NATIONAL GUIDELINES ON COMMUNITY AND HOME-BASED CARE & STANDARD OPERATING PROCEDURES

Government of Nepal
Ministry of Health & Population
National Centre for AIDS and STD Control
Teku, Kathmandu
September 2011

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Foreword

It is my pleasure to introduce the National Guidelines on Community and Home-based Care (CHBC) and Standard Operating Procedures (SOPs) to serve people infected with HIV and their families. These guidelines and SOPs are indeed a milestone in Nepal's effort to providing quality care, support and treatment for those infected and affected with HIV at their door steps. The usefulness of these guidelines and SOPs was evident from the response received from organizations currently implementing CHBC programs in Nepal. These latest guidelines and SOPs have been revised after incorporating feedbacks from organizations providing CHBC services. We hope the updated versions will better assist organizations to effectively serve those infected and affected by HIV in Nepal.

Studies and experiences show that CHBC is critical to reach those infected and affected with HIV in Nepal. CHBC is a strategic response to quality care, support and treatment and is also recognized by the National HIV and AIDS Strategic Plan 2006-2011, as one of the treatment, care and support strategies. It is crucial that CHBC services are further expanded to areas with a higher concentration of HIV-infected people and also where health care outreach services by the existing health facilities and infrastructures are inadequate. CHBC should have a strong linkages with ART services.

The guidelines are subject to ongoing review and revision in line with recommendations,best practices, lessons learned and information gathered through implementation, monitoring and evaluation of CHBC programs in Nepal. We urge all service providers to base their CHBC services on the standards prescribed in the guidelines and SOPs for providing effective and quality services thereby guaranteeing the rights of quality care, support and treatment for HIV infected and affected people.

The Government of Nepal, National Centre for AIDS and STD Control expresses sincere thanks to all the experts and organizations who have lent their expertise and resources in preparing the guidelines and SOPs. We would also like to express our sincere thanks to the United States Agency for International Development (USAID) funded ASHA Project for their financial support in the revision and re-printing of these guidelines and SOPs.

My best wishes to all the service providers and I hope these guidelines and SOPs will be helpful in providing quality care and support to HIVinfected and affected people in all parts of Nepal.

Dr. Ramesh Kumar Kharel
Director

DIRECTOR

Stop AIDS, Keep the Promise.

ACRONYMS

ANC	Antenatal Clinic
ART	Antiretroviral Therapy
CHBC	Community and Home Based Care
CBO	Community Based Organization
CoC	Continuum of Care
DACC	District AIDS Coordination Committee
DIC	Drop-in-Center
DHO	District Health Office
DPHO	District Public Health Office
EPC	Essential Package of Care
FBOs	Faith Based Organizations
FCHV	Female Community Health Volunteer
FHI	Family Health International
FSW	Female Sex Worker
GoN	Government of Nepal
HP	Health Post
IDU	Injecting Drug User
MCHW	Maternal Child Health Worker
MDG	Millennium Development Goals
MoHP	Ministry of Health and Population
NACC	National AIDS Coordination Committee
NCASC	National Centre for AIDS and STD Control
NGO	Non Government Organization
NGCHBC	National Guideline on Community and Home Based Care
NSP	National HIV/AIDS Strategic Plan
OPC	Outpatient Clinic
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
QA/QI	Quality Assurance/Quality Improvement
SHP	Sub Health Post
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis

VACC	Village AIDS Coordination Committee
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization

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Table Of Contents (Standard Operating Procedures)

Addendum on National CHBC Guidelines and Standard Operating Procedures 2009

As agreed by the National CHBC Technical Working Group, the following changes are made to the National CHBC Guidelines and Standard Operating Procedure 2009. Additions made are underlined.

NGO/CBO Approach (Page No. 7)

This set up, run or managed by a NGO/CBO, should consist of health personnel, PLHIV and volunteers in coordination with DHO/DPHO, DACC, local health facilities and various organizations in the area. Active networking and referral with essential service providers is vital for the effectiveness of this approach. The health worker will be the CHBC team leader. There will be at least one PLHIV CHBC team member in a team. Other volunteers could be added to a team, if needed. Roles and responsibilities assigned to different staff is included in the SOP on Page 25 for the application to this approach.

I. CHBC Team Composition and Workload (Page No. 25)

A. General Considerations:

- CHBC team members should be full-time/part-time staff, although they can be supported by community volunteers (e.g. community members, FCHVs, etc) ***('Paid' is removed)***

II. Roles and Responsibilities of CHBC Staff (Page No. 25)

- **CHBC Supervisor:** Provides overall oversight and management of the teams. Accompanies the CHBC team on home-visits at minimum once a month, observes visits using supervision forms and provides supportive feedback to the team following the visit. The Project Coordinator or any other appropriate staff member could be assigned as a CHBC supervisor for a CHBC project.

- **CHBC Team Leader:** Provides day-to-day supervision of the CHBC team, leads planning of team services, identifies training needs of the team, and provides on-the-spot supervision and direct home-care to clients. The team leader spends most of their time in the field with the teams providing care. They are the role model for setting a high quality standard of CHBC care. Note: If there are two members in the team, the team leader divides her/his time and accompanies one member on home visits at a time. CHBC Team Leader will be a health worker.

- **CHBC Team Member:** Provides regular, high quality care and support to PLHIV clients. Receives support and feedback from the team leader. CHBC team member should consist of at least one PLHIV.

Background

Nepal has entered a 'concentrated' epidemic with HIV prevalence consistently high among certain sub-populations such as injecting drug users (IDUs) and female sex workers (FSWs). The estimated number of total HIV infected persons (adult and children) for 2007 was 69,790, of which, 64,585 were adults (aged 15-49 years) and 1,857 were children (aged 0 to 14) (NCASC, 2008). By the end of 2007, HIV prevalence was estimated to be around 0.49 percent in the adult population (Ibid. 2008). While stigma and discrimination discourage people from seeking HIV testing, it is also creating an environment of fear and hesitancy among people living with HIV/AIDS (PLHA) in accessing essential care services. It is the right of PLHA to access quality treatment and care, and given that health facilities in this country are already stretched, it is crucial to take care and support services into the homes and communities of PLHA. Community and Home-Based Care (CHBC) stands out as an important cost effective strategy which, if delivered properly, can significantly help PLHA to maintain good health, relieve pain and other symptoms, prevent or counter opportunistic infections, and promote adherence to those in ART in the comfort of their own homes and communities.

CHBC consists of care which responds to the physical, social, emotional and spiritual needs of PLHA in the home and community environment. It consists of palliative care, prevention, Antiretroviral Therapy (ART) adherence support and linkages to other health and social services. CHBC includes PLHA self-care, care provided by family, informal visits from peers, neighbors and/or formal visits by trained CHBC workers. CHBC services are found in most countries around the world, both rich and poor, in response to the fact that most people with chronic illness prefer to spend the majority of their time at home, not in the hospital.

CHBC as a service originally developed to create a link between the home, community and the hospital to ensure that clients with chronic illnesses and their families were supported in learning how best to manage the illness while at home, to provide additional care in the home to prevent unnecessary visits to the hospital, as well as to help facilitate timely hospital referrals for acute care and regular check-ups. As with all continuum of care (CoC) services, such as out-PLHA clinic care, accessing CHBC services is voluntarily based on individual/family need (Green et al 2007).

The National HIV/AIDS Strategy Plan (NSP) (2006-2011) emphasizes CHBC as an essential 'Treatment Care and Support' component and also realizes CHBC as being critically important for people living far from treatment and care facilities, who do not have access to transport or whose mobility is otherwise restricted. The NSP (Strategy 5.3) describes CHBC as offering an opportunity of care within an environment where people are most comfortable and get love and support (better quality of life), while decreasing the burden on an already stretched health system. The NSP further comprehends CHBC as representing a partnership in care that has many advantages for the PLHA and their family, as well as for the community and the health-care system.

Rationale

Community care and support efforts have expanded almost everywhere in the world where the AIDS epidemic has appeared and has shown amazing creativity and commitment in providing comfort and hope to people living with or affected by HIV.

- CHBC services help individuals live independently and as long as they possibly can through enhancing knowledge and skills of PLHA and their families on self-care, ART adherence, dealing with stress, lessening stigma and discrimination in the home and community and ensuring access to responsive links which are needed for health care services. Various studies worldwide support the fact that ART adherence is stronger in CHBC service areas than where CHBC is not available.

- CHBC is cost effective. It also frees up hospital beds and medical personnel for the acutely ill and thus relieves the burden on the health care system.
- CHBC improve retention in care and treatment services resulting in reduced loss to follow up.
- CHBC allows PLHA to receive care in a familiar environment, continue participating in family affairs, and retain a sense of belonging to social groups.
- CHBC is not only an important mechanism for extending the continuum of care, it also promotes community awareness of HIV/AIDS, motivates behavior change and helps decrease the stigma attached to the disease.

Present Community & Home-Based Care Scenario

As HIV care services have developed and scaled up across Nepal, CHBC programs have also grown covering the entire length of the country. Although CHBC services with varying approaches can be traced back to early 2000, NCASC identified the need for CHBC services in 2002, outlining a plan for delivering CHBC services in the NSP 2002. Over the years NCASC has produced a national curriculum and led the development of a national training certification program in CHBC from which more than 2000 providers have been trained.

CHBC services are providing essential care to PLHA and their families across Nepal. A national CHBC program review of 2007 found that CHBC were significantly contributing to the national response with antiretroviral therapy (ART) adherence, improved referrals and follow-up between community and hospitals, increased self-care and understanding of HIV among clients and their families and reduction of stigma and discrimination in many of the communities where services are offered.

However, there are also areas needing attention for increasing the effectiveness of CHBC services in Nepal. The review found the following components as essential for being put into practice in this regard: guidance and policy framework for CHBC; closer relationships between CHBC services and district health office/district public health office (DHO/DPHO), District AIDS Coordination Committee (DACC) and local public health sector; improved supervision and Quality Assurance/Quality Improvement (QA/QI) systems; and, diversity of referral relationships to address social and economic support concerns of clients.

Community & Home-Based Care Guidelines

CHBC is an emerging concept in Nepal and non-governmental organizations/community based organizations (NGOs/CBOs) working with PLHA have started providing CHBC services on a small-scale in their respective work areas. With growing independent CHBC initiatives across Nepal, a national level guideline was felt to be needed by many stakeholders in order to promote a standard of quality care across all CHBC programs and to channel CHBC as a meaningful and useful service for PLHA all over Nepal. In this regard, the National Guidelines on Community and Home-based Care (NGCHBC) aims to provide an ideal framework of program and service guidelines and operating procedures to help promote the maximum efficiency of CHBC services in Nepal.

Policy Goals of Community and Home Based Care

The National HIV/AIDS Strategy (2006-2011)
The NSP (2006-2011), planned within the broader framework of the National HIV and AIDS policy, has been designed in line with the Universal Access target of 80 percent coverage with

prevention, treatment, care and support services to most-at-risk population and PLHA. The NSP under its 'Treatment, Care and Support' component (of which CHBC is a part) states that by 2011 its objective is to ensure universal access to quality treatment, diagnosis, care and support services for infected, affected and vulnerable groups in Nepal within the context of a comprehensive response to HIV/AIDS.

National Strategic Plan and CHBC Policy Goals

Expansion of CHBC services for PLHA and their families is a stated priority in NCASC's National Strategic Plan, and the Treatment, Care and Support Rollout Plan. The NCASC effort to scale-up CHBC services is part of a larger strategy to increase access among the estimated 64,585 PLHA to cotrimoxazole prophylaxis, hospital-based HIV clinical care services and ART, Tuberculosis (TB)/HIV diagnosis and treatment, and care for affected and infected children where appropriate.

The NCASC has developed a national strategy to guide the management and implementation of CHBC with following actions and objectives (Table 2.1)

Table 2.1 Community and Home Based Care (Strategy 5.3)

Strategic Results

5.3.1 Increased number of trained community workers, volunteers and family members in CHBC

5.3.2 Established linkages developed between health facilities and CHBC workers and programs

5.3.3. Increased availability of integrated and comprehensive services at the community level.

Key Actions

1. Ensure policies, strategies, guidelines and manuals for incorporating home-based care into overall national health systems
2. Ensure core training competencies and curricula for CHBC workers and treatment supporters
3. Endorse national guidelines for home care services, including basic palliative care by family members and community volunteers
4. Mobilize and build capacities of communities (including local support groups) and families for providing care and support services to the infected and affected
5. Define comprehensive package for CHBC and ensure that services are adequately delivered and used and that the quality of care is maintained
6. Promote herbal and yoga for healthy living
7. Palliative care, nutrition supplementation and food security into CHBC programs with adequate resources
8. Ensure psychosocial support
9. Set monitoring and support systems for community based treatment supporters and care providers

Policies and coordination

The three levels of AIDS Co-ordination Committees bring mobility to the NSP linking national mechanisms to the local community. The National AIDS Co-ordination Committee (NACC), the District AIDS Coordination committee (DACC) and the Village development AIDS Coordination Committee (VACC) are the coordinating bodies at the national, district, and village levels respectively. The NSP (2006-2011), on its strategic road map under 'Organization and Systems', acknowledges the importance of these coordination committees, and envisages DACC and VACC functioning in each district and village with strong linkage to the national authority by 2008. By 2010, the NSP aims for a fully functional DACC in all 75 districts.

Community and Home Based Care as an Intervention in HIV/AIDS

Community and Home Based Care
CHBC is care in the home and community which responds to the physical, social, emotional and spiritual needs of PLHA and family from diagnosis to death and bereavement. It aims to reduce suffering and increase quality of life by providing responsive care, increasing self-care skills and building the capacity of PLHA and families to live as independently as possible (definition adapted from WHO, FHI, 2004).

All humans need essentially the same things in order to live fulfilling lives. The needs of PLHA are no different, but they may need more support over the course of disease (e.g., physical needs, access to affordable health care without stigma and discrimination, ART). The role of the CHBC worker is to assist clients in meeting these needs.

CHBC is part of the CoC and supported by vital linkages to out-PLHA care/ART services, hospital in-PLHA care, PLHA support groups and psycho-social and spiritual support services. Often, the best CHBC services tend to be those which combine the strengths and skills of formal and informal caregivers, both HIV-positive and negative from health care services, NGOs, PLHA groups or faith-based organizations, with additional assistance from other lay and professional supporters such as community volunteers, social workers, counselors, nutritionists, physical therapists, and spiritual advisors.

Objectives of CHBC
The objectives of CHBC services should be as follows:

1. To improve quality life by providing palliative care and other needed services to PLHA and their families.
2. To facilitate the continuity of care from the health facility to the home and community.
3. To promote family and community awareness of HIV/AIDS prevention and care.
4. To empower the PLHA, the family, and the community with the knowledge needed to ensure long-term care and support.
5. To raise the acceptability of PLHA by the family/community, hence reducing the stigma associated with AIDS.
6. To streamline the PLHA/client referral from the institutions into the community and from the community to appropriate health and social facilities.
7. To facilitate quality community care for the infected and affected.
8. To mobilize the resources necessary for sustainability of the service.

Principles of CHBC
1. ***Service provision is based on need*:** CHBC are provided only in areas where there is an expressed need and are never driven by targets (e.g., numbers of PLHA to be reached) imposed by a government, donor, NGO, etc.
2. ***Use of home-based care services is voluntary*:** CHBC services are only provided to those who request home-care services; teams respect the individual right of PLHA to choose whether or not they would like to receive home-based care support. PLHA and families have the right to continue or discontinue services as needed.
3. ***Part of the Continuum of Care*:** CHBC services are not to be provided in lieu of hospital/clinic based care; it is part of the continuum of care for PLHA and provides more choices regarding access to services for PLHA and their families who want to receive regular care in the home environment.
4. ***Client Confidentiality*:** Client information is kept confidential at all times. Client records are managed by a limited number of authorized staff; files are locked and kept in secure location.

5. ***Home-care teams must reflect a balance*** of people who are HIV-positive and negative and a balance of individuals with health worker skills, community mobilization and advocacy skills and psychosocial support/social work skills. Job responsibilities of CHBC team staff and volunteers need to be well defined and training and supervision provided based on job description.
6. ***Provide optimal care within resources***: CHBC programs need to balance numbers of clients in need of services with resources available. Programs need to be clear about the number of clients they can reasonably support given the resources available to the program.
7. ***Home-care teams are adequately, trained and protected*:** CHBC staff and volunteers should receive adequate training to provide quality care to PLHA and to have access to universal precaution materials and psychological support to manage caregiver burn-out. They have the right to access post exposure prophylaxis (PEP) if exposed and ART if infected.
8. ***Family Centered*:** Family is the primary caregiver in the CHBC model and plays an essential role in caring for PLHA, providing encouragement and support, reinforcing adherence and providing care when they are sick. Since one of the primary responsibilities of CHBC workers is to increase the self-reliance of clients and families, CHBC should train family members on skills and knowledge in HIV prevention and care.
9. ***GIPA*:** People living with HIV understand each other's situation better than anyone and are often best placed to counsel one another and to represent their needs in decision- and policy-making forums. Involvement of PLHA is crucial for a meaningful execution of CHBC services.

CHBC services can be provided wherever there is a demand for the service. Demand tends to be higher in areas of relatively high HIV prevalence where people are sick and in need of care. CHBC should also be flexible so that services, or at least some of its components, can be provided outside of a client's home to address situations where, for reasons of confidentiality, the client may not want CHBC team home visits. In such circumstances, non-disturbing and non-obtrusive settings could be used (in agreement with the client) for rendering CHBC services depending on what services could be provided in such settings.

Persons involved in CHBC services

People who are trained to provide care for PLHA and families in the home and community are referred to as CHBC workers, teams or service providers. The people involved in CHBC and their likely roles are:

- **PLHA:** Care for themselves and develop self-care skills; become knowledgeable in HIV disease and symptom care, understand the medicines prescribed to them and how to take them, develop confidence in communicating with health care providers and others, and know when and where to seek medical services.
- **Family Caregivers:** Develop knowledge and skills in how to support their family member(s) with HIV and AIDS, including providing emotional support and assisting them in being adherent to their medicines. When PLHA are bed-bound, family members often provide on-going nursing care and basic symptom management, e.g. fever care, feeding, bathing, massage, etc., and help them in preparing for end of life.
- **Informal supporters:** Neighbors, friends, PLHA, CHBC workers, religious leaders who provide support and encouragement. They may make informal visits and provide support such as friendship, help with cooking and cleaning, praying, etc.
- **CHBC Workers:** They include people who have been trained in health care, social work, spiritual and emotional support skills. They can be health care providers, social workers, community mobilizer/advocaters, and usually are comprised of both HIV-positive and negative workers. They visit PLHA regularly, are well-linked to a hospital for back-up,

have some supplies available for basic symptom care and can provide the following type of support: self-care teaching, infection prevention support, pain relief and symptom care, counseling, help with nutrition, legal advice, spiritual counsel and family education on care and prevention, as well as other social support and referral assistance.

- **Health Facilities:** They are the point of referral for PLHA in need of out and in-PLHA care.
- **Other Services:** Nutritionists, professional psychologists, PLHA groups offering support and advocacy services, volunteers, NGOs providing loans and other income generation assistance, HIV prevention such as risk reduction for drug users and safer sex; support services for children, legal aid and human rights professionals and organizations, etc.

The Essential CHBC Package

The optimal package of services listed below defines what should be in place in order for CHBC programs to contribute towards improved quality of life for their clients.

- Be part of the Continuum of Care and have strong working relationships with district HIV care providers to ensure effective two-way referral and discharge planning.
- Adhere to the core community and home-based care principles, providing services only to those PLHA who request CHBC, respecting client confidentiality and the decisions made by the PLHA and their loved ones.
- Be an activist on behalf of their client, link their client to services their client needs and provide support.
- Keep accurate records of care provided and develop a CHBC service plan with the PLHA and family which is regularly updated based on the changing needs of the PLHA.
- Be skilled in symptom and pain reduction (management of pain, fever, diarrhea, constipation, nausea and vomiting, cough and sore throat, skin infections, rashes, insomnia, etc) and have medicines and supplies on hand to provide symptom care.
- Be able to recognize danger signs and know how to effectively refer clients to receive the services they immediately need from HIV care providers at the district hospital as part of the CoC services.
- Know why adherence is important and provide appropriate adherence support to PLHA for ART, TB treatment, cotrimoxazole prophylaxis, and other Opportunistic Infection (OI) treatment and preventative therapies.
- Provide nutritional counseling based on a basic understanding of HIV and nutrition concepts, and on how to use locally available and affordable foods to maximize nutritional intake.
- Be knowledgeable and skilled in infection control and universal precaution.
- Have CHBC supplies consistently available including palliative medicines, personal hygiene products, infection control and universal precaution materials, dressings, vitamins and food supplies, self-care teaching materials, etc.
- Be skilled in teaching PLHA and loved ones in self care, symptom and pain reduction, nutrition, hygiene, infection control/universal precautions, adherence, etc.
- Provide emotional support to clients and refer them for spiritual counseling or formal counseling as requested by the client or loved ones.
- Facilitate the development of life plans or future plans where clients make plans for their health care, education, income generation, family etc.
- Link PLHA to livelihood programs including micro-credit and grants. If services are not readily available in the community for PLHA, then advocate with family for access to these services.
- Support opportunities to empower; build self-confidence and self-reliance of PLHA and their families, including life-skills training, training on rights, public speaking, working with the media, etc.
- Assist clients and loved ones, if needed, in preparing for death, preparing wills, arranging for future child guardians and preparing funeral plans in addition to providing emotional support to grieving loved ones.

- Visit clients at regular intervals as agreed between client and provider.
- Receive adequate initial and follow-up training in the above areas.
- Receive regular supervision from a district level designated supervisor.

The CHBC Kit

- Each team should have one home-care bag which is fully stocked and refilled every time it is used. CHBC kits need to be kept clean and well organized.
- CHBC kits can be obtained from government health facilities in program areas. The standard list of supplies can be found in 'Annex 7'.
- A consistent supply of CHBC related medicines and other supplies must be kept at all times. Team members should keep a record of medications/supplies used in order to track inventory.
- Each team should place orders for supplies at least three months before the supplies are expected to run out.
- Where possible, CHBC teams should link with health facilities for restocking all or some of kit supplies.

CHBC Continuum of Care Service Delivery Approach

Following are the different service delivery approaches that can be adapted in designing CHBC programs:

NGO/CBO Approach

This setup, run or managed by a NGO/CBO, could consist of health personnel, PLHA and volunteers

in coordination with DHO/DPHO, DACC, local health facilities and various organizations in the area. Services are probably small scale and limited in jurisdiction of one's working area. Active networking and referral with essential service providers is vital for the effectiveness of this approach.

