National Guidelines for Community and Home Based Care (CHBC)

(Revised Version 2015)

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List of Annexures

Acronyms & Abbreviations

ABC	Abstinence, Being faithful, and using Condoms
AFASS	Acceptable, Feasible, Affordable, Sustainable & Safe
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
AZT	Azidothymidine
BCC	Behaviour Change Communication
BHU	Basic Health Unit
CBC	Community Based Care
CBO	Community Based Organisation
CCC	Community Care Center
CDC	Centers for Disease Control and Prevention
CHABA	Care of Children Affected by HIV and AIDS
CHBC	Community and Home-Based Care
CHC	Community Health Center
CMAM	Community Management of Acute Malnutrition
CSO	Civil Society Organizations
CTX	Cortex
DBS	Dried Blood Spots
DHO	District Health Officer
DHQ	District Head Quarter
DOTS	Directly Observed Therapy, Short Course
D4T	Didehydro-deoxythymidine
EFV	Efavirenz
EPC	Enhanced Primary Care
EQAS	External Quality Assurance System
FBO	Faith Based Organization
FDC	Fixed Dose Combination
FSW	Female Sex Workers
FP	Family Planning
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
GI	Gastro-Intestinal
GIPA	Greater Involvement of People with HIV and AIDS
GOVT	Government
HAART	Highly active anti-retroviral therapy
HBC	Home Based Care
HCP	Health Care Provider
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
I/C	In-Charge
ICTC	Integrated Counselling and Testing Center
IDU	Intravenous Drug Use
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illnesses
KABP	Knowledge, Attitude, Behaviour & Practice
MAP	Multi-country AIDS Programs
MCH	Maternal and Child Health
MOU	Memorandum of Understanding
MO	Medical Officer

NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NHS	National Health Services
NTCP	National Tuberculosis Control Programme
OI	Opportunistic Infection
OPD	Out-Patients Department
OST	Opioid substitution therapy
OW	Outreach Worker
PEP	Post-exposure Prophylaxis
PHC	Primary Health Care
PID	Patient Identification Digit
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PN	Parenteral nutrition
PPTCT	Prevention of Parent to Child Transmission
PRP	Pityriasis Rubra Pilaris
REE	Resting Energy Expenditure
RH	Reproductive Health
RHC	Reproductive Health Centre
RPR	Rapid Plasma Reagin
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TI	Targeted Intervention
USP	Universal Safety Precautions
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing
VTCT	Voluntary Testing and Counselling for Testing
WHO	World Health Organisation
ZDV	Zidovudine

Acknowledgement

The Global Fund (GF) R-9 proposal aims at reducing HIV related morbidity and mortality in Pakistan by improving access to continuum of Prevention and care (CoPC) services to Injecting Drug Users (IDUs) and enhancing the quality of Community and Home Based Care (CHBC) to People Living with HIV (PLHIV) and associated populations.

The Global Fund for AIDS, TB and Malaria, Round 9, Principal Recipient 2 (GFATM R9, PR2) also undertook the development of the National CHBC Guidelines. This document developed will provide guidelines for standardizing care and support services and is expected to improve access to HIV care and support for PLHIV and their families through the provision of effective Community and Home Based Care Services. An important aspect of this guideline is the development of monitoring & evaluation tools for the CHBC Centers to help ensure the proper implementation of the continuum of care activities.

The guideline provides the reader with the fundamental knowledge about CHBC that is expected to help design interventions that can make a much-needed difference in the lives of those infected and affected with HIV and AIDS.

NACP would like to wholeheartedly acknowledge the published work of previous authors, whose research was greatly beneficial towards drafting this document. This document is founded after extensive stakeholder consultations, research, and conceptual development, observations of practice and in depth review of the relevant community home-based care literature.

The initial guidelines developed in 2012 have been revised, to accommodate for development in various areas, including the HIV testing, treatment etc.

Glossary of Terms

ART	Antiretroviral drugs are medications for the treatment of infection by retroviruses, primarily HIV. When several such drugs, typically three or four, are taken in combination, the approach is known as highly active antiretroviral therapy, or HAART
ARV	Isolates of the retrovirus that causes AIDS
Assessment	The evaluation or estimation of the nature, quality, or ability of someone or something
Analgesics	Pain relieving medication
Auxiliary	Auxiliary is something that provides additional help or support in performing some task
Bereavement Counselling	Counselling to cope with loneliness
Capacity Building	Capacity building often refers to assistance that is provided to entities, usually societies in developing countries, which have a need to develop a certain skill or competence, or for general upgrading of performance ability.
Case Management	Case management is the coordination of community services for mental health patients by allocating a professional to be responsible for the assessment of need and implementation of care plans
Community	The people of a district or country considered collectively, esp. in the context of social values and responsibilities.
Community Development Process	Identifying other health & social services in the community, building alliances with other organizations e.g. NGOs, CBOs FBOs etc. for CHBC provision, sensitization of power holders for acceptance and support for CHBC program, Identifying and developing alternate funding sources, and fund raising activities for CHBC etc.
Continuum of care	The provision of comprehensive care from the hospital to the home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system
Endemic	Belonging to a particular region or place
Enteral nutrition	A way to provide food through a tube placed in the nose, the stomach, or the small intestine. A tube in the nose is called a nasogastric tube or nasoenteral tube. A tube that goes through the skin into the stomach is called a gastrostomy or percutaneous endoscopic gastrostomy (PEG). A tube into the small intestine is called a jejunostomy or percutaneous endoscopic jejunostomy (PEJ) tube.

Epidemic	Epidemic is generally a disease that affects many people at the same time, spreading from person to person
Esophageal	Pertaining to the Esophagus (passage connecting mouth to stomach)
Evaluation	The making of a judgment about the amount, number, or value of something; assessment
Hakims	Traditional Healer
Intravenous	Injection into a vein
Monitoring & Evaluation	A management tool that is built around a formal process for evaluating performance and impact using indicators that help measure progress toward achieving intermediate targets or ultimate goals. Monitoring systems comprise procedural arrangements for data collection, analysis and reporting
Multi-Sectoral Response	A collective response from all the sections of the organization
Ostracizing	Ostracizing is to banish someone/something from a particular place
Palliative	Relieving pain or alleviating a problem without dealing with the underlying cause
Parenteral nutrition (PN)	Feeding a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulas that contain nutrients such as salts, glucose, amino acids, lipids and added vitamins. It is called total parenteral nutrition (TPN) or total nutrient admixture (TNA) when no food is given by other routes.
Prophylaxis	Action taken to prevent disease, especially by specified means or against a specified disease
Provision of care	The act or process of providing aid or healthcare
Psychosocial	The interaction between psychological development and social environment
Recession	Recession is the time period when there is a downturn in the economic condition
Rota System	Rota System is also known as the “ladder system”. This system basically describes the pattern of succession
Stakeholders	A person or entity that directly affects or is directly affected by the risks in a business.
Stigma	A mark of disgrace associated with a particular circumstance, quality, or person: "the stigma of mental disorder"
Sustainability	The ability to sustain something; a means of configuring civilization and human activity so that society, its members and its economies are

	able to meet their needs and express their greatest potential in the present, while preserving biodiversity and natural ecosystems
Symptom	A physical or mental feature that is regarded as indicating condition of disease, particularly such a feature that is apparent to the patient
Tertiary	Third in rank or order
VCT	HIV testing with both pre-test and post-test counselling sessions
VCCT	Voluntary Confidential Counselling and Testing, primary objective of VCCT had been prevention, to influence behaviour change and prevent transmission of HIV
Vocational Training	Vocational training or education is training for job based on manual or practical activities. In other words, it is on-the-job training

1.0 INTRODUCTION AND BACKGROUND

1.1 What is Community and Home based Care

Community and Home Based care (CHBC) is defined as any form of care given to people living with HIV and AIDS and their affected families in their homes. Such care includes physical, psycho-social, and palliative activities.[1]

1.2 Rational for CHBC

Due to the upsurge of HIV and AIDS in recent years, many communities are now looking for more facilities and cost effective programs for PLHIV. Countries are now aiming to develop their own customized national guidelines & strategies for CHBC development and maintenance in resource-constrained settings. The objective is to use the available resources intelligently in tandem with proven strategies.

1.3 Importance of CHBC

CHBC is an effective method of providing cost-effective, empathic care to those infected and affected by HIV and AIDS. CHBC is not a replacement for hospital care, but instead is part of a spectrum of care that includes preventive, curative and rehabilitative care. In addition to providing support to families coping with HIV and AIDS, CHBC also contributes to prevention efforts. By involving community members in prevention, care, and support efforts, CHBC brings issues surrounding HIV and AIDS into the open, creating opportunities to clarify myths, reduce stigma, empower those infected and affected by HIV and AIDS, and influence peoples' willingness to know their HIV status and change risky behaviours.

CHBC efforts provide PLHIV and their families with practical Care Giver Skills, including basic first aid, and emotional support. CHBC programs offer palliative care, treatment of opportunistic infections, counselling and emotional support including disclosure, contraceptives, and referrals to available health services. Outreach Workers (OWs) regularly visit homes and teach family members how to provide emotional support and physical care to people living with HIV and AIDS. The CHBC programs further create strong two-way referral systems between the community and the medical facilities. This allows OWs to refer PLHIVs to local clinics or hospitals and allows hospital staff to link discharged patients back to OWs.

1.4 Importance of CHBC for PLHIV

[1] WHO.AIDS (1993), "home care handbook. Geneva"

- Encourages PLHIV to accept their status.
- Promotes the physical and psychological health of PLHIV.
- Facilitates PLHIV to be a contributing member of their community and family.
- Enables PLHIV to participate in preventative activities.
- Enables PLHIV to receive care at home.
- Facilitates PLHIV in taking their medication consistently and correctly.
- Facilitates timely referral of PLHIV for diagnostics and treatment of complications.

For the Family and Caregivers

- Holds the family together and promotes a caring attitude.
- Helps the family accept the HIV+ status of a family member.
- Makes it easier for the family to provide care and support to PLHIV.
- Encourages adherence to universal precautions while handling PLHIV.
- Facilitates referral for diagnostic tests for HIV.
- Reduces medical costs by providing advice and palliative care to PLHIV at home.
- Empowers them to participate in HIV prevention efforts.

For the Community

- Raises awareness about HIV and AIDS, clears misconceptions and helps reduce stigma.
- Enables communities to protect themselves better against HIV.
- Helps set up long-term care and other services in the community.
- Encourages more effective mobilisation and utilisation of community resources.
- Helps bring the community together to combat HIV and AIDS and advocate for more services.

For the Health System

- Helps ease demands on the health system.
- Extends responsibilities of care and support to families and communities.
- Helps create referral linkages between the formal health system and the community.

In the Continuum of Prevention and Care

- Ensures the comprehensive implementation of the continuum of care at its various stages including VCCT, detoxification and OST for IDUs, PPTCT and paediatric HIV care, home care and support, acute medical care, ARV treatment, care and planning before death and arrangements after death.

- Helps in taking preventative measures against AIDS.

1.5 Goals and Objectives of Community and Home based Care

1.5.1 Goal of CHBC

To meet the expectations of PLHIV, affected families, and communities in providing quality, need-specific care to PLHIV and their affected families so that they can maintain their independence and achieve together the best possible quality of life.

1.5.2 Objectives of CHBC Guidelines

The primary objective:

To provide practical guidance on the implementation of the program by all stakeholders

The guideline intends to synchronize the implementation of community and home base care (CHBC) at the national, provincial, district and community operational levels in a well-coordinated manner. As this is a developing document, it must be continually updated based on the recommendations of the stakeholders to reflect the changing paradigm of CHBC program.

The secondary objectives

To ensure that PLHIV receive need-specific physical care and treatment at home

- Train and support PLHIV, PLHIV's family, caregivers, OWs and community volunteers to provide physical care at home, including recognizing of symptoms, basic first aid and palliative care, advice on the use of universal precautions
- Provide treatment and care to PLHIV for mild symptoms and side-effects at home
- Refer PLHIV to health facility based services where appropriate
- Follow up on PLHIV and ensure their adherence to medication

To Ensure effectiveness of Opportunistic infection (OI) treatment and/or antiretroviral therapy (ART)

- Raise awareness on VCCT, availability of OI and ART Services and promote the use of these services
- Support and encourage adherence of PLHIV to regimens for prophylaxis and treatment of OIs, the most common being tuberculosis (TB) and Hepatitis C
- Support and encourage adherence of PLHIV to ART regimens

- Support PLHIV in monitoring and coping with mild side effects of OI and ART regimens
- Facilitate referral to health facility services for management of adverse reactions
- Follow up patients (lost to follow up, move, died) and inform the relevant authorities and families

To develop collaborative linkages with public health programmes and professional networks

- Identify other resources that can enable and enhance the scope of physical care to be provided at home
- Provide information and counselling (group or individual) to TB and Hepatitis C patients for HIV testing and facilitate referral to nearest Voluntary Confidential Counselling and Testing (VCCT) sites
- Provide information and counselling (group or individual) to women of child bearing age and pregnant women at risk for HIV for undertaking HIV testing, ANC services and facilitate referral to VCCT and PPTCT sites

To ensure that PLHIV can receive psychosocial support and counselling:

- Support establishment and facilitate activities of PLHIV Support Groups
- Provide individual, family or group counselling
- Facilitate religious groups for giving psychological and social support

To ensure that PLHIV and their family get benefits from LOCAL COMMUNITY BASED social NETWORKS

- Support income generation activities
- Lobby community leaders, government social protection schemes, NGOs, and charities to provide socio-welfare support to patients and their families
    - Seek support for children affected by HIV and AIDS, homeless patients, and poor families
    - Advocate for effective and affordable treatment for PLHIV

To raise community awareness on HIV AND AIDS prevention and the need for care and support for PLHIV

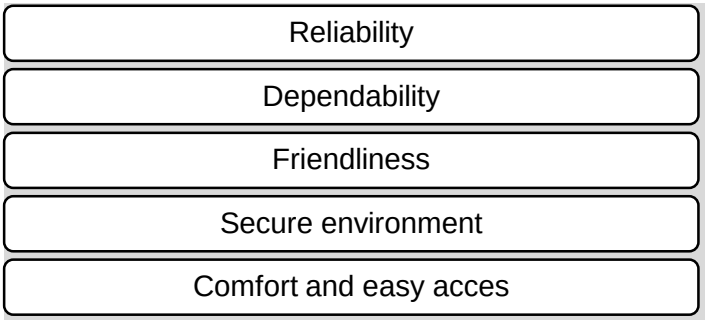
- Educate PLHIV, families and other community members on HIV and AIDS, risk and prevention, self-care, hygiene, and universal precautions
- Collaborate and participate in community activities related to HIV and AIDS

To Provide Palliative care, end of life support:

- Improve the quality of daily life at the end of life by ensuring that PLHIV receive adequate comfort measures, pain control, emotional and religious support
- Encourage community support and enlisting the help and support of friends, neighbours and other relevant people
- Support PLHIVs and their families in planning for their children before death including placement of children affected by HIV and AIDS and inheritance rights
- Provide support to the family with funeral arrangements of the deceased PLHIV
- Offer support and counselling to the family following death, especially to the children whose parent/s have died

1.6 Core Components

Every CHBC service site must communicate to their clients of the services based on the following commitments:



The underlying and fundamental commitment of the CHBC Program is the provision of the highest level of client service possible. The PLHIVs should expect from the CHBC sites:

i) *Reliability* for providing accurate and adequate information
ii) *Dependability* for maintaining strict confidentiality
iii) *Friendliness* through open and caring personal attention
iv) *Secure environment* allowing open communication and promising strict confidentiality
v) *Comfort* and easy access to all facilities

1.7 Principles of Community and Home based Care

The following principles should guide the provision of community and home based care:

- ***Right***: The right of PLHIV to choose whether or not he/she would like to receive CHBC support. Services can be continued or discontinued as desired.

- ***Component of the Continuum of Care***: CHBC services are offered as part of a package of services, which include ART and other hospital-based HIV clinical care. It provides access to services for PLHIV and their families who prefer receiving regular care in their home environment.

- ***Interdisciplinary Team***: CHBC team consists of a mix of people who are HIV positive and negative with a balance of skills for community work, mobilization, advocacy, social work and counselling skills.

- ***Case-management***: CHBC includes assessment of pain and other symptoms on every home visit through history taking and physical assessment and provision of symptomatic care and/or referral based on PLHIV needs and severity of illness.

- ***Continuity of care***: Once a PLHIV is enrolled in the CHBC program, monthly home visits are recommended if ambulatory and not in need of intensive support. However if the PLHIV is in need of more frequent support, then the CHBC team can provide regular visits as required by the PLHIV and family.

- ***Optimal care in limited resources***: CHBC programs should encourage systems and linkages to enhance the level of care being provided to the PLHIVs in resource limited settings. It is important to explore other avenues for support and funding and advocate effectively for such support in order to enhance the scope and extent for care.

- ***Confidentiality***: PLHIV information is kept confidential at all times. PLHIV records are managed by a limited number of authorized staff; files are locked and kept in secure location.

- ***Remuneration and training***: CHBC staff receives adequate training to provide quality care to PLHIV; they are appropriately paid for their work. Volunteers are also provided non-monetary incentives.

- ***Need-based***: Need assessment is done in the affected community to determine the specific services that can be provided and to identify other community services to which CHBC can build a liaison. Home care services should, therefore, be provided only in areas where there is an expressed need and should depend on the numbers of PLHIV.

1.8 Challenges of Community and Home based Care

To effectively manage CHBC program, several challenges are faced. Those most pertinent to Pakistan in this context are discussed below:

1.9 Stigma associated WITH HIV and AIDS

HIV and AIDS continue to generate fear, misunderstanding, misinformation, and discrimination. This is true not only for PLHIV, but the CHBC staff, nurses, caregivers and families are also affected by associated stigma. This often makes the situation being even more challenging for them as more then often PLHIV are shunned and isolated, forced out of their jobs or homes, refused medical treatment, stripped of their human and civic rights.

Stigma associated with HIV and AIDS has caused people with HIV and AIDS and family members to avoid accessing care. Even if the diagnosis is not HIV, some people do not access CHBC because they fear that people will assume they are HIV-infected. This makes it harder for the CHBC teams to reach out to PLHIV as they are often not open to discussing their HIV status and seeking help. The stigma associated with being HIV positive is so severe that it often forces people to go into hiding or being ostracised from the community. Communities, families and even the health and Outreach Workers (OWs) are frequently found to have stigmatizing attitudes towards people with HIV and AIDS. Within CHBC, people with chronic illnesses have also experienced stigma.

The reasons behind stigma and discrimination are varied and extremely complex. Some of these include:

- Misconceptions about HIV and AIDS especially the mode of transmission of the disease.
- Lack of clarity of the difference between PLHIV and AIDS patient.
- Lack of awareness about how PLHIV can still be contributing members of the community.
- The religious and cultural conservatism of the Pakistani society especially with issues pertaining to the sexual practices of individuals and drug abuse.

The issue of stigma can be more acute in the more affluent classes as they deem PLHIV a threat to their prestige. Combating stigma is a complex issue. Increasing community sensitivity and acceptance is very important. Education, community involvement, effective communication and psychosocial support are some of the strategies that help to reduce stigma. Stigma must be reduced so that the CHBC Centres are accessed for support and effective CHBC. First and foremost the CHBC team meetings should address stigma that often exists among the staff members. Secondly, a stigma-reducing programme should be developed for the neighbouring community. As the effects of stigma and discrimination are explored, strategies should also be developed that reduce stigmatizing attitudes and promote the effective care of PLHIV and their families.

