# An assessment of the quality of home-based care services provided by Zimbabwe Red Cross Society to people living with HIV in Midlands Province of Zimbabwe

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45th International Course in Health Development
September 22, 2008 – September 11, 2009

KIT (ROYAL TROPICAL INSTITUTE)
Development Policy & Practice/
Vrije Universiteit Amsterdam

**"An assessment of the quality of home-based care services provided by Zimbabwe Red Cross Society to people living with HIV in Midlands Province of Zimbabwe".**

A thesis submitted in partial fulfillment of the requirements of the degree of

Master of Public Health

By

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Where other people's work has been used (either from printed sources, internet or any other sources), it has been carefully acknowledged and referenced in accordance with departmental requirements.
The thesis **"An assessment of the quality of home-based care services provided by Zimbabwe Red Cross Society to people living with HIV in Midlands Province of Zimbabwe"** is my own work.

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45th International Course in Health Development (ICHD)
September 22nd, 2008 – September 11th, 2009
KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

September 2009

Organized by:

KIT (Royal Tropical Institute), Development Policy and Practice
Amsterdam, The Netherlands

In Co-operation with:

Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU)
Amsterdam, The Netherlands

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**List of abbreviations:**

| | |
|---|---|
| AIDS | acquired immunodeficiency syndrome |
| ART | antiretroviral therapies |
| CAA | Catholic AIDS Action |
| CHBC | community home based care |
| CoC | continuum of care |
| DOTS | Directly observed treatment short course |
| FHI | Family health international |
| HDN | Health and development network |
| HIV | human immunodeficiency virus |
| ICHC | integrated community home based care |
| IFRC | International Federation of the Red Cross |
| IGP | income generating project |
| IMF | international monitory fund |
| M&E | monitoring and evaluation |
| MoHCW | Ministry of healthy and child welfare |
| NAC | National AIDS Council |
| NACP | National AIDS Control Program |
| NARF | national activity report form |
| NGO | non-governmental organisation |
| OI | opportunistic infections |
| OVC | orphans and vulnerable children |
| PLHIV | people living with HIV |
| SAfAIDS | Southern Africa AIDS information dissemination service |
| TB | tuberculosis |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| USAID | United States Agency for International Development |
| VCT | voluntary counseling and testing |
| WHO | World Health Organisation |
| ZAN | Zimbabwe AIDS Network |
| ZNNP+ | Zimbabwe National Network of people living with HIV |

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**Acknowledgements**
Firstly I would like to thank Nuffic and indeed the Netherlands government for offering me the fellowship to study for the MPH. Without their support, studying for such an internationally recognized course would have remained a far fetched dream for me.

Secondly I would like to thank my thesis adviser for her guidance. She gave me room to express my thoughts, offered advice where needed and gave me the encouragement to soldier on. I am also thankful to my back-stopper who never wanted to leave anything to chance and ensured that my progress was smooth.

Thirdly I am very grateful to all the course participants for their varied experiences and abilities which came in handy during the entire course duration. I drew a lot of inspiration from the comments and advice I got from them and remain forever grateful to them.

Lastly I would like to thank my family who endured a full year without me at the height of the raging economic crisis in Zimbabwe.

## Abstract

### Introduction

This study seeks to assess the quality of community home-based care (CHBC) services provided by Red Cross in Midlands province of Zimbabwe so as to make recommendations for strengthening the quality of home based care services in Zimbabwe.

### Methodology

The study is based on a review of unpublished Red Cross reports, published CHBC literature and a questionnaire response by Red Cross Provincial CHBC coordinator (Midlands). A theoretical framework adapted from the Institute of Medicine's six elements of quality is then used to assess the quality of home based care services.

### Findings and Conclusions

Study findings show a 134.7% increase in PLHIV accessing CHBC services and a 63.5 % increase in volunteers providing care. The major categories of PLHIV care needs are physical, psychosocial, palliative and spiritual. These are changing as the epidemic progresses thus there is a continuous assessment of the changing care needs. The care being provided by Red Cross is not able to cater for all the currently known care needs of PLHIV.

It can be concluded that the quality of CHBC care being provided by Red Cross is declining when the demand for care is increasing as the HIV epidemic matures in Zimbabwe. People living with HIV are no longer able to access quality CHBC care and some of their care needs are remaining unmet.

### Recommendations

Quality of home-based care in Zimbabwe can be strengthened through increased funding, improvements in training and supervision of volunteers, improved M&E and the presence of a functional referral system.



**Key words:** home based care, home care, volunteers, HIV, AIDS, quality of care, caregiver, Red Cross, Zimbabwe


**Word count: 14949**

## Preface

During the course of my career I was once a field officer for a program which had a CHBC project caring largely for PLHIV. As I worked with the project l realized how hard volunteers worked to provide care to chronically ill people. As the Zimbabwean economy started sliding, it became increasingly difficult for programmes to provide care to clients because of funding constraints. Some even stopped care provision.

When hospitals were still fully functional in Zimbabwe, PLHIV on CHBC programmes were able to go for check-ups and treatment of opportunistic infections. This made the work of volunteers lighter. When the health system stopped functioning most PLHIV looked at CHBC as a substitute. People staying in Districts without CHBC programmes started taking their ill to relatives residing in districts that have such programmes so that they could access care from trained volunteers. I believe that the role of CHBC in the care of PLHIV in Zimbabwe is poised to increase. As such it is important to have knowledge of the quality of care that is being provided by existing programmes so that areas of weakness are identified and strengthened. This will benefit the many PLHIV who look up to CHBC programmes as their only source of care in the current Zimbabwean environment.

# Chapter 1: Introduction

Zimbabwe is a Southern African state sharing boarders with, Botswana, Mozambique, Namibia, South Africa and Zambia. It is divided into ten administrative provinces Bulawayo, Harare, Mashonaland Central, Mashonaland East, Mashonaland West, Matabeleland North, Matabeleland South, Manicaland, Masvingo and Midlands. Except for Harare and Bulawayo which are metropolitan, the rest are largely rural, with small towns for provincial capitals. The capital for Midlands is Gweru.

The 2002 population of Zimbabwe was 11.6 million (Central Statistical Office, 2007) with a birth rate of 27.72/1000 population and a death rate of 21.76/1000 population. The average life expectance for men was 37 years while women anchored the bottom of the world at 34 years (WHO, 2006).

Zimbabwe is going through an economic crisis believed to have been precipitated by the land reform programme meant to address land ownership imbalances between blacks and whites (IMF, 2007). It disrupted farming activities and disturbed the equilibrium of an otherwise well performing agrarian economy, leading to nationwide shortages of basics and hyperinflation (IMF 2007, Boysen 2008). Unemployment spiraled to 85% in 2007 (People's Health Movement 2008).

This has led to an exodus of health professionals in search of better working conditions outside the country (WHO, 2009). According to O'Brien and Gostin (2009) 51% of Zimbabwean physicians and 24% of nurses were working in industrialized countries in 2005. Most health facilities have skeletal staff. Lack of funding has seen health facilities going without drugs and other basic requirements (O'Brien and Gostin). Sometimes patients are turned away without treatment. According to Zimbabwe Herald (2009) a physician at Beitbridge Hospital admitted to referring serious cases to Musina in neighboring South Africa. Patients with chronic illnesses, including PLHIV are hit hardest. Where there are functional CHBC programmes, these are providing the best alternative care to PLHIV.

The first reported AIDS case in Zimbabwean was in 1985 (NAC, 2006). Since then prevalence increased, peaking at 26.5% in 2001. From then on, the prevalence declined to 23.2% (2003), 19.4% (2005) and 15.6% in 2007 (UNGASS Report, 2007). This is widely believed to be credited to prevention interventions.

The National AIDS Control Programme (NACP) was established in 1987 in the Ministry of Health to create HIV public awareness. Due

to an increase in NGO actors in HIV work, Zimbabwe AIDS Network (ZAN) was created in 1992 to coordinate the activities of AIDS service NGOs. ZAN was instrumental in the establishment of Zimbabwe National Network of People Living with HIV (ZNNP+) in 1992 to promote involvement of PLHIV in responses. In 1999, the National AIDS Council (NAC) was established through an Act of parliament, to coordinate multisectoral response to HIV. The national AIDS policy was developed in 1999 to create an enabling environment for HIV interventions. Government introduced the AIDS levy, a 3% tax on taxable income, to mobilizing local resources for financing responses (NAC, 2006).

Current interventions include prevention, treatment, mitigation, care and support. Lack of funds has been the greatest setback on programming. By 2005, only 25000 (7%) of the estimated 358000 eligible PLHIV were on ART (NAC, 2006)

Increases in PLHIV needing care led to the emergence of community groups offering home-based care services during the early 1990s. An upsurge of inpatients strained hospital capacities, which started discharging the chronically ill, largely PLHIV, for home care, but the process was chaotic. The MoHCW then developed discharge plan guidelines (MoHCW, 1998) meant to prepare families for patient discharge and outline the role of the healthcare system in patients' follow-up. The CHBC policy came into being in 2001, highlighting the link between the home and the healthcare system for continuity of care (MoHCW, 2001). This was followed by the National CHBC standards (MoHCW, 2004) and the National CHBC training manual (MoHCW, 2005) which were developed to standardize home-based care activities, training and processes.

Zimbabwe Red Cross is one of the biggest organisations offering programmatic CHBC to the chronically ill and PLHIV in Zimbabwe (IFRC, 2006). They currently have programmes in all provinces of the country. In Midlands their programme is in four of the seven districts, making them the biggest player in the province. A Provincial Coordinator manages the programme assisted by volunteer team leaders, while volunteer carers form the backbone of care provision.

## Chapter 2: Problem Statement and Methodology

### 2.1 Problem Statement

Zimbabwe is among the countries worst hit by HIV with a 2007 prevalence of 15.6%. At the end of 2007, there were 1,320,739 people living with the virus, 1’085,67 being adults (15-49), 60% of them adult women (15-49) and 132,930 being children (0-14) (UNGASS Report, 2007).

People living with HIV (PLHIV) are prone to bouts of opportunistic infections (OIs) because of weakened immunity. This increases their need for healthcare services. The National AIDS Council (2006) reported that, over 70% of people admitted to Zimbabwean medical wards in 2005 were treated for HIV related ailments. Jackson and Kerkhoven (1995) observed that mounting morbidity, especially from chronic illnesses increases the burden of care on healthcare services. This is supported by NAC (2006) who admitted that the capacity of the Zimbabwe healthcare delivery system was severely strained by the advent of AIDS. Shortages of drugs, ageing equipment and the exodus of health personnel to better paying jobs have exacerbated the situation over time (Stilwell, et al 2009, Johnson et al 2005, O’Brien and Gostin, 2009).

Zimbabwe is going through arguably the worst economic downturns for a country not at war, with inflation peaking at 1730% in January 2007 (IMF, 2007). Costs of goods and services have risen beyond the reach of many and health services are being paid for in foreign currency (The Sunday Mail, 2009). Those needing more frequent healthcare services like PLHIV who experience recurrent OIs are hit hardest. In 2000 Robson (2000) documented what can be the genesis of a decline in attendance to Zimbabwean healthcare facilities, possibly because of economic hardships. This decline continued in response to mounting economic adversities which peaked in 2008. Where hospital admissions were needed, many could not afford long admissions. Even those who could pay, hospital facilities could not cope because of personnel, equipment and material challenges (Stilwell et al, 2009). It became imperative for hospitals to release patients to the care of their families. As the impact of AIDS on diseases burden increased, families could not cope with caring for their sick. During mid 1990s organisation led CHBC programmes started sprouting sporadically, offering assistance with care for the chronically sick (HDN and SAfAIDS, 2007).

