

# Looking Back, Mapping Forwards:

## Research Findings on Home-based Care In Zimbabwe

NOVEMBER 2007



**SAHAIDS** Southern Africa  
HIV and AIDS Information  
Dissemination Service







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To understand more about the development of home-based care (HBC) in Zimbabwe and its future potential, Irish Aid engaged Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) and Health & Development Networks (HDN) to assess and document lessons from HBC interventions. Since 2005, Irish Aid has supported HBC initiatives in Zimbabwe, and is currently funding 15 HBC programmes throughout the country. The current project was designed to contribute to better understanding and assist evidence-based decision-making in the implementation of HBC interventions in Zimbabwe and beyond.

This publication is one of five produced in the course of the project:

- *Caring from within – Key findings and policy recommendations on home-based care in Zimbabwe*
- *Inside stories – Local experiences of home-based care in Zimbabwe*
- *Dialogue and opinion on home-based care in Zimbabwe: Summary of online discussion*
- *Looking back, mapping forwards: Research findings on home-based care in Zimbabwe*
- *Learning and sharing: Implementers' meeting report on home-based care interventions in Zimbabwe*

The goal of these publications is to guide HBC implementers, policy-makers, regional and international organizations, and donors in designing and prioritizing HBC programmes, creating policies and targeting funding to make a real difference to people's lives at the local level.

To request a CD containing all of the above publications contact:  
[publications@hdnet.org](mailto:publications@hdnet.org) or [info@safaids.net](mailto:info@safaids.net)

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# Acronyms and Abbreviations

AGM	Annual General Meeting
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
CADEC	Catholic Development Commission
CBO	Community Based Organisation
CHCC	Catholic Health Care Commission
CRS	Catholic Relief Services
DAAC	District AIDS Action Committee
ESAP	Economic Structural Adjustment Programme
ESP	Expanded Support Programme
FACT	Family AIDS Counselling Trust
GFATM	Global Fund against HIV/AIDS, TB and Malaria
HBC	Home Based Care
HDN	Health and development Network
HIV	Human Immunodeficiency Virus
IGP	Income Generating Projects
IEC	Information, Education and Communication
ISALs	Income Saving and Lending schemes
LGBTI	Lesbians, Gays, Bisexual, Transgender and Intersex
M&E	Monitoring and Evaluation
MEP	Male Empowerment Project
MOHCW	Ministry of Health and Child Welfare
MSF	Medecin San Frontieres
NAC	National AIDS Council
NACP	National AIDS Co-ordination Programme
NGO	Non Governmental Organisation
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PSG	Project Support Group
PSI	Population Service International
RH	Reproductive Health
SADC	Southern African Development Community
TASO	The AIDS Support Organisation
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on AIDS
VAAC	Village AIDS Action Committee
VCT	Voluntary Counselling and Testing
VCG	Voluntary Care Givers
VSO	Volunteer Services Overseas
WAAC	Ward AIDS Action Committee
WFP	World Food Programme
WHO	World Health Organisation
YPWC	Young People We Care
ZAN	Zimbabwe AIDS Network
ZNASP	Zimbabwe National AIDS Strategic Plan
ZNNP+	Zimbabwe National Network of People Living with HIV

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# Chapter 1: Introduction

## 1.1 Background

The HIV and AIDS epidemic has had a severe impact on individuals and communities throughout Zimbabwe. The Ministry of Health and Child Welfare (2006) estimates that 1,610,000 (2005 National Estimates) Zimbabweans, out of a population of 11.6 million, are living with HIV and AIDS. Approximately 115,000 of these are children under the age of 15. Although Zimbabwe has demonstrated a declining trend in prevalence in the adult age group (15-49) (from 24.6% in 2003 to 20.1% in 2005), primarily attributed to behaviour change, the prevalence of 18.1% in 2006 continues to be unacceptably high.

The care and support needs of people living with HIV and their families have been well-documented. Yet over the years, the increasing demand for care and support has burdened already financially stretched hospitals and clinics. The capacity of these health facilities to provide long-term care and support to chronically ill patients and their families has been eroded. For many, home-based care programmes have emerged as a valuable alternative to institutionalised medical care.

The World Health Organization (WHO) defines home-based care as 'a programme that offers health care services to support the care process in the home environment of the person with chronic disease, including HIV. Home visits may be the only service provided, or be part of an integrated programme which offers the patient and his or her family services in the home, hospital and community. (Ministry of Health and Child Welfare, 2004). Supported by community volunteers, home-based care services in Zimbabwe have provided a lifeline to people living with HIV and others facing chronic illness, as well as to their families, who struggle to cope with the impact of HIV and/or other chronic illnesses.

## 1.2 Purpose and Objectives

Since 2005, Irish Aid has been supporting home-based care (HBC) initiatives in Zimbabwe. Currently, it is funding fifteen HBC Programmes throughout the country. To understand more about the development of HBC in Zimbabwe and its future potential, Irish Aid engaged Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) and Health Development Network (HDN) to assess and document HBC programmes in Zimbabwe.

The purpose of this technical report was to document the evolution and changes within eight HBC interventions in Zimbabwe and to identify and analyse 'best practices' in HBC. The analysis aims to explore how HBC programmes are addressing issues of gender, TB, food security, OVC and access to treatment.

More specifically, the objectives of the study aimed to:

- Assess the evolution of HBC at a national level
- Review and analyse the HBC interventions made by a cross-section of Irish Aid supported civil society organisations in terms of changes, challenges and quality issues
- Draw out lessons learned by HBC interventions that can be widely shared in Zimbabwe and beyond
- Assess how people are coping with the increasingly unstable socio-economic environment

- Analyse and make recommendations on how HBC interventions can be co-ordinated through support from the national responses, including the Expanded Support Programme (ESP) and other programmes like Global Fund against HIV/AIDS, TB and Malaria (GFATM).

### 1.3 Methodology

The information presented in this report was collected using qualitative and quantitative methods including a literature review, field visits, as well as focus group discussions and key informant interviews with programme implementers and beneficiaries. The assessment was conducted with eight home-based care organisations who were purposefully selected to demonstrate the range of organisations receiving grants from Irish Aid. These included:

- Uzumba Orphan Care, Uzumba District, Mashonaland East
- Bekezela Home-Based Care, Bubi District, Matabeleland North
- Batsirai, Chinhoyi, Mashonaland West
- Catholic Health Care Commission, Makonde District, Mashonaland West
- Male Empowerment Project, Mutasa District, Manicaland
- New Dawn of Hope, Mufakose, Harare
- Dananai, Buhera District, Manicaland
- Fact Chiredzi, Chiredzi, Masvingo

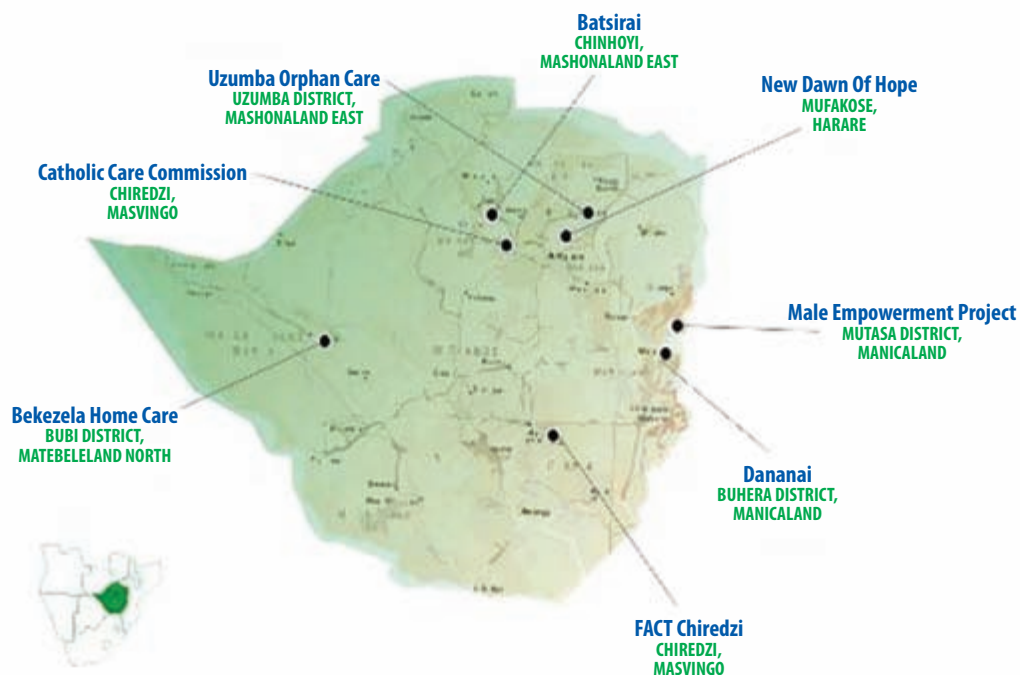


FIGURE 1

Map of Zimbabwe and Location of Home-based Care Programmes involved in the Process of Documentation

Visits to each site included interviews with the organisations' management and programme implementers, community caregivers and beneficiaries. In addition to the formal interviews, a team of local writers, known as Key Correspondents, documented case studies and stories of individuals within the communities visited. Triangulation and validation of information from the various respondents was very important. Gender considerations were taken into account at all stages of the data collection and analysis process. The tools themselves were designed in such a way that they also assessed how the project being defined as a best practice and lessons learnt from it are impacting on men and women within the project sites.

To explore the evolution and changes experienced by HBC organisations, the information collected was analysed using content analysis. To assess the best practices existing in the HBC programmes, SAfAIDS developed a Best Practice Assessment Tool or Score Card, based on seven criteria outlined by UNAIDS and SADC. These include effectiveness, relevance, ethical soundness, replicability, sustainability, innovativeness, and cost effectiveness. The criteria were broken down into key variables and scored using a scale of 0-4 (where '4' is excellent and '0' means that it needs urgent attention).



FIGURE 2 Key Correspondent Interviewing HBC Beneficiary

# Chapter 2: Eight Home-based Care Programmes Documented

## 2.1 Uzumba Orphan Care

### **Brief History**

Uzumba Orphan Care (UOC) is a community-based orphan and home-based care programme in Uzumba-Marambapfungwe. The organisation provides a range of programmes including care for Orphans and Vulnerable Children (OVC), HBC, a Youth Programme (focused on HIV prevention), legal Issues (i.e. advice on writing wills for protection of the interests of orphans) and medical assistance to clients. Founded in November 1995, UOC was established by leaders from the community's United Methodist Church as a programme to support OVC. Pastor Chitiyo of the Methodist Church, then based at Chitimbe Primary School, was touched by the increase in the number of orphans in the area and decided to mobilise the local community to do something to lessen the plight of the orphans. In describing his motivation, he said, *"Children are left out in most cases because they lack a voice. They cannot advocate for themselves and hence their pain is hardly disclosed and noticed. It takes a very experienced person to identify children in problems."*

The decision to integrate OVC with traditional HBC services was taken in 2000. This was driven by the need to work with children whose parents are affected by HIV, during their illness, as a way of minimising and managing the trauma experienced by children after the deaths of parents. OVC began visiting to provide palliative care, providing psychosocial support, counselling to both children and parents and providing basic material support, such as blankets, sheets, gloves and linen savers. The programme focuses on alleviating clients of four forms of pain: physical, social, psychological and spiritual. Caregivers from UOC also provide adherence support to clients who are already registered with clinics for TB treatment. They avail their treatment cards to the care givers who monitor and support clients to ensure that they continue their medication.

The project started with 15 female caregivers. Each represented a village within the district. Men came in as supporters of the programme, providing financial and material support, providing free labour in fields set aside by Headmen for production of food for orphans. Following the integration of HBC services, the organisation grew to include other staff and volunteers.

Currently, UOC operates in 3 districts, namely, Mrehwa, Mtoko and Uzumba-Maramba-Pfungwe and in 15 wards. The communities select clients for support. Currently UOC are reaching 214 OVC, with 375 OVC caregivers, and 206 HBC clients in 3 wards with 122 trained HBC volunteers. A clear effort is made through UOC to provide equitable services to all who need .