1.10 Child Care and HIV

HIV has increased the number of vulnerable children and families to unprecedented numbers. Some of the most complex and interrelated problems among children and families affected by HIV include:

- Added financial and physical burden on care givers in instances when children are cared for by other family members.
- After their parent's death, children can lose their rights to their family property or home.
- An increased dropout rate from schools in children being affected and infected with HIV.
- Without education, work skills or family support, children may end up in extremely vulnerable situations such as living on the streets and Increased vulnerability to drug abuse due to lack of adult care.
- Lack of proper care may result in children becoming sexually active at an early age and at risk from HIV themselves.
- Poverty for children affected by HIV and AIDS is an overwhelming problem. These children not only lack financial assistance, but also basic necessities such as clean water, drugs, food, shelter and medical supplies.
- Children often do not have information about how to protect themselves. Further they have poor access to doctors, nurses, and other health care workers and facilities.
- Children affected by HIV and AIDS often lack human and civil rights.
- Additional psychosocial stress on children working as caregivers.

As the HIV and AIDS epidemic continues its devastation, more children are being affected and even orphaned and many extended families are being stretched to the breaking-point, due to a scarcity of financial resources, and lack of social support. Care of children affected by HIV and AIDS (CHABA) is expected to be an increasing problem in Pakistan like the other developing countries. Although caring for them involves the whole community, the CHBC team is often the first contact in identifying CHABA. The CHBC team (including the extended family) is therefore often responsible for initiating the process of providing comprehensive, planned care for this group of vulnerable children. Members of the CHBC services face the challenge of working in partnership with various community groups for finding the best possible/available solution for orphan care.

Strategies for the care of orphaned children affected by HIV and AIDS include the following, in order of preference:

- Every possible effort must be made to trace blood family and or relatives.

- Placement with non-relative family units should be made only if absolutely necessary and after careful caregiver selection, or foster care on a formal basis. Whilst making the consideration traditional norms, religion culture and values should be kept into consideration.
- If finding difficulty in finding traditional foster homes for orphans, arrangements such as paid foster mothers living together with small groups of orphans or adolescents caring for younger siblings with the support of the community can be considered. This should only be preferred as a last resort when all other options are inappropriate or unavailable.

The magnitude of the growing crisis of children affected by HIV and AIDS requires a multi-sectoral response, as no single program/organization can alone handle the challenges being faced. The magnitude of this problem will have to be addressed at international, national, local, and community levels. Government, non-governmental organizations (NGOs) and other institutions and organizations will have to combine their efforts to provide effective programs and strategies to care for children affected and infected by HIV and AIDS.

1.11 Confidentiality

Confidentiality is especially challenging in providing effective CHBC to PLHIV. Some PLHIV do not want family members or the CHBC team to know that they are living with HIV. Some PLHIV present symptoms of opportunistic infections but refuse to be tested for HIV. These challenges need to be tackled for providing access to treatment, prevention, care and effective case management of PLHIV. CHBC team members must encourage and support shared confidentiality. However, overall the rights of PLHIV must be respected which often leads to ethical dilemmas for the CHBC team.

Many communities now have access to voluntary confidential counselling and testing (VCCT) facilities available through clinics or the local hospital. PLHIV can be counselled for undergoing the diagnostic tests through effective interpersonal communication and support. Knowledge of HIV diagnosis can lead to effective prevention, treatment and care.

1.12 High Illiteracy Rate

High illiteracy rate amongst the target group can act as a barrier to effective care. This is further complicated by the low literacy level amongst the caregivers as they do not access care-giving educational activities, may not follow the medical and hygiene protocol, and may not diligently follow the disease progression of their family members/clients. PLHIV, family members, health and social welfare professionals, community health workers and community volunteers, all require adequate education and training in prevention, treatment and care.

Innovative instructional methods, including pre-literate, should be developed to provide training to PLHIV, families, and CHBC team members.

1.13 Lack of Awareness about CHBC Programs

In Pakistan no formal referral system is in place for the proper implementation of the continuum of care program for PLHIV. As a consequence health and social welfare professionals working in hospitals and clinics are often unaware of CHBC programmes. CHBC is often missing in hospital discharge plans or when receiving HIV positive lab results. Other potential community resources and agencies might also be unaware of the CHBC services.

A formalised and comprehensive referral system should be in place for the facilitation of PLHIV and their families. This mechanism should be communicated at all levels through formal SOPs and MOUs with respective organizations, healthcare facilities, and laboratories. It is important to develop appropriate communication materials, undertake advocacy and work in close collaboration with the associated professionals. Additionally CHBC team members should also help in raising awareness of these services to the broader community involved in caring for PLHIV and families.

1.14 Economic distress

The economic indicators for the general population in Pakistan are very poor. Further, the prevalence of HIV is found to be most acute in the economically marginalised communities. In many resource-limited settings, PLHIV and their families have to pay for health care, including medicines and supplies, which further enhance the economic burden. Eventually, some families can no longer access care.

The CHBC team is expected to play an important role in ensuring that PLHIV and their family members (including children affected by HIV and AIDS) have access to health and social welfare, regardless of their ability to pay. This might include providing a payment waiver system or assistance with developing a community fund for CHBC. These strategies can be very challenging in communities where poverty is extreme and needs are immense. Policies have to be established in consultation with stakeholders and followed consistently to ensure that people in extreme poverty have access to care.

Some of the proposed measures to tackle this challenge include providing an adequate food basket that fulfils the nutritional needs of PLHIV and affected family members such as the dependants and the care givers. Skill development for generating some economic activity for PLHIVs and affected family members through vocational training is also encouraged. The importance of having access to start-up capital for entrepreneurial ventures should also be promoted.

1.15 Access to CHBC Programs

PLHIV and family members often experience difficulty in accessing care. The reasons for this include poverty, lack of knowledge about CHBC and other community resources, lack of transport and the reluctance due to the stigma associated with HIV and AIDS. Comprehensive care involves PLHIV and family members being able to travel to health facilities and referral sites. In addition, it is also important for the CHBC team to have access to adequate transport facility for visiting homes of PLHIV as and when required. Access to comprehensive CHBC can only be provided when there is an adequate means of transport.

1.16 Limited Resources & Sustainability

There are instances where CHBC programmes receive limited financial support to cater for programme activities. During scenarios marked by limited resources universal coverage is not possible and can only be provided only to a limited number of PLHIV. Further the treatment centres can experience shortages of ARVs resulting in interrupted treatment cycles for PLHIV with the inevitable risk of drug resistance.

The CHBC activities have to be implemented and executed in resource limited settings in Pakistan. The important resources that are not meeting the current needs include:

1.17 Human Resources: There is an apparent insufficient number of adequately trained personnel to carry out CHBC activities/programs. This can be traced to the fact that this is a stigmatized profession and there is a lack of training and capacity building opportunities for them. With regards to this the non-availability of counsellors especially expert paediatric counsellors for children infected with HIV is a mounting challenge as the number of infected and affected children is expected to rise significantly.

1.18 Technical Expertise: There is lack of technical expertise in key areas of monitoring and evaluation, program management, and implementation of activities/services in CHBC programs.

1.19 Absence of Referral Systems/Links: Effective CHBC programs require a strong two-way referral system, which can only be achieved through dealing with the operational challenges unique to the key players; Government, District Health System, NGO/Development Partners, CHBC Programs.

1.20 Institutional Resources/Logistics: The CHBC programs face various logistical issues, especially with regards to transportation. The variety of logistical issues can all be traced back to the lack of funds. These include but are not limited to meagre presence of nutritional packages for PLHIV and their family, CHBC kits, telephones/internet access, educational/informational material and the means to transport personnel and/or PLHIVs. It is

important that the CHBC Centres explore areas of resource mobilization and seek grants for research activities and for other supportive packages for PLHIV.

1.21 TB/HIV Co-Infection

Despite TB treatment being provided free of charge in most of the developing countries now, the high prevalence of HIV has facilitated the reappearance of the disease. This is usually consequent upon the economic recession with the governments overstretched in terms of both financial and human resources. Although HIV/TB co-infection is impacting many PLHIV and the communities, few of the CHBC Centres are addressing TB as part of their continuum of care services. For identified cases of TB/HIV co-infection, regular follow-up by CHBC Team, ensuring compliance and adherence to the therapy, can play an important role in dealing with this challenge.

1.22 Hepatitis/HIV Co-infection

Injecting drugs is one of the main ways people become infected not only with HIV but also with the hepatitis C virus (HCV).[2] Hepatitis C is a leading cause of illness and death for individuals infected with both HIV and hepatitis C. As the Hepatitis C usually remains invisible until the advanced stages of the illness, often the patients are unaware that they had become infected. Timely diagnosis and treatment can help control the progression of the disease.

PLHIV should be provided access to ongoing screening for Hepatitis C. Patients may be unaware of how hepatitis C may be transmitted via blood and may not freely discuss all risk behaviours that may lead to hepatitis C infection as these behaviours are often stigmatized. OWs can play an important role in building awareness about Hepatitis C Co-infection and the associated high-risk behaviours.

1.23 Geographic Scatter of Patients

In Pakistan AIDS is not endemic to most communities. PLHIV are often found dispersed over wide geographic areas. In combination with other factors such as stigma it makes it even more difficult for the CHBC teams to access PLHIV and provide them with regular follow up services. Launching new programs/support services and assessing their impact is complicated by constrained resources limited economies of scale.

1.24 Care for the Caregiver

The CHBC team members and family caregivers frequently experience fatigue, anxiety, depression and lack of motivation and the will to continue caring for PLHIVs. This burnout is

[2] 1.L. E. Taylor, M. Holubar, K. Wu, R. J. Bosch, D. L. Wyles, J. A. Davis, K. H. Mayer, K. E. Sherman, K. T. Tashima, (2011) , "Incident Hepatitis C Virus Infection among US HIV-Infected Men Enrolled in Clinical Trials. Clinical Infectious Diseases"

a consequence of excessive emotional and physical strain in the absence of requisite care and support for the caregivers.

Regular support sessions at the CHBC both for the family and centre caregivers, ensuring recreational breaks and maintaining a rotation system at the CHBC Centre for the staff are all simple strategies to address the burnout. It is important to enhance the circle of caregivers for PLHIV by involving OWs, relatives, friends, spiritual leaders, neighbours and community volunteers. Building the capacity of volunteer caregivers can contribute towards reducing the excessive strain on the family and CHBC team caregivers.

1.25 Lack of Community Involvement

Due to the social stigma attached to topics surrounding HIV and AIDS, lack of awareness and effective mobilization in this domain CHBC programs are often faced with a lack of community involvement. Effective and efficient methodologies need to be developed to assure strong involvement of communities and identifying a locally relevant, combined prevention approach. Further, community prevention and treatment preparedness must precede and continue in parallel to health facility scale up efforts. Another crucial aspect is establishing a bi-directional link between health facilities and community services. This ensures coordination and consistency among the services and education and messages delivered by health workers, and PLHIV on the clinical team at the health facility and by OWs, NGO's and CBOs in the community. Actions initiated for community treatment preparedness and PLHIV empowerment, with PLHIV working as OWs, trainers, and on the clinical team, especially as peer counsellors, are also greatly beneficial.

1.26 Cultural, Sexual and Religious Issues

Cultural, sexual, religious, and legal influences often make discussion about sexual practices, preferences, sexual desires, the number and type of sexual partners, and the use of birth control difficult. Topics pertaining to illicit drug use and sexual practices are still largely taboo in Pakistani culture and are associated with embarrassment, shame, guilt and rejection. These sexual practices might include men having sex with men, sexual abuse, child abuse, and heterosexual intercourse. Caregivers may also experience these feelings of embarrassment, shame, and guilt as they practice certain risk behaviours in their own personal lives. The additional fear of HIV and AIDS as a fatal illness further adds to the complexity of the situation. In some communities, the use of condoms as a method of birth control (as well as control of HIV transmission) is not sanctioned by the religious leaders.

1.27 Compromised Care

Resource limited settings in most instances combined with negative attitudes, beliefs and values, or misinformation about HIV, significantly limit a caregiver's ability to provide effective,

respectful and dignified care for PLHIV and their families. Some examples of common negative behaviours of caregivers and health care workers include:

- Condemning PLHIV
- Isolating or avoiding PLHIV due to embarrassment or lack of knowledge
- Refusing to treat or care for PLHIV or their family
- Reluctance to disclose one's own HIV-positive status to other people for fear of discrimination, isolation, and condemnation
- The inability to discuss sexual practices, preferences and desires because of embarrassment, shame or guilt etc. This includes avoiding discussion and counselling about crucial topics such as risky behaviours and HIV prevention and care.
- The reluctance to approach of PLHIV and family in a nonjudgmental, caring and supportive manner.

1.28 Strategies for Addressing the Challenges and Enhance Care

1.28.1 Retrospection

To address the challenges mentioned above first, PLHIV, caregivers and other members of the community must examine their own beliefs, values, assumptions and attitudes toward HIV and AIDS. This is particularly true in the case of OWs and doctors as recent documentation suggests that they are some of the worst offenders in discriminating against, and refusing to care for, PLHIV. Such behaviours are unacceptable. However, change will only come about through examining long-standing negative thoughts, feelings and behaviours. This can be done individually or with peer group support.

1.28.2 Education

The irrational and often exaggerated fears associated with HIV and AIDS can be directly addressed through educational programs based on sound medical, social and psychological knowledge. To be successful, such programs must be sustained and supported over a long period of time. Knowledge about HIV and AIDS is constantly expanding, and caregivers must be continually updated through continuing education programs. They can then take on the important role of educating others. That is, they can advocate, for relevant issues pertaining to universal precautions but also for universal tolerance and knowledge about AIDS.

1.28.3 Prevention

Prevention strategies will continue to be compromised if fear, ignorance, intolerance and discrimination against HIV infected persons persist. Care givers have a responsibility to help normalize HIV so that the modes of transmission and prevention can be addressed without the emotional and attitudinal overlay that limits open dialogue about AIDS.

1.28.3 Care

Effective and dignified care can only be given where respect and compassion for others is present. Re-examining and challenge long-held beliefs, values, assumptions and attitudes will go a long way to providing compassionate and respectful care. Such care can then be demonstrated to others. When health care is provided with both knowledge and compassion, in a setting of dignity and respect only then it is truly effective.

2.0 STANDARDS OR COMMUNITY & HOME BASED CARE

CHBC aims at providing timely access to quality diagnosis, treatment, care and support services for infected and affected groups within the context of a comprehensive national response to HIV and AIDS.

2.1 Components/Elements of CHBC

The essential elements of CHBC are as follows:[3]

1. Provision of care
2. Continuum of care
3. Education
4. Supplies and equipment
5. Staffing
6. Financing and sustainability
7. Monitoring and evaluation

Each of these categories is divided into subcategories that provide details of the elements that are important in ensuring sustainable and effective CHBC. All these elements are interlinked and connected to each other. Implementing all these elements together might not be realistic in resource-constrained situations. It is therefore pertinent to set priorities among these elements and then work toward achieving the full spectrum of services in an incremental manner

CATEGORY	SUBCATEGORY
PROVISION OF CARE	Basic Physical care Palliative care Psycho-social support & counselling Care of affected & infected children
CONTINUUM OF CARE	Accessibility Continuity of care Knowledge of Community resources Accessing other forms of community care Community coordination Record-keeping for PLHIV Case- finding Case management
EDUCATION	Curriculum development Education management & curricular delivery Outreach Education to reduce stigma Mass media involvement

[3] Elizabeth Lindsey, World Health Organization (2002), "Community Home Based Care in Resource Limited Settings, A Framework for Action"

	Evaluation of education
SUPPLIES & EQUIPMENT	Location of CHBC team Health centre supplies Management, monitoring &record keeping Home-based care kits
STAFFING	Recruitment Supervising and coordinating CHBC Retaining staff
FINANCING AND SUSTAINABILITY	Budget and finance management Technical support Community funding Encouraging volunteers Pooling resources Out-of-Pocket payments Free services
MONITORING AND EVALUATION	Quality assurance Quality of care indicators Monitoring and supervision Informal evaluation Formal evaluation Flexibility

2.3 Staffing Structure of A CHBC Site

The provision of CHBC services is a human resource intensive activity. For effective CHBC, decisions have to be made about the correct mix of the staff. Moreover staff supervision, recruitment and retention are other issues to deal with.

2.4 CHBC Team Structure

The core CHBC team comprises of PLHIV, family caregivers, doctor, counsellor, nurse and outreach workers. The outreach worker may be a nurse, health assistant, auxiliary health worker, auxiliary nurse midwife, or other paramedical staff. Other notables that may be peripherally part of the team when relevant are community and religious leaders, traditional healers, community volunteers, neighbours, community organizations and groups (including groups of people with HIV and AIDS, children affected by HIV and AIDS, young people and women). Other opinion leaders may also support CHBC where relevant, such as businessmen, journalists and media personalities. The number of CHBC teams depends on the PLHIV volume and geographical diversity.

2.5 Staff Mix

Establishing an effective mix of CHBC staff is important. The ratio of professionals, outreach workers and community volunteers including PLHIV should be determined. This staff mix should depend on:

- The roles and responsibilities of various team members

- The knowledge and skills of the CHBC team
- The health care needs of PLHIV and available resources.

As proposed in detail in the document later the CHBC staff should include a project manager, doctor, counsellor, OWs, lab technician and janitorial staff. If available the services of community volunteers can also be utilised greatly to provide effective care within the home. Hakims who carry a respectable image in most communities may also be engaged in the provision of care.

Keeping in mind the cultural sensitivities of Pakistan It is important to have an appropriate gender balance in the staff. Care giving and counselling is a lot more acceptable and effective if provided by the same gender due to cultural and religious barriers.

2.6 Supervising Staff Activities

The day to day supervision of staff and coordination of staff activities is the responsibility of the project manager. The project manager has to gain the respect of the CHBC team and the local community in order to handle his leadership role effectively. In addition, the project manager also has to have access available resources and advocate for CHBC funding. The supervision and coordination of the activities must be done in an organised, transparent and documented method. The following documents in the annex can help the project manager achieve this:

- CHBC Activities Monitoring Checklists
- Monthly Record of Support Services for PLHIV
- Monthly staff details at CHBC
- Supervision Checklist

2.6 Recruitment Hiring

Members of the CHBC team should be recruited based on their skill and qualifications. Non-cognitive qualities such as empathy, sensitivity, non-judgmental attitude, confidentiality and motivation are also important considerations. Most CHBC programs have the following staff members:

- Doctor (Full time, part time or visiting depending on the workload)
- Nurse (Full time, part time or visiting depending on the workload)
- Counsellors
- Outreach Workers
- Administrative staff
- Housekeeping and support staff

If available, the services of community volunteer team members can also be utilised. They are usually PLHIVs and are recruited from within the community.