Zimbabwe Red Cross Society is among the first NGOs to offer programmatic CHBC services catering for people with chronic

illnesses, including AIDS in 1998 (IFRC, 2006) taking advantage of their already existing pool of volunteers to provide care to clients.
Since the start of the Red Cross CHBC programme, it has gone through changes in terms of coverage, number of clients, volunteers and services offered. While CHBC is supposed to complement hospital care (FHI, 2001) the situation in Zimbabwe has allowed it to become more of a substitute (Robson, 2000). Given the position CHBC has claimed on the care for PLHIV in Zimbabwe, and the fact that care is provided by volunteers, it is important to know the quality of care. To date no assessment has been done specifically on the quality of care provided, yet more and more new clients are accessing CHBC services every year (NAC, 2006). This study seeks to review the quality of CHBC services being provided by Red Cross in Midlands province so as to make recommendations for the strengthening of CHBC service quality in Zimbabwe.

## 2.2 STUDY OBJECTIVES

### 2.2.1 General Objective

To review the quality of CHBC services offered to PLHIV by Zimbabwe Red Cross in Midlands province from 2005 to 2008 and offer recommendations for the strengthening of CHBC service quality in Zimbabwe.

### 2.2.2 Specific Objectives

1. Assess the annual numbers of active community based volunteer care givers on the CHBC programme during the years in question and find out reasons for any changes.
2. Trace the annual numbers of CHBC clients from 2005 to 2008 and explore the reasons for any changes.
3. Explore the care needs of CHBC clients.
4. Analyze CHBC services offered by Red Cross in relation to care needs of clients.
5. Compare the quality of CHBC services provided by Red Cross in Midlands with that provided by another Zimbabwean organisation and others in neighboring countries.
6. Offer suggestions and recommendations for the strengthening of the quality of CHBC services in Zimbabwe.

## 2.3 Intended Readership

Zimbabwe Red Cross Society is the primary reader as they are keen to use the results of this study to strengthen the quality of their CHBC programme. It is also intended for the readership of ZNNP+, NGOs involved in CHBC and the National AIDS Council.

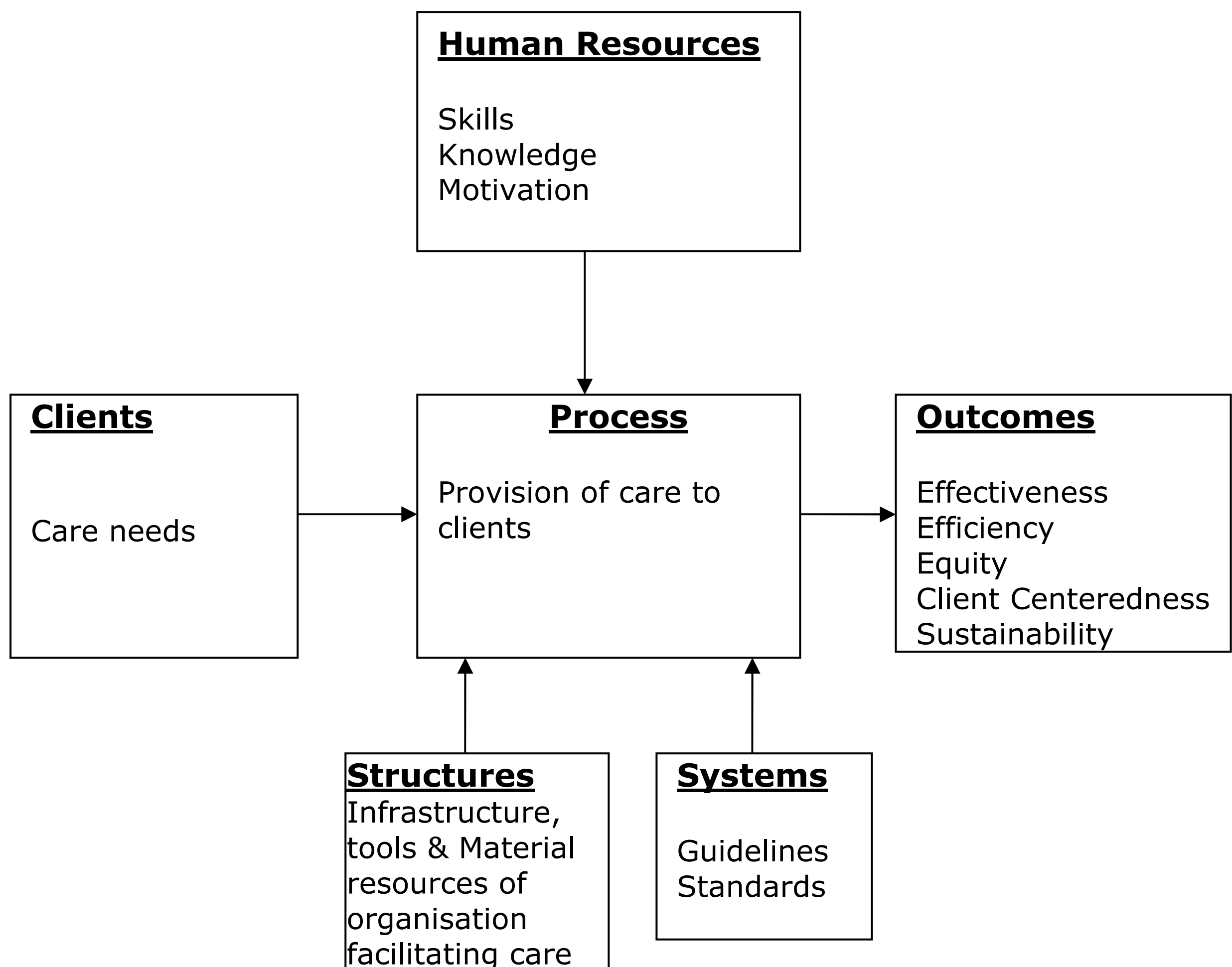
## 2.4 Research Methodology

The research is based on secondary data in the form of unpublished annual reports (2005-2008) from Zimbabwe Red Cross Society, which have been supplemented with primary data from one questionnaire completed by Red Cross Provincial CHBC Coordinator. Data were also obtained from the review of CHBC literature from Zimbabwe and neighboring countries. The literature search was conducted through Scopus, Pubmed, Google scholar, WHO, and UNAIDS websites using the search words, home based care, HIV, AIDS, PLHIV, volunteer caregiver, home care, quality of care, South Africa, Namibia, Zimbabwe.

## 2.5 Conceptual Framework

Quality of care has been assessed using a framework adapted from the Institute of Medicine's six elements of quality (Institute of Medicine, 2001).

Fig.2.1 Quality of Care Framework




*Source: Adapted by author from six elements of quality care, Institute of Medicine (2001)*

The Institute of Medicine's six elements of quality has been adapted by removing one of the outcomes (safety) because it is not easy to measure. The 'care system' has been broken into stand-alone components of human resources, systems and structures. This has been done to ensure that all components pertaining to the provision of care in home or community settings are captured.

According to the adapted framework healthcare is made up of the clients, structures, systems, human resources and outcomes. Clients are the people in need of care. Structures are the materials resources the organisation makes available for the provision of care. Systems encompass guidelines and standards (national and/or organizational) which are needed for quality care provision. These are usually evidence based and meant to ensure that care provision conforms to set standards and follow agreed guidelines. Human resources provide care, supervision and coordination. Their ability to provide quality care depends on knowledge, skills, and motivation. The interface of these components produces outcomes which are assessed through the following elements:

1. **Client centeredness:** Is client care provided in a way that is responsive to client needs? Are client values guiding care decisions?
2. **Effectiveness:** Is the care provided sound and able to make clients get well, improve or feel better?
3. **Efficiency:** Is waste of equipment, supplies, and time minimized?
4. **Equity:** Is care consistent across gender, ethnic, geographic and socioeconomic lines?
5. **Sustainability:** Is provision of care well supported financially and materially such that clients are able to receive care continuously?

The adapted framework is ideal for the study because it broadens the concept of quality of care to cater for different contexts, thus taking into account the diverse environments in which CHBC is given. It does not institutionalize care to a health facility setting, making it possible to assess care provided in home settings. In comparison with the Quality of Care Framework by Peabody, Taguiwalo, Robalino and Frenk (2006) which emphasises on institutional, social, cultural and political factors as they relate to quality of care at national level, this adaptation focuses on the care provider-client relationship at local level, which is what happens in CHBC.

## 2.6 Limitations of study

The study is based on secondary data which were collected for report writing and therefore leave out some important data which would have been included if primary data had been collected. Secondly all the reports and literature reviewed look at quality care from the side of implementing organisations. They do not include what clients and their families feel about the quality of care being provided. Contributions from volunteers on their perceptions of the quality of care they are providing and what motivates them to give care are not covered despite that they are central to answering the question of quality of care in CHBC.

## 2.7 Thesis set up

Objective 1, 2 and 3 are answered in chapter 4; objectives 4 and 5 are answered in chapters 4 and 5 while objective 6 is answered in chapter 6.

## CHAPTER 3: Continuum of care, quality of care and the care needs for PLHIV

### 3. Introduction

This chapter defines community home based care and quality of care in addition to reviewing literature on the continuum of care, caregivers and the care needs of PLHIV.

### 3.1 Continuum of care for PLHIV

According to FHI (2007) the continuum of care (CoC) is a network that links, coordinates, and consolidates care, treatment and support services for PLHIV. It can also be looked at as a group of services that together provide comprehensive support to PLHIV and their families. This builds on WHO (1993) view that the CoC ensures that care for PLHIV includes communities and families in a spectrum that provides care throughout their lives.

The importance of CoC stems from the very nature of HIV infection. According to WHO (1993) HIV/AIDS is different from other health problems in that infection is lifelong and eventually fatal. Because PLHIV have compromised immunities, MoHCW (2004) explained that they face bouts of often life threatening illnesses, sandwiched by periods of reasonably good health. Population Council (2004) therefore reiterates the need to provide PLHIV with care from the time of diagnosis till death. Since care is needed for life, the continuum through which care is offered should, as of necessity be well established (FHI, 2007).

Players in the CoC include VCT centers, primary, secondary and tertiary healthcare centers, governments, NGOs, family members, volunteers and supportive community networks (WHO, 1993). Population Council (2004) observed that these players cannot function independent of each other. Despite the existence of both differences and overlaps in what players do FHI (2007) believes that for PLHIV to get the best benefits, the need for coordinated efforts between and among players cannot be overemphasized. Earlier on, WHO (1993) underscored the need for an effective referral network between the communities and the healthcare delivery system from the time a person enters the CoC till death. This ensures continuity of care as PHLIV move from one level of care to another (MoHCW, 1998).

According to Population Council (2004) CHBC provides psychosocial, medical and nursing support while the healthcare delivery system provides diagnoses, clinical management of OIs and treatment of acute conditions. It is widely agreed that CHBC is one element of the CoC which is considered particularly important in poor countries

(WHO 2004, WHO 1993, Population Council 2004 and FHI 2007) where "..hospitals are overcrowded with chronically ill patients leaving very little room for the care of acute medical conditions" (MoHCW, 1998:5). Chronically ill patients can be discharged for CHBC with interspaced hospital visits for check ups or treatment of acute bouts of OIs (Population Council, 2004). It is argued by MoHCW (1998) that this reduces the burden of care on healthcare delivery facilities giving them room to deal with acute conditions and other cases.

### 3.2 Community Home Based care

The World Health Organisation (2002:8) defines CHBC as "..any form of care given to sick people in their homes. Such care includes physical, psychological, palliative and spiritual activities". Population Council (2004:34) defined it with a deliberate bias towards caregivers as, "A universe of clinical and non-clinical care provided by lay, volunteer or professional providers who are linked to a programme". It is emphasized that CHBC draws largely from the strengths of families and communities. An ideal CHBC team according to MoHCW (2004) comprises family caregivers, health and social welfare personnel, community health workers and community volunteers with the support of other stakeholders.

