Acknowledgements

This Community Home-Based Care Policy document bears the imprint of individuals and organisations that are providing care and support to Persons Living with HIV(PLHIV) in our communities and is the first ever to be developed in Ghana. Our sincere gratitude goes to all those who have contributed in diverse ways to develop this policy.

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Foreword

The multi-sectoral response to HIV and AIDS and STI has been guided by the National HIV and AIDS, STI Policy. In line with efforts to continue and sustain the progress of the multi-sectoral response in the country, the Ghana AIDS Commission (GAC) in collaboration with key partners and stakeholders developed a National HIV & AIDS Strategic Plan 2011-2015 (NSP 2011-2015) to direct the implementation of the national HIV and AIDS response until 2015.

Many organizations and communities are now expanding into new programmatic areas, including home-based care for Persons Living with HIV (PLHIV).

Community Home - Based Care (CHBC) interventions in Ghana are at a nascent stage and a national strategy and guidelines is critical to guide its implementation. In Ghana, Community Home-Based Care (CHBC) is being implemented mostly by Civil Society Organizations along with the Ghana Health Service staff mandated to carry out home visits to clients. Unfortunately, CHBC activities are carried out in a policy vacuum, without established mechanisms for coordination and no standardized training of service providers.

The Ghana AIDS Commission in collaboration with development partners and stakeholders have developed this country-specific CHBC policy and guidelines which will target policy-makers and administrators, middle managers and those who develop and run CHBC programs. It is expected that this document will assist in developing effective partnerships among these groups of people in developing and expanding CHBC programs in the country. It will also enable those who manage and run the programs to share information and feedback with senior administrators, thus guiding a well-coordinated and standardized CHBC program across the country.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral drugs
ART	Antiretroviral Therapy
CBO	Community Based Organization
CHAG	Christian Health Association of Ghana
CHBC	Community Home Based Care
CHPS	Community Health Planning and Services
CSO	Civil Society Organization
FBO	Faith Based Organization
GAC	Ghana AIDS Commission
GHS	Ghana Health Service
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
LEAP	Livelihood Empowerment Against Poverty
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
OIs	Opportunistic Infections
ORS	Oral Re-hydration Salt
OVC	Orphans and Vulnerable Children
PLHIV	Persons Living with HIV
PPP	Private-Public Partnerships
PwP	Prevention with Positives
TB	Tuberculosis
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Section 1:
Background

The National HIV & AIDS Strategic Plan 2011-2015 identifies the need for a Policy Framework for Community Home-Based Care as critical for its successful implementation.

Home-based care has a variety of typologies, each representing a different delivery scheme, mix of services, staff and reach [PHRplus, 2004]. Some of the identified types include facility-based, community-based and integrated services. The emphasis of each type of program tends to differ. Facility-based programs often focus on medical aspects of care involving teams including health professionals who can provide higher levels of care. Community-based programs emphasize psycho-social support to PLHIV and their families and deliver their services primarily through volunteer networks in the community together with program staff and health professionals

The World Health Organization (WHO) defines Community Home-Based Care (CHBC) Services as 'any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual care. Community Home-Based Care (CHBC) thus is "the care given to an individual in his/her own environment by his/her family and supported by skilled welfare officers and communities to meet not only the physical and health needs, but also the spiritual, material, and psychosocial needs" (Gaborone Declaration on CHBC, 2001).

Definition of CHBC within the Ghanaian Context

In the context of this document - Community Home-Based Care (CHBC) is defined by key Ghanaian stakeholders providing HIV and AIDS care and support services as 'the holistic and collaborative effort to enhance the quality of life of persons infected and affected by HIV and AIDS by care and support providers including the family, the community and the client'. CHBC contributes significantly to the national response by reinforcing ART adherence, palliative care, improving referrals and follow-up between the community and health facilities, increasing self-care and the understanding of HIV and AIDS among clients and their families. HIV-related stigma and discrimination is reduced in many of the communities where HIV services are offered (NSP 2011-2015). Appropriate implementation and functioning of CHBC will aid in achieving the impact results in the National HIV & AIDS Strategic Plan 2011-2015: the reduction of new HIV infections by 50% by 2015 and reduced morbidity and mortality among PLHIV.

Policy goal

The goal of this CHBC policy is to enhance the provision of high quality and comprehensive CHBC for PLHIV.

