual and social support.
- Number of family support groups volunteering to participate in the provision of counselling support activities.
- Number of discharge clients referred from institutions to voluntary counselling services at local level and vice versa.

3.4 RESEARCH

Some suggested areas for operational research include:

- Psychosocial impact of HIV/AIDS/TB on clients, families and community e.g. burnout syndrome of caregivers, depression, and suicidal inclinations.
- Quality of counselling and social support available to families.
- Relationship between availability and use of VCT services and behavioural change.

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CHAPTER 4

PROVIDING SUPPORT TO THE MOTHER INFECTED WITH HIV/AIDS, HER BABY AND FAMILY

Phsyco-social Support Helps an HIV Positive Pregnant woman live Positively

Source: Community Home Based Care Unit Photo Files. WHO/AFRO HIV/AIDS

4.1 INTRODUCTION

The severity of the HIV/AIDS/TB pandemic, as well as the variety of scientific programme interventions on prevention of mother to-child transmission (PMTCT) of HIV derived from pilot projects in Africa, challenges governments and partners to support the development of PMTCT programmes as an integrated part of the continuum of care for the management of the client/patient with HIV/AIDS/TB.

Effective PMTCT of HIV and TB requires action at different levels of the health and social services, in the community and in the home. This demands guidance for improving the coverage and range of services offered, and improving the quality of service delivery from initial planning to implementation of programmes. It is with this in mind that some essential components of the PMTCT are being addressed in this chapter.

In order to establish quality care, planners and implementers of PMTCT of HIV under CHBC settings must consider the following key areas:

To assess:

- The number of personnel available to provide HIV prevention services for the woman at antenatal care services during delivery and post-*natally.*
- The availability of counselling services on HIV/AIDS/TB and its related conditions.
- The availability of VCT services for those who are pregnant and are not aware of their HIV status. (This is important for early recognition of symptoms and for referral for HIV/AIDS medical care).
- The health status, care and support needs of HIV/AIDS/TB mothers during pregnancy and after delivery, and for their children.
- The needs of families and community support groups for information, education and communication skills to provide appropriate support to mothers and children with HIV/AIDS/TB.
- The type of training required for provision of CHBC services by families, community groups, caregivers and health care workers to recognise when to refer the mother and child for medical and counselling services.
- The knowledge required on nutritional and food needs of the HIV infected woman before and after delivery for the baby and the mother.

4.2 PROPOSED BROAD ACTIVITIES

- Development of a discharge and follow-up system for the mother and child.
- Assessment of:
- the mother's physical, medical, social, emotional status and need for care and support of ailments which are associated with HIV infection, TB and pregnancy.

- health and social support resources available and accessible to the mother through the PMTCT intervention programme
- The physical, social and emotional status of the family.
- Adequate family resources available to support the pregnant mother.
- The opinions and attitudes of families and community on breast-feeding and substitute feedings.

- Identify specific persons who are involved in the implementation of activities.
  - Collaborate with relevant programmes, agencies and groups
  - Plan for resources required for prevention and support of MTCT

4.2.1 Develop a care plan for PMTCT

Before delivery include the following:

- Nutrition education. Specific topics on types of food to eat and food preparation and safety. Start discussions about infant feeding particularly issues related to breast-feeding and replacement feeding early in the pregnancy, as it relates to HIV The advantages and disadvantages of the different feeding options.
- Counselling about safe sexual practices

Delivery issues

- Education for the delivery team on minimising vaginal examinations.
- Adherence to strict universal precautions during delivery and for the baby (refer to training manuals on PMTCT for specific obstetric management).
- ART for the child and herself.
- Education on what to do if the mother suffers from symptoms of HIVAIDS related conditions.

After delivery include the following:

- Continue to educate and counsel on feeding options.
- Educate about HIV/AIDS/TB warning signs, what to do and where to go for medical care.
- Educate on family planning methods

Be sure to cover:

- Planning for relief of symptoms and prevention of complications by prevention, early diagnosis and appropriate treatment of opportunistic infections
- Establishing VCT services for mothers who would like to know their HIV sero-status.
- Establishing counselling and psychosocial support systems for continuous services for the mothers infected with HIV/AIDS/TB and also affected families

- Providing accurate information and support on available options for prevention of MTCT of HIV and TB.

- Reducing physical and psychological discomfort and stigma for a mother who may decide not to breast-feed.
- Building families' capacity to support the woman in her choice of infant feeding.
- Maximising the functional, developmental and educational potential of the child within the limitations caused by HIV infection.
- Preventing the transmission of infections from mother and child to the family caregivers and other household members and vice versa.

4.2.2 Develop and conduct a training programme

- Train core groups of Trainers (TOT) on elements of PMTCT intervention as well as in the planning, implementation, monitoring and evaluation of this service.
- Prepare family groups through IEC training sessions for PMTCT of HIV and TB.
- Develop multi-level training materials, manuals and protocols for training caregivers and health workers at the local and district levels.
- Conduct multisectoral meetings and in-service training activities for traditional birth attendants and healers, family members and community groups on planning and implementation of prevention of MTCT within CHBC services for mothers and their families.
- Conduct counselling training sessions for groups and families.
- Integrate PMTCT into reproductive health programmes and activities.

4.3 MONITORING AND EVALUATION OF PMTCT ACTIVITIES

- Establish an information system for recording, monitoring, supervising and evaluating MTCT activities after delivery and on care for the child.
- Develop a schedule for conducting supervision and support activities at all levels of CHBC for prevention of MTCT.
- Develop and use supervision tools such as checklists.
- Conduct observation visits in homes and assess the extent to which mother and child-care activities are being conducted.
- Review records and conduct feedback sessions on the performance of health care providers and families in the home and at MTCT clinics.

4.3.1 Monitoring indicators for PMTCT

- Number of pregnant mothers tested at VCT service centres
- Number of mothers with HIV/AIDS receiving PMTCT interventions.
- Number of health institutions referring HIV/AIDS mothers and/or children participating in PMTCT interventions to CHBC services for home care.

- Number of mothers expressing satisfaction with CHBC services.
- Number of support groups formed by communities to provide physical, spiritual and social support to mothers and their families participating in MTCT prevention programmes.

4.4 RESEARCH

Some areas for operational research include:

- Traditional practices with respect to substituting breast-feeding
- Studies to determine KABP about voluntary HIV testing
- MTCT prevention practices at the local level
- Evaluation of self-reported and observed behaviour changes amongst the specific groups towards whom MTCT related counselling and IEC had been targeted.

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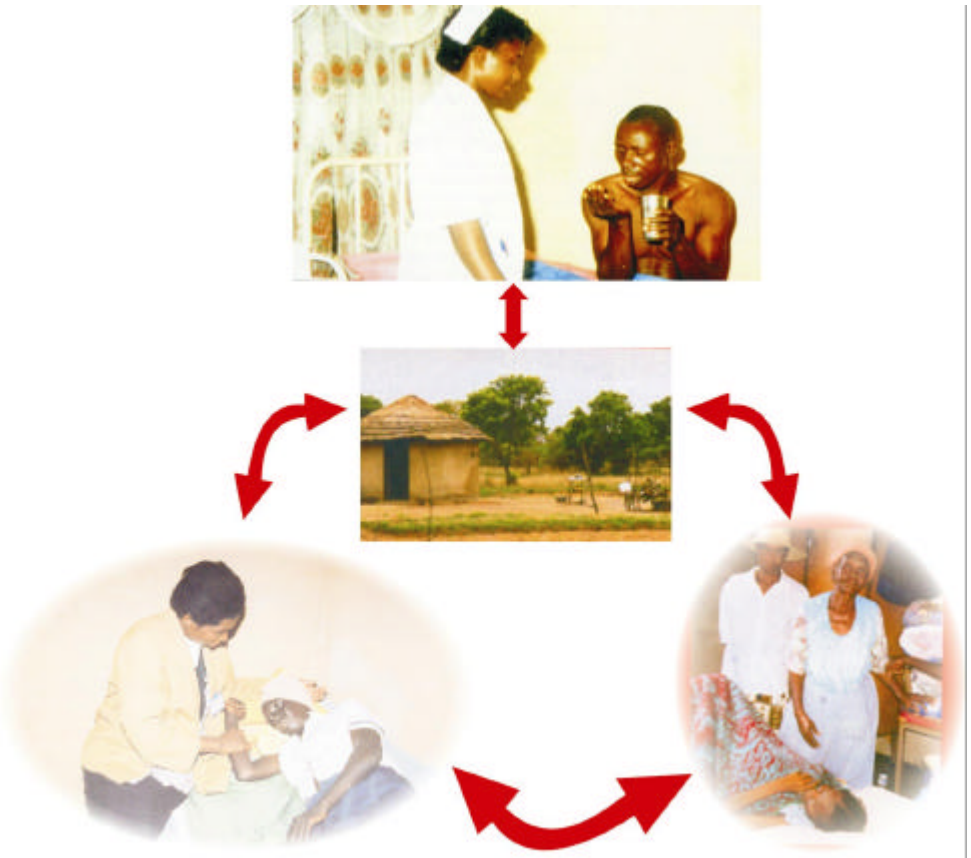
CHAPTER 5

PROVIDING ANTI-RETROVIRAL THERAPY (ART) WITHIN THE CONTINUUM OF HIV/AIDS/TB CARE THROUGH CHBC SERVICES



Source: Community Home Based Care Unit Photo Files. WHO/AFRO HIV/AIDS

5.1 INTRODUCTION

Affordable anti-retroviral (ARV) medicines for reducing viral load in persons infected with HIV are becoming widely available and are in use in many countries. Safe and effective use of these drugs requires trained health care providers at health facility, community and home based care levels.

When planning and implementing ARV therapy as part of the continuum of care for patients with HIV/AIDS /TB, governments should develop standard treatment guidelines for providing high quality and cost effective services. This should include training of doctors, nurses, counsellors and other caregivers. Emphasis should be on all hospitals where many patients with HIV/AIDS/TB are managed, and from where referrals are made to other levels. It is imperative that governments establish standard regimens for ARV therapy and guidelines for their use and for monitoring the patients.

In the process, planners and implementers must consider the following key areas:

- The availability of health care personnel to provide health education, counselling and follow-up support services for the pregnant woman and the family to support ART.
- The total number of health care providers required to provide HIV/AIDS and ART counselling care and follow-up support services for monitoring adherence to treatment.

- The readiness of the health system to provide ARVs to patients with HIV/AIDS/TB and their families.
- The educational needs of the communities and families participating in the provision of ARV-related care and support.
- Family and community resources available as well as those required to promote and sustain a safe and effective ARV Programme by patients and families at home.
- The availability of trained community groups with information, education and skills to supervise patients on ARV therapy and to identify signs of non-adherence to ARVs and refer.
- The equipped comprehensive HIV/AIDS/TB health care facility to monitor ARV treatment in the home.
- The training required in ARV and CHBC for families, community groups, caregivers and health care workers. This should also include the use of referral procedures to ensure continuous medical and nursing support.
- The patient's health and financial status before starting ARV therapy.
- The reliability and sustainability of the financial sources of family members and friends responsible for financing the patient's ARV therapy.