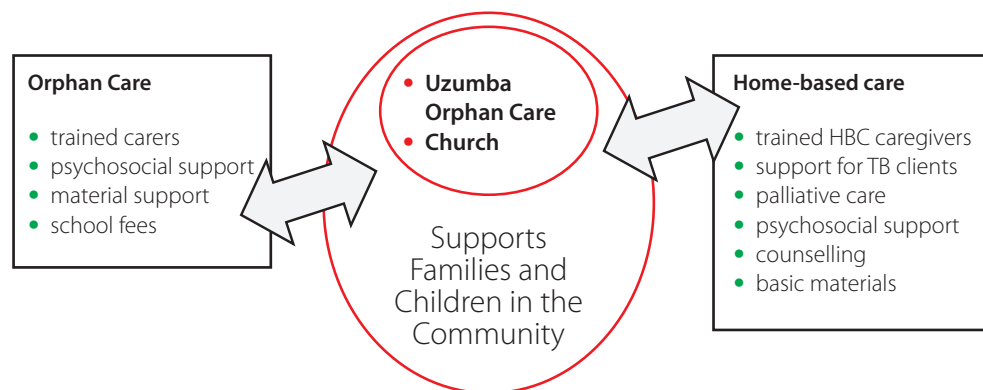
### **Planning**

UOC has a five-year strategic plan, which is guided by the national HBC and national HIV and AIDS strategy and policies, and was developed with the participation of stakeholders such as the District AIDS Action Committee (DAAC), the Ministry of Health and Child Welfare (MOHCW), traditional leaders, religious leaders and others. UOC reviews the strategic plan every year. The annual participatory review is combined with their annual general meeting (AGM). Through this mechanism the UOC tries to ensure that programmes remain relevant and responsive to the needs or problems of the surrounding communities.

Implementation plans are developed from the overall strategic plan on the basis of available resources. Work plans are also produced every year and managers develop quarterly plans in line with donor quarterly disbursements. Field officers share the plans with volunteers in the monthly meetings. All work-plans are supported by a monitoring and evaluation (M&E) plan to monitor the achievement of results.

The annual participatory review (APR) precedes the formulation of the annual work-plan. Before the APR, UOC conducts a project audit as an organisation. The audit explores the objectives of each project and assesses achievements and challenges on the ground. The organisation then uses the information obtained to inform the training plan. As a result, the training plans are based on identified training needs and are closely tailored to attainment of project goals or objectives.

### **Programme Design**



**FIGURE 3** Programme Design of Uzumba Orphan Care

### **Funding**

In general, UOC has limited resources but caters to a large range of clients. Among other donors, UOC receives support from Irish Aid for its HBC programme in 3 wards. Irish Aid provides HBC kits, free medical assistance to clients, and funding for support groups. Catholic Relief Services (CRS) funds OVC. SAT provides support in the form of capacity development and OVC programming. Both HIVOS and Centre for Disease Control (CDC) provide funding for youth programmes focusing on HIV prevention and capacity development.

### **Volunteer Management (Selection, Training and Retention)**

As with many community programmes, UOC's work is dependent on a strong network of volunteers. The communities select and recommend volunteers for the programme. In addition, community members support the activities by making food contributions as and when requested.

Most volunteers are guided by their Christian values and hence perceive volunteerism as a calling. To enable their volunteers to do the work effectively, UOC provides volunteers with HBC kits, bicycles, volunteer uniforms and support for their income generating projects (IGPs). To minimise costs on transport and long distance travel, the organisation assigns caregivers to work in the areas where they live. They also assist OVC with purchase of educational materials. UOC supports its volunteers by supplying them with the tools they need for work, mobilising the community to recognise the significance of volunteer service and encourage them to share experiences during monthly meetings in 'Care of Carers' sessions.

The training of volunteers is done by MOHCW when resources permit. Training teaches volunteers to facilitate care within the household by building the skills of primary caregivers through practical demonstrations. Monitoring visits are made to clients or to children in school as one method employed by UOC to evaluate the effectiveness of the training undertaken at any one time. In addition, monthly meetings are used to reflect on impact of training.

### **Gender Balance**

Through the years, female volunteers expressed concerns about their ability to fully care for men. As a result, UOC started recruiting and training male volunteers to support their HBC and OVC programmes. The approach for male involvement has been modelled on the Africare: Male Involvement HBC programme.

## **2.2 Bekezela Home Based Care Project**

### **Brief History**

Bekezela home-based care project is a community-based organisation operating in Bubi district of Matabeleland North Province. The organisation runs four main activities namely HBC, orphan care, girl guides and boy scouts, reproductive health (RH) and early childhood development programmes. Initiated in 1994, the HBC programme is the oldest. Until recently, it operated in eleven wards, but due to challenges in funding the programme has scaled down to five wards in the district (9, 11, 15, 19 and 21).

In 1994, Isabel Saungweme, a nurse at Inyathi District Hospital, noticed the hardships faced by people discharged from hospital into a non-caring environment, where stigma and discrimination were high and patients were closed in homes and shunned by their families. Following an exchange visit with TASO (an AIDS support organisation in Uganda), she advocated with the chief of Bubi area, Chief Khumalo, to start an HBC programme. With his support, she founded Bekezela HBC Project and has remained the director of the organisation.

The HBC programme is linked to Inyathi hospital, where patients are discharged from hospital and referred to Bekezela HBC programme. The HBC programme caters for clients with all chronic illnesses including HIV and AIDS, diabetes, hypertension, cancer and heart disease. In 2006, Bekezela HBC programme reached out to 489 beneficiaries.

**TABLE 1** Beneficiaries reached by Bekezela HBC Project

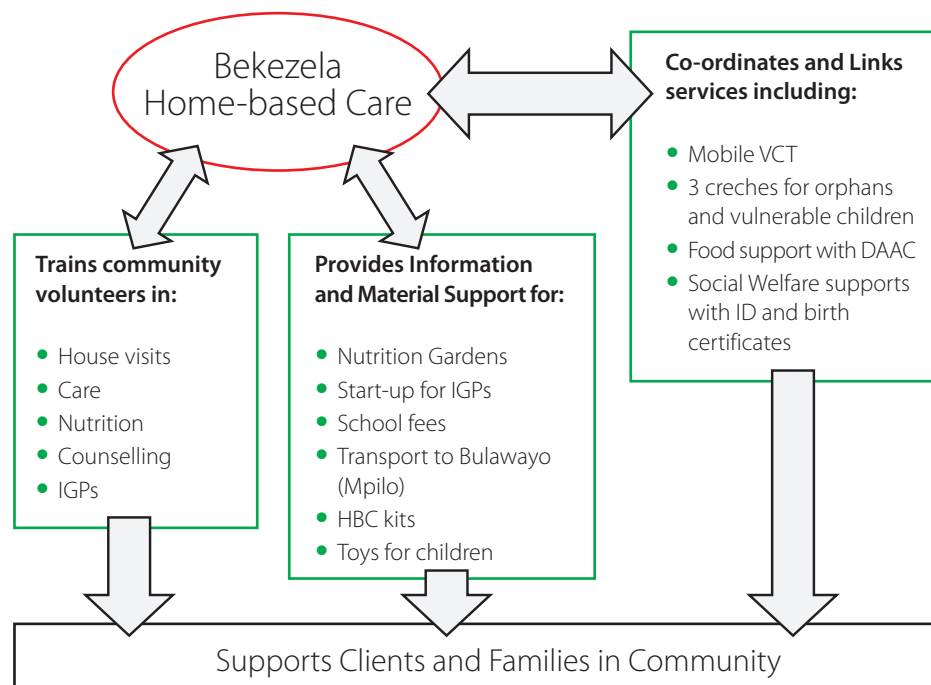
<b>Category of Clients</b>	<b>Males</b>	<b>Females</b>	<b>Total</b>
Ambulatory	161	215	<b>376</b>
House bound	37	47	<b>84</b>
Bed ridden	15	14	<b>29</b>
<b>Total</b>	<b>212</b>	<b>277</b>	<b>489</b>

### **Programme Design**

Clients are provided with drugs (pain killers), food (vegetables), herbal treatment services, and education on HIV prevention methods. The HBC programme offers mobile voluntary counselling and testing (VCT) services to the community, in partnership with Population Services International (PSI). Unfortunately, there is no antiretroviral therapy (ART) programme and the Bekezela programme has insufficient medical facilities linked with it. One doctor is shared between Inyathi and Tsholotsho hospitals. Bekezela HBC programme provides access to ART programmes by transporting clients to Mpilo hospital in Bulawayo, or St. Luke's in Tsholotsho. However, this service needs to be provided systematically, so that clients are aware of a set date per week or per month, for this visit. Currently, the transport is available only when Bekezela is visiting either of these sites.

A unique programme offered by Bekezela was the development of their herbal garden. For clients with limited access to antiretrovirals (ARVs) and other drugs, herbal therapy has been considered very successful “*Ngasengimtshiyile umntanami kodwa ngatotoba ngaya eBekezela banginika izihlahla. Khathesi ngiqine njenge nsimbi*”, (I almost died leaving my child but I crawled to Bekezela centre and they gave me herbs. Now I’m as strong as iron), said a beneficiary from Bekezela HBC programme, Ward 11 of Bubi district. Secondary caregivers, people living with HIV (PLHIV), widows, orphans and their guardians are provided with skills on a variety of income generating projects (IGPs) such as poultry projects, soap making and nutrition gardens. However, currently, most of the IGPs are not being implemented due to the unavailability of water and raw materials.

In addition, Bekezela offers support to 2,378 orphans and children living under difficult circumstances. This support is in the form of school fees, books as well as psychosocial support. Bekezela has successfully established three crèches in seven villages and provides toys and clothes for the children.



**FIGURE 4** Programme Design for Bekezela Home Based Care

**Funding**

As with many of the HBC organisations, Bekezela cited funding as a key challenge. With only limited funding, the organisation has taken the decision to scale down its HBC programme from 11 to 5 wards. This move was taken in order to preserve the quality of its service within the most needy communities. Currently, it has also stopped its IGPs work due to a lack of resources (water and raw materials).

Bekezela has used networking as a key strategy to provide care and source provisions for its clients. For example, it has networked with the DAAC, which has provided fish, mealie-meal (10kg) and a bar of soap to be shared between six people. This support was provided for one year only. The local social welfare department assists Bekezela with patient relocation and sourcing national documents such as national IDs, birth and death certificates.

Besides Irish Aid, Bekezela is receiving funding for its different programmes from CRS, HIVOS and Bernard Van Leer Foundation.

### ***Volunteer Management (Selection, Training and Retention)***

Bekezela currently has 300 trained secondary caregivers, of which 40 are male. The training programme is based on National AIDS Council (NAC) and PACT, Zimbabwe packages. The programme uses lecture and group discussion methods. Sometimes specialists in areas such as nutrition, ART and children's issues are invited as guest presenters. Emerging issues are included in refresher courses, which are held annually. Secondary caregivers are equipped with skills on HBC, basic counselling and nutrition. After training, these volunteers also train primary care givers in HBC skills and nutrition.

Volunteers who train as secondary caregivers are selected and endorsed through community meetings. They are supervised by Bekezela home-based care supervisors, who are based at the centre. To retain and support their caregivers, the project gives volunteers a bar of soap once in 3 months depending on availability, free medical services, uniforms, community ploughs and plants in the ploughing season. In addition, Bekezela tries to provide other opportunities for training and growth among their volunteers, for example, when other organisations such as World Vision, need volunteers for their work. Burnout of caregivers is a real challenge and difficult to manage, however Bekezela tries to address it by developing a supportive volunteer policy and encouraging income-generating opportunities.

### ***Gender Balance***

Within the Bekezela HBC project, very few men participate in care giving, although the organisation welcomed them into the programme as secondary caregivers in 1996 (40 out of 300 volunteers). Clients feel that the few men who do participate are equally good carers as women. It was suggested that they take more time to listen and probe for any problems. The men who do participate receive the same incentives as women, but this does not seem to draw more of them into the programme. Programme implementers at Bekezela felt that there has been a cultural shift and an acceptance that men also have a responsibility in HBC, but that there is still a need to identify a means of motivation so that more men will participate in the future.

## **2.3 Batsirai Home Based Care Programme**

### ***Brief History***

Batsirai Group is a provincial non-governmental organisation (NGO), based in Mashonaland West and established in 1988, by health care workers previously employed by Chinhoyi General Hospital. The organisation was established to address the increasing number of HIV and AIDS related deaths in the province and to set up prevention and support systems that would mitigate the impact of HIV and AIDS in the district. The programme began when Batsirai implemented an HBC programme. The goal of the HBC programme is to provide the best possible quality of life to chronically and terminally ill patients, irrespective of sex, age, colour, economic, socio-cultural or religious background. The HBC programme covers four districts in Mashonaland West Province (Makonde - 18 wards, Kadoma - 4 wards, Hurungwe - 4 wards and Chinhoyi Urban). The HBC programme aims to facilitate continuity of care from health care institutions to the community, to provide support that enables clients to live as actively as possible within a community outreach model, provide HBC skills to secondary care givers and to support orphans and vulnerable children arising from HBC households. The HBC programme currently reaches out to 1,987 beneficiaries, of which 733 are male and 1254 female.