Policy Objectives

- To provide guidance to service providers in the provision of standardized and coordinated HIV and AIDS related community home-based care
- To provide high-quality and appropriate support within the continuum of care
- To empower persons infected and affected by HIV and AIDS with requisite knowledge and skills to be independent and achieve an improved quality of life
- To promote psychosocial support and counselling for people infected and affected by HIV and AIDS
- To promote family and community awareness of HIV and AIDS prevention and care
- To serve as a policy document for stakeholders and service providers in the HIV and AIDS sector

Rationale for CHBC Policy

The rationale for this CHBC policy is to have in place a comprehensive CBHC policy that provides guidance for stakeholders and service providers and their activities. In Ghana, Community Home-Based Care (CHBC) is being implemented mostly by Civil Society Organizations along with the Ghana Health Service staff mandated to carry out home visits to clients. Unfortunately, CHBC activities are carried out in a policy vacuum, without established mechanisms for coordination and no standardized training of service providers. The National Policy on CHBC will take cognizance of all the challenges identified and map out strategies to adequately address each one of them. (Refer to Situational analysis matrix in Annex 1). The policy will facilitate efforts to address challenges associated with community home-based care.

Process of Development

A well-defined process was conducted to fulfill the scope of work in developing this policy and guidelines for CHBC.

1. An extensive literature review was conducted to provide a contextual framework for the development of the policy

2. The first stakeholders' meeting was held in December 2011 to kick-off the policy development process. The main goal of the meeting was to allow stakeholders to participate in the policy development process and also provide some key

guidelines as they are wholly involved in the provision of care and support for persons infected and affected by HIV and AIDS in Ghana. The meeting also helped to define and examine CHBC in the Ghanaian setting; the occurrence thereof, the conduct as well as proposed development and regulation.

3. A rapid mapping of CHBC facilities and service providers for HIV and AIDS infected and affected clients across Ghana was conducted. A team of 13 field officers were deployed over a period of 5-10 days to all 10 regions of Ghana to investigate the occurrence and conduct of CHBC across Ghana through Global Positioning System (GPS) mapping and questionnaire administration.

   This exercise was informed by the 1st Stakeholders meeting which define CHBC in the Ghanaian setting; collated known CHBC services for verification on the field and provided a solid foundation on which to execute the mapping exercise

4. A second stakeholders meeting, comprising a smaller group of stakeholders was held in February 2012 to preview and validate the information gathered by the Rapid Mapping Exercise and finalize a first draft CHBC Policy & Guidelines.

5. The final CHBC Policy & Guidelines with a directory of CHBC facilities and services across the country was presented at a validation meeting to an expanded group of stakeholders on 30th March 2012 for a final review and acceptance by GAC.

Section 2:

Policy Situation Analysis

In 2010, it was estimated that 112,549 children and adults needed anti-retroviral therapy (ART) but less than 40% received the needed therapy (NACP, 2010 Annual Report). Majority of those not receiving ART and co-trimoxazole (Septrin) were women and children living in areas far from service provision centers (GAC, 2010 Joint Program Review Report). A continuum of health care services that will attempt to bridge the unmet need for care and support as well as bring basic services to the doorstep of these vulnerable groups will reduce morbidity, mortality and costly hospitalization.

CHBC programs have been established in many parts of the world as a community response to the HIV epidemic. It has resulted in an increased number of PLHIV accessing some form of treatment in the face of limited health care resources since it acts as a continuum of health care service delivery. CHBC is also associated with better ART adherence, retention in care and improved survival.

Importantly, studies show that CHBC improves PLHIV physical, emotional and social wellbeing.

Additionally, the HIV epidemic has placed severe strains on communities in relation to the functioning of family, community and social structures that often extends beyond traditional health care.

Ghana adopted the March 2001 Gaborone declaration on CHBC to guide the implementation and monitoring of CHBC activities. However, program reviews and anecdotal evidence shows that different models of CHBC and sub-standard services were being delivered in a non-standardized and uncoordinated way in various communities (GAC, 2010 Joint Program Review Report).

Currently, the most effective care and support services available in Ghana do not extensively address challenges of care within the family, at the home and in the community. These challenges include adherence monitoring, tracing treatment defaulters, helping pregnant women with HIV access and complete PMTCT services, weak linkages and/or referrals between facilities and the communities, unmet need (availability and accessibility) of co-trimoxazole prophylaxis, inadequate psychosocial support and human resources capacity. The identification of these challenges led to the development of the CHBC policy and guidelines.