Government Approach

The setup could consist of volunteers, Female Community Health Volunteers (FCHV), Village Health Workers (VHW), PLHA, Maternal Child Health Worker (MCHW) and community level health staff for referral to government health facilities. The role of the government is essential in monitoring and facilitating NGOs/CBOs for quality service delivery

Comprehensive Approach

Utilizing resources from the private and government sectors, the comprehensive approach could have the capacity to provide all essential services related to HIV care and support and could feature essential service providers (e.g. peer PLHA, health workers, social workers, FBOs, counselors, nutritionists, and community volunteers). An ideal service delivery approach, it can have strong linkages between the home, community and health facilities (up to tertiary level hospitals). Every CHBC setup should strive for creating such a comprehensive CHBC approach in their areas.

Community Care Approach

Community based care can be provided in Drop-in Centers (DICs), Voluntary Counseling and Testing Centers (VCTs), or any community facilities that do not jeopardize client's confidentiality. Community care is essential under various circumstances which prevent clients from receiving CHBC services in their homes. Further, the option of community care should also be given to clients whose houses are extremely difficult for CHBC providers to reach, especially in the

rural areas. In such instances, clients should be given the option of community care, where services could be offered in areas where clients can travel. In urban settings, PLHA can also access community based care and support from DIC, clinics, crisis homes, or other convenient places. Support of self help groups are crucial in addressing the socio-economic needs of PLHA and his/her family members, especially when community and neighborly help, for various reasons, is limited. Self help groups can contribute in helping families with daily activities such as ART adherence, cooking, child care, running errands, etc. Additionally self help groups can also be advantageous in rural settings where housing settlement is sparse or one lives in lesser proximity with their neighbors.

Standard maintenance in adverse situations

CHBC services can be difficult to operate in areas with extremely limited resources, however, in such situations it should be the goal of service providers to maintain a minimum standard of services as to what could be considered as a comparatively acceptable standard of CHBC service in adverse ground situations (e.g. areas lacking basic infrastructure, facilities, and health facilities, etc.). CHBC services need to have the following minimum standards to qualify it as an acceptable CHBC provider:

- CHBC team should include parmedical / nurse and PLHA
- Referral mechanism with at least a HP/SHP
- Availability of essential supplies of CHBC kit
- Active networking with organizations and support groups involved in care and support of PLHA.
- Coordination with DACC and VACC

Roles and Responsibilities of Major Stakeholders in CHBC

In line with the NSP (2006-2011) organization and system of service delivery, CHBC activities should be carried out with the three tier system of NACC, DACC, and VACC, representing the national, district and the village level activities respectively. Following are the roles and responsibilities envisaged for the three levels:

i. National-level responsibilities

At the national level, directions are needed to guide the planning, implementation, regulation and monitoring of CHBC. GoN will coordinate this effort with stakeholders to ensure universal access and quality services for PLHA, with special attention to the following issues:

1) Policy development

- Secure political commitment for CHBC
- Develop policies, guidelines and regulations for CHBC (including orphan care)
- Develop national strategies to reduce stigma

2) Program development and coordination

- Integrate CHBC into existing health system and the NSP
- Develop CHBC training program
- Promote partnerships with NGOs, PLHA groups and private organizations

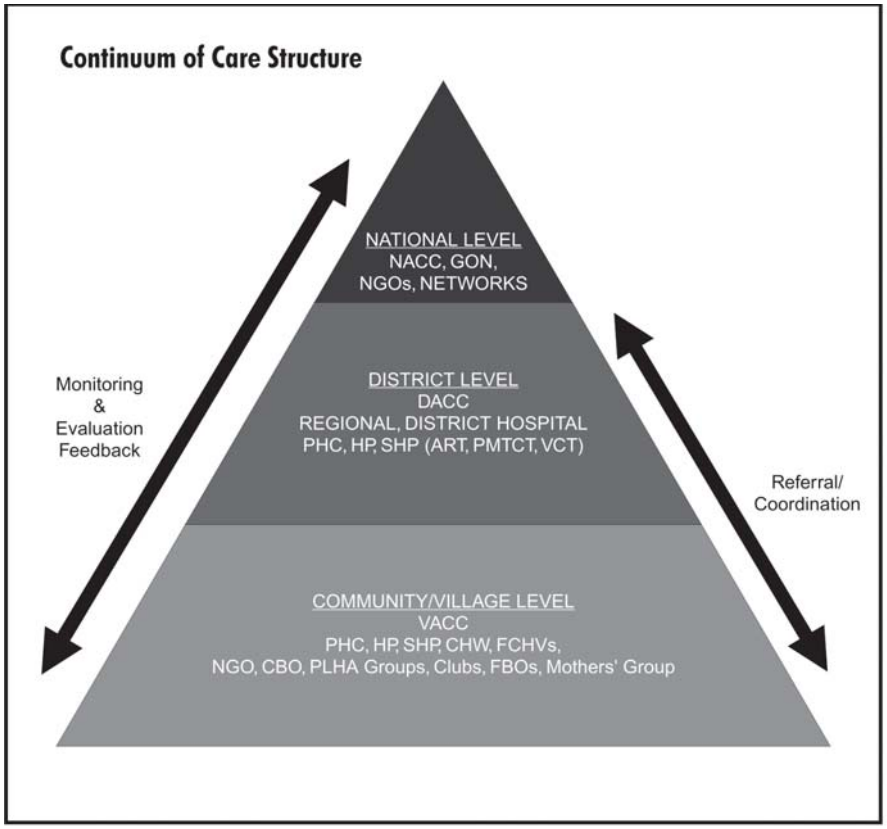
3) Resource mobilization

- Develop human resources
- Provide material resources
- Allocate resources and funds

4) Monitoring and Evaluation

- Monitor and evaluate CHBC activities in the country

Figure 1: Continuum of Care Structure



ii. District-level responsibilities

The major stakeholders at the district level include DHO/DPHO, DACC, various government line agencies, regional/district hospitals, NGOs, and PLHA groups. Following are major responsibilities envisaged for district level stakeholders:

1) Program development and implementation

- Follow CHBC guidelines for district activities.
- Establish quality assurance mechanisms for any activities geared towards infected and affected people, including children affected by AIDS .
- Work as an interface between the policies outlined by the national system and the actual planning, implementation and evaluation of CHBC programs at the local community level.
- Determine the level of administration at the district level and the responsibility to be decentralized to the local level.
- Provide trainings for CHBC workers and other stakeholders.
- Assist in accessing CHBC supplies for NGOs.
- Coordinate and collaborate efforts and develop district level plans involving all stakeholders (e.g., hospitals, PLHA alliances, municipalities, CHBC providers)
- Develop district level plans involving all stakeholders.
- Ensure proper referral for CoC, universal access, coordination and collaboration with all stakeholders.
- Strengthen networking with national level CHBC committee to ensure adequate medical supplies.

2) Monitoring and supervision

- Monitor standards of quality for CHBC services in the district
- Coordinate with NGOs/CBOs for supervision and monitoring of CHBC services
- Communicate CHBC indicators with the national level

3) Resource mobilization

- Allocate resources based on clearly defined priorities set by the national level guideline
- Ensure proper referral for CoC and universal access

iii. VDC or local-level responsibilities

The major stakeholders at the VDC or local/community level include: primary health center (PHC), health post (HP) and sub-health post (SHP), FCHVs, NGOs, CBOs, clubs and PLHA groups, community groups, volunteers, influential leaders, and VDC personnel. Following are the major roles and responsibilities that are needed to be fulfilled at the VDC or local level.

Program development and implementation

- Develop strategies that promote effective leadership and mobilize the community (care givers, PLHA, health and social service workers, community volunteers, community members and influential leaders) in planning and implementing CHBC.
- Implement CHBC guidelines and standard operating procedures in service delivery
- Integrate CHBC into existing public health facilities and community services (with health facilities and social sector)
- Provide physical, emotional and spiritual care and support
- Establish a continuum of care
- Allocate resources into CHBC programs where feasible
- Develop mechanisms for educating the PLHA, caregivers, CHBC teams, and the community
- Ensure adequate medicines and supplies for the CHBC program through DHO/DPHO, PHC, HP, SHP
- Create communication between various levels of administration to facilitate services and information

Role of Key VDC/Community Level Stakeholders

Local/community level stakeholders are the flag bearers of CHBC services. Their roles and responsibilities are crucial in assuring quality care for PLHA. The guideline presumes the following roles and responsibilities from the key local level actors:

PHC, HP, and SHP

- Provide medical care in accordance to the directives provided by DACC or district level supervisor
- Ensure adequate medical supplies
- Develop referral mechanism in coordination with district level stakeholders and health facilities
- Maintain coordination with PLHA networks
- Provide essential feedback to DACC

NGOs/CBOs

- Coordinate with PHC, HP, SHP, VDCs in carrying out care and support activities
- Advocate for rights and quality care of PLHA
- Identify mechanisms for resource generation
- Promote CHBC services in areas where HIV concentration is high and associated with stigma and discrimination
- Coordinate and collaborate with community leader, institutions, groups, clubs, PLHA networks and government institutions for a collective response to treatment and care of PLHA
- Include PLHA as part of the CHBC program

VDC/VACC

- Follow and assist VDC policies and program support
- Assist community efforts on PLHA care and support
- Coordinate with NGOs/CBOs for supervision and monitoring of CHBC services
- Develop village level plans involving all stakeholders
- Ensure proper referral for CoC, universal access, coordination and collaboration with all stakeholders
- Monitoring and supervision of local CHBC programs
- Resource mobilization for local CHBC programs

PLHA Networks

- Form support groups of PLHA
- Identify resources for support groups
- Encourage PLHA to seek treatment and at-risk population to check their status
- Serve as a linkage between support groups/PLHA and NGO/CBOs, donors, health service providers, and government personnel
- Advocate for quality treatment rights of PLHA without stigma and discrimination

Elements of Community and Home-Based Care Program

Introduction to elements

CHBC goes side-by-side with prevention and should therefore be an integral part of services. In this way it will offer quality of life to PLHA and contribute to the reduction of HIV transmission. To ensure that PLHA get comprehensive care, it is essential to integrate care at all levels such as individual, family, community, health and welfare activities systems. Investing in care at home can decrease the social impact of AIDS, enhance preventive measures, prevent the spread of secondary infections and help strengthen the existing health care systems.

The elements of comprehensive CHBC are:

1. Clinical care
2. Nursing care
3. Psychological and spiritual care
4. Palliative care
5. End of life care
6. Social support

1. Clinical Care

Clinical care in the context of home-based care is the continuation of medical care at home. The idea is to ensure CoC and treatment receiving from the health facility (referred to as the continuum of care). It is a collaborative care provision by the CHBC workers, the family members, and the community. Clinical care can be linked with CHBC by identifying and training CHBC workers within the system and from community organizations to ensure a smooth referral network between health facilities and communities for the management of opportunistic infections. Clinical care intends to:

Clinical Care components
■ Documentation of home-based care activities by each implementer at all levels to avoid duplication. ■ Team work and networking among all health care providers at both the health facility and the community level. ■ Proper drugs and nursing supplies to health facility and CHBC workers at home visits (see annex 4) ■ Understanding of the referral system by care providers, the family, and the PLHA to avoid wasting time when referral is necessary. ■ Supervision of CHBC workers in the use of simple drugs and supplies of the home care kits by their respective clinical team.

- Ensure early detection and treatment of OIs and other complications that occur as a result of HIV/AIDS
- Reduce the suffering from conditions associated with HIV/AIDS infection
- Referral as per clinical WHO staging and TB screening

2. Nursing /Physical Care

Nursing is the art of assisting individuals, sick or healthy, to do those things they would do if they had the strength, knowledge, or will. Nursing/physical care for PLHA is aimed at alleviating physical and psychological symptoms as well as maximizing the level of functionability of the affected person. Nursing care also entails assisting clients for a peaceful death. A systematic assessment of the needs of the sick individual and provision of care to meet those needs is important in achieving the aims. While the PLHA is still in the hospital, recruitment into CHBC

program for PLHA and relatives who can benefit and prepare a hospital discharge plan should be taken as a priority. The main objectives of nursing care are to:

- Alleviate physical and psychological symptoms
- Maximize the level of functionability of the affected person
- Systematically assess the need of the sick

Components of Nursing Care/Physical care
■ Provide education on nutrition
■ Ensure that ART, Cotrim, TB and other medications are taken as per prescription to ensure adherence and compliance
■ Symptom and pain management
■ Observe PLHA to detect problems: dehydration, dyspnoea, dysphagia, oedema, fever and other symptom management
■ Refer client as and when needed and take PLHA to the hospital or health facility as need arises e.g. danger signs
■ Simple wound dressing
■ Exercise and meditation
■ Provide self care knowledge and skills for PLHA and families
■ Refer pregnant women in ANC/PMTCT prophylaxis treatment and VCT site for HIV testing for children at 18 months.
■ Postpartum care and referral for family planning.
■ Reassure the PLHA at all times

3. Psychological and Spiritual Care

This component includes psychological and spiritual care, anxiety reduction, promotion of positive living, and helping PLHA live positively. The objectives of emotional and spiritual care are to:

- Offer psychological and spiritual care to PLHA and their families
- Encourage PLHA to adopt a positive living attitude
- Control the spread of HIV/AIDS through information dissemination, promotion of safer sex, and advocacy for behavior change
- Help PLHA to be protected from infection
- Help PLHA make well informed decisions about sex and sexuality
- Help communities to avoid condemnation of the infected and affected; encourage communities to respond to the welfare of the infected and affected
- Give hope to everyone especially to the sick and the caregivers.

Components of Psychological and Spiritual Care
■ Meditation
■ Faith /Prayer
■ Feeling there is meaning and purpose in life
■ Coping skills
■ Access to support group
■ Counseling and support in disclosing status

It is important to stress to learners that each person has his/her own spiritual and cultural beliefs and practices that are part of their heritage. With appropriate spiritual support, the PLHA may feel that their life is and has been meaningful, accept forgiveness by others, forgive others and understand that God accepts them.

4. Palliative Care

Palliative care generally refers to care of people whose disease does not respond to curative treatment. Palliative care eases symptoms and keeps the patient as comfortable as possible. The aim is to improve quality of life through reducing physical, emotional, social and spiritual suffering from diagnosis through death. From this perspective, virtually all of the various elements of care described in these guidelines can be considered palliative.

HIV infection brings with it a wide array of minor and major health and psychosocial problems, as well as an increased susceptibility to potentially fatal infections. Unlike most other life-threatening diseases, however, it also carries a level of stigmatization that leaves infected persons feeling alienated and discriminated against. Often these are not just feelings; they are the facts of life for persons with HIV/AIDS. Thus PLHA experience a multitude of physical ailments compounded by psychological, emotional, and spiritual problems.

Components of Palliative Care

- Assess and treat mild to moderate pain; refer for severe pain
- Assess and treat mild to moderate symptoms (e.g. nausea, diarrhea, skin problems, etc.)
- Refer PLHA when they present with physical problems that need to be assessed and treated at the HIV clinic
- Provide care for medicine side-effects
- Nursing care to promote comfort in the home during each stage of the disease
- Provide emotional support including counseling, refer when depression, anxiety or other serious mental health problems are identified
- Help the PLHA cope with stigma and self-blame
- Provide social support services
- Permit the PLHA to take responsibility for the course of care
- Assist the PLHA and the family to prepare for the death, psychologically, spiritually, and physically
- Help families with bereavement
- Provide support for children of PLHA
- Provide non-discriminatory, non-judgmental care.

5. End of life Care

A PLHA is referred to as being in the terminal stage of a disease when the infection or illness has progressed beyond what medicine can cure. This is, therefore, a period in which, despite all the treatment given, the PLHA does not respond. End of life care neither hastens nor postpones death. Dying occurs in its own time as the major organs of a person stop functioning. During this period all care providers in both health institutions and the home need to take precautions to avoid burnout syndrome. The end of life care PLHA should never be considered less than they were in the early stages of the illness. PLHA needs include spiritual care, psychological and emotional support, and physical, including nursing, care. The end of life care continues palliative care. Its main aim is to prepare the PLHA and the family members for the impending death and to help the PLHA die with dignity.

Components of end of life care

- Enhancing the quality of life of the PLHA.
- Relieving pain and other distressing symptoms.
- Providing practical emotional support for the PLHA and the family members.
- Helping PLHA and family members to organize their lives and orient them to the forthcoming death. This can include assistance with writing or verbalizing wills.
- Facilitating a comfortable and dignified death.

- Ensuring bereavement support to the family after the death.
- Help with the needs of children in the household

6. Social Support

Social support is important for all human beings and for PLHA it is even more crucial to live a life of dignity despite the prevalent stigma and discrimination. Social support for HIV infected people is the creation of an enabling environment for the PLHA by all involved in providing care. It incorporates information dissemination and referral to support groups and welfare, economic and legal services. The objectives of social support are to:

- Contribute to the social and material well being of the PLHA
- Involve the community in the care of PLHA and affected families
- Provide relief for the family caregivers from the burden of care
- Raise awareness among community members on issues related to the transmission of HIV
- Develop a social safety net for affected children

Components of Social Support

- Love and acceptance from all around by reducing stigma and discrimination
- Source of income/ employment/income generating activities , access to loans /grants
- Confidentiality regarding HIV status by all who know about it.
- Security of person and property.
- Respect and help with the activities of daily living. E.g. assisting with shopping , child care households chores, farming
- Support group of PLHA and Activism.
- Care of orphans and children in need, including any necessary legal interventions, especially regarding property inheritance.
- Children's education.
- Access to health services including safe and affordable drugs.
- Mobilizing community needs.

Safety Precautions and Infection Prevention

Safety precautions and infection prevention must work in both directions to protect the PLHA as well as to protect the caregiver. CHBC programs must provide information and training on infection prevention to PLHA and caregivers alike:

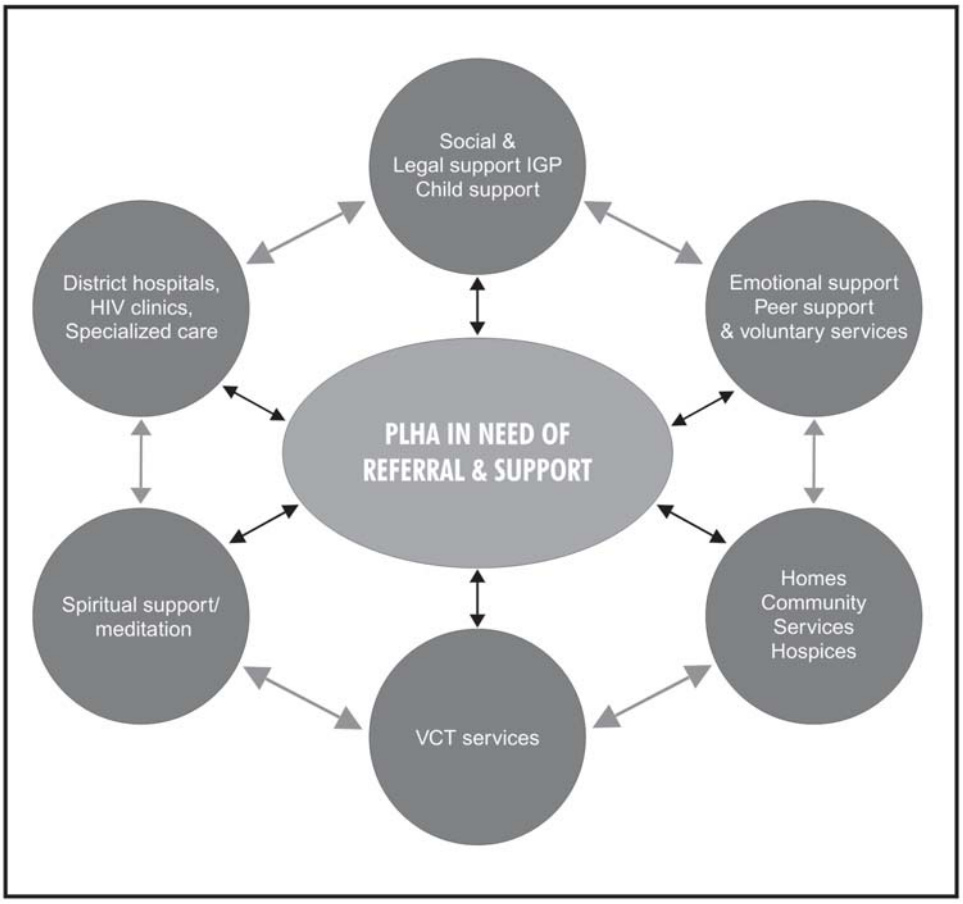
1. Protecting the PLHA
Persons infected with HIV have low immunity and even relatively common or "simple" infections such as a cold or the flu can be dangerous. CHBC team leaders must inform team members about the need to take care to avoid situations where they might pass infections to the PLHA. Both PLHA and caregivers should be screened for TB and treated as appropriate.

2. Protecting the Caregivers
All persons involved in direct care of PLHA, professionals or volunteers, must be informed of the possibility of contracting the virus through contact with contaminated body fluids. All caregivers must be trained in basic procedures for handling body fluids and practicing infection prevention procedures such as wearing gloves or other protective gear or using disinfectants. Caregivers who are accidentally exposed should follow guidelines for anti-retroviral post exposure.

3. Protecting the Community
PLHA who are sexually active may infect others with the disease. Thus their right to privacy and confidentiality ends when they behave in a way that threatens other members of the community. The CHBC team leader, in consultation with relevant health authorities and self help groups, should determine the best course of action in such case.

Referal & Networking

Referral helps to ensure the care continuum for HIV infected and affected people, such as orphans and dependents, through networking/coordination and the identification and utilization of all available resources. For example, screening for and prompt treatment of both TB and STDs are critical to contain the progression of HIV, thus, referral should be made to local DOTS clinic or other health facilities services to screen for TB and STD. Referral and networking is an essential mechanism for assuring treatment rights of PLHA in situations where health services, expertise and facilities catering to PLHA may not be available.



The Referral Framework

Following would be an ideal referral framework to build upon:

- The DACCs will work closely with the VACCs and local CHBC services to identify appropriate referral points for a range of services (medical, legal, social, spiritual, etc.) likely to be needed by PLHA and their families'.
- Within each home-care team a specific team member will be designated as responsible for ensuring that referrals are done promptly and appropriately.
- The CHBC workers on the CHBC teams will be trained to recognize the need for referrals, to consult as needed to determine the source of required services, and to assist the PLHA and their families to make the necessary contacts.
- A 'Referral Directory' will be created for organizing contact information of important referral points (example provided below).

