



MINISTRY OF HEALTH AND SOCIAL SERVICES

Guidelines for Implementing National Policy on Community-Based Health Care

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PREFACE



Community Based Health Care (CBHC) is a strategy to empower and motivate communities to initiate, strengthen and own community actions and household practices that will promote health and prevent illnesses. Communities and civil society organisations actively complement the work of government to provide much needed support to community members. Human *Immuno-Deficiency Virus/ Acquired Immune Deficiency Syndrome* (HIV/AIDS), Malaria and Tuberculosis have placed a high burden on communities which has prompted many community members to involve themselves in voluntary work. This work is vital to the Namibian nation and is strongly supported by the Government of the Republic of Namibia (GRN).

The Ministry of Health and Social Services (MoHSS) has developed the Policy on CBHC which lays a detailed foundation to further build, support and sustain capacity at community and household levels. The Policy emphasises that CBHC needs the support of a number of key stakeholders, namely the community itself, and local, regional and national organisations and structures. The Policy outlines the framework to ensure the delivery of quality CBHC services. These guidelines describes the resources required to enable Community Health Care Providers (CHCPs) to make an effective contribution – namely high quality standardised training, tools, recognition, motivation, reimbursement of expenses and in some cases remuneration.

These Guidelines for implementing CBHC aim to further operationalise the Policy by detailing the roles that each key stakeholder needs to play. It also addresses the key component of community based health care – the CHCPs. The guidelines were developed from inputs made during the National Conference on Volunteers held in December 2006, the consultative meeting of Stakeholders held in November 2007 and the National Consultative Workshop on Home Based Care held in February 2008. Further inputs and refinements have been made by civil society and government stakeholders from all regions.

I would like to thank the Sub-Division of Community Based Health Care & School Health in the Directorate of Primary Health Care Services for driving the process and technical assistance from Ashby Associates, Advanced Community-Based Health Care Services Namibia (CoHeNa), and United State Agency for International Development (USAID) through Private Agency Collaborative Together (PACT) Namibia for technical support. I also appreciate the Namibia Non-governmental Organisation Forum (NANGOF)'s role in providing opportunities for feedback from civil society.

I urge all partners in community based health care and managers of CHCPs to use the CBHC Policy and these guidelines so that our CHCPs are further enabled and supported to deliver quality community health care services.



MR. S.M. KAHIJORO KAHUURE
PERMANENT SECRETARY

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBHC	Community based Health Care
CBRPs	Community Based Resource Persons
CBO	Community Based Organisation
CDC	Constituency Development Committee
CHC	Clinic Health Committee
CHCPs	Community Health Care Providers
CHPA	Chief Health Programme Administrator
CHW	Community Health Workers
CoHeNa	Advanced Community Health Care Services Namibia
DOTS	Directly Observed Treatment Support
DCC	District Coordination Committee
HBC	Home Based Care
FBO	Faith Based Organisation
FHD	Family Health Division
HIS	Health Information System
HIV	Human Immune -deficiency Virus
HW	Health Worker
IEC	Information-Education-Communication
MOHSS	Ministry of Health and Social Services
MGECW	Ministry of Gender Equality and Child Welfare
NANGOF	Namibia Non-governmental Organisation Forum
NGO	Non Governmental Organisation
NIDs	National Immunisation Days
ORS	Oral Rehydration Salt
PHCS	Primary Health Care Services
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Rural Appraisal
RDCC	Regional Development Coordinating Committee
RD	Regional Director
R/N	Registered nurse
RMT	Regional Management Team
TB	Tuberculosis
TBA s	Traditional Birth Attendants
TH	Traditional Healer
TOT s	Training / Trainers of Trainers
UNAM	University of Namibia
VDC	Village Development Committee
V/CHC	Village/Community Health Committee
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

Community Based Health Care (CBHC) is a strategy to empower communities to take charge of initiatives that will promote public health, reduce ill health and mortality among children, adolescents and adults. It also aims to enhance community ownership of joint efforts and self-reliance in resource mobilisation and problem solving. It addresses all aspects of health care - preventive, promotive, curative, palliative, rehabilitative including environmental and reproductive and sexual health - at community level. CBHC extends coverage of services and increases the number of potential beneficiaries by directly involving the community in health and development activities.

The Ministry of Health and Social Services (MoHSS) has recently developed a National Policy on CBHC which details the policy framework of roles and responsibilities of all the key stakeholders. Other policies, guidelines and standards are existing to complement technical aspects of CBHC such as:

- Reproductive Health Policy
- Prevention of Mother-to-Child Transmission of HIV Guidelines
- Nutrition Management for people living with HIV/AIDS Guidelines
- Infant and Young Child Feeding Guidelines
- Voluntary Counselling and Testing Guidelines
- National HIV/AIDS policy
- Mental Health policy
- Community Based Rehabilitation Programme Document
- Integrated management of childhood illness Approach
- Integrated management of Adolescent & Adulthood illness Approach
- School Health Policy
- Tuberculosis Guidelines
- Malaria Policy
- National Oral Health Promotion Policy

Community Health Care Providers (CHCPs) work at community level to promote health and welfare. They often work as volunteers or paid providers. Among others they include Traditional Healers, Traditional Birth Attendants, Home-Based Caregivers, Peer Counsellors, Health Educators, Health Promoters, Family Visitors and other persons engaged in health. Over 20 000 CHCPs are currently playing a range of vital roles in CBHC. The majority of CHCPs are delivering various Community home based care services and advocating for HIV/AIDS prevention and care under the supervision of a range of civil society organisations.

There are an increasing number of clinics, mobile health teams and community health care providers who fulfil a vital role in bringing health care to the household level.

With growing experiences in community work and with increasing numbers of stakeholders involved, the division of Family Health within MoHSS has recognized the key areas that need to be strengthened:

- The link between communities and health services at primary level
- Resourcing CBHC

- Support for CHCPs
- Understanding of the role of the CHCP
- Monitoring of services provided by CHCPs.

These guidelines have been developed to assist community-based organisations (CBOs), non-governmental organisations (NGOs), faith-based organisations (FBOs) and the MoHSS Primary Health Care strengthen the delivery of CBHC services and to nurture and sustain their CBHC providers. In many communities CHCPs act as agents for change and catalysts for development activities – from encouraging literacy to raising awareness on health and welfare needs and rights. One of the most important developmental and promotional roles of CHCPs is to act as a bridge between the community, the formal health services and other sectors. Community Resource Persons (CRPs) are available in the community and can be contacted for advise when their services are needed. The CRPs includes traditional leaders, teachers, religious leaders, extension workers, farmers, business people, politicians and committee members of existing committees in the community.