Methodology
The policy objectives will be achieved through examining and situating in the Ghanaian HIV and AIDS context, the following core elements of CHBC:

1. provision of basic physical and nursing care
2. continuum of care – includes accessibility, referrals, care and support services for the infected and affected
3. staffing
4. nutritional support for Persons Living with HIV
5. communication and preventive care – education and involvement of mass media
6. supplies and equipment
7. finance and sustainability
8. monitoring and evaluation

NB: A Matrix of situation analysis in appendix 1

POLICY OBJECTIVES IN RELATION TO CORE ELEMENTS

Objective	Core Elements
To provide high-quality and appropriate support within the continuum of careThis includes finance and sustainability; human and material resources.	1, 2, 3, 4, 6, 7, 8
To empower persons infected and affected by HIV and AIDS with requisite knowledge and skills to be independent and achieve an improved quality of life	3,5,7,8
To promote psychosocial support and counseling for people infected and affected by HIV and AIDS	2, 3, 5, 7, 8
To promote family and community awareness of HIV and AIDS prevention and care	3, 5, 7, 8
To monitor and evaluate CHBC programmes and projects	8

Section 3:
Eligibility

3.1 Eligibility Criteria
CHBC is intended to reach those who most need it. PLHIV with particular need for CHBC include:

- PLHIV who are symptomatic or have AIDS
- PLHIV just starting ART (first 3 months)
- Pregnant PLHIV enrolled in PMTCT services
- Children Living with HIV (ages 0-5)
- HIV/TB patients
- PLHIV who are lost-to-follow-up; frequently miss clinic appointments
- Children and families affected by HIV and AIDS who require CHBC
- Others as determined by supporting organizations

3.2 Eligibility Assessment
Each organization providing CHBC should develop a tailored eligibility criteria based on the above and organizational priorities. Standardized tools should be developed for the evaluation and assessment of eligibility based on the criteria. The process of assessment should be objective, fair, transparent, relevant and consistent across CHBC programs. An assessment tool should be adaptable to reflect the needs of the community.

Section 4:

Ensuring Access to Quality and Standardized CHBC services

The essential core elements of CHBC are divided into eight main categories; each of these broad categories contains many sub-categories that provide details of the elements that are important in ensuring sustainable and effective CHBC.

The following are the core elements of CHBC:

1. provision of basic physical and nursing care
2. continuum of care – includes accessibility, referrals, care and support services for the infected and affected
3. staffing
4. nutritional support for Persons Living with HIV and AIDS
5. communication and preventive care – education and involvement of mass media
6. supplies and equipment
7. finance and sustainability
8. monitoring and evaluation

4.1 Provision of CHBC Services

4.1.1 Basic Physical and Nursing Care

Basic nursing care includes positioning and mobility, bathing, simple wound cleansing, skin care, oral hygiene, adequate ventilation, guidance and support for adequate nutrition, physical therapy i.e. supporting the client to walk, toilet, washing of bed sheet, pain management, infection prevention and control in the home as well as administration of prescribed drugs such as medication for Opportunistic Infections (OIs) and antiretroviral drugs (ARVs).

Some recommended medication and supplies to be provided should include but not be limited to: pain relievers, vitamins, oral re-hydration salt (ORS), torchlight, scissors, chlorine solution, plaster, bandage, savlon solution, menthylated spirit, cotton wool and gauze dressing.

Symptom management includes managing pain, reducing fever, treating conditions such as diarrhoea and vomiting, cough, skin, mouth and genital problems with approved pharmaceutical products and the treatment of neuro-physiological symptoms.

i. *Care Kits:* CHBC providers need to carry along basic home care kits that have medicines and supplies. Contents of care kits should include the limited medical supplies such as disposable gloves, plaster, bandage, savlon solution and/or soap and condoms.

ii. *ART adherence support and management of side-effects:* This includes providing intensive support to PLHIV who are on ART for the first time (up to 3 months until stable), caring for side-effects such as nausea, dizziness, headache, mild rash, and recognizing danger signs of ARV toxicity.

iii. *PMTCT support:* Involves identifying and referring pregnant women with HIV who are not yet enrolled in PMTCT services, ensuring they are adhering to their ARVs, providing intensive support after delivery, watching for danger signs in mother and infant and providing co-trimoxazole and infant feeding support.

iv. *Screening for TB:* TB/HIV patients are at increased risk of death. CHBC teams will screen for TB symptoms in clients, using the Ghana Health Service (GHS) guidelines and refer all those who are TB symptomatic for diagnosis. This also includes teaching the family infection prevention, providing TB treatment adherence support and awareness of danger signs.

v. *Standard precautions:* Regular hand washing, using disinfectants, proper disposal of sharp instrument and rubbish, use of protective devices to avoid contact with body fluids. Care for caregivers and protecting the infected is the focus in the universal precaution.

vi. *Danger signs and referral:* CHBC providers need to recognise danger signs of HIV infection, Opportunistic Infections (OIs) and treatment toxicity and refer clients for appropriate care.

4.1.2 Continuum of Care

A continuum of care (CoC) involves a network of resources and services that provide holistic and comprehensive support for ill persons, their caregivers and other family members. A detailed directory of health facilities will be available and accessible within the community and at information centers.

This will facilitate referrals and maintain a linkage system, follow-up, monitoring and case management between the CHBC and the health facilities. Referrals can be given for diagnosis and / or follow-up treatment on TB, HIV, OIs, STIs and other conditions.