5.2 PROPOSED BROAD ACTIVITIES

5.2.1 Development of guidelines and reference materials on ARV therapy, patient care, counselling, IEC and CHBC for use by health workers and other caregivers.

Develop:

- National Guidelines for management of ARV Therapy in patients with HIV/AIDS/TB
- Discharge and follow-up procedures including monitoring toxicity and resistance to ARV therapy.
- Recording, reporting and referral systems among health and social services in monitoring ARV therapy and care
- Simple and practical instructions on ARV use.

5.2.2 Mobilisation of human and financial support for ARV therapy to ensure sustainability of treatment.

- Establish linkages with hospitals, private physicians, clinics, pharmacies and families involved in ARV therapy, PLWHA and community groups providing various forms of community care.
- Initiate/strengthen linkages with health institutions and providing social services, psychosocial and spiritual support for patients on long-term care such as ART.

5.2.3 Support for health institutions in the delivery of ARV at peripheral level:

- Develop a care plan for ARV therapy.
- Obtain assistance from medical supply units on storage and ordering of adequate stocks of ARVs.
- Identify persons who will be involved in the implementation of programmes and provide training.
- Identify the most cost-effective way of supplying drugs in the home for long term care of the HIV/AIDS/TB chronically ill patient.
- Strengthen the capacity of community support groups, to integrate services to care for the PLWHA/TB patient on ARV therapy into their daily activities.

5.2.4 Development and implementation of training programmes on home care and social support activities for HIV/AIDS/TB patients on ARV therapy.

- Train core groups of Trainers in elements of ARV therapy as well as in the planning, implementation, monitoring and evaluation of the services.
- Strengthen family support groups at local level in homes or other community settings to provide counselling for patients receiving ARV therapy.
- Produce multi-level training materials, manuals and protocols for use in training caregivers, counsellors and health workers at the local and district levels on ARV therapy in the home.
- Conduct family and community counselling training sessions for families and other cadres of health care workers on efficient monitoring of ARV therapy.

- Develop monitoring indicators for assessing the impact of ARV therapy supervised by families and support groups within CHBC service on HIV/AIDS/TB.

5.3 MONITORING AND EVALUATION OF ART ACTIVITIES

Monitoring is essential in guiding the use of ARV therapy. The following should be considered:

To-

- Establish an information system for monitoring, supervision and evaluation of ARV therapy and care provided to patients and their families.
- Develop schedules and checklists for conducting supervision and support activities at the local, district and provincial levels for those on ARV therapy.
- Monitor ARV use and observe for early manifestations of ARV related complications and side effects, and promptly refer to ARV treatment centre for appropriate action.
- Monitor adherence to ARV therapy schedules.
- Review records of care providers or listen to reports by patients and families on the quality of care.
- Conduct regular performance appraisals of CHBC providers on the provision of ARV therapy.
- Conduct ongoing assessments of the knowledge required by family caregivers and professional health care workers in TB and HIV programmes in the provision of ARV therapy.

ARV Monitoring indicators

- Number of patients with HIV/AIDS/TB receiving ARV therapy from their homes.
- Number of home visits carried out to individual patients with HIV/AIDS/TB on ARV therapy.
- Number of patients with HIV/AIDS/TB and families who have requested to be cared for in the homes while on ARV therapy.
- Number of health care facilities offering ARV therapy referring their patients for home-care.
- Number of patients on ARV therapy expressing satisfaction with CHBC services.
- Number of family and community counselling groups formed to support ARV therapy through CHBC services.

5.4 RESEARCH

Some suggested areas for operational research include:

- Research on the impact of ARV therapy on the individual and the family.
- Studies to determine KAPB about the role of ARV drugs on prevention and control of HIV/AIDS/TB at local level.
- A cluster of operational research studies in some specific localities to evaluate

self-reported and observed behaviour changes amongst those on ARV therapy.

- ARV therapy compliance or sustainability studies.

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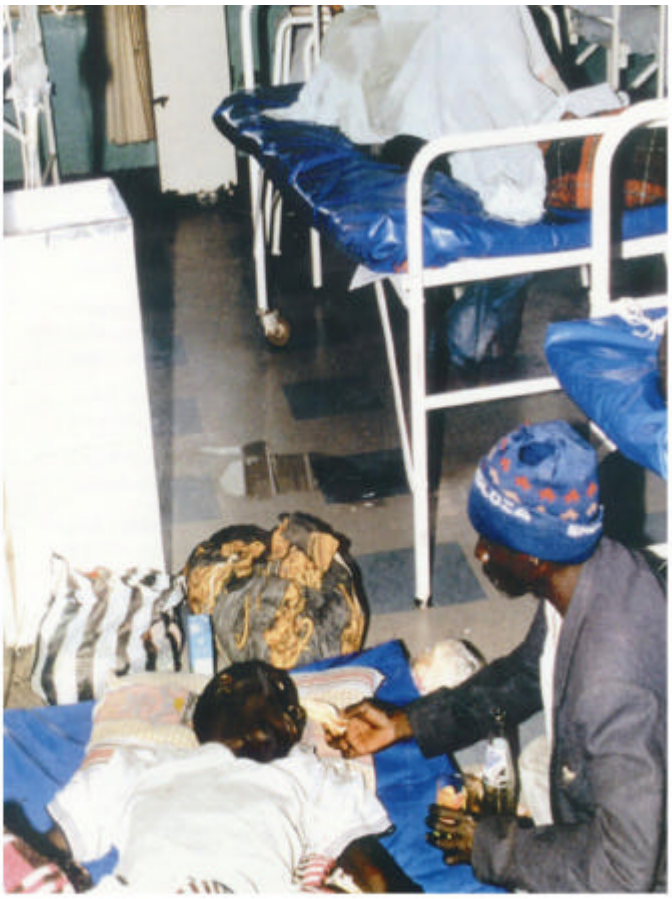
CHAPTER 6

PROVIDING CARE FOR THE TERMINALLY ILL



Including Family Members In the caring process within the health facility can ensure the continuum of care.

Source: MINISTRY OF HEALTH , UGANDA

6.1 INTRODUCTION

The prevalence of the HIV/AIDS/TB pandemic, and other chronic illnesses such as cancers and cardiovascular diseases are increasing in Africa, resulting in the need for long-term care (LTC) facilities to be established. LTC is necessary for clients who are not fully capable of self-care on a long-term basis. It includes activities necessary for daily living and encompasses a broad array of services such as personal care and assistance with feeding. The care giving is usually rendered by caregivers from families and friends, as well as professionals from the health and social sectors, and other volunteers in the community. The services, whether delivered at home or in institutional settings, are designed to minimise pain and discomfort and address the psychosocial impact of the illness. They are also aimed at preparing for the burial and other relevant procedures when death occurs.

In order to establish quality care, planners and implementers of long-term care must consider the following key objectives for the care of the terminally ill:

- To determine the health status, care and support needs of the terminally ill HIV/AIDS/TB clients.
- To identify family and community resources available to promote and sustain the implementation of direct terminal care to clients receiving CHBC.
- To provide training in CHBC for families, community groups, caregivers and health care workers in the provision of adequate, dignified palliative care.
- To determine the human and financial resources and capacity of the families to provide care and support at the time of death and during bereavement.

6.2 PROPOSED BROAD ACTIVITIES

6.2.1 Establishment of the prevailing situation regarding the patient, family and their environment

- Conduct assessment of the client, family and community health care and social support required during the terminal stages of illness and after death
- Identify and learn from care and social support systems operating within the small and larger community setting, that have experience in terminal care and bereavement support
- Assess the medical stage of the HIV disease and existence of opportunistic infections such as Tuberculosis.
- Identify the physical, emotional and mental problems associated with the terminal illness.
- Discuss the last wishes of the client such as burial arrangements etc.
- Identify human, health and social support available and accessible to the client and family.
- Identify community, social and cultural problems associated with HIV/AIDS/TB and death

Assess:

- The family's experiences when looking after a terminally ill patient who subsequently dies and their willingness to help and support other families
- Location of close relatives, particularly children, parents and spouses of the clients
- Interaction patterns within family members, friends, workmates, etc
- Linkages with health and other community social services.
- Persons available to take charge of proceedings when death occurs.
- The capacity of the community to understand the nature of illness, providing care, mobilising resources and responding to the client's needs.
- The social and cultural environment and the ability of families to cope with death.

6.2.2 Mobilisation of family and community support for CHBC of the terminally ill at the local, district and provincial/regional levels.

- Enlist the participation of community leaders, and other key people in the care of the terminally ill, from the planning stages of the illness to death and bereavement.
- Develop reference materials on the terminally ill for use by health workers and other caregivers.
- Establish information systems for monitoring, supervision and evaluation of care rendered to the terminally ill patients and their families.
- Establish mechanisms for linkages with hospitals, clinics, pharmacies and families, PLWHA and community groups providing various forms of community care for the terminally ill.
- Develop discharge and follow-up plans for visiting the terminally ill.

6.2.3 Provide terminal care

- Develop a care plan for the terminally ill which, among other things, promotes comfort, dignity, emotional and spiritual support as well as preventing the spread of infections from patient to family caregivers and other household members
- Identify persons who are involved in the implementation of the programme of activities within the community.
- Collaborate with other active and relevant programmes, agencies and groups.
- Monitor terminal care provided to the patient.
- Conduct follow-up and supervision visits to homes with the terminally sick patient
- Develop and conduct training programmes for care providers.

6.2.4 Development of capacity of caregivers in terminal care at all levels

- Develop multi-level training materials, manuals and protocols for use in training caregivers, counsellors and health workers at the local and district levels on terminal care.
- Train core trainers on key issues of the terminally ill (with AIDS and TB) patient care such as in planning, implementation, monitoring and evaluation with emphasis on HIV/AIDS and TB care.

- Support provision of protective materials for the prevention of infection in the home during the handling of the body before burial.
- Conduct in-service training programmes to improve and update skills of all involved to promote the quality of care and support services provided to terminally ill patients and their families emphasising HIV/AIDS/TB infection control procedures.

6.3 MONITORING AND EVALUATION OF TERMINAL CARE ACTIVITIES

- Develop schedules and checklists for supervising care activities at all levels for the terminally ill patient in the home.
- Determine procedures to be used at various levels.
- Conduct on-site observation visits to homes and assess the extent to which terminal care and bereavement activities have been conducted.
- Conduct regular meetings at village level to appraise family groups and other interested parties on CHBC activities for the terminally ill.
- Review records of care providers or listen to oral evidence by clients' and families on the quality of care.
- Conduct regular performance appraisals of the CHBC providers in terminal care.