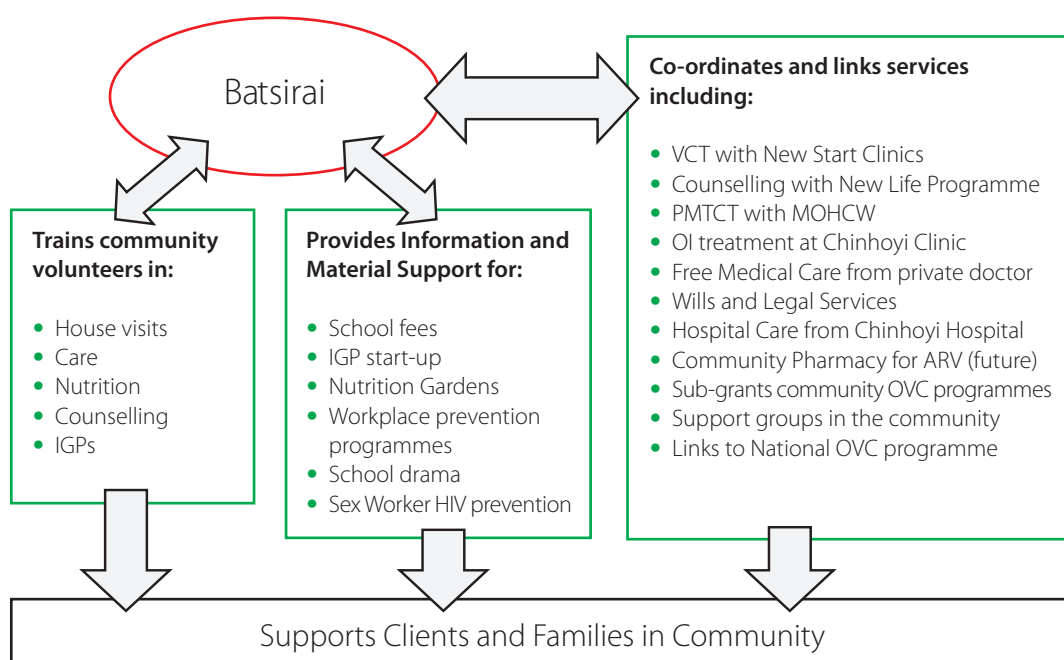
### ***Planning***

The organisation held its first strategic planning meeting in 1996. This meeting laid the foundation of the organisation as a provincial NGO and outlined the activities offered to the community through the HBC programme and volunteers. Another strategic planning meeting was held in 2005, during which a strategic plan for 2005-2008 was developed. The planning process for the strategic document was purposefully participatory with involvement from Batsirai staff, volunteers and the community at large. The HBC programme is guided by national strategies such as the

Zimbabwe National AIDS Strategic Plan, National Home Based Care Standards, National HBC policy and OVC policy among others. These policies are also in line with international themes running at any given time.

### Programme Design

As a provincial NGO, Batsirai has adopted an integrated approach to its HBC programme and developed partnerships with other organisations in the communities, to provide a comprehensive range of services required by its clients. The HBC programme targets all members of the community including vulnerable groups such as sex workers, children, and in- and out-of school youth. This is conducted through information sharing with key people in the community and also through drama.



**FIGURE 5** Programme Design for Batsirai

The basis of Batsirai’s home-based care programme is the volunteer caregivers whose primary activities include: conducting home visits for clients; client assessment and referral for appropriate services; onsite training of care and support; counselling clients and family on drug adherence; providing information on treatment, nutrition and livelihood activities, and compiling activity reports. Throughout these activities, the volunteers aim to transfer their skills to family members, who take on the role of primary caregiver. During their house visits, the volunteer uses home-based care kits which are tailored to the needs of each individual client’s needs. The provision of individualise packages as opposed to standard ones is beneficial in terms of cost reduction, and specific requirements per client are sourced. Supportive counselling services are offered to clients, family, to children and the community. The aim is to assist the families and the community to cope and deal with caring for the sick.

The HBC programme encourages members to engage in IGPs to sustain their lives. Money generated from IGPs is channelled toward medical expenses, food and the general upkeep of the family. The programme supported two peer support groups to run a sewing project producing school uniforms. The support groups are Yeukai in Chinhoyi urban with 5 members and Muvhami in Makonde with 12 members.

Batsirai continues with the formation of support groups throughout the province. Currently, there are 21 groups registered with Batsirai, with a total membership of 395 (187 males and 208 females). Support group members are trained in selection, planning and management of IGPs, where

beneficiaries with the same needs are identified and matched with suitable IGPs which bring returns at the appropriate time for the group members. Training is also provided for internal saving and lending to ensure that members engage in viable IGPs and have the knowledge and skills for handling cash generated from IGPs.

As an integrated programme, Batsirai manages, co-ordinates or facilitates links to a number of services within the community, which provide the necessary support services to enable clients to receive comprehensive care throughout their illness. For example, a key component of Batsirai's programme, is their provision of treatment for Opportunistic Infections (OIs). Batsirai HBC programme has engaged the services of the OI Clinic at Chinhoyi Provincial Hospital and of a private medical practitioner, who sees clients from the HBC programme for free. If clients have received a prescription from their private doctor, but due to the high cost of drugs cannot afford to buy them, Batsirai purchases the drugs for the clients. The volunteers of the HBC programme also serve as peer counsellors at the OI Clinic. To ensure that clients have access to the treatment they need, Batsirai has also applied for a licence to establish a community pharmacy, which in the future, is expected to assist communities to have access to drugs and ARVs. A pharmacist will be employed to run the pharmacy and there will be two medical doctors to treat OIs and administer ARVs. This is to be initiated as soon as the licence is issued - the application was submitted in 2006.

Currently, 73 of Batsirai's HBC clients are receiving ARVs, of which 20 males and 53 females. However, it was noted that for an ARV treatment programme to be successful there is a need for the hospital to ensure that its CD4 count testing machine at Chinhoyi Provincial hospital is always working. Clients indicated during the study that the machine is always down and this delays clients from enrolling on the treatment programme.

Since 1999, Batsirai has also managed two New Start Centres in Chinhoyi (one in the city centre and another at Chinhoyi Provincial Hospital), as well as providing mobile VCT services. Its VCT services reach out to approximately 11,000 people per year. In addition, Batsirai has provided support for prevention of mother-to-child transmission (PMTCT) for HIV positive mothers in collaboration with the MOHCW. The HBC programme offers post-test counselling to HIV positive mothers and links them to the hospital, which follows them through until delivery. Closely linked to the VCT programme is the New Life Programme, which started in 2006. This programme provides post-test support in the form of counselling, psychosocial support, family planning, treatment and positive prevention.

Batsirai orphan care programme started in 1993, as a direct result of the HBC programme. After parents die, the HBC programme offers continuous support to the surviving children. The OVC programme offers scholastic support up to university level. In 2006, one of the beneficiaries of Batsirai's OVC programme graduated as a medical doctor, while three others are still in medical school. Others are at various educational levels. It is important to note that the Batsirai OVC programme is part of the Government's national OVC programme and spearheads this programme in Mashonaland West. The Batsirai programme also sub-grants to seven other OVC organisations.

The OVC programme collaborates with a legal organisation to support children in legal matters, such as wills and inheritance. Every week a day is set aside for a free legal clinic at Batsirai and the community has benefited immensely from this support. Children are also assisted in acquiring national documents from the Registrar General's office.

Finally, Batsirai also provides basic HIV prevention programmes for a variety of groups, including commercial sex workers. Batsirai has assisted companies to develop HIV workplace programmes and is in the process of developing their own HIV and AIDS workplace policy, which they would like to take to health workers and other community structures.

### **Funding**

The main donor for Batsirai's HBC programme is Irish Aid. However, the organisation's diverse resources are received from different donors, including UNICEF for the OVC project, USAID (VCT), DfID through PSI (New Life programme), UNFPA (prevention), EU (PMTCT) and CDC for administration.

### **Volunteer Management (Selection, Training and Retention)**

Batsirai currently has 870 trained secondary caregivers, with 634 females and 236 males. The community leaders and the communities select volunteers. The volunteer selection criteria include; candidates who are able to read and write, who are trustworthy, respected and approachable.

Volunteers are trained through an initial course, which is then followed up by refresher courses on emerging issues, such as ART. Spot training and mentoring are also offered during support visits by Batsirai HBC programme staff. Volunteers are equipped with skills on HBC, basic counselling and nutrition. Batsirai trains a larger number of volunteers than it expects to retain, as it anticipates dropouts. To support its volunteers, Batsirai also trains the client's family, so as lessen the burden on the volunteer and builds the volunteer's capacity to be self sustained through exchange visits to other organisations for information sharing. Also, Batsirai provides incentives to volunteers, which include training, t-shirts, hats, stationery, seeds, drip kits and certificates.

Volunteers are provided with skills to develop nutrition gardens for their families. They are encouraged to lead by example and motivate others in the community to emulate them in the establishment of their own gardens. The organisation also provides drip kits for irrigation, in areas where water is not readily available. The nutrition gardens are seen as an opportunity to promote better health through improved access to quality food, as well as a source of income for both the volunteers and their clients. Volunteers are encouraged to grow herbs in their gardens as alternative therapy for opportunistic infections.

### **Gender Balance**

There is less male involvement in the HBC programme with 236 men versus 634 women. "*Men are not socialised to be carers*"; said D. Gapare, Batsirai Group Director. Men assist in bathing and feeding male clients, fetching water and firewood and counselling clients and their families. Male involvement is low even in support groups. Kushingisana support group in Chinhoyi urban has 28 members and of these, only three are male.

## **2.4 Catholic Health Care Commission**

### **Brief History**

The Diocese of Chinhoyi home-based care programme has been in existence since 1991. During this time, it was operating as a health department under Catholic Development Commission (CADEC) and was functional in five Mission Hospitals and in three other parishes. In 2001, an evaluation report indicated the need for the health care component to be an independent entity if it were to be effective. Hence the Catholic Health Care Commission (CHCC) was formed.

### **Planning**

The Catholic Health Care Commission has a policy making body and an executing arm. The policy making body consists of the Bishop, his Ex-Officio, and the CHCC team, which includes the pastoral representative and the staff on the ground; the Health Co-ordinator, the Herbal Project Manager, and doctors, matrons and administrators from each Mission hospital. CHCC provides home-based care services to nine focal areas, including Mhangura, Karoi, Mutorashanga, Hurungwe, Mt Darwin, St Kizito, St Johns (Alaska), Sacred Heart (Banket) and Guruve. Regular meetings are held with caregivers to discuss the challenges they face on the ground.

### Programme Design

CHCC has a number of programmes which include OVC (educational assistance), a Youth Programme (Prevention, life skills), care of OVC and HBC. CHCC emphasises psychosocial support for people living positively. CHCC is guided by the national strategy, HBC and National HIV and AIDS policies, and also works closely with the MOHCW in most of its activities, which include training of care givers, supervisors and so on. In total, CHCC has 300 patients and 30 caregivers.

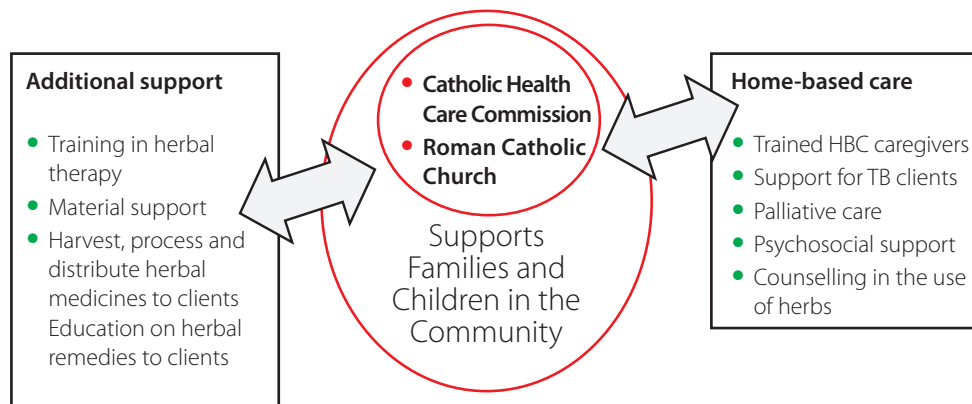


FIGURE 6 Programme design for CHCC

To combat the scarcity of medicines, especially for the poor, CHCC introduced a new project using herbal remedies as a way of sustaining lives and treating OIs. The Herbal project started in 2002s. As highlighted by the Herbal Project Manager, Mr Taurai Mpofu, "We had no medication to give them despite visiting them to assist in whatever way we give could. The caregivers did not have any drugs to dispense and so it was a challenge for us". CHCC liaised with Fambidzanai Permaculture for herbs and seedlings known to be effective internationally and locally. In all the communities the herbal gardens are available either at the Parish, or at caregivers' and clients' homes.