A critical component of the CoC is ART defaulter tracing. There is significant migration as well as stock-outs of medicines, illness and death that lead to PLHIV loss-to-follow-up. CHBC providers play a critical role in tracing those lost-to-follow-up and ensuring they are able to re-enroll in care. CHBC providers should also help to trace and re-enroll PLHIV who are pre-ART. This population is even more vulnerable to HIV care drop-out.

To ensure continuity of the care received, patients who are discharged and or referred to CHBC should be given adequate information on their health status, other forms of care, when to return for hospital review and who will care for them at the community level. In addition, continuity of care will be facilitated with the use of approved referral documents.

Up-to-date records on the ill person's condition, treatment regimens and referrals should be kept with the person at the CHBC centre or at the local health facility. By so doing the next provider can continue with care having up to date information on medical history of the person.

Supportive and preventive care form part of the continuum of care. Supportive care will focus on provision of education, nutrition and food supplement, disinfectants, provision of income generating activity while preventive care will focus on the provision of condoms and lubricants, distribution of mosquito nets and other such preventive services.

4.1.3 Palliative Care

Palliative care is the combination of active and compassionate long-term therapies intended to comfort and support individuals and families living with a life-threatening illness from diagnosis to death. It strives to meet the physical, psychological, social and spiritual needs of clients and caregivers.

Adults and children who require palliative care to improve the quality of their daily lives will be offered this service. In the case of terminally ill clients, the benefits of palliative care will be to facilitate dying in peace without pain and with dignity within the confines of any laws. Care for the terminally ill will combine pain relief, spiritual and emotional support for the infected and the affected.

Affected families will be provided with information, linkages and referrals to address issues related to funeral plans, fate of survivors, inheritance rights and bereavement counseling. For details in provision of palliative care, see GHS guidelines.

4.1.4 Psychosocial Support and Counseling

Both caregivers and PLHIV CHBC clients will be given psychosocial support and counseling, with the aim of improving their mental health and quality of life. Counseling family members also reduces stigma and enables family members to care for PLHIV without fear of infection. However, issues of lack of confidentiality regarding client status challenge effective CHBC for PLHIV.

Psychosocial care such as pre & post test counseling, behavior change counseling, addressing depression and anxiety, family counseling in stigma reduction, spiritual and pastoral support, death and bereavement counseling should be provided.

Good interpersonal communication, spiritual support and guidance, respect, dignity and empathy are essential elements in administering psychosocial support.

4.2. Care of Children Infected and Affected

Children infected and affected by HIV and AIDS suffer a great deal of health, emotional, social and economic hardships which could lead to sex work, school dropouts, poverty, stigmatization, discrimination, depression, early marriages, malnutrition, street living, aggression, drug abuse, insomnia, child abuse and child labor.

The Department of Social Welfare with technical and financial support from UNICEF has developed and disseminated the National Policy Guidelines on OVC and Plan of Action for the Ministry of Gender, Children and Social Protection. The package of services provided includes shelter, education, food and nutrition, healthcare, social protection and psychosocial support.

The GAC and MOH/GHS will work in collaboration with the Departments of Social Welfare and Children to establish and strengthen strategies through adequate resourcing to identify and address the needs of OVC eligible to receive CHBC services.

4.3 Staffing

Staffing for CHBC will be the responsibility of the entity coordinating and managing the program. However, GAC through its implementing partners will have an oversight responsibility in ensuring that all staff are adequately trained and equipped to ensure the effective delivery of CHBC services.

Four factors key to staffing for a successful CHBC program are:

- Develop clear guidelines and criteria for recruitment of skilled staff
- Develop clear documented and disseminated roles and responsibilities
- Develop a standardized set of tools to ensure delivery of quality basic services for training
- Develop strategies to facilitate staff retention

Providers of CHBC services will form teams at all levels to ensure a broad-base of expertise and experience for the success of the program.

The recommended multi-disciplinary team will comprise 3 or more of the following to include:

- Health care providers
- Traditional Leaders
- Health care workers
- Social Workers
- Persons Living with HIV
- Models of Hope
- Traditional healers
- Spiritual/Religious Leaders
- Community/Opinion Leaders
- Civil Society Organizations
- Private sector health practitioners
- Family and other caregivers
- Volunteers

It is critical for PLHIV to play a leading role in CHBC service provision. They are best placed to provide psychosocial support and advice about coping with the virus. They are also effective at identifying peers who require CHBC services.

It is important to include Traditional/Spiritual healers as part of the CHBC team as people in both rural and urban areas seek care from them and the communities accept their practices. Traditional and spiritual healers also have high credibility within the community because they have a history of having managed some illnesses successfully.