6.3.1 Terminal Care Monitoring Indicators

- Number of patients with HIV/AIDS/TB receiving terminal care in their homes.
- Number of home visits carried out to patients with HIV/AIDS/TB to provide terminal care, monitor or supervise the implementation of CHBC activities.
- Number of patients and families expressing satisfaction with CHBC for their terminally ill patients.
- Number of patients counselled to accept death, making their wills and other final arrangements as a result of psychosocial support during their terminal illness.
- Number of support groups formed by communities to provide physical, spiritual and social support to terminally ill patients and their families affected by HIV/AIDS.

6.4 RESEARCH

Some suggested areas for operational research include:

- Research on traditional practices with respect to the care of the terminally ill clients and bereavement.
- Baseline survey studies to determine KABP about the care and support of terminally ill patients, particularly with HIV/AIDS and TB at all levels.
- Studies to evaluate self-reported and observed behaviour changes amongst those who have experienced coping with the reality of a dying relative due to HIV/AIDS/TB.

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CHAPTER 7

MOBILISING COMMUNITY RESOURCES IN SUPPORT OF THE IMPLEMENTATION OF CHBC

Mobilizing nutritious food items is a critical step in the treatment plan for people living with HIV/AIDS and TB.

Source: Community Home Based Care Unit Photo Files. WHO/AFRO HIV/AIDS

7.1 INTRODUCTION

Evidence has shown that by providing support for families to care for a client with HIV/AIDS/TB in the community, the quality of life of the client improves. It is necessary to provide the appropriate resources to the family/caregivers to offer comfort and relieve pain and suffering. In addition, education and training should be provided for the family caregivers to make them self-reliant in mobilising care supplies within the community setting.

In order to mobilise families and community groups to support CHBC activities, implementers and planners must ensure that the following objectives are pursued:

- Identifying:
  - Existing community resources and activities for supporting those infected and affected by HIV/AIDS/TB.
  - The various groups in the private and public sector who are committed to undertaking support activities.
  - Family and community support groups to be trained in income generating as well as resource mobilisation skills, for different aspects of care and counselling.
- Promoting co-operation and linkages between political and socio-economic groups.
- Initiating resource mobilisation activities that can support PLWHA and their families.

7.2 PROPOSED BROAD ACTIVITIES

7.2.1 Identification of community resource capacity to cater for the needs of the sick.

- Collect information on the various resources existing and required for the successful implementation of CHBC such as respite homes, day care centres, hospices etc
- Use information obtained from analysis of community assessments to determine the specific programmes that can be established to support families in providing integrated services to clients.
- Collaborate with relevant sectors such as: the business community, NGOs and donors
- Mobilise the community through meetings and campaigns targeting community groups.
- Involve traditional healers and other community based care providers in the implementation of activities

7.2.2 Involvement of community leaders of various sectors in the planning process for resource mobilisation

- Identify and train cooperative members in resource mobilisation.
- Negotiate with companies for nutritional supplements, medicines for adults and children, supplies and logistical support, including means of transport that can be sustained.

- Present information and statistics on the epidemiology of HIV/AIDS/TB locally and internationally for advocacy purposes.
- Discuss the results with the community, community leaders, health care workers and other appropriate stakeholders.
- Assist in use of data for programme development.
- Adopt approaches that have been used by communities in other countries to meet the different resource needs of HIV/AIDS/TB client and their families.
- Prepare proposals for developmental projects to ensure food security and income generation.
- Collaborate with other relevant programmes, agencies and groups to mobilise human, financial and material resources.
- Conduct training on resource mobilisation for various groups and stakeholders
- Assist local teams to develop proposals for funding integrated activities including long-term care.
- Train community groups in resource management, income generation, basic financial management, marketing, record keeping and budgeting.

7.2.3 Integration of CHBC activities into other community development and primary health care activities at local level to maximise utilisation of scarce resources.

- Identification of family and community volunteers to participate in the planning and implementation of integrated HIV/AIDS/TB CHBC and support services.
- Identifying specific groups from the public and private sectors that can be involved in the implementation of HIV/AIDS/TB activities
- Monitoring, supervision and evaluation of community mobilisation activities in collaboration with health workers and other organisations

7.2.4 Utilisation of traditional structures (traditional healers, traditional birth attendants) at community level to advocate for integrated HIV/AIDS/TB programmes

- Identify their roles and responsibilities as partners in health care delivery
- Develop appropriate training programmes so that they can assist with patient management.
- Develop a care of the carers supportive programme, particularly for orphan heads of families and the elderly, to improve their skills and prevent burn out

7.3 MONITORING AND EVALUATION OF RESOURCE MOBILISATION ACTIVITIES

Establish a feedback mechanism for all partners regarding mobilisation and utilisation of resources.

7.3.1 Monitoring indicators for resource mobilisation

- Number of community groups mobilised to carry out income generating activities
- Number of community groups and teams sustaining CHBC activities in their localities utilising their own resources
- Number of training sessions in resource mobilisation, distribution and utilisation
- Number of HIV/AIDS/TB clients and families receiving social support and care from community groups.
- Number of community groups collaborating with NGOs and other sectors in providing resources to support HBC services to the infected and affected
- Number of community leaders taking responsibility for initiating and sustaining resource mobilisation activities in their villages and districts
- The amount of locally mobilised financial and material resources for CHBC activities.

7.4 RESEARCH

Some suggested areas for operational research include

- Qualitative studies on the impact of resources provided by family and community groups.
- Assessment of the dependency ratio resulting from HIV/AIDS/TB.
- Assessment of recourse needs of elderly and young care providers giving care to HIV/AIDS/TB clients at household level.
- Nutritional needs of HIV/AIDS/TB patients in long term care

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CHAPTER 8

STRENGTHENING MULTI SECTORAL COLLABORATION FOR THE IMPLEMENTATION OF INTEGRATED HIV/AIDS/TB CHBC SERVICES

All age groups and sexes in the community have a vital role to play in strengthening HIV/AIDS and TB activities.

Source: Community Home Based Care Unit Photo Files. WHO/AFRO HIV/AIDS

8.1 INTRODUCTION

HIV/AIDS and TB are no longer considered as merely being health issues, but as broader phenomena, which have developmental implications. In strengthening CHBC programmes, it is important to form linkages with different partners including those working outside the health sector. Lessons learned from countries that have developed multisectoral interventions have shown that collaboration is the most efficient way to foster the integration of comprehensive services (e.g. diagnosis, treatment, prevention, psychosocial counselling and care) at all levels. Establishing a multisectoral and multidisciplinary response to the HIV/AIDS/TB epidemics harmonises the approaches, mobilises resources and ensures effectiveness. This creates a spirit of ownership for CHBC among various service providers, families and communities; and helps to broaden provision of care for HIV/AIDS/TB clients.

In strengthening multisectoral collaboration for integrated HIV/AIDS/TB activities, certain key areas need to be considered by planners and implementers. These broadly include:

- Identifying resource needs for planning, implementation and monitoring of integrated CHBC for people with HIV/AIDS/TB and other HIV/AIDS related conditions.

- Establishing active participation of all groups in the planning and implementation of CHBC services in order to maximise programme effectiveness by:

    - Networking with government, non-governmental and other partner agencies, health worker groups and caregivers in providing CHBC services to individuals and families.
    - Mobilising different types of resources from partners and stakeholders to ensure provision of an essential care package for HIV/AIDS/TB within the continuum of care.

8.2 PROPOSED BROAD ACTIVITIES

8.2.1 Determination of the potential of different agencies and groups for contribution towards the provision of comprehensive CHBC.

- Maintain a register/directory of all relevant agencies and NGOs involved in and/or with the potential for supporting different types of CHBC activities at all levels.
- Assess the scope of interest, technical competence and resources that each group has to offer.
- Conduct regular CHBC joint planning and implementation with various partners involving NACP, NTP and CHBC focal persons and carry out joint monitoring and supervision visits.

8.2.2 Development of joint measures for inter-agency and inter-organisational resource mobilisation and other joint activities to facilitate coherence of efforts and appropriate use of resources.

- Promote collaborative planning for the implementation, monitoring, supervision and evaluation of CHBC activities at different levels.
- Establish referral networks for clients within their local areas and other levels taking into consideration the role, function, and types of support available in a particular agency.
- Familiarise collaborating groups with different HIV/AIDS/TB CHBC structures and guidelines available and promote their use during programme implementation.
- Conduct regular in-service training for stakeholders in HIV/AIDS/TB and CHBC as necessary.

8.2.3 Establishment of focal points/persons for CHBC in each agency and group to facilitate efficient communication and networking in the areas of operation.

- Increase the human resource base by identifying and addressing the training needs of NGOs and agencies at all levels.
- Develop capacity of groups for the planning and provision of CHBC and mobilise the support of community leaders

8.3 MONITOR AND EVALUATE MULTI-SECTORAL COLLABORATION ACTIVITIES

Aim at establishing a formal recording and reporting system that will produce periodic reports on the progress of activities, achievements, constraints and future plans for different agencies. Activities include:

- Reviewing activities carried out in the homes, i.e. client monitoring, home visits.
- Following-up on caregivers affiliated to different partners and health workers trained in CHBC to assess the standard of care provided to clients with HIV/AIDS and their families.

- Conducting interviews with affected families and community groups receiving care and support from the collaborating groups to determine the extent to which services, information and support have been offered.

8.3.1 Monitoring indicators for multi-sectoral collaboration

- Number of regular joint planning meetings held.
- Number of joint supervision and monitoring visits undertaken at the local, district or provincial/regional levels.
- Number of multi-agency CHBC plans developed for providing care, and other forms of social support.

8.4 RESEARCH

Proposed areas for research include:

- Assessment of training needs in specific agencies
- Assessment of the cost-effectiveness and cost implication of collaboration.
- Effectiveness of collaboration in raising resources for the implementation of integrated HIV/AIDS/TB activities

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CHAPTER 9

STRENGTHENING HUMAN RESOURCE DEVELOPMENT FOR THE IMPLEMENTATION OF INTEGRATED HIV/AIDS/TB CHBC SERVICES

All age groups and sexes in the community have a vital role to play in strengthening HIV/AIDS and TB activities.

Source: Community Home Based Care Unit Photo Files. WHO/AFRO HIV/AIDS

9.1 INTRODUCTION

Experience has shown that the implementation of effective CHBC programmes for HIV/AIDS/TB requires the continuous strengthening of the human resource base at all levels. This includes the introduction of integrated HIV/AIDS/TB content into the basic and in-service training curricula of a broad range of health and related service providers, including those at community level. In order to establish integrated training programmes on HIV/AIDS/TB care, planners and implementers must consider identifying:

- Different potential service providers, namely health, social and community service workers, family members, other caregivers and interested community groups.
- Training needs of the different service providers in HIV/AIDS/TB and CHBC.
- Trainers of trainers at all levels and in all sectors to provide human resources for cascade training.
- In-service and continuing education needs of trainers and providers, and provide guidance on key steps to planning CHBC training programmes.