For this study CHBC is defined as: Any form of programmatic care, clinical and/or non-clinical, which is given to chronically sick people in their homes by lay, volunteer or professional caregivers.

According to FHI (2001:589) CHBC "..should not be considered as an alternative to hospital care". Instead it should be a complement. This is echoed by Population Council (2004) who admit that CHBC clients should have interspaced visits to hospitals. The World Health Organisation (2002) saw it as the best resort for the poor, who at the time of illness are least able to afford catastrophic hospital fees and therefore avoid attending health facilities. This changes the view of CHBC from being complementary to being analogous to hospital care, a point supported by Uys (2003:271) who states that where PLHIV are not able to access hospital care, "this dramatically increases the importance of alternatives such as community home based care". This view is shared by Shaibu (2006:89) who noticed an increase in CHBC activities in Botswana, "… following a shift from hospital care to community care because of the HIV/AIDS epidemic". Shaibu (2006) explains that CHBC is seen as an important intervention strategy in managing HIV/AIDS in view of the shortages of nursing and other healthcare personnel in Botswana.

### 3.3 Care needs for PLHIV

Since HIV/AIDS is an emerging condition, the complete range of exact care needs for PLHIV is still at compilation stage. A number of publications, including WHO (2002) and Uys (2003) have documented broad categories of care needs for PLHIV as a starting point. According to the WHO (2002) definition of CHBC, these diverse needs are grouped into four broad categories, namely, physical, psychosocial, palliative and spiritual care needs. Under these broad categories FHI (2007) observed that new needs are continuously emerging with the maturing of the epidemic. This builds on an earlier WHO (2002) observation that CHBC programmes are constantly evolving in response to changing care needs of PLHIV and their families. For example, as many parents succumbed to AIDS (WHO, 2002) orphan care became a critical care concern much later on the HIV/AIDS timeline. A concrete case is presented by Whiteside (2008) of Uganda where HIV prevalence peaked in 1989 while the number of orphans crested fourteen years latter in 2003. This inadvertently calls for continuous and deliberately proactive ways of scanning the caring environment for emerging care needs, especially by those at the forefront of care provision. Campbell et al (2008) argue that among other players, volunteers and family members play an important role in the regular assessment of care needs for PLHIV. This involves regular observations of and consultations with the clients and their families, coupled with the ability to transform any such identified needs into care provision (HDN and SAfAIDS, 2008).

### 3.4 Caregivers

Caregivers in CHBC include family members of PLHIV, healthcare personnel and volunteers (WHO 2004 and Population Council 2004). National AIDS Council (2006) believes that Volunteers represent the 'front line' of programmatic CHBC efforts and services. This is because the majority of CHBC programmes depend largely on volunteers for care provision (Benyera et al 2008, Uys 2003 and HDN and SAfAIDS 2007).

Volunteers in CHBC programmes in Southern Africa present a skewed gender imbalance in favor of females. Campbell et al (2008) cited numerous studies indicating that over 80% of caregivers, be they volunteers or family members, are female. The participation of men is slowly gathering momentum due to deliberate efforts to include them in the provision of care (Johnson et al, 2005). However this is hampered by men's ascribed breadwinner role where communities expect them to engage in paid employment to fend for their families (Johnson et al, 2005).

### 3.5 Quality healthcare

In order to assess and improve quality of healthcare services, it is important that quality be defined first. Van Lerberghe, Tellier, and Van Dormael (1993) admit that quality is elusive to define because users, providers and policy makers understand it in different ways. This is compounded by the fact that for a long time in developing countries, quantity has been synonymous with quality (Peabody et al, 2006). Since production and consumption of healthcare services occurs concurrently, this makes it difficult for neither providers nor receivers of care to objectively observe and define it.

For this study, three authorities have been preferred, whose definitions, when put together best represent healthcare quality as it relates to CHBC.

Institute of Medicine (2001:1293), it is "….the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".

DeGeyndt (1995:12) says "It includes accurate diagnosis, adequate therapy, documentation, comprehensiveness, availability, outcomes for patients and knowledge of the provider in meeting the needs of the patients".

Roemer and Montoya-Aguilar (1988:3) define it as "..the degree to which the resources for healthcare or the services included in it correspond to specified standards. These standards, if applied are generally expected to lead to desired results".

Drawing from these, this study's definition is: Quality healthcare service is the degree to which healthcare services provided by knowledgeable and skilled providers following specified standards are able to provide desirable health outcomes to a defined group(s) of people.

## Chapter 4: Home based care in Zimbabwe and neighboring countries.

### 4. Introduction

This chapter presents findings on Red Cross CHBC in Midlands and other selected programmes. Irish Aid CHBC of Mashonaland West province (Zimbabwe) has been chosen as a local comparison because of its proximity to Midlands and coverage similarity with Red Cross. The Integrated Community Home Based Care (ICHC) of South Africa has been included because it is the only one for which data were available for that country. In Namibia the Catholic AIDS Action (CAA) was chosen for having more relevant data than other Namibian programmes for which data were accessed.

Findings from these are presented following the provisions of the adapted theoretical framework (Fig. 2.1) being used to assess CHBC quality in this study. Table 4.1 gives a summary of the CHBC programmes reviewed.

Table 4.1 Programme summaries

| | *Red Cross* | *Irish Aid* | *ICHC* | *CAA* |
|---|---|---|---|---|
| Clients | -PLHIV, other chronically ill<br>-increasing clients<br>-had 3117 clients in 2008 | -PLHIV, other chronically ill<br>-decreasing clients<br>-90% clients are PLHIV | -PLHIV, other chronically ill<br>-increasing clients | -PLHIV, other chronically ill<br>-increasing clients<br>-had 2574 clients in 2002 |
| Human resources | -volunteer based, more female than male volunteers<br>-4 weeks volunteer training, 3 weeks theory and one week ward placement<br>-regular refresher courses<br>-us$10 monthly volunteer allowance and incentives<br>-long service award<br>-low volunteer drop out<br>-had 394 volunteers in 2008 | -volunteer based, more female than male volunteers<br>-two weeks training for volunteers<br>-us$10 monthly volunteer allowance and incentives<br>-volunteer laid off during downsizing. | -based on qualified caregivers and registered nurses, volunteers as auxiliaries<br>- 3 months caregiver training with theory and placements<br>-6 days training for volunteers<br>-monthly wage for caregivers<br>-caregiver drop out low | -volunteer based, more female than male volunteers<br>-3 stage volunteers training with theory and field practice<br>-regular refresher courses, retreats and conferences<br>-us$1 monthly volunteer allowance, other incentives and funeral assistance<br>-low volunteer drop out |
| Systems | -follow national CHBC standards and national CHBC training manual<br>-volunteer guidelines<br>-non functional hospital referral system<br>-volunteer supervision by team leaders reporting to provincial coordinator<br>-weak M&E | -slightly functional hospital referral system<br>-some volunteers supervised by professionals others by team leaders<br>-no clear M&E | -functional hospital referral system<br>-caregivers supervised by registered nurses<br>-no clear M&E | -functional hospital referral system<br>-volunteers supervised by team leaders and CAA staff<br>-organized data collection |
| Structures | -strong funding from local and external sources<br>-regular kit replenishment 2005-2006 and irregular | -insufficient funding from Irish Aid<br>-kit replenishment irregular, only twice in 2006 | -very strong funding, private/public partnership & material support from NGOs<br>-kit replenishment regular, | -strong funding from local and external sources<br>-Kit replenishment always regular |

|  |  |  |  |  |
|---|---|---|---|---|
|  | replenishment 2007-2008<br>-project car, bicycles for team leaders<br>-provincial and district offices present | -some projects have cars, motorcycles, all team leaders have bicycles<br>-project offices present | supplies obtainable at local hospitals and mobile clinics<br>-project cars available<br>-uses countrywide hospice offices, some hospitals also provide offices. | -project cars present, bicycles for all the volunteers and their team leaders<br>-Have regional office |
| **Outcomes**<br><br>Client centeredness | -volunteers continuously assess client needs<br>-care based on client condition | -volunteers continuously assess client needs<br>-care based on client condition | -caregivers continuously assess client needs<br>-care based on client condition<br>-child care for clients | -volunteers continuously assess client needs<br>-care based on client condition<br>-advocacy on clients' behalf |
| Effectiveness | -good OI management using herbs and drugs<br>-clients get better<br>-no ARVs | -good OI management<br>-clients get better<br>-no ARVs | -good OI management<br>-clients get better<br>-no ARVs | -good OI management<br>-clients get better<br>-no ARVs |
| Efficiency | -less travel and more care time for volunteers<br>-using the same volunteers for OVC and food distribution | -less travel and more care time for volunteers | -caregivers with low workloads work in clinics<br>- same caregivers for childcare | -less travel and more care time for volunteers<br>-using the same volunteers for OVC and IGP |
| Equity | -covers 4 of 7 districts only<br>-rural coverage only<br>-more female volunteers<br>-same care for all clients | -covers 4 of 7 districts only<br>-rural coverage only<br>-more female volunteers<br>-same care for all clients | -covers both urban and rural<br>-more female caregivers<br>-same care for all clients | -does not cover whole region<br>-covers rural areas only<br>More female volunteer<br>-same care for clients |
| Sustainability | -enough funding<br>-ongoing volunteer recruitment<br>-family member training<br>-transfers for relocating clients | -insufficient funding<br>-scaling down activities<br>-volunteers laid off<br>-some volunteers see caring as a calling from God | -sufficient funding<br>-caregivers earn wage<br>Hospice being capacitated<br>-readily available caregivers | enough funding<br>-ongoing volunteer recruitment<br>-family member training |

### 4.1.0 Zimbabwe Red Cross Society Midlands CHBC

Zimbabwe Red Cross Society CHBC programme operates in four of the seven districts of Midlands province. Although there are other smaller CHBC players in the province covering not more than one district each, Red Cross is the biggest player. The NAC coordinates players to ensure equitable coverage and avoid overlaps.

### 4.1.1 Clients

Clients are made up of PLHIV, those with other chronic illnesses and those not yet tested. There was a steady increase in the number of clients each year (Table 4.2) (Phiri 2008). The highest increase of more than 53% is in 2006, the period when other CHBC projects started scaling down. In 2007 and 2008 this increase was decreasing.

Table 4.2 Annual numbers of clients

| *Year* | *Male* | *Female* | *Total* | *Change* |
|---|---|---|---|---|
| 2005 | 491 | 837 | 1328 | -------- |
| 2006 | 712 | 1326 | 2038 | +53.5% |
| 2007 | 832 | 1763 | 2595 | +27.3% |
| 2008 | 958 | 2159 | 3117 | +20.1% |

*Source: Phiri (2005-2008)*

Table 4.3 Number of clients by category (2008)

| *Category* | *Male* | *Female* |
|---|---|---|
| Bedridden | 138 | 62 |
| Home bound/not bedridden | 113 | 203 |
| On ART | 21 | 77 |
| On TB Treatment | 130 | 58 |
| Mobile | 697 | 1821 |
| Total | 1099 | 2159 |

*Source: Phiri (2008)*

According to Phiri (2005) Red Cross had a partnership with World Food Programme for provision of food to clients after realizing that lack of food was affecting drug intake. Food distribution started in 2005 and ended third quarter of 2007 (Phiri, 2007).