The team will be responsible for planning care and support activities for the client. The focal point for coordinating CHBC will be at the community level with a key opinion leader spearheading the program. This will help in reducing HIV-related stigma and discrimination and encourage community ownership.

A case manager will be chosen to be the team leader at the health facility level to supervise the provision of care, facilitate access to home-care kit medicines and supplies and connect the client to other services that may be required. The selected team leader will be trained by the sub-district and district health teams and will in turn train the caregivers and volunteers. Supervision will be conducted through routine program monitoring visits.

Care givers will receive mandatory training at the onset of their service delivery and will be continually educated through workshops and field visits. This will enhance their skills and knowledge and prepare them for long-term care if necessary. Their education can be managed by monitoring their activities and conducting refresher training for them.

All core team members should have knowledge and skills in record keeping, monitoring and evaluation. Volunteers should have some personal experience with family or friends who are PLHIV, or who died of AIDS.

Recruiting and retaining staff remains the mandate of the lead institution at the various levels of intervention. Staff will need to be supported, motivated and encouraged to prevent burn out and further loss of interest in home-based care provision.

Provision of household services and other instrumental activities of daily living will not be part of CHBC programs. These activities are optional for the caregiver coming to provide services.

4.4 Nutritional Support for PLHIV

Good nutrition is essential for maintaining strength and the body's immune system. It is an important factor in the management of HIV and AIDS. At the initial point of

being diagnosed HIV positive, attention to nutrition should commence. Information and education on good nutrition should be part of the post-test counseling and subsequent sessions.

The MOH/GHS with support from the World Health Organization has developed and disseminated Guidelines on Nutrition for PLHIV. These guidelines should be reviewed and adhered to accordingly.

4.5 Communication and Preventive Care

Effective communication is essential for a successful CHBC program. The important components of effective interpersonal communication include respect and dignity, a non-judgmental attitude and empathy, cultural sensitivity and respect for traditional practices. Empathy involves listening to the other person's fears and concerns. The quality of life of a PLHIV and family receiving CHBC services can be significantly impacted through the simple act of listening. Strategies such as support groups and interpersonal and individual communication strategies should be adopted at the community level.

Even though the level of HIV awareness and knowledge is more than 90% in Ghana, there is the need for continuous education and information on preventive care, treatment literacy, HIV testing and counseling, benefits of ART and CHBC particularly at the community level to ensure the intended change in behavior.

An important component of CHBC service delivery is Prevention with Positives (PwP) also known as Positive Health, Dignity and Prevention. This involves assessing individual HIV prevention needs of clients such as counseling and access to condoms and lubricants, family planning information and commodities, ART adherence, couple counseling and disclosure and routine STI screening and treatment. Depression and anxiety are associated with sexual risk taking in PLHIV so it is also important that psychosocial support is part of PwP services.

The implementation of the National HIV and AIDS Behavior Change Communication Strategy 2011-2015 will facilitate a successful CHBC program.

4.6 Supplies and Equipment

The CHBC program will include the provision of limited medical supplies such as disposable gloves, plaster, bandage, savlon solution and/or soap and condoms. Home-based care kits carried along for home care must be equipped with essential supplies to

meet the needs of the ill and to protect the caregiver. Essential medication for Opportunistic Infections, TB, anti-malaria and prescribed food supplements must be available through local health facilities. Items such as bedding/linens should not be included in the kit due to issues of sustainability. Provision of food may be included in the CHBC program as food forms an integral part of the client's physical need. Food supplements will be provided but selectively by prescription. The services to be provided by CHBC in Ghana will not be restricted to either physical or emotional care. Continuous counseling and education as well as physical and psychosocial care should be given to the clients.

The availability, accessibility, distribution and management of supplies and equipment should be prioritized based on needs of PLHIV receiving CHBC services and availability of funding. Supplies and equipment for CHBC services should be kept at a central location which is accessible to all levels of intervention. This could be with the regional/ district/sub-district medical stores or a CSO within the community.

The CHBC team should be able to access CHBC kits at the level of intervention. These CHBC kits should be available and appropriate for the services to be provided. As a cost-effective measure and where applicable, supplies and equipment should be developed and obtained domestically.

4.7 Financing and Sustainability

One of the most important challenges facing the CHBC program is financing and sustainability over the long term. Mobilization of resources should be a core activity. Ideally, the Government of Ghana should be the primary financier of the CHBC program along with contributions from the faith-based community, localities and NGOs.

The Ghana AIDS Commission in collaboration with the Ministry of Health/Ghana Health Service should advocate for and promote the appropriate allocation of funding within the budgets of Local Government Agencies to ensure the successful implementation, monitoring and evaluation of CHBC programs.