### Funding

Irish Aid has supported a special focus on medicinal herbs to treat common opportunistic infections faced by PLHIV. In addition, Irish Aid supports the programme with HBC kits, training, bicycles for volunteers, caregiver uniforms including shoes and badges, and seedlings for the herbal gardens. CRS provides funding for additional programmes for CHCC's OVC and Youth programmes (educational assistance and survival skills).

### Volunteer Management (Selection, Training and Retention)

The total population served by the Irish Aid project is 300 people, who are cared for by 30 caregivers. CHCC's ideal ratio per caregiver is one caregiver to ten patients. However, as highlighted by one caregiver Mrs Mubayiwa, in St Kizito parish, the situation on the ground is not like that. "Every caregiver is supposed to have ten patients but with the demand for our services and the herbs, the number of clients is increasing up to 25 clients per caregiver and you cannot ignore the clients if they want help"

### VOLUNTEERS WITH CHCC ARE EXPECTED TO:

- Pay regular visits to clients on HBC twice each week, or thrice if they are bedridden
- Attend meetings at nearest health centre for reports, information and resource sharing
- Maintain herbal gardens within the respective areas
- Harvest, process and distribute herbal medicines to clients
- Counsel both HBC clients and the affected on issues concerning HIV and AIDS (Psycho-social support)
- Document the information pertaining to the needs, progress and reports obtained from HBC clients and the primary caregivers
- Refer to the hospital where necessary
- Information on general hygiene
- Provide education on writing wills
- Provide education on herbal remedies to clients and primary care givers
- Offer adherence support to clients on TB treatment (DOTS) or ART in their areas

To support and motivate the volunteer caregivers, CHCC provides volunteers with: HBC kits, bicycles and volunteer uniforms, including badges and shoes, refresher courses and regular support visits.

The caregivers receive training twice a year. The training aims to enhance the volunteers' skills in nursing care, counselling, and provision of health education and herbal remedies. The Health Co-ordinator for CHCC, Mrs. Nyamayaro, emphasises that their caregivers are trained not to discriminate against any type of disease. She stated that *"We train them to treat them equally and with similar respect. Even those positive must not be discriminated against"*. The actual training of the volunteers involves a participatory approach and practical work. CHCC abides by the national standard guidelines on HBC training.

#### **Gender Balance**

CHCC still have a challenge on gender balance. CHCC managed to recruit 26 females and only four males in all nine operational areas. However women caregivers have expressed their limitations in giving care to males. As highlighted by Mrs Nyamayaro, *"We are trying to mainstream male caregivers to come on board we want men to prove that they are equally competent to nurse patients"*.

## **2.5 Dananai Home Based Care**

### **Brief History**

Dananai was established in 1992, as an extension of the Roman Catholic Church-funded Murambinda Mission Hospital. At this time, the hospital noted an increase in patients coming for treatment of opportunistic infections. However, many did not seem to get better. Those who were admitted were not fit to be discharged. Due to the escalating numbers, the hospital authorities decided that some had to be discharged to their homes, but the hospital would continue to follow their progress and provide them the necessary treatment.

The number of patients discharged for home care continued to increase and soon became too many for the hospital outreach team. It was decided that a cadre of locally based volunteer caregivers should be trained, to offer basic primary care services to clients. The majority of individuals trained were church members who felt spiritually called upon to serve. The model of home care then changed from being hospital-run to one that was community-based. The initial approach was to provide palliative care, which caused the community to openly criticise Dananai's

intervention, as it was perceived to be synonymous with death. From the community's perspective, all the patients visited by Dananai volunteers eventually died. This perception has since changed with the advent of ARVs and an ART service as part of Dananai's HBC programme.

Irish Aid is in four wards, that is, 12, 16, 18 and 19 and covers 1,200 clients, all of whom are located in Buhera North. Of these, less than 10% are bed-ridden, due to the advent of ARVs, about 15% are home-bound and the mobile (up-and-about) constitute 75%. All clients are HIV- positive.

### **Planning**

Every November, Dananai meets with volunteer caregivers to get feedback on the needs of clients. The HBC co-ordinator also meets with assistants including the driver and the finance person. Everyone is invited to make a contribution to the coming year's annual work-plan. Ideas from clients, volunteers and staff are incorporated into the annual work-plan and budget. Feedback on the final plan and budget is provided to all players, including the primary care givers.

Dananai's annual work-plan is further subdivided into a quarterly plan. Each activity is accounted for by a report on the respective activity, noting achievements or problems. People on the ground measure the impact on a daily basis. On the plans, clients are recorded by category; home-bound, bed-bound and mobile. These categories have implications for the nature of care and support required or expected:

- (1) Home-bound - should be visited twice a week by secondary caregiver
- (2) Bed-bound - to be visited thrice a week or more by the secondary caregiver
- (3) The mobile - can actually make a trip to the secondary caregiver to seek attention

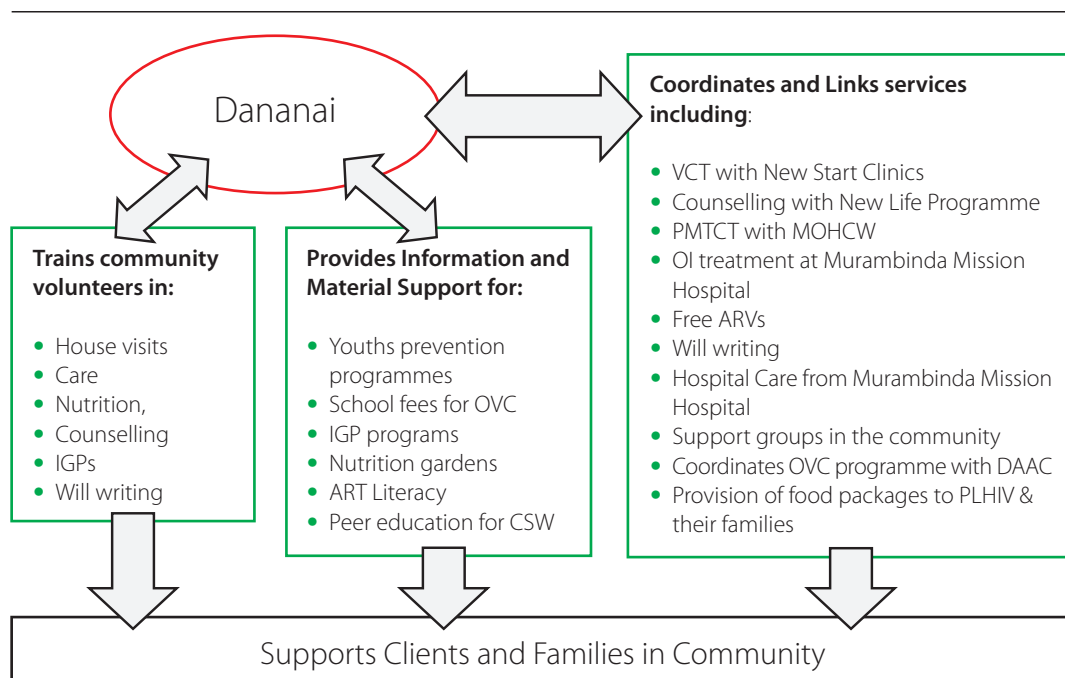
### **Funding**

*Two main donors, Irish Aid and Project Support Group (PSG) fund the Dananai Project. Irish Aid funds activities in four wards and PSG sponsors the other 16 wards.*

### **Programme Design**

Dananai's HBC programme design is principally modelled around a supermarket approach. It is a highly integrated model offering comprehensive services under one umbrella. The HBC service covers OVC, Youths Programme, Prevention, Treatment, Nutrition/Food distribution and IGPs. At the core of HBC services is the provision of HBC kits, house visits, nutrition guidance, adherence to medication, psycho-social support to both clients and OVC, assistance with will writing and the provision of basic information about HIV and AIDS to clients and their families. The activity of will writing emerged from noting that orphans of HBC clients were being left with nothing to live on because members of the extended family helped themselves to whatever remained of

the deceased's estate and the need to look after orphans by way of starting an OVC programme arose. The OVC programme entails provision of educational support and food packs with assistance from WFP. As the orphans grew up to become adults there were new threats of them being infected by the virus, hence Dananai started a 'Youth We Care' programme for behaviour change, involving information dissemination on HIV and AIDS issues.



**FIGURE 7** Programme Design for Dananai Home-Based Care

The HBC programme had to be integrated with IGPs to attend to the socio-economic needs of clients and their families, and these were introduced in the form of nutrition gardens, manual peanut butter making machines and small livestock production. However scarcity of water is a major challenge to the nutrition gardens.

Another facet of Dananai HBC is their VCT service, which is located next to the OI clinic. The VCT programme is strongly driven by a prevention programme with the active involvement of support groups for PLHIV. However, the issue of shared confidentiality is still an issue, with some husbands presenting themselves for testing but being unwilling to share their test results with their wives, especially when they are found to be HIV positive.

The ART clinic is a crucial component of Dananai HBC programme. It ensures that HBC clients and prospective clients (staged by WHO standards) are enrolled for ART. This has resulted in the HBC programme shifting from palliative care to client recovery. Nonetheless, adherence remains a problem for some rural people who cannot afford the bus fare to visit ART centres, which although they have now been decentralised to local clinics, are still far away from some clients.

#### **Volunteer Management (Selection, Training and Retention)**

Currently, Dananai has 65 group leaders who supervise 254 volunteers. While the initial selection was of people coming from different churches, it is well known that their respective Headmen can select those who have expressed interest in becoming caregivers. In terms of personal attributes, generally the expectation is that the prospective volunteers are approachable (*"anosvikika"*) and kind people. Dananai has a Code of Conduct for volunteer management. The Code stipulates that volunteers should not visit the client when drunk and in addition it requires that when a volunteer leaves his area of operation he/she should notify the group leader or other members.

The caregivers are trained for two weeks and later undergo refresher courses. They are trained in the provision of quality of care and support, as well as report writing. During training, a number of topics are covered and these include basic primary nursing care, hygiene, and information on HIV and AIDS, counselling, nutrition, communication and positive living. Training of caregivers is conducted by a multiplicity of partners. The HBC co-ordinator covers basic primary care, while other partners such as MSF (Medicin San Frontieres) cover treatment or dispensing of ARVs, and the Nutrition Department of the MOHCW covers issues to do with care and nutrition. Irish Aid

provides funding and technical assistance is provided by the DAAC. Training on TB is facilitated through the organisation, TB Alert. Secondary caregivers are trained in the identification of potential TB cases and general awareness in how people get TB. Dananai also trains caregivers in identifying needy orphans and helps organise behaviour change workshops for OVC. For herbs, The Centre, in Harare, has provided an expert to work with Dananai and the caregivers to train them and provide seeds for growing herbs.

Dananai uses participatory methods, including role-plays, focus group discussions and others to train its caregivers and all 254 caregivers have been trained. Dananai volunteers noted that they used to receive additional training several times a year, but this has changed over time in line with the economic environment. This was highlighted by one volunteer in Bedza ward, who said, *“When Dananai started we used to go to Murambinda for refresher courses four or five times a year but these days either its only once or twice a year”*. As a follow up on training, Dananai has a form or checklist of activities done. The group leaders or caregivers use a list to check the quality of care being provided. Assistants to the co-ordinator use the same checklist for random spot checks.