Where clients die, volunteers can stay overnight providing bereavement counseling and offering moral support. General counseling is also offered where clients have identified problems (Phiri 2005, 2007, 2008)

*Analysis*
Statistics are not showing the number of PLHIV and naming the other chronic illnesses. There are more female (69%) than male (31%) clients. This can be explained by the fact that there are more females (60%) living with the virus nationally. Since the difference here is greater this may be further explained by the fact that males usually present themselves late for care, which further explains why there are more bedridden male clients. The categorization of clients has loopholes for it does not cater for combinations e.g. bedridden and on ART. This gives room for double counting. Even then, table 4.2 gives a 2008 total of 958 male and 2159 female clients while table 4.3 gives 1099 and 2221 respectively for the same year, a clear mismatch which might have resulted from possible double counting. Clients on TB treatment are low. This may be because some already finished treatment before or that the decline in hospital referrals with the advent of volunteer doctor visits resulted in low case detection (see 4.1.3). While tools for collecting Zimbabwe data on TB/HIV co-infection were only piloted in 2007 and have not yet yielded national figures, WHO, quoted by UNGASS report (2007) estimates the prevalence of co-infection at 80%. At 3.1%, the number of people on ART is lower than the national coverage of 7% (NAC 2006) but might indeed mirror the reality of shortage of funds to purchase ARVs in Zimbabwe. There is also the conspicuous absence of deceased clients' records.

The volunteer to client ratio increased in 2006 and has remained stable at 1:8 volunteers to clients. This is lower than the national workload standard of one volunteer to ten clients (MoHCW, 2004)

Table 4.4 Volunteers to clients

| *Year* | *Volunteers* | *Clients* | *Ratio* |
|---|---|---|---|
| 2005 | 241 | 1328 | 1:5.5 |
| 2006 | 256 | 2038 | 1:8 |
| 2007 | 328 | 2595 | 1:8 |
| 2008 | 394 | 3117 | 1:8 |

*Source: Phiri (2005-2008)*

### 4.1.2 Human resources
Volunteer selection involves Village heads, chiefs, church and local elders as a way of community involvement. Selection is based on integrity and eagerness to give care. Interested PHLIV are encouraged to take part in line with meaningful involvement of PLHIV (Phiri, 2005)

Selected volunteers undergo a four week basic training course comprising three weeks of theory and one week placement in hospital wards at Gweru Provincial Hospital. Training is offered by hospital staff in collaboration with external resource persons. The training curriculum is from MoHCW and covers topics on basic information on STIs, HIV/AIDS and TB, counseling and client care.

Table 4.5 Volunteers who did basic training (2005-2008)

| *Year* | *Male* | *Female* | *Total* |
|---|---|---|---|
| 2005 | 11 | 24 | 35 |
| 2006 | - | - | - |
| 2007 | 21 | 30 | 51 |
| 2008 | 22 | 27 | 49 |

*Source: Phiri (2005-2008)*

Questionnaire response indicate the following trained volunteers

Table 4.6 Trained volunteers at each year end

| *Year* | *Volunteers* | | | *Reasons for changes* |
|---|---|---|---|---|
| | *Male* | *Female* | *Total* | |
| 2005 | 32 | 209 | 241 | ------------------------------------------ |
| 2006 | 37 | 219 | 256 | -Trained volunteers joined from other programmes. |
| 2007 | 64 | 264 | 328 | -New volunteers trained and trained volunteers joined from other programmes. |
| 2008 | 91 | 303 | 394 | -New volunteers trained and trained volunteers joined from other programmes. |

Newly trained volunteers are assigned to work in their villages, (Phiri, 2006)

Refresher courses are done to update volunteers’ knowledge and skills. Training needs are identified from supervision reports and the analyses of clients care needs by volunteers Phiri (2005 and 2008).

Table 4.7 Refresher courses held and subjects covered

| *Year* | *No. of courses* | *Subjects covered* |
|---|---|---|
| 2005 | 6 | Client care<br>IGPs<br>Support group formation<br>Memory book writing<br>Training of trainers |
| 2006 | 7 | DOTS<br>Introduction to ART<br>Basic counseling<br>IGPs<br>OVC support |
| 2007 | 4 | Bereavement counseling<br>Psychosocial support<br>VCT |
| 2008 | 4 | OVC support<br>Herbal remedies<br>Family Counseling |

*Source: Phiri (2005-2008)*

Volunteers get US$10 monthly allowance and other incentives (Questionnaire, Phiri 2008)

Table 4.8 Volunteer incentives

| *Incentive* | *Quantity* | *Frequency* |
|---|---|---|
| T-Shirts | Varies | When available |
| Hats | Varies | When available |
| Allowance | US10 | Monthly |
| Bicycles | 1 | Once |
| Hampers | 1 | Annually |
| Used clothes | Varies | When available |
| IGPs | - | |
| Uniforms | Set | When worn out |
| Bags | 1 | Whenever available |
| Certificates | 1 | Once |
| Long service certificates and hampers | - | Every five years of continuous service |
| Maize seed | 5kg | Annually |

Volunteer attrition has been very low at Red Cross, (Phiri 2005, 2006, 2007 and 2008).

Table 4.9 Volunteer drop-outs (2005-2008)

| *Year* | *Volunteers at year start* | *Volunteers at year end* | *Drop outs* | *Drop out %* |
|---|---|---|---|---|
| 2005 | - | 241 | 12 | - |
| 2006 | 241 | 256 | 9 | 3.7 |
| 2007 | 256 | 328 | 7 | 2.7 |
| 2008 | 328 | 394 | 14 | 4.3 |

*Source: Phiri (2005-2008)*

*Analysis*
The four weeks training assumes a homogeneous group of trainees, when in reality volunteers are of different literacy levels. Illiterate volunteers may need more time. Placement of trainees in hospital wards does not mirror the home environment and trainees miss out on subtle aspects of home care. There is a commendable 190.6% increase in male volunteers compared to the 47% increase in females from 2005-2008, though there is no mention of the number of PLHIV who are volunteers. Where trained volunteers join from other programmes this reduces training costs but there is no evidence of quality control measures to check their knowledge and skills and upgrade them where necessary. The US10 monthly allowance is low but clothes and seed are highly valued by volunteers. Long service award is an innovative way of keeping experienced volunteers and it is a highly valued accolade among them.

### 4.1.3 Systems
Red Cross follows the national CHBC standards in the provision of care. According to Phiri (2005) there are also organisational guidelines for volunteers but these were not enumerated.

Hospital patients are referred to CHBC through local clinics (MoHCW, 1998). Phiri (2007) explains that relatives can bring their sick while volunteers also identify clients. Each caregiver keeps a list of their clients while the team leaders keep registers of clients under their supervision (Phiri 2005 and 2008).

Volunteers within geographic proximity form a team, headed by a team leader who supervises their work. Each team meets weekly to discuss issues and update each other. Team leaders report to the Provincial coordinator, who reports to the Provincial Manager (Phiri 2005 and 2006). All team leaders meet monthly with the provincial coordinator at the nearest clinic in their area.

Table 4.10 Supervision levels

| *Supervisor* | *Type of Supervision* | *Frequency* |
|---|---|---|
| Team leader | Home visits | Daily |
| | Client care reports | weekly |
| Provincial Coordinator | Home visits | Random |
| | Team leader reports | Monthly |
| Provincial Manager | Programme performance | Quarterly |

Phiri (2005 and 2006) indicated a functional referral system between CHBC and local healthcare facilities. Healthcare personnel were unable to follow-up on clients because they are understaffed. According to Phiri (2007 and 2008) most clients referred to healthcare facilities got prescriptions to buy drugs because clinics had none. Referrals to hospitals declined since end of 2006 and Red Cross engaged volunteer doctors to visit critical clients starting second quarter of 2007. Client visits by volunteer doctors continued throughout 2008 (Phiri 2008) at which point volunteers rarely referred clients to hospitals.

Red Cross procures OI treatment drugs for clients, which are stored at local hospitals/clinics. Volunteers get the drugs from there to replenish their kits while prescription drugs are dispensed by volunteer doctors (Phiri 2007).

Without specifying the data collected and the instruments used, Phiri (2008) states that monitoring and evaluation data are collected by volunteers, who submit them to team leaders. The Provincial Coordinator collates the data, processes them to write reports and to complete national activity report forms (NARF) for submission to NAC to feed into the national M&E (Phiri 2008).

*Analysis*

When team leaders supervise volunteers, their abilities to solve problems and offer sound advice cannot always be depended on because they get the same training. While some team leaders are experienced enough to do this, they may have structural limitations and need to be complemented by more knowledgeable supervisors periodically. Supervising all team leaders is a mammoth task for the Provincial coordinator who may end up loosing grip with happenings at grassroots level. Use of volunteer doctors is a brilliant idea but frequency of their visits could be low because they are full-time employees elsewhere. When semi-literate volunteers collect data, quality can be compromised. This can result in reporting incorrect data.

### 4.1.4 Structures

There is a Provincial office in Gweru manned by secretariat and four district offices manned by volunteers. A CHBC project vehicle is available for use by the Provincial Coordinator while volunteer team leaders have bicycles for transport (Phiri 2005). In the two pilot districts (Shurugwi and Zvishavane) all volunteers trained before 2005 have bicycles while in other districts only those with scattered clients have (Phiri 2005)

Funding comes from Zimbabwe Red Cross, Federation of Red Cross, Japanese Red Cross and British Red Cross. Since 2005, rising inflation eroded the value of money, making it difficult to replenish kits. Ongoing activities were maintained but planned expansion was shelved (Phiri 2006, 2007 and 2008).

All volunteers have home-based care kits which carry medicines and care accessories. According to Phiri (2005) the kits met national CHBC kit standard requirements (MoHCW, 2004) by 2005. Replenishment of kits during 2005-2006 was constant (Phiri 2005 and 2006). However Phiri (2007 and 2008) indicate irregular replenishment of kits citing unavailability of supplies locally. Zimbabwe Red Cross had to source from other national Red Cross societies, but these were not enough and volunteers had to do with minimum basics (Phiri 2008)

*Analysis*

District offices are strategic for coordination of local responses, but their being manned by volunteers does not add as much value to HBC quality control. The effects of inflation have been confined to the replenishment of kits without giving an insight into its effects on all aspects of care provision. Phiri (2008) states that volunteers worked with minimum basics at some point, these basics are not specified to give an idea of how far short they fall of required standards.

### 4.1.5 Outcomes

#### I. Client centeredness

Volunteers observe clients for any major changes to assess care needs (Phiri 2005). They also ask clients and their families about special care needs that need to be addressed. Identified needs are presented to the Provincial coordinator and form the bases for refresher courses and care provision (Phiri 2007). According to Phiri (2006) volunteers can come up with solutions to some of the needs, and share these among themselves at group weekly meetings.

*Analysis*
Client needs identification by volunteers is the ideal. In some cases implementation may not be as described. In terms of training needs analysis, it is highly possible that Red Cross watches national trends in training or draws on lessons from best practices to structure refresher courses, instead of consulting volunteers as stated. The sharing of ideas to solve client problems by volunteers encourages innovativeness, but certain innovations with human lives may need professional opinions before implementation.

**II. Effectiveness**
When drugs are available, many OIs are treated and clients get well quickly (Phiri 2005). With drug shortages, integration of herbal remedies helped in management of some OIs, especially during 2007-2008 when replenishment of kits was erratic (Phiri 2008)

High volunteer retention at Red Cross means caregivers become better with practice. Experienced caregivers are usually preferred by clients (Phiri 2007)

Phiri (2005) stated that the greatest health improvements are noticed on new clients during their first weeks on CHBC. He goes to say bedridden clients start walking and this gives caregivers pride and confidence for being able to make a difference.

*Analysis*
Use of herbs for OI management is encouraged but there is no clarity on what Red Cross does with clients on ART. This is because some herbs are known to react with ARVs as observed by Clayden (2004). It has to be clarifies to volunteers that herbs cannot replace ARVs or any other drugs for that matter.

**III. Efficiency**
The same volunteers for CHBC are used for OVC support, food distribution and IGPs, allowing the programme to do more with the same manpower (Phiri 2007).