The formation of Public-Private Partnerships (PPP) at all levels of implementation should also be advocated and promoted. Mechanisms should be established to facilitate the provision of services at the community level.

The level of funding should include the cost of providing CHBC services to ensure affordability and appropriateness. The availability, accessibility and sustainability of funding are necessary for a successful program and for its maintenance.

4.7.1 Allowances

Cash allowances will not be given to families to encourage them access CHBC services. If there is a strong need for cash allowances, these should be mobilized locally through the NHIS, LEAP and other similar initiatives to facilitate the acquisition of services by the beneficiaries.

Benefits for the client will be determined through a needs assessment and as such there will not be a predetermined minimum and maximum limit to the benefits to the client.

4.7.2 Compensation

Family caregivers will not be compensated for their caregiving. However in instances where there is a loan given for income generation activities, the caregiver will be encouraged to make the most out of the opportunity.

4.7.3 Respite Care

Respite care is defined as the provision of short-term temporary relief for those who are caring for family members. These relief services are given to caregivers to lessen their workload and mitigate burnout. Respite Care for caregivers will not be included in CHBC in Ghana.

4.7.4 Transportation

Transportation costs of CHBC beneficiaries and their family caregivers will not be covered by the CHBC program unless required for urgent referrals based on the regulations of each specific service. However, if the caregiver is a non-family member and works for the program, his/her transportation costs should be covered by the program.

4.8 Monitoring & Evaluation

The CHBC program will be monitored and evaluated according to the National Monitoring and Evaluation (M&E) Plan to identify challenges, key achievements/success, needs, areas for improvement and to track the overall implementation of the program. This will be undertaken by the Research, Monitoring and Evaluation (RM&E) Division of the GAC and in collaboration with its implementing partners through program quality review and assurance activities. (Refer to National M&E Plan 2011-2015).

4.8.1 Quality Standards

WHO guidelines and other international guidelines and procedures will be used to define the criteria for assessing the establishment and regulation of quality standards. These standards will however be adapted, incorporating consumer/community input to suit the Ghanaian environment. Conducting monitoring and evaluation and reviewing performance based on the results will facilitate quality assurance.

CHBC service providers will be provided with clear indicators on the services they are providing and will submit monthly reports through the existing M&E reporting system.

Both external and internal evaluators will regularly conduct quality assurance reviews of CHBC based on agreed standards of care. In addition, formal CHBC evaluations and dissemination of the key findings and recommendations should also be conducted.

A central information system (CIS) for CHBC managed by the national level data quality manager will be established. This central system will provide home visit registers, enrollment forms, HTC forms, commodity stock forms and referral forms among others.

Section 5:
Guidelines to Implementation of the Policy

The implementation, monitoring and evaluation of the CHBC program cannot be accomplished by a single sector or type of service. The GAC in collaboration with key sector ministries and implementing partners are critical for the successful development, implementation, monitoring and evaluation of the CHBC program.

The District AIDS Committee (DAC) should have the mandate to coordinate all CHBC activities within the District. The overall coordination and management is within the mandate of the GAC in collaboration with key sector ministries and implementing partners. Ministries, Departments and Agencies that have programmes that target PLHIV and other vulnerable groups should allocate resources to CHBC.

5.1 National Level Roles and Responsibilities

At the national level, development of appropriate policies and guidelines to facilitate the planning, legislation and regulation of CHBC services is done .The lead coordinating and management body at that level, GAC is also responsible for the allocation of resources, supervision, monitoring and evaluation.

GAC will ensure that HIV-related stigma and discrimination is addressed within the context of CHBC. Roles and responsibilities of CHBC at the national level may include the following:

- Developing strategies for the coordination and management of CHBC programs at all levels;
- Advocating for political will and commitment;
- Mobilization of technical, human , material and financial resources;
- Budgeting and allocating resources;
- Promoting and sustaining PPPs and inter-sectoral collaboration;
- Ensuring that CHBC programmes are implemented, monitored supervised and evaluated within the context of the National M&E Plan;
- Developing an effective referral and linkage mechanism; and
- Ensuring comprehensive IEC and BCC materials are developed;

5.2 Regional Level Roles and Responsibilities

The Regional level is responsible for the allocation of resources and providing oversight in reference to clearly defined priorities set by the national level. The implementation,

monitoring and evaluation of the CHBC at the regional level should be coordinated by the Technical Support Units of GAC in collaboration with the Regional AIDS Committees.