Example of a Referral Directory

1. Name of the provider or agency: Family planning association of Nepal (FPAN)
2. Contact person: Dinesh Kumar Joshi
3. Postal address: Pulchowk, Haat Bazzar, Butwol, Rupandehi branch
4. Telephone: 071-540081
5. Fax : 071-543882
6. E-mail addresses: dineshfpn@beci.com.np
7. Target population(s): Women/Men reproductive age and youth adolescence (girls and boys)
8. Current service area(s):
   - Family planning service
   - Sexually transmitted infection (STI) Treatment
   - Prevention of Mother to Child Transmission (PMTCT) /Ante-natal service
   - Counseling
   - ART sites
   - Religious place
   - PLHA network
   - VCT

Resource Mobilization

Resource mobilization entails identifying and using all available services or goods required to meet the identified needs of the PLHA, the family, community and essential service outlets. It is essential to ensure resource mobilization so that goals set at various levels of CHBC are achieved.

Types of Resources needed for Effective and Sustainable Care

Resources are required at every level of the home-based care continuum, and the players at every level should be expected to contribute to the greatest extent possible. Necessary resources for effective and sustainable CHBC services can be considered in three categories (the 3 Ms): manpower (the people needed), material (the goods, services, and financial support), and moments (the time required).

i) Manpower

These are the individuals who voluntarily spare their time to assist the PLHA or the PLHAs family and children. Persons who can be counted as human resources include:

- Health workers at all levels
- Family members, relatives/friends
- Community leaders
- Spiritual, political, and administrative leaders like sub-chiefs, VDC leaders
- Community volunteers, social workers

In late stages of the disease, PLHA become too weak to support themselves; this condition calls for continuous assistance from relatives and friends.

ii) Material

AIDS is a long, expensive, and debilitating illness rendering PLHA incapable of meeting even the most basic needs of everyday life such as fetching water or firewood. Children may drop out of school for lack of fees, food production and storage could be minimal, and frequent sickness form opportunistic infections can stain the family income. Material resources are needed in these circumstances to care for PLHA and their families; therefore, CHBC kits and transport for home visits are required.

iii) Moments

Caring for people who are infected or affected by HIV/AIDS can be very time consuming and emotionally draining. The constant demands can also be very stressful. PLHA themselves are also under stress and often in pain. However, being present is a major source of psychological and moral support, and friends and relatives should understand the importance of sparing time not only to help out as needed, but just to be with the PLHA and the family members.

Mobilizing Identified Resources

CHBC is a collaborative partnership of various stakeholders and benefactors in providing care and support to the infected and the affected. Potential partners need to be identified in all three levels (national, district, and village level) who can assist in identifying resources. At the district level, the DACCs are mandated to take the lead in identifying and mobilizing community resources at the local level; they should coordinate efforts with the private sector and NGOs in the area.

Sustainability

A number of measures can be taken to promote the sustainability of CHBC:

- Helping the community to identify with the problems of PLHA through gomba/churches/mosques/temples, and other social gatherings. Utilizing such socially accepted platforms will motivate them to accept the sick and the related interventions.
- Encouraging a multi-disciplinary involvement of all government ministries to address cross cutting issues such as improved land use and increased food production.
- Participating in and collaborating with the local DACC to ensure the full benefit of community support to PLHA and their families.
- Empowering the family and the community to use locally available resources.
- Training the community on aspects of care and infection control at home.
- Monitoring and evaluating CHBC activities through spot checks and field reports to ensure that program objectives are attained
- Encouraging regular meetings for the community to discuss issues related to HIV/AIDS.
- Empowering communities to establish income-generating activities to support the provision and replenishment of home care kits for needy PLHA/families.

Monitoring & Evaluation

Monitoring is an ongoing process of reviewing planned activities to ensure that they are carried out in such a way that the goals and objectives of a particular intervention are likely to be met. Evaluation is the process of assessing the actual progress toward goals and the impact of programs on target groups. Without this continual feedback loop, CHBC programs can become obsolete and no longer meet the changing needs of the community. Therefore, all CHBC programs should include a provision for monitoring and evaluation (M&E) to ensure that quality services are provided in a timely, effective, and cost-effective way.

Objectives of Monitoring and Evaluation in CHBC

- Ensure that guidelines in the provision of CHBC are being adhered to.
- Assess the impact of the program on the affected and the infected.
- Assess the viability of the program to help make alterations and substitutions for the success of the program.
- Help identify constraints and possible solutions.
- Establish proper organizational structures for supervision purposes.
- Enhance accountability and transparency.
- Document program activities and progress.
- Identify best practices with the idea of replicating them to the greatest extent possible.

Conducting Monitoring & Evaluation in CHBC Settings

The District CHBC committees formed under DACC are responsible for the M&E of various CHBC programs in their areas to ensure maintenance of service quality in accordance to the GON CHBC guidelines. The DACC are responsible for monitoring the implementation of HIV/AIDS policies in their respective areas of jurisdiction. At the local level, VACC and concerned stakeholders are charged with the development and implementation of M & E systems for AIDS related activities within their areas. Monitoring reports should be submitted quarterly and annually to DACC, and DACC should provide subsequent reports to GoN (NCASC) during the same time intervals The CHBC program should follow the national M&E system to comprehend the national level outcomes and impact of CHBC services.

The GoN (NCASC) in consultation with other stakeholders will take the responsibility of designing formal evaluation criteria and brief it with DACC who should take the responsibility of informing the criteria to VACC. The CHBC M&E information will contribute to the National Monitoring and Evaluation Plan indicator: "number of people receiving palliative care and support (without ARV)." Additional data will be collected monthly from CHBC programs and reported to GoN, which includes the following:

1. Total number of households' served by CHBC programs
2. Total number of individuals by age and sex (including family members) reached by CHBC programs - medical, psycho-social, and economical support
3. Total number of HIV infected individuals receiving CHBC services
4. Total number of children receiving CHBC services
5. Total number of HIV infected individuals referred to Clinic/Hospital for care and treatment
6. Total number of PLHA/individual loss and deaths
7. Drug stock-in and stock-out
8. Total of number CHBC team members trained
9. Number of PLHA (groups) involved in community activities

Note: QA &QI format (annex 10) will collect overall data and monthly data will be collected using CHBC adult and child forms

Certification Training, Capacity Building & Mentoring

- Certification Training: All CHBC team members are required to participate in the initial 7-day CHBC training before offering CHBC services. Those who have completed TOT training are expected to train their teams in CHBC using the national CHBC curriculum. CHBC programmers will periodically provide refresher trainings for CHBC service providers.

- Capacity building and mentoring: Capacity building and mentoring helps in constantly updating, reenergizing and encouraging CHBC staff with new updates and developments on CHBC and service delivery. Every month during the CHBC team meeting, a skills building session should be held. Topics should be chosen which are needed by the team (e.g. PMTCT). Team leaders and project supervisors need to provide routine on-the-job mentoring of CHBC team members. GoN staff and technical experts can also mentor CHBC teams as appropriate. Experts related to different components within CHBC and other experts in community service delivery such as community workers, social workers, etc., can also contribute to the mentoring of CHBC staff.

STANDARD OPERATING PROCEDURES FOR COMMUNITY AND HOME BASED CARE

Introduction

About the Standard Operating Procedure

The primary objective of the CHBC Standard Operating Procedures (SOPs) is to provide information on procedures for quality care delivery. Specific objectives are to:

- Provide CHBC teams with essential information on how to provide quality palliative care to PLHA - both those on ART and not on ART;
- Provide CHBC teams with operational information about how to organize and deliver CHBC services;
- Ensure that CHBC service delivery procedures are performed consistently to maintain quality;
- Support a continuum of care for people with HIV/AIDS and their families;
- Serve as a quality assurance tool for management to evaluate service delivery and reinforce performance in accordance with national guidelines.

Who can use the CHBC SOP manual?

The CHBC SOP manual is intended for use by the following people:

- CHBC teams;
- CHBC volunteers;
- CHBC supervisors;
- NGO/CBO program staff; and,
- Hospital HIV care and ART clinic managers

CHBC Team Structure and Responsibilities

I.CHBC Team Composition and Workload

A. General Considerations:

- CHBC team members should be full-time paid staff, although they can and should be supported by community volunteers (e.g., community members, FCHVs, etc).
- CHBC teams need to reflect a balance of staff that are HIV-positive and negative and should strive for a balance of individuals with health worker skills, community mobilization/ advocacy skills and psychosocial support/social work skills in the formation of CHBC teams.
- A well-balanced CHBC team consists of one team leader and 1-3 team members for a total of 2-4 staff. The number of staff needed depends on client load-the number of people needing CHBC.
- Client load is determined by the CHBC team based on their judgment of their physical limit given the following factors. :
  - the extent to which the clients are sick or need intensive support from the CHBC team - the higher number of sick clients means more frequent visits to each household;
  - distance and time needed to travel to home; mode of transportation ;
  - Staff time - whether or not the team is working full time as CHBC providers.
- CHBC service providers need to assist the CHBC team in calculating the maximum number of clients per team.

B. Number of CHBC visits:

In order to ensure quality of care and to prevent neglect, home-visits are conducted with the following frequency:

- Clients who are asymptomatic and do not need much assistance from the home-care team visits once every three months or depending on the needs of the client.
- Clients who are symptomatic but stable need once a month or more frequent visits.
- Clients who are in serious need of support or care should be visited as frequently as needed by the client and family.
- Clients just starting ART should be visited 2-3 times a week (for the first four weeks on ART) to provide adherence support and education on how to take the pills, to develop ART adherence support measures (e.g. treatment reminder calendars), to assist in side-effect management and to refer clients with severe side-effects or poor adherence.
- Clients discharged from in-patient care at the hospital often need regular follow-up until their condition has been stabilized. CHBC team members should visit as frequently as needed given the health situation of the client.

II. Roles and Responsibilities of CHBC Staff:

- **CHBC Supervisor:** Provides overall oversight and management of the teams. Accompanies the CHBC team on home-visits at minimum once a month, observes visits using supervision forms and provides supportive feedback to the team following the visit.

- **CHBC Team Leader:** Provides day-to-day supervision of the CHBC team, leads planning of team services, identifies training needs of the team, and provides on-the-spot supervision and direct home-care to clients. The team leader spends most of their time in the field with the teams providing care. They are the role model for setting a high quality standard of CHBC care. Note: If there are two members in the team, the team leader divides her/his time and accompanies one member on home visits at a time.

- **CHBC Team Member:** Provides regular, high quality care and support to PLHA clients. Receives support and feedback from the team leader.

- **CHBC Volunteer:** In the event that client load is high or clients are very difficult to reach (e.g. hilly areas), the service provider may wish to recruit CHBC volunteers to support the CHBC team in providing routine care to all its clients.

Community and Home Care Team Considerations

- **Client Confidentiality:** All CHBC staff and assistants should maintain client confidentiality at all times.

- **Dress code:** CHBC team members do not wear a uniform but dress appropriately and politely. To protect clients, they do not wear anything which indicates they are working in the field of HIV/AIDS.

- **Home-care bag:** CHBC team members bring a bag containing home-care medicines and supplies but the bag should not look medical - it should look like a bag which is common in the area: backpack, shoulder bag, etc. This is done to protect client confidentiality.

- **Staff substitution during absence:** When CHBC staff are absent because of training, holiday or illness, they need to identify a team member as a substitute home-caregiver or family member who is educated by the CHBC team member to provide necessary care so that care to the client is not interrupted.

- **On-call:** CHBC members can face burn-out in their work, so wherever possible establishing an 'on-call' system could help arrange work load and limit overburdening of staff. Since clients may call at any time, day or night, CHBC teams, where ever possible, should develop an on-call system where one team (or team members) is/are available in turns to care for emergency cases outside of work hours.

III. Communication

A. General Communication

- The CHBC Team should have a communication system in place (e.g. access to public telephone) in order to communicate with the hospital during an emergency or to get clinical support including referrals. This is very important and could save a client's life.

B. Communication between clients and home care team

- CHBC clients need to be able to contact home care team members in the event of an emergency. Home care team members should develop CHBC Contact Cards with their work contact numbers and office address. In addition, the team members should establish an on- call system so that one member is available at all times in the event of an emergency.

IV. Transport

Since CHBC requires traveling to homes, CHBC programs need to pay for team transport costs. CHBC service providers will develop transparent and fair transport rules and regulations according to existing policies.

Client Enrollment in the CHBC Service

I. Referrals to the CHBC program

- Clients enter the CHBC program by referral through the following channels:
- HIV voluntary counseling and testing (VCT) sites
- NGO's from surrounding districts who interact with PLHA
- District and other hospitals
- PMTCT services
- TB services
- Primary Health Care Centers
- Self referral
- When a client is referred by another service, s/he ideally brings a letter of referral to present to the CHBC team.
- When a client has no medical record with an HIV-positive test result, regardless of current or previous symptoms or illnesses, they are referred to VCT before registration.
- All HIV-infected clients who choose to be regularly followed-up by CHBC will be registered for the program.

II. New Client Registration

- All clients are registered for CHBC by the CHBC team. S/he records the patient's name, address, phone number (if available), date of birth, age, sex, marital status, and other emergency contact details in the register.
- A new file is prepared for the client with a unique code number on the green front cover and recorded again on each page of the record.
- The files will be taken on home visits and completed in the home using the first visit client contact form. (See Annex 3a).

Procedure of First Home Visits

I. Before the visit:

- Ensure you have approval from the client (or their caregiver if the client is very ill or otherwise unable to request care themselves) to visit them at home.
- Ask the client if it is acceptable to speak openly about their HIV status in their home or not. If not, ask the client how they would prefer you to present your visit to the family. It is useful to make a list in the client's file of who in the family is and is not aware of their HIV status.
- Set a time and date for the visit which is both convenient to you and the client
- Make a new file for the new client and assign them a client code (all client files are coded and names are not included).
- Prepare the home care supplies and forms for the visit.
- Arrange transport.

II. During the visit:

- As you approach the house, observe the physical environment. When you first arrive at the clients home, warmly greet the client and their family
- Introduce yourself and your team member(s) and the work of the home-care team
- Make friendly conversation with the new client and family members for a few minutes
- After you feel that the family is comfortable with you, ask the new client if it is ok for you to ask some questions and to do the basic physical assessment.

> **Important:** If you observe the client is in critical condition, quickly determine if he can be transported to the hospital, and if the client and family approves of making this referral. If the family agrees, call the hospital to make emergency referral and accompany the client to the hospital so you can help them get emergency care.
>
> If the client is in a terminal condition, the client and his family need to make a very difficult decision, on whether to refer the client to a hospital or not. If the client is aware, s/he needs to lead in the decision-making process. Help to make this decision but do not make it yourself. It is helpful to discuss this topic at earlier visits so that the client is able to make his/her choices understood to the family and the CHBC team without waiting for a crises situation.

***[Note: Client Needs Assessment** (involve the family caregiver if this is ok with your client. It is better for the family caregiver to be present, if possible, so they can learn care giving techniques from you)]*

- Sit at equal level with the client.
- Assure the client that all information taken by you is **confidential** and will only be used by the home care team.
- Communicate respectfully and warmly during needs assessment.
- Take basic client information in the record form, e.g. marital status, number of children. If the client is in need of immediate care, skip this section and go straight to the physical needs assessment. You can always fill this information in once the client's most pressing problems have been prioritized.

➔ **Start with the history and physical needs assessment**

- Take client's vital signs
- Ask the client how they are feeling and what they feel their most pressing worries and needs are. Their concerns might be physical, emotional, social or spiritual. If the client is

too ill to respond, you can ask the caregiver.

- During the first visit, take complete history using the first visit client intake form
- During each subsequent follow-up visit, take history based on previous visit findings and recommendations using the follow-up visit form

Note: *If you determine an immediate need for the client to go to the district health center or hospital, stop the history taking and arrange for immediate referral if the family agrees.*

- Ask the client to show you any medicines they are taking. Ask the client and caregiver to tell you how and when to take each medicine that they have been prescribed. If they are not clear on the medicines, review the medicines and prescription with them and help the family to **prepare a calendar for remembering** when and how to take the medicines. If they are taking medicines which are inappropriate, counsel them on this issue.
- Now start the **basic physical assessment** of your client.
- **Based on history and exam provide symptom and nursing care and support** to the client as needed; discuss with client and family what you are doing and why it is important. Demonstrate care giving skills to family caregiver/PLHA as needed and leave supplies that the PLHA/family can use to manage the problem themselves in the home.
- If the client needs to be **referred to the health center or hospital** for out-patient or in-patient care, help to arrange a time and transport for this referral, as needed.
- Ask the client and family members if they have questions, or want to know anything about how to take better care for them. Provide your client with the **PLHA self-care handbook;** refer to it as you explain self-care techniques.
- Ask your client if they are in a **PLHA support group.** If not, give them information about the local groups, the number of the group leader and the time and place of the next meeting.

➔ **Now ask the client how they have been feeling emotionally**

- Ask open ended questions such as:
  - Is there anything that is worrying you?
  - How you have been able to sleep?
- Listen with empathy.
- Paraphrase what the client has said
- Assist the client in brainstorming ways they can respond to the issues raised
- Then, help the client to decide on a course of action
- If the client is very depressed, distressed and expresses the desire to commit suicide, get help! Contact your supervisor right away.

➔ **Now ask about social needs:**

- Ask the client the questions in the client record form such as:
  - Does the client, household have enough food to eat?
  - What is their monthly income?
  - Do they need income generation support?
  - How are their children?
- If the client needs food, assess the amount of food they are able to provide for themselves. Discuss with the home-care team the amount of food that would be an appropriate supplement.
- Provide referral information to your client about local social support services which could assist the client with their specific social needs and concerns.
- Arrange follow-up and referral as appropriate.

➔ **Now ask about spiritual needs:**

- Ask the client if they are actively involved in a religion.
- Explain that you only ask to know whether or not they would like your assistance in helping them receive support from a religious leader of their faith.
- Provide referral information to your client about local religious support services within the faith of your client.
- Arrange, follow-up on referral as appropriate.

Note: *Stop the needs assessment whenever the client seems too tired to continue, you can always continue it on your next visit.*

Assessment- Caregiver

Follow the above steps with the caregiver, if the client is too ill to respond. In summary:

- Sit at equal level with the caregiver
- Begin asking the caregiver to provide information on the well being of the client, themselves and the household as a whole.
- Take care of any immediate food, universal precautions, nursing and/or medical needs of the caregiver. Leave materials as needed with the caregiver. Provide instructions to the caregiver in how to use materials you have given them.
- Stop assessment if the caregiver is unable to continue.

III. End of visit:

- Ask the client and caregiver if they have any other questions or requests.
- Summarize the visit findings: problems identified, problems addressed during the visit and the next steps to address other problems.
- Ensure you have left the needed supplies with client/family to care for physical and social problems identified during the visit.
- Arrange and help with referrals if needed.
- Schedule a time and date for your next visit.

IV. After the visit:

- Review client record form to ensure it is correct.
- Record medicines or supplies which were given to the client in the logbook.
- Place the client's file in the locked file cabinet where client files are kept.
- **Follow-up on any referrals** you helped make for your client to ensure that they are able to receive the care that they need.
- Refill the home care kit as needed for the next visit
- **Debrief** with your supervisor about what you felt went well on this visit and what you would like to improve for the next visit. **Ask for advice and help** from your supervisor, particularly if there were issues with your client that you were not sure about how to respond to.

Symptom Care:Doing a Basic Physical Assessment

After you have observed, asked and listened, you will need to look and feel to gain a better understanding of the symptoms faced by your client and to understand what is normal physically for your client.

Explain to your client that you would like to feel them to get a better idea of how they are doing physically. Ask your client if it is ok if you touch them. If they agree, start the basic physical assessment. Pay special attention when you do the basic physical assessment to the areas of the body where your client says they are having a problem.

The below steps explain how to do the basic physical examination and what to do if you find certain physical problems. Not all home care giving steps are listed below. Once you have identified which symptoms the client has, you can also use the self-care book for ideas about how to provide home-care for the symptom, if the client does not need to be immediately referred to the hospital.

> Doing the physical assessment is very important because it helps you to know what is normal for your client. If you know what is normal, you will also be better able to recognize what is abnormal -- if there is something wrong with your client.

1. Vital Signs

- **Check temperature by:**
  - Placing the back (not palm) of your hand on your forehead and the client's forehead. Leave your hands there until you begin to feel differences between the temperatures of your head and theirs. This is not an exact method but if you do not have a thermometer it can give you an idea if your client has a fever.
  - Or, by using a thermometer. Only use a thermometer if you know how to read it.
  - Action: If they have a fever more than 37.2 °C (99.0 °F), provide fever care to reduce the fever. If the fever is > 38.5°C (101.4°F), provide paracetamol (one or two 500mg tablets every 4-6 hours).
  - If the fever remains high after providing fever care, or you find other problems in addition to fever (such as yellow eyes or chronic cough) refer them to the hospital.
  - If the fever is 40-42°C (104-107.6°F), it is a very serious sign and indicates that your client needs immediate medical attention. Provide fever care including paracetamol and refer.

- **Check the pulse :**
  - The pulse is usually found on the side of the lower neck, on the inner side of the elbow, or at the wrist. While taking pulse:
  - Use the first and second fingertips, press firmly but gently on the arteries until you feel a pulse.
  - Start counting the pulse when the clock's second hand is on the 12.
  - Count the pulse for full 60 seconds.
  - When counting, do not watch the clock continuously, but concentrate on the beats of the pulse.
    - **Action:** *The normal pulse range for a healthy adult ranges from 60 to 100 beats per minute. If the pulse is more than 10 points above or below this range it is a sign that the client is in ill-health and they need to be referred to the hospital.*

- **Check the breathing (respiration rate) of your client by:**
  - The respiration rate is the number of breaths a person takes per minute. To check the rate of your client, you will count the number of breaths they take in one minute by counting how many times their chest rises. You may put your hand on the belly of the client to feel the movement.
  - Respiration rates may increase with fever, illness, and with other medical conditions.
  - When checking respiration, it is important to also note whether a person has any difficulty breathing.
    - **Action:** *At rest, normal respiration rate for healthy adults ranges from 13 to 20 breaths per minute. Respiration rates over 25 or below 12 breaths per minute (when at rest) is a sign that the client is in ill-health and they need to be referred to the hospital. If the client is having difficulty breathing, this is very serious and means they need to be referred to the hospital urgently.*

2. Physical Exam

- **Start with the head and then work your way down to their eyes, and mouth.**
  - Observe their face in general
  - Does their skin color look normal?
  - Do they look very pale, almost blue?
  - Does their face look yellow?
    - **Action:** *Blue color of face including lip and tongue is a danger sign, if it is associated with breathing difficulties arrange immediate transfer to the hospital.*
    - Now, look into their eyes.
    - Look in their eyes to see if they are/have:
      - Yellow
      - Very red
      - Unusual spots on their eyes
      - Sores near/around their eyes
      - Pink rash near/around their eyes
      - Sunken

    - **Action:** *If you see any of these problems it is a sign that something is wrong and you need to refer them to the hospital.*
    - Gently pull down the lower eye lid to see the color of the skin (the conjunctiva). If it is very light (pale), and not pink/red then this could be a sign of anemia.