9.2 PROPOSED BROAD ACTIVITIES

9.2.1 Strengthening of the existing HIV/AIDS/TB programmes in clinical and CHBC aspects.

- Identify specific persons to be involved in the implementation of activities.
- Collaborate with other active and relevant programmes, agencies and groups to start the training programme.
- Plan for resources needed for scaling-up activities keeping in-line with the policy guidelines for planning training programmes for CHBC professional health care workers and the HBC providers.
- Assess the learning needs of different categories of people regarding HIV/AIDS/TB and CHBC. Specific attention must be given to the training needs of the HBC providers using a Care Kit with medicines and essential nursing care items.
- Integrate CHBC pre-service and in-service training on HIV/AIDS/TB into training programmes in collaboration with training institutions. Emphasis on improving clinical management for early detection of TB in the PLWHA and referral for treatment. (Annex 4).
- Train HIV/AIDS/TB caregivers in CHBC programmes to develop skills in providing comprehensive/ holistic care, support and counselling to the infected people and their affected families

9.2.2 Promotion and support of increased collaboration and coordination in all training programmes for different cadres of health and other care personnel.

- Establishment of a team for planning HRD training programmes together with partners, implementers and supervisors.
- Improvement of health care structures for delivering healthcare services at health centres and HBC services.

- Formation of task forces for integration of HIV/AIDS/TB into the curricula of different disciplines and support of the necessary changes.
- Plan and implement in-service and pre-service education programmes in clinical and community integrated care for the persons infected with HIV/AIDS/TB.
- Conduct education and training programmes for various levels of health and other care workers and community groups
- Mobilisation of multisectoral educators particularly in medical, nursing, environmental health, pharmacy, rehabilitation, traditional medicine, and social work to support integrating CHBC for HIV/AIDS/TB in curricula of the basic and post-basic programmes.
- Promotion of networking activities within the existing training programmes particularly for health, traditional medicine, social work, women and youth development to facilitate the integration of HIV/AIDS/TB CHBC content into PHC and other social developmental activities.

9.2.3 Review the current situation

- The numbers to be trained. Consider:
  - The magnitude of the problem
  - The medical condition of the patient with HIV/AIDS/TB

- The geographical coverage of health care facilities in relation to homes of the patients.
- Funding available to conduct the training required to satisfactorily acquire the skill needed to provide CHBC to the HIV/AIDS /TB patient using the Kit of medicines and other nursing care items.

9.2.4 Harmonisation/Review of the training curriculum

- Review and list functions and tasks by level and by professional category.
- Develop and revise the job descriptions for all providers of care so as to ensure that the training corresponds with the needs of the community, and the national policy guidelines.
- Ensure that the training curriculum is made up of theory and practice sessions. The theory should be taught in the language that is understood by the provider. The practical sessions should be done in the clinical area as well as visits to the health post and the Home of a sick person. Family counselling sessions should be built in to the practical sessions, which will be observed by the facilitator.
- Convene a workshop to extract the relevant content from existing HIV/IDS/TB training materials. Develop a package of training materials and teaching aides on comprehensive management of both diseases HIV/AIDS/TB.
- The facilitators should allocate time in the programme to work with the trainee alone and in pairs depending on the skills being taught.

- A minimum of 15 participants and a maximum of 20 participants are recommended as acceptable for each trainer of trainers training session. The same number of participants is recommended for CHBC providers /volunteers training. The maximum number is acceptable depending on the level of education of the participants.
- Plan for a period of 10 days for the supervisors, trainers and home-care providers' training. A three-week training programme for the professional who will be providing medical back-up services to the HBC provider is highly recommended.
- Prepare a rollout /medium-term training plan for future in-service and continuing education training workshops. The training materials, budget and timeframe must be developed and agreed upon before funds are requested and allocated.
- Prepare a monitoring and supervision plan.

9.3 MONITORING AND EVALUATION OF HUMAN RESOURCE DEVELOPMENT ACTIVITIES

- Agree on the roles and responsibilities of each partner, service provider, training institution, supervisor and manager.
- Develop a monitoring plan with those designated to supervise the implementation of training and other services.
- Supervisory plan to observe training activities at all levels, especially the competencies of the newly trained personnel.
- Plan to periodically review records, reports, lesson plans and course materials for updating the content.
- Follow-up care providers after training. Conduct self-assessment and performance appraisals in the operational areas.
- Plan site visits with teams from AIDS and TB training institutions. Plan to conduct monitoring visits with the supervisors responsible for observing practices. (It helps to reinforce good practices and agree on standards.)

9.3.1 Monitoring indicators

- Number of trainers trained at the various levels on HIV/AIDS/TB CHBC.
- Number of health workers, social workers and other groups trained in aspects of CHBC at different levels.
- Number of trained persons providing the standard CHBC care using the Kit on clients with HIV/AIDS/TB.
- Number of in-service education programmes implemented for improving the skills of health workers, social workers and family caregivers using the Kit in the provision of integrated CHBC.
- Number of training programmes into which HIV/AIDS/TB CHBC content has been integrated.
- Quality of CHBC provided by those trained.
- Number of reports submitted of joint monitoring visits within the agreed timeframe.

9.4 RESEARCH

Some suggested areas of research include:

- Existing competencies and profile of practice and caring skills in homes and at community health centres.
- KABP studies to explore training needs of trained workers in HIV/AIDS/TB and CHBC in integrated services.
- The relevance and effectiveness of integrating CHBC content into basic programmes in medical and nursing schools and other related programmes.

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ANNEX 1: Needs assessment tool on the situation of CHBC for HIV/AIDS and TB Programmes.

Data collection on the current situation and trends of the disease. The information is important for developing an effective response to any problem. An in-depth understanding of the different issues that surround the development of the programme is essential for planning, implementing and monitoring national programmes. These include:

a) Magnitude of the problem in the Community

- Determine: The presence of chronically ill patients in the community.
- The impact of HIV/AIDS and TB in that community and the need for CHBC
- Who is affected, where they are, where they seek care and what the referral systems are.
- What the other aggravating circumstances are – e.g. poverty, inadequate knowledge and attitudes towards HIV/AIDS TB and CHBC.

b) The client

- **Assess types of needs** – physical, psychological, socio-economic and spiritual needs of a patient living with HIV/AIDS/TB. This includes defining the physical, mental and spiritual needs for care and support. Obtain information on ongoing treatments. e.g. TB, ARVs

c) The family:

Assess:

- The Information and education needs of the family regarding patient management and the provision of HIV/AIDS and TB CHBC.
- Presence of caregivers and their ages.
- Attitudes towards home based care.
- Willingness of the family to accept outsiders for the provision of home based care.
- Availability of resources for nursing care and the accessibility of back-up support systems to provide more advanced treatment as required.
- Availability of supplies for infection control and other services, especially clinical care.
- Availability of medicines for symptom control, including pain relief.

d) The Community

Assess:-

- Training required for the community groups in patient management and referral.
- The social and cultural environment, support systems of the community, social and cultural problems within families related to HIV/AIDS and TB e.g. stigma, isolation, violence and abuse occurring in the home.

- The levels of community involvement and participation in the care and support of the infected and the affected.
- Community's perceptions of HIV and AIDS and other chronic and terminal illnesses.
- Knowledge about CHBC
- Attitudes of the community towards CHBC in its broad perspective.
- Possibility of the community leaders and youths to form support groups and other social support and care initiatives.
- The training needs of the Community.
- Cultural and traditional beliefs in the community, which are likely to compromise the quality of care.

The above information will assist the country in developing a strategic plan focused on community needs.

ANNEX II: CHECK LIST FOR IMPLEMENTATION OF INTEGRATED HIV/AIDS/TB COMMUNITY AND HOME BASED CARE JOINT ACTIVITIES

A checklist is instrumental in obtaining information in areas of joint collaboration between partners, organisations and programmes such as TB and HIV/AIDS. The results help to identify the requirements for developing collaborative activities.

PREPARATORY PHASE

1. Formation of Task Forces at different levels
   - Inter-sectoral
   - Interagency working groups
   - Community groups

2. Review and revise:

2.1 Policies, guidelines, systems and any existing reports (e.g. lessons learned from model projects as necessary). Key areas to review:

- DOTS management and HIV/AIDS management, in general, for improving access to TB and HIV care
  - Restructuring of diagnostic services.
  - Microscopic network
  - Supervision and
  - Reference laboratory.
- Surveillance of TB
- Surveillance of HIV
  - Case finding e.g. HIV testing and TB screening
  - Case management: Treatment of TB and HIV
  - Medicines and supplies
- Communication, community education and strategy.

2.2 Existing referral and support networks for service delivery.

2.3 Staffing situation of different cadres and at different levels.

2.4 Assess:
- Service delivery
- Availability of essential equipment and supplies- medicines for management of opportunistic infections including TB, case management of the adult and children both under and over five years old.
- Availability of existing referral and support networks for service delivery.
- Nutrition counselling.
- Communication strategy for health workers, policy makers and communities.
- Family planning services.
- Educational needs.

3. Sensitisation of policy-makers for consensus on the programme

   - Provide technical guidance to medical personnel, community leaders, programme managers, government, international partners and the private sector

IMPLEMENTATION PHASE

1. Develop a: Care supply list
   Ordering schedule
   Delivery plan
   Monitoring system

2. **Establish or strengthen the existing model project e.g. pilot project on TB preventive therapy and cotrimoxazole prophylactic therapy.**

   - **Operational level.**
     - Use the existing health systems and community networks for decision-making during the implementation of the programme.
     - Ensure that there is availability of a referral and follow-up network.

- **Management Decisions**
  - made at operational level should be adapted.
  - Policy guidelines developed
  - Resource allocation made

3. Detailed budgeting and planning with timeframes
4. Develop a human resources plan
   - Pre-service, In-service and continuing education plan.
   - Cadres to be trained
   - Materials to be adapted or developed
5. Develop a supply plan
6. Quantify needs
7. Develop ordering schedule
8. Develop delivery plan
9. Develop a monitoring system

MONITORING AND SUPERVISION PHASE

Monitoring and Supervision

- Identify a coordinator/focal person responsible for example:
  - Monitoring programme and service delivery
  - Reporting
  - Holding regular meetings with service providers and trainers
  - Reordering of CHBC Kits
  - Obtaining financial support

SITE SELECTION

1. Criteria for site selection for phased implementation of integrated services
   - HIV prevalence
   - TB prevalence
   - Case load: Health status of clients e.g. HIV status known, symptomatic with HIV/AIDS related conditions and or with HIV/AIDS and TB.
   - Quality of existing TB and HIV services
   - Availability of counselling facilities

2. **Criteria for receiving additional support for scaling up of integrated HIV/AIDS TB projects.**
   - Evidence of:
     - Systematic implementation of service provision
     - Existence of model projects from which lessons have been learned

Planning:
Plans reflecting objectives, targets, indicators, timeframe and responsible persons.

Implementation:
- Reports reflecting: level of achievement of targets (planned versus accomplished)
- Financial reports – against budgeted activities.