National policies and guidelines should be adapted to meet the needs of the regions where applicable. Roles and responsibilities at the Regional level may include the following:

- Coordinating and management of CHBC program;
- Advocating and mobilizing resources for capacity building of CHBC team
- Ensuring a budget line for CHBC program;
- Ensuring availability, accessibility and affordability of CHBC services to those in need;
- Developing and sustaining PPPs and inter-sectoral collaboration;
- Reducing HIV-related stigma and discrimination within the context of CHBC programmes;
- Establishing a regional pool of CHBC trainers;
- Monitoring and evaluation of CHBC programs; and
- Communicating between the national and district levels of Government

5.3 District Level Roles and Responsibilities

The District level is responsible for the allocation of resources with reference to clearly defined priorities set by the national and regional levels. The implementation, monitoring and evaluation of the CHBC at the district level should be coordinated by the District Health Management Team in collaboration with the District AIDS Coordinating team.

National policies and guidelines should be adapted to meet the needs of the districts where applicable. Roles and responsibilities at the District level may include the following:

- Coordination and management of CHBC program;
- Advocating and mobilizing resources;
- Promoting the capacity building of CHBC team;
- Ensuring a budget line for CHBC program;
- Allocating resources (technical, material and financial);
- Ensuring availability, accessibility and affordability of CHBC services to those in need;
- Establishing a waiver system or free service for those who cannot afford to pay (based on the CHBC eligibility criteria);
- Developing and sustaining PPPs and inter-sectoral collaboration;
- Reducing HIV-related stigma and discrimination within the context of CHBC programmes;

- Establishing a district pool of CHBC trainers;
- Monitoring and evaluation of CHBC programs; and
- Communicating between the regional and community levels of Government

5.4 Community Level Roles and Responsibilities

The implementation of CHBC is undertaken at the community level. The community's culture, traditions and norms play a critical role for the successful implementation of CHBC services at the community level. The leadership and dynamics of the community are also a critical component.

To ensure the successful implementation of CHBC services at the community level, effective strategies must be developed to facilitate the promotion of effective leadership and the mobilization of the community for action. Community involvement includes the participation of care-givers/providers, PLHIV, health care and social workers, community volunteers, tradition/spiritual healers and other community opinion leaders. All these stakeholders should be involved at all the levels of development, implementation, monitoring and evaluation to ensure ownership efficiency and sustainability. Integration of CHBC programs into existing community services and agencies should be encouraged.

The service provider is key to the implementation of CHBC at the community level. The roles and responsibilities of the service provider at the community level are:

- Identifying who needs care and referring when necessary;
- Providing physical, nursing, emotional and spiritual care and support;
- Ensuring the client is provided services in the context of the continuum of care;
- Ensuring adherence to treatment;
- Providing education for PLHIV and caregivers;
- Adequately managing CHBC kits and equipment;
- Mobilizing resources through innovative strategies to sustain the CHBC programme;
- Establishing partnership with all service providers (private and public) at the community level;
- Documenting and reporting activities to GAC through DACs;.
- Communicating effectively with the district and within the community; and
- Attending community level coordination meetings

According to the Models of Hope manual, the service provider is key to the implementation of CHBC at the community level. The roles and responsibilities of the Models of Hope at the community level are:

- Identifying who needs care and facilitating their access to care and support services;
- Providing physical, nursing, emotional and spiritual care and support;
- Referring when necessary and following up on referrals;
- Ensuring the client is provided services in the context of the continuum of care
- Ensuring adherence to treatment;
- Organizing PLHIV for support group meetings and following-up on peers who fail to attend support group meetings (within their immediate environment);
- Facilitating the sharing of experiences at support group meetings and serving as positive role models to PLHIV at the community level;
- Supporting PLHIV whose rights have been abused by linking them to relevant bodies in the community;
- Providing education for PLHIV and caregivers as well as distributing Infornmation, Education and Communication (IEC) materials;
- Adequately managing CHBC kits and equipment;
- Mobilizing resources through innovative strategies to sustain the CHBC programme;
- Establishing partnership with all service providers (private and public) at the community level;
- Communicating effectively with the district and within the community;
- Attending community level coordination meetings; and
- Documenting and reporting activities to GAC through DACs.

Section 6:

Integration of Stakeholders in CHBC

The GAC as a coordinating and management body will take the lead role by engaging all stakeholders in the implementation and management of CHBC. GAC in collaboration with key stakeholders and partners will harness all stakeholders' expertise and inputs to guide program development.

Civil Society Organizations (NGO, FBO, CBO, PLHIV groups), the media and the private sector can contribute to the implementation of CHBC in Ghana. They can be contracted to provide capacity building and logistics for CHBC implementation and financial support where possible.

All stakeholders (community volunteers, health care workers, social welfare professionals, PLHIV, chronically ill clients, care-givers/providers and traditional/spiritual healers and traditional leaders) involved in the provision of CHBC services and Government, will require training in both formal and informal strategies to educate the community and ensure the effective delivery of CHBC services.