#### ROLE OF VOLUNTEER CARE- GIVERS WITH DANANAI

- Home visits
- Train primary caregivers on basic nursing, nutrition depending on whether the client is on TB treatment, or on ARVs.
- Counselling on Treatment literacy
- Training on low input gardening for both volunteers and beneficiaries
- Hygiene
- Reminding clients on review dates
- Counselling
- Educating clients on will writing

Guarding against volunteer burnout is also a significant element of Dananai’s volunteer management plan. Firstly, volunteer caregivers are advised to spent 2 hours or less per day with patients. They are also counselled every month during monthly meetings. Internal or inter-ward exchange visits are organised to expose the caregivers to each other’s work challenges, thereby assisting each other to cope physically and psychologically with whatever burden of care they face.

Volunteer retention is taken seriously and Dananai provides a number of incentives. These include; T-shirts, shirt, trousers or skirt, shoes, bicycles, home-based care kits and satchel. The significance of incentives was underscored by one volunteer who remarked that: *“Yes we understand that we volunteered this job but we also want something to motivate ourselves and also recognising our efforts and to make our families survive because sometimes we spend the whole day visiting clients and this does not make our families survive.”*

*In addition, to these incentives, men are assisted with income generating projects. Men are recognised as breadwinners and are provided with capital for projects to realise a bit of cash to help sustain their families. Otherwise they would go elsewhere to seek ‘chouviri’ (alternative form of livelihood). Hence, male volunteers have been provided with peanut butter making machines (manual and electric), as well as bicycles and a rabbit project (this project is passed on to clients and OVC. Caregivers have to benefit first but some clients are already also benefiting).*

Volunteers are expected to submit reports to their supervisors every month, who then submit them to the HBC field officers and the Co-ordinator. The caregivers visit clients two to three times a week. In the words of one volunteer, *“At first we used to move from door to door looking for patients, but now the people are now chasing after us and we are friends”*

Dananai tries to attend to issues of stigma and discrimination by raising awareness on clients' rights, in training and other fora. Generally this has led to a marked reduction in clients experiencing stigma and discrimination. Previously orphans of people who died of AIDS lived alone, but now they are increasingly being taken care of by next of kin. Caregivers have brought about harmony in homes especially on stigma and discrimination. As one caregiver in Murambinda said, "*Kare kwaiva nekusemana kusingaite asi mazuva ano vanhu vava kunzwisisa ruzivo rwatiri kuvapa maererano nechirwere. Muchidimbu ndingangoti taudza runyararo pakati pemhuri.*"<sup>1</sup>

### **Gender Balance**

With reference to coverage of gender issues, in training, Dananai tries to empower men to be more involved in issues of care through male empowerment training. The organisation undertook a look-and-learn mission with the Male Empowerment Project in Hauna (Mutasa District). In 2000, out of the 300 care givers there were only six men, but now with male empowerment awareness, in the four Irish AIDS wards the ratio is 50-50 (120 caregivers; 60 males and 60 females. )

## **2.6 Male Empowerment Project (MEP)**

### **Brief History**

The Male Empowerment Project (MEP) in community Home-Based Care (CHBC) is a gender based care and support initiative, launched by Africare in Mutasa District, in February, 2002. Initially Kodak funded the project and it was scaled up when Development Co-operation Ireland (now Irish Aid) and John Snow International Project when they came on board. The initiative came about to address the findings of a baseline survey conducted by Africare, in the wards where it was involved in orphan care. The survey indicated that only female secondary caregivers were providing physical nursing care to PLHIV in Mutasa. This was noted amidst a situation where male clients felt they would get better support if they were visited by male caregivers. Besides, it emerged that prevention efforts could be better leveraged if males were actively involved. The baseline also found out that about 70% of admissions at Hauna District Hospital, the major referral hospital in the district, were related to HIV and AIDS. The poorly resourced local health institutions were overstretched in terms of meeting the needs of their communities, and HBC provided an alternative path to care and support of PLHIV in the area. The goal of Male Empowerment HBC project was therefore to increase male participation in HIV prevention, care and support for PLHIV, while supporting the involvement of female MOHCW-trained caregivers. The focus was on social change, where both men and women share the responsibility for providing care and support to immediate family members and to communities at large, while providing a link to other much needed support services.

Research findings on HIV indicate that men are in the forefront of the spread of HIV, hence the need for their involvement in prevention, care and support. According to Mr. Rambwiwa, the Africare Officer for MEP, "*Men cannot hide behind patriarchy and machismo. That role needed to be revisited to ensure that more men owned up to their role in the spreading of the virus and also get more involved in dealing with the consequences of the spreading of the virus-HBC.*"

During phase 1 of the project (Feb 2002 to March 2003), eighty men were recruited in four wards, Mandeya, Samanga A and B and Zindi. They were trained in history taking and recording; HIV and AIDS transmission, disease progression, and prevention; basic nursing care and bereavement counselling. Each volunteer caregiver (VCG) continued to offer services to their clients and received a home-based care kit that was replenished regularly. The initial group of trainee caregivers was not well received by the community, because they had been picked from other areas and made to work in an area where they did not stay. Besides being costly for the VCGs, this practice was unpopular. In the words of one member of the community, the question posed was,

<sup>1</sup> In the past people used to discriminate against PLHIV but nowadays with the knowledge we are giving them about the disease the situation is different. In short, we have brought tremendous harmony to the affected families.

*“Matisarudzira munhu wenyu. Ko isu hatinavo here vanobva muno medu vangazvigona”, meaning, “You have made a selection on our behalf and given us your person. Aren’t there any people in our community capable of being trained to offer similar services”.*

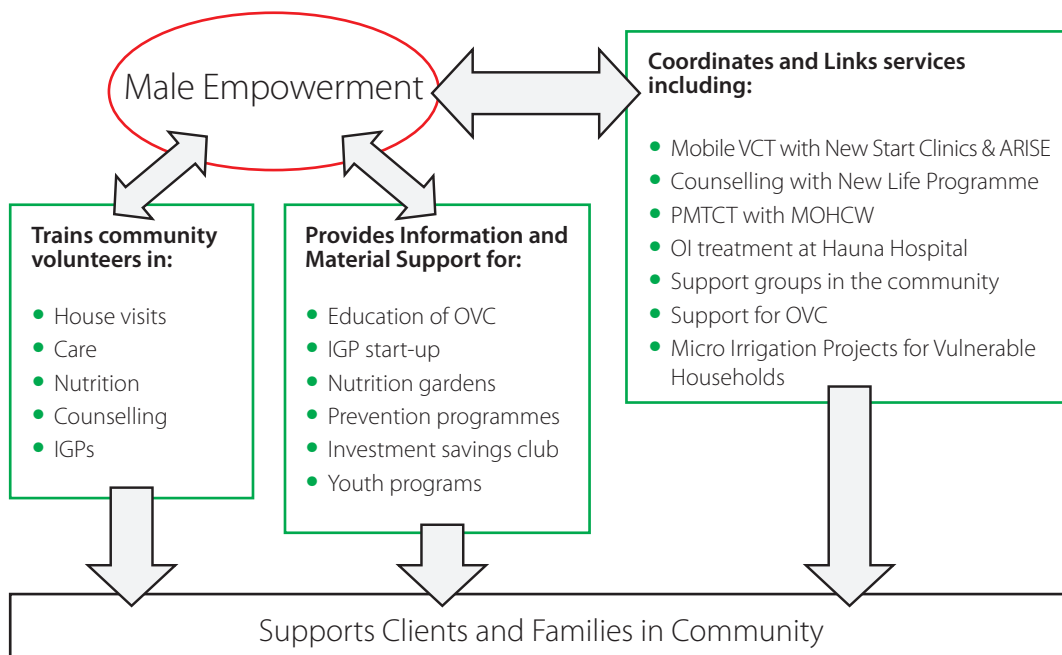
In Phase II (April 2003 to August 2004), the project expanded to two additional Wards and incorporated female VCGs in all six wards, who were from the Ministry of Health. The total number of VCGs rose to 240 with fifty percent representation of the sexes. Phase III (January 2005 to December 2005) expanded the project into two other wards. An additional 80 VCGs were recruited along with eight supervisors to strengthen the monitoring and support of VCGs in all eight wards.

MEP currently operates in 9 wards in Mutasa District, which consists of about 180 villages. In all, 1,400 clients are involved, including PLHIV

### Planning

Stakeholders participate in generating a detailed implementation plan. The plan developed at the beginning of the project, provides the general strategic scope. It is then the responsibility of the officer to share the contents of the plan with volunteers through workshops, on-site training, field trips and home visits. The implementation plan highlights roles and activities to be achieved through the work of volunteers. The plans are backed by M&E tools which are designed to capture the project implementation process. The MEP monitoring and evaluation tools feed into the national system.

### Programme Design



**FIGURE 8** Programme Design Male Empowerment Project

MEP has an integrated HBC programme which comprises VCGs, the Young People We Care (YPWC), Nutrition on Wheels (NOW), VCT and Protection for Children Affected by HIV/AIDS (COPE for CABA), the Micro Irrigation Projects for Vulnerable Households (MIPVH) and an Income Saving and Lending scheme. Members of the YPWC project assist the VCGs in their HBC work by carrying out household chores such as fetching water and firewood, lessening the VCGs burden of care and support for clients. More importantly the youths’ participation in supporting clients, including PLHIV, has the effect of keeping the youths out of mischief and deterring them from engaging in early sex. In essence, it is a good prevention strategy.

MIPVH has greatly improved the lives of households affected by HIV and AIDS. The drip kits provided under this project ensured the availability of sustainable nutrition in households affected by AIDS. MEP integrated the micro irrigation projects with the home nutrition gardens (HNG) concept and provided starter seed packs to 800 HBC client households to improve their food security and nutritional status. The organisation established a 'live fence' nursery at their sub-office in Mutasa. Two HNG have been identified to become demonstration sites meant to promote live fencing. However, the greatest challenge is the maintenance of broken-down drip kits and the lack of appropriate fencing materials to secure their garden produce from animals.

A sustainable nutritional support for Orphans and other vulnerable children was launched at Muterere High School in Mandeya ward, supporting 55 OVC households utilising the pass-on-the-gift concept. This initiative has also been adopted under phase four of the male empowerment initiative to provide small livestock (rabbits) to HBC client households. The drip irrigated low input gardens are complemented by small livestock production projects with the provision of starter rabbits.

Africare provided rabbits to HBC client households in three male empowerment wards. The intervention has benefited 87 HBC households in Muparutsa, Samanga B and Samaringa wards. The initial 37 households received two Does (female rabbits for breeding). Each household is expected to pass on 8 female rabbits to 4 additional households, until a total of 250 households are reached. Beneficiaries utilise excess rabbits for household consumption, as well as improving their economic status. This has greatly transformed the quality of life in households affected by HIV and AIDS.

MEP through Africare (a WFP implementing Agency), provided nutritional support to vulnerable households, through a targeted feeding project called the Nutrition on Wheels (NOW) project. HBC clients and OVC identified through the male empowerment project received monthly food rations, comprising of 10kg of cereals, 1.8 kg of pulses and 0.45 kg of vegetable oil. The initiative benefited more than 70,000 individuals in 24 wards, including beneficiaries registered from 3 non-male empowerment wards with the help of Ward AIDS Action Committees (WAAC), local clinics and MOHCW trained VCGs. The support of monthly food rations was provided up to September 2007.

A local CBO, ARISE, in collaboration with the New Start Centre from Mutare, compliments the project to provide voluntary counselling and testing (VCT) services in the MEP wards. As a result of the mobile VCT, a total of 21 support groups for PLHIV have been formed. The support groups have a total membership of 624 registered PLHIV from 10 wards. Zimbabwe National Network for PLHIV (ZNNP+) compliments the support provided by ARISE and mobilises PLHIV in other wards.

Africare has integrated the income saving and lending concept to the male empowerment HBC project. The organisation formed 24 self-managed ISALs with more than 160 VCGs, OVC and PLHIV. The initiative is intended to encourage self-reliance, which will ultimately improve their economic status. ISALs are made up of small manageable groups of not more than 10 members. Members are encouraged to make monthly contributions towards their self-managed savings club. The fund grows by lending the money to group members and charging interest of between 25 to 50% per month. Group members have access to loans, which they use to fund their children's education, buy agricultural inputs, and cover medical expenses and food for their families. The groups generated more than seventeen and a half million Zimbabwe dollars which was in circulation for the period January to June 2007. The organisation provides skills that ensure members are able to manage the voluntary savings groups.