    - **Action:** *If you think they may have anemia, refer them to the hospital. This could be a danger sign if they are taking ARVs.*
    - Ask the client if:
      - Their eyes are very itchy
      - They are having any difficulty seeing
      - They feel pain in their eyes

    - **Action:** *If they say yes to the above, this it is a sign that something is wrong and you need to refer them to the hospital.*
    - Now, using a torch, look in their nose
    - Is there a lot a mucous, is it irritated?

    - **Action:** *If they say yes to the above, this it is a sign that something is wrong and you need to refer them to the hospital.*
    - Now, using a torch, look in their ears
    - Are they clean, is there discharge, are they irritated?

- Ask the client if:
  - They have any pain in their ears
  - They are able to hear as they did before they were sick or if anything is different.

- **Action:** *If they say yes to the above, this it is a sign that something is wrong and you need to refer them to the hospital.*
- Now, look at their mouth
- Are their lips very dry or cracked?

- **Action:** *If they have dry lips, apply petroleum jelly to them and teach your client and family how to keep the lips moist.*
- Do they have any blisters, or ulcers on their lips?

- **Action:** *If they have blisters, ask if they are painful. If yes, treat for pain. If the blister is open, clean it with salt water or gentian violet. Also ask if they have other blisters on their body and if they are painful. If so, this is a sign that something is wrong and you need to refer them to the hospital.*
- Now, ask them to open their mouth
- Look at their tongue
- Are there white, patchy spots on their tongue?
- Can they swallow easily or not? If not, are they able to eat? Drink? Take their medicines?

- **Action:** *If they have white, patchy spots on their tongue, help the client to gently brush their teeth with salt water and then apply gentian violet (or antifungal medicine if prescribed by the doctor) to the tongue and mouth; teach the PLHA and family how to provide mouth care. If it is painful for them to swallow, eat, drink and/or take their medicines this is a danger sign, you need to refer them to the hospital.*
- Look at their gums and teeth
- Are there gums red and bleeding?
- Do they have any tooth pain (tooth decay)?
- Do they have bad breath?

- **Action:** *If they have these problems, please show the client and their family how to keep the mouth and, teeth clean through regular brushing and gargling with salt. Also refer them to the hospital if they have tooth pain/decay or bleeding gums to the hospital.*

- **Now feel the lymph nodes, first along the side of the neck**
  - Feel for a hard lump under the ear and the jaw.
  - If you feel nothing, this is normal
  - If you feel small hard lumps:
    - Ask the client if it is painful for you to touch them
    - Note if the hard lumps are only on one side, or on both sides of the neck

    - **Action:** *If they have this problem, it could be normal, or it could be the sign of an infection. If the client also has other symptom (fever, difficulty swallowing, cough), this is a sign that something is wrong and you need to refer them to the hospital.*
    - If you feel/see large hard lumps:
    - Ask the client if it is painful for you to touch them
    - Note if the hard lumps are only on one side, or on both sides of the neck

- Ask if it is also difficult for the client to swallow

- **Action:** *If they have this problem, this is a sign that something is wrong and you need to refer them to the hospital.*
- Feel for a hard lump in the underarms of your client.
  - Ask the client if it is painful for you to touch them
  - Note if the hard lumps are only on one side, or on both sides of the neck

- **Action:** *If they have this problem, it could be normal, or it could be the sign of an infection. If the client also has other symptom (fever, skin infection near the underarm, sore breasts/nipples - if they are female; cough), this is a sign that something is wrong and you need to refer them to the hospital.*
- Feel for a hard lump in the groin area of your client.
  - Only do this if your client approves of you touching their groin area
  - Ask the client if it is painful for you to touch them
  - Note if there are only one or two lumps

- **Action:** *If they have this problem, it could be normal, or it could be the sign of an infection. If the client also has other symptom (fever, pain in the groin, sore in the genital area or genital discharge), this is a sign that something is wrong and you need to refer them to the hospital.*
- Now gently feel/palpate the client's abdomen
- Note: If the client has a full bladder, feeling their stomach may hurt. If possible, the client should go to the toilet before the exam
- Gently feel the stomach, moving slowly in circular motion. The stomach should feel soft,
- Ask the client if it hurts as you feel their stomach
  - Does the client feel any pain when you press?
  - How strong is the pain and where is the pain?
  - Do you feel any unusual hardness in the stomach?

- **Action:** *If you feel unusual hardness in the stomach and/or the client feels strong pain when you press/touch the stomach, this is a sign that something is wrong and you need to refer them to the hospital.*

- **Now look at and feel the skin of the client.**
  - Note: If you observe a rash on the trunk, arms, legs this could be the sign of a serious problem. Please refer your client as soon as you can to the hospital.
  - Look on the skin of the trunk, front and back
    - Does the skin look dry, scaly?

    - **Action:** *If they have dry skin, moisten the skin with a little water, then apply petroleum jelly; teach your client and family how to keep the skin moist.*
    - Do they have a rash? Lumps? Are they itchy?
    - Do they have a wound or abscess? Are they infected? (pus, red, swollen?)
      - Do they have blisters which are all together on one part of the back or stomach? Are these blisters painful?

- **Action:** *Provide appropriate care for the skin problem (see self-care book). If there is a wound which is very infected, this is dangerous, especially if they also have a fever; refer the client to the hospital.*

- Look and feel the arms, hands and legs of the client
  - How do their nails look? Are they an abnormal color (blue, red, black?)
  - Are there any itchy bumps on their hands? In between their fingers?
  - Does the skin look dry, scaly?
  - When you do the dehydration skin-test, does the skin return quickly to its normal place or not?

- **Action:** *If they have dry skin, moisten the skin with a little water, then apply petroleum jelly; teach your client and family how to keep the skin moist. If the dehydration skin-test shows that the client is dehydrated, you will need to encourage them to drink ORS and refer them to the hospital as soon as possible.*

- **Discuss:** Once you have completed the basic physical examination, explain clearly, using common language to your client what you have found. Discuss with the PLHA and the family what you think needs to be done.

- **Decide/Do:** Take action as agreed mutually by the PLHA, family and you.

- **Follow-up and repeat:** When you visit your client again, refer to the findings and actions to be taken decided on in the last visit. Review how the client feels now; ask about what action was taken, and then do another basic physical assessment to compare the well-being of their client from the last visit to how they are feeling now.

First Home-Visit Protocol for Urgent referral - Adult with HIV

During your first visit, you may come across a client who is very sick. Please follow these steps during each first visit to decide what to do:

- Assess urgency of client condition
- If client appears stable, continue with normal home-visit,
- If they are not stable, explain situation and ask the client and family if they agree to hospital referral.
  - If client/family says '**yes**' to referral
    - Take measures to stabilize client (fever care, better positioning for easy breathing, etc)
    - Treat pain- this will improve comfort during referral
    - Arrange transport and appointment with referral site
    - Go with client to the referral site to help them access the care they need
    - Record vital signs and other information that will help the hospital to better understand the problem of your client.
  - If client/family says 'no' to referral
    - Continue with first-contact assessment and schedule follow-up visit
    - Assess for pain and other symptoms. Treat and provide other measures of comfort.
    - Provide CHBC team contact information in the event the client/family needs urgent help or decides to go to the hospital.
  - If client/family says 'no' to referral AND client near death
    - Provide needed care
    - Train caregiver to make the client as comfortable as possible
    - If pain present, provide the caregiver with enough pain medicine for around the clock pain control
    - Train caregiver how to provide medicines on time
    - Provide medicines and other supplies as needed
    - Assess for emotional and spiritual support needs (counseling for family members; planning for children; need for visit from local religious leader)
    - Provide CHBC team contact information in the event the client/family needs urgent help or decides to go to the hospital.

Danger Signs:

1. Unconsciousness
2. Shock (weak or fast pulse; cold skin)
3. Cannot breath very well, and/or breath is very fast and shallow
4. Convulsing (now or recently)
5. Severe headache; stiff neck
6. Severe pain
7. Severe dehydration (sunken eyes, skin test)
8. High fever; prolonged fever
9. Prolonged cough for two weeks and is very weak

If the client is sick, or stable, but taking ARVs, also refer if:

- They have a severe rash all over the body
- They are very weak and pale
- **They are still sick even though they are taking ARV medicines**

- They are not taking their ARV medicines correctly (same time/every day)
  Note: *Cotrimoxazole can also cause a rash all over the body. If you see this in an adult or child taking this medicine, please refer immediately to the hospital.*

Remember: All clients need to be asked if they want to enroll in a hospital-based HIV care and ART clinic and PLHA support group in case they have not already done so. If there are family support groups in place, then also notify the family about the time and location of these meetings.

Referrals and Discharge Planning

I. Referrals

Referrals are essential for helping PLHA to meet their physical, emotional, social and spiritual needs. The following are the types of referral relationships that are important to meet needs:

- Physical Needs
  - Medical Care
    - Referral to local hospital for - OI/ART, TB, antenatal clinic (ANC)/PMTCT, etc.
  - Nutrition and clean water
    - Referral to NGO which provides food support, vitamins, seeds and other support for kitchen gardens, wells and bore holes, toilets, etc
  - Housing
    - Referral to NGOs which support improving homes (e.g. rebuilding the roof), assistance with housing for the homeless, etc

- Emotional Needs
  - Counseling
    - Refer to a counselor as needed at an NGO or mental health department in the local hospital
  - Peer support
    - Joining a support group

- Social Needs
  - Economic support
    - NGOs which provide grants, loans, skills training and other assistance
  - Legal protection
    - NGOs which can help protect property and belongings of people; protection from violence and abuse, etc
  - Services for children
    - NGOs which support access to schooling - uniforms, books, school fees; child protection if children are being abused; foster care and orphanages as a last resort if there is no where else for children to stay

- Spiritual Needs
  - Meditation
    - NGOs which can build skills in meditation including prayers and breathing techniques
  - Special religious support
    - Organizing visits from religious leaders to the home or visits to holy places directly or through referral

CHBC team members need to accompany the client to the referral site not only to assist them in locating the site but also in helping them to access the service. CHBC team members should be proactive in accompanying their clients to services, particularly if clients are new to the service.

Referral forms need to be completed for all referrals. See Annex 3.

II. Discharge Planning

CHBC team members should track the progress of their clients who are receiving in-patient care to ensure they are aware of their client's diagnosis, treatment and possible duration of stay at the facility. CHBC team members can then assist clients during discharge and monitor their progress at home.

Prevention for Positives

CHBC teams need to review HIV transmission risks and prevention needs on each visit. This review includes, at a minimum, the following:

1. Screening for HIV Transmission Behaviors and STIs

a. During the first CHBC visits, conduct a brief, non-judgmental, but specific risk assessment. Be sensitive to who is nearby during the visit. If many people are around, assessing behaviors related to transmission of HIV may not be easy - assess with sensitivity.
   1. Determine current risk for transmitting and/or re-acquiring HIV or transmitting other STIs to/from others.
   2. Ask questions both open-ended and directed:
      - Is the client sexually active?
      - Any signs or symptoms of sexually transmitted infections, especially at the sexual organs, anal and oral regions?
      - How many partners and of what gender?
      - Nature of sexual activity (e.g. anal, vaginal, oral) and partners' HIV status?
      - Use of safer sex practices, if any?
      - Challenges, if any, for implementation of safer sex practices?
        - Current alcohol, legal or illicit drug (opiates, amphetamines) use
   3. If the client is sexually active provide them with the following information:
      - Unprotected sex between consensual HIV-positive individuals still contains risks:

   1) STI transmission or 2) transmission of HIV superinfection (i.e., re-infection with a different strain of the HIV virus)
      - Provide information about how to use condoms and equip the client with an adequate supply of condoms
   4. If the client is an active injecting drug user, provide information on not sharing needles and syringes and provide the client with an adequate supply of clean needles and syringes
      - Refer to drug treatment program if client wishes to join a program
   5. Refer patients to STI clinic for:
      - Regular screening for asymptomatic STIs
      - Yearly cervical PAP smear for women, if available

2. Follow-up CHBC visits

Reinforce prevention messages:
- At each CHBC visit
- Through longer or more intensive interventions if needed
- Provide referrals for additional prevention counseling as needed

3. Contraception evaluation and referral

a. All clients should be asked about contraception. Contraception is an issue for all PLHA whether male or female, single, married, widowed or separated.

b. If the client wants to use a contraception method in addition to condoms refer them for family planning services when needed with assisted referral as necessary.
   Note: *The recommendation is to use both condoms to prevent STI and HIV transmission and another family planning method for pregnancy prevention.*

c. All adolescents need family planning counseling.

4. PLHA wishing to have children:
- For couples where both the woman and the man are HIV positive, pre-conception counseling should be counducted including:

- Encouragement to discuss the choice with their doctor who can provide them with information on when the best time is to have a child.
- You can also provide the following information:
  1) If they are taking ART, they'll have to wait until there is less HIV in their body - the doctor will tell them when this is. If they are not yet ready to take ART, the doctor can tell them if they are in good enough health to have a child.
  2) About the PMTCT program
  3) Issues with infant feeding - tell the client to ask their doctors about this
  4) That their health may not always be good and that they'll need to consider that in planning for the future of the child - who will take care of the child if anything happens to them?
  - For discordant partners where the woman is HIV negative and the man HIV positive, pre-conception counseling should be done including:
    - Risk of HIV transmission from the man to the woman.
    - Limiting unprotected sex to the most fertile days of the woman's cycle only. Couples need to be taught how to estimate the most fertile days of the cycle. The doctor will help the couple know when this is.
    - Discussion of chances of transmitting HIV to the child during pregnancy, birth or breastfeeding, if the woman becomes infected.
    - About the PMTCT program
    - Issues with infant feeding - tell the client to ask their doctors about this
    - Repeated HIV testing for the woman should be discussed.
    - That their health may not always be good and that they will need to consider that in planning for the future of the child - who will take care of the child if anything happens to them?
  - For discordant partners where the woman is HIV positive and the man HIV negative, pre-conception counseling should be done including:
    - Risk of HIV transmission from the woman to the man, if unprotected vaginal-penile intercourse.
    - To consult their doctor about ways that the woman can become pregnant while reducing the risk of HIV
    - Discussion of chances of transmitting HIV to the child during pregnancy, birth or breastfeeding, if the woman becomes infected.
    - About the PMTCT program
    - Issues with infant feeding - tell the client to ask their doctors about this
    - That their health may not always be good and that they will need to consider that in planning for the future of the child - who will take care of the child if anything happens to them?
  - Make referral whenever you feel it is necessary.

5. Facilitate the Notification of Sexual and other At-Risk Partners

Patient-led process for individuals determined to be at risk

- Support HIV status disclosure
  - To sexual and other partners at risk for HIV infection
  - Only if and when it is **safe** for the patient to do so
- Facilitate the provision of
  - Information, education
  - Voluntary HIV counseling and testing
  - Appropriate referral

ART Adherence for Adults and Children

A. ART for Adults

- PLHA start ART after they are assessed by a trained doctor at a MoHP ART hospital, and the doctor and a committee of different individuals decide, based on clinical findings, that the PLHA is ready to start taking ART
- Each PLHA will be prescribed ARV medicines which are appropriate to them. Not all will have the same regimen.
- The most common ART regimens in Nepal for 1st line therapy are:

1. Zidovudine(AZT) plus Lamivudine (3TC) plus Nevirapine (NVP)
2. Zidovudine (AZT) plus Lamivudine (3TC) plus Efavirenz (EFV)
3. Stavudine (d4T) plus Lamivudine (3TC) plus Nevirapine (NVP)
4. Stavudine (d4T) plus Lamivudine (3TC) plus Efavirenz (EFV)

Note: *For most adult clients and children less than 3 years of age, the preferred first line regimen will be:* ***Zidovudine (AZT) plus Lamivudine (3TC) plus Nevirapine (NVP)***

Note: For PLHA starting Nevirapine they will take only 1 pill 1 time a day for 2 weeks. After that they will take 2 pills a day - one in the morning and one in the evening. This is normal and is done to help the body adjust to taking Nevirapine which some people can have an allergic reaction to.

B. Adherence

- Adherence is taking the right doses, at the right time, the right way every day. HIV can easily become resistant to ARVs if they are not taken exactly right. The only way to make sure the medicines work as best they can is to support clients to take their medicines exactly as prescribed by their doctor.
- The role of the CHBC team is to reinforce correct information regarding when the client needs to take their medicines. The CHBC team must listen very carefully to what the doctor prescribed and make sure they understand the regiment correctly so they can provide the correct support and information to the CHBC team. The CHBC teams can also check the ART booklet given to each client to check the prescription and make sure they are relaying the correct information to the client.
- On each visit, the CHBC team will ask the client how they are doing with taking their medicines. Ask: "How it is going with taking your medicine? Have you forgotten any doses?"
- They will ask to see the ART booklet or prescription.
- The CHBC team will do a pill count to compare the amount of ART the client has to the prescription.
- Help PLHA to develop ways to better remember to take their medicines including using a calendar and/or watch (if affordable). Train a family member to support the PLHA in remembering when to take ART.
- If the client is not remembering to take their medicines correctly and exactly on time, refer the client to the hospital that is prescribing ART.

C. Forgetting doses:

Reasons for missing doses may vary from simply forgetting, travel, work hours, running out of pills, sharing medications, etc. Most of these reasons are linked to barriers that the patient faces. Identifying and addressing barriers has been discussed in earlier modules. Patients can be given the following advice:

1. When you notice that you missed a dose, take your pills right away.

NEXT DOSE

2. If the next planned pill-taking time is four or more hours away, take your next dose at the planned time and continue on regular schedule
3. If your next planned pill-taking time is less than four hours away, DO NOT take your next dose. Instead, wait four hours and then take your next dose.
4. Do not take two doses at one time.
5. If it is already time for the next dose, just take that dose and carry on with the treatment schedule. Mark the calendar for the missed dose with the reason for missing medication.
6. If severe side-effects occur, inform the doctor, adherence counselor or health worker.

d. Side-effects

1. Side effects are normal within the first few weeks of starting ART. Reassure the client that they are normal.
2. Provide symptom care as needed to help the client manage common side-effects. Common side-effects include headache, nausea, dizziness, and diarrhea. Skin color changes and tingly feelings in the arms, legs, fingers and toes are also common.
3. Refer the client to the hospital that prescribed ART if you see any of the following:

a. Client continues to be very sick even after taking ART
b. Client gets better and then in a few weeks starts to get sick again
c. Client is very pale and weak (anemic)
d. Client develops wet rash on the body

- **ART for Children**
  - Help a client to plan how they will integrate ART into the child's daily routine. This can be complicated for children who go to school. Teachers may have to become involved to support adherence while children are in school.
  - Listen carefully to the instructions of the health care provider. The child's dose of medicine will change frequently according to his/her weight.
  - If the child is old enough to understand she/he should be fully involved in the responsibility of taking ART the correct way. Even young children can get involved in their own care.
  - Help the client and family to find a reliable system to help remind them of the time to give the ART, such as an alarm clock or other person in the household who has a watch. Involve the child in helping to be reminded when they need to take their medicines.
  - Provide ideas to the family about how to offer the child choices of taking the medicine e.g. with juice or water, in a cup or with a syringe. Give small amounts of water. Drinking large amounts of water can make a child vomit. Follow the medicine with a treat such as a piece of fruit or bread.
  - Teach the family to use an ART calendar to record when each dose has been given. Involve the child in recording if he/she is old enough.

Prevention of Mother to Child Transmission (PMTCT)

A. Drug prophylaxis:
According to Nepal National PMTCT Guidelines 2007, prevention of mother to child transmission can be achieved by providing: Single dose of Nevirapine 200 mg at the start of labor to an HIV positive mother and 2mg/kg body weight of Nevirapine (NVP) suspension to the infant immediately after birth. If mother has received no ARV prophylaxis then give NVP 2mg/kg oral suspension immediately after birth and Zidovudine(ZDV) 4 mg/kg twice a day for 7 days to the newborn.

When ZDV oral suspension not available:
NVP 2mg/kg oral suspension immediately after birth and one dose of NVP oral suspension 72 hours after birth to the newborn.

According to 2006 WHO Recommended PMTCT Protocol for pregnant women who are not yet eligible for ART

Mother Antepartum Intrapartum Postpartum	 AZT starting at 28 weeks of pregnancy or as soon as feasible thereafter Sd-NVP + AZT/3TC AZT/3TC × 7 days
Infant	Sd-NVP + AZT × 7 days

B. Breastfeeding
1. Infant feeding by HIV-infected women is a complicated topic and families deserve comprehensive and ongoing counseling on this issue
2. HIV can be transmitted from mother to child by breastfeeding
3. However, these risks need to be weighed against the greatly increased risk of morbidity and mortality in infants who are not breastfed primarily due to infectious causes.
4. If alternatives to breast-feeding are safe, available, affordable, sustainable and acceptable, breast milk substitutes may be the best way to feed the child.
5. Women who require ART and who are breast-feeding should continue their ongoing ART regimen. Studies are underway looking at maternal ART as a prophylactic to infant infection through breast milk. One thing that is very clear, if a women decides to breastfeed, it should be "exclusive breastfeeding". This means no other foods or drinks (even water) are given during the first 6 months of the babies' life, except breast milk. Mixed feeding has the highest chance of passing HIV to the baby.

C. Role of CHBC Team in PMTCT
- Help refer pregnant women with HIV to the hospital for check-ups according to schedule
- Support the pregnant woman to remember to take her vitamins as prescribed by the doctor (e.g. iron)
- Discuss feeding choices with the woman before delivery or refer to an experienced infant feeding counselor.
- Support the pregnant woman to deliver at a hospital with PMTCT services.
- After the mother has delivered the baby, watch out for danger signs:
  a. Baby unconscious
  b. Vomiting a lot
  c. Very lethargic, not moving much
  d. Having convulsions
- After delivery, watch for general danger signs in newborn babies. These are no different in HIV infected/exposed babies than other babies, but may occur more frequently.
- Support the mother and baby to take cotrimoxazole as prescribed by the doctor
- Support the mother to feed her child however she decides to feed them (either exclusive breastfeeding or infant formula)
- Inform mothers on disadvantages of mixed feeding.

Infant Feeding Choices

Issue:

1. Babies living in most conditions in Nepal should be exclusively breastfed for the first 6 months of life. This means only breast milk, no food, other liquids, juices or even water.
2. Although we know that HIV can be transmitted by breast feeding, there is overwhelming data that in settings like Nepal, the negative consequences of replacement feeding young infants greatly outweighs the avoidance of possible HIV transmission in most instances.
3. Child and infant health statistics in Nepal show high under-5 mortality from diarrhea and respiratory disease and a high rate of malnutrition.
4. Water/sanitation statistics show that 57% of rural households have no toilet facilities and only 9% of the rural populations adequately treat their water.
5. This makes replacement feeding very risky in most settings in Nepal.