2.7 Service Delivery Package for Community and Home Based Care[4]

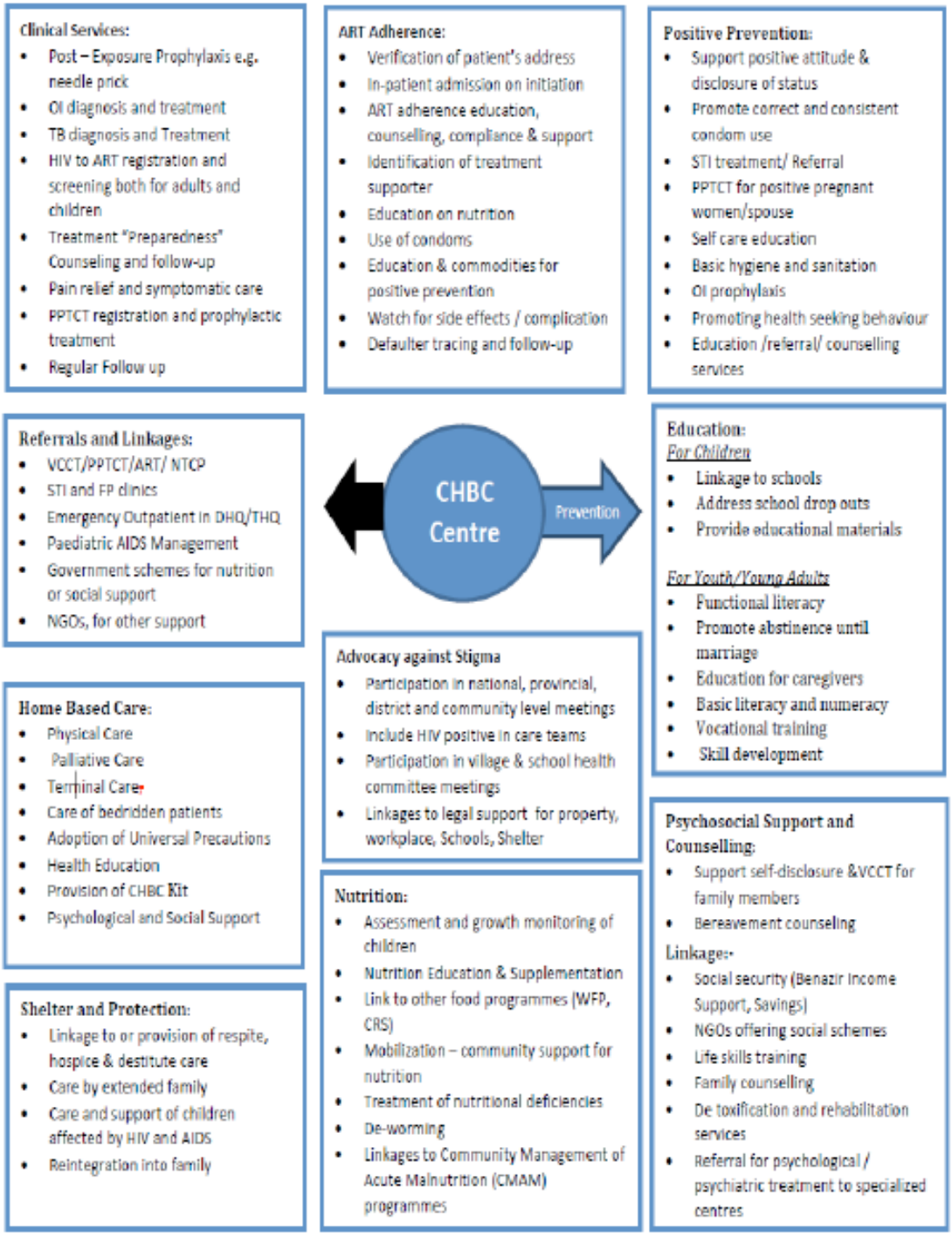
The care and support activities for PLHIV can vary but are essentially depicted in the table below:

Essential Care	Additional Activities Of Intermediate Complexity and / or Cost	Additional Activities Of High Complexity and / or Cost
Nutrition support Nursing and para-medical care Psychological support Prevention of parent to child transmission. Community activities to reduce stigma & discrimination. Health education Initiation of HAART where clinically indicated Counselling on adherence to ART	Prevention and treatment for tuberculosis. Treatment of HIV-related malignancies, extensive herpes. Support for children affected by HIV and AIDS Income generating activities Medical care for family members Ongoing counselling support Treatment of Hepatitis C	Laboratory monitoring of adherence to HAART Treatment of HIV-related infections that are difficult to diagnose and/or expensive to treat, and malignancies Community services to reduce the economic and social impact of HIV infection

2.8 Standard Services at CHBC Site

[4]Source: WHO and UNAIDS (2000) Care and Support Activities for PLWHA, as Defined by WHO and UNAIDS 2000

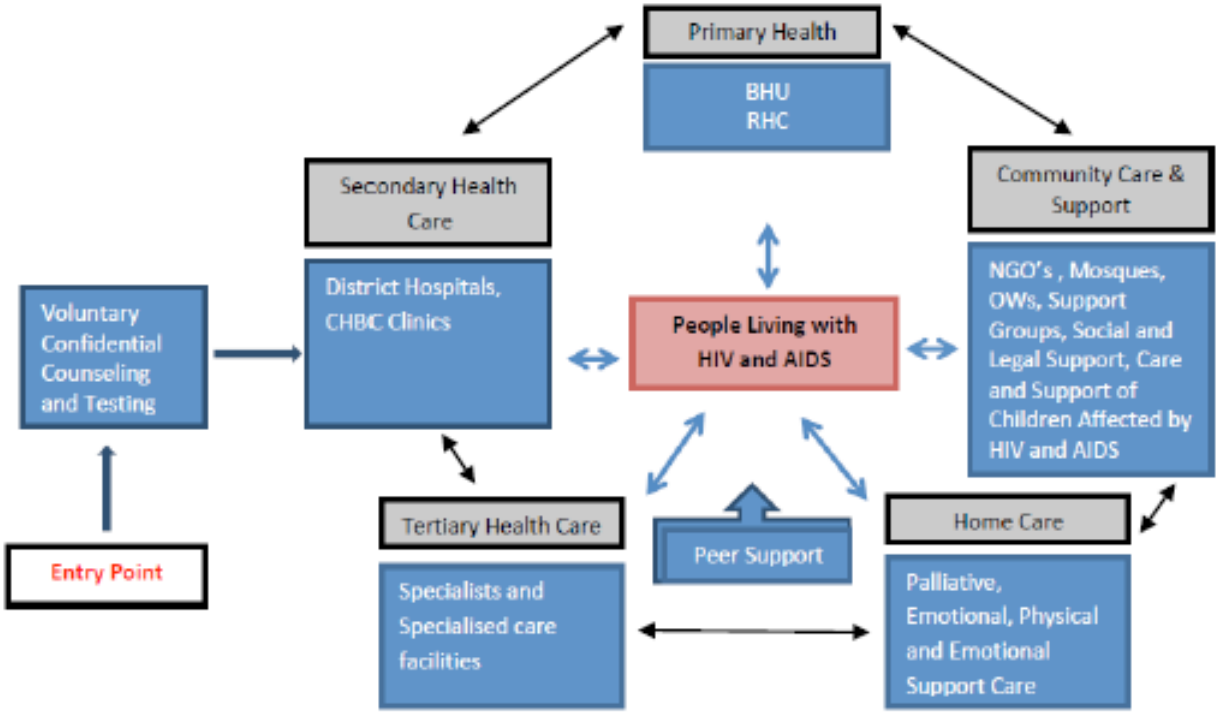
Service Delivery Model[5]



2.9 Stakeholders of CHBC and their Proposed Generic Roles and Responsibilities

[5] **National Aids Control Organization, Government Of India (2007), "Operational Guideline For Community Care Centres"**

The Comprehensive Continuum of care involves the close working and co-ordination of various stakeholders. The following diagram helps in outlining the interactions amongst the various stakeholders[6]:



2.10 Provincial Level Roles and Responsibilities for CHBC[7]

- Securing political commitment for CHBC
- Financing and securing funds for CHBC
- Promoting inter-sectoral collaboration
- Integrating CHBC into a continuum of care framework
- Planning ongoing financing and sustainability
- Developing policies, guidelines and regulations for CHBC (including care of children affected by HIV and AIDS)
- Developing a legal framework for contracting and subcontracting
- Forming provincial level strategies to lessen stigma
- Developing CHBC education programmes Developing strategies for organizing and managing CHBC
- Developing strategies and time frames for monitoring and evaluation
- Developing effective referral mechanisms

[4]WHO (2000),"The Comprehensive Continuum of Care. Key elements in care, treatment and support"

[7] WHO The Cross Cluster Initiative on Home-Based Long-Term Care, non-communicable diseases and mental health and the department of HIV/AIDS, Family and Community Health (2002), "Community Home Based Care in Resource Limited Settings, A framework for action",

- Developing human resources
- Providing material resources
- Allocating resources and funds
- Sustaining partnerships with NGOs and private organizations
- Communicating between the different levels of administration

Note: The provincial governments can decide on policies that best suit their needs and context. Some roles and responsibilities, however, should be coherent between all the provinces such as policies and guidelines. A supervisory/ Co-ordination body at the centre can fulfill this role

2.11 District Level Roles and Responsibilities for CHBC

- Promoting capacity-building
- Defining priorities
- Administering funds
- Ensuring accessibility
- Establishing a waiver system or free service for those who cannot afford to pay
- Monitoring standards, including a system of referral
- Planning and monitoring care of children affected by HIV and AIDS
- Reducing stigma
- Developing partnerships with complementary organizations within established contractual policies
- Allocating resources
- Recruiting and training CHBC managers
- Planning the administration of CHBC education
- Planning the administration of monitoring and evaluation Communicating between levels of government

2.12 Community Level Roles and Responsibilities for CHBC

- Providing physical, emotional and spiritual care and support
- Establishing a continuum of care
- Developing mechanisms for educating PLHIV, caregivers and CHBC
- teams
- Ensuring adequate supplies and equipment for the CHBC programme
- Recruiting and retaining an adequate and appropriate mix of staff
- Developing effective methods for monitoring and evaluating CHBC
- Addressing the financing and sustainability of CHBC
- Creating intersectoral communication between various levels of administration

2.13 Ethical Guidelines for Community and Home Based Care and Case Management

The CHBC team must follow certain guidelines while working with PLHIV and their families.

- Outreach Worker/Counsellor as well as all support staff is bound to maintain confidentiality regarding all information of the client that has become known to them during their interaction.
- Outreach Worker/Counsellor/Project Manager shall inform the PLHIV and obtain his/her consent before conducting the session and before allowing another person to observe or monitor the counselling session.
- Outreach Worker/Counsellor shall keep the records secure. Oral or written consent is obtained from the PLHIV before any information about the PLHIV is requested from or released to other individuals, agencies or institutions. Such information should be limited to what would be appropriately deemed necessary for provision of services to the client. Such information should be accessible only to personnel directly involved in provision of services to the PLHIV.
- Outreach Worker/Counsellor will inform the Project Manager and seek their advice whenever the PLHIV's condition or a particular situation indicates clear and imminent harm to the PLHIV or others.
- Outreach Worker/Counsellor will respect the social, cultural, religious norms and values, worth and respect of all people and promote this value in their work.
- Outreach Worker/Counsellor will always act in the best interest of the PLHIV; and will not abuse, neglect, or exploit a PLHIV.
- Outreach Worker/Counsellor will make every effort to provide access to treatment, including advising PLHIVs about resources and services, taking into account the financial constraints of the PLHIV.
- Outreach Worker/ Counsellor will recognise and respect diversity among people and counter discrimination and oppressive behaviour.
- Outreach Worker/ Counsellor will abide by the laws of the society in which he/she practice.
- Outreach Worker/ Counsellor will respect all human rights particularly right for information about the illness, treatment, testing procedure and its implications.

- Outreach Worker/ Counsellor will not counsel when his/her functioning capacity is significantly impaired by personal or emotional difficulties, illness, alcohol, drugs or any other cause.
- Outreach Worker/ Counsellor will take steps to maintain and develop his/her competence throughout professional life.
- There is an ethical responsibility to use supervision for appropriate personal and professional support and development, and to seek training and other opportunities for continuing professional development.

3.0 STANDARD SERVICES AT THE CHBC CENTRE

3.1 Home Based Care

The care that is provided to PLHIV can be at three levels:

1. Physical Care
2. Palliative Care
3. Terminal Care

3.2 Physical Care

Physical care in the home setting involves the following:

3.2.1 Providing basic nursing care which is the same for HIV-related illness as is for any person who is ill

- Positioning and mobility
- Bathing
- Wound cleansing, skin care
- Oral hygiene
- Adequate ventilation
- Guidance and support for adequate nutrition

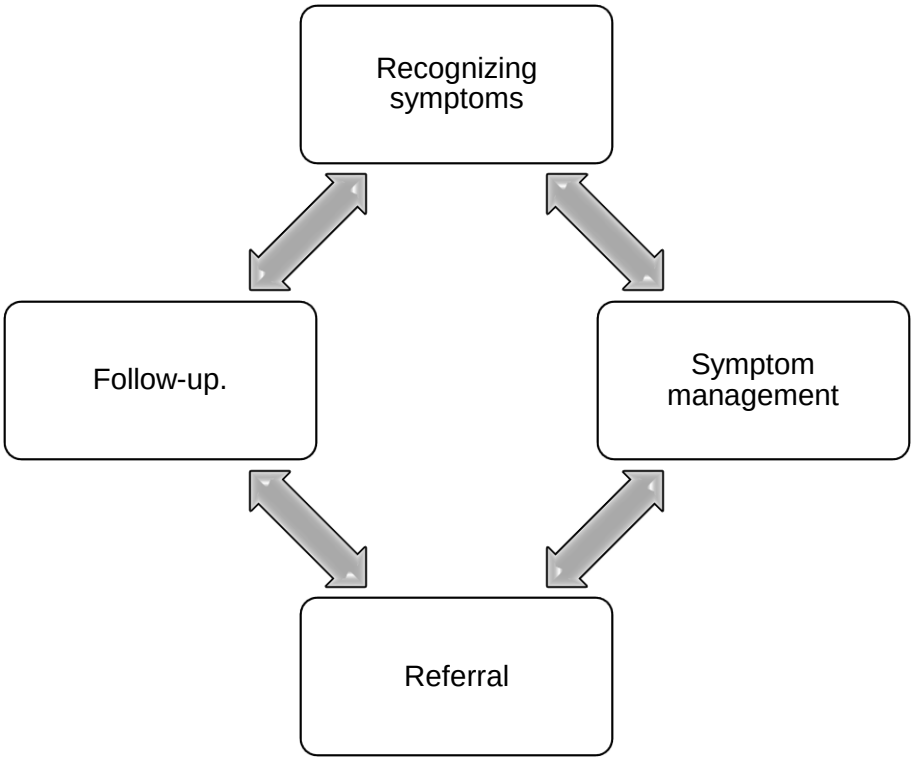
3.2.2 Undertaking measures to comfort PLHIV

- Recognizing symptoms
- Symptom management
- Referral
- Follow-up

3.2.3 Educating on the use of universal precautions for infection control

These are critical in the care and prevention of HIV and are to be taken regardless of the PLHIV's condition and include:

- Hand-washing
- Avoiding contact with blood or body fluids by using gloves and diapers etc.
- Cleaning linen with soap and water
- Using disinfectants and detergents and
- Burning or safely disposing of the waste.



3.2.4 Management of Opportunistic Infections

Opportunistic infections are those that invade the body when the immune system is not working adequately. Progressive HIV infection results in reduced immunity making PLHIV more vulnerable to opportunistic infection.

Tuberculosis being the commonest opportunistic infection, other infections affecting PLHIV includes septicaemia, pneumonia, fungal infections of the skin, mouth and throat, unexplained fever, chronic diarrhoea with weight loss.

Anti-tuberculosis drugs are equally effective in PLHIV as in those not infected with HIV. The therapy is cost effective and widely available even in the developing countries. Adherence and compliance to the therapy are major challenges where CHBC workers can play an effective role.

3.2.5 Symptom Management

Symptom management depends on the PLHIV's condition. However, basic symptom management includes:

- Reducing fever
- Relieving pain

- Treating minor ailments like diarrhoea, vomiting, cough; skin, mouth, throat, genital problems, general tiredness/ weakness
- Treating neuro-physiological symptoms.

These treatments might include pharmaceutical preparations or the use of traditional remedies and herbal treatments. The CHBC team should have basic home care kits that contain the basic medicines and supplies for home care. For people with HIV or AIDS, various treatments may be given for opportunistic infections, the most common being tuberculosis. Tuberculosis medication is usually administered through a directly observed therapy, a short course (DOTS) programme. However, these medicines might be given as part of the CHBC programme or through a separate community service. Treatment for preventing opportunistic infections can be made available through CHBC referral.

3.2.6 Pain Relief

Pain relief is an essential element of CHBC care. In resource-limited settings, medicines can be scarce. Aspirin and Paracetamol are often available but not given in adequate doses to relieve pain. Trained OWs can administer Class A controlled drugs. Such Class A drugs includes morphine injections, tablets, oral mixture and other narcotics. These drugs must be provided in accordance with the national laws on dangerous drugs and with the national drug policy. Members of the CHBC team should be familiar with these policies and guidelines. A doctor should prescribe these analgesics, and at least one member of the CHBC should be qualified to administer Class A drugs. Herbal remedies and traditional therapies can also be effective in relieving pain.

3.3 Palliative Care

Palliative is defined as an approach that improves the quality of life of PLHIVs and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

Palliative care is the combination of active and compassionate therapies to comfort and support PLHIVs and their families. During periods of illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual needs, while remaining sensitive to personal, cultural, and religious values, beliefs and practices.

Palliative care should start at the time of diagnosis and can be combined with therapies for treating opportunistic illness; or it may be the total focus of care. Palliative care requires a team approach including PLHIV, the families, caregivers and other health and social service providers and considers the needs of the whole person. It includes:

- Medical and nursing care
- Social and emotional support
- Counselling
- Spiritual care

It emphasizes living, encourages hope, and helps people to make the most of each day. The palliative caregiver must treat PLHIV with respect and acceptance, acknowledge their right to privacy and confidentiality, and respond caringly to their individual needs. An essential part of effective palliative care is the provision of support for caregivers and service providers. Such support will enable them to work through their own emotions and grief related to the care they are providing.

3.3.1 Palliative Care Benefits

Palliative care helps in improving the quality of life for the PLHIV, as it:

- Offers relief from pain and other worrisome symptoms
- Affirms the right of the PLHIV and family to participate in informed discussions and make treatment choices
- Affirms life and regards dying as a normal process
- Neither quickens nor slows down death
- Provides relief from pain and other distressing symptoms
- Integrates psychological and spiritual aspects of care
- Provides a support system to help PLHIV live as actively as possible until death
- Provides a support system to help the family and loved ones cope during the PLHIV's illness and/or bereavement.
- Combines the psychological and spiritual components of PLHIV care
- Offers a support system to help PLHIVs live as actively as possible until death
- Offers a support system to help the family cope during the PLHIV illness and in their own bereavement
- Uses a team approach to address the needs of PLHIVs and their families, including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness

Palliative care is more effective in the early course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

3.4 Terminal Care

Terminal care aims to improve the quality of life at the end of life, by relieving symptoms and enabling a person to die in comfort, with dignity, and in keeping with their wishes.