## **Funding**

The following donors have funded MEP activities:

- 1) Irish Aid – training of care givers, as well as funding a spectrum of activities such as administration, salaries, procurement of HBC kits and others
- 2) John Snow International (JSI) - funded the roll out programme from the initial four wards to eight in Mutasa District
- 3) Kodak - funded the inception of the project but only in two wards
- 4) International Fund for Agricultural Development

Currently 70% of MEP funds are committed to programme implementation, while the remainder goes to salaries and administration costs.

## **Volunteer Management (Selection, Training and Retention)**

On the selection of caregivers the following components were included in the criteria for caregivers; functional literacy; commitment to freely assist community members, respected by the community; maturity, and approachability, as defined by the community. The headmen are also involved in the selection of the caregivers and recommend certain people. The selection and training of VCGs of both sexes is intended to ensure that clients of both sexes have equal access to project services. Female VCGs were selected from a group that had previously worked with the MOHCW

MEP has noted that the older the VCG, the better the quality of care and the longer one is likely to be involved in the provision of volunteer care and support services. In addition, the longer the distance one travels to render one's services the more taxed one becomes and is tempted to give up. The trick in retention therefore is to make sure people offer volunteer services near their homes. The combination of being more mature, operating around one's home and dealing with acquaintances, makes older age an asset to the provision of volunteer services. Older people care also better able to endure pain and the trauma of seeing people dying. In the words of the Africare Officer: "*Vatsiga hana uye vatira nendufu* (They have become accustomed to seeing people die)" Older VCGs no longer have the desire to leave home and seek employment in distant places. The fact that they are selected by the local community encourages them to remain in the volunteer service since it also brings the prestige of trust from one's community.

Africare (MEP) has its own volunteer policy, which binds the organisation to attend to the welfare of VCGs such as addressing issues of burn out. MEP undertakes one to one counselling with VCGs or refers them to professional counselling NGOs, such as ARISE, based at Hauna Growth Point. The organisation also ensures that VCGs have a manageable number of clients i.e. not more than six patients per volunteer, two hours per client per week and a total of 12 hours per week.

## **Training**

The content of the training plan is informed by the findings of the baseline study and also by national HBC standards. In training, MEP uses the lecture method, group discussion, demonstrations and role-plays. Initial training for volunteers takes one to two weeks and refresher courses are held once a year per group of VCGs. Trainees are assessed both before and after training and at the end of each training a course evaluation is conducted.

Later refresher courses are organised to continuously update VCGs on job related skills and knowledge. These refresher courses utilise a participatory approach that enables all members to take part during the training process. The content is similar to the initial training except that some of the topics address gaps identified during the initial training courses. This ensures that new VCGs (especially the men who were novices in this field) would be able to implement activities without problems.

The wife of one beneficiary commented on refresher courses during a focus group discussion: *“Visits have been very helpful to me as I now have so much knowledge on how to look after my husband. The refresher course taught me so much as well as supports me in the care of my husband. During the refresher courses they check if we have bathed, fed or exercised my husband*

Community leaders such as village heads, local councillors and church ministers also took part in some of the participatory trainings when refresher courses were being held in their wards. This helped to improve appreciation of the project activities by the community leaders. On monitoring and evaluation issues the caregivers report to the supervisor and submit reports every month. The supervisor submits the reports to the local clinic and to the Africare HBC co-ordinator. In their respective wards the caregivers meet one Monday a month to update each other on their work and to discuss any challenges they may have.

The Africare volunteer policy is silent on incentives. However, the first phase was characterised by the provision of HBC kits and T-shirts as volunteer uniforms. The second phase saw volunteers being issued with bicycles and cash, though this was later discontinued because of the cost constraints of operating in a hyper-inflationary macro-economic environment. The last form of incentive was the provision of food packs from WFP.

### **Gender Balance**

The inclusion of both male and female caregivers allowed the project to serve both male and female clients, according to their needs and comfort levels. An equal number of males and females serve as VCGs and volunteer supervisors.

## **2.7 New Dawn of Hope**

### **Brief History**

New Dawn of Hope is a community-based organisation in Mufakose high density suburb in the south west district of Harare. The majority of people living in Mufakose are descendants of migrant workers from neighbouring countries i.e. Malawi, Zambia and Mozambique. The HBC programme for New Dawn of Hope under the Irish Aid programme, started in January 2006. The programme was implemented in three wards, namely wards 34, 35 and 36).

The New Dawn of Hope project offers a Home-based care package, which includes HIV counselling to clients, basic home-based medical care, nutrition support and advice, HIV and STI education, counselling for family members, psychosocial support and basic education assistance to orphans of their clients. New Dawn of Hope has implemented a participatory approach in its programme activities by involving local leaders and also empowering the communities with self-reliance skills to ensure sustainability. The HBC project has been built on volunteerism and has managed to recruit 74 caregivers who are responsible for the provision of care and support to 237 clients in Mufakose.

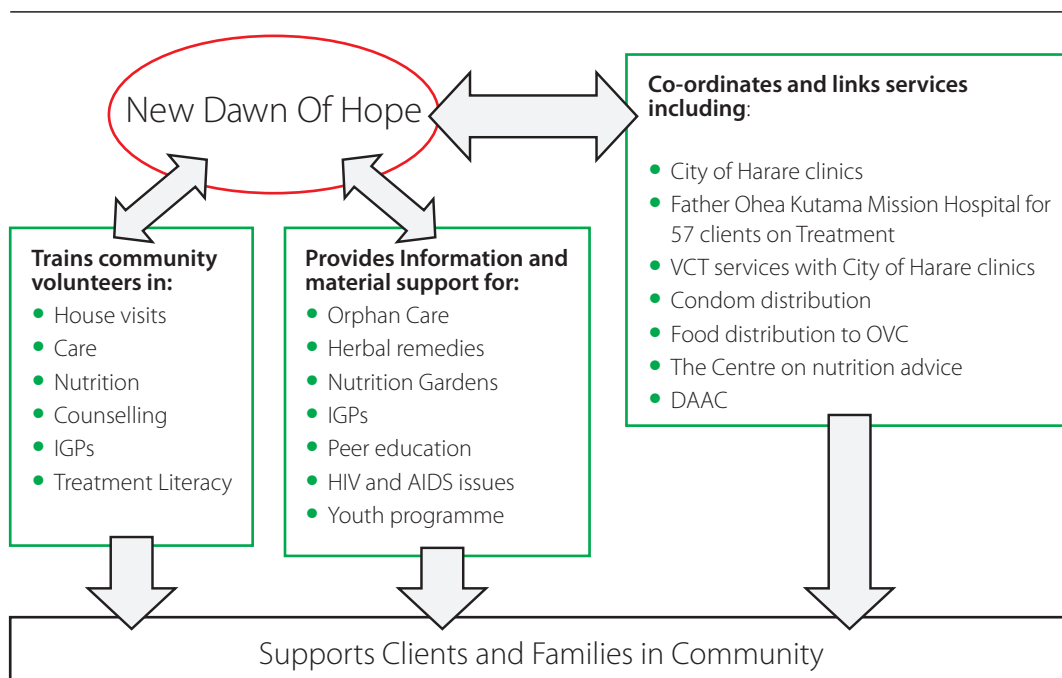
### **Planning**

New Dawn of Hope believes in participatory planning. In pursuit of this value the organisation ensures that the stakeholders and volunteers are fully involved in all planning processes, from the formulation of the strategic plan to the development of the annual work-plan.

### **Programme Design**

New Dawn of Hope has a number of programmes, which comprise: care of OVC; the HBC programme, which emphasises psychosocial support to people living positively; a Youth Programme (for prevention, condom distribution, awareness and information dissemination); nutrition support and advice; income generating projects and food distribution. Clients already registered with clinics for TB or ARV treatment give their Treatment Cards to caregivers who check their adherence to medication.

Like most organisations with HBC programmes, New Dawn of Hope is guided by the national strategy, HBC and National HIV and AIDS policies and also works hand in hand with the District



**FIGURE 9** Programme Design for New Dawn of Hope

Aids Co-ordinators, the local clinic and Mission hospitals such as the Father O’Shea Mission Hospital, which also offers antiretroviral drugs to their 57 clients. Client selection is done by the community or by beneficiaries who refer other clients to New Dawn of Hope offices and present their cases. New Dawn of Hope’s discharge of clients is on death or transfer to another area.

### **Funding**

New Dawn of Hope is funded by a number of donors:

- Irish Aid provides HBC kits, volunteer uniforms, bicycles for supervisors, medical fees for clients, education assistance
- Action Aid/JSI provides trainings in treatment literacy and food packs
- ZIMSUN pays for educational assistance to OVC, blankets and clothes
- Lotto provides HBC kits
- Island Hospaz provides clinic services for children
- Mayor’s Cheer Fund covers educational assistance, clothes, blankets for OVC
- VSO has supported training for caregivers

### **Volunteer Management (Selection, Training and Retention)**

Individuals are invited to be considered for a volunteer position. The Programme Officer reads out the conditions and the volunteer is agreeable then they begin to work. The volunteer provides service in their own area of residence, normally under two supervisors.

For New Dawn of Hope, volunteers are required to work two days a week and four hours a day. The caregivers are not supposed to report for duty when they are ill, nor are they supposed to volunteer for any other organisation. Caregivers must not abuse the organisation’s property for other purposes, or New Dawn of Hope will withdraw the property from the individual.

New Dawn of Hope has an effective way of managing caregivers, including follow-up visits by the HBC promoter, supervisor, field officer and Programme officer. They also have a weekly reporting system, whereby the caregiver completes a form on the activities and services that he/she has given to clients, which are submitted to their supervisors who then submit to the field officer. The primary care giver also keeps a client report form, which is usually completed by the caregiver and is there to monitor both the volunteer and the patient. After completion it is submitted to New Dawn. Monitoring of visits to clients by volunteers is also employed to evaluate the effectiveness of training undertaken at any one time.

Out of the 74 caregivers, only 25 receive some form of incentive. The package includes cash and Corn/soya porridge. However volunteers are sometimes given an allowance if they participate in workshops as a form of motivation. Volunteers are provided with HBC kits, bicycles and volunteer uniforms and New Dawn of Hope also supports their income generating projects (IGPs). The client to volunteer ratio is ideally one carer to two clients but on the ground, each caregiver is taking care of four to five clients.

New Dawn of Hope has been addressing the issue of burn-out through a strategy which includes counselling and encouraging the volunteers to rest.

Training for volunteers usually covers 10–14 days and utilises the facilitation approach combined with practical activities. MOHCW and other relevant players such as Island Hospice carry out most of the training of volunteers. Refresher courses are done as and when the need arises and when there is enough funding. In addition, monthly meetings are used as time to reflect on the impact of training. To date 74 volunteers have been trained and are working. Volunteer training topics include: basic nursing care, counselling, treatment literacy, basic facts on HIV and AIDS, positive living, report writing skills, nutrition, hygiene and nutrition.

#### ***Community Ownership and Involvement***

The community has provided volunteers for the programme and supports the activities by making food contributions as and when requested. They also assist OVC with the purchase of educational materials. Volunteers are also involved in cooking food for OVC every Wednesday at a central place in Mufakose.

#### ***Gender Balance***

For New Dawn of Hope gender balance is still a challenge and female caregivers are predominant. However, some women have expressed concern over their limitations in providing care to males.