Monitoring:
Reports of analysed information from the monitoring tools – Care Provider, Patient, Management and the Supervisors' Reporting Form.
Reports on pattern of use of different kit items

- Capacity to cope with additional responsibilities
  - Trained personnel
  - Coordinator(s) / and supervisors for CHBC activities
  - Established trained volunteers
  - Availability of support services

- Need for expansion
  - Documented increase in patient load and/or demand for CHBC services

ANNEX III: LABORATORY DIAGNOSIS OF HIV

The Diagnosis of HIV infection is usually made on the basis of the detection of antibodies to HIV.

Serological Tests for HIV are grouped into:

a) Screening Tests (Initial Tests)
b) Confirmatory Tests (Supplemental Tests)

The most commonly used screening tests are the ELISAs
ELISAs are the most appropriate for testing large numbers of samples per day, require skilled technical staff, equipment maintenance and a steady power supply, and are the most suitable for larger hospitals.

The latest ELISAs – so-called 3rd generation or sandwich ELISAs - are extremely sensitive and have reduced the window period considerably.

Rapid/simple tests do not require special equipment or highly trained staff. However the trained staff member must follow the professional legislation and code of practice. Rapid/simple tests are appropriate for use in small laboratories which process low numbers of specimens daily, and for emergency testing.

Confirmatory tests are usually used in national reference laboratories. Confirmatory tests are generally expensive.

Studies have shown that combinations of ELISAs or simple/rapid tests can provide results as reliable as confirmatory tests at a much lower cost. It is thus recommended that countries adopt testing strategies that use simple/rapid ELISAs and tests rather than ELISA/Western Blot for HIV antibody detection.

Objectives of HIV Testing

- To ensure the safety of blood for transfusion or organ/tissue transplant
- To conduct surveillance
- To diagnose HIV infection

UNAIDS and WHO recommend three testing strategies to maximise accuracy while minimising cost. The most appropriate strategy will depend on the reason for the test and the prevalence of HIV in the population.

Rapid/Simple assays

Simple, instrument-free assays are also available and are now widely used in Africa. They include agglutination, immunofiltration (flow through tests), immunochromatographic (lateral flow tests), and dipstick assays. The appearance of coloured dot or line, or an agglutination pattern indicates a positive result. Most of these tests, such as agglutination assays, are less rapid because they require about 30 minutes to 2 hours to be completed. In general, these tests are most suitable for use in laboratories that have limited facilities and process low numbers of specimens.

Importance of rapid/simple assays

Although ELISA-based serodiagnostic algorithms are highly cost effective, their application in resource-poor settings is limited by several factors. They require well-trained personnel, need a constant supply of electricity, and maintenance of equipment. Rapid assays have high sensitivity and specificity and perform as well as ELISAs on specimens from persons seroconverting for non-B HIV-1 subtypes [8]. Rapid enzyme immunoassays (EIAs) circumvent the issue of low rates of return for serologic results associated with ELISA-based testing algorithms because results can be delivered on the same day. In addition, their performance have improved considerably, and some do not require reconstitution of reagents and refrigeration; thus, making them very suitable for use in resource limiting settings. Studies have shown that using rapid EIA testing algorithms result in remarkable increase in the number of women identified as HIV-positive eligible to receive the short-course zidovudine that reduces mother-infant transmission of HIV [9].

Algorithms based on rapid assays could be very useful for voluntary testing and counselling (VCT) in rural areas; indeed, recent studies have demonstrated the usefulness of VCT using ELISAs in preventing HIV transmission in other less developed countries. Currently, rapid assays are playing a critical role in public health in Africa because the low rates of return for serologic results associated with HIV ELISA-testing can severely affect HIV prevention efforts in developing countries.

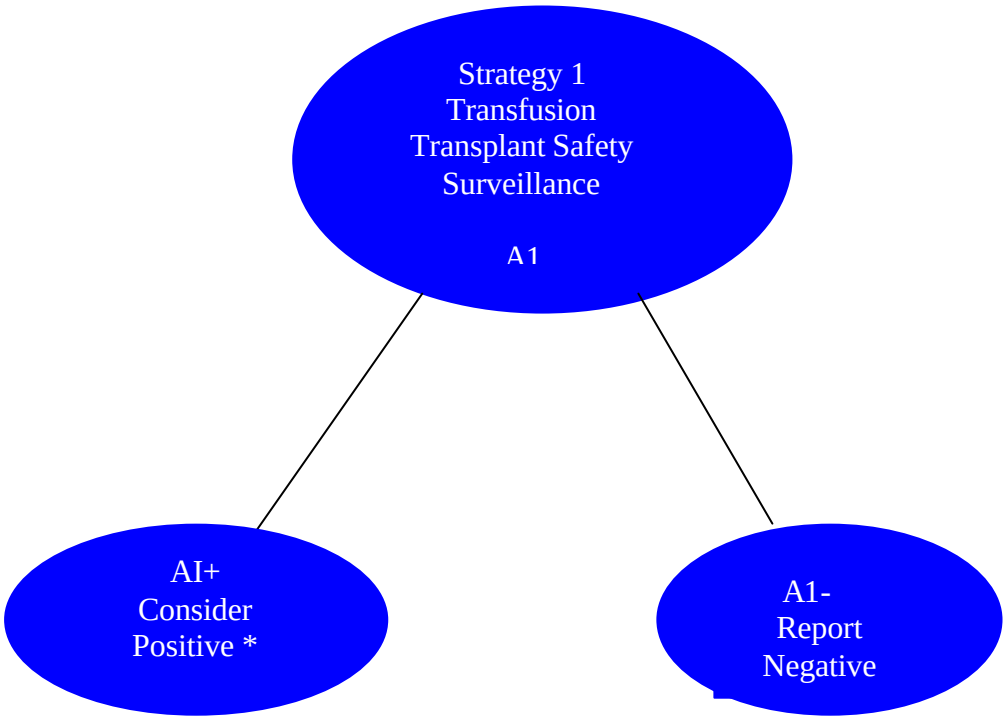
UNAIDS and WHO Recommendations for HIV Testing Strategies:

Objective of Testing	HIV Prevalence	Testing Strategy
Transfusion/Transplant	All Prevalences	I
Surveillance	>10%	I
	<10%	II
Diagnosis of symptoms of HIV	>30%	I
	<30%	II
Asymptomatic	>10%	II
	<10%	III

Strategies for HIV testing

Strategy I

Serum/plasma is tested with one ELISA or rapid/simple assay. Serum that is reactive is considered antibody positive.

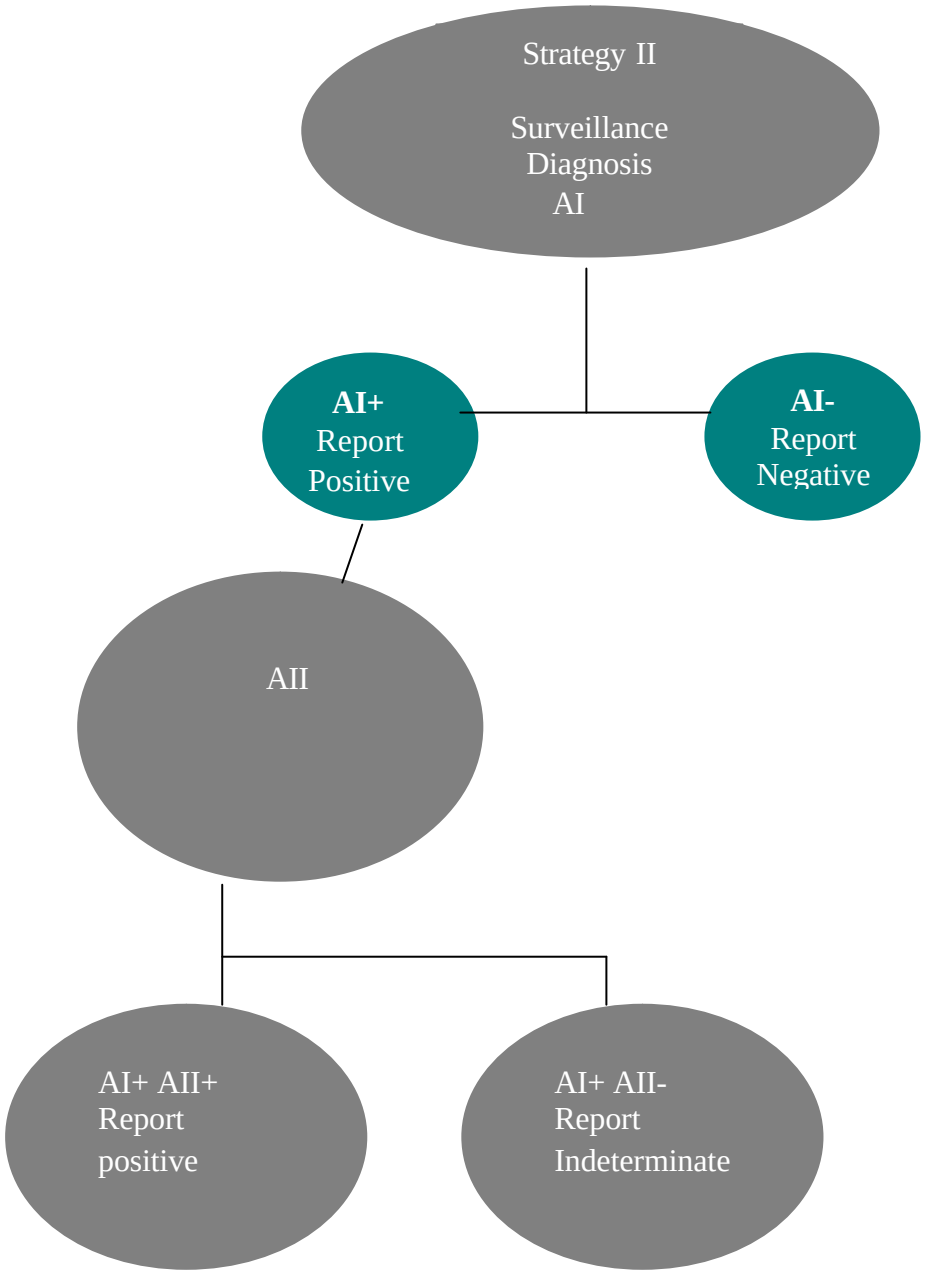


*Such a result is not adequate for diagnostic purposes;

Whatever the final diagnosis, donations which were initially reactive should not be used for transfusion or transplants.