Risks of replacement feeding:

- The infant does not benefit from the immune protection that breast milk contains.
- There is a high chance of contamination unless there is:
  1. strict cleanliness;
  2. access to running water in the house;
  3. avoidance of bottles;
  4. boiling of all water given to baby; and,
  5. sterilization of feeding cup and spoon between each feed.
- Very importantly, if there is not a continuous supply of formula, malnourishment and/or mixed feeding is likely.
- Risk of death in replacement feeding babies is between 2 to 3 times higher than in exclusive breast fed babies in rural settings (7.6% to 15%)

Risks of breastfeeding:

1. Breastfeeding until 2 years of age (mixed feeding) carries the risk of transmitting HIV of about 15%.
2. With mixed breastfeeding until 6 months of age, the risk is 5-10%.
3. Most recent data shows that with 6 months of exclusive breastfeeding, the risk is about 4%.

Who should replacement feed (formula feed) instead of breastfeed?

Women who meet the following AFASS criteria should be encouraged to formula feed.

Acceptable: The mother perceives no significant barrier(s) to choosing a feeding option for cultural or social reasons or for fear of stigma and discrimination.

Feasible: The mother (or other family member) has adequate time, knowledge, skills, and other resources to prepare feedings and to feed the infant as well as the support to cope with family, community, and social pressures.

Affordable: The mother and family, with available community and/or health system support, can pay for the costs of the replacement feedings -including all ingredients, fuel and clean water - without compromising the family's health and nutrition spending.

Sustainable: The mother has access to a continuous and uninterrupted supply of all ingredients and commodities needed to implement the feeding option safely for as long as the infant needs it.

Safe: Replacement foods are correctly and hygienically stored and prepared in nutritionally adequate quantities; infants are fed with clean hands using clean utensils, preferably with cups.

Children known to be HIV infected
Encourage prolonged breastfeeding (even mixed feeding after 6 months). Since the child already has the virus it is important that he/she receives the nutrients and protective factors of breast milk.

Mother's health and breastfeeding
Recent large studies show that breastfeeding does not compromise the mother's health or worsen her HIV disease.

Children over 6 months of age:
- Babies need more than just breast milk after 6 months.
- To continue breastfeeding after 6 months, subjects the child to mixed feeding.
- According to Nepal National Pediatric HIV guidelines 2006:
- First option is to give breast milk substitutes and appropriate complementary feeds (stop breastfeeding). It is possible to prepare replacement feeds from modified animal milk at this stage (cheaper and more available than infant formula).
- Abrupt and complete weaning is necessary to prevent mixed feeding. Mothers will need extra support during this time
- Recent studies show that abrupt and early weaning (especially before 6 months of age) from breast milk is risky with increased rates of diarrhoea, gastroenteritis and death.
- If replacement feeds are not safe and feasible there is an option of continuing breastfeeding.

Counseling on Exclusive Breastfeeding:
- Close follow-up with ongoing counselling of mothers about how to safely breastfeed their baby is essential.
- CHBC team should ideally meet with parents during pregnancy, just after delivery and as the child is growing.
- Issues that should be discussed include:
- How to increase milk supply in times when "there is not enough milk"
- Preventing or treating maternal breast infections
- Early treatment of infant mouth infections
- Avoidance of giving baby "extra water"
- Strict adherence to exclusive breastfeeding
- Getting appropriate HIV care, including initiating ART as soon as indicated.
- Promoting 100% adherence to ART for those women who are breastfeeding while taking ART (early studies show that ART is likely to be very effective to prevent breast milk transmission)

Advantage of cup feeding
- Breast milk substitutes should be given from a cup
- Cups are safer, as they are easier to clean
- Cup feeding is better than feeding with bottles and nipples
- Cup feeding helps to provide more contact with the infant and provided more psychological stimulation.

How to feed an infant with a cup
- Hold the infant sitting upright or semi- upright on your lap.
- Hold the cup of milk to the infant's lips.
- Tip the cup so that the milk just reaches the infant's lips.
- Do not pour the milk into the infant's mouth.
- Hold the cup to the infant's lips and let the infant take it.
- When the infant has had enough, he/she will close its mouth and take in no more milk.
- Measure the infant's intake at each feeding over 24 hours.

Caring for Children

A. HIV Diagnosis

- For infants born to HIV positive women, whether they participated in a PMTCT program or not, the infant is tested for HIV at 9 and 18 months.
- The CHBC team should support the parents to refer the infant for HIV testing at this time.

Note: The child will need to be tested 3-months after the mom stops breastfeeding

- Since the CHBC and other HIV care services are new in many areas, there will be older children with HIV who have not yet been tested. The CHBC team should inform HIV positive parents/child's caregivers of the benefits of testing their children for HIV.

- CHBC teams should facilitate referral for HIV testing for children, helping with transport and assisting the family in accessing the testing service

- Signs that the child may have HIV which require immediate referral to the hospital include:
  - The infant is symptomatic with two or more of the following:
  - Oral thrush;
  - Severe pneumonia;
  - Severe sepsis.

B. Danger Signs

1. CHBC Teams also need to know danger signs in infants and children
   1. Unconscious
   2. Vomiting a lot
   3. Very lethargic, not moving much
   4. Having convulsions
   5. Difficulty breathing
   6. Coughing more than 3 weeks
   7. Not growing
   8. Chronic ear infections
   9. Thrush in the throat

2. Refer the child to the hospital if these signs are seen. Children with HIV need to be referred quickly because HIV is very serious in children.

C. Caring for children infected with and affected by HIV

- All children need -
  1. Love and a stable family
  2. To live in their community - not in an orphanage unless there is no choice
  3. Opportunities to learn and play
  4. To be safe and secure and protected from abuse
  5. Good nutrition
  6. Good personal and environmental hygiene
  7. Growth and development monitoring

8. Prompt treatment for illness
9. Immunizations

- HIV can cause many problems for children. It can cause them to -
  1. be afraid about their future
  2. feel angry
  3. lose confidence in themselves
  4. feel sad, guilty or ashamed
  5. suffer stigma and discrimination
  6. lose their home
  7. be separated from loved ones
  8. drop out of school
  9. lack food, shelter, clothing
  10. lack guidance and care
  11. not get good health care
  12. be forced to do adult work
  13. be vulnerable to abuse

3. The CHBC Team can do the following to help children living with and affected by HIV
   1. Assess their needs every time they visit the house
      a. Check for danger signs every time and refer right away as needed
      b. Check their immunization card to make sure they are getting the protection they need
      c. Ask about/assess nutrition to see how well children are getting the nutrients they need
      d. Check their emotional and social well-being. Are they playing? Do they have friends? Are they active and engaged or shy or sad?
   2. Provide lots of love and encouragement
   3. Help parents to plan for their future
   4. Make referrals to services as needed

D. Reference Information on Cotrimoxazole

SITUATION	AGE	Who needs Cotrimoxazole?
HIV EXPOSED INFANTS AND CHILDREN	Any Age	All exposed babies from 4-6 weeks after birth continuing until at least 3 months after stopping breastfeeding with negative HIV test
HIV INFECTED INFANTS AND CHILDREN (confirmed)	Less than 1 year of age	All regardless of CD4 or clinical status
	1-4 years of age	Those with symptomatic HIV conditions and / or CD4 count < 25% (or absolute 1000/mm^3)
	> 5 years of age	Those with symptomatic HIV conditions and / or CD4 count < 350/mm^3

Cotrimoxazole dosing for children: To be given once daily				
Recommended daily dosage	Suspension (5 ml syrup 200mg/40mg)	Pediatric Tablet (100mg/20mg)	Single strength adult tablet (400mg/80mg)	Double strength adult tablet (800mg/160mg)
< 6 months 100mg SMX/ 20mg TMP	2.5 ml	One tablet	---	---
6 months - 5 years 200mg SMX/ 40mg TMP	5 ml	Two tablets	Half tablet	---
6 - 14 years 400mg SMX/ 80mg TMP	10 ml	Four tablets	One tablet	Half tablet
> 14 years 800mg SMZ/ 160mg TMP	---	---	Two tablets	One Tablet

What to do at home?

1) Discuss benefits of HIV testing with parents
2) Refer all HIV-exposed children who are 9 months or older for HIV testing and checkup.
3) Assess needs of children and provide care and support as relevant (future planning, wills, foster care placement, emotional support, cognitive development, schooling, birth registration, property rights for orphans and nutrition. Also look at status of primary caregiver)
4) Assess their needs every time they visit the house
   a. Check for danger signs every time and refer right away as needed
   b. Check their immunization card to make sure they are getting the protection they need. (They should receive and extra measles vaccine at 6 months as well as 9 months).
   c. Check whether they should be on Cotrimoxazole prophylaxis and if so they are taking it with correct dosing.
   d. Ask about ART adherence and side-effects
   e. Ask about/assess nutrition to see how well children are getting the nutrients they need
   f. Check their emotional and social well-being. Are they playing? Do they have friends? Are they active and engaged or shy or sad?
   g. Check to see whether they are going to HIV clinic for regular check-ups as per National Pediatric HIV guidelines.
5) Provide lots of love and encouragement
6) Help parents to plan for their future
7) Make referrals to services as needed

Immunization of Children infected with HIV

Infants born to mothers who are HIV-infected should be immunized according to the national paediatric guideline, 2006.

Table :1	
Age of Infant	**Vaccine**
Birth	BCG*, OPV-0
6 weeks	DPT-1, OPV-1, HB-1
10 weeks	DPT-2, OPV-2, HB-2
14 weeks	DPT-3, OPV-3, HB-3
6 months	Extra dose of Measles
9 months	Measles

Key:
BCG = Bacille Calmette Guerin
OPV = Oral Polio Vaccine
DPT = Diphtheria, Pertussis, Tetanus
HB = Hepatitis B

Nutrition & HIV

A. Background:

1. Depending upon the stage of the disease, HIV causes the following:
   - Reduction in food intake
   - Difficulties related to digestion
   - Difficulties related to absorption
   - Altered metabolism of nutrients (e.g. metabolism of carbohydrates/lipids may be altered in HIV-infected persons)
   - Altered body functions: inability to produce saliva, other digestive juices
   - Improper utilization of fats

2. Increased resting energy expenditure (REE) is observed in HIV-infected adults.
   - Energy requirements are likely to increase by 10% to maintain body weight and physical activity in asymptomatic HIV-infected adults, and maintain growth in asymptomatic children.
   - Once HIV infection becomes symptomatic, and subsequently after the development of AIDS, energy requirements increase by approximately 20-30% to maintain adult body weight.

3. Nutritional counseling must be provided every time PLHA visit the clinic. It is aimed at providing the following necessary practical guidelines on nutrition to PLHA and their caregivers:
   1. Simple steps on food handling and safety:
      - Cook food thoroughly.
      - Eat cooked food immediately.
      - Store food carefully.
      - Re-heat cooked food thoroughly.
      - Avoid contact between raw and cooked food.
      - Wash your hands thoroughly before and after cooking. Keep kitchen surfaces clean.
      - Protect food from rodents, insects and animals.
      - Use clean water.
   2. Commonly available food items and their nutritional content
   3. Recommendations on which food items to avoid:
      - Raw eggs
      - Food that has not been thoroughly cooked, especially meat and chicken
      - Unboiled water or juices made with unboiled water.
      - Alcohol and coffee
      - Stale food

4. Symptom-based nutritional care and support (see Table N.1 below)

5. Nutrition and ART, including food-drug interactions
   Paying greater attention to diet and nutrition may enhance the acceptability and effectiveness of ART, as well as adherence to it. Give counseling on correct nutrition and foods that can enhance the well-being of PLHA. Food can affect the absorption, metabolism, distribution and excretion of medication. Medication too can affect the metabolism of food.

Table 2: Symptom-based Nutritional Care		
Symptoms	**Management**	
Loss of appetite	☐☐	Eat small, frequent meals (5-6 meals/day)
	☐☐	Eat nutritious snacks
	☐☐	Drink plenty of liquids
	☐☐	Take walks before meals-the fresh air helps to stimulate appetite
	☐☐	Have family or friends assist with the preparation of food
	☐☐	Take light exercise and do light activity
	☐☐	Add flavor to drinks and food
Mouth ulcer	☐☐	Avoid citrus fruits, and acidic and spicy foods
	☐☐	Eat food at room temperature
	☐☐	Eat soft and moist food
	☐☐	Avoid caffeine and alcohol
Candidiais	☐☐	Eat soft, cool and bland foods (such as rice porridge, oatmeal, mashed vegetables, apple juice, milk)
	☐☐	Add garlic (optional)
	☐☐	Avoid sugar (glucose, cane sugar), yeast, caffeine, spicy food, carbonated drinks and alcohol
Nausea and vomiting	☐☐	Eat small, frequent meals
	☐☐	Avoid being on an empty stomach as this makes the nausea worse
	☐☐	Eat bland food
	☐☐	Avoid food with strong or unpleasant odors
	☐☐	Drink plenty of liquids
	☐☐	Rest and relax after meals
	☐☐	Avoid lying down immediately after eating
	☐☐	Avoid coffee and alcohol
Constipation	☐☐	Eat fiber-rich and sprouted food
	☐☐	Take light exercise and do light activity
	☐☐	Drink plenty of water
	☐☐	Take warm drinks
Anemia	☐☐	Eat meat and fish
	☐☐	Eat cereals
	☐☐	Eat a variety of green leafy vegetables. The best way for the body to utilize iron from plant sources is to combine food rich in iron with a food rich in vitamin C, such as oranges, lemons, tomatoes and papaya

B Referral for Nutrition Package:

- If the client is unable to maintain an adequate diet due to financial hardship, referral to appropriate government services, local NGOs or INGOs, for the provision of food staples and/or support should be made.

Logistics Management

Objective
The objective of logistics management is to have the right goods, in the right quantities, in the right condition, delivered to the right place, at the right time, for the right cost.

Responsibilities
The responsibilities for proper logistics management are to:
1. Store HIV/AIDS commodities properly and maintain serviceability, safety and security of stock.
2. Account for quantities of the stock on hand and those at risk of expiry, or damaged, or no longer used at the facility.
3. Maintain *stock book* and fill out logistics forms.
4. Conduct physical checking of inventory at specified times.
5. Ensure that the quality of commodities is maintained.
6. Account for CHBC drugs & supplies dispensed with the use CHBC *Drugs Daily Consumption Record.*
7. Complete *Combined Report - Requisition and Issue Forms for CHBC Drugs* every two months, also referred to as a Logistics Management Information System (LMIS) report, if there is an arrangement to receive the drugs from the NCASC.
8. Receive commodities as per established procedures.
9. Monitor logistics activities and supervise the personnel who implement them.

Principal steps in logistics management
1. Selection of commodities that best serve CHBC clients based on appropriate guidelines.
2. Forecasting of the quantities of the commodities that will be required for a specific period, and their procurement or acquisition. One needs to follow the national SOP Manual for HIV/ AIDS Commodities, for obtaining CHBC drugs from DPHO/DHO and other government health facilities.
3. Management of inventory through the maintenance of:
   - Minimum stock of two months: i.e. place an order for the acquisition of a commodity when its stock reaches a level that is adequate for the next two months.
   - Maximum stock of four months: i.e. the amount of the commodity the site acquires is such that it is adequate for the next four months.
   - Emergency order point of one month: i.e. the system of placing an emergency order if the commodity is adequate for only one month.
   - Proper storage of the commodities. Refer to the national SOP Manual for HIV/ AIDS Commodities for a guideline.
   - First expiry first out: i.e. earlier use of commodities that expire earlier.
   - Regular conduction of physical checking of inventory. Refer to the national SOP Manual for HIV/ AIDS Commodities for a guideline.
   - Adequate recording system that gives information about stock in hand, commodities in pipeline and the usage of commodities.
4. Adequate supply of money and manpower for logistics management.
5. Supervision of the logistics system for its smooth running.
6. Evaluation of the logistics systems to see its impact on other elements of a CHBC program.
   Maintaining Client Files and CHBC Kits

I. Maintaining Client Information and Files
- All clients need to be given a code number and a file (using an opaque file folder so information inside cannot be seen).

- Client files are kept in a locked cabinet to which only a few staff will have access. Files should not be left out in the open to protect client confidentiality.

- Files should be well organized (e.g., by code number, district, team, etc.) and easy to access. If possible, files should be kept as hanging files so it is easy to organize and use them.

- Files of individuals who have died, been discharged or who are lost to follow-up should be kept on record for 5 years. After which they should be destroyed to protect confidentiality of clients/family.

- On each CHBC visit, the team takes the client file and follow-up visit form with them in order to update information on the client's needs/well-being. CHBC teams will write down client need findings and care/services provided on every visit.

II. CHBC Kits

- Each team should have one home-care bag; which is refilled at the end of every day in order to be ready for the next day's visits.
- There is a list of all medicines and supplies which should be kept in the CHBC bag
- CHBC kits are kept clean and well-organized
- A consistent supply of CHBC related medicines and other supplies must be kept at all times
- Team members should keep a record of medications/supplies used in order to track inventory.
- Each team should place orders for supplies at least two months before the supplies run out.

Where possible, the CHBC program should work with the DPHO/DHO/DPHO or government health facilities to access kit supplies (e.g. paracetamol, ORS, vitamins [B, iron, folic acid], condoms). Note: (See annex 7 for suggested kit contents and supply inventory).

PLHA Support Groups & Family Member Support Groups

I. PLHA Support Groups

PLHA participation is an integral component of CHBC. If the SERVICE PROVIDER providing CHBC is not a PLHA group or not linked to a PLHA group then it needs to either partner with existing PLHA groups or facilitate the development of PLHA self-help groups in the area where CHBC is provided.

II. Family Caregiver Support Groups

Family members play an essential role in caring for PLHA, providing encouragement and support, reinforcing adherence and providing care when they are sick. Care giving can be stressful, particularly when people do not know how HIV is transmitted and how to provide care.

The CHBC program needs to address the following in their program to ensure family members are adequately supported and involved in the program:

- Where feasible, the CHBC team supports the PLHA client to disclose HIV status to the family and provides information to the family about how HIV is transmitted
- Provide informal and formal training to family members in HIV, providing care and adherence support (see below)
- Organize family member support groups where, family members of PLHA can meet on a routine basis (e.g. once a month) to discuss any concerns, learn new skills and receive support from each other.

III. Client and Family skills building

Since one of the primary responsibilities of CHBC workers is to increase the self-service of clients and families, CHBC teams train clients and family members on skills and knowledge in HIV prevention and care. This can be done through integrating self-care teaching at PLHA self-help group meetings; running trainings for family caregivers and PLHA in prioritized care and prevention topics; and through the informal teaching done during home-visits.

Community Mobilization

I. Building awareness of the CHBC program

Since CHBC services are new in some areas and the DPHO, DACC and key hospitals are not aware of them, the CHBC program needs to orient key government, NGO and community representatives on the role of the CHBC program. This can be done by:

1. Meeting with each group individually to brief them on CHBC;
2. Holding an orientation meeting on CHBC with key organizations; and,
3. Providing updates on the program through regular DACC and other coordination meetings.

The purpose of the CHBC orientation is to:

- Improve referral relationships;
- Increase support and awareness of CHBC activities among key agencies;
- Develop a formal link with hospitals offering HIV care and ART (HCC); and,
- Improve access to key resources such as medicines available in the DPHO which can be used in CHBC kits.

II. Developing linkages to community resources

Service providers are required to network with existing essential providers such as hospitals, clinics, Red Cross and NGOs for various support services (income generation, legal aid, food assistance). Service providers are encouraged to develop referral agreements with core services including hospitals providing HIV clinical care and ART for adults and children, TB-DOTS centers and PMTCT services.

III. Community education and support building

Since stigma and discrimination remain strong in many communities in Nepal, CHBC teams should conduct focused community awareness activities in areas where their clients live. This could include:

- Conducting meetings with community leaders to gain their support for PLHA care and to encourage their involvement in stigma and discrimination reduction activities;
- Conducting HIV awareness and stigma and discrimination reduction activities among communities where PLHA clients live;
- Organizing community planning meetings where the community includes HIV issues into the VDC and commits to providing support in specific areas (egg assistance in supporting referrals to the hospital, helping affected children to go to school, etc.); and
- Organizing community meetings and partnerships with religious leaders who can include messages of love and empathy towards people with HIV/AIDS in prayers, during religious ceremonies.

CHBC Monitering and Supervision

I. Roles and responsibilities

A. Role of Service Providers

CHBC Supervisor: The role of the CHBC Supervisor is to supervise the CHBC team on a routine basis (at a minimum accompany the CHBC team on home-visits once a month), provide supportive feedback to the team and to ensure that the team follows this SOP and CHBC quality standards. The supervisor is responsible for contacting a CHBC specialist if quality problems are identified. It is recommended that the supervisor conduct more frequent supervision visits at the start of the program to help improve the team's skills in CHBC from the very beginning of the program.

Team Leader Role: The CHBC team leader is the first line supervisor for the CHBC team. They have the primary responsibility of ensuring high quality CHBC service delivery. The Team Leader will accompany the Team Member(s) on home visits every day and will identify areas of development for the team and provide mentoring or mini-training accordingly. The Team Leader is expected to be a role model, providing very high quality care and setting a quality standard for team members.

B. Role of DACC/VACC staff members

DACC/VACC officers will be responsible for providing routine supervision to CHBC activities (including observing home-visits) using standard CHBC project supervision tools.

Technical Staff: Government technical unit staff members will form a CHBC monitoring and supervision team consisting of the government health personnel, PLHA representatives and senior nurses. This CHBC monitoring and supervision team will assess the quality of the Service Provider's CHBC teams as per GoN and as per service providers plan. This team will use standard CHBC program Quality Assurance (QA) Tools to assess services and program quality.

Field Staff: The designated DPHO/DPHO officer will be responsible for providing routine supervision to CHBC activities (including observing home-visits) using standard CHBC Project supervision tools.

II. Supervision Procedures, Checklists and Tools

- **Routine home-visit observations:** Both service provider and VACC staff will be involved in routine supervision of CHBC services. During routine visits the supervision checklist for observing home-visits will be used by the service provider and VACC supervisors in assessing the quality of home-visits (Annex 6).
- **QA/QI Assessment:** A formal QA/QI assessment should be conducted. However, the QA/QI checklist can be used as an informal assessment tool during routine supervision visits.
- **Program Reviews:** Periodically, will work with an individual Service provider to implement a program review. This is a process evaluation where the management, quality of CHBC services and client perceptions of services are assessed in order to help the program identify strengths and areas for program improvement
- **Program Evaluation:** The quality of life of CHBC clients may be assessed to determine the impact of the program.