## **2.8 Fact Chiredzi Home-based Care Programme**

### ***Brief History***

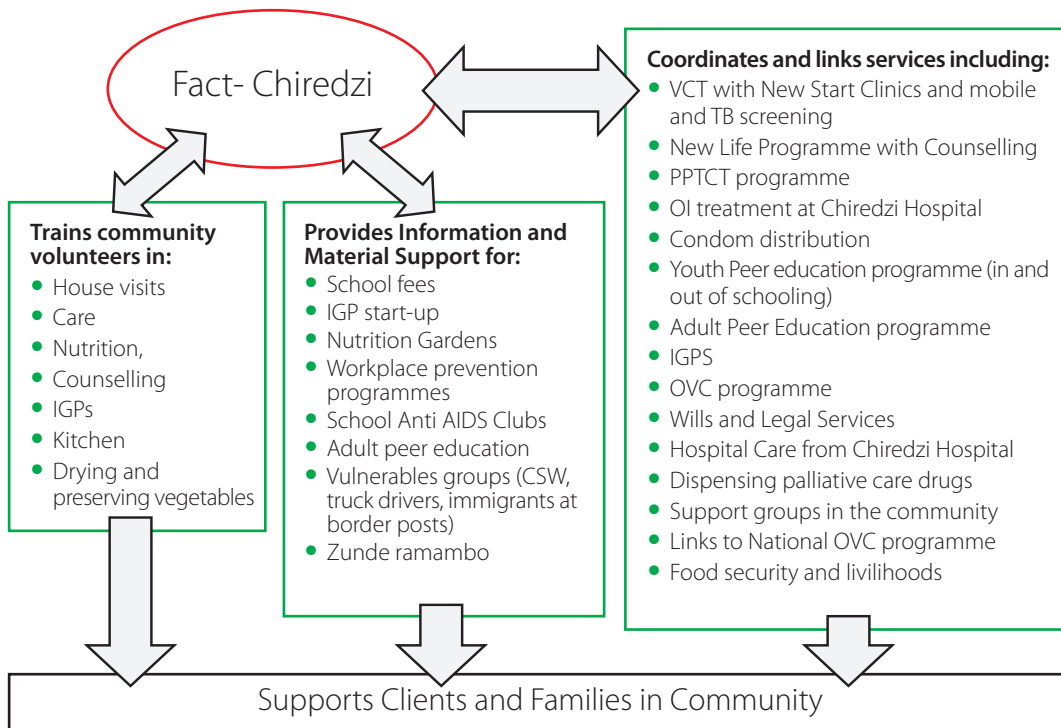
Family AIDS Caring Trust (FACT) -Chiredzi is a Christian interdenominational AIDS service Organisation registered with the Department of Social Welfare situated in Chiredzi District, Masvingo Province in South-Eastern Zimbabwe. It was formed in August 1992 by a concerned group of Christians to serve the poorest and most vulnerable individuals in Chiredzi Urban. As FACT-Chiredzi grew, it also reached out into the surrounding farms, Chiredzi Urban, Matibi II and Sangwe communal areas. Its initial activities were focused on prevention among youth, vulnerable adults and rural groups. It then developed HIV and AIDS voluntary counselling, community care and support services for AIDS orphans and people with HIV, and their families.

Currently, FACT-Chiredzi has expanded to cover Ngundu Business Centre, the border posts of Crooks, Chicualacuala and Sango, Zaka and Bikita rural communities including new settlements; Gwachara, Feversham, Muzembi, Chipimbi, Chizvirizvi and Samba Ranch; Growth Points (Ngundu, Zaka and Bikita rural communities); Mwenezi and the commercial Farms of Hippo Valley and Mkwesine.

### ***Planning***

The organisation conducts strategic planning meetings when necessary as well as annual planning meetings. HBC volunteers and the community also contribute towards the planning process. Staff conduct needs assessments before developing their work-plan. These issues are considered at the planning meeting. The last planning meetings were held in December 2006 and July 2007.

## Programme Design



**FIGURE 10** Programme Design for FACT Chiredzi

The HBC programme reaches out to 1,000 clients and targets people with chronic illnesses such as cancer, diabetes, hypertension and PLHIV. Volunteers are provided with HBC kits, which comprise gloves, bar soap, Vaseline, Jik, macintosh, bandages, betadine, IEC materials. However the contents vary due to different donors. Some include a bucket, dietary mix and sheets. Volunteers assist with bathing, feeding and counselling HBC clients. They also train family members on how to care for their sick relative.

The HBC programme provides post-test services to clients visiting the New Start Centre within the FACT offices as well as supportive counselling to workplace programmes. FACT works with Mkwazine and Hippo Valley Estates and the Zimbabwe Sugar Association, which are private sector companies. The HBC programme also offers information to pregnant mothers at Chiredzi General Hospital and facilitates their enrolment onto the PMTCT programme. Adult peer educators are also trained to educate communities in high-risk groups such as truck drivers, sex workers and immigrants at the border posts. Condom distribution is also one of the services provided.

FACT-Chiredzi HBC programme has a department responsible for co-ordinating IGPs, targeted at orphans, secondary care givers, the client's family and the community at large. The IGPs are mainly agro-business related. There are two flourishing nutrition gardens, one in Chiredzi urban and another in Ngwana resettlement area. The community, including HBC members, owns both gardens. Members of the community gardens are empowered with gardening skills and grow vegetables such as rape, chomolia, carrots, onions, beetroots, peas, green beans and tomatoes. In the urban garden, only one member is growing herbs but at Ngwana there are no herbal gardens. The community members are also taught to dry the vegetables for use later in the year when vegetable are not readily available. The Chiredzi urban garden members have a unit they use to dry vegetables which takes about 4-5 hours. They are currently sourcing suitable packaging so that they can sell the dried vegetables to a wider market. The HBC programme offers drip irrigation to nutrition garden members so that they spend less time in the garden. They are also supported with fencing materials and seeds. There is a chicken run within the Chiredzi urban garden, but the project is not currently functional due to shortage of poultry feed and day old chicks.

It is important that the community is educated on herbs as alternative therapy to ARVs. It was also recommended that the community should grow a wider range of vegetables to include spinach, as it is highly nutritious. Ngwana garden produces a lot of vegetables, which can be sold to supermarkets in Chiredzi urban. This community needs to be assisted with marketing their produce for they have the potential to yield better profits.

All IGPs at FACT Chiredzi are required to donate 10% of their proceeds to marginalised groups and these funds are used to support the orphan care programme.

### **Funding**

FACT Chiredzi activities are funded by Irish AID, EED, Partnership Project, PSI, Africa Groups of Sweden, Project Support Group, Global Fund, Children of the World, OAK Zimbabwe Foundation and the National AIDS Council.

### **Volunteer Management (Selection, Training and Retention)**

FACT-Chiredzi currently has 476 trained secondary caregivers with 376 females and 100 males. Volunteers are selected by the community. A meeting is held to introduce the community to HBC and to the volunteer concept. The community then selects suitable volunteers based on their character and Christian values. Occasionally, the police are also involved in the selection process where OVCs are involved.

The training programme consists of an initial course where volunteers are equipped with skills on HBC, basic counselling and nutrition. HBC and psychosocial support training manuals are used to conduct the training, which is conducted by the FACT HBC coordinators. Volunteers are also trained to screen clients with TB through identification of symptomatic presentation. These clients are then referred to Chiredzi General Hospital for further screening. Quarterly refresher courses are run, which include emerging issues such as ART and are organised at village level. After training, volunteers also train primary care givers in HBC skills and nutrition.

Volunteer activities include: conducting home visits, client assessment and referral for appropriate services, on site training for care and support, counselling clients and family on drug adherence, providing information on treatment, nutrition and livelihood activities, and compiling activity reports. A volunteer dedicates three to four hours a day, nearly every day if they stay close to the client's homestead. Each caregiver works with three clients. FACT-Chiredzi ensures that no volunteer is assigned to a client who lives more than five kilometres away. The volunteers also offer spiritual support since they are all from Christian backgrounds.

The HBC programme has a volunteer policy that addresses the welfare of volunteers. Volunteer burnout is dealt with by holding monthly meetings, where volunteers share experiences and challenges. The HBC co-ordinators are part of this meeting and help to counsel volunteers. Retention of volunteers is by equipping them with skills to run IGPs and also assisting them to access ARVs from Chiredzi hospital should they need them. Volunteer incentives include uniforms, two bars of soap per quarter, bicycles for supervisors and a Christmas party with presents depending on availability of funds. Volunteer retention is through engaging volunteers in IGPs so that they can sustain themselves.

### **Gender Balance**

There is very little male involvement in the FACT Chiredzi HBC programme, with only 21% of the caregivers being men and 79% women. The poor participation by men is because they want to be paid for services rendered. However, the programme continues to encourage men to assist in HBC activities. In Ngwana, a base commander and a male teacher are HBC caregivers. School teachers have been engaged as HBC caregivers in this ward as this helps them understand the programme encourages them to identify OVC in their area.

# Chapter 3: Findings

## 3.1 Evolution of Home-based Care

Home-based care is not a new concept among African people. There has always been an expectation of providing care and support within families and communities. Traditionally, women were entirely responsible for caring for the sick while men provided support in the form of food, firewood, shelter and water.

The home care services offered prior to and soon after independence, focused on people who were terminally ill with illnesses such as TB, cancer and hypertension. The hospital environment was not congested, and could afford to care for ill patients longer. There was adequate medication for most ailments, including opportunistic infections. During this period, when terminally ill patients were discharged from hospitals to home care, the respective hospital assigned a community nurse to follow up on the patient, advise on basic nursing care and provide psychosocial support. This was a medical approach to care with a palliative (pain alleviation) focus. There were few terminally ill patients so hospitals could afford to assign community nurses for follow-up, while most households were able to accommodate a relative who was discharged for home care.

### ***The Silent Epidemic (1980-1985)***

As early as 1981, AIDS was identified in the US among the 'gay' community. Internationally, prevention messages began to be communicated yet there was a general denial of the disease's existence in Africa. During this period of post-independence euphoria, Zimbabwe experienced a silent epidemic, until 1985, when the first case of AIDS was identified and acknowledged, but there was no publication of infection rates or illness. During this period there was also a notable increase in reported STI cases. However, Zimbabweans did not attach importance to HIV or its linkages to STIs.

### ***Medicalisation, Sensationalisation and Moralisation of HIV (1986-1990)***

This period was characterised by government's shift from denial phase to acceptance and action. Government established the National AIDS Control Programme and engaged in the mobilisation of resources towards prevention. A key activity during this period was the production and dissemination of fear-inducing IEC materials. Messages such as "AIDS kills...Beware!" and pictures of skulls and crossbones and coffins were used on posters about HIV. The nature and character of the virus was sensationalised, primarily by service providers, while at the same time, churches moralised about HIV and linked it to promiscuity and sin.

Anyone suspected of having the disease was isolated into 'high-care' quarantine units as AIDS was considered a highly contagious disease. There was a tendency towards institutional care and the emergence of 'care homes', such as Mashambanzou and others scattered around the country. This created high levels of fear, stigma and discrimination among the general population. Nonetheless, despite the stigma and discrimination, people such as Auxilla Chimusoro, publicly disclosed her status in 1989 and played a key role in educating people about the disease.

The numbers of people presenting with AIDS increased exponentially. From the single case identified in 1985, cases increased to 10,551 by 1991, putting a lot of pressure on the health sector. Simultaneously, the health care sector was undergoing restructuring following the introduction

of the Economic Structural Adjustment program (ESAP) in 1990. Under ESAP, Zimbabwe was to expedite its economic growth through the introduction of cost recovery measures, which meant that hospitals were expected to charge market related tariffs for their services to all people. The cumulative impact of the resulting neglect of non-productive sectors such as health, was a serious decline in the quality of health services and shortages of essential drugs. Hospital beds were constantly occupied, resulting in more discharges and strict screening processes.

At the same time more research was being done and more information was being made available about HIV. It became clear that there was no cure. As a result, hospitals began to send home people suspected of living with HIV when it appeared that they were not responding to the available treatments. Communities and families resented what they saw as a clear example of “dumping” of responsibilities by government.

Isabel Saungweme, the Director and Founder of Bekezela Home-based Care office said, *“It wasn’t easy for the general community to receive these people due to the environment of stigma and discrimination that existed”*. According to the HBC director of Dananai, when they visited communities in the early days, they were labelled, *“vaurai”* (killers). This was principally because there was no treatment, as such everyone visited by volunteers eventually died. On the other hand, relatives of clients would share similar pessimistic sentiments such as, *“Mwari dai machimuzorodza henyu”* (Oh God, give him rest). This was the context in which HBC interventions such as Batsirai (1988) arose.

#### ***Rise of Advocacy, Care and Support (1991-1995)***

The period 1991-1995 was very eventful in the nation’s commitment to respond to the epidemic, with more HIV and AIDS focused NGOs being formed, donors becoming more generous in funding HIV and AIDS activities and churches coming on board to give care and support to PLHIV. The Zimbabwe Aids Network (ZAN) was formed and PLHIV began shaking off the stigma and coming out to help in advocacy, care and support of people infected and affected. HBC was adopted as a national strategy, yet the policy would only be developed several years later.

The spread of the virus and the increase in mortality necessitated the establishment of many HBC interventions such as CHCC (1992), Fact Chiredzi (1992), Dananai (1992), and many others. Struggling to cope with the epidemic, communities were seeking a solution. Various models of HBC began to appear, including a church-linked model, the hospital-linked model, and the vertical community model.