The purposes of these guidelines are to:

- guide the implementation of the CBHC policy and detail the roles and responsibilities of all key stakeholders;
- guide the organisations on how to manage the CHCPs

1.2 OBJECTIVES AND STRATEGIES OF COMMUNITY BASED HEALTH CARE

1.2.1 Objectives

The Objectives of CBHC program:

- To facilitate the continuity and quality of the client's care from the health facility to the home and community.
- To promote family and community awareness of disease prevention and care related to chronic illnesses;
- To reduce stigma and discrimination of people living with HIV and AIDS and other diseases or disabilities.
- To ensure efficient referrals from health institutions into the community and from the community to appropriate health and social facilities for clients.
- To increase access to prevention education, treatment, care and support aimed at reducing transmission of diseases, reduce morbidity and mortality.
- To optimize quality of life and reduce suffering, symptoms and pain for those with chronic and terminal illness and their families through the provision of palliative care.
- To give chronic and terminally ill clients and orphans and vulnerable children the choice to receive care in their own home and community

1.2.2 Strategies

CBHC should be regarded as a holistic system of care with provisions for:

- Building capacity of the household, community, and institutional level and instituting measures to ensure the economic sustainability of community based health care.
- Building and supporting referral networks/ linkages and collaboration among participating entities.
- Ensuring appropriate, cost-effective access to quality health care and support

- Fostering the active participation and involvement of those most able to provide support to the community at all levels.
- Partnering with other sectors and leveraging other resources for social assistance, including linkages with education, economic strengthening, agriculture and safe water supply, OVC programs and child protection in order to ensure a comprehensive response to the epidemic and further promote program sustainability and effectiveness.
- Ensuring that orphans and vulnerable children are well supported and cared for in the community.
- Ensuring respect for the basic human rights of people living with HIV and other chronic illnesses.
- Addressing the differential gender impact of the HIV/AIDS epidemic, including the need to involve men in the provision of care for persons living with HIV/AIDS and other diseases and to ensure men access the treatment, care and support they need.
- Encouraging the active participation and involvement of those affected by the illness and their families
- Caring for care providers, in order to minimize the physical and spiritual exhaustion that can come with giving prolonged care to the terminally ill.
- Developing the vital role of home-based care as the link between prevention, testing and counselling, treatment and care.
- Addressing the reproductive health and family planning needs of chronically and terminally ill clients, especially persons living with HIV;

1.2.3. Community Entry

Community involvement and participation have been shown to contribute greatly to the achievement of programme goals. Whether a health problem is deemed a national priority or whether the problem is localized, the participation of the community in providing solutions is critical. In either case there is a need for dialogue between the health care delivery system and the community.

The Health Centre / Clinic staff, the Outreach team staff and the CHCP should encourage community involvement and participation and give the community the necessary skills to take the lead in problem identification and finding solutions to the problem. They should remember that communities are diverse and complex. This requires them to be sensitive to the culture and traditions of that community. For this reason health workers and CHCPs need to know and follow the local customs and protocols for meeting community leaders. The process of entry into the community should therefore be carefully planned and conducted as follows:

- From the Regional level the purpose of soliciting the support of the community should be discussed with the Health Programme Administrators, who in turn will sensitize DCC.
- District level sensitizes Health Centre and Clinic staffs.
- The Health Centre /Clinic staff and a representative DCC or PHC Supervisor should enter the community through the community leaders. For the problems that have been identified from the national, regional or district level; the Traditional Authority (TA) is the best level of entry into the community. Therefore the Traditional Authority is the first person to contact in the community.
 - It is an advantage if the health worker speaks the language the TA speaks.
 - Health workers should not promise things they cannot deliver. They should always remember that first impressions last.
- Health workers should always prepare what they want to present to the

Traditional Authority. They should explain the objective of their visit, nature of the problem to be solved, magnitude of the problem, who is most affected and the contributing factors. They should discuss with the TA the importance of the TA's position in assisting to solve the problem and importance of community involvement in health issues. They should propose possible ways they would like to work with the community and ask for the TA's approval and input.

- Following this the TA will now organize a meeting between the health workers with the Community Development Committee (CDC), comprising of Village Headmen, representatives of Religious leaders, youth, politicians, and other influential leaders in the community to explain the intended purpose, and seek their approval and support.
- Village Headman (VH) and VHC in collaboration with Health workers, HEWs and CHCPs meet the community to explain and obtain consensus on the way forward. The Health worker will be required to explain again the issues for which they seek community involvement.
- Where the problem originates from the community, the community should be encouraged to report the matter to the CHCPs or VHC / CHC members who will report to the Health Centre / Clinic staff.
- The Health Centre / Clinic staff should go back to the community to verify the problem and later report to the PHC Supervisor.
- The PHC Supervisor, the Health Centre/ Clinic staff and the Outreach team staff should act together to assist the community solve the problem.
- The DCC should commend the community for reporting the matter to the Health facilities / Outreach points staff and encourage them to continue the collaboration.
- Once the health workers have entered the community, information flow between the health delivery system and the community is the same. This does not depend on the origin of the problem to be tackled.

CHAPTER 2: ROLES AND RESPONSIBILITIES

This Chapter describes the roles and responsibilities of different actors and stakeholders at community, district, regional and national level in supporting the CBHC policy implementation process.

Community Health Care Providers are a valuable community resource that should be nurtured. With the growing demand on organisations to deliver quality programmes, CHCPs become key to achieving the desired outcomes. The following guidelines suggest ways in which organisations can provide good management of their CHCPs.

Namibia Non Governmental Organisation Forum (NANGOF)'s database of civil society organisations recorded more than 20,000 volunteers (including those do not do health activities) in 2007, most of whom contributed to community based health care. These Organisations perform the following functions:

- **Advocacy** such as prevention, education and awareness is undertaken by community based Health Promoters, Health Educators, and Peer Educators;
- **Service delivery** such as Community home based care, community based rehabilitation of people with disabilities, child care and treatment adherence is undertaken by home-based care givers, Directly Observed Treatment Support and other CHCPs.
- **Coordination and networking** functions are undertaken by Health committee members at many levels such as clinic, village, community and constituency levels.

Each programme attracts and recruits different kinds of CHCPs, of varying age groups. Different organisations train CHCPs using different training materials. The education background varies widely but the older CHCPs often have only a few years of schooling. Younger CHCPs tend to have had some secondary education and an increasing number have completed Grade 12. Few of the rural CHCPs have a regular income. They are often the heads of the household and carry the responsibility of managing all the domestic and agricultural work.