III. CHBC Program Quality Review Meeting

DACC will conduct reviews of all CHBC programs. In the review, concerned CHBC project staff and representatives of service providers (CHBC supervisor and CHBC Team Leader) meet to discuss program achievements, challenges and steps to be taken for improvement over the next 6 months.

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Annex 1a: Team Leader Job Description

Community and Home Based Care Team Leader

Job Description
The fundamental goal of the CHBC Team Member is to ensure that quality services are provided to the infected and the affected. The services include clinical, nursing, emotional and social support that will promote their self reliance and self-confidence.

Specific job duties of the CHBC Team Leader include the following:

1. PROVIDE QUALITY CHBC SERVICE
- Set the standard for CHBC by demonstrating high quality skills and respect for clients in the community.
- Conduct referral resource mapping in your area with partners: PLHA groups, mass-media organizations and others. Meet with key referral resources to work out cross-referral relationships with them.
- Ensure that all team members understand what is expected of them by reviewing their job descriptions with them, by reviewing the QA forms, by monitoring the work of the team on a daily basis and by providing them with supportive supervision and feedback each time you observe their performance.
- Conduct home visits for PLHA to provide a range of services (symptom and pain relief, emotional support, adherence counseling, end-of-life care, future planning, referrals, etc) to clients based on their prioritized needs. Follow the home visit steps as per SOP when visiting each client whether it is the first visit or a follow-up visit.

2. SUPERVISION, MONITORING AND REPORTING

Arrange weekly team meetings to plan who the team will visit that week. Discuss issues about clients, which need to be resolved including referral, follow-up, etc
- Ensure your team visits home-based care clients at least once a week, unless the client is doing well and only needs a monthly or two weekly maintenance visits. When the client is in need of more constant care and support, ensure that the team is visiting the client as frequently as needed.
- Accept thrice-weekly supervision from the project coordinator. Openly accept supportive feedback from supervisors for skill, knowledge and attitude improvement.
- Provide monthly reports of CHBC activities on time to the home-care supervisor or project coordinator.

3. OTHER DUTIES
- Assist Project coordinator for team member job performance review
- Participate in DACC, the ART selection committee and other hospital or district committee meetings as relevant to the local setting
- Perform other duties as appropriate

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Must be a Nepali citizen.
- Prior work experience in HIV/AIDS
- Excellent interpersonal relationship.
- Ability to work with team and other NGOs.
- Must be willing to travel for home visit

Annex 1b: Team Member Job Description

Community and Home Based Care Team Member

Job Description
The fundamental goal of the CHBC Team Member is to ensure that quality services are provided to the infected and the affected. The services include clinical, nursing, emotional and social support that will promote their self reliance and self-confidence.

Specific job duties of the CHBC Team Member include the following:

- Conduct home visits for PLHA who request CHBC services - the CHBC team can only visit clients who have invited them to provide CHBC service. Visiting homes without prior approval can cause serious harm to the client and their family.
- Visit home-based care clients every two weeks, unless the client is doing well and needs less frequent (e.g. monthly) visits. When the client is in need of more constant care and support, visit the client as frequently as needed.
- Provide a range of services (symptom and pain relief, emotional support, adherence counseling, end-of-life care, future planning, referrals, etc) to clients based on their prioritized needs. When visiting each client whether it is the first visit or a follow-up visit as per CHBC SOP.
- Provide follow-up support on time to your clients. If they have been referred to the hospital, check on your client to ensure they are receiving the services they need. Visit your client just after they have returned home from the hospital/referral site to ensure they are recovering well and that family members know how to provide care for them. Assist with referrals at all times, even at night.
- Provide family education on cleanliness, hygiene using self care book series.
- If there are CHBC Assistants in the program, the CHBC Team Member supervises their work by observing them once a week after they have been trained and once every month after they are performing their work satisfactorily.
- Work very closely with the local PLHA support groups to support clients and respond to their needs. In many cases, the PLHA support group may be able to provide significant support to clients and is a great resource.
- Ensure strong linkages with NGOs support organizations so that clients with children are able to access and receive the best care possible.
- Accept daily supervision from the CHBC Team Leader and monthly supervision from the Project Coordinator three times a month. Openly accept supportive feedback from supervisors for skill, knowledge and attitude improvement.
- Provide monthly reports of CHBC activities on time to the CHBC team leader;
- Attend regular team meetings to plan weekly schedule for CHBC and referral support
- Perform other duties as appropriate.

Knowledge, Skills, Experience and Abilities Required:
- Must be a Nepali citizen
- Ability to read and write Nepali and English
- Prior work experience in HIV and AIDS
- Excellent interpersonal relationship
- Ability to work with team and other NGOs
- Must be willing to travel for home visit

Annex 1c: CHBC Volunteer Job Description

Community and Home Based Care Volunteer (infected or affected)

Job Description
The fundamental goal of the CHBC Team Member is to ensure that quality services are provided to the infected and the affected. The services include clinical, nursing, emotional and social support that will promote their self reliance and self-confidence.

Specific job duties of the CHBC **Volunteer** include the following:

- Conduct home visits for PLHA who request CHBC services - the CHBC team can only visit clients who have invited them to provide CHBC services. Visiting homes without prior approval can cause serious harm to the client and their family.
- Visit home-based care clients every week or twice a week or monthly or as per client condition. When the client is in need of more constant care and support, visit the client as frequently as needed.
- Provide a range of services, symptom care (home remedies for diarrhea, fever, skin problem, etc.), hygiene care, emotional support, adherence counseling, spiritual support, nutritional support, future planning, referrals, etc) to clients based on their prioritized needs. When visiting each client whether it is the first visit or a follow-up visit as per CHBC SOP.
- Provide follow-up support on time to your clients. If they have been referred to the hospital, check on your client to ensure they are receiving the services they need. Visit your client just after they have returned home from the hospital/referral site to ensure they are recovering well and that family members know how to provide care for them. Assist with referrals at all times, even at night in coordination with Team Leader or CHBC Team Member.
- Work very closely with the local PLHA support groups to support clients and respond to their needs. In many cases, the PLHA support group may be able to provide significant support to clients and is a great resource.
- Accept supervision from the CHBC Team Leader or Team Member and monthly supervision from the Project Coordinator. Openly accept supportive feedback from supervisors for skill, knowledge and attitude improvement.
- Provide reports of CHBC activities on time to the CHBC team member.
- Attend regular team meetings to plan weekly or monthly schedule for CHBC and referral support.
- Perform other duties as appropriate.

Knowledge, Skills, Experience and Abilities Required:
- Must be a Nepali citizen
- Ability to read and write Nepali
- Prior work experience in HIV and AIDS
- Excellent interpersonal relationship
- Ability to work with team and other NGOs
- Must be willing to travel for home visit

Annex 2a: Registration Form

Community Home-Based Care
Registration Form

ID No.: | | | | | | |

Date:_ _ / _ _ / _ _

PATIENT IDENTIFICATION

Patient name: _____

Address: Ward _____ Municipality/VDC _____ District _____ Zone _____

Telephone number:

Home _____ Work _____ Mobile _____

Date of birth: _____ Gender: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er)

Occupation: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Address: Ward _____ Municipality/VDC _____ District _____ Zone _____

Telephone number:

Home _____ Work _____ Mobile _____

REFERRAL INFORMATION

REFERRED/ ADVISED BY:

☐ Hospital

☐ STI Clinic

☐ VCT Center

☐ Friend / Family member

☐ Sexual or Injecting partners

☐ Others please specify

_____

1 Crisis Center

Annex 2b: Identity Card

Address

.....

.....

.....

.....

Phone .....

Identify Number

DIS: SERVICEPROVIDER: IREG. MTH: Reg. Yr. Reg. No.	ID/CODE#

Follow up Dates:

Annex 3a: CHBC Form

Home Based Care: Adult- First Contact Form

Date: _____ Client receiving service at: Home: _____ Community: _____

Target Group: _____ Sex: Male: _____ Female: _____

Part 1: HIV-status, general information			
1a. HIV status ☐ HIV status unknown ☐ HIV-infected	1b. Disclosure: Ok to discuss client's HIV status with the primary caregiver? ☐ Yes ☐ No Ok to discuss client's HIV status with other family members? ☐ Yes ☐ No 1. Can speak about HIV status opening 2. Can only discuss HIV status with following family members: _____		2a. Education - Last completed level of schooling:
2b. Literacy: Reading ☐ Yes ☐ No Writing ☐ Yes ☐ No	3a. Working: ☐ Yes ☐ No 3b. Job:_____	4. Marital status: 1 = Single 3 = Widowed 2 = Married 4 = Divorced	5a. Have children? ☐ Yes ☐ No 5b. Number of children: _____

Part 2: History, Symptoms and Care							
6a. Within the last month, do you have any symptoms? ☐ Yes ☐ No / If yes, specify below							
	Symptoms	**Yes**	**Now has**		**Symptoms**	**Yes**	**Now has**
• Major Danger Signs	**Has a severe pink rash on the arms, legs, chest, face, etc**			**GI tract**	**Vomiting everything**		
	Convulsions				**Acute Diarrhoea > 3 loose stools in 24 hrs**		
	Very ill or unconscious				**Chronic Diarrhoea >14 days**		
	Signs of severe dehydration (dry tongue; sunken eyes; less elastic skin; less urine)				Mild diarrhoea: 3 loose stools; no blood		
General	**Weight loss >10% of normal body weight**				Oral thrush		
	In severe pain				Poor appetite		

	In mild-moderate pain			Skin	**Any rash while on ARVs or cotrimoxazole**		
	Swollen lymph nodes for > 2 weeks				**Painful rash (eg herpes zoster)**		
	Fever > 39 C for more 24 hours				Painful sores in corner of mouth		
	Low grade fever of 37.5-39 C for > 2 weeks				Itchy skin		
• Respiration	**Difficulty breathing/ breathing fast/bluish colour**				Genital discharge/itchiness Lumpy rash - (eg scabies, fungal infection)		
	Persistent cough >2 weeks				**Persistent headache**		
	Recurrent or chronic chest or sinus infection			Neuro	**Changes in vision; speech, ability to walk, tingling, numbness**		
					Sadness; anxious; withdrawn		

** Grey = Give home symptomatic treatment as appropriate and then refer to HIV clinic ASAP!*
** White = Give home symptomatic treatment as appropriate; refer in 1 week if does not improve.*

6b. Other symptoms:			
7. Last CD4: ____/mm3 Test Date: ___/___/_____	Check prescription on every visit 8. What medications is the client previously or currently taking? 0 None or checked for TB ☐ Yes ☐ NO TB treatment ☐ Previously ☐ Currently Cotrimoxazole Prophylaxis ☐ Previously ☐ Currently ART (specify) ☐ Previously ☐ Currently Vitamins ART treatment started date _____ TB treatment started date _____ Cotrimoxazole started date _____		

Vital Signs/Physical Examination/Care provided				
9. Temp: _____ ^{0}C	Pulse: ____ /min	Breaths: ___/min	Blood pressure: ___/___ * If possible to measure	Weight: ____kg * If possible to measure

10. Pain assessment: 1-2-3-4-5-6-7-8-9-10 ……..…. Or, normal ☐ moderate ☐ severe ☐	
11. Physical examination findings:	
12. Care provided:	
13. Medicines provided/indications/dressing	14. Self-care education provided: ☐ Yes ☐ NO 15. Safer sex education provided: ☐ Yes ☐ NO 16. Condom provided: ☐ Yes ☐ NO 17. Other services (e.g. distribution) ☐ Yes ☐ NO

Part 3: Adherence and Referral	
18a. **ART adherence assessment** ☐ Client is very clear on how to take medicines and demonstrate adherence ☐ Client needs education on adherence ☐ Client needs to be referred to HIV clinic for adherence support	19. Action taken if needed:
18b. **Cotrimoxazole and TB medicines** ☐ Client is very clear on how to take medicines and demonstrates good adherence ☐ Client needs to be referred to HIV clinic for adherence support	
18c. Referral needed for: ☐ TB screening ☐ Urgent medical care/ HIV clinic ☐ Routine medical care/ HIV clinic O/I ☐ Nutrition ☐ PLHA support group ☐ Adherence Support ☐ Other:_____	20a. Site Referred To/ Contact:
20b. Referral Follow-up Actions Required	

Part 4: Social /Emotional /Spiritual wellbeing assessment

21. Are there any social, emotional, spiritual problems identified such as: access to school for children, income etc?
Issues identified:

Action agreed to _____

21. When is the client's next CHBC appointment? Date: ___/____/_____

Completed by:
Signature and Name: _____ Date: __/__ /_____

Annex 3b: Adult Client Follow-up Form

Please update this form, based on any changes in the below areas since the last visit.

Part 1: History, Symptoms and Care

1a. Within the last month, do you have any symptoms? ☐ Yes ☐ No / If yes, specify below

	Symptoms	Yes	Now has		Symptoms	Yes	Now has
• Major Danger Signs	**Has a severe pink rash on the arms, legs, chest, face, etc**			GI tract	**Vomiting everything**		
	Convulsions				**Acute Diarrhoea > 3 loose stools in 24 hrs**		
	Very ill or unconscious				**Chronic Diarrhoea >14 days**		
	Signs of severe dehydration (dry tongue; sunken eyes; less elastic skin; less urine)				Mild diarrhoea: 3 loose stools; no blood		
General	**Weight loss >10% of normal body weight**				Oral thrush		
	In severe pain				Poor appetite		
	In mild-moderate pain			Skin	**Any rash while on ARVs or cotrimoxazole**		
	Swollen lymph nodes for > 2 weeks				**Painful rash (eg herpes zoster)**		
	Fever > 39 C for more 24 hours				Painful sores in corner of mouth		
	Low grade fever of 37.5-39 C for > 2 weeks				Itchy skin		
					Genital discharge/itchiness		
Respiration	**Difficulty breathing/ breathing fast/bluish colour**				Lumpy rash - (eg scabies, fungal infection)		
	Persistent cough >2 weeks			Neuro	**Persistent headache**		
	Recurrent or chronic chest or sinus infection				**Changes in vision; speech, ability to walk**		
					Sad; anxious; tingling , numbness		

** Grey = Give home symptomatic treatment as appropriate and then refer to HIV clinic ASAP!*
** White = Give home symptomatic treatment as appropriate; refer in 1 week if does not improve.*

<table>
<tr><td colspan="5">1b. Other symptoms:</td></tr>
<tr><td colspan="2">2. Last CD4:
____/mm3
Test Date:
___/___/_____</td><td colspan="3">3. What medications is the client previously or currently taking? 0 None or
TB treatment ☐ Previously ☐ Currently
Cotrimoxazole Prophylaxis ☐ Previously ☐ Currently
ART (specify)_____ ☐ Previously ☐ Currently
Vitamins ☐ Previously ☐ Currently

Other (herbal, traditional agents, complementary, non-prescription, etc.)
_____ ☐ Previously ☐ Currently
_____ ☐ Previously ☐ Currently</td></tr>
<tr><td colspan="5">Vital Signs/Physical Examination/Care provided</td></tr>
<tr><td>4.
Temp:
_____^{0}C</td><td>Pulse:
____ /min</td><td>Breaths:
___/min</td><td>Blood pressure:
___/___
* If possible to measure</td><td>Weight:
____kg
* If possible to measure</td></tr>
<tr><td colspan="5">5. Pain assessment: 1-2-3-4-5-6-7-8-9-10 ……..…... Or, normal ☐ moderate ☐ severe ☐</td></tr>
<tr><td colspan="5">6. Physical examination findings:</td></tr>
<tr><td colspan="5">7. Care provided:</td></tr>
<tr><td colspan="2">8. Medicines provided/indications/dressing</td><td colspan="3">9. Self-care education provided:
☐ Yes ☐ NO
10. Safer sex education provided:
☐ Yes ☐ NO
11. Number of individual received 'self-care education
12. Condom provided: ☐ Yes ☐ NO
13. Other services (e.g. distribution)
☐ Yes ☐ NO</td></tr>
</table>

Part 3: Adherence and Referral	
14a. **ART adherence assessment** ☐ Client is very clear on how to take medicines and demonstrate adherence ☐ Client needs education on adherence ☐ Client needs to be referred to HIV clinic for adherence support	14b. Action taken if needed:
14c. **Cotrimoxazole and TB medicines** ☐ Client is very clear on how to take medicines and demonstrates good adherence ☐ Client needs to be referred to HIV clinic for adherence support	
15a. **Referral needed for:** ☐ TB screening ☐ Urgent medical care/ HIV clinic ☐ Routine medical care/ HIV clinic O/I ☐ Nutrition ☐ PLHA support group ☐ Adherence Support ☐ Other: _____	15b. Site Referred To/ Contact:
15c. Referral Follow-up Actions Required:	
Part 4: Social /Emotional /Spiritual wellbeing assessment	
16a. Are there any social ,emotional ,spiritual problems identified such as : access to school for children, income etc Issues identified: _____ Action agreed to _____	
16b. Remarks: Please specify loss to follow up or death _____	

21. When is the client's next CHBC appointment? Date: ___/____/_____

Completed by:
Signature and Name: Date: __/__ /_____

Annex 3c: Child Assessment Form

Home Based Care: Adult- First Contact Form

Date: _____ Client receiving service at: Home: _____ Community: _____

Target Group: _____ Sex: Male: _____ Female: _____

Referral from:	Date of birth:	Age:

Section 1: Child Health and Nutrition

1.1 Immunizations provided on schedule? ☐ Yes ☐ No	1.2 Immunizations completed? ☐ Yes ☐ No	1.3 Growth Chart Checked? ☐ Yes ☐ No	1.4 Growth Chart Normal? ☐ Yes ☐ No	1.5 Has the child been given anthelmintic medicine? ☐ Yes ☐ No	1.6 Child has an appetite? ☐ Yes ☐ No Is eating normally? ☐ Yes ☐ No

1.7 If yes, how is the child fed? ☐ Only breast feeding ☐ Mixed feeding (mother's, animal milk, package milk) ☐ Artificial feeding	1.8 Child's HIV status has been checked? ☐ Yes ☐ No	1.9 Child is: ☐ HIV-Positive ☐ HIV-Negative	1.10 If positive, child is enrolled at health facilities? ☐ Yes ☐ No

Section 2: Health Details

Health Details, Signs, Symptoms and Care

2.1 Any symptoms seen in child after month's end? ☐ Yes ☐ No / If yes, specify below

Sign/Symptom	Yes	No	Sign/Symptom	Yes	No
Child feeling any pains (such as head aches). Simple aches and pains			Nausea and vomiting		
Severe pain			Loose motion for more than 3 times in 24 hours		
Lymph node swelling			Dehydration: for example, during diarrhea, dry tongue, eyes sunken, dry skin, low urinary output, loss of elasticity		
Fever			Sore in mouth and throat		

Sign/Symptom	Yes	No	Sign/Symptom	Yes	No
Coughing for more than two weeks			Change in vision		
Recurrent sinusitis and difficulty breathing			Any rashes while taking ART and/ or cotrimoxazole		
Recurrent chest infection (pneumonia)			Herpes zoster, scabies, fungal infection, any skin rashes		
Ear infection			Skin itching		
Simple or general symptoms can be treated at home, however in case of severe symptoms report to EPC or hospital.					

2.2 Refer immediately if other symptoms or danger signs are seen

2.3
Last CD4 ...../mm

Checkup date: __/__ /____

ART started: __/__ /____

Check prescription on every visit

2.4
Is the child taking ART? ☐ Yes ☐ No

Is the child screened for TB? ☐ Yes ☐ No

Is the child taking TB medicines? ☐ Yes ☐ No

Is the child taking cotrimoxazole? ☐ Yes ☐ No

Is the child taking Vitamins? ☐ Yes ☐ No

Suggestions: _____

_____

Important indications/ Physical checkup

2.4 Temperature _____ F/C	Pulse: ____ /min	Breathing: ___/min	Blood pressure* ___/___ (* only if possible to measure	Weight** ____/kg (** If possible to measure)

2.6 Please indicate findings during physical checkup

2.7 Pain assessment: 1-2-3-4-5-6-7-8-9-10..... Or, normal ☐ moderate ☐ severe ☐

2.8 Please indicate if medicine is made available and treated with	2.9 Self-care education provided: ☐ Yes ☐ NO

Suggestions:

Part 3: ART Adherence and Referral? (Please ask if child is on ART, TB, and Cotrimoxazole)	
3.1 ART adherence assessment • Is the child/family well aware on how to take the medicines? ☐ Yes ☐ No • Is the child taking ART on right time and in right way? ☐ Yes ☐ No • Reinforcement on ART adherence ☐ Yes ☐ No	3.1. Action taken if needed:
3.3 Cotrimoxazole and TB medicines/treatment • Is the child/family well aware on how to take the medicines? ☐ Yes ☐ No • Is the child taking Cotrimoxazole (prophylaxis) on right time and in right way? ☐ Yes ☐ No • Is the child taking TB medicines on right time and in right way? ☐ Yes ☐ No	3.3 Action taken if needed:
3.5 Reporting needs Important medical test ☐ General checkup ☐ Nutrition ☐ Immunization ☐ ART adherence support ☐ TB screening or diagnosis ☐ OI treatment ☐ others _____	3.6 Is emotional support provided? 0 Yes 0 No
Next home visit time? Date: _____ CHBC provider's name and signature _____ date _____ On remarks please notify on any deaths or loss to follow up during home visit. Remarks _____	

Important Note:

Please supervise on whether Immunization (as detailed below) are given to children within one year to save them from diseases for exposed or infected infants

Birth: B.C.G In 6 weeks: D.P.T (first) OPV-1 HB-1 In 10 weeks: D.P.T (second) OPV -2 HB-2	In 14 weeks: D.P.T (third) OPV -3 HB-3 In 6 months: Extra dose of Measles In 9 months: Measles

Note : *(1) This form is developed for children aged under 15 & (2) Refer first visit form before going for follow-up visit*

Home Based Care : Child Assessment and Follow-up form

Date: Client receiving service at: Home ____ Community ___

Target group Sex: Male ___ Female ___

Indicate number of times self care/ emotional support provided :	Date of birth: Age:	Prepared by : CHBC

Follow up date	Write physical check-up evaluation	Major concern and needs - health care: 1. TB, ART adherence Cotrimoxazole (prevention) 2. symptom/care 3. Emotional support 4. Self-care education 5. Nutrition 6. Family and social discrimination 7. Rearing 8. Education	Work needed to fulfill needs: (Direct care or referral) Mention reasons for referral	Who will take responsibility (family or CHBC provider) ?	Accomplished date :	Date for next follow-up	Remarks (deaths or loss to follow-up)	Signature of CHBC provider

Follow up date	Write physical check-up evaluation	Major concern and needs - health care: 1. TB, ART adherence Cotrimoxazole (prevention) 2. symptom/care 3. Emotional support 4. Self-care education 5. Nutrition 6. Family and social discrimination 7. Rearing 8. Education	Work needed to fulfill needs: (Direct care or referral) Mention reasons for referral	Who will take responsibility (family or CHBC provider) ?	Accomplished date :	Date for next follow-up	Remarks (deaths or loss to follow-up)	Signature of CHBC provider

Follow up date	Write physical check-up evaluation	Major concern and needs - health care: 1. TB, ART adherence Cotrimoxazole (prevention) 2. symptom/care 3. Emotional support 4. Self-care education 5. Nutrition 6. Family and social discrimination 7. Rearing 8. Education	Work needed to fulfill needs: (Direct care or referral) Mention reasons for referral	Who will take responsibility (family or CHBC provider) ?	Accomplished date :	Date for next follow-up	Remarks (deaths or loss to follow-up)	Signature of CHBC provider

Note : (1) This form is developed for children aged under 15 & (2) Refer first visit form before going for follow-up visit

Annex 4: Client Referral Forms

Client Referral Form

Name of the Service Center: _____

Date: _____

Name *(Optional, false name are acceptable)*: _____

Age / Sex: _____

Code (if Applicable): ☐

Referred by: _____

Reasons for the referral

☐ Medical checkup/management ☐ TB Screening/Treatment ☐ Home care assistance

☐ ART service ☐ STI Case management ☐ VCT

☐ Financial /Social support ☐ Essential Package of Care ☐ Support group/post test club

☐ Drugs and alcohol counseling ☐ Family planning services ☐ Psychological support

☐ Crisis Management ☐ CD4 Count

☐ Others Specify: _____

Chief complaints: _____

_____

_____

_____

Treatment (if provided):

Referred to: _____

Signature: _____

Name/Designation: _____ _____

Date : _____

Annex 5: Log Sheet for CHBC Services

District/municipality _____ **District/VDC/Ward** _____

SN	Date	Full name	Age		Address	Asympto-matic*	Symptoma-tic**	Bedridden***	CD4	ART	Cotrim	TB	Other O/I	Lost contact	Death	Discharge	Remarks
			Male	Female													
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
11																	
12																	
13																	
14																	
15																	
16																	
17																	
18																	

*Note: * = no presence of symptoms; ** = presence of symptoms, *** = limited to his/her bed only, due to sickness and fatigue*

Annex 6: Supervisor Check-list

Community and Home Based Care Supervisor Check-list

The supervisor check-list form is to be used as a guide in reviewing the performance of home-care teams during home-care visits. The check-list is a guide, not all of it may apply to the visit you observe, as not all services may be needed by the client on a given visit.