More serious clients are accorded more care time while the asymptomatic get less time. Volunteers also train family members to provide care (Phiri 2005).

**IV. Equity**
The programme covers four of seven districts in Midlands, leaving out three districts. Male and female clients are said to access the same care (Phiri 2005) but, given that there are more female than

male volunteers this can affect access to care by male clients. According to Phiri (2006) although there are also less male clients, these are scattered and the available male volunteers cannot easily cover them all.

Phiri (2005) claims that clients get similar care irrespective of socioeconomic status while Phiri (2006) discourages volunteers from offering preferential care to clients whose families offer them presents. This shows that equity is compromised at some point since the poor volunteers can easily be enticed by presents. Care is also said to be offered equally across religious denomination and tribes (Phiri, 2005).

*Analysis*
Equitability across tribes is tricky given that Midlands has Ndebele and Shona tribes who are historical foes. On religion, personal experience has shown that volunteers offer preferential care to clients of similar religious affiliations with them. Where volunteers are given presents by relatives of clients, they are likely to give preferential care and this disadvantages poorer clients

**V. Sustainability**
Every village has volunteers, allowing clients to get care when they need it, even at night Phiri (2006). When volunteers are away, others replace them to ensure continuity of care.

Ongoing recruitment and training of volunteers ensures continued availability of carers (Phiri 2006). When the economy was at its worst Red Cross did not scale down and clients continued accessing care (Phiri 2008). Volunteers train family members to enable them to provide care between volunteer visits (Phiri 2005). However not all households have members to be trained and not all available members agree to be trained.

Relocating clients are given transfers for continuity of care (Phiri 2006) while incoming clients are accepted into the programme.

*Analysis*
Calling on volunteers at night is good for clients but may have repercussions on volunteers' marital relations and burn-out. Discouraging it denies clients care while encouraging it over-stretches volunteers. Giving due attention to relocating clients is very good because it allows them to continue receiving care.

Table 4.11 Client transfers 2005-2008

| *Year* | *Transfers in* | *Transfers out* |
|---|---|---|
| 2005 | 6 | 8 |
| 2006 | 11 | 9 |
| 2007 | 15 | 4 |
| 2008 | 21 | 6 |
| Total | 53 | 27 |

*Source: Phiri (2005-2008)*

Phiri (2007) believes that involvement of community leaders in volunteer selection fosters community ownership, contributing to volunteer retention and sustainability of CHBC.

Zimbabwe Red Cross has a broader funding base domestically and internationally (Phiri 2007). Although there is more to sustainability than funding, in Zimbabwe good funding is a major component of sustainability.

*Analysis*
Clients who came to Midlands are almost twice those who left. This may be because other programmes were scaling down or clients were looking for better services because of the presence of volunteer doctors at Red Cross.

## 4.2 Irish Aid CHBC programme: Mashonaland West province (Zimbabwe)

Irish Aid sponsors CHBC in Mashonaland west province. The programme is made up of nine different projects which follow Irish Aid operational systems. Four districts are covered without overlaps among projects. It is a neighboring province to midlands.

### 4.2.1 Clients

Clients are not all PLHIV, except in two hospital based projects (Benyera et al 2008). The same authors found out that 90% of clients were PLHIV.

According to HDN and SAfAIDS (2008) client care needs depend on, whether or not they are on ARVs, TB/HIV co-infection, marital status, stage of disease and the presence of children under the legal age (Benyera, 2008).

### 4.2.2 Human resources

Volunteers, who are selected by community leaders, form the backbone of the programme (Johnson et al 2005, and Benyera et al 2008). Selection is based on trustworthiness and interest to give care (Benyera et al 2008). Faith based projects select volunteers

from their denominations, although they provide care to all (HDN and SAfAIDS 2007).

Volunteers go through two weeks' training coordinated by Irish Aid following the NAC training manual (Johnson et al 2005).

Trained volunteers are deployed according to their areas of residence (HDN and SAfAIDS 2008)

Refresher courses are held either as planned or because of emerging issues. According to HDN and SAfAIDS (2008) three refresher courses were held in 2005.

Volunteers get a monthly allowance of US$10 (HDN and SAfAIDS, 2008). Individual projects give additional incentives like soap, shoes, free medical care and IGP money (HDN and SAfAIDS, 2007). Benyera et al (2008) noted high intrinsic motivation in faith-based projects where volunteers consider care-giving a calling from God. Although there are more female volunteers HDN and SAfAIDS (2008) noted that faith based projects have more male volunteers.

Two weeks training for volunteers of limited literacy is rather short. This could be complemented by more refresher courses but then there were only three in 2005. Volunteer drop-out figures would have been useful to show retention but they were not available. The province is dominated by Christians. Most Zimbabwean Christians see care for the sick as a calling from God. This may help explain the high male involvement in faith based projects.

### 4.2.3 Systems

A Provincial officer coordinates the programme. Each project has a CHBC officer-in-charge who reports to the provincial coordinator (Benyera et al 2008). At four projects, professional staff supervises volunteers, while at five projects supervisors are chosen from among volunteers (HDN and SAfAIDS 2008).

According to Benyera et al (2008) Irish Aid gives both written guidelines and word of mouth instructions on care provision depending on literacy. Working hours range from two to four hours per day but most caregivers go beyond because of increased caseloads and seriousness of illness (Benyera et al, 2008).

For Hospital based projects most clients are referred by hospitals while other projects also get clients from, community referrals and syndromic assessments by volunteers (HDN and SAfAIDS, 2008).
Irish Aid insists on accurate client records and data collection, although not all caregivers can write. According to Benyera et al

(2008) caregivers record date of visit; service offered, referrals, areas needing attention, client complaints, and a general assessment of client state. Supervisors keep summarised records.

In my view, volunteer supervision is best where professionals back up volunteer team leaders. The use of oral and written guidelines is plausible as it ensures uniformity of care and easy adherence to standards. Data collection looks well organized because volunteers know what they are expected to record. Since similar data are collected, it is easy to collate and analyze them.

### 4.2.4 Structures

Funding comes from Irish Aid, although some projects have additional funding sources for other activities (HDN and SAfAIDS 2008). In 2007, Irish Aid reduced CHBC funding resulting in some projects scaling down activities and laying off volunteers (Benyera et al, 2008)

Trained volunteers get kits containing medicines and materials for care provision. Benyera, et al (2008) found that in 2006, kits were replenished only twice because of funding constraints. This is supported by HDN and SAfAIDS (2008) who added that some volunteers ended up improvising use of plastic bags for gloves.

All projects have offices; only four have vehicles while two have motorcycles However Benyera et al (2008) noted that those without vehicles cover small areas so this does not compromise their work. Both Benyera et al (2008) and HDN and SAfAIDS (2008) documented that supervisors have bicycles, while volunteers do not.

Replenishing CHBC kits only twice a year has far reaching consequences on quality of care, especially where local clinics have no drugs. This mirrors the real situation in Zimbabwe, where most CHBC programmes are struggling to replenish kits. The improvision of plastics for gloves was mainly noticed in areas where scaling down had taken effect and some volunteers continued giving care of their own accord.

### 4.2.5 Outcomes

#### I. Client centeredness

According to HDN and SAfAIDS (2008) care is tailored to need, with bedridden clients getting more attention than asymptomatic ones. Generally bedridden clients are visited from daily to four times a week, home bound clients twice a week and asymptomatic clients fortnightly (HDN and SAfAIDS, 2008)

Volunteers are proactive in probing for specific needs from clients and families so as to customize care (HDN and SAfAIDS, 2008)

It is not clear however, if different client preferences and life styles are taken into account during care provision. If not, the identification of client needs to provide suitable care becomes mere lip-service.

**II. Effectiveness**

Volunteers follow laid down proven guidelines during care provision and this increases effectiveness of the care (Benyera et al 2008).

Benyera et al (2008) found that Irish Aid clients exhibited higher adherence to ARV and TB treatment than those not on CHBC in the same province. According to HDN and SAfAIDS (2008) volunteers are happy to care for clients on ARVs because they show visible recovery giving them hope, confidence and the satisfaction of making a difference. One volunteer remarked "..these days we are nursing our clients to life unlike in the past when we nursed them to death" (HDN and SAfAIDS, 2008:43). However Irish Aid does not provide ARVs.

**III. Efficiency**

Allocating volunteers to clients closer their homes is meant to reduce travel time and increases care time (Benyera et al, 2008). In reality clients are usually scattered making it inevitable for volunteers to walk long distances. Supervisors use bicycles to increase mobility and supervision coverage (HDN and SAfAIDS, 2008).

HDN and SAfAIDS (2008) revealed that when kits were being replenished regularly, volunteers were wasteful, giving drugs to friends and relatives. In times of shortages, they became judicious in using the little supplies they had.

With the hardships in Zimbabwe it remains a challenge for volunteers to deny medicines to sick relatives while local clinics have none. This affects clients who end up not getting drugs when they need them. Team leaders' bicycles can be given for use by family members and relatives, resulting in supervisors having to walk, thus failing to do their work well.

**IV. Equity**

The programme caters for rural areas only leaving out towns (Benyera et al 2008). Even though, not all rural districts, wards and villages are covered.

Clients are said to receive the same care irrespective of religion, sex, or socioeconomic status. While most of the volunteers are female HDN and SAfAIDS (2008) observed an increase in male caregivers in church based projects.

**V. Sustainability**

Where volunteers are away colleagues look after their clients to ensure continuity of care (HDN and SAfAIDS, 2008). The training of interested family members ensures long term client care. Funding reduction resulted in scaling down of activities by some projects. However HDN and SAfAIDS (2008) found that, where activities stopped, most caregivers, especially the elderly Christians, continued giving care to clients since they consider caring a calling from God.

The drying up of funding is common in Zimbabwe. Many programmes folded because of this. The operating environment is not sustainable because of spiraling inflation and skewed exchange rate policies. The view of care as a calling from God is a strongly held view among Zimbabwean Christians and aids sustainability of care provision.

### 4.3. Integrated Community Home Based Care ICHC (South Africa)

In 1997 the department of health through USAID funding started implementing ICHC in South Africa, integrating home-based care for PLHIV into existing hospice activities (Fox, 2002). This partnership tapped into hospice palliative care and outreach experience to benefit the growing number of PLHIV in need of similar care. ICHC is now being implemented from all hospice centers across the country, after having started with three pilots in 1997 (Fox 2002).

#### 4.3.1 Client

Clients are a mixture of those with chronic illnesses like cancer, hypertension etc and PLHIV (Uys 2003 and Fox 2002). According to Uys (2003) there is little stigma associated with PLHIV on ICHC since hospices is already known for dealing with terminal illnesses.

Uys (2002) noted that the greatest client care needs include counseling/information, symptom control, hygiene care, wound care, psychosocial support and welfare. Care being provided includes pre and post-test counseling, health education, bereavement counseling, facilitating family meetings, partner counseling and training of family carers. At one site caregivers established a day centers for children of clients and orphans after noticing that sick parents had childcare problems (Fox 2002).

The establishment of a day care center shows that caregivers assess the needs of clients and act on them. This is also backed by the availability of resources.

### 4.3.2 Human resources

The three cadres of ICHC personnel are hospice registered nurses, caregivers and volunteers. Caregivers are the backbone of care provision with support from volunteers. Recruitment and training of caregivers is collaborative effort by hospice, government and other NGOs. Training, which uses the department of health curriculum lasts three months and includes theory and clinical placements (Fox, 2002 and Uys, 2002). According to Fox (2002) volunteer are exclusively found in rural areas and their training is non-formal, shorter and less intense. It takes place for six days, (once a week over 6weeks). They complement caregivers by supervising 2-4 clients (Fox, 2002) working in their areas of residence. According to Uys (2003) all the caregivers completed high school education, while volunteers have varying levels of literacy, with some illiterate.