CHCPs become involved for a variety of reasons. Some of the most common motivating factors include:

- Wanting to help someone in need within the family, or within the neighbourhood or parish;
- Getting inspired by knowing someone who was or is involved.
- Wanting to respond to the needs of others, the sick, the dying and those left behind;
- Wanting to live out their religious beliefs;
- Wanting to assist in helping the nation to fight the spread of AIDS and other diseases;
- Wanting to learn and gain skills / experience to increase their job prospects.

This Chapter describes the roles and responsibilities of different actors and stakeholders at community, district, regional and national level in supporting the CBHC policy implementation process.

2.1 COMMUNITY LEVEL

2.1.1 Community Health Care Providers

The roles and responsibilities of the CHCP according to their job description include:

1. To sensitise and mobilise the community for health and development actions;
2. To refer patients/clients to clinics, health centres and other related supportive services, if and when necessary e.g. social welfare.
3. To participate in outreach services and mobile clinics including briefing the staff on relevant matters arising in their respective catchment areas; assisting at the outreach visits according to their field guide; mobilising community members to attend outreach sessions.
4. To share the knowledge they have gained and transfer their skills to other community members e.g. household carers;
5. To collect data according to CBHC monitoring tools. Each CHCP will give the collected data to his/her supervisor and to outreach team. The supervisor will ensure the data is sent to the nearest health facility to be entered into the MoHSS Health Information System (HIS) as well as to the NGO service provider's data monitoring system;
6. To disseminate health and development information to community members;
7. To distribute commodities such as Oral Rehydration Solution and condoms;
8. To educate and develop skills of households on the prevention of common illnesses.
9. To provide health promotive, palliative and rehabilitative services according to the local situation and service organisation.
10. To provide care and support and do follow- ups in the community.

Examples of Expected Roles of the CHCPs:

Health Promoters/ Health Educators

- Giving health education to individuals, families and groups (in the community and health facilities).
- Growth monitoring and checking immunisation status of under 5year old children and refer missed opportunities to the clinic
- Promote a healthy lifestyle (educate about healthy diet; effects of alcohol, drugs and tobacco).
- Promote environmental, home and personal hygiene
- Promote good sanitation and safe water
- Promote breastfeeding and utilisation of family planning
- Promote use of Antenatal care (ANC) and Post natal care (PNC) services
- Conduct home visits and making referrals to health workers, social workers and Health Inspectors.
- Completing and submitting monthly reports and keeping the clients register up to date.
- Give appropriate first aid for ARI, diarrhoea, fever and headache

Peer Educators

- Distributing condoms
- Educating and counselling youth on life skills, HIV/ AIDS
- Promoting risk free practices and behaviour

Field Promoters

- Health education, IEC and campaigns on TB,STD,/HIV/AIDS
- Advocacy and community mobilisation for participation in community based TB, HIV/AIDS control and management activities.
- Case detection including collection of sputum and sending it to the laboratory for testing
- Defaulter tracing
- Counselling and Home based care activities
- Establishment and strengthening community based structures to deal with the control and management of TB, STD, HIV/ AIDS.
- Condom promotion and distribution.
- Planning and report writing.

Community Home based care providers

- Provide preventative care and health promotion on health education, hygiene, nutrition, immunization, Prevention of Mother to child Transmission (PMTCT) and prevention of diseases especially infectious diseases such as HIV, TB, and other diseases such as Malaria, prevention of disabilities and nutrition counselling and provision of information on services available.
- Educate on Treatment Adherence
- Provision of Emotional, Psychological and Spiritual Care
- Assist access to welfare services such as social grants for children and people with disabilities
- Provide information about and referrals to support groups and other agencies, e.g. church groups
- Refer clients to health facilities
- Distribute condoms
- Support with activities of daily living: bathing, feeding, mouth wash, prevention and care of bedsores, personal and general hygiene etc.

Traditional Birth Attendants

- Raise awareness and educate about key issues relating to pregnancy and childbirth in the community
- Routinely refer pregnant women to health facilities during pregnancy for ANC, for delivery and after birth for PNC, immunisation and Family planning
- Conduct clean and safe delivery (**only in case of emergencies**)
- Identify danger signs during pregnancy, delivery and after delivery and refer to the nearest health facilities.
- Keep records and send reports on monthly to the nearest health facility
- Lead by good example and challenge traditional practices which may damage the health of mother or baby.

Traditional Healers

- Referring clients to the health facility
- Participating in IEC: HIV/AIDS, STI, TB, Malaria, Family planning and other Reproductive health issues
- Identify Acute Respiratory Infection (ARI), malnutrition and other killer symptoms in children for early referral.
- Encourage mothers to go to the health facility for ANC, delivery and postnatal care
- Promote risk free practices and behaviours

2.1.2 Village Health Committees (VHC), Community or Clinic Health Committees (CHC) and Traditional Leaders

Roles of local level health committees such as VHC and CHC include:

1. To help in the identification and coordination of the health needs in their communities;
2. To facilitate the selection of CHCPs, provide guidance, support and motivation to them and promote cooperation and respect between CHCPs and the community;
3. To support and assist implementation of the activities of health workers and CHCPs at the primary facility and support service delivery;
4. To organise health activities at community level such as the provision of health posts/mobile clinic venues for outreach services, national health events and awareness campaigns;
5. To mobilise resources and determine the contribution by the community for a programme/project/initiative. Resources required for CBHC at this level may include provision of a place for community meetings, gathering of any contributions in kind and/or funds from community members and other resources including incentives for CHCPs.

Roles of Traditional Leaders include:

1. To call and preside over different community meetings
2. Mobilisation of community and ensure active participation of community members in health activities;
3. Promoting risk free practices and behaviours by identifying alternatives to risky cultural practices
4. Monitoring activities of CHCPs

Roles of Religious leaders include:

1. Providing spiritual guidance
2. Promoting moral ethics
3. Promoting abstinence before marriage and faithfulness between couples
4. Assisting in giving information and education on HIV/AIDS, STI, TB, safe motherhood and other health issues.