3.4.1 Terminal Care for PLHIV

In the developed world, the end stage of the illness might occur in a hospice or a special terminal care facility. In most cases in Pakistan, however, dying at home is the only available and or viable option for the PLHIV. The primary concern in terminal and palliative care is to make PLHIV as comfortable as possible by providing medical, spiritual, emotional, practical, and psychosocial support both to the PLHIV and to his/her loved ones. Even where resources are severely limited, good palliative care can be given.

The decision to stop medical treatment must be made by PLHIV (if this is possible) and the family or loved ones and in conjunction with the community workers. Care then shifts to make the dying person as comfortable as possible, and to prepare emotionally and spiritually for death. Such care includes both practical and nursing care issues, as discussed below.

3.4.2 Principles of Terminal Care

- Provide spiritual and emotional/ grieving support for PLHIV and their loved ones
- Prepare PLHIV, their families, and caregivers for death. This includes advice concerning avoiding any traditional death rites which would spread infection
- Ensure appropriate provision is made for the children involved and that their rights are respected
- Provide bereavement support to the family and loved ones following death.

3.4.3 Practical Issues

PLHIV (if able) should make the choice about a suitable place to die. This choice might include hospital or their own home. In most instances, PLHIV remain at home till they die.

In developed countries hospice and terminal care centres usually have specially trained staff to care for both the person who is dying and the loved ones. In Pakistan’s context, where the PLHIV mostly opts to remain at home, the family, and other caregivers will require special training to provide appropriate terminal care to him/her.

The following considerations for providing good palliative/terminal home care will be dependent upon adequate resources. However, whenever possible, care should include:

- Health support services: The local or nearby health centre must be briefed about the person's condition, so that staff can provide the caregivers advice and appropriate medical supplies.

- Guaranteeing adequate family and social support: This will help reduce the pressure on the caregivers, who are usually the women in the family. It will mobilize relatives and friends to help in household or related tasks, and hence build support for the sick person. The OWs should discuss how to mobilize the support of local community leaders, outreach agencies, neighbours, and members of community or religious associations. This might be an important time to facilitate reconciliation with estranged family and/or friends.
- Placing PLHIV in a light, well-ventilated room: The room should ideally be quiet, comfortable, and yet close enough to the rest of the family to remain involved in family life.

With HIV and AIDS, there is a growing realization that comprehensive care must include care associated with death and dying. Caring for PLHIV in the terminal stages of AIDS puts a great strain on everyone involved. For individuals who choose to die at home, where resources are scarce, care for the dying has traditionally been provided by communities and families, and might involve spiritual support. Families, friends, communities, OWs, volunteers, and others will be affected in this process.

One of the most difficult aspects of caring for PLHIV is deciding when to stop active treatment and to begin to prepare the person and his/her family for dying. In practice, the boundary between the two activities is often indistinct, with both terminal and interventional care continuing in tandem. The decision to stop treatment requires considerable skill, and sensitivity. Whenever possible, the decision should be taken by health care professionals, PLIHV, family members and loved ones.

It is often difficult to decide when aggressive medical treatment should end and when palliative care might begin. Palliative care would begin when: medical treatment is no longer effective, the side-effects outweigh the benefits, the PLHIV opts to discontinue aggressive therapy, or the PLHIV's vital organs begin to fail.

3.4.4 Challenges in Terminal Care Of PLHIV:

HIV poses a unique set of challenges to the caregivers, PLHIV, the families, the communities and OWs. Those specific to terminal care of PLHIV include the following:

- AIDS may affect whole families when parents and children become infected.
- People who die from AIDS usually die at a young age.
- The stigma and fear associated with HIV and AIDS often means that the diseases and death are not openly spoken of and suitable arrangements for death might not be made.
- Estrangement of family and friends often occurs.

- Sometimes PLHIV lose contact with families and friends due to conflicting values related to sexuality or lifestyle choices.
- Community and family support might be lacking because of the stigma, fear and isolation associated with HIV.
- The care of the PLHIV is often left to the family (and to women in particular), who are often both unprepared and untrained.
- The course of terminal care for PLHIV is unpredictable. Opportunistic infections and illnesses are often unpleasant and difficult to manage. These can include: foul odour, chronic diarrhoea, vomiting, skin lesions, seeing the person in pain, dementia, confusion, aggression, and depression.
- The caregiver can develop feelings of powerlessness and helplessness.
- Caring for someone who is dying at home is expensive. The caregiver must consider the loss of income, the cost of medical and pharmaceutical supplies, and the expense of a funeral.
- Problems or complications with inheritance can further increase the poverty of women and children.
- The physical burden of caring for PLHIV.
- The emotional burden for the care-givers of seeing a loved one dying.

3.5 Funeral Support

- Provide support to the bereaved family in arranging the funeral of the deceased patient.

3.6 Specific Services Rendered By CHBC Team

3.6.1 Actively Identify and Register PLHIV in the Community

- Work to identify PLHIVs in the area
- Encourage and refer members of the community to undertake VCCT if they have been in vulnerable situations
- Encourage identified PLHIVs to register with the CHBC centre
- Encourage the identified PLHIV to encourage their family to undertake VCCT
- Encourage the PLHIV to maintain regular contact with the CHBC centre and staff

Note: Please refer to the annexure for the Membership Form

3.6.2 Provide Prevention Information

- Promote the “ABCDs” (abstinence, being faithful, using condoms, and do not share needles). Remember that “abstinence-only” can cause more transmission because

many people are unable to stay abstinent. Therefore, when they do have sex, they are not prepared to practice safer sex. Because of this, everyone needs to know about condoms.

- Encourage discussions about HIV risk and vulnerability among groups of women, men, girls, boys, and elders.
- Work to reduce stigma and increase awareness about HIV and AIDS.
- Explain to people why they may be vulnerable to HIV.
- Refer people for STI diagnosis and treatment.
- Provide condoms and information on how and why to use them.
- Provide information on other Family Planning methods and where to get them.
- Identify pregnant women for PPTCT and help them get services and follow-up.
- Involve the community in CHBC efforts and advocate for more attention and resources for care and support

3.6.3 Provide Nursing Care, First Aid, and Other Health Services to PLHIV

- Identify the immediate nursing care needs.
- Assess condition of PLHIV for medical referral if necessary.
- Provide the basic nursing care needed.
- Refer for further care, as needed.
- Support PLHIV adherence to ART, as necessary.

Note: Please refer to the annexure for the Medical Health Assessment Form

3.6.4 Transfer Knowledge & Nursing Care Skills to Primary Caregivers

- Identify the learning needs of caregiver and PLHIV.
- Plan and organize the transfer of knowledge and skills.
- Give knowledge and skills to caregivers and self-care skills to PLHIV.
- Make a plan of care with the caregivers and PLHIV.
- Always have a caring attitude.
- Keep confidential records related to CHBC activities

3.6.5 Provide Supportive Follow-Up to the Trained Primary Caregiver(S) and PLHIV

- Conduct regular follow-up visits to the trained caregiver and PLHIV.
- Help PLHIV and caregivers follow action plans and solve problems.
- Keep records of actions taken.

Note: Please refer to the annexure for the Monthly Home Visit Form

3.6.6 Provide Referrals and Links to Specialized Care and Support Services

- Help PLHIV and caregivers to identify the support needed (medical, nursing spiritual, emotional, psychological, economic, nutritional, and legal).
- Identify the individuals/groups/organizations that can provide the support.
- Link PLHIV and families to the identified groups.
- Help plan for transportation if needed, or help set up home visits.
- Follow-up to assure coordination of services along the entire continuum of prevention and care.
- Be involved in social/ economic schemes to support PLHIV and family members. Tap into resources such as food aid, kitchen gardens for nutritional support.
- Find religious, civic, government, and NGO sources to support education, housing, clothing, and feeding needs. Provide basic community level counselling to help PLHIV and family members make decisions, cope, and seek the care and support they need.
- Identify factions that offer legal support and assistance with writing a will, planning for surviving children and family members, protection against loss of property, and other legal issues faced by PLHIV and their family members.

Note: Please refer to the annexure for the Referral Form

3.6.7 Mobilize the Community for Chbc Services

- Organize education activities within communities to create a supportive environment for CHBC and PLHIV.
- Participate in community level advocacy activities to create a supportive policy environment.
- Combat stigma in the community in general as well as in everyday relationships with friends, family, and households of PLHIV.
- Encourage the community to start and participate in CHBC activities for PLHIV.

3.7 Adherence Support Services

Adherence refers to ensuring the drugs are taken exactly as they have been prescribed and also at the correct time. Any diet restrictions must be followed carefully alongside with the medicine. HIV drugs only show their affects if they are constantly present in the patient's system. If the level of the drugs drops to a significantly low level, then it is possible for the virus to start resisting the drugs and their effect will be minimized.

3.8 Role & Responsibilities of CHBC Staff

- PLHIVs must be advised to seek medical advice for their infective symptoms prior to initiating any treatment.
- On initiation of treatment, PLHIV is to be advised on how many tablets are to be taken and how often do they need to take them, and if there are any food or storage restrictions.
- PLHIV must be encouraged to discuss openly any difficulties or side effects when on the medication with the CHBC staff. CHBC Staff should facilitate them in seeking medical help for additional medication or replacing a particular medicine causing serious side effects.
- The dosage of drugs can be sorted for each day, or a pill-box can be utilized. This will help in checking if any dose has been missed out.
- Extra drugs should be kept in handy if PLHIV is travelling so that he does not run out of them.
- Some medicines for pain relief and wound care can be provided to PLHIV.
- Adequate support should be acquired from family members or friends to ensure that the treatment plan is being followed. Constant reminders can be provided by the support group.
- CHBC staff can help PLHIV share experiences of other PLHIVs on similar treatment.
- Medicines to counteract nausea and diarrhoea should be kept handy even before treatment is started as these are the most common side effects once the therapy is started. Most combinations are twice-daily regimens. This usually means taking them every 12 hours. However, several drugs only need to be taken once a day. This usually means taking every 24 hours. PLHIVs must be counselled that completely forgetting to take a once-daily dose may be more serious than forgetting a twice-daily one.
- OWs/Counsellors should make use of available adherence materials for both children and adults available at the provincial level such as calendars, wrist-bands, games, booklet on ARV side-effects, etc.

3.9 Treatment Plans

The OWs/Counsellors at the CHBC can help develop a treatment plan as per the instructions of the prescribing doctor. This will consist of the following:

- Which pills to take?
- How many to take?
- When to take them?

- Whether to take them with food or an empty stomach?

Treatment plans can also be obtained from the local clinic or can be developed by the CHBC Team and usually have information as depicted below:

My Treatment Plan			
Name of ARV	**Number of Pills**	**When**	**Comments**
D4T	1	8 am to 8 pm *(every 12 hours)*	
3TC	1	8 am to 8 pm *(every 12 hours)*	
EFV	2	8 pm	*Avoid taking pills with a high carbohydrate meal*

Treatment Helper

A caregiver such as a family member, friend or relative can be taken on board before starting the ART. He/she can act as PLHIV's 'treatment helper'. This helper shall be responsible for the following:

- Constant reminders for taking the medicines as prescribed
- Helping PLHIV if she/he is encountering any side effects
- Accompany PLHIV when visiting the CHBC or Health Facility

3.10 Treatment Record

A treatment record is used for verifying what pills were taken and when exactly. In this manner, ART medicines can be recorded at the same time every day. This will help ensure that the virus is kept under control. A sample treatment record is depicted below. A calendar can be used for this purpose as well.

Treatment Record							
Did I take any ART medicines							
Yes/ No	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Morning							
Evening							
How ART medicines							

made me feel today?							

3.11 Centre Based Care

- All CHBC service sites provide services to all PLHIV in the catchment area.
- All PLHIV found are offered VCCT services.
- All PLHIV are screened for tuberculosis (TB) using the standard questionnaire, and referred for further TB diagnosis and treatment at least every three months.
- All PLHIV are referred for CD4 testing.
- All PLHIV are assessed for OIs and treated accordingly.
- All enrolled PLHIV undergo World Health Organization clinical staging at every visit.
- All enrolled PLHIV receive regular follow-up health checks: Stage 1 every three months; Stage 2, 3 and 4 every month.
- All PLHIV clients with a CD4 count <500 are started and continued on Cotrimoxazole prophylaxis.
- All ART eligible PLHIV are referred to ART sites. Children are referred to paediatric AIDS clinicians.
- All HIV positive pregnant women are referred for PPTCT.
- All PLHIV have gender and age appropriate growth charts (height, weight, head circumference) in their medical record files, updated at each visit.
- All adult PLHIV are asked about family planning and contraception needs at each visit.
- All PLHIV receive positive prevention counselling as appropriate (harm reduction, PPTCT, condom use, conception) at each visit

3.12 Guidelines, Equipment and Commodities Kept At All CHBC Sites Includes;

- The National CHBC Guidelines
- IEC materials for PLHIV Counselling
- STI and OI drugs
- CHBC Essential Tool kit
- National ART, OI, PPTCT, VCCT and Paediatric Guidelines
- National Paediatric Desk Reference Tool for clinical care and ARV dosing
- World Health Organization STI Management Flow Chart
- World Health Organization Clinical Staging Chart
- Growth Charts
- IEC materials for STI and HIV positive counselling for PLHIV
- Other equipment and commodities as necessary
- HIV Counselling and Testing Guidelines
- Confidential records of HIV-positive patients

- Rapid Tests for VCCT – National Testing Algorithm
- Membership Form (First Home Visit Form)
- Medical Assessment Form
- Counselling Form
- Referral Form

Summary of Services Provided at the Chbc and Requirements for the Same[8]

Types of Services	Activities	Human Resources	Infrastructure Required and Supplies
Counselling Services	• Drug and treatment adherence, treatment education • Couple counselling/ Family planning • Counselling for infant feeding • Reproductive health (e.g. use of contraceptives, condom demonstration and distribution, family planning for HIV positive couples etc) • Nutritional counselling • Psychological Support	• Trained counsellors	• Separate facilities for integrated counselling services(for males and females) • Audio Visual equipments DVDs etc • Patient education tools, posters, health promotion material etc
Nutritional Counselling and support for in patients	• Balanced diet for PLHIV • Provision of nutritional supplements • Nutritional education to PLHIV and caregivers.	• Cook • Helpers • Nurses trained in Nutritional Education	• Kitchens with utensils and facilities • Dining room • Nutritional Supplements
Treatment and Patient Management	• Provision of comprehensive care for prevention and treatment of OI and other illness in PLHIV • Basic Laboratory services • Coordination with ART centre and other Basic laboratory services for forward and back referral • Transfer of referral data and information	• Doctor • Nurses • Lab Technician	• Out-patient Services • Availability of in-patient care • Basic laboratory facilities and facilities for minor surgical procedures • Drugs and treatment for minor OI • Transportation facilities for patients movement- ambulance • PEP Kits • Personal protection kit

[8] Operational Guidelines for Community Care Centres, National Aids Control Program, India 2007

			e.g. gloves, goggles, plastic apron etc • Infection control and waste management equipment e.g. colour coded buckets, needle destroyers. • IT equipment for communication and reporting e.g. computer, fax/printer, scanner, broadband internet connection. MIS Systems
Referral and Outreach	• Outreach for follow up of PLHIV for ART adherence • Trace and retrieve defaulters • Conveyance to referral centres • Facilitation of home based care • Coordination with referral centres for support	• Outreach workers for providing health services	• Transportation facility-Vehicle Hire • Telephone line for patients to call up
Other Support Services	• Support for PLHIV who face social rejection • Link with legal services • Offer of spiritual services and fitness programs such as yoga • Recreational facilities • Advocacy with various stakeholders • To provide linkage to PLHIV with PLHIV peer support networks • To empower income generation and self help groups • To facilitate PLHIV to access available resources provided by government and NGO agencies • To facilitate linkages between other service providers and patients, like educational help for the children and Income generation programmes	• Community Volunteers	• Recreation facilities e.g space to run peer support activities, lounge for education and recreation etc • Audiovisual equipment e.g. TV, DVD, CDs, Radio etc. • Motivate other service services and fitness providers and agencies programmes such as youth volunteers, peer Yoga groups, community support etc

4.0 SUPPORT SERVICES

The CHBC staffs also actively provide a host of support services that help in improving the quality of life for the PLHIV, their family and the caregivers. They include the following:

4.1 Counselling for HIV and AIDS

Counselling services entail the provision of support and strength to individuals, couples, families or groups by qualified persons. PLHIV and family members who require CHBC may be unaware of the service or how to access home care. It is therefore important for members of the CHBC to find PLHIV in the community and to encourage other community members to refer PLHIV and families needing the service. Such case-finding is often performed through word of mouth and through CHBC community volunteers. These volunteers usually live in the community and know a great deal about what is going on. They can therefore mediate and communicate with the larger community. In addition, volunteers are often the first to know when a family needs help. Case-finding also promotes early detection, treatment and access to other community resources.

Voluntary confidential counselling and testing (VCCT) should be the part and parcel of CHBC programme. PLHIV can be encouraged to be tested through effective interpersonal communication and support. Knowledge of HIV diagnosis can lead to effective prevention, treatment and care. Voluntary confidential counselling and testing is therefore an integral component in providing care to PLHIV. It should:

- Aim to enable PLHIV to better cope with their HIV positive status and the various challenges posed by their situation. It should aid them in their decision making process and relieve them of the associated stress
- At all times be a confidential process between a PLHIV the counsellor
- Should keep into consideration the consent of PLHIV at all times
- Be extended to spouses, sex partners and relatives (family-level counselling, based on the concept of shared confidentiality
- Should also be given to HIV negative individuals to encourage positive behaviour change in them.

4.2 The Counselling Process

The objective of HIV counselling includes both prevention and care. It is typically done by a professionally trained counsellor. In the absence of such, other members of the CHBC staff can be trained to provide similar services. Counselling must be methodological and done keeping in mind the specific conditions associated with PLHIV. Further, it should be a process

involving a series of sessions as well as follow-up. It can be done in any location that offers peace of mind and confidentiality for PLHIV. The counselling process includes:

- Evaluating the personal risk of HIV transmission
- Discussing how to prevent infection
- Discussing the importance of ART and adherence
- Emotional support for PLHIV

4.3 Types of Counselling

Two types of counselling according to site are practised. They are:

1. Clinic-based counselling is that which is provided in a formal session. This includes situations in which counselling is provided by a trained professional, such as a doctor, social worker, nurse or psychologist typically in a hospital, health centre or clinic.
2. Community-based counselling is that which is provided by one community member trained in counselling to another community or family member in a non-formal environment such as a village or urban neighbourhood.

4.4 Voluntary HIV Testing

HIV counselling is often given in connection with a voluntary HIV test. Many communities now have access to voluntary confidential counselling and testing through clinics or at the local hospital. Ill people can be encouraged to be tested through effective interpersonal communication and support.

Such counselling helps to prepare PLHIV for the HIV test, explains the implications of knowing that one is or is not infected with HIV, and facilitates discussion about ways to cope with knowing one's HIV status.

It helps correct myths and misinformation around HIV and AIDS. To allay anxieties while awaiting the test result, some individuals may seek support not only from their own families, OWs and knowledgeable community volunteers.

National HIV Testing Strategy is based on three rapid test conducted at the same facility to avoid any sort of lost to follow-up or missed the clients. However, in case of undetermined HIV Test the client, shall be referred to nearby testing facility, with an appropriate follow-up.