Strategy II

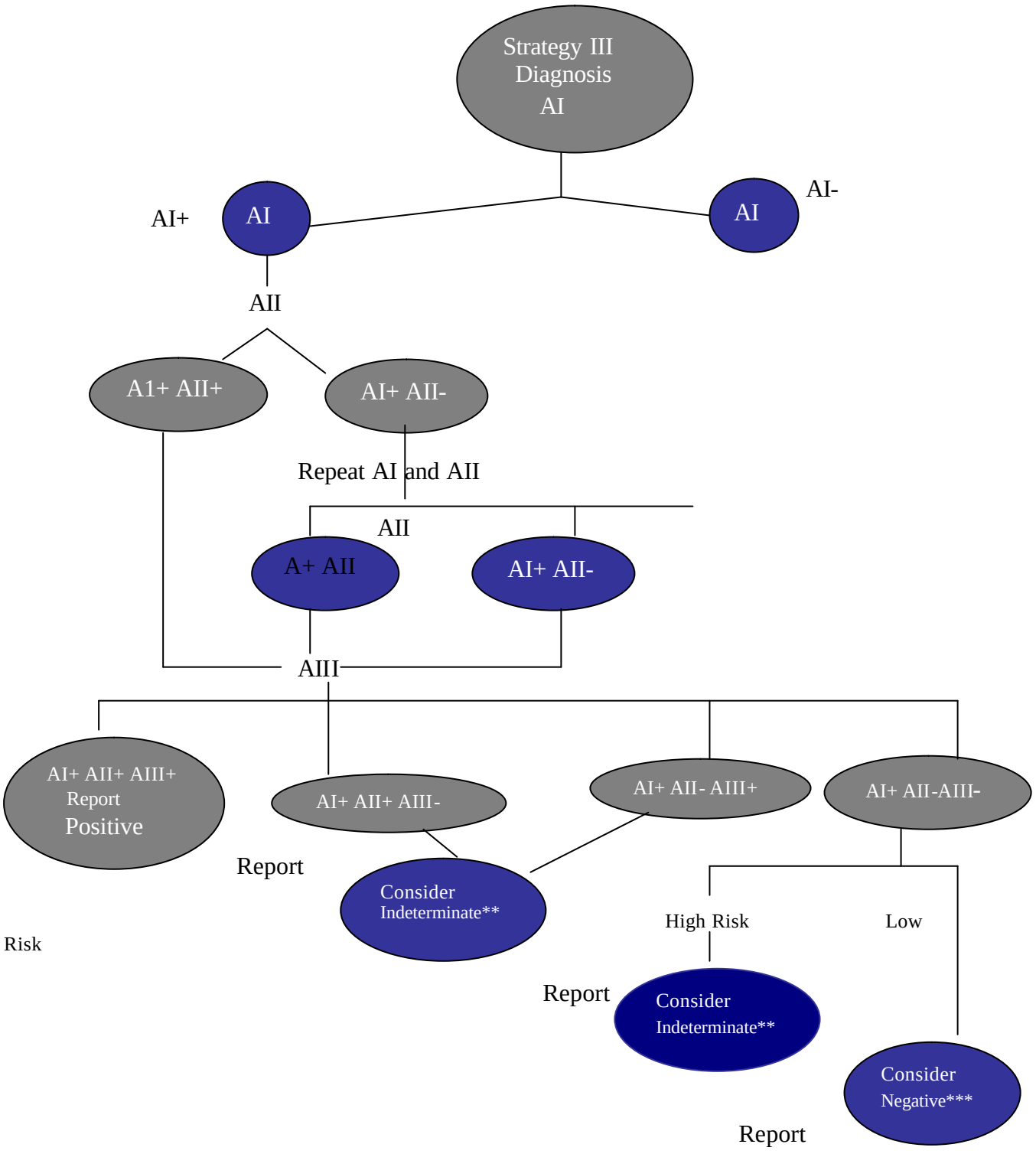
- The serum/plasma is first tested with one ELISA or rapid/simple assay
- Any serum found reactive on the first assay is re-tested with a second ELISA or rapid/simple assay based on a different antigen preparation and/or different test principle.
- Serum that is reactive on both tests is considered HIV antibody positive.
- Serum that is non-reactive on the first test is considered HIV antibody negative.
- Any serum that is reactive on the first test but non-reactive on the second test should be re-tested with the two assays.
- Concordance results after repeat testing will indicate a positive or negative result.
- If the results of the two assays remain discordant the serum is considered indeterminate.



For newly diagnosed individuals, a positive result should be confirmed on a second sample.
**Testing should be repeated on a second sample taken after 14 days

Strategy III

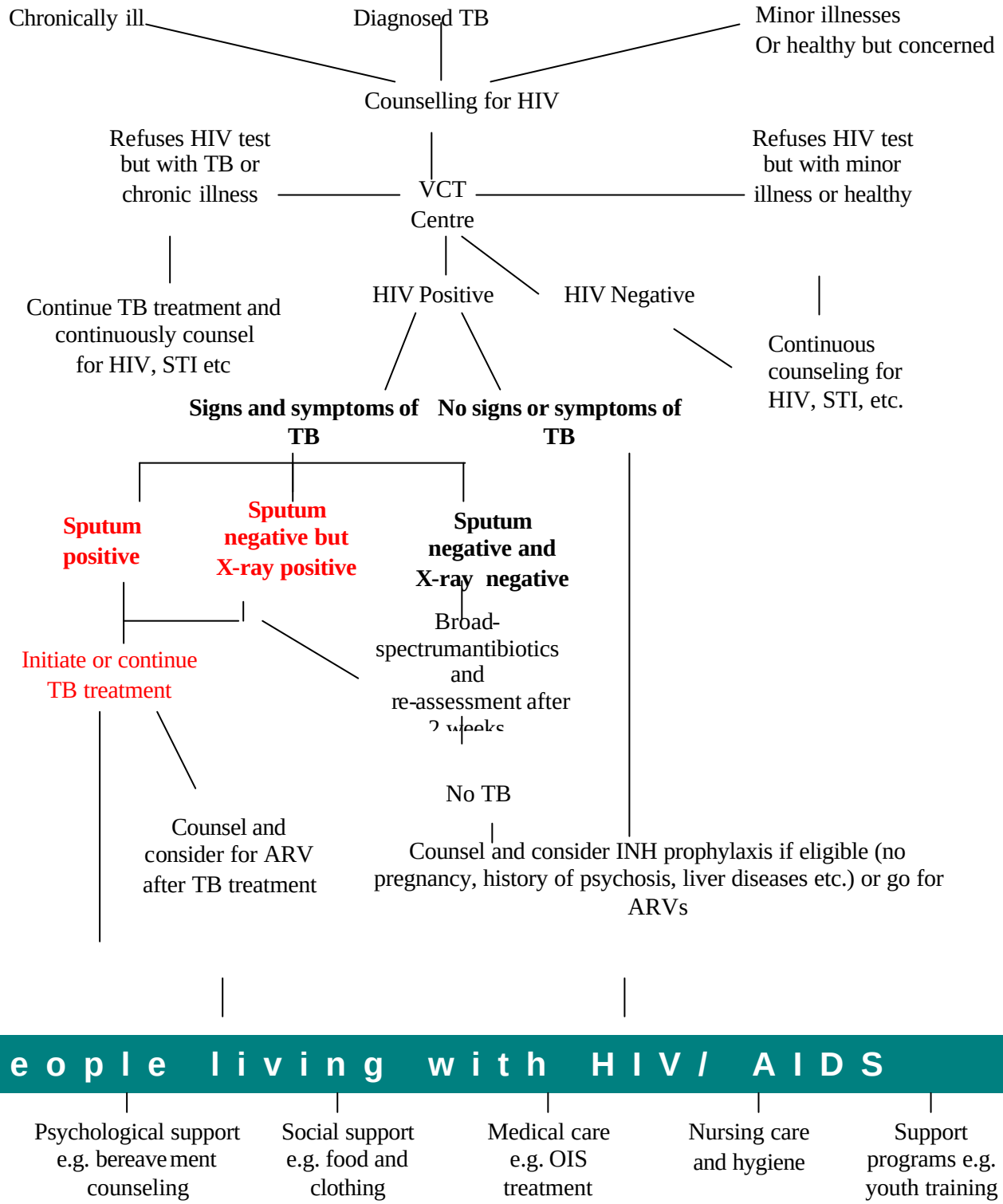
- As in strategy II, the serum is first tested with one ELISA or simple/rapid assay, and any reactive samples are re-tested using a different assay.
- Serum that is non-reactive on the first test is considered HIV antibody negative.
- Serum that is reactive in the first test but non-reactive in the second assay should be repeated with both tests.
- Strategy III, however, requires a third test if serum is found reactive on the second assay, or is reactive on the repeated first assay. The three tests in this strategy should be on different antigen preparations and/or different test principles.
- Serum reactive on all three tests is considered HIV antibody positive.
- Serum that remains discordant in the second assay, or is reactive in the first and second tests but non-reactive in the third test, is considered to be indeterminate.
- Serum that is reactive on the first assay and non-reactive on the second and third assays is considered indeterminate for individuals who may have been exposed to HIV in the last three months and negative for those who have not been exposed to any risk for HIV infection.



- For newly diagnosed individuals, a positive result should be confirmed on a second sample.
- Testing should be repeated on a second sample taken after 14 days in the absence of any risk of HIV infection.

ANNEX IV: CLINICAL ALGORITHM FOR MANAGEMENT OF TB IN PLWHAS

Community Education and Counselling Programme



ANNEX V: PROPOSED HIV/AIDS INTEGRATED TRAINING CURRICULUM

Course plan for home-based care givers

Summary of units for training curriculum

UNIT	CONTENT	THEORY HOURS	CLINICAL HOURS
1	• Introduction to home based care concept - Descriptive definition of HBC - Basic needs of patient living with HIV/AIDS or other chronically ill patients. - Scope and Roles of an HBC provider - Community sensitisation for HBC support (initiating and sustaining)	4	-
2	• Principles of HBC and the caring model - The caring model - Providing basic nursing care to patients - The referral system - The discharge planning process	10	20
3	• Basic facts about HIV/AIDS - HIV infection and AIDS transmission, prevention and medication	3	-
4	• *Provision of HBC for the most common conditions seen in persons living with HIV/AIDS and other chronic illnesses* - *STI* • *Sexually Transmitted Infections* - *Common sexually transmitted diseases* - *Transmission, incidence, treatment and prevention* - *Implications of untreated STDs* • *Tuberculosis* - *Epidemiology* • *Recognition* • *Transmission* • *Prevention* - *Signs and symptoms* - *Diagnosis for TB and HIV/AIDS* - *Management of the dual infection* • *AIDS related Symptoms* - *Symptoms of HIV infection: cough, diarrhoea, vomiting, respiratory problems, skin complaints, joint pain etc.* • *Nursing care* - *Symptomatic management of wounds, respiratory problems, vomiting and diarrhoea, skin complaints, pain*	10 3 3 3 3 3	20

	etc. the care of a debilitated patient • *Medications* - *Recognising and advising prescribed medication* - *Traditional medication* • Holistic care - Holistic care of patient and family. Support of Voluntary Health Care Workers. Pain management, medication and counselling for adherence ***(This section is integrated into all modules)***		
5	• Nutrition - The concept of nutrition. locally available nutritious foods - Cooking, preserving, boiling storing. Breast feeding and preparation of substitute foods • Malnutrition and Disease - Recognition of Malnutrition - Diseases associated with malnutrition management of malnutrition • Pregnancy - Ante natal care. Nutrition in pregnancy. Postnatal care. Home delivery. • Family Planning - Child spacing. Available contraception. Access to contraceptive advice • Child care - Recognition, childhood developmental steps. Breast feeding, nutrition and weaning. Under 5's clinic. - Growth charts - Hygiene • Childhood disease - Recognising and treatment of symptoms of: • Childhood disease • Immunisation programme • Sexuality - Sexuality, sex and marriage - Customs and local beliefs • Community Support of Survivors and Future Developments - Care for widows and orphans. Community response to death in a family. Legal issues, setting up income generating groups, support groups, community education. • Introduction to Supportive Counselling	3 3 3 3 3 3 3 3	8

	- Basic pre-test, and post-test support and counselling. Confidentiality and non-judgmental issues • Support. Family counselling, counselling for referral to HIV testing services, follow-up supportive counselling	4	
	• Using HBC monitoring forms integrated into Health Management Information system	4	3
	• Field practice - Feedback, revision and evaluation - Post-course assessment, future plans and support		
	TOTAL (approximate)	**??**	**??**

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ANNEX VI: TRAINING OUTLINE FOR HEALTH CARE WORKERS ON HIV/AIDS & TB

Topics to be covered

1. HIV Epidemiology:
   - 1.1 What is HIV?
   - 1.2 What is AIDS?
   - 1.3 How is HIV diagnosed?
   - 1.4 How is AIDS diagnosed?
   - 1.5 What are HIV/AIDS opportunistic infections?
   - 1.6 How does childhood HIV/AIDS differ from adult HIV/AIDS?