2.1.3. Outreach Points, Clinics and health centres

Clinics, outreach points and health centres are the first level of health care services in PHC and are in direct contact with communities. The roles and responsibilities of the health workers at these facilities in charge of CBHC include:

1. To promote local leadership in health development through participatory planning and regular review with the community;
2. To facilitate participatory needs assessment and conduct community meeting to address health concerns reported by communities.
3. To participate in the recruitment, selection, orientation, training and refresher training of CHCPs;
4. To arrange meetings with CHCPs at least four times a year to share experiences, identify needs and address challenges;
5. To keep records of the activities of CHCPs;
6. To act as the referral facilities for CHCPs;
7. To assist the CHCP in providing health education; curative care of common

diseases, nutrition promotion, immunisation, environmental sanitation, and follow-up of TB/ART defaulters;

8. To provide and adequately refill home based care kits on a regular basis, in line with ministerial policy and keep records;
9. To compile and provide reports to MoHSS district level on CBHC activities.
10. To establish good relationship with CHCPs and fully integrate CHCPs into their outreach services activities
11. To share health information statistics collected within their respective catchment area/clinic/health centre.

2.2 LOCAL AND DISTRICT LEVEL

2.2.1 Local Government Structures

The roles and responsibilities of local government structures such as Local Authorities (LAs) include:

1. To coordinate the mobilisation of local resources such as provision of a place for community meetings, gathering of any contributions in kind and/or funds and other resources including incentives for CHCPs;
2. To advocate for community support for CHCPs;
3. To co-ordinate CBHC activities and submit community health issues to the Constituency Development Committee (CDC) and Regional Development Coordinating Committee (RDCC) for discussion and problem solving together with the District Primary Health Care Supervisor.

2.2.2 The MoHSS's District Coordination Committee (DCC)

The roles and responsibilities of the MoHSS DCC include:

1. To oversee and coordinate the implementation of the CBHC activities and projects at district levels.
2. To mobilise and allocate resources and to ensure that enough supplies are available for the outreach services, clinics and health centres;
3. To mobilise and allocate resources for supplies of tools and incentives for CHCPs;
4. To support the CBHC service provider to design and deliver both orientation and training of CHCPs.
5. To ensure regular integrated and supportive supervisory visits to clinics, health centres and CHCPs.
6. To maintain with the nurse in charge of CBHC/outreach services in the district an up-to-date list of all CHCPs in the district desegregated by clinics/health centres and outreach visiting point/health post. The database will indicate the name and address of the CHCPs and the training courses received. It will also contain information on equipment / supplies / incentives issued to the CHCPs.
7. To monitor, with the Registered Nurse (R/N), the proper use of all supplies given to CHCPs. The replenishing of supplies for CHCPs such as HBC kits will be made from the district health facility budget and the records of their stock levels will be kept at the clinic/health centre level.
8. To serve as the monitoring centre for health statistics collected in the district. After a preliminary evaluation of data they are forwarded to the regional level. Feedback about the collected data will be given to the clinic and health centre staff and the communities at large.
9. To compile and submit reports to regional level.

2.3 REGIONAL LEVEL

2.3.1 The Regional Council

The responsibilities of the Regional Council will be:

1. To strengthen coordination committees between local, regional and national levels to promote integrated and effective community health care, including other sectors.
2. To promote use of effective feedback mechanisms between communities and coordination committees at sub-national levels.
3. To promote the integration of CBHC services at sub-regional level (HIV/AIDS, TB, malaria, nutrition, rehabilitation, water & sanitation etc).
4. To organise regular public events at all levels that give recognition to contribution made by CHCPs.
5. To hold annual partnership meetings at regional and local levels to set resource contributions towards CBHC programmes to ensure sustainability.
6. To establish efficient resource mobilisation mechanisms.
7. To build capacity of members of coordination committees and strengthen support mechanisms.

2.3.2 The MOHSS Regional Level

The roles and responsibilities of the MoHSS Regional Management Team (RMT) include:

1. To be responsible for planning, coordination for supportive supervision and monitoring of CBHC activities. RMT will ensure that national policy is correctly interpreted and operationalised in the respective districts.
2. To promote through the Chief Health Programme Administrator (CHPA) for Family Health Services, the CBHC agenda at the RMT and the Regional Development Coordinating Committee meetings in collaboration with the Regional Director (RD).
3. Through the CHPA for Family Health services, to mobilize and allocate resources for CBHC activities such as tools and incentives for CHCPs through district level.
4. To raise awareness on community health issues at relevant national level meetings.
5. Through the CHPA for Family Health Services, to compile health information from the districts' management information system (MIS) and other sources on CBHC activities on monthly basis. Feed back about the compiled data will be given to the district level, through the RDCC.
6. Coordinate all CHBC activities and facilitate CHBC networks. Wherever possible, NGOs, FBOs, CBOs and community support groups shall have separate catchment areas for service delivery to avoid duplication of services.
7. To train trainers from both MoHSS and civil society organisations in the region to offer the standard community and home-based care curriculum and to supervise the quality of the training offered.
8. To coordinate services with other regional bodies such as RACOCs and other relevant bodies.
9. To establish and distribute a standardized and up-to-date directory on referral and networking points in the region.

2.4 THE NATIONAL LEVEL

2.4.1 The MoHSS at National Level

The Sub-Division of Community Based Health Care within the Division of Family Health, in the Directorate of Primary Health Care, is responsible for coordinating CBHC. The CBHC Sub-Division will be responsible for the following actions:

1. Coordinate and promote CBHC programmes at national and regional level through the Family Health Division in the PHC Directorate to avoid duplication of services and facilitate national coverage;
2. To develop policies and guidelines, standards, training manuals and field guide on aspects of CBHC, ensuring civil society and community participation;
3. To ensure that the manual on community home based care will be kept up-to-date and where possible standardise training content and ensure course accreditation for TOTs and CHCPs;
4. Provide training for regional trainers so that they can act as regional training resource persons, training other trainers in community home-based care in the region.
5. Coordinate and promote an effective supply chain of HBC kit materials and other supplies
6. Conduct reviews on progress, quality of training, and CHCP management;
7. Coordinate with other divisions of the MoHSS, especially DSP, TB program, Cancer programme, etc.
8. Compile and provide reports to MoHSS National level on CBHC activities that are attaining to the standards as well as inform on the qualitative aspect of monitoring and coordination process.
9. Establish a budget line for supporting CHCP management and provide funds for community based health care programmes including a contribution to a package of incentives.
10. Regularly review guidelines on the implementation of CBHC including CHCP management.
11. Monitor implementation of policies and funding.
12. Disseminate findings of evaluations of all community health programmes to encourage sharing and learning from experiences.