4.4.1 Pre Test Counselling

Pre-test counselling provides information to the individual about the technical aspects of testing and the various implications of being diagnosed as being HIV positive or negative. During the counselling testing should be discussed as a positive step that is interlinked to changes in risk behaviour, coping and increasing the quality of life. It should focus on:

1. The person's personal history of risk behaviours, or exposure to HIV
2. Assessment of the person's knowledge regarding HIV and AIDS, including methods of transmission. The person's previous experiences in dealing with crisis situations should also be investigated.

4.4.2 Components of Pre Test Counselling

4.4.2.1 Assessment of Risk: For assessing the chances that the person has previously been exposed to HIV, the following need to be considered:

- The sexual practices of the person. Particularly high -risk practices such as vaginal and anal intercourse without a condom, or exposure to unprotected high-risk groups such as sex workers.
- The association of the person with high-risk prevalence for HIV infection (intravenous drug users, male, *hijra* and female sex workers and their clients, prisoners, migrant workers, males who have sex with males, and health care workers where the use of Universal Precautions is unsatisfactory).
- Whether the person has ever received a blood transfusion, organ transplant, or blood or body products.
- The exposure of the person to non-sterile invasive procedures, such as operations, injections or tattooing.

4.4.2.2 Assessment of Understanding: While assessing the need for HIV testing, the following questions need to be asked:

- The reason for requesting the test
- The behavioural patterns or symptoms of alarm
- The knowledge of the person about the test and its uses
- The person's beliefs and knowledge about HIV transmission and its relationship to at risk behaviours
- The emotional and social support for the person (e.g. family, friends, etc.)
- Previous record of the person in receiving VCCT
- The emotional preparedness of the person in either case

4.4.3 Preparation for pre-test counselling

Effective pre-test counselling is essential. It will prepare the person for the test by:

- Discussing confidentiality and informed consent for the HIV test
- Explaining the implications of knowing one is infected or not

- Exploring the associated implications for marriage, pregnancy, finances, work, and stigma
- Emotional preparedness of the person and coping mechanisms
- Promoting discussion on taboo topics such as sexuality, sexual practices and drug abuse.
- Promoting discussion on relationships, with a focus on the importance on the benefits of shared confidentiality between the person and his/her loved ones
- Sharing information on how to prevent HIV transmission, correcting myths, misinformation and misunderstandings related to HIV and AIDS

4.4.4 Benefits of pre-test counselling

Pre-test counselling helps people to make informed choices. However, it is important to note that it should not be forced on people who do not want pre-test counselling before taking the HIV test. In addition the decision to be tested should be an informed one. Informed consent implies awareness of the possible implications of a test result (including the window period). The nurse/paramedic/caregiver must help the person understand the policy on consent, and should explain the limits and consequences of testing. If the test is positive, there are considerable benefits to providing this service which include:

- Increased acceptance of HIV status and improved ability to cope with the situation and take better decisions.
- Early detection of opportunistic infections
- Early start of preventive therapy, reproductive health advice, including contraceptive advice, and other useful information and education
- Early social and peer support normalizing
- Early and better planning for future care such as making a will and care for children affected by HIV and AIDS

4.5 Post Test Counselling

Post-test counselling helps PLHIV understand and cope with the HIV test result. In post-test counselling, it is important to put the person being counselled at ease. If possible, the room should be peaceful. The counsellor should then tell the person the test result.

The counsellor prepares PLHIV for the result, discloses the result and then addresses any additional queries. Important points of discussion may include ways to reduce the risk of infection or transmission. HIV test result should always be given with appropriate counselling. The form of post-test counselling depends on what the test result is.

The result (either positive or negative) should then be discussed, including how the person feels about the result. Further information can be provided, though the person may be shocked, and may not fully comprehend all the information. In some circumstances, the post-test setting might provide the only chance to counsel this person. At this stage it is helpful to repeat the information just presented, or to have some basic facts written down. It is important for the person to have time to reflect on the result and understand the next course of action.

4.6 After Positive HIV Test Result

- In case of a positive result, the counsellor needs to disclose the news clearly but gently, keeping in mind the cultural nuances. Any form of speculation should be avoided, and clear, factual explanations of what the news means should be given. This should be followed by providing emotional support and discussing with PLHIV on how best to cope, including information on relevant referral services.
- The emotional impact of the news should be assessed. At this point normal reactions would include fear of dying, job loss, family acceptance, and/or concern about the quality of life.
- Then the effects of treatment and response by society should be explored.
- If there is a concern that the person might not return for follow up counselling, then information about relevant health services should be provided. This would include available medical treatments such as antiretroviral therapy or treatment for opportunistic infections, and social services for financial and ongoing emotional support.
- However, if follow up counselling is the case, then it would be advisable to leave this information to a later date when the person is better able to absorb the details and explore the available options.
- The person's understanding and ability to use preventive methods should be assessed. Misinformation should be cleared and useful knowledge should be shared. Aids such as free condoms and disposable syringes can be given out during this session.
- The counselling should be ongoing. This helps the PLHIV to better accept their HIV status, and cope better. Shared confidentiality and including loved ones in the process should be encouraged.

4.7 After Negative HIV Test Result

In post-test counselling, it is important to put the person being counselled at ease. If possible, the room should be peaceful. The counsellor should then tell the person the test result.

Counselling is also vital after a negative result. While the client is likely to feel relief, the counsellor must emphasize several points.

- Due to the “window period”, a negative result may not mean absence of infection, and the client might wish to consider returning for a repeat test after 3-6 months.
- Emphasize HIV prevention, providing support to help the client adopt and sustain safer behaviours

Note: For more details please refer the National HIV Counselling and Testing Guidelines, 2005.

4.8 Counselling for Children

As the AIDS epidemic grows, children are increasingly affected. Apart from those themselves infected with HIV, they include children where one or both of the parents are either living with HIV or AIDS or have died of AIDS. These children have special counselling needs, such as:

- The emotional trauma of witnessing their parents being ill or dying.
- Discrimination and negative attitudes from other children and adults.
- Emotional stress about their own continuing illness.
- Stress of being a caregiver.
- Uncertainty for the future.
- Increased vulnerability to exploitation in the absence of parental care.
- Counselling related to sexual issues and on the avoidance of risk behaviour.

Note: For more details please refer to the National HIV Counselling Guidelines for Children and Adolescents, 2008.

4.9 Counselling for Pregnant Women

Counselling is crucial for pregnant women—or women wanting to become pregnant— who are either HIV-positive or unaware of their HIV status. It facilitates them in making informed decisions about:

- Becoming pregnant if HIV-positive
- The importance of taking a test before pregnancy
- The decision to have children if HIV positive or sero-discordant
- The importance of breastfeeding and making an exclusive breastfeeding choice

For those who are already pregnant, counselling can also discuss the various possibilities of minimising the transfer of infection to the child. This includes the use of antiretroviral therapy as prophylaxis to reduce the risk of transmitting HIV to the unborn child, and breastfeeding and other infant feeding options. Where possible, and by the client consent, it is advantageous

to involve her male partner in the counselling sessions. In case an HIV infected woman chooses to be pregnant she should have counselling available to her before becoming pregnant. Counselling and counselling support for CHBC is available at PPTCT sites to all women of reproductive age or pregnant.

Note: For more details please refer to the Consolidated Guidelines for Prevention and Treatment of HIV in Pakistan 2014

4.10 Nutritional Counselling

Nutrition counselling is an ongoing process conducted usually by a registered dietician who helps an individual in assessing his/ her daily dietary intake and in turn helps identify the areas where change is required. The individual is able to maintain and if needed, bring a change, in the dietary intake with the help of the informative material, follow-up and support provided by the nutrition counsellor.

Nutrition Counselling for PLHIV helps maintain a healthy lifestyle and guides towards better food choices that give more energy and improve immunity. As the immune system is strengthened, an individual may have a possible longevity of life.

Note: For more details please refer to to the Consolidated Guidelines for Prevention and Treatment of HIV in Pakistan 2014

4.11 Commonly Encountered Nutritional Problems in PLHIV

Nutritional problems caused by HIV include muscle wasting, metabolic alterations, anorexia, gastrointestinal disorders (which include chronic diarrhoea), weight loss, vitamin and mineral deficiencies and high level of fats and sugar in blood.

Wasting: Wasting was recognized, as an AIDS-defining condition, by US Center of Disease Control and Prevention (CDC), in 1987. [9]When there is weight loss of at least 10 % in the presence of chronic diarrhoea and fever (persisting for 30 days), it is labelled as a “Wasting syndrome”.

Metabolic Disorders: PLHIV have increased resting energy expenditure (REE), especially if suffering from opportunistic infections. Wasting is mostly caused by decreased intake with resultant weight loss.

Anorexia: PLHIV may experience anorexia due to the HIV itself, a secondary infection or due to the medication for either. Food intake in PLHIV may be affected by oral or esophageal

[9] Council of State and Territorial Epidemiologists; AIDS Program, Center for Infectious Diseases, (1987) “Revision of the CDC surveillance case definition for acquired immunodeficiency syndrome. “MMWR Morb Mortal Wkly

complications such as candidiasis or opthous ulcers. Nausea due to medical therapy may also decrease food intake. Isolation, depression, altered taste buds and fatigue all cause anorexia.

Gastrointestinal Disorders: GI disorders in PLHIV include chronic diarrhoea and parasitic infections. These lead to nutritional deficiencies.

Lipodystrophy: It is characterized by a redistribution of fat in the body and metabolic changes that accompany HIV and AIDS. With lipodystrophy, fat often accumulates in the back of a patient's neck, giving a "buffalo hump" appearance, and in the belly. Fat loss also frequently occurs in the face, arms, legs, and buttocks. Metabolic changes associated with lipodystrophy include elevated cholesterol levels and insulin resistance.

HIV in Adults: Due to poor absorption, reduced intake, elevated utilization of high-energy foods and at the same time loss of micronutrients leads to nutritional deficiencies.

HIV and Pregnant Women: A normal pregnant woman is slightly immuno-suppressed to protect the fetus from a maternal antibody response to genetic material that is foreign (e.g., the father's genes). The Pregnant PLHIV is although not highly susceptible to infections, but whenever catch an infection are often found resistant to treatment.

HIV and Children: A child often gets infected with HIV being borne to a mother who is HIV positive during pregnancy, labour, delivery or breastfeeding. The child may also get HIV during blood transfusion, sexual contact or from the use of an illicit drug. Due to HIV, the child's growth spurt is affected and he/she is unable to gain proper weight. This is further complicated by frequent episodes of diarrhoea.

Nutritional Counselling in CHBC

PLHIV are prone to nutritional deficiency at any time during the course of their illness. Nutritional Counselling helps the PLHIV identify the required energy intake and make proper food choices. Each PLHIV should be given an individualized diet plan based on their weight and nutritional status. CHBC staff should help manage anorexia, nausea, diarrhoea, food intolerances, ulcers related to oral cavity and oesophagus. They need to emphasize on the need to maintain the required energy intake even if suffering from a loss of appetite. Information regarding food-borne illnesses and food safety should also be included in the counselling sessions as this would enable the PLHIV in making well-informed choices. The CHBC staff should monitor the weight of PLHIV and introduce enteral or parenteral nutrition when required. High Cholesterol can be dealt with by educating PLHIV to choose diet rich in high fibre foods, low in saturated fat, alcohol and sweets.

Pregnant PLHIV should be provided education regarding perinatal care and importance of nutrition quite early in pregnancy. The CHBC Staff should visit them regularly during

pregnancy and ensure healthy, high energy dietary intake. They should be educated on how to properly handle, store and cook food and encouraged to take smaller frequent meals. They must be encouraged to take oral iron and vitamin supplements as these will help prevent anaemia and reduce the risk of maternal mortality, congenital anomalies and foetal mortality.

4.12 Group Counselling

Counselling for the PLHIV should be an ongoing process and group counselling can form an integral part of providing ongoing support to the PLHIV. Such support helps to improve their quality of life as well as to enhance their ability to cope and make informed decisions about ongoing care. Group counselling typically entails encouraging the PLHIV to join a peer support group to learn where and how to access services, to find educational resources, and to obtain treatment. Spiritual and religious support might also be required, as well as support related to financial concerns and care for the family after the person's death.

The CHBC team can facilitate group counselling for the PLHIV by making referrals to appropriate identified groups. The CHBC Centres can also organise support group meetings for all the PLHIVs that they are catering to and encourage PLHIV to join them. The support groups should be organised by the OWs with assistance from the Project Manager and Counsellor. For this the CHBC team will need to provide the following support services for organising such meetings. The support services can include identification of PLHIVs in the community, managing correspondence with them, providing secretarial support for the meetings, organising venues, refreshments and stationary for the meetings and facilitating the meetings through organised discussions etc. Throughout the process maximum involvement and participation of the PLHIVs should be ensured. During the support group meeting, keeping in mind the sensitivities of the specific group and community the counsellor should:

- Facilitate a well-structured open ended discussion
- Maintain a respectful, non-judgmental attitude
- Promote active listening, including accurate reflection of the issues or concerns
- Ask supportive questions that raise important issues, in caring, non-judgmental ways
- Be aware of their verbal and non-verbal behaviours
- Provide practical support, advice and information discussing options for care, prevention, and support
- Encourage the PLHIV and caregivers to make their own decisions
- Create an encouraging and caring atmosphere
- Make sure that the discussion addresses all vital concerns
- Make sure that everyone is included in the discussion

4.13 Supportive Counselling to PLHIV and Families

Stigma associated with HIV and AIDS has caused PLHIV and family members to avoid accessing care. Intricacies are involved in fighting stigma. However, increasing community sensitivity and acceptance is very important. Education, meaningful disclosure to family members, community involvement, effective communication and psychosocial support are some of the strategies that help to reduce stigma. Breaking the silence surrounding HIV and AIDS is of prime importance. From this ensues acceptance by families and the larger community.

The CHBC Staff must meet the HIV-infected person and his/her family after the initial meeting for providing them with the support that helps them in improving their quality of life. They must be encouraged to undertake baseline investigations and educated on universal precautions. The CHBC staff can play a vital role in enhancing the ability of PLHIV in coping with the disease and for making informed decisions about ongoing care. PLHIV can be encouraged to join a support group and educated on safer injecting and safer sexual practices. The caregivers can treat OI by timely referral and treatment and can play a role in overdose management.

4.14 Bereavement Counselling

Providing support and counselling is very important for the family and members of the CHBC team as they provide care to a person who is dying and to the family following death.

Families and friends often have little social support, or may have become isolated while caring for PLHIV. Bereavement support should be made available before the person dies, and for as long afterwards as people need it. People react to death in different ways, and need different types of support. For some, it can take months or years to come to terms with loss. Additionally, people's responses may be affected by the way the person died: for example, whether PLHIV died alone and in pain, or died peacefully, surrounded by loved ones. Those left behind often blame themselves if they think they could have done more.

4.15 Spiritual Support

This is usually offered by the religious organizations and is influenced by the religion, beliefs and values of PLHIV. This is challenging if PLHIV had not been very close to his religion or has rigid beliefs. Spiritual support can be managed by the CHBC Workers by acknowledging their spiritual needs, respecting their religious beliefs and identifying a suitable person for providing spiritual support.

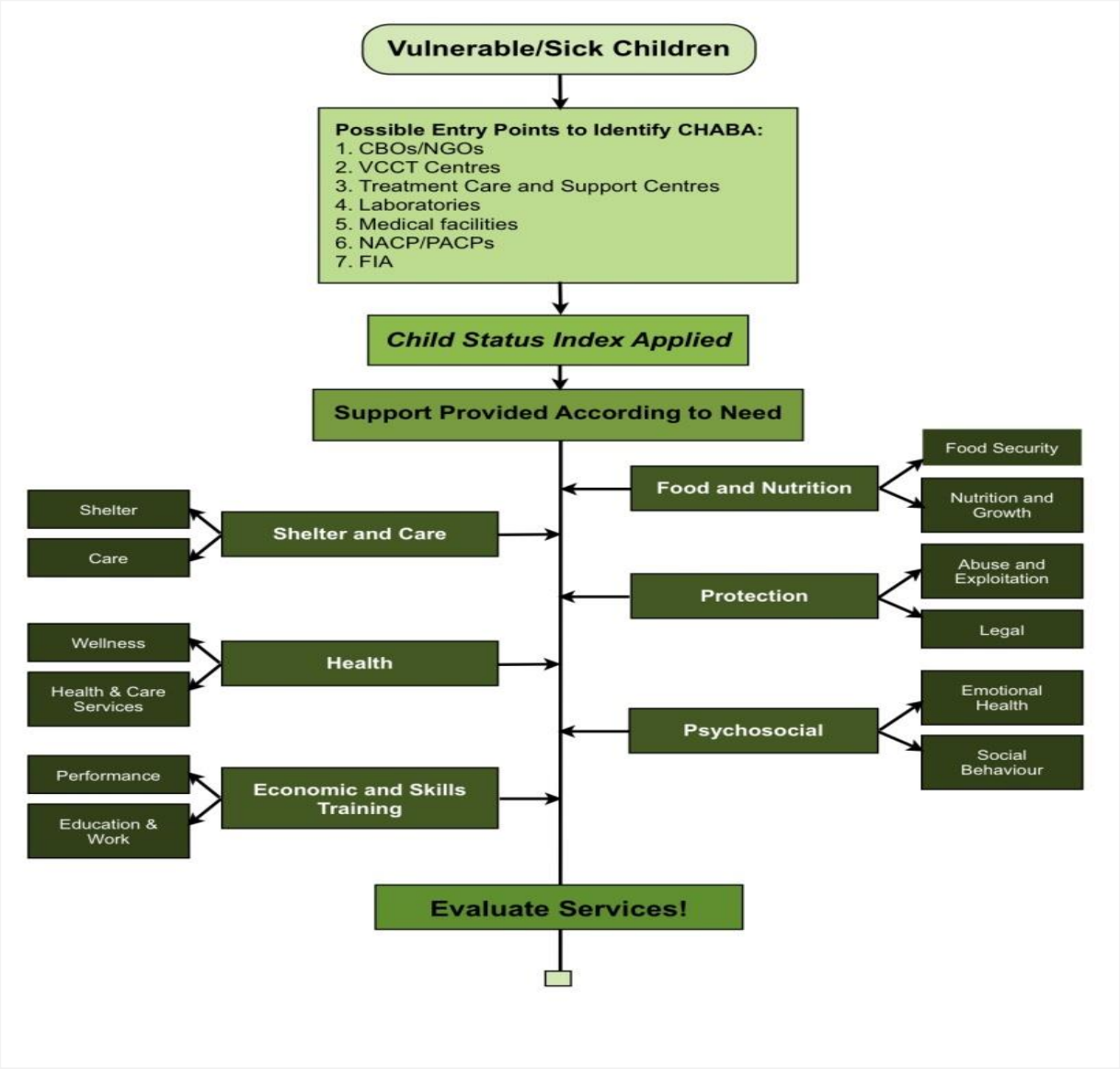
4.16 Care of Affected and Infected Children[10]

HIV and AIDS enormously affect children's lives. The economics of HIV and AIDS on families can lead to malnutrition, sex work, living and working on the streets, or early marriages. School dropouts increase as HIV affected children often have to leave school to care for sick family members or young siblings. In addition, emotional imbalance can lead to depression, aggression, anxiety, drug abuse, and lack of sleep.