Quality of care provision is reviewed every six months and areas for improvement identified. These feed into refreshers courses which are part of the continuous learning process (Fox 2002)

Caregivers are almost exclusively female as 6 of 7 sites visited (Uys 2003) had females only with one male in one group. The same goes for volunteers; in addition all registered nurses are female.

Caregivers received a 2001 wage of R1700 with a 10% annual increment. The majority of volunteers receive no incentives, only their leaders get a monthly stipend (Campbell 2008). Despite this Fox (2002) observed that volunteers are a motivated cadre because they aspire to be engaged as caregivers where they can earn a wage.

ICHC represents a neat blend of registered nurses and caregivers of a defined educational standard. Caregiver training is long enough to cover essentials. Even the training of volunteers, though short in contact time, is well staggered in recognition of varying literacy levels and resultant uneven understanding.

### 4.3.3 Systems

Clients enter ICHC through hospital, community, friends and self referrals (Uys 2002). According to Fox (2002) caregivers go to hospitals to receive referrals, and transport the clients to their homes. This is why some hospitals provide offices for ICHC staff (Fox, 2002)

Caregivers' daily work is planned by registered nurses, but caregivers far from hospice centers plan their own work and meet hospice nurses at Friday weekly meetings (Fox 2002). Hospice nurses supervise caregivers close to hospices. Those further are supervised by personnel from nearest clinics. Working hours are between 6-8/day but are adjustable as caregivers can sleep over when clients die (Fox, 2008). Where clients need clinical diagnoses, registered nurses are called in (Fox, 2002). Cases beyond registered nurses are referred to hospitals. Since most hospices have own doctors, most clients are referred there (Fox, 2008). Caregivers with low workloads sometimes work in clinics (Uys 2002).

Not much is mentioned on M&E but both Fox (2002) and Uys (2003) agree that caregivers record data during client visits. What these data are used for and how they feed into the national system is not stated.

The complementary nature of ICHC and hospital care comes out clearly. Supervision is done by well qualified personnel who can give sound advice to caregivers. Since caregivers are paid a wage, they have good reason to work hard because it is their livelihood, unlike the case with volunteers.

#### 4.3.4 Structures

The ICHC is a government initiative (Fox, 2002) with financial support from state sourced funds. Material support also comes from other NGOs, albeit inconsistently (Uys, 2002).

According to Uys (2002) ICHC uses hospice offices and related infrastructure for programme implementation. Some hospitals give ICHC offices to facilitate coordination of discharged clients. All centers have vehicles for transporting caregivers while transport money is provided for those with no access to cars (Fox, 2002)

The government distributes HBC kits to caregivers (Mabude, 2008) while replenishment supplies are obtainable from nearest clinics and hospitals. In rural areas where these are absent, mobile clinics come monthly and caregivers are able to get supplies (Campbell et al, 2007).

This shows good public/private partnership which took advantage to build on existing structures and skills. This is possible in South Africa where government is able to attract funding.

### 4.3.5 Outcomes

**I. Client centeredness**
Most clients are visited 2-4 times monthly with the more serious ones seven or more times (Uys 2003). There are daily visits to bedridden clients while caregivers may also assist with funeral arrangements. Assessment of client needs is an ongoing process (Orner, 2006)

**II. Effectiveness**
Caregivers are good at breaking stigma and giving peace of mind to clients. A client interviewed by Uys (2002:101) remarked, "I now feel like a living thing again". Improved client health is a result of OI management and monitoring of adherence to treatment (Fox 2002).

Most caregivers complained of feeling miserable because of their inability to meet clients' needs for food and cash (Russel and Schneider, 2008). Lack of food affects taking of drugs and slows treatment.

Stigma reduction is an important aspect of ICHC effectiveness. Once clients break stigma they are inclined to access care more readily. The issue of lack of food is a cause for concern to all caregivers. Impoverished and hungry clients give them little hope.

**III. Efficiency**
Some rural caregivers spend up to one hour travelling to one client since clients are scattered (Fox 2002). Resources like gloves, linen savers and drugs are used only when necessary (Uys 2002). Constant availability of registered nurses to take care of serious cases allows clients to get the correct care on time. This reduces complications and expedites treatment.

**IV. Equity**
The programme covers both rural and urban areas; although its coverage is not even across the country (uys, 2001). Since most caregivers are female, Orner (2002) observed that male clients were reluctant to access care. Akintola (2008) found that 50% of families of PLHIV have access to external caregivers, suggesting the other half has no access.

**V. Sustainability**
There is a functional client referral system from one level of care to another (Uys 2003 and Fox 2002) meaning that care provision is continuous. Caregivers are always there since there are no major drop-outs (Fox 2002). Supplementing caregivers with volunteers who stay close to clients ensures constant care.

Caregivers from ICHC are targeted by NGOs for better paying jobs (Fox, 2008). Campbell (2002) noted high drop-out rates among volunteers who get no incentives. This leaves care gaps.

According to Campbell (2002) the synergistic public-private partnership of ICHC gives greater chances of sustainability.

The sourced funding is being used to strengthen the capacity of hospice and strengthening links with health facilities. These will remain intact when funding ends. The involvement of government gives the programme a national flair and commitment by citizens.

## 4.4 Catholic AIDS Action (CAA) (Namibia)

Catholic AIDS Action was established in 1998 and became Namibia's first national faith-based response to HIV/AIDS. To date it has grown and has offices and staff in nine of the country's thirteen regions (Steinitz, 2003).

### 4.4.1 Clients

Since 1998 the number of clients has risen exponentially as the HIV epidemic matured (Steinitz 2003). Clients are not all PLHIV. There are clients with other illnesses and those who have not yet been tested. As of September 2002, the programme had 2574 home based care clients and 13000 orphans receiving care (Steinitz, 2003).

Clients' needs are varied (Steinitz 2003) and volunteers are actively involved in identification of these in liaison with clients and their family members. At their monthly meetings, volunteers identify "neediest cases", of clients in deep trouble who are then accorded emergence assistance, advocacy or follow-up. For orphans, volunteers also act as surrogate aunties and uncles in line with Namibian tradition (Steinitz, 2003).

### 4.4.2 Human resources

Volunteers come from churches and general community (Steinitz 2003). Most of them are women in their mid thirties to mid fifties. As of September 2002 the programme had 1289 active volunteers (Steinitz, 2003), although they were not disaggregated by gender.

After recruitment, volunteers go through training conducted by CAA's local staff (Steinitz, 2003). A standardized curriculum is used throughout the country and training is conducted in local language. The training is in three stages of 28 hours each (84 hours total) over six to eight months. Between sessions, trainees go to practice what they would have learned. Trainers provide on-site supervision. When sessions resume, they start with review of field practices

before going on to new material. Problems encountered by trainees are solved and important learning points emphasized. Graduation takes place with great fanfare in local churches or community settings (Steinitz, 2003).

Trained volunteers get T-shirts, badges, kits and supplies. These are seen as signs of recognition and leadership as they enable volunteers to make a difference in the lives of clients. The opportunity to distribute food and assistance to clients and OVC gives volunteers the first instance of authority they have ever been given outside their own families and it motivates them (Steinitz, 2003)

Volunteers get a monthly allowance of US$1. Larger incentives are given during Easter and Christmas periods and these vary, e.g. mosquito nets (2001) and umbrellas (2002). There are annual volunteer retreats, regional conferences and follow-up trainings that are held for quality assurance and to reduce burn-out.

Volunteers groups get funding to start IGPs, the commonest being gardening, sewing and coffin making. Since 2001 all active volunteers and their immediate families are eligible for funeral benefits irrespective of cause of death. Volunteer drop-out rate is less than 10% per year (Steinitz, 2003).

The training programme is staggered to allow trainees to go and practice because care giving demands more of skills. Trainees gain experience in home environments, making it easy for them to continue after training. The training period of six to eight months acknowledges the differences of trainee educational backgrounds and pace of learning. The allowance of US1 is way too low but is complemented by other incentives e.g. funeral assistances, bicycles. There are deliberate efforts to reduce burn-out by taking volunteers for retreats. This is also good for team building.

### 4.4.3 Systems

CAA works closely with hospitals and each hospital assigns one or two CHBC liaison personnel who work with volunteers. This is however affected by staff shortages (Steinitz, 2003).

Clients are assessed first and then admitted upon fulfilling the inclusion criteria (Steinitz, 2003). Volunteers also act as recruiting agents for VCT. The programme is organized because it has inclusion criteria to guide in the selection of clients for the programme.

When visiting clients, volunteers go in pairs or threes. This is meant to build mutual support, reduce burn-out, ensure continuity of care, reduce stigma and allow one-to-one contact with both clients and their family members. This is a good way of encouraging team work and sharing of ideas. Pairing literate and illiterate volunteers improves data capture.

Volunteers are clustered into 88 groups according to geographic location. Each group selects officers who take charge of group finances, accountability, supplies, donated bicycles and IGP activities (Steinitz, 2003). They meet weekly to exchange information, referrals as well as discuss issues of mutual interest. Volunteers have monthly meetings with CAA Regional staff for accountability, organisational updates, refresher training and to receive replenishments for kits. Each group receives US$20 monthly, for distribution to identified clients as emergency food, soap, disinfectants, or cash (Steinitz, 2003)

Volunteers complete data sheets when they visit clients. These are updated and handed in every month-end before volunteers receive their allowances Steinitz (2003).

### 4.4.4 Structures

CAA has offices in nine of Namibia's thirteen regions. Each region has vehicles for CHBC. Funding comes from the Catholic Church in Namibia and its partners abroad. They procure replenishments for kits on a regular basis. Volunteers have bicycles and are paid monthly allowances. The government helps by providing brochures and literature on HIV and STIs (Steinitz, 2003).

The provision of literature shows government's political commitment. CAA feels supported and has the energy to go ahead. Providing bicycles to all volunteers is a rare feat indicative of sound funding. It adds to volunteer motivation.

### 4.4.5 Outcomes

#### I. Client centeredness

Volunteers also train willing family members to care for clients. Clients are counseled on positive living, eating balanced diets of local foods and how to prevent further spread of infection. Volunteers also undertake advocacy on behalf of clients to ensure that other service providers like government, hospitals, schools etc, fulfill their legal and formal obligations to clients and their families. They also encourage will writing or oral articulation of wishes in the presence of witnesses among their clients for the long term care of children (Steinitz, 2003)

It is true that clients have issues with other duty bearers which they cannot pursue because they are ill. When volunteers advocate these on behalf of clients, it shows good client centeredness.

**II. Effectiveness**
Weekly and monthly meetings identify clients with the greatest needs for care and then care is tailored to suit them. This has been seen to help clients recover quickly. Volunteers always have drugs and accessories for early management of OIs. As a result most OIs are managed without referrals.

**III. Efficiency**
The working of volunteers in twos and threes ensures that clients and family members are attended to concurrently. Training current volunteers to do OVC work is cheaper and more effective than establishing a different OVC programme. It reduces costs of recruitment and gives continuity to orphans who get used to volunteers who cared for their late parents, then caring for them. According to Steinitz (2003) in 2002 Catholic AIDS Action estimated its per- client-visit cost at US$0.80.

**IV. Equity**
The programme operates in both rural and urban areas. Infected children are also taken care of in the programme. However as Steinitz (2003) pointed out, volunteers are largely female. Shortage of male volunteers could contribute to why men present themselves late for CHBC.

**V. Sustainability**
Funding base is firm as evidenced by the ability to replenish kits regularly. The working of volunteers in twos and threes ensures continuity of care when one is not there. Training of family members ensures that the client is able to get quality care between volunteer visits. Volunteerism in this programme is built on existing religious structures and beliefs. This is entrenched in local values and can go on even when the donor pulls out because the community remains being guided by the same values.