2.4.2 Civil Society Organisations - NGOs, FBOs and CBOs

The roles and responsibilities of the Civil Society Organisations include:

1. To conduct, at the outset of a CBHC programme or new initiative, a needs assessment of the community;
2. To involve the community at all stages of the programme;
3. To manage their CHCPs, according to these guidelines;
4. To build the capacity of CHCPs, with the participation of MoHSS health professionals, through training, refresher courses and during supervision;
5. To work in partnership with the MoHSS to provide adequate tools for their CHCPs;
6. To provide training on CHCP systems and provide supportive supervision;
7. To be transparent with regard to their financial status and organisation;
8. To be responsible for collecting and collating data on their activities and impacts of CBHC. This data will be used to track progress for their own purposes and for national programming and will be shared with communities and the MoHSS as well as other stakeholders.

CHAPTER 3

COMMUNITY HEALTH CARE PROVIDER (CHCP) MANAGEMENT

3.1 INTRODUCTION

CHCPs are a cornerstone to achieving community based health care. To maximize their contributions, CHCPs need on-going training, resource materials, support, supervision, recognition, and reimbursement for costs incurred through their work. Communities, Regional councils and Local authorities, Civil Society service providers, health workers and community development workers all have responsibility towards meeting the needs of CHCPs.

CHCPs should be managed in a way that values their knowledge and experience. This can be done by providing opportunities for more experienced CHCPs to work with other staff in providing orientation, training and induction of new CHCPs. This gives the experienced CHCPs recognition and increased levels of responsibility.

In developing quality assurance for a programme that makes use of CHCP it is necessary to:

- Establish the purpose for having CHCPs
- Appoint staff members to coordinate the work of CHCPs
- Respond to CHCPs' inquiries
- Hold induction, orientation and training for CHCP
- Enable a safe and conducive environment for CHCPs
- Enable CHCPs opportunities to share their knowledge
- Ensure that CHCPs have an enjoyable productive and sociable time
- Give feedback and make CHCPs know that their contribution is valuable or worthwhile

3.2 MANAGEMENT

3.2.1 Description of duties

CHCPs require a clear, complete, and current definition and description of the duties and responsibilities of the position which they are expected to fill within the agency.

It is best to ensure that positions take into account the CHCP's needs as well as that of the organisation. It essential to clarify the CHCP's responsibilities, which are the actual tasks that the CHCP is expected to perform in a way that make them easy to understand and undertake. Therefore, prior to any CHCP assignment or recruitment effort, a description of duty should be developed for each CHCP position. The descriptions should be reviewed and updated at least every two years, or whenever the work involved in the position changes substantially.

The following should be included:

- **Authority**, which defines the parameters that the CHCP should work within and explains the extent to which the CHCP can make decisions about how work is to be carried out.
- **Accountability**, which means that the CHCP needs to have a goal that is oriented toward results. The CHCP should be responsible for producing results as a way of indicating that the work is value and important.
- **Purpose of the task** or assignment
- **Results to be achieved** – the short-term impacts of the CHCP's work
- **Designated supervisor and frequency of review meetings**
- **Suggested duties or activities** - including M&E
- **Measurements**, which can be defined as how the CHCP will know if he or she has successfully achieved the results. These should be discussed and agreed upon in advance with the CHCP.
- **Evaluation criteria** – how is the performance of the CHCP measured
- **A list of attributes (skills and personal qualities) needed** by the CHCP
- **Time frame** for the performance of the job where applicable
- **Site** where the CHCP will work
- **A description of tools to be provided, levels of reimbursement and any other incentives.**
- **CHCP's and supervisor's signatures** showing commitment / agreement to their duties.

According to the Namibia Non-Governmental Organisations Forum (NANGOF)'s code of practice for Civil Society Organisations "Working with Volunteers", all CHCP positions should have a set duration. It is highly recommended that this term shall not be longer than a year, with an option for renewal at the discretion of both parties. All CHCP assignments shall end at the conclusion of their set term, without expectation of re-assignment of that position to the incumbent.

3.2.2 Selection and Recruitment

CHCP recruitment means attracting and inviting people to consider involvement in the organisation. Simple as it may seem, it is important to get enough CHCPs who are qualified for the positions you wish to fill.

Selection of CHCPs can be through existing community structures. This means that people are invited through community structures to CHCP themselves and only those that are considered suitable are selected.

The following CHCP selection criteria should be suitable for most CBHC programmes. CHCP should generally be:

- A mature male / female age 18 years upwards unless it is a youth programme;
- Respected by the community;
- A resident of the area;
- Able to speak a local language – preferably several different languages
- Able to read and write – a substantial amount of current CHCPs are illiterate so it should not be a requirement, but it is an advantage, especially in urban areas and for those reading medication;
- Able to hold confidential information.

Characteristics include:

- Be committed service providers with the aim of making a positive change to the overall well-being of the community, in a sustainable manner;

- Be faithful to the commitment and exemplary;
- Be trustworthy;
- Be willing to attend positively to vulnerable groups;
- Recognise the structures, norms, values and taboos of the community;
- Be willing to work according to the structure of the community;
- Be accountable and responsible (to the necessary structures).

3.2.3 Screening and interviewing

Personal conduct during recruitment pays dividends. It is best to meet and interview all potential CHCPs to ascertain their suitability for and interest in that position.

The purpose of carrying out interviews includes to:

- Assess the match of the person with the CHCP position, thus through interviews the skills, abilities, interests and wishes of the CHCP are revealed.
- Allow the potential CHCP to understand the proposed CHCP description of duties and the nature of the organisation
- Give the potential CHCP a chance to ask any questions that he or she might have about the position and get answers.

Formulation of interview questions should be done prior to the interview and use of a standardised recruitment form can make the selection of CHCPs easier. A standardised candidate evaluation form enables the interviewers to assess a person's skills and quality and how far the candidate meets each requirement.

3.2.4 Orientation and training

The service organisation should ensure that the CHCPs have been properly orientated. Orientation includes giving an adequate background on the issues arising in community health care in their specific area, networking and referral points, information on the service organisation itself - its operation and its procedures. CHCPs should be made to clearly know and understand what is expected of them. They should understand the relevant rules and regulations of the organisation. Orientation and Training are important processes of providing CHCPs with the information which they require to perform their work effectively.

A good orientation programme will provide the CHCP with the following types of information:

- Description and history of the organisation;
- Mission, goals, and objectives of the organisation;
- Description of the overall programmes and clientele of the organisation;
- Sketch of the organisation's structure or organogram;
- Orientation to the facilities and layout of the organisation;
- Knowledge building of general policies and procedures;
- Description of the CHCP management system;
- The nature and operation of the programme or activity for which they are recruited.

The purpose is to provide the CHCP with a context within which to work. The better the CHCP understands what the organisation is and how it operates, the better the CHCP will be able to fit his or her own actions into proper methods of behaviour and to display initiative in developing further ways to be helpful to the organisation.