These children face poverty, stigma, discrimination and frequent deaths of family members and friends. Psychosocial support is therefore an essential component of CHBC. It can be done by promoting a conducive environment for psychosocial support for affected children and by trying to get a positive response by families, communities, governments and religious organizations.

The National Guidelines for the Care and Support of Children Affected by HIV and AIDS in Pakistan 2010 provides guidance through the Child Effort Index tool on determining specific vulnerabilities and identifying relevant services:

[10]Source: National Guidelines for the Care and Support of Children Affected by HIV and AIDS in Pakistan, 2010 and the National HIV Counselling Guidelines for Children and Adolescents, 2008.


Vulnerable/Sick Children
Possible Entry Points to Identify CHABA:
1. CBOs/NGOs
2. VCCT Centres
3. Treatment Care and Support Centres
4. Laboratories
5. Medical facilities
6. NACP/PACPs
7. FIA
Child Status Index Applied
Support Provided According to Need
Food and Nutrition
Food Security
Nutrition and Growth
Protection
Abuse and Exploitation
Legal
Psychosocial
Emotional Health
Social Behaviour
Shelter and Care
Shelter
Care
Health
Wellness
Health & Care Services
Economic and Skills Training
Performance
Education & Work
Evaluate Services!

The table below outlines the interventions for children that can be effectively delivered at various levels of health care:

Community delivery of interventions through Outreach workers, community based organizations etc	Primary care at a first-level health facility (health centre or outpatient clinics)	District Hospital	Regional or central hospital, specialist physicians, including paediatricians
Promotion of key family practices critical for maternal and child health and nutrition for all women and children: ✓ Promote physical growth and mental development (such as infant and young child feeding); ✓ Prevent disease (such as immunization, insecticide-treated nest, isoniazid preventive therapy, vitamin a supplementation, safe water and hygiene and screening for malnutrition; ✓ Facilitate appropriate home care; and ✓ Facilitate care seeking behaviour. **Outreach services:** Work with primary care facilities to organize outreach services for high-impact interventions (such as through Children's Health Days) **Additional focus for HIV-affected families:** ✓ Parental and caregiver education ✓ Nutrition support (community health workers or community therapeutic centres) for: ▪ Early and exclusive breastfeeding for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) ▪ Appropriate complementary foods from 6 months of age ▪ Ensuring adequate micronutrients (vitamin A, iron and zinc) through diet or supplementation; and ▪ Ready-to-use supplementary and therapeutic foods. ✓ Home management of diarrhoeal disease and fever ✓ Support for adherence to treatment and care and administration of medication to children ✓ TB contact tracing and community DOTS ✓ HIV case-finding, defaulter tracing and case follow-up ✓ Psychological support	**Primary care through maternal and child health services, including:** ✓ Regular growth monitoring; ✓ Prevention services including immunization, vitamin A supplementation and zinc: and ✓ Syndrome management of fever and malaria pneumonia, diarrhoeal disease, ear infections, skin problems, etc **Provider-initiated HIV testing & counseling:** ✓ HIV-exposed infant (virological + serological) including DBS ✓ Pregnant women ✓ Symptomatic child ✓ Siblings and other family members of the person who has HIV **First-line antiretroviral therapy** ✓ Clinical staging ✓ Adherence preparation and support ✓ Recommend or initiate first-line antiretroviral therapy ✓ Adjust dose as child grows ✓ Clinical and immunological monitoring ✓ Manage non-severe and recognize severe drug toxicity ✓ Follow-up for stable children **HIV Care:** ✓ *Opportunistic infections*: manage non-severe opportunistic infections; recognize and refer severe opportunistic infections ✓ *Co-trimoxazole* preventive treatment; initiate co-trimoxazole preventive treatment from 4-6 weeks of age ✓ *Psychosocial support*: disclosure, other psychological support ✓ *Nutrition* ▪ Nutritional counseling and support (as in the community list in the left column) ▪ Macro-nutritional support according to nutrition assessment and clinical conditions ▪ Follow-up care for severe malnutrition after initial facility care ✓ *TB* ▪ Diagnose and manage TB ▪ Isoniazid prophylactic therapy ▪ Support community DOTS ✓ Palliative care: back up to home-based palliative care ✓ Developmental: developmental assessment and support **Community health worker support:** Support function for community health workers (technical, supply and logistical)	**Antiretroviral therapy:** ✓ Perform *clinical* & immunological staging ✓ Initiate *antiretroviral* therapy in complicated cases ✓ Oversee initiation of first line antiretroviral therapy in uncomplicated cases by the primary care team ✓ Manage serious complications of antiretroviral therapy **HIV Care:** ✓ *Opportunistic infections*: assess and manage severe opportunistic infections ✓ *Malnutrition*: Management of severe malnutrition ✓ *TB*: diagnose and start TB treatment in the context of HIV infection **Inpatient Care** **Outreach**: provide outreach antiretroviral therapy services to satellite heath centres and clinics	**Referral** : for uncommon and certain severe opportunistic infections, antiretroviral therapy toxicity and oncology **Clinical Mentoring:** ✓ Review cases of suspected treatment failure ✓ Makes decision on switching to second-line antiretroviral therapy **Laboratory:** ✓ Virological tests from DBS filter paper and sends back results ✓ CD4 ✓ Monitoring of toxicity **Inpatient Care**

4.17 Care for the Caregiver

HIV and AIDS place a significant burden on the caregivers who care for PLHIV. Caring for PLHIV is usually carried out by family members who serve as 'primary caregivers' and by the OW's who are recruited and trained to provide services. In some cases community volunteers that are usually PLHIV can also perform this role, however their instance is less in Pakistan.

In Pakistan the caregivers often experience poverty, social isolation, stigma, psychological distress, and lack basic care giving education. It has been observed that the burden of caring for PLHIV, as either primary caregivers or volunteers, is largely provided by women. These caregivers suffer neglect. It has been observed that caregivers are often inadequately assisted by relatives, friends, neighbours, private individuals, grassroots traditional and political leaders, and other service delivery networks like the NGOs and CBOs. This results in caregivers being overwhelmed by their responsibilities making the coping process even more difficult. This is even more so in women and they feel stressed out with the magnitude and multiplicity of tasks they have to perform. This additionally leads to young girls missing school, increased vulnerability to physical and sexual harassment and depression.

Strong support system to the caregivers is, hence, necessary for the proper implementation of CHBC care giving. For caregivers both the internal factors (such as knowledge) and external (such as money or friends) are necessary to help one cope with a stressful event. Social support or resources provided by other people to enhance caregiver's self-esteem, psychosocial support, and assistance are critical in helping the coping process.

As mentioned before poverty of the caregivers is a significant challenge in this regard. Poverty mitigation factors, such as access to micro finance facilities and vocational training need to be put in place to alleviate their situation. Strategies and mechanism of funding the caregivers to start small and viable income-generating projects could possibly address the poverty and meet the food needs of the caregivers. Additionally receiving –post exposure prophylaxis information, preparatory information, continued training and support from the CHBC workers become important components influencing coping and provision of quality care among home-care providers. For this purpose counselling/debriefings, formation of caregivers support groups, implementation of motivation strategies for the caregivers, provision of adequate care package and food basket are deemed important.

Another challenge that the caregivers face is a lack of any motivation in their care giving work. Care giving to a PLHIV is often demotivating, demoralizing, lacking in incentives, recognition and rewards. This results in making coping even more difficult. Lack of incentives, is a major reason why care giving does not attract young women and men. Giving incentives could

include giving stipends, bonuses, supportive words, food items, toiletries, relieving somebody before s/he gets overwhelmed, allowing caregivers to work in turns, and monetary payments.

In addition to address the challenges posed by the caregivers strategies to include the relatively younger and educated persons into the CHBC programme need to be explored. This could complement and help alleviate the illiteracy of the caregivers. Strong advocacy and encouragement to fully participate and complement the duties of the elderly caregivers needs to be scaled up.

Advocacy campaigns targeting civil society to increase and step up assistance to community care programmes should be scaled up. National and local campaign advocates, lobbyists, and leaders, both at local and national levels, should be at the forefront to challenge all to increase their community support to care giving.

The importance of counselling in facilitating the grieving process by being there for the caregivers also needs to be emphasized. Amongst other ways this can be done by non-judgmental listening and assuring the PLHIVs that they are not going crazy; and that the acute pain they are experiencing is grief in process and the state will not last forever. Grieving process experienced in care giving can temporarily be disabling and working through it by counselling ultimately brings strength. The caregivers and PLHIVs need to be empowered both psychologically and psychosocially. Counselling helps to make a caregiver come into grips with the reality of the problem situation and make one feels s/he is not going crazy, instils hope and confidence, make one free to seek support, and share with others.

It is also recommended that the government, NGOs, and other care-friendly organizations put in place a strategy ensuring and forcing caregivers' supervision, counselling, and monitoring of the care programmes. This would improve the coping challenges experienced by the caregivers. This is likely to reduce burn-out and make coping by the caregivers an easier task.

The role of outreach workers in the care programmes should include making make counselling visits to the caregivers for psychological empowerment and assess their socioeconomic conditions for possible help intervention; facilitate the process of positive change of attitudes and norms relating to care giving among the caregivers; and therefore give way to increased care-giving productivity.

The importance of providing caregivers with incentives has been emphasized and addressed in other countries. It is recommended that the government, NGOs, and care authorities create a provision or an environment resulting in caregivers' recognition and appreciation of their tasks. Considering some monetary allowance would be important. Hence, this could serve as

a reason to significantly enhance the caregivers' morale. Running self-help groups or support networks for caregivers is another strategy that can provide respite to them.

4.18 Inheritance Planning

People often fear open discussion of illness and death. Family members often need help in discussing death and making plans for the future. Such plans might include how children who have lost one or both parents to HIV will be taken care of, where will they be placed, inheritance services and making a will etc.

CHBC Staff can play a vital role in adequately preparing the dying person and their family members, discuss with them issues relates to the inheritance rights and encourage them to make a will. This is important as dying without a will often denies off spring and other family members (especially women) their right to inheritance.

It is important that a will is written when the person is of sound mind, can think and make decisions in the best interest of his loved one. He must not be forced by anyone in doing so.

A will ensures that property, land and valuables are passed on to people that PLHIV had wished for, after his/her death. Trustees of executors are specified who will ensure that the will is acted upon It further elaborates the custodian arrangement of children and can appoint guardians if the other partner is not there to take care of them.

4.19 Legal Support

It is very important that Legal support organizations/structures should be identified and consulted in the communities. Linkage to legal support organizations should be established, such as AGHS Legal Aid Cell, Pakistan International Human Rights Organization, Lawyers for Human Rights and Legal Aid (LHRLA), etc. Adequate legal support should be provided to children and families of PLHIV. Any legal support provided must be adequately documented.

Dying without a will often denies children and other family members their right to inheritance. It is therefore important to help the dying person and family members to adequately prepare for death, including placement of children who have lost one or both parents to AIDS and inheritance rights.

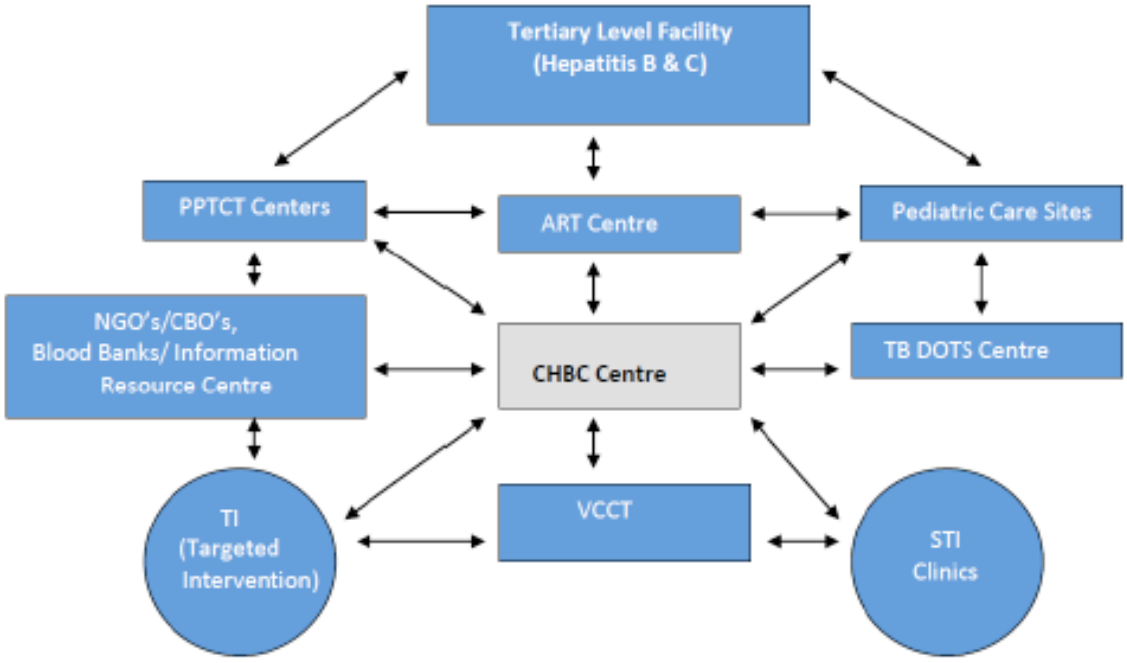
5.0 REFERRAL SUPPORT SERVICES

Decentralization

District management is responsible for monitoring standards of quality and allocating resources for CHBC based on priorities set by the Central Government (Provincial Government). District guidelines for CHBC should therefore be established. The District management is the bridge between the policies and guidelines outlined by the central administration and the implementation of CHBC programmes at the local or community level.

5.1 Integration of Referral Mechanisms

The following scheme details the linkages of the CHBC with other services established by the programme:



5.2 District-Level Responsibilities for CHBC

These include:

- Capacity-building of activities and human resources related to CHBC in the district
- Defining priorities related to CHBC staff at the District Level
- Administering of funds for CHBC activities at the District Level
- Ensuring accessibility of CHBC services by the PLHIVs
- Establishing a waiver system/free of cost service for non-affording PLHIVs

- Monitoring standards for CHBC services (including a system of referral, reducing stigma, developing partnerships with other organizations) both at government and non-government level within established policies
- Allocation of resources
- Recruiting and training CHBC managers and staff
- Planning the administration of defined CHBC training and education.

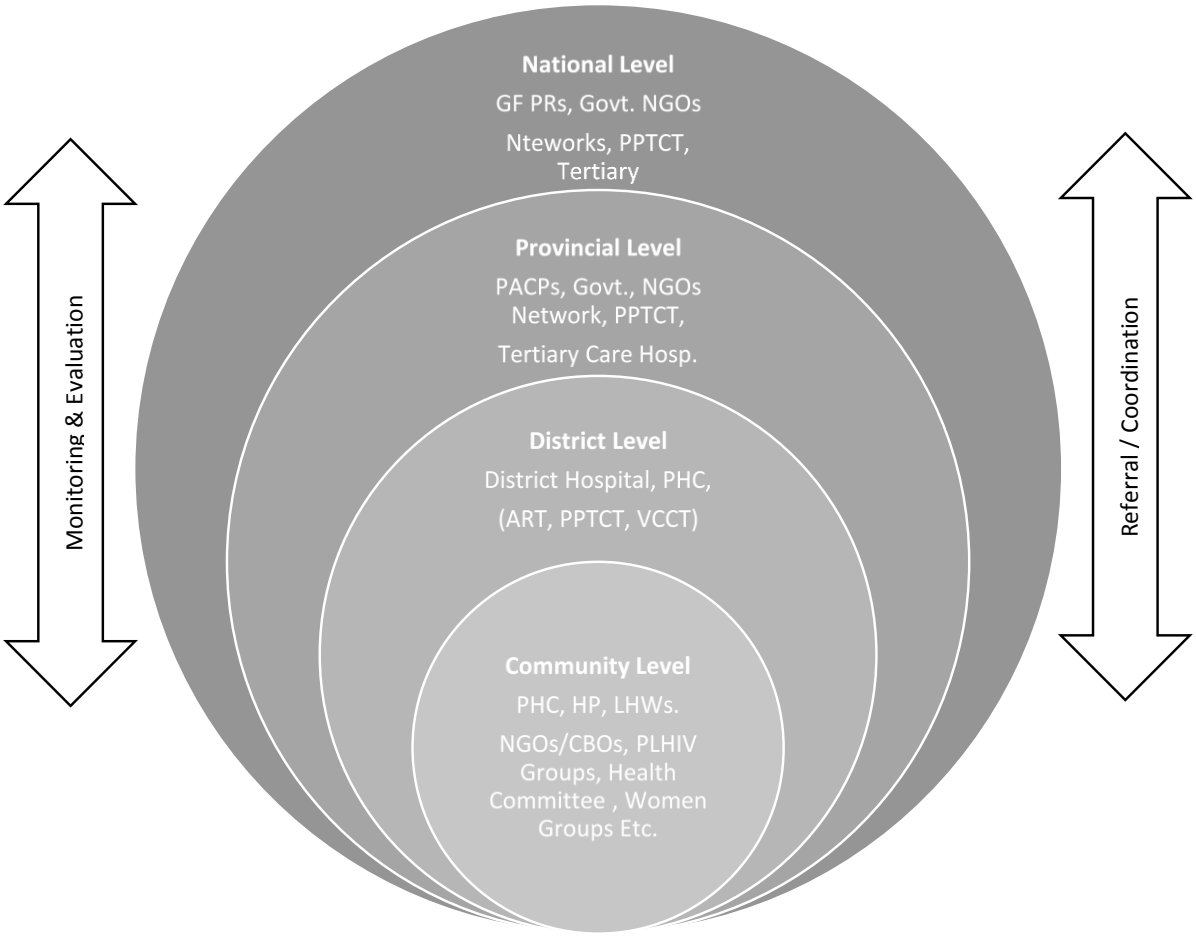
5.3 Effective Delivery of CHBC Services at District Level can be Provided By:

Effective delivery of CHBC services at district level can be provided by:

- Developing district management teams
- Assessing and listing community resources (such as zakat money, donated sites for CHBC, local NGO's etc.)
- Providing education to CHBC staff for effective coordination and referral
- Hiring a CHBC coordinator to oversee comprehensive care for PLHIV and their families while respecting the confidentiality of all beneficiaries.

Developing district management teams is mandatory. This team will be responsible for establishing partnerships with local health centres, NGOs, faith-based organizations, traditional healers and other community organizations and groups. This team is also responsible for developing a district resource list that includes a description and the location of community resources and the services they provide. In addition, the teams should aim to develop an action plan to ensure holistic management and home care for people with HIV and AIDS. Training of health and social service workers should be the responsibility of the district government. Training sessions should therefore be provided to train trainers at the district level health centre. These trainers, in turn, can train OWs, volunteers, and family members.

5.4 Referral Mechanism



5.5 CD4 and Viral Load Tests

The absolute CD4 count is frequently used to monitor the extent of immune suppression in persons with HIV. With HIV, the absolute CD4 count declines as the infection progresses.