2. TB Epidemiology:
   - 2.1 What is TB?
   - 2.2 How does TB spread?
   - 2.3 How is TB diagnosed?
   - 2.4 How is TB managed?
   - 2.5 How does childhood TB differ from adult TB?

3. TB HIV Epidemiology:
   - 3.1 HIV/TB interactions
   - 3.2 Presentation of HIV/AIDS related Tuberculosis
   - 3.3 Interventions to control HIV/AIDS
   - 3.4 Interventions to control TB

4. Interventions to control combined TB & HIV/AIDS epidemics
   - 4.1 Interventions directly against Tuberculosis: TB case finding and cure; TB Preventive therapy, immunizations
   - 4.2 Transmission, interventions against other HIV-related morbidity and mortality among TB patients
   - 4.3 Home and community care of HIV/AIDS and TB patients

5. Monitoring and evaluation:
   - 5.1 Basic TB control indicators: Case finding and treatment outcome indicators
   - 5.2 Basic HIV/AIDS prevention, care and support indicators
   - 5.3 Process and impact indicators for collaborative TB/HIV/AIDS activities

REFERENCE:

WHO Regional Office for Africa, Guidelines for Clinical Management of HIV Infection and HIV-Related Illnesses, 2003.

Nigeria, Training Guidelines for Tuberculosis Programme, Supervision, Monitoring and Evaluation, Federal Ministry of Health, Department of Public Health, 2000.

ANNEX VII: THE WHO/AFRO RECOMMENDED MONITORING TOOL FOR CHBC MANAGEMENT AND SERVICE DELIVERY

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

COMMUNITY HOME BASED CARE MONITORING TOOL

Quarterly Reporting Form

"Supervisor"

REGIONAL PROGRAMME ON HIV/AIDS

INSTRUCTIONS

The supervisor, who is also the trainer of the HCG should be responsible for supervising the care-giver. Supervisors need to complete the required Quarterly Report Form for supervisors. The form has four sections**: I) General Information Section, II) Inventory of Medicines and Supplies Section, III) Partnerships at community level and ; IV) Constraints and Recommendations**

How to complete:

General Information Section

Using information from the HCG patient monitoring form, complete this section. The HCG will submit this form at the end of every quarter or whenever her stocks are low. There will be one form for each patient assisted by the HCG. Consequently, information entered will be the total of all information recorded by all HCG.

Inventory of Medicines and supplies section

This section is filled at the end of every quarter, using the aggregate of information provider by HCGs on all HBC clients seen during the quarter. It is submitted with the "patient management" section at all times. Due to the conditions and needs of some clients, the HCG ***may*** need additional materials within the quarter. Whenever this is the case, he/she is allowed to submit only the "Utilization of Kit Items" Section of his/her form when requesting for replenishment. In countries where separation of the "Utilization of Kit Items" section from the overall form is not feasible due to the design of the form, a supplementary slip may be given.

Partnerships at Community Level Section

Information required for completing this section is obtained through interviews with the clinic staff, CHBC teams, committees at community level, the NGOs, FBOs or CBOs providing services. Interviews are held during the supervisor's visit to the community.

Constraints and recommendations Section

Information about constraints is obtained from the HCG's form. The supervisor makes recommendations based on her overall observations and analysis of care provided by all HCGs, families, communities and partners.

COMMUNITY HOME BASED CARE PROGRAMME

Supervisor's Quarterly Report Form

General Information

Name of District: Reporting period:	---------- Month: ---------- to ----------
Name of Community: Population:	_____
Number of trained volunteers in the community: Number reporting this quarter:	( ) ( )
No. of Patients assisted by HCG this quarter:	
Number of families benefiting from CHBC services this quarter:	
Number of deaths from long-term illness this quarter:	
Number of patients referred to HCGs this quarter:	
Number referred by HCG this quarter:	

COMMUNITY HOME BASED CARE PROGRAMME

Inventory of medicines and supplies

QUARTER: _____

Instructions: **Have a separate ledger for recording all medicines supplied to CHBC giver. ARV prophylaxis and HAART will be recorded as or if recommended by national authorities.**		
MEDICINES/SUPPLIES	**QUANTITY**	**COMMENTS**
Metronidazole Oral Suspension		
Acetylsalicylic acid Tablet	.	
Paracetamol Tablet		
Paracetamol Syrup		
Cotrimoxazole Tablets		
Cotrimoxazole Suspension		
Cloxacillin Capsules		
Cloxacillin Syrup		
Amoxacillin Capsules		
Amoxacillin Granules		
Ketoconazole ointment		
Nystatin Ointment		
Nystatin Suspension		
Recommended TB medication		
ARV Prophylaxis		
HAART		
Vitamin A Capsules		
Vitamin B Complex Tablets		
Ferrous sulfate + Folic Acid Tablets		
Gentian Violet		
Anti-malarial chloroquine		
Disposable gloves		
Calamine Lotion		
Oral rehydration sachets		
Condom male		
Condoms female		
Disposable towels		
Draw Sheets		
Mackintosh		
Cotton Wool		
Gauze Swabs		
Bandages (crepe 75 mm roll+100mm roll)		
Others:		

NOTE: Professional health workers will be advised by the clinical team on the monitoring and supervision of patients on Anti-retroviral treatment (ART) to ensure that there is adherence to the medication regime.

Partnerships at community

Number of working hours provided by the HCG this quarter: ( )

Number of NGOs supporting CHBC in the district this quarter: ( )

What types of services did they provide?

You may take as many options as necessary.

( ) Food supplements

( ) Food rations

( ) Kit Items for replenishments

( ) Money for school fees

Other; Specify: _____

Constraints and Recommendations

What were the constraints to Home-based Care (HBC) activities this quarter?

( ) Transport difficulties
( ) Stock-out of medicines
( ) Inadequate support from supervisors
( ) Inadequate support from community

Recommendations

_____

_____

_____

_____

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

COMMUNITY HOME BASED CARE

MONITORING TOOL ON PATIENT MANAGEMENT

Quarterly Reporting Form

"COMMUNITY HOME-CARE GIVERS"

REGIONAL PROGRAMME ON AIDS

INSTRUCTION FOR RECORDING PATIENT'S CONDITION

This generic form has been made simple to help Home Care Givers (HCG) monitor the improvement in the clients' health condition and report to their supervisors every quarter. The form will be kept in the home by the patient or family members. The caregiver will ONLY have to TICK the correct response. There are only few places on the form where a little bit of writing is required. The HCG may request assistance from literate family members as needed.

1) On the first and follow up visits to the patient's home, the HCG will complete the first part of this form which is called **"General Information"**. If she is illiterate, family members or anyone recommended by the family may record the information on the General Information Section of the form. Following this step, the HCG will assess the patient and fill in the column titled **"First visit"** by ticking the correct response. The HCG will submit the form to her/his supervisor at the end of every quarter or within a time decided by the district health system. The form provided in this Tool covers a period of 10 weeks. Countries may modify the form to reflect weekly or bi-monthly visits.

2) The HCG will provide services in line with her/his training and terms of reference as stipulated in the National Policy. Training programmes must build the capacity of HCG to competently fill out the form.

3) There is a section for recording medicines and supplies dispensed by the HCG to her patient. This should be done during each visit. Tick **"Y"** if the medicine was given or the supplied used/issued. Write in the amount used or issued in the column where **"Q"** is indicated. The HCG **MUST** provide correct education on use of the medicines or supplies if medicines or supplies are left with family members for the patient's use. It is important to acknowledge the family hierarchy for decision making on any care issues.

4) Counseling must be ***provided*** to the patient and family members on each visit. To ensure that adequate time is available for counseling, the HCG must make appointments with family members and patient.

5) The HCG must refer patients needing special care. Whenever referral is made, the HCG must record the referral in the "**INV**" column of the "patient management form" by writing **"R".** The supervisor must be notified as soon as possible. It is recommended that countries develop a referral card utilizing the ongoing referral system.

General Information:

Name of the patient (optional):_____

Name of District:_____

Period of Care: (months) _____ to _____

Name of Community:_____

Patient's Marital status: Married ( ) Single ( ) Widowed ( )

Age : _____ Sex:_____

Occupation/Vocation:_____

To be completed by care giver:

1. How did you get to know about the patient?
   ( ) Referred by Health Centre ( ) Referred by family
   ( ) Referred by community leaders ( ) Others

2. Baseline information on needs, care and support:

Needs	Extent of Needs		
	Lacking	Minimum	Average
Money for school Fees			
Food			
Spiritual Support			
Antiseptics			
Counselling			
Pain medication			
Social support			
Legal support			
Activities for Daily Living (ADL)			

Care and support provided on initial visit

	Yes	No	Comments
Referral			
Counselling			
Spiritual support			
Gave medicines			
Physical support			
Give food			
Other			
Education about medicines			

Comments:

Name of caregiver: _____

PATIENT MANAGEMENT FORM

Patient's Name or code: _____ Place: _____ Age: ___

Tick the condition (s) that best describe your OBSERVATION of the patient on the following visits. In the Box labeled **care and support (C/S)**, record any referral made by placing **(R)** in the box. If care and support other than referral was made, abbreviate that support. For example, Sponged = **SP,** Counselled = **CL**, Assisted = **AS, M = medicines**. Countries may decide to use abbreviations best understood by caregivers.