After observing the work of the home-care team, provide supportive feedback to the home-care team in a private place back in the office. Supportive feedback means that you encourage the home-care team and do not criticize or blame them; you ask them about what they thought about the quality of the service they provided to the client and then provide them with specific feedback about what they did well and what they need to improve. Keep notes of what was discussed on this form and bring the supervision findings from previous visits with you every time you supervise the team so you can refer back to the feedback you provided to the team on previous visits.

Supervision of each home-care team needs to be done at least once a month by the Project Coordinator and once a month **by the Designated Supervisor**.

Date and time of visit: _____ Ward/district: _____

Names of home care team providers: _____

Name and title of supervisor: _____

I. Pre-visit

	The home-care team:	
1.1	1. Brought a fully stocked home-care kit with them	Yes ☐ No ☐ NA ☐
1.2	2. Brought the client file and client contact forms with them	Yes ☐ No ☐ NA ☐
1.3	3. Made an appointment with the client. The client is aware of and has agreed to the visit	Yes ☐ No ☐ NA ☐
Comments:		

II. During the home-visit

	General Communication Skills:	
2.1	☐ Warmly greets the client	Yes ☐ No ☐ NA ☐
2.2	☐ Introduces the team and anyone else who is new to the client	Yes ☐ No ☐ NA ☐
2.3	☐ Respectfully communicates with the client	Yes ☐ No ☐ NA ☐
2.4	☐ Sits close to the client	Yes ☐ No ☐ NA ☐

General Communication Skills:		
2.5	☐ Makes general conversation with the family and PLHA if appropriate before starting to discuss health and other concerns of the client	Yes ☐ No ☐ NA ☐
2.6	☐ Observes the cleanliness and hygiene of the home, client's bed area and client	Yes ☐ No ☐ NA ☐
Comments:		
History and physical exam skills:		
2.7	☐ Asks the client to talk about how they are feeling and to discuss any concerns they might have about their health or other issues	Yes ☐ No ☐ NA ☐
2.8	☐ Listens carefully and respectfully to the client	Yes ☐ No ☐ NA ☐
2.9	☐ Is able to prioritize the most immediate needs of the client and address those issues first (symptom care, nursing care, social and emotional care)	Yes ☐ No ☐ NA ☐
2.10	☐ Conducts a complete history • Asks about improvement or worsening of problems identified in the previous visit Asks about other problems, such as: • Diarrhea • Fever • Pain • Skin problems • Sore mouth • Cough or difficulty breathing • Inability to sleep • Inability/lack of desire to eat • Forgetfulness or confusion • Constipation • Genital pain or itchiness • Emotional state (sadness, anxiety, etc)	Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐
2.11	☐ Asks the client explain and show what medicines they are currently taking	Yes ☐ No ☐ NA ☐
2.12	☐ Washes hands (or does alcohol rub) before and after conducting the physical exam	Yes ☐ No ☐ NA ☐
2.13	☐ Assessed vital signs+ • Temperature • Pulse • Breaths per minute • Pain • Blood Pressure (if measurable) • Weight (if measurable)	Yes ☐ No ☐ NA ☐

2.14	☐ Assessed vital signs+ • Temperature • Pulse • Breaths per minute • Pain • Blood Pressure (if measurable) • Weight (if measurable)	Yes ☐ No ☐ NA ☐
2.15	☐ Conducts a basic physical examination • Eyes • Nose • Mouth and throat • Lymph nodes (neck, underarms) • Abdomen • Groin/Genitals • Thoroughly examines the skin	Yes ☐ No ☐ NA ☐
2.16	☐ Provides symptom care/ nursing care needed by the client as identified by the client's concerns, history and the physical exam	Yes ☐ No ☐ NA ☐
	Comments:	
2.17	☐ Is able to prioritize most uncomfortable/ serious symptoms and provide care for them first before caring for less aggravating/ serious symptoms	Yes ☐ No ☐ NA ☐
2.18	☐ Provides clear information on how to take medicines or use supplies given to manage the symptom(s). Writes down instructions of how to take medicines *(e.g. if giving paracetamol/ codeine for chronic moderate pain provides information and a time schedule for taking medicine 'around the clock')*	Yes ☐ No ☐ NA ☐
2.19	☐ If client is in serious condition, is able to recognize the serious condition and respond appropriately	Yes ☐ No ☐ NA ☐
2.20	☐ If the client is at the end-stage, the home-care team provides end-of-life care to the client (ensures client is comfortable, provides pain medicine as needed, provides emotional comfort to client and family, talks to client about death if they want to, etc)	Yes ☐ No ☐ NA ☐
2.21	☐ Detailed Medicine Check/Adherence Support: • Asks client to show medicines they are currently taking • Asks client if they are having any problems in remember to take their medicines	Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐

	• Asks if they are experiencing any side effects • If they are taking ARVs, ask to see their pill box to see if they have forgotten to take any pills; also asks to see their ARV calendar to review if the client is using it correctly • Provides respectful corrective adherence reinforcement skills if required (e.g. how to use pill box, reminder calendar, use of family member as treatment supporter) and refers to OPC for further adherence counseling if indicated • Assesses if the medicines are kept in a safe and appropriate place	Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐
2.22	☐ If needed, correctly arranges for referral for client to regional or district level hospitals	Yes ☐ No ☐ NA ☐
2.23	☐ Fills out client contact form but does not let form completion distract from providing care to the client	Yes ☐ No ☐ NA ☐
	Comments:	
	Self-care Teaching Skills (only assess if teaching is done during the visit)	
2.24	☐ Correctly identifies a skill to teach the client and caregiver based on needs identified during the history taking and physical assessment • Explains the purpose of the skill clearly • Demonstrates how to do it • Had the caregiver and client practice the skill • Does not teach too many skills or confuse the client with too much information	Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐
2.25	☐ Asks if client has the self-care book; if not, gives the client a self-care book and uses it when teaching the client and caregiver a new skill	Yes ☐ No ☐ NA ☐
	☐ Uses language which is clear and simple; uses words that are understandable; does not use terminology	Yes ☐ No ☐ NA ☐
	Emotional Support Skills	
2.26	☐ Asks the client how they were feeling emotionally ☐ Listens carefully and respectfully to the client's worries and concerns.	Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐

	☐ Demonstrates correct counseling skills • Correct non-verbal communication: nodding, eye contact, reflecting the mood of the client, facing the client • Listens and does not interrupt the client • Asks open ended questions • Reflects on and paraphrases the statements of the client • Asks the client what they would like to do in response to the problem they have raised • Does not advise the client to do anything; does not use sentences like 'you should do this' • Summarizes the conversation including the actions that the client has decided to take and what the CHBC team will do if anything to support the client in the action they have decided to take	Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐
2.27	☐ The CHBC team informs the client and caregiver about the PLHA and Caregiver support groups including the date and time of the next meetings	Yes ☐ No ☐ NA ☐
	Comments:	
Assesses social support needs:		
2.28	☐ Assesses whether or not the client and caregiver have social or material needs (assistance with finding work, food, better shelter, etc)	Yes ☐ No ☐ NA ☐
2.29	☐ Assists client in preparing plan to address social needs	Yes ☐ No ☐ NA ☐
2.30	☐ If client has children, asks about how the children are doing physically, emotionally, socially	Yes ☐ No ☐ NA ☐
2.31	☐ Performs physical check of children as needed	Yes ☐ No ☐ NA ☐
2.32	☐ Discusses future planning with client if requested regarding preparing a will, securing property and identifying a future caregiver for their children	Yes ☐ No ☐ NA ☐
	Comments:	

Assesses spiritual care needs:		
2.33	☐ Asks the client if they need support in accessing support from a religious leader of their faith	Yes ☐ No ☐ NA ☐
2.34	☐ Assists client in preparing referral to access spiritual support	Yes ☐ No ☐ NA ☐
	Comments:	
End of Visit:		
2.35	☐ Summarizes main findings and action decided on during the visit	Yes ☐ No ☐ NA ☐
2.36	☐ Asks the client and family if there is anything else they need help with	Yes ☐ No ☐ NA ☐
	☐ Schedules a time and date for the next visit	Yes ☐ No ☐ NA ☐
2.37	☐ Provide contact information of CHBC team if relevant (i.e. first visit)	Yes ☐ No ☐ NA ☐
	Comments:	

III. Post-visit (after the visit, back in the office)

The home-care team:		
3.1	☐ Review history record form to ensure it is correct	Yes ☐ No ☐ NA ☐
3.3	☐ Record medicines or supplies which were given to the client in the logbook	Yes ☐ No ☐ NA ☐
3.3	☐ Place the client's form in the locked file cabinet where client forms are kept	Yes ☐ No ☐ NA ☐
3.4	☐ Provide correct instruction of a place to follow-up on any referrals made for the client to ensure that the service is received.	Yes ☐ No ☐ NA ☐
3.5	☐ Refill the home care kit as needed for the next visit	Yes ☐ No ☐ NA ☐
	Comments:	

Overall positive feedback and suggestions for improvement discussed with and agreed to by the home-care team:

Annex 7: Home Care Kits

Home Based Care Supplies for Trained Health Care Worker (Nurse, and community health worker)

Medication Name	Dose	Unit	Indication
Paracetamol	500 mg	Pill	Fever, analgesia (mild pain)
Paracetamol syrup	120 mg/5cc - 60 cc bottle	Bottle	Fever, younger children, analgesia
Ibuprofen	200 mg	Pill	Analgesia, fever, anti-inflammatory. Can use when cannot use paracetamol.
Gentian Violet	Paint	Bottle	Thrush
Albendazole	100 mg	Pill	Helminth Infections
Scabicide (Permethrin or Benzyl Benzoate or 1%Gamma Benzin Hexachloride)	Topical	Bottle	Scabies
Nystatin or Candid Mouth Paint, Cotrimazole			Anitfungal lozenge
Tinidazole (1 Gm or Metronidazole (400mg)			Antidiarrheal
Bisacodyl e.g.(Dulcolax)	5 mg	Pill	Constipation
Domperidone	5 mg		Antiemetic
Hyoscine 10 mg e.g. (Buscopan) or Drotaverine 40 mg (Drotin)	10 mg	Pill	Abdomen Pain
Diclofenac Gel	Topical	Tube	Joint Pain
Calamine Lotion	Topical	Bottle	Itch, symptom relief
Iron	Fixed dose	Pills	Anemia
Multivitamin	Fixed dose	Pills	Vitamin supplementation
Multivitamin syrup	Fixed dose	Bottle	Vitamin supplementation

Other Supplies:

Item	Unit
Vaseline	
Zinc Oxide Talcum Powder	
Medicated Balm	
Ethanol	
Hydrogen Peroxide	
Povidine iodine	
Bleach	
Oral Rehydration Salts	
Condoms	
Thermometer auxiliary clinical flat type	
Sphygmomanometer and Stethoscope	
Nail Cutter	
Scissors (small, steel)	Sachet
Kidney tray (small, steel)	Packet
Small plastic bowels for holding or preparing solutions, povidine iodine; salt water for cleaning wounds	
Steel jar to hold cotton	
Tweezers & artery forceps	
Gloves (small & medium)	Box (100)
Cotton wool	Rolls
Gauze 4x4 sterile	Boxes
Utility gloves	
Bandage Tape	
Antiseptic Soap	Bars
Soap dish	
Bed Sheets	
Hand Towels	
Plastic sheeting (for incontinence/ to protect bed)	
Home care kit bag	
Flashlight and spare batteries	

Plastic bags	
Wooden tongue depressor	
Notebook with calendar	
Pens	
Self-care Handbook (published by FHI/USAID)	
Container to hold sharps (scissors, nail clippers, etc)	
Plastic apron	
Cotton mask	

Home Based Care Supplies for Trained Lay CHBC Worker (PLHA, support group members, etc. who are not formally trained health care workers)

Medication Name	Dose	Unit	Indication
Paracetamol	500 mg	Pill	Fever, analgesia
Ibuprofen	200 mg	Pill	Analgesia, fever, anti-inflammatory. Can use when cannot use paracetamol.
Gentian Violet	Paint	Bottle	Thrush
Scabicide (Permethrin or Benzyl Benzoate)		Bottle	Scabies
Calamine Lotion	Topical	Bottle	Itch, symptom relief
Petroleum Jelly	Topical	Tube	Itch, dry skin
Zinc Oxide Talcum Powder	Topical	Bottle	Skin irritation
Medicated Balm	Topical	Jar	Skin breakdown, headache, nausea
Ethanol	Topical	Bottle	Disinfectant
Povidine iodine	Topical	Bottle	Disinfectant
Bleach		Bottle	Disinfectant
Condoms	Packet	Condom	Prevention of HIV Transmission

Other Supplies:

Item	Unit	Unit/Team
Thermometer auxiliary clinical flat type		
Nail Cutter		
Scissors (small, steel)		
Kidney tray (small, steel)		
Swab sticks	Box	
Small plastic bowels for holding or preparing solutions, povidine iodine; salt water for cleaning wounds		
Steel jar to hold cotton		
Tweezers		
Gloves (small & medium)	Box (100)	
Cotton wool	Rolls	
Gauze 4x4	Boxes	
Bandage Tape		
Antiseptic Soap	Bars	
Soap dish		
Bed Sheets		
Hand Towels		
Plastic sheeting (for incontinence/ to protect bed)		
Home care kit bag		
Flashlight		
Plastic bags		
Notebook		
Pens		
Self-care Handbook		
Container to hold sharps (scissors, nail clippers, etc)		

Annex 8: CHBC Kit and Supplies Stock Book

Product: _____

Unit: _____

Date	Transaction	Opening balance	Received	Issued	Loss/ adjustment	Ending balance	Quantity on order	Initiala and remarks

Annex 9: Monthly Consumption Record of Supplies

Organization: _____ **Month:** _____ **Year:** _____ **No. of clients served:** _____

S. N.	Date	Patient No.	Used for																												Dispensed by
Total dispensed this week																															
Total dispensed so far this month																															

Annex 10: CHBC Service QA/QI Checklist

Assessment team member: _____ **Date:** _____

Facility Name: _____

Method	**O = observation, R = record, SI = staff interview, MI = management interview, CI = client interview, NA = not applicable**
Score	**0 = poor, 1 = need to improve, 2 = good, 3 = excellent, NA = not applicable,**

Reminder: This checklist is a standalone list and should not be used in conjunction with other facility or service assessment lists.

1. Training	Method	Score (0-3)	Observations/rationale for score
1.1 CHBC teams have been trained/certified under national curriculum	R	2	
1.2 CHBC teams have received or will receive training in caring for children living with and affected by HIV under national curriculum	SI/MI	1	
1.3 CHBC teams have been provided a technical overview in areas appropriate to client population (e.g., drug use, harm reduction, substitution therapy; needs of MSM, SWs, youth; reproductive health, including family planning and PMTCT).			
1.4 CHBC teams are receiving on-the-job mentoring and support.			
1.5 CHBC teams have received or there is a plan for them to receive periodic refresher and advanced training.			

2. Program planning and approach	Method	Score (0-3)	Observations/rationale for score
2.1 HIV care needs are assessed in a participatory manner: a CHBC service needs assessment is conducted before the initiation of services. PLHA and families are involved in the needs assessment.			
2.2 CHBC services are strategic: CHBC services are provided in locations of greatest number and concentration of PLHA in need of care services.			
2.3 CHBC services are voluntary: CHBC is only provided to PLHA or family who request the service. No coercive incentives are advertised (e.g., food) to urge clients to accept CHBC services. 2.4 The service is family centered: the design of the CHBC program is family centered and includes provision of care to children.			
2.5 Cost barriers are reduced: CHBC service is free of charge or otherwise made affordable to those who need it.			
2.6 CHBC service is offered in a clearly defined geographic area.			
2.7 CHBC is linked to clinic/hospital-based care: CHBC service is either based in an HIV outpatient clinic (OPC), drop-in center (DIC) or other HIV service center; or otherwise linked to a facility which provides HIV care, treatment and support.			
2.8 The CHBC service is demonstratively part of a network of HIV and related services (e.g., participates in continuum of care or other referral/coordination system).			
2.9 Community mobilization: gathering support from the community is being explored or underway as part of the CHBC program.			
2.10 Community resources are being contributed to the CHBC program (e.g., labor, food, support for funerals, donations, etc.).			

3. Management and administration	Method	Score (0-3)	Observations/rationale for score
3.1 CHBC services are adequately staffed There is a balanced client-to-team ratio *Note: The optimal number of PLHA clients per team should be determined by each program. Formula should include at least the following: 1) distance/travel time to homes, 2) level of effort (team full-time or part-time), and 3) funding /resources available and 4) security issues.*			
3.2 CHBC teams are interdisciplinary; they include PLHA, health care workers, social workers or others as needed.			
3.3 Written job descriptions for staff/volunteers are available. Staff/ volunteers have been given a copy of their JD and are aware of their roles and responsibilities.			
3.4 Staff are fairly remunerated for the work performed. Volunteers are provided some incentive for motivation.			
3.5 Staff members are recruited according to IA or other agreed recruitment practices.			
3.6 A system is in place to cross-train staff/volunteers to ensure CHBC team members can be replaced efficiently.			
3.7 Staff performance is appraised annually. Results are available on file.			
3.8 Staff members working with children are aware of child protection laws.			
3.9 There is a designated CHBC supervisor. The supervisor routinely observes and mentors CHBC teams. The supervisor uses supervision checklists and provides feedback to staff on performance.			

3. Management and administration	Method	Score (0-3)	Observations/rationale for score
3.10 Provisions are made to help CHBC staff/volunteers manage burnout (e.g., through group/individual counseling, work breaks, on call rotation, leave etc.).			
3.11 Written procedures (SOPs) detailing how the CHBC services are to be implemented are accessible to all relevant staff. Managers and staff have been trained on these procedures.			
3.12 Staff and volunteers report that they are receiving ongoing mentoring, encouragement, supportive supervision to fulfill their responsibilities from supervisors and team members.			
3.13 A CHBC program organogram with names of staff members and clear lines of supervision is available.			
3.14 There are regular staff meetings. Minutes from staff meetings are available for review.			
3.15 Program reports, including service coverage indicators, are filed and readily available for review.			
3.16 Targets have been set for key performance indicators (e.g., number of people receiving services).			
3.17 Performance against targets is reviewed by managers and staff.			
3.18 The number of CHBC clients served during last quarter meets or exceeds targets.			
3.19 It is made clear to CHBC staff that CHBC is a voluntary service. Although targets might have been set, they cannot violate client rights to choose CHBC to meet that target.			

3. Management and administration	Method	Score (0-3)	Observations/rationale for score
3.20 All CHBC teams have had Hepatitis B serology checked and if negative, have been offered vaccination.			
3.21 Security for CHBC teams has been assessed and addressed as appropriate.			
3.22 PEP, HIV care and ART are available to all staff/volunteers with occupational exposure to HIV, and are provided free of charge.			
3.23 Prophylaxis, and care and treatment (or referral) for other diseases which staff/volunteers are exposed to while on the job are provided free of charge (e.g., TB, Hep B/, malaria, etc.).			
3.24 Given long periods of outdoor exposure, teams are provided, as relevant, with measures to protect them from the elements, including raincoats, umbrellas, sleeping bag, , etc.			

4. General operational issues	Method	Score (0-3)	Observations/rationale for score
4.1 The CHBC team has a base/office where they meet, rest, keep files, and store medicines and other consumables. The space includes basic facilities (e.g., toilets, running water).			
4.2 If relevant, visual and auditory privacy for clients are maintained (applicable only if the CHBC team also sees clients at the office).			
4.3 The CHBC teams take all necessary precautions to protect client confidentiality and privacy through their dress, etc. CHBC teams do not wear uniforms, use bags or have other distinguishing features which would indicate that they are working in HIV care.			

4. General operational issues	Method	Score (0-3)	Observations/rationale for score
4.4 Essential referral relationships have been established with a HIV care and treatment outpatient clinic, TB services, inpatient care ANC, IMCI, STI, RH/FP); and social welfare services, income-generation services, schools, child support, etc.,and other services deemed essential by the program.			
4.5 Referral forms are available and used by CHBC team members.			
4.6 A service referral directory is available and was updated in the last year.			
4.7 Primary referral site for facility-based HIV care and treatment is satisfied with referral relationship with CHBC service.			
4.8 CHBC staff members have a means of communication with referral sites and teams (e.g., phone, email and internet access).			
4.9 There is an 'on-call' system in place where clients can contact a member of the CHBC in the event of an emergency.			
4.10 A CHBC team transport system is in place. An appropriate and safe transport system is being used for home visits and referrals. Teams are provided transport fees and field allowance as needed.			
4.11 If relevant, CHBC teams participate in regular case review meetings with the outpatient clinic/hospital they are linked with in order to improve quality of coordination, follow-up and referrals.			