CD4 and Viral Load tests are being offered at the identified Tertiary Care facilities. A CHBC Centre must identify and establish linkages with a nearby facility offering these tests in order to make referrals for PLHIV. If the patient has to travel far for the test and may require an overnight stay, the CHBC staff should arrange for transport and accommodation to facilitate them.

5.6 Referral for CD4 Test

An HIV positive person should get a CD4 test as early as possible to get a baseline assessment of his/her immune system. Subsequent to the baseline test, the frequency of testing can vary as per the National ART Guidelines If the person is asymptomatic and not on ART, CD4 count is recommended every 6-12 months depending upon the clinical picture, (e.g. if PLHIV is not on ART but he/she develop TB then CD4 should be done earlier) to monitor when treatment would be required. Once on ART, the CD4 count should be taken every 6 months to make sure that the immune system is strengthening.

5.6 Referral for Viral Load

The viral load is the concentration of a virus, such as HIV, in blood. It is generally recommended when ART is initiated; the viral load test should be done after 2-8 weeks and then should be repeated every 3-4 months.

5.7 ART Sites for Advanced Medical Care

Antiretroviral treatment (ART) is an amalgamation of medicines that can be given to an HIV positive person with a CD4 count of below 350. This treatment has been known to delay or hinder the replication of the HIV virus, and hence prevent it from attacking the immune system. It is important to bear in mind that this treatment is not a cure for HIV, but hinders further harm to the immune system. Once the immune system is strengthened to an extent, it can combat further infections such as TB, diarrhoea, pneumonia, etc., thereby enabling PLHIV and AIDS patients to live a longer and improved quality of life.

5.8 Referral for ART

Anti-Retroviral Therapy is being provided at:

1. HIV treatment centres at Tertiary care hospitals
2. HIV treatment centres at DHQ hospitals

5.9 Indications for ART Therapy

All HIV positive people, including children, will require treatment at some stage. However, this varies greatly for everyone as HIV infection in PLHIV progresses at a different rate. Experience from studies conducted reveals:

- 1/3rd of PLHIVs will remain well for up to 10 years after acquiring infection without any form of treatment.
- Treatment will be required by 60% of PLHIVs after 4 to 5 years.
- A minor percentage (2-3%) will require immediate treatment after acquiring infection
- 2-3% can go on for 15-20 years without treatment
- 35% of children born with HIV will die within the first year and 52% within the first two years of life without treatment. [11]

If CD4 test facility is not available, ART Therapy can be linked to the clinical stages of HIV. The general guideline in this context is outlined below:

Stage 1	Primary HIV Infection	ART not initiated

[11] NACP, A booklet to support Non-Governmental Organizations(NGO's) to provide care and support interventions in their communities,

Stage 2	Clinically Asymptomatic Stage	ART not initiated
Stage 3	Symptomatic HIV infection	ART initiated and usually effective
Stage 4	Progression from HIV to AIDS	ART initiated and partly effective

5.10 Role of CHBC Staff in ART

Accepting life-long ART is not easy, it is therefore important for the CHBC Staff to mentally prepare PLHIV for the treatment. It is important that they view it positively and accept the fact that there is no existing cure for HIV; the disease is now a part of their lives; and ART can enhance the quality of their lives.

Initially as ART is started, PLHIV will be visiting doctors quite frequently but once stability is achieved, CHBC staff will play a greater role in ensuring adherence to the therapy. In the first year of treatment, referral to doctors is made usually once every month, however in later years, the referrals could be made every two months, depending on the PLHIV's clinical progression and adherence to ART. Doctors and the CHBC Staff can play a pivotal role in preparing PLHIV for ART by effectively handling their concerns.

Once ART is initiated, CHBC Staff can guide and counsel for ART adherence, give support, offer advice about side effects and help them to take their medications correctly

5.11Pregnancy and ART

ART enables people with HIV and AIDS to feel healthier and live longer lives. When the treatment has its desired impact, couples often decide to have a baby. Although PLHIV possess the right to have a baby, it is essential to plan it out thoroughly with the PPTCT team.

Safe delivery options need to be carefully analyzed and discussed with doctors as well as with partners/husbands. The aim is to help minimize the chances of transferring HIV to the child. Women should be referred to the PPTCT sites for appropriate obstetric care including delivery, and infant feeding counselling.

5.12 Children and ART

In essence, the treatment mechanism for children with HIV is quite similar to that for the adults. The immune system and drug absorption rate can however be very different in babies, toddlers, infants, children, adolescents and adults. Hence there are separate treatment guidelines for children. Pakistan's National ART Guidelines include information on treating children.

CHBC staff is expected to guide caregivers at home in adherence to ART. Creative strategies are to be devised to ensure children adhere to their daily medications Nationally developed

ART adherence tools for children are available at the Provincial AIDS Control Programmes and with identified pediatric AIDS clinicians.The staff must also ensure that the child receives immunizations as per national EPI vaccination protocol except BCG which should not be given to HIV positive symptomatic children.

5.13 TB Services

CHBC Staff can be the first one to pick symptoms of Tuberculosis during home visits. PLHIV must be referred to the TB centre for diagnosis if the symptoms indicate so. Tuberculosis medication is usually administered through a directly observed therapy, short course (DOTS) programme. These medicines can be given as part of the CHBC programme, through a separate community service or a local health facility.

Although treatment is given for longer durations ranging from 6-12 months, TB is a curable disease. TB Treatment is through the use of more than one medicine which is called Anti Tuberculosis Therapy ATT. The standard "short" course treatment for TB is Isoniazid, Rifampacin, (also known as Rifampin in the United States), Pyrazinamide, and Ethambutol for two months, then Isoniazid and Rifampicin alone for further four months Infection reduces significantly in the first two months and CHBC Staff must enquire about the increase in appetite and should notice weight gain during home visits. It is important to ensure adherence for full recovery. Regular follow up in the health facility both at TB centre and HIV treatment centre must also be ensured by the CHBC staff.

5.14 Sexual and Reproductive Health Services

It is pertinent to provide both HIV and STI services together because both the HIV and STI risk groups overlap, as sexual contact is the most common mode of transmission for both types of infections. Also, the presence of STIs increases the chance of HIV transmission. STI and HIV counselling services can be effectively provided by the same staff. It is important for the CHBC staff to ensure “syndromic management” as well as partner management for treating the STIs.

5.15 Prevention of Parent to Child Transmission (PPTCT)

For prevention of parent to child transmission of HIV a four-pronged strategy has been adopted.

5.15.1 Steps (Prongs) of Prevention of Parent to Child Transmission of HIV

Prong I	Prong II	Prong III	Prong IV
Increasing HIV prevention and general awareness in women and men	Preventing unwanted pregnancies in HIV positive women	Preventing HIV transmission from HIV positive mother to her infant	Linking HIV positive women and their children into a continuum of care and support services

Routine HIV screening of all women presenting for antenatal or delivery care to health facilities is not recommended at present due to the incurred costs and the state of epidemic in country. However, VCCT for vulnerable or at risk women is recommended wherever they present for care.

The risk of MTCT among HIV-infected pregnant women can be effectively minimized by using specific interventions that include ART treatment or prophylaxis during pregnancy and labour depending upon the CD4 and prophylaxis to the infant as per the National PPTCT Guidelines; choosing safe delivery options and exclusive breast feeding for one year with continuation of ARV for the mother throughout the period of breast feeding.

Note: For more details please refer to the WHO Global PPTCT Framework

5.15.2 Fundamental PPTCT Interventions

1. Comprehensive maternal and child health services
2. VCCT for all pregnant women at-risk for HIV
3. ARV prophylaxis or treatment depending upon the CD4
4. Choosing appropriate mode of delivery
5. Exclusive breast feeding with mother on ARVs throughout the period of breast feeding
6. Care and support for HIV positive women and their families

5.16 Nutritional Advice

Nutrition advice, counselling, care and support for HIV-infected pregnant and lactating women is especially important because the dual burden of HIV and pregnancy can produce nutritional vulnerability, especially in poor women. Energy requirements for HIV-infected asymptomatic pregnant women are 10% more than HIV-uninfected pregnant women.

5.17 Comprehensive PPTCT Services:

- VCCT
- History and physical examination
- Nutritional assessment (weight, height, mid-arm circumference)

- Screening for sexually transmitted infections
- Screening for tuberculosis if suggested by history or physical examination (tuberculin skin test and chest X-ray)
- Haemoglobin measurement
- Tetanus Toxoid administration
- Iron and Folate supplementation
- Nutrition counselling
- Information and advice on PPTCT interventions
- Information and support on infant feeding
- Information on family planning
- Infectious disease expert consultation for assessment of HIV disease status
- Management of other infections
- Diagnosis and treatment of sexually transmitted infections (STI). Pregnant women are screened for genital infections especially syphilis, in view of the fact that increased HIV genital tract replication may occur due to other local infections
- Provision of ARVs for prophylaxis and for treatment as indicated
- PPTCT MCH care team (obstetrician, paediatrician, nurse, HIV counsellor, outreach worker)
- Referral links with outreach service providers to PLHIV for care and support

Note: With the introduction of the new National PPTCT Guidelines in 2011, most PPTCT clients will be on a one year prophylactic regimen or life-long ART if they need it for their own health. Both ARV prophylaxis and treatment are initiated at the HIV treatment and care centres. Adherence is equally important with PPTCT regimens and CHBC teams should support adherence and clinical monitoring as with other PLHIV clients on ART.

6.0 ESTABLISHING AND MAINTAINING CHBC

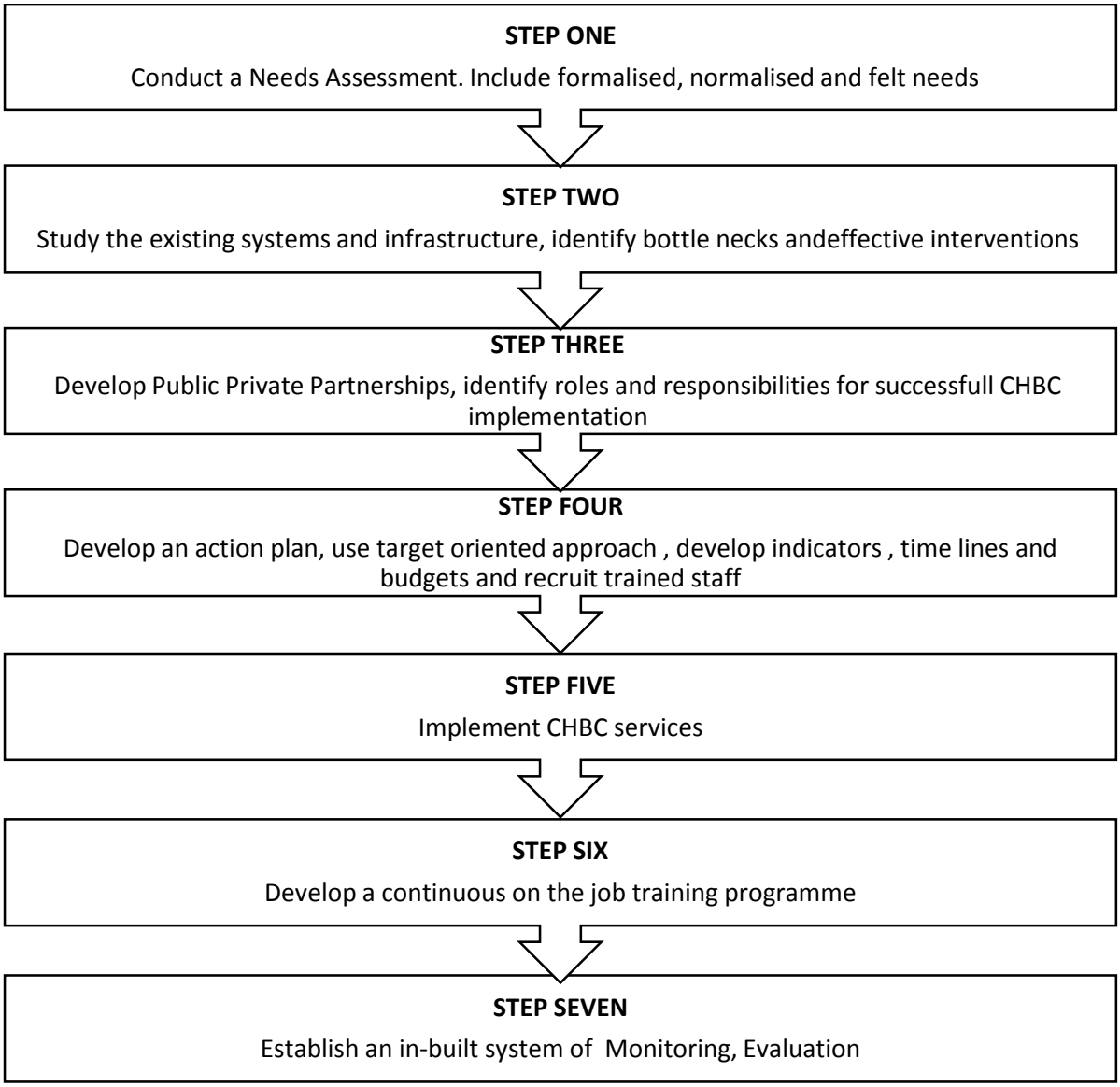
A systematic effort is required to develop new CHBC projects and revitalize existing programmes.

6.1 A Sequenced Process

The sequenced process comprises of six building blocks:

1. Entry phase
2. Community assessment
3. Needs assessment
4. Planning
5. Implementation
6. Evaluation

6.12 Basic Steps for Planning, Implementing, Monitoring and Evaluating the Chbc Programme and Activities



The phases are interlinked and connected to each other. However, once the programme is implemented, sustainability with respect to community commitment and timely response to the changing needs of PLHIV, families and the CHBC team are critical elements to be taken into account. Resource mobilization, monitoring and evaluation of the programme are therefore essential components.

PHASE	FOCUS OF ATTENTION	MAJOR TASKS[12]
Entry phase: community assessment	The existing situation	Create a community team Learn about the community Assess with the community team what is already being done and available in the community

[12] The Cross Cluster Initiative on Home-Based Long-Term Care, non-communicable diseases and mental health and the department of HIV/AIDS, Family and Community Health, WHO (2002) "Community Home Based Care in Resource Limited Settings, A framework for action"

		Discuss and plan for improving CHBC or introducing new services
Needs assessment phase	The needs of family caregivers, PLHIV paid and voluntary community workers Community acceptance	Gather information on the needs of PLHIV, caregivers and potential members of the CHBC team Learn what skills and resources already exist Involve key stakeholders and local community members in accepting and promoting CHBC Promote community mobilization
Planning phase	Responding to health and support needs; Community action.	Explore and choose methods to respond to the health and support needs and plan CHBC Obtain necessary resources
Action phase	Community action	Implement CHBC plans
Renewal phase	Evaluation and responsiveness	Determine what has been learned Make changes to programme as necessary Re-examine

6.3 The Entry Phase

It is desirable to develop a work force of people who are interested in developing and improving CHBC in their communities. The idea is to learn about the targeted community as much as possible as presenting new ideas can result in resentment and resistance. Therefore, having considerable knowledge about the community may aid in getting acceptance of a new or improved programme.

The community assessment comprises of knowing about the structure of the health and social welfare system, existing agencies and organizations, relationship of law enforcement agencies with the respective communities, expected number of PLHIV in the vicinity, past history of the community and its physical characteristics, population, economy and power structures. Learning about the health and social welfare system within the community and at the district level is important. Existing health and social welfare personnel are important stakeholders involved. Information should be obtained about the roles of these health and social welfare work force. This will provide ideas as how CHBC can be incorporated into these existing programmes. Information should therefore be collected about:

- Existing health & social services
- The responsibilities of health & social personnel for these services
- The authority figures for policy making
- Sanctioning of resources
- Recruiting staff

- Evaluation of services
- Linkages between health & social services
- The staff mix and the pay-roll structures
- Number of volunteer health & social welfare workers
- The CHBC services already present in the community

Information regarding community agencies and organizations like NGOs, religious organizations, community-based organizations and other community groups is mandatory. It is important to know about these various agencies and services, to determine whether or not CHBC activities are included in their programmes and to consider a possibility of collaborative and corroborative services.

For each such organization the following information is needed:

- Roles and responsibilities of the service agency
- Complement of workers within each agency
- Services that fit into the larger health and social welfare framework

6.4 Community Perspective

It must be remembered that community's perceptions and opinions of CHBC will determine how the CHBC programme accomplishes its goal. Information is therefore needed regarding the acceptance of previous community programmes and ventures, identifying which programmes were more successful than others and what accounted for their success, conflicts of interest and mechanisms of conflict resolution, community alliances and support structures, peoples' perceptions and opinions about CHBC.

6.5 Topography

The geological features and terrain of a community affect initiation and management of CHBC. Availability of roads, transport and accessibility for ill, family, caregivers and CHBC personnel differ in urban and rural localities. Therefore hut settlements and slum areas need additional resources and specific planning for introduction of CHBC programmes.

Consideration also has to be given to whether the dwellings and homes are scattered apart or close together. Places of community gatherings such as meeting places, schools and places of worship must be known so that community meetings can be held there to support CHBC.

The information must pertain to the type of community whether urban, rural or slum, the distance people travel to fetch water, house-hold commodities, medicines, utilities and to visit local health centres or pharmacies.

6.6 Communication

Information is also required for type of transport available, condition of roads, type of houses, types of businesses in the community. Capacity of resource mobilization, income-generating activities and sources of outside funding should also be identified.

6.7 Demography

Obtaining information about demographic features of the community also aids in assessing basic health needs and in shaping the plan and implementation of CHBC. It is important to know whether the community is stable in size or increasing or decreasing as many people may have to leave an area to find work due to economic meltdown in recent years and either return periodically or send money to family members. This work related emigration can affect the community, especially the number of female-headed households.

6.8 Eclectic Mix

The religious, ethnic and racial mix of the population is also important to consider. Information about languages spoken in the community, presence of minority groups, marginalized groups such as very poor, orphans, street children, male, hijra and female sex workers, prisoners , and drug injectors is extremely essential as these communities might greatly need CHBC, but their access to community resources might be limited.

6.9 Financial Viability

The economic status of the community affects the health of its people and their ability to access CHBC. Knowledge about the average house-hold income is therefore important to assess whether or not the family can meet its basic needs. Information regarding the socio-economic status of the community whether poor or middle class ,major sources of income, type of economy whether agricultural or based on industry and recent economic fluctuations is critical to determine the support and sustainability of CHBC programmes.

6.10 Community Participation

Meeting and knowing community leaders, spiritual leaders, members of faith-based organizations, members of NGOs & community-based organizations and mass media personalities are important as they exercise enormous influence over the community. Bringing them on board and piggy backing on these to initiate CHBC is extremely important. Identifying

social networks and opening channels of communication to penetrate and sensitize these power icons and run advocacy campaigns for CHBC is highly recommended.

Relationships need to be built. Community norms, values, customs have to be learned, so as not to invite offence or resentment. Therefore community participation right from the very inception of community assessment must be aimed for.

6.11 The Needs Assessment Phase

6.11.1 Assessing Needs of the Target Group

In this phase the needs of the target group must be taken into account. This includes specific needs of the PLHIV that include physical, psychosocial, economic and spiritual needs. Information regarding ongoing treatment e.g. TB, ART etc must be collected.