Condition	Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit		
	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s
Physical																														
- Can't sit alone																														
-Can't walk alone																														
-Can't speak																														
-Can't turn in bed																														
- Sweating a lot																														
- Burning Feet																														
- Dried mouth																														
- Difficulty in swallowing																														
- Vomiting																														
- Diarrhea																														
- - Weight loss																														
- Need for education about sexual practices ***(if sexually active)***																														

Condition	Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit		
	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s
Chest Infection																														
- Non productive Cough																														
- Productive cough without blood																														
-Productive cough with blood																														
- Breathing with difficulty																														
- Chest pain																														
STI																														
- Vaginal discharge foul smelling																														
- Non-foul smelling vaginal discharge																														
- Urethral discharge																														
- Sore on the penis																														
- Vaginal sores																														
Dermatological																														
- Skin rash																														
- Itching																														
Psychosocial																														
- Lonely																														
- Anxious																														
- Depressed																														
- Confused																														
- Cheerful																														
- Worried																														
- Needs Counseling																														

Condition	Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit			Visit		
	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s	Y	N	C/s
Environment																														
- Safe drinking water																														
- Clean surroundings																														
- Clean bed linen - Clean toilet																														
Socio-economic																														
- Money for school fees																														
- Food																														
- Housing																														
- Financial independence																														
Comments:																														

Instruction: Tick the one (s) that apply (ies).

Overall condition of the patient at the end of the quarter:

☐ Return to normal duties

☐ Responding well to medication

☐ Still not well

☐ Referred to hospital

☐ End of life care

☐ Died

UTILIZATION OF KIT ITEMS

Below is a table of approved medicines and supplies for use in CHBC programmes by CHBC care givers and health professionals. Record medicines and or supplies you provide as a trained health care worker or caregiver. Please tick **"yes"** when you give the medicines or supplies and ***do not*** write anything if you did not. Where children are treated, the quantity supplied will reflect whether medicines were provided to a child or an adult. Each country will adapt this list according to national guidelines.

Medicines and supplies	**Visit**		**Visit**		**Visit**		**Visit**		**Visit**		**Visit**		**Visit**		**Visit**		**Visit**		**Visit**	
	Y	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**	**Y**	**Q**
Multivitamin tablets)																				
Iron tablets																				
Tylenol tablets																				
Panadol																				
Cafenol																				
Codeine*																				
Other pain killers																				
Cough mixture																				
Gentian Violet																				
Antifungal cream/ointment																				
ORS or SSS																				
Food ration																				
Talcum																				
Vaseline																				
Bandages																				
Gauze-mug																				
Gloves																				
Macintosh																				
Jik/Bleach																				
Bucket with Lid																				
Face Towel																				
Bath towel																				
Bed sheet																				
Follow up supervision of medicines																				
TB medications supervised ARV (Prophylaxis)*																				
HAART*																				
Prescribed class A*																				
Injectables*																				

* Provided by a health professional

Family Support end of life care

Transport

1. Is transport provided Yes [ ] No [ ]

2. Which mode of transport is provided:

Bicycle [ ] Car [ ] Local bus [ ] Reimbursement [ ]

Summary of quarter activities include:

Good things	**Difficult**
Transport	

Name of Care Giver:_____

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

THE RECOMMENDED COMMUNITY-HOME BASED CARE KIT

REGIONAL PROGRAMME ON HIV/AIDS

1 Why The Kit

1.1 Advantages to the patient and the care provider:

- Facilitates access to essential drugs for treating major diseases including AIDS opportunistic
  infections such as diarrhoea, tuberculosis, and childhood illness.
- Reliable source for ensuring adherence to treatment and drug quality.

Advantages to the Health care system:

- ***Limits the range of essential drugs to those necessary.***
- Simplifies budgeting, procurement, storage, transport and supply management.
- Facilitates equitable availability of supplies and drugs.
- Contributes to more rationale prescribing, dispensing and use of drugs.

1.2 What does the Kit contain?

The KIT contains Care items and basic drugs (see attached list). Cadres rendering services at different levels of care can actually use it with appropriate modifications. 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 drugs in the Kit act as a checklist for comprehensive patient management.

1.3 **Who would use the kit?**

Health care workers at different levels of the health system, community and family members in the home – (see proposed levels of use of the kit)

The Provincial or District level which is a referral institution - wherever a Medical Doctor can prescribe **Class A**. Drugs.

Mid-Level which is a Clinic/ First level Centre where a Trained Coordinator can prescribe or administer non-prescriptive drugs and perform simple care related procedures during supervisory and support home visits. (Use of drugs is guided by four basic headings; diagnosis, prescribing, dispensing and consumption by the patient.)

The Community level which is a Day Care Centre or Home, where a Community-Based Organisation/Volunteers/and/or care provider undertakes the day- to day care activities.

RECOMMENDED LIST
MEDICINES AND SUPPLIES FOR COMMUNITY/ HOME BASED CARE KITS

NO	ITEM	PRESENTATION
1	Home Base Care Bag (for nurse & volunteer)	
2	Home visit reporting forms (country specific)	Amend existing referral/follow-up form to accommodate C/HBC.
3	Ball pen	
4	Soap and container with holes for water drainage	
5	Disposable Towels	Pack of 10
6	Heavy duty gloves	
7	Non- sterile disposable gloves	
8	Plastic Apron	
9	Mackintosh sheets/incontinent reusable protective pads	
10	Draw Sheets	
11	Adult diapers	Small, medium and large sizes
12	Skin protection cream	Jars 200mls size preferred.
13	Skin wash	
14	Gauze Swabs	Pack of 100
15	Bandages – crepe 75 mm roll+ 100mm roll	
16	Bowls (for cotton wool and solutions)	
17	Cotton wool	100g
18	Wooden tongue depressor	
19	Towel Forceps	
20	Clip Forceps	
21	Blood pressure apparatus and stethoscope	
22	Axillary thermometer	
23	Hand Flash light + battery	
24	Scissors	
25	Skin antiseptic with dispenser(appropriate packs for wound and foley catheter care)	
26	Condom: male and female (optional but highly recommended)	
27	Umbrella (foldable)	
28	Bicycle with carrier	
29	Calamine Lotion	Lotion 50 ml vial
30	Oral rehydration salts	Powder 27.9 g (sachets)
31	Nystatin	Tablet 500 mg or pessaries 100 000UI
32	Paracetamol	Tablet 500 mg or syrup 125 mgs/5mls
33	Acetylsalicylic acid	Tablet 300 mgs
34	Ferrous sulphate and folic acid	Equiv. 60 mgs iron + 400 microg folic acid

35	Ferrous sulphate	Oral solution equiv.25 mgs iron (as sulphate)/ mls.
36	Retinol Palmintate (Vitamin A)	Sugar coated tablets 10 000 IU : 5.5 mgs
37	Foley catheters x 2 way x size 16 & 18 and catheter care (betadine swabs or alcohol solution) for cleaning the skin.	
38	Ketoconazole	Tablet 200 mg
39	Ketoconazole	Oral suspension 100 mg/5ml
40	Griseofulvine	Tablet 250 mg
41	Metronidazole	Tablet 500 mg
42	Metronidazole	Oral suspension 200 mg/5ml
43	Acriflavian	Tablet 200 mgs
44	Amoxycillin	Tablets 500 mgs
45	Doxycycline	Tablet 100 mgs
46	Sulphamethoxazole + trimethoprim	Tablets 480 mgs + 80 mgs
47	Sulphamethoxazole + trimethoprim	Oral suspension 20 mg + 40 mg/5ml
48	Erythromycin	Tablets 250 mgs
49	Ascorbic acid	Tablet 50 mg
50	Vitamin B Complex Inj	10 ml Ampoule
51	Chloroquine	Tablet 100 mg base
52	Chloroquine	Syrup 50 mg (as phosphate or sulphate)/5ml
53	Sulfadoxine Pyrimethamine	Tablet 500 mg + 25 mg
54	Promethazine	Tablets 10 mgs
55	Feeding Tubes and containers/bags for food	Medium and large(1 of each size)
56	Tetracycline	Tablets or syrup
57	Ringers Lactate + set	Intravenous solution 500 MLS
58	Disposable needles and syringes	Various sizes for intramuscular injections
59	Tuberculosis medication as recommended by clinical team.	
60	ARV Prophylaxis	
61	HAART	
62	Class “A“ analgesics for use by professional palliative care team members.	

FOOD SUPPLEMENTS

These include food rations, nutritional packets etc. The HCG and professional may want to source these items from community groups, NGOs or any other food-based organization. It is important to give the patient some food before serving medication.

PAIN MEDICATION CLASS 'A' DRUGS

- The care provider is a professional who is trained and licensed to handle class 'A' or Dangerous Drugs. Under the Dangerous Drug Act and in accordance with the National Drug Policy, the professional must hold a current license to acquire and administer these drugs. Within the C/HBC programme, it is advisable to have such a professional covered by a registered palliative/long term care facility. In this case, she or he can administer:

  - Morphine injection, Morphine mixture,
  - Morphine tablets and Doxycycline Caps.

PAIN MEDICATIONS/OVER THE COUNTER

- A trained professional may administered advanced pain medications . Such medications include: Voltaren, Ibuprofen, Valoid and Metocloperamide.

WOUND CLEANSER

Liquid betadine with instructions for mixing and usage.

CLEANING LIQUID

Disinfectant with instructions for mixing and usage.

**** NOTE: The following is recommended for guiding programmes in the acquisition, and administration of medicines found on the recommended list:***

1. Essential items and drugs recommended for basic nursing care by a trained HCG or clinic based nurse:
   - Item numbers 1 to 17 are essential items.
   - Item numbers 21,22,27,28 and 29 are optional. This is administered based on the national policy and training received by the healthcare worker or HCG.

2. Essential items and drugs recommended for the extension of medical / clinical care in the delivery of Community Home Based Care Services by a professional health care worker:
   - Items number 18 to 59.

3. Essential drugs recommended for pain management in CHBC services by a professional health care worker with specialized training in palliative care including pain management:
   - Class "A" DRUGS. Examples of countries with extensive experience in providing such services are Botswana, Uganda, Zimbabwe, Cameroon and South Africa.

Proposed levels of service delivery and use of the Kit.

Levels	Cadres	Criteria
1	Senior health worker, may be doctor, clinical officer, palliative care nurse specialist	Trained in palliative care
2	Registered health worker	According to expertise
3	Community - based Provider/ trained Volunteer/ Family	With supervision

Cadres at levels 1 and 2 have responsibilities for home -based care visits, supervision, monitoring, and reporting. Training in this light is required for this cadre.

Types of Kit and contents

Cadre	Contents (will vary according to affordability and need)
1	Analgesics including oral liquid morphine, antibiotics and anti-fungals for opportunistic disease, equipment for minor procedures in the home, oral and back-up TB drugs.
2	Medications including antibiotics, simple analgesics and medicines for opportunistic infections. Equipment for minor procedures in the home.
3	Supply items e.g. linen, dressings etc and simple pain killers only. Some may have food. Oral drugs and back-up TB drugs or ARV prophylaxis as policies permit.

Efforts have been made to harmonize service delivery in countries using the Kit. Standardization is not really possible. The most important aspect is for local adaptation to take place.