An effective training programme operates by identifying those skills, knowledge and behaviour which would be essential in good job performance and then designing a training format which instructs the CHCP. It should be practical, experiential, and tailored to the individual needs of the CHCP.

CHCPs should receive specific formal and or on-the-job training to provide them with the information and skills necessary to perform their CHCP assignment. The timing and methods for delivery of such training should be appropriate to the complexity and demands of the position and the capabilities of the CHCP.

It is helpful to involve both staff and experienced CHCPs in designing and delivering the training. Staff members with responsibility over delivery of services by CHCPs should have an active role in the design and delivery of both orientation and training of CHCPs. Those staff that will be in a supervisory capacity to CHCPs should also deliver on-the-job training through skills transfer to CHCPs assigned to them.

CHCPs should be encouraged to improve their levels of skill during their terms of service. Additional training and educational opportunities such as refresher courses should be made available to CHCPs during their stay with the organisation. This continuing education may include both additional information on performance of their current assignment as well as more general information, and might be provided either by the organisation or by participation in educational programmes provided by other groups.

The training should include:

- How CHCPs can perform their particular job, according to specific MoHSS quality standards and curricula relevant for each type of CBHC activity.
- What they are not supposed to do in their job.
- What to do if an emergency or unforeseen situation arises.
- What skills, knowledge and behaviour are needed to perform the job
- How to solve problems
- The basic facts about the disease(s) or situation the programme is addressing
- What records to keep and how to keep these
- What training opportunities exist
- How the evaluation of their work is done

3.2.5 CHCP Supportive Supervision

Any person, who has been trained to carry out certain roles and functions within an organisation or community, needs to get feedback on their performance. This is critical in the community health care sector where performance directly affects the quality of life of those needing care and treatment and infection rates of disease.

All community health care organisations shall ensure that all levels of CHCPs working in the community have adequate supervision. Supportive supervision requires time, care and skills to develop and maintain interpersonal relations on both a professional and a personal basis.

Who provides the supervision?

Supportive supervision of a group of CHCPs shall be done monthly for at least three hours, by a permanent and experienced staff member. The supervisor shall be involved in all aspects of the work and evaluation of CHCPs with whom they are connected.

To facilitate effective supervision for CHCPs, the staff who are responsible for managing CHCPs should be trained or retrained in areas such as:

- CHCP management
- Facilitation skills
- Skills transfer
- Conflict management
- Project management
- Facilitative supervision
- Record keeping

Supportive supervisory visits will aim to improve the quality of service delivery by addressing performance, capacity and confidence building of the CHCPs. Every opportunity will be taken to discuss and address the expectations of the community, the needs of the CHCPs and other issues. All key partners in each CBHC programme will know their role in supporting and motivating the CHCPs. Programme managers will ensure that the resources required for regular supportive supervision are provided for in the implementation plan.

Programme supervisors will supervise the CHCPs, with the possible assistance of Community Health Committee members, whilst the district PHC supervisor/ Principal registered nurse will supervise the clinic/health centre staff. The main function of the national and regional levels will be to supervise the next lower level. There should be a supportive supervision tool to be used by each level when conducting the supportive supervision visit.

3.2.6 Case load of CHBC providers

These guidelines recognise that the focus and work of CHCPs differs considerably as do clients' needs. Different organisations have different systems for allocating clients to a CHBC provider. Care should be taken that CHCPs are not overwhelmed by having too many clients as this opens up possibilities for poor quality of services and burn-out. Community health care service organisations should ensure that they have enough trained CHCPs to serve all the clients in a community

3.2.7 Caring for Carers

All Stakeholders should recognise that caring for clients and their families can produce stresses and strains on CHCPs. CBHC service organisations should nurture the mental and physical well-being of people who provide care in the community. Such care should include helping CHCPs and family caregivers to relieve stress and lead a healthy lifestyle. Different coping strategies can be promoted, such as adjusting the pace or approach of work, use of stress management techniques, peer counselling and having a support network. CHCPs and their supervisors will be trained on how to recognize signs of burn out and stress in self and others.

3.2.8 Building skills and career paths

CHCPs should be helped to move on by exposing them to opportunities that enables them to grow. CHCPs should be encouraged to develop their skills and knowledge and should be assisted into new CHCP jobs which may assume additional and greater responsibilities. To this end, the CHCP's organisation should maintain appropriate records of CHCP experience that will assist the CHCP in their own development (future career opportunities, both paid and unpaid).

3.2.9 Cessation of Duties

In accepting a position, the CHCPs should agree to actively perform their duties to the best of their abilities, to work according to the standards laid down by the organisation and to remain loyal to the values, goals and procedures of the organisation. The CHCP should maintain a good image of the organisation to the clients and the community.

CHCPs may be relieved of their services under the following circumstances:

- theft of property or misuse of equipment or materials
- abuse or mistreatment of clients or co-workers
- failure to abide by organisational policies and procedures
- failure to meet physical or mental standards of performance
- failure to satisfactorily perform assigned duties
- any other relevant misconduct.

CHCPs may resign from their CBHC service organisation at any time. It is requested that CHCPs who intend to resign provide advance notice of their departure. Exit interviews, where possible, should be conducted with CHCPs who are leaving their positions. The interview should ascertain why the CHCP is leaving the position, suggestions the CHCP may have to improving the position, and the possibility of involving the CHCP in some other capacity with the same organisation.

CHCPs should not be allowed to perform professional services for which certification or a licence is required unless currently certified or licensed to do so. The CHCP supervisor should maintain a copy of any such certificate or licence to protect the organisation from litigation.

3.3 STANDARDISED PACKAGE FOR CHCP

CHCP recognition is the process of rewarding and motivating those CHCPs who have contributed effectively to the organisation. As indicated in the CBHC policy, any organisation that provides a service using CHCPs should give on-going recognition, appreciation and motivation to their CHCPs.

3.3.1 Tools, Equipment and I.E.C. Material

CHCPs should be provided with the basic equipment, supplies and Information, Education and Communication (I.E.C.) materials needed to fulfil their responsibilities and job descriptions effectively. These may be home based care or First Aid kits, posters and pamphlets but should also include personal items such as ID cards, manuals/handbooks, field guide, uniforms, shoes, and bags.

A wide variation exists in terms of distances covered by CHCPs. Although the majority operate within their community and serve three-to-seven nearby villages, others travel far. In some areas, bicycles may enable the CHCPs to be far more effective.