In the church-linked model, the first volunteer groups were formed and driven by Christian values. Care volunteers visited homes to support in spiritual, “end of life” counselling and provide welfare support. In the hospital-linked model, community-outreach nurses provided follow-up care and surveillance to patients who had been discharged. In this model, HBC intervention was primarily an extension of hospital services. The third, a vertical community model, emerged to fill the gap in waning services due to increased pressure and lack of resources. Hospitals trained interested community groups, which provided an exit strategy for the hospitals. These community-based models were increasingly funded by NGOs.

In 1992, the Zimbabwe AIDS Network (ZAN) was formed as an umbrella body for the HIV and AIDS-related service organisations brought about by the reality of the epidemic. It was intended to formalise the numerous NGOs, which had mushroomed and to rationalise the use of the available donor funding. Advocacy and pressure from people living with HIV resulted in the formation of Zimbabwe National Network of People Living with HIV (ZNNP<sup>+</sup>), also in 1992. Of particular significance to the establishment of ZNNP<sup>+</sup> was the formation of support groups that assisted the HBC clients with psychosocial support and fighting HIV related stigma. The mobilisation of people living with HIV created a substantial change for HBC programmes and predominantly HIV positive clients were now being worked with by a cadre of HIV positive caregivers.

Equally, the introduction of VCT in 1995, in Zimbabwe, represented government's acceptance of the magnitude of the problem and its determination to take appropriate action. With the introduction of VCT many people who had contracted HIV became aware of their status and were discharged from hospitals into home-based care. The increase in demand for HBC required a corresponding increase in funding for either the establishment of new HBC centres, or sustaining the care activities of existing HBCs.

### ***Expansion of Care and Support- Multi-sectoral Approach (1996-2000)***

With a weakening economy and a burgeoning number of PLHIV, the government recognised that the health system alone could not cope with the impact of epidemic (increasing numbers of OVC, poverty and nutrition). In 1999, the Government streamlined the activities of NACP by creating the National AIDS Council and the AIDS and TB Unit in the Ministry of Health, as well as launched the National AIDS Policy. The role of NAC was to coordinate all national HIV and AIDS activities and interventions, including monitoring and evaluation. To facilitate the work of NAC, the Government introduced the innovative National AIDS Trust Fund commonly referred to as the AIDS Levy, which collected 3% tax on all taxable income. The Levy was to support HIV prevention efforts and care through decentralised structures.

The National AIDS Policy recognised Community Home Based Care (CHBC) as an extension of the health care delivery system to be fully developed and supported as an essential component of the continuum of care for PLHIV and their families. It also expressly called for the development of guidelines for an effective referral and discharge plan of patients to CHBC as an integral part of a continuum of care. It was at this time that HBC programmes were engaged in an extensive training of volunteers and primary carers. The models shifted from a focus on the volunteers as the primary care provider to volunteers becoming facilitators of care by training family members to become the primary caregivers. This shift was primarily driven by the rate of burnout experienced by volunteers. The provision of quality care became the key principle supported by the development of a minimum care package (HBC Kit). In addition, the National AIDS Policy (NAP) was calling for efforts to address burnout among care providers. This has become a very indispensable and integral part of volunteer management in CHBC programmes.

The impact of HIV and AIDS had ripple effects through the HBC interventions. With the emergence of OVC, death of breadwinners and increased poverty, there was a recognised need to integrate initiatives. Organisations that had been established for orphan care recognised the need to provide HBC to parents of potential orphans, while HBC organisations could not continue to ignore the orphans left behind by their clients. With breadwinners ill and dying, households were increasingly vulnerable. HBC interventions were being called upon to develop income-generating initiatives and provide livelihood support for remaining family members.

### ***The Storm of Home Based Care (2001 – 2005)***

The HIV epidemic was now wreaking havoc in Zimbabwe. During this period, the number of people living with HIV, had risen from ten thousand to a million, while the number of orphans increased to 800,000. Official records estimated that approximately 3,000 people were dying every week, and inflation was skyrocketing. Over 60% of people in Zimbabwe were unemployed and the bulk of Zimbabweans were living on less than a dollar a day. Zimbabwe declared HIV to be a state of emergency in 2002 as allowed for under the WTO's Doha Declaration of 2001 on Trade-Related Aspects of Intellectual Property Rights (TRIPS). This allows governments to issue compulsory licences for the production of essential medicines to control diseases of public health importance.

In this period, close to 500 The number of HBC has since decreased. According to ZAN, there are 120 registered HBC programmes in 2007. NGOs were providing HBC. The health sector as a whole was not spared from the economic challenges, resulting in substantial brain drain and the disintegration of the hospital-linked models of HBC. HBC programmes were now dependent on churches, NGOs and communities, with minimal support from Government through the AIDS Levy.

To support the ongoing integration of HBC and OVC programmes, the Zimbabwe National Orphan Care Policy was introduced. In addition, communities and programme implementers recognised the gendered impact of HBC, which placed the burden of care squarely on the shoulders of women, prompting calls for more male involvement in HBC.

In 2001 the Community Home Based Care Policy (CHBC) came into being. Its purpose was to ensure continuity of care from the health care institution to the community; to prescribe the minimum package of care for the community home-based care programme; to highlight the value of community home based care to the people of Zimbabwe; to make the resources available known to both the community and health care givers; to solicit for support for the community and the health care givers; and to assist the care givers in the implementation of the community home-based care policy.

Most home care programmes and services were falling short of the ideal quality and effectiveness of service provision. The National Community Home Based Care Standards (2004) and the National Home Based Care Training Manual (2005) were developed as a way of standardising home-based care activities, training and processes. The purpose was to give programme managers and home-based care providers a foundation from which to identify gaps in their services and to seek the training and support they need. The manual prescribes a minimum package of care.

In the absence of ART and overall desperation for survival, many people living with HIV sought out and adopted a wide variety of therapies, many of which were false and harmful. Nonetheless there was a substantial body of successful, though as yet undocumented and researched, herbal treatment support for those who could not access ARVs. As a result herbal therapy began to be introduced by HBC interventions with the establishment of medicinal gardens. This had a very positive effect on people living with HIV and gave them the hope to live longer. In December 2003, the World Health Organization (WHO) launched the landmark '3 by 5' initiative, which dramatically changed the world's view of the possibility of making treatment available to people in developing countries.

#### ***From 'Bed-ridden' to 'Up and About': The Period of Hope (2006-2007)***

Prior to this period, HBC programmes were primarily involved in palliative care (pain lessening). With the introduction of antiretroviral drugs (limited though the number of initial beneficiaries were), and the establishment of a locally manufactured brand of ART through Varichem, a national manufacturing company, the course of HBC in Zimbabwe has changed. As Lois Chingandu, Executive Director of SAFAIDS emphasised, "*with ART, HBC has shifted from nursing people to the grave, to nursing people to life*". ARVs have been described as a "window of hope" for volunteers (Makumbe, personal communication). In a study conducted by CAFOD (2006) in Zimbabwe, it was found that over 50% (200) of clients who were bedridden and being cared for by implementing partners in Manyame district in the last review period, were now mobile. This change has been attributed to the introduction of ARVs. With treatment, clients have moved from being inactive to becoming active members of the community, capable of doing household chores or working in the fields. The community now views volunteers as "angels" as opposed to "killers". Yet the challenge remains that only a few are benefiting out of so many who need treatment (82,000 receiving treatment versus 400,000 in need).

Despite the significant reduction in prevalence from 33% (2001) to 18.1% (2006), hyperinflation continued to make the socio-economic environment difficult for acquisition of ARVs. The high levels of poverty also made it difficult for most PLHIV to fund their own access to ARVs, as well as to sustain adequate levels of nutrition. During this period, Zimbabwe has witnessed the re-emergence of diseases such as TB, which had been successfully controlled. Increased poverty levels have reduced the effectiveness of the national TB treatment programme, and strategies to integrate HIV and TB programmes have not yet been fully implemented.

The Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) was launched by the Government of Zimbabwe in July 2006, for the purpose of articulating the shared sense of direction and targets for the national response for the period 2006 to 2010. The Plan reinforces the multi-sectoral approach, yet also introduces the concept of universal access to prevention, care, treatment and support. It highlights the need to care for volunteers and to enhance male involvement in HBC. For HBC organisations, the ZNASP proposed that HBC kits be replenished through NAC and to reinforce the integration of nutrition programmes.

In 2006, the Government of Zimbabwe also formulated a behaviour change policy (BCP). The BCP policy is expected to have far reaching impact in reducing the spread of HIV and AIDS, since its emphasis is on prevention. The spin off of this policy will be the reduction in the number of new infections and subsequently also of those in need of home-based care services. The policy is premised on the age-old wisdom that 'Prevention is Better than Cure'.

### KEY LESSONS LEARNED

Over the past 27 years, the nature of home-based care interventions have changed in response to emerging challenges and dynamics of the HIV epidemic in Zimbabwe.

- The discovery of HIV, a virus previously unknown to the medical fraternity, caught the nation unaware. However, in view of socio-economic and political challenges being experienced in the country, the Government has excelled in its role of policy formulation and in the promotion of HIV prevention, which is evidenced in the decline of HIV prevalence in the country.
- The evolution of home-based care was characterised by 'fire-fighting' as opposed to strategic thinking or planning. From the point of discovery, information and data on HIV and AIDS were being gathered, but were not necessarily being used to inform policy or programme direction until well after the issue has exploded (for example, statistics warned of the increased demand for health services due to HIV and AIDS, yet little was put in place to service this need.)

## 3.2 Best Practice in Home-based Care

Best Practice in HBC may be defined as a body of knowledge about HBC that is based on practical experiences and lessons learnt in a maturing field, that can be replicated to improve the quality of intervention, and that has as its objective, the enhancement of quality of home-based care<sup>3</sup>. In order to identify best practice in home-based care, it is necessary to employ a set of criteria for assessing the HBC status quo on the ground in the eight organisations. The best practice criteria used were adapted from the UNAIDS/SADC best practice criteria in HIV and AIDS interventions. The criteria comprise seven elements, namely; effectiveness, relevance, ethical soundness, replicability, sustainability, innovativeness and cost effectiveness. SAfAIDS and HDN then developed a Scorecard for measuring best practice using the seven elements. Each of the elements was further sub-divided into specific variables to be considered in determining best practice. The table shows the variables included in each of the seven elements.

<sup>3</sup> This definition is adapted from the SADC definition on Best Practices in HIV and AIDS.

Element	Variable(s)
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>• Project/programme design or structure – clarity of goals, objectives and targets (Logical Framework)</li> <li>• Integration of programme activities</li> <li>• Community Involvement - addressing of community needs; community participation in programme design, implementation and evaluation (community ownership)</li> <li>• Establish monitoring and evaluation systems</li> <li>• Impact assessment at beneficiary level</li> </ul>
<b>Cost Effectiveness</b>	<ul style="list-style-type: none"> <li>• Timely service delivery proportionate to available resources</li> <li>• Improved quality of life for clients</li> <li>• Measure of cost per client</li> <li>• Adequacy of resources (human, financial and equipment) for project management</li> <li>• Multiplier effect</li> <li>• Cost reduction mechanisms</li> </ul>
<b>Relevance</b>	<ul style="list-style-type: none"> <li>• Addressing community needs</li> <li>• Social, cultural, religious and political acceptability</li> <li>• Compatibility with socio-economic and political trends</li> </ul>
<b>Ethical soundness</b>	<ul style="list-style-type: none"> <li>• Confidentiality, informed consent, and respect for human rights and dignity</li> <li>• Respect for interests of vulnerable groups</li> <li>• Equitable distribution of resources and services</li> </ul>
<b>Innovativeness</b>	<ul style="list-style-type: none"> <li>• Uniqueness of programme</li> <li>• Uniqueness in reaching beneficiaries, utilisation of available resources</li> <li>• Contribution to the base of knowledge</li> </ul>
<b>Replicability</b>	<ul style="list-style-type: none"> <li>• Programme exemplariness</li> <li>• Programme adaptability</li> <li>• Documentation of programme</li> <li>• Potential for scale-up</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>• Programme sustainability – beneficiary support, perceived community ownership; skills transfer; programme in line with national and HIV and AIDS trends.</li> <li>• Financial sustainability – knowledge of potential donors and funding patterns; accessing diverse resources; cost sharing mechanisms; strategies and capacity for fundraising</li> <li>• Active marketing and awareness building – appropriate language for IEC materials</li> </ul>

### 3.2.1 Effectiveness

Under effectiveness, the study focused on programme design (logical framework), integration, community involvement and the monitoring and evaluation framework. Below are some processes illustrating best practice in programme effectiveness.