## Chapter 5: Discussion

### 5. Introduction

This chapter discusses study findings and reviewed literature.

### 5.1 Clients

CHBC programmes are made up largely of PLHIV and clients with other chronic illnesses. This is supported by Uys (2003) who admits that while programmatic CHBC services in high HIV prevalence countries are primary meant for PLHIV, including clients with other chronic illnesses is good for, among other reasons, stigma reduction. At ICHC Hospice was already known to care for chronically ill people and the introduction of PLHIV was observed to have attracted little stigma. Over 90% of Irish Aid clients are PLHIV (Benyera et al 2008) and the same can be inferred of Red Cross clients because of the epidemiological similarities in the two programme areas.

The number of clients in need of CHBC services is on the increase. WHO (2002) foresaw an increase in CHBC programming when they developed guidelines for expanding CHBC in resource-limited settings. Shaibu (2006) noted an increase in CHBC clients in Botswana as the HIV epidemic progressed. Red Cross, ICHC and CAA all witnessed increases in clients except for Irish Aid who were downsizing. Red Cross had a 53.5% client increase in 2006, a period when some CHBC programmes in Zimbabwe started scaling down because of the harsh economic environment. They absorbed clients from such closing down programmes.

Knowledge of clients' care needs in CHBC is necessary for the provision of appropriate care. Family Health International (2007) found out that there are constantly emerging care needs for PLHIV as the epidemic matures. Campbell et al (2008) urge volunteers and family members to take the lead in continuously assessing the care needs of PLHIV. At CAA, volunteers identify the 'neediest cases' who are then assisted with emergence resources and advocacy. The establishment of a day care center by ICHC is indicative of identified need to assist clients with childcare. Red Cross sourced food after realizing that clients needed it. They are also assisting OVC with school related assistance after noting increased school drop-outs. While all the programmes are involved in the continuous identification of client needs, it does not come out clearly in neither of them how the identified needs are communicated within the organisations such that decisions to tailor make care are made.

**5.2 Human resources**
Volunteers form the backbone of CHBC programmes. This is in line with the observation by NAC (2006) that volunteers represent the 'front line' of CHBC efforts and services. Red Cross, CAA and Irish Aid depend on volunteers. ICHC uses registered nurses and salaried caregivers with volunteers as auxiliaries. Resources permitting, the South African arrangement is good but with the current situation, this remains a pipe dream for Zimbabwe.

Training is pivotal for the transfer of knowledge and skills to volunteers. While Irish Aid's two weeks basic training is too short to master the basics of home care, the Red Cross three weeks of continuous learning appears too long for illiterate and semi-literate volunteers. Besides most volunteers are parents who cannot afford to be away from families for long. The CAA 28-hour sessions recognize these factors and accommodate the short concentration span in adult learners. Red Cross places trainees in hospital wards to get practical skills. They have the chance to learn from experienced nurses but miss out on the realities of home care. The CAA system gives volunteers the much needed hands-on experience by sending them to practice on clients in their homes.

Refresher courses are vital for keeping volunteers abreast with contemporary knowledge and skills. During 2005-2008 Red Cross held an average of five refreshers courses per year. Irish Aid has three refresher courses planned for each year while ICHC does performance evaluation every six months then hold refresher courses to fill identified gaps. The many refresher courses held by Red Cross may show concern for continuous quality care improvement on one hand while on the other they might have been meant to re-train volunteers coming from other programmes without upgrading the skills of the existing ones. The ICHC system of performance evaluation is a more objective way of identifying training needs. This may not be possible with volunteer based programmes considering the time that would be needed to appraise the performances of volunteers in their large numbers.

Volunteers can be motivated through the provision of incentives. Red Cross and Irish Aid give monthly allowances of US10; CAA gives US1 while ICHC gives a R1700 wage. Though low, the US10 allowances possibly forms the only dependable source of income for most Red Cross volunteers who also get maize seed and second hand clothes which they value highly. The Red Cross long service award is an innovative and cheap way of retaining and motivating volunteers. It is very prestigious among volunteers. This contributes greatly to the low annual drop-out rates averaging 3.6% while CAA has 10%. The funeral assistance by CAA is a step higher, as it also

caters for volunteers' family members making it an outstanding motivator which Red Cross cannot afford, given the high funeral costs in Zimbabwe.

**5.3 Systems**

A good referral system is necessary for the smooth transition of PLHIV from one level of care to another. This is in line with WHO (1993) who accentuated the need for an effective referral network between communities and the healthcare delivery system from the time a person tests positive till death. Referrals to and from CHBC programmes and hospitals are important since the two are complementary (FHI, 2001). All the CHBC programmes reviewed get some clients through hospital referrals. Referrals to and from hospitals are functional at ICHC and CAA, while Red Cross has a weak link with hospitals. Phiri (2008) indicates declining referrals to hospitals starting 2006 till 2008 when there were rarely any. When Red Cross brought in volunteer doctors to fill this gap, it allowed CHBC to effectively replace hospital care. This is supported by Shaibu (2006) who built on the ideas of Uys (2003) that CHBC can be an alternative to hospital care in countries where the poor cannot access hospital care for varying reasons. The Red Cross situation is a response to a crisis. Under normal circumstances CHBC should not replace hospital care because clients will always need acute case management, clinical laboratory tests and diagnoses which cannot be done at home. Even in this case Red Cross does not explain how doctors carried out diagnoses which needed laboratory equipment when they went out on CHBC.

Volunteer supervision is crucial for the delivery of quality CHBC client care. At ICHC supervision of caregivers is done by registered nurses who also take care of cases which caregivers cannot handle. Irish Aid uses well educated project officers to complement supervision by volunteer team leaders while Red Cross relies entirely on volunteer team leader for volunteer supervision. Since volunteers are of the same training, there is need for better educated and more informed supervisors to complement team leaders.

Data collection is necessary for programme monitoring and evaluation and generation of other useful information. Red Cross makes efforts to keep client and volunteer records but record keeping is not systematic, leaving out a lot of valuable data e.g., number of PLHIV on the programme, numbers of volunteers who attended refresher courses. Only ICHC has clarity on number of PLHIV and the types of illnesses of other clients. There is also the conspicuous absence of number of clients who died. This is despite the fact that all the programmes reviewed acknowledge that when

clients die, volunteers sometimes spent nights at the funerals. The Red Cross categorization of clients gives room for double counting because it remains unclear how they can classify a bedridden client who is on ART if one looks at their categories which take 'on ART' as one category and 'bedridden' as another.

### 5.4 Structures

Red Cross has a stable CHBC funding base from local and external sources sufficient to support the provision of quality care in a stable economic environment. They not only maintained activities but also increased clients and volunteers at a time when Irish Aid and other organisations were scaling down because of funding constraints. Their failure to replenish kits during 2007-2008 was because of the unavailability of required materials locally.

Constantly replenished kits are needed for quality care provision in CHBC. At ICHC caregivers get kit supplies from the nearest hospitals to ensure constant supply. However it is not clear if hospitals always have needed materials in stock. Red Cross replenished kits regularly during 2005-2006 (Phiri, 2006) unlike Irish Aid who did so only twice in 2006 (Benyera, 2008). Red Cross kit replenishment was erratic in 2007-2008. However even when supplies were not available locally they sourced from other Red Cross national societies and distributed to volunteers. They exhibit great concern for kit replenishment and client care. Notwithstanding their resourcefulness, quality of care was inevitably affected when they did not have sufficient supplies.

Strategically positioned offices are vital for the coordination of CHBC. Red Cross, ICHC and CAA have offices at provincial and district level. While ICHC and CAA have more qualified employees at their local offices, Red Cross district offices are manned by volunteers. Since all volunteers are of similar training, it is highly likely that those at the district have a low threshold of the extent to which they can advise and supervise those in the field. Red Cross has not made use of such existing infrastructures to enhance quality control.

### 5.5 Outcomes

#### 5.5.1 Client centeredness

Care provision in CHBC should take into account the care needs of clients. Volunteers always assess clients' care needs as a way of ensuring that care is tailor-made to suit clients. However it is not clear how clients' different lifestyles, preferences, habits etc are catered for in care provision.

Red Cross, CAA, ICHC and Irish Aid all train willing relatives on client care. This builds on the views of MoHCW (2004) who called for the passing of care skills to family members as important players in CHBC. Trained family members can complement the work of volunteers. However not all family members will be willing to be trained while in other cases there will be no family members to be trained. It is not explained how Red Cross varies (if they do) visits to clients who have family members who can take care of them and those who have no other carers besides volunteers.

### 5.5.2 Effectiveness

Constant volunteer visits foster adherence to treatment. Bedridden clients start walking while clients on ARVs show visible weight gains, and OIs are treated without referrals to hospitals. The use of herbal remedies by Red Cross in managing some OIs in the face of drug shortages proved helpful. However herbs cannot replace conventional drugs. Volunteers need to be wary of clients on ARVs, which are known to react with some herbs. Caring for clients with access to food expedites recovery. This may explain why Red Cross courted WFP to provide food to their clients while in Botswana volunteers shun impoverished clients without food because they say their caring efforts are in futility.

### 5.5.3 Efficiency

Optimum use of CHBC resources is important in resource-limited settings. Volunteers are always allocated to clients close to their homes to reduce travel time and allow more time for care. Using the same pool of volunteers for OVC care, food distribution and IGPs means more work is done with fewer resources and money saved goes to improving care provision. The use of drugs and materials from the kits has to be done judiciously to ensure that clients benefit more from them. In Zimbabwe where clinics have no drugs, volunteers are tempted to give drugs to sick relatives and friends. This jeopardizes clients with weakened immunities when they need the drugs and they will be finished.

### 5.5.4 Equity

CHBC services are not fairly available to all PLHIV who need them. Red Cross and Irish Aid cover four rural districts each while CAA and ICHC also cover limited areas. Only ICHC covers urban areas, largely because Hospice was based in urban centers. Red Cross and Irish Aid deliberately leave out towns.

There are more female than male volunteers. This is backed by numerous surveys cited by Campbell et al (2008) which indicate that more than 80% of PLHIV carers in Africa are female. Irish Aid is the only one with 1:1 ratios of male to female volunteers in some

projects. The situation is worse at ICHC with few male caregivers in addition to all female registered nurses. Red Cross put efforts to address this as evidenced by the 184.4% male volunteer increase which reduced the male to female volunteer ratio from 1:7 to 1:3. The male volunteers increase might signal deepening economic crisis in Zimbabwe where men face fewer options to fend for their families. Fewer male volunteers affect male clients' access to care, which may be the reason why males present themselves late for CHBC care. Although male clients are less than female ones, the distribution of the few male volunteers is such that they are not able to cover the scattered male clients.

Sometimes volunteers give preferential care to few clients. Personal experience has shown that religious volunteers are more passionate when caring for clients of similar religion denomination. Volunteers can give more care to clients whose relatives give presents to them Phiri (2006). This disadvantages poorer clients and is difficult to check where most volunteers are poor and value the presents. Midlands is home to both Ndebele and Shona tribes who are historical foes. It remains a big challenge for a Shona volunteer to give same care to Ndebele and Shona clients and vice-versus.

### 5.5.5 Sustainability

Adequate funding is needed for the continuity of CHBC programmes. Surviving in the harsh Zimbabwean economic environment means the Red Cross programme is well funded. Under similar conditions, Irish Aid reduced funding leading to scaling down of activities. ICHC has good funding because of the partnership between the state and hospice. Government sourced funding is developing the capacity of Hospice to provide care to PLHIV such that when funding ends, ICHC can continue caring for PLHIV. This is far fetched in Zimbabwe where government has many competing priorities and little money.