3.3.2 Recognition and Motivation

Any organisation that provides a service using CHCPs will give recognition, appreciation and motivation to them. This will include, but not be limited to:

- Assessing performance and give feedback on their assessment;
- Holding public ceremonies to give awards and certificates of achievement;

- Providing other means of identification such as T shirt, hat, umbrella which boosts community confidence and promotes the programme (as stated in the Policy on Community Based Health Care).
- Including CHCPs in staff activities and other organised events – ceremonies, retreats, outings, end of year parties;
- Involving CHCPs in strategic planning & design & in decision making process;
- Employing CHCPs through internal recruitment when staff vacancies occur so that there are career paths for them;

3.3.3 Reimbursements for Transport and other expenses

Any person who has spent money on transport or phone calls should be reimbursed (paid back), according to a signed agreement with their service organisation. Community health care organisations and their partners will strive to include reimbursements in their package for CHCPs. Often CHCPs spend their own money to get clients to a health facility. Many use their cell phone credit or telephone to organise transport and referrals, to seek advice and to coordinate with their group leader, their supervisor and fellow providers. Reimbursement will be dependent on the agreement between the CHCP and the service organisation and should be in line with the government policy.

3.3.4 Remuneration

Given that the majority of CHCPs are unemployed and spend several hours a day, several days a week working in an unpaid capacity, a combination of financial and/or in-kind remuneration is a real need for many.

These CBHC Guidelines aim to increase the quality of service delivery to the community, by community members themselves. Amongst community health care service organisations and health professionals there is a growing realisation that quality service delivery requires quality training, supportive supervision and some form of remuneration. The level of remuneration should not undermine the ethos of service to one's community but should be in recognition of the demands and responsibilities that go with quality community based health care services.

Incentives to CHCPs / volunteers

- Estimated monthly allowance to be paid either by Government or NGOs a minimum amount of N\$ 250.00- N\$500.00 per month
- Exemption from health facility fees
- Reimbursement for cost incurred on behalf of the client and programme

Package of necessary equipment

- Initial training and refresher course.
- Identity card.
- T-Shirts, shoes, umbrella, kit
- Some mode of transport e.g. bicycle, motorbike

The level of remuneration should be set out in the agreement between the CHCP and the service organisation.

At present, a person who receives any remuneration whether in cash or in kind, or is supervised in any way, is regarded as an employee. The Labour Act of 2007 (Act no. of 2007) is hereby recognised and will be referred to in all

matters regarding employment issues. Furthermore, any person receiving more than N\$300 will be registered under the Social Security Act. Applications for exemption to the Labour Act can be made with the Minister of Labour.

There are widespread regional and local variations in CBHC programmes and in the resource levels of service provider organisations. The CBHC Policy and Guidelines reflect the realisation that key stakeholders have to negotiate their contributions to such a package.

The continuation of the provision of incentives offered at the beginning of a programme should be ensured in order to avoid high attrition rates known to follow any reduction of remuneration or discontent of double standards by not receiving for the same amount of work.

CHAPTER 4: MONITORING, EVALUATION AND REPORTING

Specific CBHC services shall develop their own monitoring plans to track progress in reaching the CBHC policy objectives, their own specific objectives and results and to assess the performance of their staff and CHCPs in providing quality services. It is recommended that minimum standards for quality services be set with indicators to measure progress.

4.1 MONITORING TOOLS

4.1.2 Supervision

The MoHSS will carry out periodic integrated supervisory and supportive visits at all levels. This will be done through: integrated community working group planning / review meetings, and biennial and annual report writing. Examples of monitoring tools used for supervision can be found on page 22 figure 1 appraisal form

4.1.2 Qualitative and Quantitative data collection

Each service provider and the Sub-Division CBHC will be responsible for recording and analysing both quantitative data (numbers) and qualitative (e.g. levels of satisfaction) to measure progress and change.

Ongoing collection of community-based information on service delivery will be carried out on a regular basis. The clinic will record relevant data and submit it to District levels quarterly to enter onto the Health Information System.

Outcome / Impact level Indicators:

- Increased number of clients / patients cared for by CHCPs;
- Increased number of clients / patients referred to health facilities, when required;
- Positive change in knowledge, attitudes, behaviour and practices relating to health in target communities;

Process Indicators

- Improved level of community participation:
 - Increased No. of community members (M/F) participating in programme planning, implementation and management.
- % of CHCPs in communities in regular contact with health facilities.

Management Indicators

- A functioning system of coordination, collaboration and referrals for effective community health care in place:

- A community health care structure (e.g. V/CHC, Constituency AIDS Co-ordinating Committee (CACOC) and District AIDS Co-ordinating Committee (DACOC) providing effective coordination and collaboration
- CBHC regularly discussed at MoHSS meetings at district, regional and national levels
- Level of integrated management of community based health care activities: HIV/AIDS, TB, Malaria, Nutrition, Water, Sanitation and Reproductive Health
- A community based information system within the HIS improved and sustained.
- Increased level of confidence among programme beneficiaries in programme management.

Implementation Indicators

- No. of CHCPs trained, supervised, and supported.
- No. of people reached through community based health care
- Level of client satisfaction with service provision

4.1.3 Regular reviews and planning

Information collected through monitoring will feed into regular internal reviews. An external evaluation will be conducted at least every five years to assess achievements, opportunities and challenges and to adjust annual and strategic plans.

Below is an example of a performance Appraisal form :

Figure 1: Example of Community Health Care Provider Performance Appraisal Form

CHCP PERFORMANCE APPRAISAL ¹			
A. DETAILS			
NAME		TITLE	
Name of Supervisor		Started in Organisation	Date: / /
Date of last Appraisal	Date: / /	Date of this Appraisal	Date: / /

Appraisal agreed by CHCP	(signature)
Appraisal agreed by Supervisor/ Appraiser	(signature)

B. REVIEW OF JOB DESCRIPTION
What changes are needed to the job description to reflect CURRENT duties?

C. COMPETENCIES		
(1 – unacceptable, 2 – improvement required, 3 – satisfactory, 4 – good, 5 – outstanding, n/a – not applicable)	CHCP's Score	Supervisor's Score
a. Do the hours spent match the job description?		
b. Is the provision of services to clients and family members of the required standard and accuracy?		
c. Is initiative shown in overcoming obstacles to the completion of duties?		
d. Can tasks be appropriately prioritised (so that urgent issues are dealt with first)?		
e. Are issues followed-up on adequately?		
f. Does the CHCP have the knowledge and skills to perform the normal duties contained in the job description?		
g. Are reports completed according to set deadlines and with a minimum of mistakes?		
h. What is the standard of verbal communication (both speaking and listening)?		
i. Does the CHCP represent the organisation well to community members and other stakeholders (e.g. GRN officials, visitors)?		
j. Do you feel supported adequately by the organisation?		