6.1 Education and Communication

Education and communication will be aimed at increasing the knowledge and skills on HIV prevention, treatment, care and support services and HIV-related stigma and discrimination reduction programs. The GAC in collaboration with key sector Ministries implementing partners and other appropriate training agencies will develop a curriculum and training materials for training CHBC service providers.

Education will be provided at targeted public or community gatherings (schools, faith-based and social gatherings) on the transmission, prevention, treatment and care of HIV and AIDS in an area where CHBC is provided. The mass media may be involved as a means to educate the public or community on CHBC and issues related to HIV on a regular basis.

6.2 Stakeholders

GAC will ensure that a Terms of Reference or job description is provided for the CHBC teams. PLHIV and/or chronically ill clients will assist by:

- Identifying the primary caregiver;
- Collaborating with the caregiver to overcome fear and denial of HIV and AIDS;
- Providing accurate information;
- Agreeing to adhere to rules of care provision;
- Adhering to rules of medication;
- Resolving to take personal responsibility to stop further transmission of HIV;
- Resolving to join support groups; and
- Referral of other chronically ill people to caregivers

Family and other caregivers will be responsible for:
- Caring for the PLHIV and/or chronically ill client at home;
- Collaborating with the CHBC team including other care providers such as spiritual and traditional healers;
- Accepting the reality of the situation; and
- Supporting HIV-related stigma reduction programs

The Community will be responsible for:
- Showing acceptable attitudes towards PLHIV by creating the needed environment for PLHIV to access treatment;;
- Mobilizing technical, financial and material resources
- Supervising the provision of CHBC services;
- Forming support groups;
- Collaborating with existing agencies to meet the needs of the infected and affected; and
- Advocating for the rights of the PLHIV, linking and providing feedback to the health facility and family caregiver

Traditional/Opinion Leaders will be responsible for:
- Advocacy and the promotion of CHBC programs;
- Ensuring community ownership;
- Mobilizing technical and financial support; and
- Reducing HIV-related stigma and discrimination

The Health Facility (where the client receives initial care) will be responsible for:
- Making the initial diagnosis and delivering clinical care;
- Supplying simple drugs and basic home nursing supplies;
- Providing technical support; and
- Linking the client to CHBC services

Traditional and Spiritual Healers will be responsible for:
- Providing traditional and spiritual support in collaboration with the CHBC team and PLHIVs; and
- Referring clients to the health facility / CHBC team in a timely manner

Civil Society Organizations will be responsible for:
- Mobilizing resources (technical, material and financial);
- Advocating and promoting CHBC services;
- Working in collaboration or as part of the CHBC team at all levels;
- Supporting the implementation, monitoring and evaluation of CHBC services;
- Reducing HIV-related stigma and discrimination;
- Participating in community level meetings;
- Working in collaboration with DAC; and
- Providing data through timely reporting

The Media will be responsible for:
- Promoting and creating demand for CHBC services;
- Advocating for continuous financial resources for CHBC services; and
- Reducing HIV-related stigma and discrimination

Volunteers will be responsible for:
- Supporting the implementation, monitoring and evaluation of CHBC services;
- Identifying PLHIV who need CHBC services;
- Ensuring the confidentiality of clients;
- Contributing to HIV-related stigma and discrimination reduction; and
- Carrying out tasks as defined by CHBC team

Government will be responsible for:
- Creating an enabling environment – development of policies, guidelines, regulation, legal framework and formation of National CHBC task team;
- Mobilization and allocation of resources;
- Supporting capacity building activities; and
- Procuring drugs, supplies, equipment and commodities

Development Partners will be responsible for:

- Mobilizing and providing resources;
- Supporting implementation, monitoring and evaluation of CHBC services;
- Supporting stigma and discrimination interventions;
- Supporting research on stigma and discrimination impact on service uptake; and
- Building and strengthening partnerships

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Section 7:

Appendix

Appendix 1:

Matrix of Situational Analysis

Component	Weakness	Strength	Proposed interventions
Policies, Guidelines and other Standards e.g. Training Manuals (availability, content, dissemination, effectiveness)	Disorganized and individual concepts of CHBC models in use There are no national policies on guidelines on Community Home-Based care and Nutrition in HIV	Adopted Gaborone declaration on Community Home-Based care (March 2001)	Develop and disseminate national policy and guidelines on community Home-Based care and services Develop and disseminate national policy and guidelines on nutrition in HIV
Program Management, leadership, financial resources, integration and co-ordination, Stakeholders (NGO's)	Inadequate monitoring of community Home based care services Weak coordination of activities at the community level Inadequate financial support from Government	There is an established structure for coordination and management Civil society organizations as key Implementing partner	Strengthen Monitoring and Evaluation of Community Home-Based care services Advocate for direct financial commitment from Government

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Appendix 3:
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