CHBC programmes should be able to provide care continuously throughout the lives of PLHIV. Red Cross trained new volunteers each year, except for 2006 to ensure there are enough carers. Volunteers are allocated clients close to where they stay so that they are able to give care whenever it is needed. When a volunteer is not there, another one is assigned to take care of their clients. Training of family members ensures continued client care between volunteer visits. Red Cross gives transfers to leaving clients and accepts those coming from other CHBC programmes, to ensure continuity of care. Continuation of care into bereavement counseling and orphan care by Red Cross shows the sustainability of care beyond the death of a client.

In Zimbabwe, during the farming season, volunteers have to grow food crops for family consumption. Farming is demanding and competes with care giving. Since farming forms the bases of Zimbabwean rural families' livelihoods, volunteers end up putting more effort to farming than care. Clients may end up going without constant care when they need it.

### 5.6 Use of framework

The framework used was useful in assessing the quality of CHBC care. This is because of its ability to break down quality care into the component elements of clients, human resources, systems, structures and outcomes. It yielded more valuable information dealing with each component at a time instead of looking at the whole concept of quality care at once. At the end conclusions were easier to draw by looking at how each of the components of the framework fulfilled the requirements for quality care.

For this study the framework helped in making the assessment at hand. However an addition can be made to it by including family and community as one of the components to be looked at when assessing quality of care through collection of primary data.

## Chapter 6: Conclusions and recommendations

### 6 Introduction

In view of the study objectives and the foregoing findings, the following conclusions can be made:

### 6.1 conclusions

There has been an increase in the number of volunteer caregivers at Red Cross as evidenced by a 63.5% increase form 2005-2008. This is not only indicative of the high demand for CHBC services but also the position that CHBC is destined to take in care of PLHIV in Zimbabwe. Similar increases have been noted in South Africa and Namibia.

The number of CHBC clients increased by 134.7% from 2005 to 2008. This indicates more and more infected people are coming forward to access CHBC care.

The care needs of PLHIV are made up of four major categories of physical, psychosocial, palliative and spiritual needs. Under these are specific care needs which include the need for ARVs, TB treatment, adherence monitoring, food, OI management, orphan support, child care, bereavement counseling, will writing and stigma reduction. These depend largely on, stage of disease, recurrence of OIs, TB/HIV co-infection and availability of ARVs. It has emerged that the care needs for PLHIV are changing as the epidemic matures, thus volunteers and family members are always assessing these needs.

The CHBC services being offered by Red Cross include OI management, general counseling, bereavement counseling, OVC support, provision of food, adherence monitoring for both ART and TB treatment. The programme is not offering ARVs which are very important for the prolonging of life among PLHIV.

The quality of CHBC care provided by Red Cross is higher than that provided by Irish aid with respect to human resources (their volunteers have better training, low drop-out and better motivated) outcomes (they have better equity, effectiveness, client centeredness, efficiency) and structures (better funding and kit replenishment) but it is weaker on systems (poor link with hospitals, weak M&E). However when compared with other CHBC programmes in neighboring countries, the quality of CHBC offered by Red Cross is competitive in human resources and structures while it is weaker in all outcomes and systems.

## 6.2 Recommendations

The following recommendations can be made to implementers, policymakers and researchers for the strengthening of the quality of CHBC services in Zimbabwe.

### 6.2.1 Implementers

#### 6.2.1.1 Funding partnership

A funding partnership between Red Cross and the government of Zimbabwe needs to be set up. This will be able to pull resources from both sides for the provision of quality CHBC care. The partnership will benefit from the CHBC experience accrued by Red Cross over the years, their existing infrastructure and human resources in all provinces of Zimbabwe. For this the government of Zimbabwe can make use of the window of funding opportunities created by the formation of a government of national unity and approach donors who are sympathetic to the breakdown in the country's health delivery system.

#### 6.2.1.2 Volunteer training

A longer basic training programme for volunteers which interspaces theory and village-based placements should be developed. The training, which can take between three and four months avoids overloading trainees with too much theory at one go while allowing them time to practice what they would have learned with real clients. Theory sessions should not exceed five continuous days each while placements can be two to three weeks each. In addition to this refresher courses should be based on assessed training needs. To this end, the Ministry of Health and all CHBC implementers can meet and submit inputs for the revision of the current training curriculum then task a team of adult learning specialists to develop a suitable curriculum with supervision of the ministry of health, NAC and representatives of implementers. The curriculum developers will also be mandated to come up with guidelines on how to assess volunteer training needs and designing refresher courses basing on identified training needs.

#### 6.2.1.3 Volunteer supervision

There is need to establish volunteer guidelines for dispensing care and supervision standards. These will be used alongside the existing CHBC standards. In this regard all implementing organisations can meet and draw guidelines on how to dispense standard care as well as developing supervision guidelines. Organisations then agree to select team leaders from volunteers who are numerate and literate. They should be given further training above that of volunteers and their training should include basic supervision and performance appraisal skills.

#### 6.2.1.4 Monitoring and evaluation

A good data collection system needs to be set up. This allows for the collection of data from programmes for organisational use and for feeding into the national M&E system. To achieve this all CHBC implementers should meet and design common instruments which are easy to use but able to captures all the important data. This should be done in collaboration with NAC M&E department so that implementers are guided on how to ensure that they collect data on all core national indicators for CHBC. Clear roles are also assigned as to who collects what data, how often, who verifies them and how are the data transmitted to the next level and how often.

#### 6.2.1.5 Promotion of herbal remedies

Promote the establishment of herbal gardens and teach volunteers on their use. Implementers take the initiative to engage the national botanical gardens staff and other nationally recognized organisations dealing with herbs and have thorough knowledge of herbs so that they are enlightened on which herbs they can plant. This should be followed by the training of volunteers as well as the production of manuals in English and local languages on the uses of the different herbs and how to prepare them for use. Individual programmes can then start herbal gardens and giving their volunteers continuous training as need be.

#### 6.2.1.6 Increase male involvement

There is need to increase the number of male volunteers. To change the perceptions of men towards care it is important to engage Padare (Men's Forum) an organisation for men. Since Padare has an HIV/AIDS department, it is best to get their buy-in and then do collaborative advocacy between them and CHBC organisations to encourage men to take up caring for the sick.

#### 6.2.1.7 Provision of ARVs and TB treatment

Eligible clients on CHBC should be provided with ARVs and TB treatment. The life prolonging ARVs give hope to both the clients and their families. To achieve this, implementing organisations can train volunteers to monitor and refer coughing clients for TB testing so that they get treatment if they are positive. For ARVs CHBC implementers can seek to establish partnerships with organisations already providing ARVs without a CHBC component. Alternatively CHBC implementers can make strong representations to get ARV funding when Zimbabwe is applying for global fund funding. When organisations apply for CHBC funding from donors, they can form a general consensus that ARVs should be included on their proposals.

### 6.2.2 Policy

#### 6.2.2.1 Standardized volunteer incentives

The incentives for volunteer have to be standardized so that all volunteers get the same package and are aware of it. For this, implementing organisations and the volunteers themselves need to lobby government to put in place a policy for volunteer incentives. There is also need for implementers to convene forums to discuss this issue with funding partners so that they get the buy-in and support of donors in that regard.

#### 6.2.2.2 Effective referral system

A clear and functional referral system between CHBC implementers and the health delivery system should be established. This calls for a policy which ensures that all CBHC implementers are registered with their nearest healthcare centers and define the relations between them. For this to happen implementers can lobby for the inclusion of such an addendum to the existing discharge plan guidelines. Since government is short of staff to have designated stand alone liaison persons for CHBC in the public facilities, implementers can appoint these from their team leaders.

### 6.2.3 Research

Further comprehensive research needs to be carried out on this subject. This research should include NGO doing CHBC, volunteers, hospitals, clinics, clients and their families in assessing the quality of home based care services since all of them have important roles to play in the quality of home based care services. Key informants can also be drawn from among community leaders.

Annex I

**Questionnaire for Provincial CHBC Coordinator – Midlands.**

An assessment of the quality of home based care services provided by Zimbabwe Red Cross Society to people living with HIV in Midlands province of Zimbabwe.

***Instruction for completion***
*You are requested to complete this questionnaire by writing your answers in the spaces provided. Feel free to give more information on additional sheets of paper if the provided spaces are not enough.*

1. Complete the following table stating the numbers of active volunteer care givers that you had as of December of each of the years shown. If there were any changes in numbers explain what caused the changes in the column 'reasons for changes,

| Year | Active Caregivers | | |
|---|---|---|---|
| | Male | Female | |
| 2005 | | | Reasons for changes |
| 2006 | | | |
| 2007 | | | |
| 2008 | | | |

2. How many clients were on your home based care registers as of December of each of the years shown on the table below? State the reasons for changes in the number of clients in the column 'reasons for changes'

| Year | No. of Clients | | |
|---|---|---|---|
| | Male | Female | |
| 2005 | | | Reasons for changes |
| 2006 | | | |
| 2007 | | | |
| 2008 | | | |

3. List the care needs for the CHBC clients on your programme. (These include needs identified by care givers, relatives of clients and those that have been raised by the clients themselves). Against each need state the services that your organisation is offering. Where no services are being offered put "N/A".

| Care need | Services being provided |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

4. For each of the care needs whose services you have denoted with "N/A" in number 3 above, state the reasons why your organisation is not able to provide services to those care needs.

| Care needs | Reasons for not providing services |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

5. What problems do care givers face in providing care to CHBC clients
    -
    -
    -
    -
    -
    -
    -
6. How many of your care givers as at December 2008 had undergone the first basic training given to caregivers by your organisation and how many had not yet gone through it.

| Trained | Untrained |
|---|---|
| | |

7. When you train care givers, for the first time how long does the training programme take?

8. List all the subjects that are covered in the first basic training course for care givers?
    -
    -
    -
    -
9. Do Red Cross care givers attend any refresher training courses?

10. If yes, please complete the following table to show the course that have been attended by caregivers from 2005 to 2008 (these include course that have been facilitated by Red Cross personnel and those provided by other parties and attended by Red Cross caregivers)

| Year | No. of courses | Subjects covered |
|---|---|---|
| 2005 | | |
| 2006 | | |
| 2007 | | |
| 2008 | | |

11. Who supervises care givers when they go out and provide care to clients?

12. On the table below, state the types of supervision that are carried out for caregivers, the supervisors and the frequency of each type of supervision.

| Type of supervision | Position or title of Supervisor | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

13. Are there any documents that care givers and their supervisors complete during their work? If yes, please complete the following table with respect to the documents completed, who completes them and how often.

| Document completed | Completed by | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

14. Do care givers hold any meetings?

15. If yes, please complete the following table with respect to the types of meetings, how often they are held and issues discussed at the meetings.

| Name/Type of meeting | Frequency | Issues discussed at meeting |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

16. Does the Red Cross give any incentives to care givers?

17. If yes, name the incentives, the quantities (where applicable) and the frequency at which the incentives are given out.

| Incentive Type | Quantity | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

18. Complete the following table with respect to the materials/provisions that care giver need for their daily work. (Two have been listed as examples). Tick the appropriate column to indicate the availability of these to Red Cross caregivers in Midlands. *(Please refer to the key below the table).*

| Materials/Provisions | Availability | | | |
|---|---|---|---|---|
| | Always available | Reasonably available | Sometimes available | Rarely available |
| Rubber gloves | | | | |
| Linen savers | | | | |
| | | | | |
| | | | | |
| | | | | |

**KEY**

**Always available:** Care givers always have these

**Reasonably available:** When they run out, supplies come within one month

**Sometimes available:** When they run out, supplies come after one month and before six months.

**Rarely available:** When they run out supplies come after six months

**End of questionnaire**

***Thank you for taking the time to go through this questionnaire.***

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