¹ Adapted from Catholic AIDS Action Staff Appraisal Form

k.	Other (describe)		
l.	Other (describe)		

D. ADDITIONAL COMMENTS ON COMPETENCIES

If any of the above agreed scores are exceptional (that is 1,2 or 5) please give additional information (including examples of behaviour that evidence the score). Where the score is 1 or 2 briefly describe plan to improve performance.

REF	Comments

E. DEVELOPMENT PLAN

Give summary of the training needs or other plans for development

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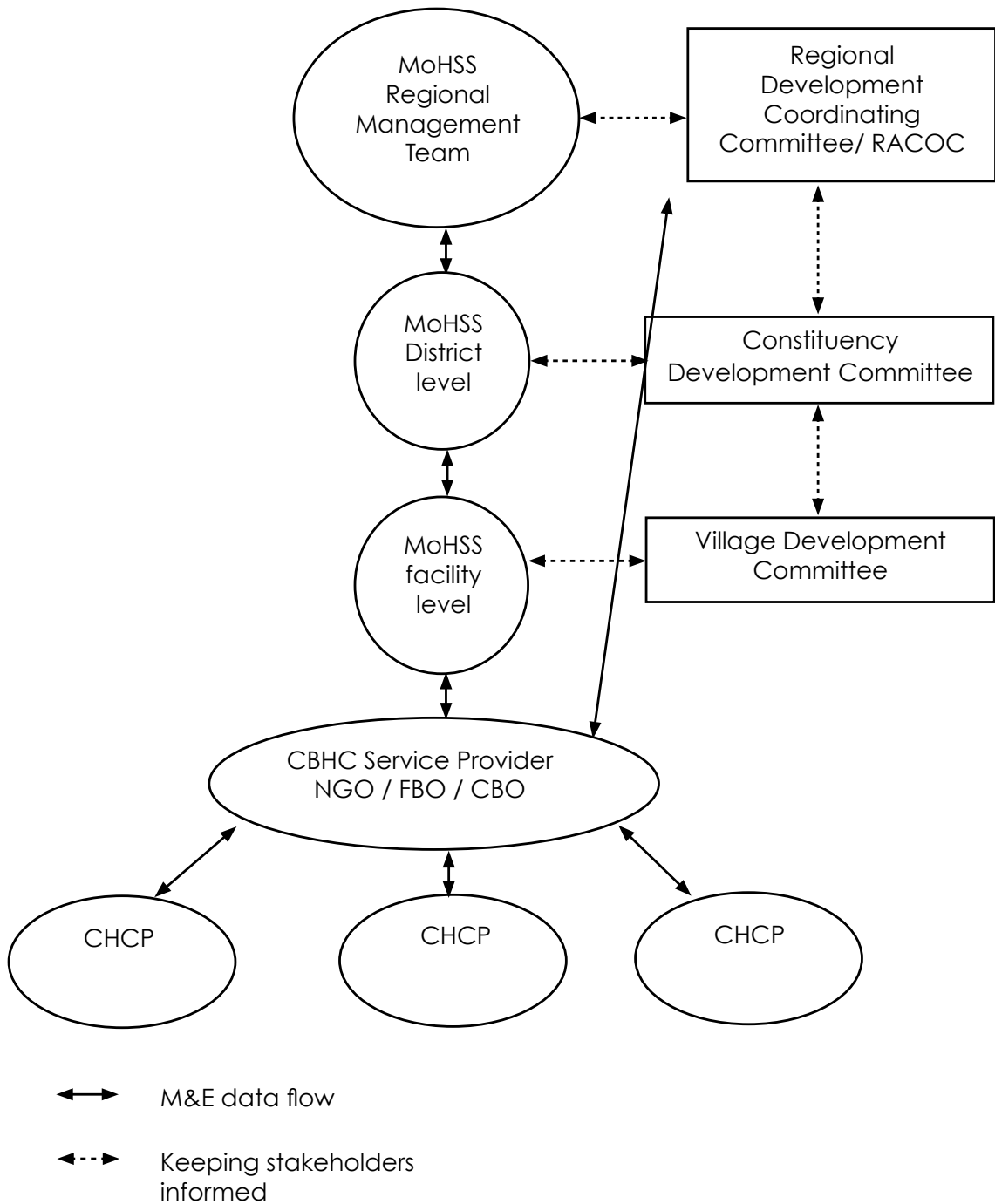
F. OTHER ISSUES

List other issues that either supervisor or CHCP want to raise

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4.2 CHANNELS FOR REPORTING

Figure 2: To show the flow of information from the CHCPs to partners and stakeholders



It is the responsibility of CBHC service delivery organisations to collect data on their activities and keep the local health facility informed on a regular basis. The health facility collates this data and reports to the MoHSS district and to the local health committee. The political leadership is kept informed through councillors at constituency level and regional levels. National and Regional NGOs and FBOs should also be reporting to the Regional Council through RACOCs.

GLOSSARY

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

Community involvement is essential to achieve the prevention, provide treatment and support care services. Communities possess untapped resources that can be used to make health care more accessible, affordable and acceptable. Community involvement in health extends the reach of health care to the maximum number of people, particularly the poorest.

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

Community Development Committee is recognised by the Local Authorities as representatives of that given community, and calls community meetings to make participatory decisions.

Community Health Care Providers (CHCPs) are health promoters, home based care providers, traditional birth attendants, traditional healers and private persons engaged in health, as well extension workers from other sectors working for their community to promote health.

Household is a person or a group of persons living together and sharing a common source of food.

Home-based care providers make a significant contribution to CBHC within this larger group. They visit homes and support and provide palliative care to people with chronic illnesses and their families.

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

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

Orientation aims to introduce, new ideas, skills or methods of work to the existing staff category or CHCPs.

Participatory Rural Appraisal (PRA) has been defined as a family of approaches and methods used to enable local people to share, enhance and analyse their knowledge of life and conditions to plan and act.

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

Training is the process of instructing CHCPs in the specific job-related skills and behaviour that they will need to perform their particular CHCP duties.

Traditional Birth Attendants (TBAs) are found in many communities in Namibia. They are often greatly respected in their communities and have an important role to play in contributing to reproductive health care.

Traditional healers are highly respected in communities and community members have confidence in their information. Traditional healers have immense influence in their communities and can present a positive or a negative force towards the promotion of health and development, depending on their conviction and involvement.

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