5. Infection control practices	Method	Score (0-3)	Observations/rationale for score
5.1 Masks and gloves are available to CHBC team and are being used correctly.			
5.2 There is a first aid box in the office which is available to staff, including simple methods for eye washing, covering of cuts and lesions.			
5.3 PEP is available on site or close by, an algorithm describing management of an exposure is present and staff members are trained in PEP. PEP register is maintained and updated.			
5.4 Infection control during CHBC visits: sharps (needles, syringes), contaminated scissors, tweezers, etc. are cleaned (as feasible) and packed on site in puncture-proof bags/containers for transport back to the office. Soiled materials (e.g., bandages, cotton wool) are bagged and sealed for disposal using standard procedures (see below).			
5.5 Procedures exist for the safe disposal of all waste (incineration and dumping) in accordance with MoHP standards.			
5.6 Instruments are cleaned with clean water and detergent.			
5.7 Sodium hypochlorite solution or chlorine solution is available and prepared at the right strength (e.g., 0.5% for chlorine solution).			
5.8 Instruments are sterilized by autoclave at 1210C at 106 KPa pressure for 30 minutes (for wrapped) or 20 minutes (unwrapped).			
5.9 Sterile instruments are stored in a clean and dry place.			

6. CHBC records and client registration	Method	Score (0-3)	Observations/rationale for score
6.1 Standard MoHP approved client registration and filing system (that maintains confidentiality) is in place and being maintained at all times.			
6.2 Files are kept in a locked cabinet. Access to files is limited to only those designated. A coding system is used so that names of clients are protected.			
6.3 All staff members use standardized MoHP approved data collection forms (e.g., client history and follow-up visit forms, registers).			
6.4 There is evidence that CHBC teams promptly and completely fill in 'client first visit' and 'follow-up visit' forms.			
6.5 CHBC client folders are coded and filed in an organized manner. There is a system for managing active and inactive files (e.g., files of individuals who have died, refuse service, who are lost to follow up or who have been discharged from the service).			
6.6 CHBC teams update client-held record books on every visit (if applicable to program).			
6.7 For CHBC teams based at an HIV clinic, there is an attempt to link or integrate CHBC client records into facility client records.			

7. CHBC supplies	Method	Score (0-3)	Observations/rationale for score
7.1 CHBC teams have a home care kits (bag of essential care supplies). The kits are stored in a safe and dry place, and are replenished as needed.			
7.2 CHBC kit is contained in a bag selected by the CHBC team that is comfortable to carry (e.g., a backpack).			
7.3 CHBC kits contain a standard set of symptom care medicines and supplies approved by MoHP.			
7.4 Where care is provided to children, the kits contain medicines appropriate to them.			
7.5 Home care supplies are consistently available. No stock-outs have been reported in the past 3 months.			
7.6 CHBC teams are trained to use the medicines and supplies in the kit.			

Score Method: A = available; NA = not available; St = stocked

7. CHBC supplies	Method	Score (0-3)	Observations/rationale for score
7.1 Home-care teams have access to the following medicines and supplies: This list must be adapted to the needs of clients and available medicines in each area.			
7.1.1 Sterile disposable gloves			
7.1.2 Masks			
7.1.3 Soap for hand washing			
7.1.4 Sterilizing fluid for cleaning equipment, blood spills			

7. CHBC supplies	Method	Score (0-3)	Observations/rationale for score
7.1.5 Analgesics for mild pain (combination of a few e.g., paracetamol, aspirin, ibuprofen, diclofenac)			
7.1.6 Analgesics for moderate pain [paracetamol/ codeine (500mg/ 30mg),			
7.1.7 Tinidazole 1 Gm or Metronidazole 400 mg.,			
7.1.8 Domperidone			
7.1.9 Hyoscine 10 mg e.g. (Buscopan) or Drotaverine 40 mg (Drotin)			
7.1.10 Antifungal lozenge, pessary and cream (e.g., clotrimazole, miconazole, nystatin)			
7.1.11 Antifungal solution (gentian violet)			
7.1.12 Constipation e.g., (Dulcolax)			
7.1.13 Gentian Violet			
7.1.14 Scabicide (e.g., benzyl benzoate, permethrin)			
7.1.15 Petroleum jelly/vaseline			
7.1.16 Calamine lotion			
7.1.17 Zinc oxide talcum powder			
7.1.18 Medicated balm			
7.1.19 Rubbing alcohol			
7.1.20 Hydrogen peroxide			

7. CHBC supplies	Method	Score (0-3)	Observations/rationale for score
7.1.21 Povidine iodine			
7.1.22 Multivitamin			
7.1.23 Vitamin B complex			
7.1.24 ORS			
7.1.25 Condoms			
7.1.26 Sphygmomanometer and Stethoscope			
7.1.27 Wound dressing sets			
7.1.28 Scissors, tweezers and container for sharps			
7.1.29 Tongue depressors, flashlight and back-up batteries			
7.1.30 Plastic bags for refuse and materials for disposal at facility			
7.1.31 Self-care information (self-care book, pamphlets, etc.)			
7.1.32 Local service information (e.g., harm reduction, OVC/CABA care)			
7.1.33 Iron pills			
7.1.34 Flash light and spare batteries			
7.1.35 Notebook with calendar			
7.1.36 Self-care Handbook (published by FHI/USAID)			
7.1.37 Plastic apron			

8. Home-based care visits			
8.1 General home visit planning	**Method**	**Score (0-3)**	**Observations/rationale for score**
8.1.1 CHBC program has formally defined what services it will and will not offer. It has communicated these limitations to partners and clients.			
8.1.2 Client visits are made with optimum frequency to ensure continuity of care and prevent neglect.			
8.1.3 Clients are prioritized. Those with greater care needs are visited with greater frequency than those who only require routine visits.			
8.1.4 Clients are visited by the same team to promote stable and continuous care.			
8.1.5 There is a weekly home visit plan in place. Team plans and schedules home visits together.			
8.2 Home visit observation	**Method**	**Score (0-3)**	**Observations/rationale for score**
8.2.1 CHBC members are well prepared and bring appropriate supplies according to patient needs.			
8.2.2 CHBC teams make appointments with client and family. Client and family know the CHBC team is coming.			
8.2.3 CHBC team greets clients and family in an appropriate manner, including introduction of CHBC team members and observers.			
8.2.4 CHBC members do not ignore PLHA, family or children and communicate respectfully and clearly with them. Attempts are made to make PLHA and family comfortable with every visit.			

8.2.5 CHBC members start the visit by enquiring after the needs of PLHA and family, and following up on previously identified needs. CHBC members conduct a holistic assessment, asking about physical, emotional, social and spiritual needs.			
8.2.6 When caring for families, the CHBC team addresses needs of the whole family, not just the individual with HIV (family-centered care).			
Home visit observation	**Method**	**Score (0-3)**	**Observations/rationale for score**
Physical care and support			
8.2.7 CHBC team member takes client history: asks about new signs or symptoms (e.g., pain, symptoms and side effects). 8.2.8 CHBC team member checks the client-held care book (if used as part of the HIV care program and as appropriate) for previous clinic visits, medicines prescribed and next clinic appointment.			
8.2.9 CHBC team member reviews new and old medicines being taken; asks to see medicines; clarifies what each is being taken for; and checks how well the client understands their prescriptions.			
8.2.10 CHBC team member washes hands before/after providing care and takes other infection prevention measures, as appropriate (e.g., gloving).			
8.2.11 CHBC team member takes vital signs (pulse, temperature, respiration, BP), informs PLHA of the results and documents them in client file.			
8.2.12 CHBC team member asks client if they have pain and uses pain scale to determine the severity of pain (e.g., 0-10 or another scale). Results are documented in the client file.			

8.2.13	CHBC team member does basic physical exam: examines eyes, mouth, tongue, lymph nodes, abdomen, skin and genitals (as appropriate).			
8.2.14	CHBC team member correctly classifies signs and symptoms to determine if the client needs more skilled care for acute conditions or if danger signs are present. If referral is needed, the team member informs client/family of findings, asks client/family for approval to refer, and makes referrals promptly and according to protocol.			
8.2.15	CHBC team member discusses exam findings with client and family, and explains the care they will provide.			
8.2.16	CHBC team member provides care (appropriate to findings) to PLHA (manages pain, bed sores and other symptoms).			
8.2.17	CHBC team member teaches PLHA/family how to manage problems identified and when to refer.			
8.2.18	CHBC team member provides care supplies needed to manage problem identified.			
8.2.19	ART and cotrimoxazole prophylaxis adherence: CHBC team member asks client about ability to adhere to medicines. As per the local adherence protocol, the team member performs a pill count; checks medicine calendar, pill boxes or other tools used by the program/client to support adherence; asks about side effects; and provides side-effect care and information to the client and family.			
8.2.20	TB med check: if client is being treated for TB, CHBC team member checks TB forms and adherence to medicines, asks about medicine side effects, and provides side effect care and information to the client and family, as needed.			

8.2.21 If client is bed-bound, CHBC team member teaches family how to clean and care for skin and change position to prevent bed sores; how to provide bowel and bladder care; and how to feed, hydrate and comfort client.			
8.2.22 If client is near end of life, CHBC team member provides responsive and appropriate end-of-life care (pain, symptoms, skin care; counseling, preparations).			
8.2.23 CHBC team member assesses availability to and intake of food and clean water, and if the client is able to eat three balanced meals a day; reviews overall family access to food; and develops plans to address any barriers to food for client and family.			
8.2.24 CHBC team member provides self-care and positive living counseling, as appropriate.			
8.2.25 CHBC team member uses available educational tools (the self-care series books) and other tools to promote self-care skills and self-reliance of clients, and provides such tools to the client, as appropriate.			
8.2.26 CHBC team member provides information on safer sex, family planning, PMTCT, harm reduction, as needed.			
Emotional, social and spiritual support			
8.2.27 CHBC team member assesses client's and families' emotional, social and spiritual needs.			
8.2.28 CHBC team member assesses in a sensitive manner experiences with stigma and discrimination (self-stigma; stigma and discrimination from family, neighbors, health care workers and others) and helps client develop a plan for coping with stigma and discrimination.			

8.2.29 CHBC team member communicates respectfully and openly but without providing advice or directing client to a specific choice.			
8.2.30 CHBC team member provides emotional support, including active listening, empathy and active problem solving.			
8.2.31 CHBC team member helps client and family to prepare a social, emotional, spiritual support plan.			
8.2.32 If relevant, CHBC team member provides information to client/family regarding referrals (e.g., income generation, schooling, support, child protection.); and actively supports clients/family in linking to key services.			
8.2.33 If appropriate, CHBC team member arranges for follow-up counseling with client/family.			
8.2.34 In case of danger signs (intention of harm to self/others), CHBC team member provides support and arranges for additional help to client/family.			
8.2.35 CHBC team member refers client and family to PLHA and family support groups if they are not already members.			
Safer sex, family planning and PMTCT			
8.2.36 As relevant, CHBC team member provides client with basic information on safer sex, family planning, PMTCT and on how to access services.			
8.2.37 If not already seeking care at an HIV clinic, CHBC team member provides information on clinics and actively supports referral if client opts to go.			

8.2.38	For female/couple clients wanting to be or already pregnant, CHBC team member provides information on benefits of PMTCT service and actively supports referral to service if clients opt to go.			
8.2.39	CHBC team member provides supportive counseling, including assistance with partner disclosure and coping with partner reaction.			
8.2.40	For women/couples enrolled in PMTCT program, CHBC team member reviews clinic visit schedule and provides support if needed in attending routine clinics.			
8.2.41	CHBC team member asks about PMTCT ARV and cotrimoxazole adherence and side effects, and provides support.			
8.2.42	CHBC team member asks about other routine ANC support (access to Fe & Folic Acid, TT, etc.) and provides referral to ANC services as needed.			
8.2.43	CHBC team member checks for pregnancy-related danger signs as part of overall history and exam taking: hemorrhaging, swollen legs, dizziness, anemia, etc.			
8.2.44	CHBC team member notifies PMTCT service provider if client has missed an appointment, cannot afford transport to services, is not able to be adherent to ARV or is experiencing side effects.			
8.2.45	CHBC team member assesses emotional, social and spiritual needs (as above).			
8.2.46	CHBC team member visits family just after delivery to provide continuity of care.			
8.2.47	CHBC team member checks for post-partum danger signs: hemorrhaging, infection, anemia, etc.			

If caring for an HIV-exposed child			
8.2.48 CHBC team member checks for danger signs; refers if danger signs identified.			
8.2.49 If < age 5, CHBC team member checks the client-health care book (if used as part of the HIV care program and as appropriate) for previous clinic visits, medicines prescribed and next clinic appointment.			
8.2.50 CHBC team member assesses infant feeding, counsels mother/caregiver about implications of mixed feeding and provides support for either exclusive breast or exclusive formula feeding (as per local guidelines / mother's choice).			
8.2.51 CHBC team member asks about cotrimoxazole adherence, side-effects and provides support; checks the level of understanding of the caregiver in how cotrim should be taken by the child; as per local adherence protocol, does a pill count, checks medicine calendar, pill boxes, etc.; helps family manage adherence; and refers child to the clinic if problems with adherence are identified.			
8.2.52 CHBC team member provides information on HIV testing for infants and support in accessing HIV counseling and testing if the family opts for it.			
8.2.53 CHBC team member checks yellow growth monitoring and immunization card (ensures child is getting immunizations on schedule, growing well, etc.).			
8.2.54 CHBC team member assesses availability to food and nutritional intake, and makes plan to address any barriers to food for client and family.			
8.2.55 CHBC team member asks about use of/access to local nutrition supplies/services (e.g., multi-vitamin syrup, deworming, Suppemental feeding)			

8.2.56 CHBC team member assesses physical, emotional, social, cognitive and spiritual needs of children, and provides care and support as relevant, including: future planning, wills, foster care placement, emotional support, and cognitive development, including play, nutrition and health care.			
8.2.57 CHBC team member arranges for referrals to supportive services.			
8.2.58 CHBC team member refers child to play group activities (or other early childhood development programs), if appropriate.			
If caring for HIV+ child			
8.2.59 CHBC team member checks for danger signs (general childhood and HIV-related illness); and promptly refers child if danger signs are identified.			
8.2.60 CHBC team member checks the client-held care book (if used as part of the HIV care program) for previous clinic visits, medicines prescribed and next clinic appointment.			
8.2.61 CHBC team member assesses infant feeding, counsels mother/caregiver about dangers of mixed feeding and provides support for either exclusive breast or exclusive formula feeding (as per local guidelines/mother's choice).			
8.2.62 CHBC team member asks about cotrimoxazole, TB and ART adherence, side-effects and provides support; checks the level of understanding of the caregiver in how ART, cotrim, TB and other medication should be taken by the child; as per local adherence protocol, does a pill count, checks medicine calendar, pill boxes, etc.; helps family manage complicated adherence (e.g., taking medicines at school); and refers child to ART clinic if problems with adherence are identified.			
8.2.63 If < age 5, CHBC team member checks yellow IMCI growth monitoring and immunization card (ensures child is getting immunizations on schedule, growing well, etc.).			

8.2.64 CHBC team member assesses availability to food and nutritional intake, and develops a plan to address any barriers to food for client and family.			
8.2.65 CHBC team member asks about use of/access to local nutrition supplies/services (e.g., multi-vitamin syrup, deworming, supplemental feeding,).			
8.2.66 CHBC team member assesses needs of children and provides care and support as relevant (future planning, wills, foster care placement, emotional support, cognitive development, including play, schooling support, nutrition and health care).			
8.2.67 CHBC team member informs family of available support services (e.g., play groups for children > 3 yrs of age; family caregiver support groups; youth groups, etc.).			
8.2.68 CHBC team member arranges for referrals to supportive services as needed.			
8.2.69 CHBC team member refers child to play group activities (or other early childhood development programs), if appropriate.			
If child is HIV status unknown			
8.2.70 CHBC team member checks for danger signs (general childhood and HIV-related illness); promptly refers child if danger signs are identified.			
8.2.71 If < 5 years of age, CHBC team member checks growth monitoring and immunization card (ensures child is getting immunizations on schedule, growing well, etc.).			
8.2.72 CHBC team member assesses availability to food and nutritional intake, and develops a plan to address any barriers to food for client and family.			

8.2.73 CHBC team member asks about use of/access to local nutrition supplies/services (e.g., multi-vitamin syrup, deworming, supplemental feeding and WFP food packages).			
8.2.74 CHBC team member assesses needs of children and provides care and support as relevant (future planning, wills, foster-care placement, emotional support, schooling support, nutrition and health care).			
8.2.75 CHBC team member refers child to play group activities (or other early childhood development programs), if appropriate.			
8.2.76 CHBC team member arranges for referrals to supportive services as needed.			
8.2.77 CHBC team member provides information on HIV counseling and testing to caregivers support in accessing CT if the family opts for it.			
If child is HIV negative			
8.2.78 CHBC team member checks for childhood illness danger signs; refers if danger signs identified.			
8.2.79 If < age 5, CHBC team member checks growth monitoring and immunization card (ensures child is getting immunizations on schedule, growing well, etc.).			
8.2.80 CHBC team member assesses availability to food and nutritional intake, and develops a plan to address any barriers to food for client and family.			
8.2.81 CHBC team member asks about use of/access to local nutrition supplies/services (e.g., multi-vitamin syrup, deworming,			

8.2.82 CHBC team member assesses needs of children and provides care and support as relevant (future planning, wills, foster-care placement, emotional support, schooling support, nutrition and health care).			
8.2.83 CHBC team member refers child to play group activities (or other early childhood development programs), if appropriate.			
8.2.84 CHBC team member arranges for referrals to supportive services as needed.			
End of home visit/follow up			
8.2.85 CHBC team member asks if the client/family have any remaining needs or questions.			
8.2.86 CHBC team member summarizes main findings and main actions to be taken with client and family, and checks with client and family to ensure that they agree with findings and next steps.			
8.2.87 CHBC team member makes appointment for follow-up visit with client and reminds client of upcoming clinic appointments.			
8.2.88 CHBC team member debriefs with supervisor and/or OPC clinic staff if any issues were raised that CHBC team was unable to address.			
8.2.89 CHBC team member correctly documents and files report in locked cabinet.			
8.2.90 CHBC team member replenishes CHBC kits as needed.			

9. Community services (assess if relevant to program)				
	9.1. Community mobilization/awareness building	**Method**	**Score (0-3)**	**Observations/rationale for score**
9.1.1	Communities involved are prioritized by the program; those more affected by HIV receive priority focus of community awareness and mobilization.			
9.1.2	Community awareness campaigns contain appropriate and relevant content: HIV transmission and prevention, stigma and discrimination reduction, how to access services, etc.			
9.1.3	Community awareness activities are organized with adequate frequency to contribute to changes in knowledge among community members.			
9.1.4	Community mobilization techniques are appropriate to the local area and include a focus on building involvement in and ownership of CHBC work.			
9.1.5	PLHA provides input and shape content and implementation of community activities.			
9.1.6	There is evidence of community involvement and ownership of the program.			
9.1.7	Where community barriers to PLHA accessing support and services exist, the CHBC program is strategically addressing such barriers.			
9.1.8	Link to VACC/MACC and DACC for resource mobilization			

9.2 Community care		Method	Score (0-3)	Observations/rationale for score
9.2.1	CHBC teams provide care to homeless, migrant/mobile PLHA, not wanting or able to receive care in the home, in the community or at other locations (e.g., drop-in center, shelter, hospice, crisis center).			
9.2.2	CHBC teams meet clients at their preferred location and optimize privacy for clients given the environment of care (street, park, etc.).			
9.2.3	CHBC teams follow procedures under Home-based care visits when assessing needs and providing care.			
9.2.4	CHBC teams support client to access a stable living environment if that is what the client wants.			
9.2.5	For homeless, migrants/mobile populations, CHBC teams work with others to address shelter needs.			
9.2.6	CHBC teams assist client in reuniting with family, if that is what client wants.			

10. Monitoring and evaluation		Method	Score (0-3)	Observations/rationale for score
10.1	Client satisfaction			
10.1.1	Clients feel confidentiality is being maintained by CHBC team.			
10.1.2	Clients feel that they are being treated with respect and dignity by CHBC team.			
10.1.3	Clients feel CHBC team comes to their home with adequate frequency.			

10. Monitoring and evaluation		Method	Score (0-3)	Observations/rationale for score
10.1.4	Clients feel adequately supported and that needs are being met.			
10.1.5	Clients report satisfactory experiences with referral services.			
10.1.6	Clients are given opportunity to provide feedback about the CHBC services and other related issues.			
10.2	CHBC reporting and data collection			
10.2.1	Data collection forms are available in project files and used correctly.			
10.2.2	Data collected at each level of staff is correct and complete.			
10.2.3	Quarterly reports are completed and submitted			
10.2.4	CHBC teams understand what is being measured by report forms and how to collect the data.			
10.2.5	CHBC teams participate in/lead data analysis and in using findings to adapt the program.			
10.2.6	A process is in place for routine and participatory team analysis of program data.			
10.3	CHBC QA/QI and evaluation			
10.3.1	Routine program process evaluation is conducted which includes QA/QI.			
10.3.2	As relevant, periodic outcome evaluation of the program is conducted, including assessing the quality of life of clients.			

TOTAL SCORE:	/	TOTAL MS MET:	/	NUMBER NAS CIRCLED	/

Annex 11: List of Contributors

CHBC Technical Working Group Members:

1.	Dr. Hemant Chandra Ojha	Focal Person, CHBC, NCASC
2.	Ms. Usha Bhatta	Public Health Officer, NCASC
3.	Mr. Krishna Prasad Nagila	Public Health Inspector, NCASC
4.	Mr. Rajesh Prasad Khanal	Program Officer, NCASC
5.	Dr. Keshav Kumar Yogi	Technical Unit Head, ASHA Project/FHI 360 Nepal
6.	Ms. Neera Thakur	Technical Officer-Community Initiatives, ASHA Project/FHI 360 Nepal
7.	Dr. Atul Dahal	National Professional Officer, WHO
8.	Mr. Prakash Yogi	MIS/Program Officer, NAP+N
9.	Dr. Lochana Shrestha	Save the Children
10.	Ms. Bishnu Ghimire	Executive Director, Sakriya Sewa Samaj
11.	Mr. Joel Githinji	HIV and AIDS Advisor, UMN
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