The family needs include an assessment on the information, education and communication needs of families with respect to patient management and CHBC. Information about the presence of home caregivers and their ages, attitudes towards home based care, willingness to accept external caregivers, availability of resources and back up support for home and advanced clinical care must be obtained.

The staff needs include an assessment regarding the training requirements for the CHBC team e.g. paid and volunteer health and social welfare personnel in patient management and referral must be determined.

The major needs of the target group must be taken into account and then priorities must be set. Emphasis should be on identifying priority home needs of PLHIV, children affected by HIV and AIDS, family members, and paid/unpaid CHBC team members.

Note: (Please refer to the Annex for the Community Needs Assessment Checklist)

Assessing Community Needs and Gaining Acceptance

The second step is to gain acceptance and assess community needs. Three sets of people within the broader community are very important in gaining acceptance and assessing needs. They are:

1. **The initiators:** The initiators should take the need for a CHBC programme to the opinion leaders.
2. **The opinion leaders**: Their formal approval is important before the CHBC programme is taken to the community as a whole.

3. **The community action group**: Respected community members who introduce the programme to the larger community form the action group, involving the overall community in identifying needs and suggesting possible solutions.

Community needs assessment may therefore include knowledge about:

- The socio- cultural, environment and support systems of the community.
- Socio- cultural issues e.g. stigma, isolation, violence and abuse occurring in the homes.
- The levels of community involvement and participation in the care and support of the infected and the affected.
- Community's perceptions of HIV and AIDS.
- CHBC and attitudes of the community towards CHBC
- Possibility of the members of the community to form support groups.
- The training needs of the community.
- Cultural and traditional beliefs in the community, which are likely to compromise the quality of care.

6.12 The Planning Phase

6.12.1 Setting Priorities and Identifying Resources

The above information will aid in formulating a strategic plan focused on community needs. In essence, setting priorities for CHBC depends upon the needs assessment done with the target group and the overall community. However, priorities are also dependent on availability of resources both financial and human. Implementation of some elements of CHBC may be incremental. Mobilizing and tapping into available resources would therefore take priority over developing new resources. It is important to start with resources that are available, affordable and accessible for CHBC.

Based on the needs assessment, the identified needs are prioritized and a plan is developed that utilizes the existing resources and enlists strategies for mobilizing additional resources.

6.12.2 Identifying Referral and Support Network Linkages

During the planning phase obtaining information in areas of joint collaboration between organizations and programmes such as TB and HIV is a prerequisite. The knowledge can be used to identify the requirements for designing corroborative services. The plan should therefore include:

1. **Formation of Task Forces at different levels**. This includes:

- Inter-sectoral
- Interagency working groups
- Community groups

2. **Reviewing and revision of existing policies, guidelines on HIV and AIDS management**. This includes:

   - Reviewing existing diagnostic services
   - Reference laboratory
   - Surveillance of HIV
   - Case finding e.g. HIV testing and TB and Hep C screening; PPTCT
   - Case management: Treatment of HIV and TB and management of Hep C
   - Medicines and supplies
   - Communication and community education strategies

3. **Information on existing referral and support networks for service delivery**

4. **Information on staffing situation of different cadres and at different levels**

5. **Propositions for the assessment of:**

   - Service delivery
   - Availability of essential equipment and supplies
   - Medicines for management of opportunistic infections including TB for PLHIV
   - Case management of the adult and children both under and over five years old
   - Existing referral and support networks for service delivery
   - Communication strategy for health workers, policy makers and communities
   - Family planning services
   - Educational needs

6. **Mechanisms for sensitization of policy-makers** for consensus on the programme

7. **Technical guidance** for medical personnel, community leaders, programme managers, government, international partners and the private sector

6.13 Community Mobilization

Involving the target group in planning CHBC is very important. PLHIV, families and paid and voluntary health and social welfare personnel should be involved in this planning process.

Moreover community activists, high-ups and influential persons/opinion leaders should be consulted. People who can influence the development of CHBC and its eventual outcome should also be involved in the planning process. Developing a CHBC committee and planning community meetings are important steps in developing a CHBC programme.

6.14 Recruiting the Human Resource

The strategies enlisted help in identifying the human resource essential for effectively implementing them. The essential skills are enlisted and training needs are identified for effectively executing the plan.

6.15 Establishing Timelines & Setting Performance Indicators

The identified needs assist in establishing the objectives of the CHBC programme and the related strategies for achieving them. Commitment to action might include deciding on a time frame. It is important to have the objectives time bound so that the progress can be monitored against defined target outputs.

6.16 Financial Input

The activities indicate the resources required for implementing them. These are priced to establish the budget required for executing the activities. The timelines are helpful in outlining monthly, quarterly and annual financial needs. It is important that funding opportunities are explored and community and other stakeholders are involved in resource mobilization.

6.17 Structure of a Draft Plan

The initial draft plan should include:

- A statement of need with background information about the priority needs for CHBC.
- A value statement about how the programme should be run.
- Goal and objectives for CHBC.
- Human resource plan: Roles, tasks of different stakeholders must be addressed.
- Time frames for implementation; time lines should be determined and decisions made about who will undertake the action.
- Monitoring and Evaluation plan for CHBC
- Budget: The budget should contain a list of resources required to effectively implement or scale up the programme. Plans on how to tap and mobilize these resources should also be included. This should address adequate funding, collaboration with other community services etc.

Note: Please refer to the annex for Planning for establishment of CHBC Program for PLHIV Checklist.

6.18 The Implementation Phase

Implementation means putting into action all the plans that have been developed in the previous phase. Implementation should address issues related to the provision of care, continuum of care, staffing, education, supplies, equipment, funding and monitoring of the programme.

Policy guidelines that need to be developed and issues addressed in the implementation phase include:

- Enlisting of the physical care needs of PLHIV.
- Decision about incorporating palliative care into CHBC.
- Psychosocial and counselling needs of PLHIV, families and members of the health care team.
- Designing of ways to reduce caregiver burnout and stigma against PLHIV.
- Decision how to include care of children affected by HIV and AIDS into CHBC
- Development of strategies to help PLHIV in accessing CHBC
- Ensuring that the required system of transport is in place
- Ensuring that the required system of record keeping is in place
- Development of referral system and follow-up network
- Identification of key community coordinators
- Recruitment of health, social welfare staff and volunteers for CHBC
- Development of strategies for staff retention
- Development of CHBC team which entails training of CHBC supervisors, development of CHBC curriculum, training of CHBC team, hiring of educators, designing of a pre-service, In-service and continuing education plan, establishment of criteria for evaluation of education, Finding a location of CHBC
- Development of essential drug list for CHBC
- Development of list for supplies, equipment and contents of CHBC kits
- Development of purchase/ordering system for supplies and medicines
- Storage facilities for equipment and supplies
- Development of public-private partnerships for sharing resources
- Development and monitoring of CHBC budget

6.18.1 Essentials of a Successful Programme Implementation

1. Development of:

- Care supply list
- Ordering schedule
- Delivery plan
- Monitoring system

2. Designing of a pilot project on CHBC services
3. Using existing health systems and community networks for decision-making during the implementation of the programme.
4. Development of referral and follow-up networks.
5. Development of Policy Guidelines
6. Making resource allocations
7. Doing detailed budgeting and planning with time frames
8. Development of a human resource plan
    - Designing a pre-service, in-service and continuing education plan.
    - Training different cadres of workers
    - Adapting and developing educational materials
9. Development of a supply plan
10. Quantification of needs

Note: Please refer to the annex for the Implementation of CHBC Program for PLHIV Checklist

Monitoring and Supervision Phase

Evaluation is a continuous part of the CHBC programme. It should occur on a continual basis and changes should be made to the programme where necessary. In addition, timelines should be agreed and communicated for all the activities related to monitoring and evaluation. Thus effective and sustainable CHBC should evolve and change based on the needs of the target group and the broader community. This continual feedback loop is necessary in meeting the needs of the community.

The main tasks in this phase entail:

6.19 Identifying a Coordinator

He/she will be responsible for:

- Monitoring programme and service delivery
- Reporting
- Holding regular meetings with service providers and trainers
- Reordering of CHBC Kits
- Acquiring financial support

6.19 Establishing Criteria for Site Selection

Develop criteria for site selection for phased implementation of CHBC services. Collect data on:

- HIV prevalence
- TB prevalence
- Case-load: Health status of clients e.g. HIV status known, symptomatic with HIV or AIDS related conditions and or with HIV, AIDS and TB.
- Quality of existing TB and HIV services
- Availability of counselling facilities
- Nearby existing CHBC centres

Creating Chbc Indicators for Monitoring

Monitoring the CHBC programme involves supervision to ensure adequate and effective care delivery. CHBC indicators for monitoring thus include:

- Supervising care delivery
- On-site visits and peer supervision, monitoring essential drugs, supplies and equipment
- Monitoring an adequate staff mix
- Monitoring CHBC education

Recording statistics on the CHBC programme, such as the number PLHIV, diagnoses, monitoring number of referrals and treatment regimens and monitoring the CHBC budget.

Indicators for Monitoring and Reporting the Progress of the CHBC

6.20 Indicators for National Level

- Number of health centres covered by CHBC teams
- Number of community and home based care teams
- Number of PLHIV receiving CHBC services
- Number of people including TB patients referred for VCCT

6.20.1 Indicators for Provincial Network for CHBC

- Number of regular coordinating meetings
- Number of regular report to national level
- Number of field supervision visits
- Number of community home based care teams
- Number of health centres covered by CHBC teams

- Number of PLHIV receiving CHBC services
- Number of people including TB patients referred for VCCT

6.20.2 Indicators for CHBC Teams

- Number of PLHIV referred to OI/ART services, support groups, TB program, and PMTCT programmes.
- Number of PLHIV receiving CHBC Services
- Number of people referred for VCT
- Number of home visits

6.21 Reviewing Criteria for Receiving Additional Support for Scaling Up of CHBC Services

The monitoring mechanism when in place helps in generating evidence that can be used to reflect performance for justifying a request for enhanced support. The CHBC Monitoring Checklist for Project Managers can be used to review criteria for receiving additional support for scaling up of CHBC Services. Funding agencies would typically require the CHBC Centre to:

Provide evidence of:

- Systematic implementation of service provision.
- Lessons learnt from existing services.
- Plans reflecting objectives, targets, indicators, timeframes and responsible persons.

Furnish reports that reflect the level of achievement of targets (planned versus accomplished)

This includes:

- Financial reports – against budgeted activities.
- Reports of analysed information from the monitoring tools – Care Provider, Patient, Management and the Supervisors' Reporting Forms.
- Reports on pattern of use of different kit items

Exhibit capacity to cope with additional responsibilities

This includes evidence of various resources including:

- Trained personnel
- Coordinator(s) / and supervisors for CHBC activities
- Trained volunteers
- Availability of support services

Justify need for expansion

This includes:

- Documented increase in patient load and/or demand for CHBC services Successful implementation for CHBC services require a systematic approach and sustainability and continuous support will rest on evidence of achievement of positive outcomes.

7.0 STAFFING FOR THE CHBC PROGRAM

Staffing Structure for a CHBC Centre

Proposed Staffing Structure for CHBC

Sr.	Designation	FT/PT	Required Number
1	Doctor (Male/ Female)	Part time/Full time	1
2	Nurse/Paramedical (Male/ Female)	Part time/Full time	2
3	Project Manager	Full time	1
4	Admin & Finance Officer	Full time	1
5	Counsellors/ Psychologist	Full time	1
6	Outreach Workers	Full time	3
7	Laboratory Technician	Full time/Part Time	1
8	Driver	Full time	1
9	Janitorial Staff	Full time	2

SKILLS, Competencies and responsibilities of the chbc staff

The following list of skills and other competencies for CHBC team members should be aimed for:

Doctor

The doctor at the CHBC site will be a qualified professional medical practitioner with a thorough knowledge of topics pertaining to HIV and AIDS. They are primarily responsible for the diagnosis and medical treatment of PLHIV. They may be part time or full time depending on the need. Further, they may act as consultants to CHBC team. To document the health status of the PLHIV they will use the Medical Assessment Form for PLHIV and the Referral Form for referring to medical services. Further their responsibilities will include:

Provision of medical services	• Provision of outpatient care. • Diagnosis, prophylaxis and treatment of opportunistic infections. • Monitoring of PLHIV initiated on ART, including adherence. • Monitoring of PLHIV receiving pre ART care. • Maintain case records for all patients. • Ensure infection control practices are in place at the Centre. • Ensure adherence to Universal Precautions.
Provision of Psycho- social support	• Counsel patients on treatment, OI drug adherence and drug dependence for IDU PLHIV. • Encourage patient treatment literacy and give education. • Encourage positive prevention and positive living. • Give information on proper nutrition. • Prescribe nutritional supplementation if required.
Administrative	• Review stock of medicines periodically and discuss supply requirements with the Administrator/ Coordinator. • Review stock of reagents and chemicals and discuss the same with the administrator/coordinator. • Review the record keeping by the nurses/paramedicals and recommend training if any required.

Nurse / Paramedical

A qualified nurse or paramedical staffs is one who has undertaken a standard training program and passed the examinations set by national or provincial governments. Specific CHBC skills and other competencies of the nurse/paramedical include: supervising, monitoring and managing the CHBC services, diagnosing and treating common conditions in collaboration with a physician, case management, serving as a case coordinator and referral agent, educating other CHBC team members and as a support person and counsellor for the ill person, family and CHBC team.

Nursing Care	Take the vital signs and follow-up reading of the patients as per requirement. Maintaining follow-up charts. Provide medicine intake to the patients as per doctor's prescription. Watch out for any changes in conditions and report to the doctor. Counsel patients on different aspects such as treatment adherence, drug intake as per regimen prescribed, nutrition, and safe sexual behaviour, positive prevention and positive living, reproductive health choices. Provide basic antenatal and natal care including taking vitals, providing information and infant counselling support. Provide nutritional supplements as required Maintenance of patient records and case sheets
Administrative	Coordinate and track the referrals from and to other medical facilities. Report on the referred case from other facilities. Report on stocks of medicines and other consumables. Provide data on the formats required for monitoring. Maintain a register of drugs dispensed and stock of drugs received. Function as case managers for overview of the referrals and linkages integrated care of the PLHIV's case. In-charge of coordinating the outreach workers to follow the treatment and follow up plan as decided for the PLHIV by the clinical team.
Others	Practice Universal precaution principles. Participate in the staff meetings and provide feedback.

Project Manager

The project managers will have a supervisory role and will be responsible for ensuring the smooth functioning of the CHBC centre. They will be responsible for the formal and informal Monitoring & Evaluation activities at the CHBC centre and coordination with sub-office. They will also actively identify areas for capacity building and resource mobilisation in their domain.

Administrative	Hire qualified staff for CHBC on contractual basis. Attend training programmes organized by funding agencies.. Ensure that the recruited staff undergoes induction training and subsequent refresher trainings every year at CHBCs. Maintain the attendance register and ensure timely payment of salary for CHBC staff.
Demand Generation	Ensure good patient up-take by establishing linkages with the ART Centres, PPTCT sites, other hospitals, PLHIV networks, NGOs, as well

	as with the medical practitioners and district and other healthcare facilities in the area.
Quality Assurance	Ensure that high quality counselling services are provided in the CHBC by conducting client satisfaction surveys and assessing the knowledge and attitudes of clients prior to and after counselling through interviews with a sample of clients. Ensure high quality care and support services are offered regularly to the patients admitted in CHBC programme. Ensure diet requirements are provided to patients as per the client chart and sample the food being supplied. Examine the patient records and the maintenance of the same and the administration of the drugs. Examine the client records for any referral made for medical & support services and the outcome of such referral.
Supply and logistics	Ensure that the minimum space as well as equipment and communication material required for CHBC is in place at all times.
Monitoring & Supervision	Supervise the functioning of the CHBC through monthly staffing review with the staff. Ensure data quality checks to ensure accuracy of data generated by CHBC staff by checking with the registers and records maintained by the CHBC. Ensure that monthly/ quarterly reports are sent in a timely manner to funding agency.
Other	Ensure that all staff at the facility are sensitized on the package of services available for the control and prevention of HIV so as to build ownership and also remove myths and misconceptions and prevent instances of stigma and discrimination.

Counsellor

The counsellor is also an integral part of the core CHBC team. They are ideally trained psychologists with an expertise in HIV counselling and other related topics. To document some of their activities they will use the Counselling Form. Further their responsibilities include:

Essential Counselling	Provide adherence counselling on treatment and drug adherence Provide nutrition counselling to PLHIV Positive living and life after infection Provide psycho-social support Provide counselling on safer sexual and injecting practices and on primary prevention Provide follow up counselling on repeat visits Support outreach team
Desirable Counselling	Family counselling on stigma and discrimination Family counselling on home based care Provide counselling on other support services available Bereavement counselling
Administrative	Maintain individual confidential counselling records and counselling sheets Facilitate establishment of linkages with support groups and PLHIV networks Maintain contacts with support groups in the local area for referring PLHIV from the centre Reporting on feedback back to the doctor regarding individual cases

	Reporting to the administrator on the data requirements for monitoring and reporting respecting confidentiality

Outreach worker

Outreach Workers are usually trained by a doctor/nurse/paramedical and other health and social service personnel to care for people in the CHBC centres and within the home. This training will vary depending on the setting and the existing capacities of the service personnel. Outreach workers usually form the backbone of the CHBC team. They live in the communities and know the population well. They regularly attend to the needs of the registered PLHIV living in the community and help in identifying new PLHIV in the community. The skills and other competencies of the community health worker include: the use of universal precautions, providing basic nursing care, providing palliative care, administering DOTS treatment for tuberculosis, administering other treatments (under the supervision of the nurse/paramedical), providing psychosocial support and counselling within the home and local Health Centre, referring the PLHIV and family and educating PLHIV and family on basic nutrition, nursing care and treatment They also assist in arranging for PLHIV and families to receive welfare support such as food, blankets, clothing, transport and assistance with funerals. These volunteers may also carry out practical jobs such as cooking, cleaning, washing and fetching water and firewood.

Social Worker

Social worker is a qualified practitioner who provides assistance with financial, legal and social support. He/she may be part of the CHBC team or may act as complementary practitioner supporting the team, ill person and family. The competencies of social workers include: helping families in accessing grants, facilitating financial support, supporting affected children and providing assistance and advocacy with legal matters. Social workers also refer families to other resources and agencies and provide psychosocial counselling to PLHIV and their family members.

Community Volunteer

Community volunteers are attached to the CHBC. They are usually PLHIV and work on a part time basis. They assist the PLHIV in tasks such as arranging support group meetings, awareness raising sessions, data compilation etc.

Other Potential CHBC Practitioners

People who also provide care to PLHIV and family members at community level and sometimes at home include the following:

- Pharmacists also provide an important complementary service. PLHIV and family members often consult pharmacists for symptom relief, medical supplies and for preventive therapy.
- Respected traditional healers might also provide care. Herbal treatments and other traditional remedies can often effectively relieve symptoms.

Retaining Staff

Caring for PLHIV and family members at home presents many challenges. The CHBC team often feels exhausted as it tries to care for increasing numbers of PLHIV and families with few resources. Some of the CHBC team members are also HIV-infected or have family members who are. Under such difficult circumstances, retaining CHBC team members and supporting, motivating and encouraging them to provide effective care comprise a challenge. Strategies important for sustainability include:

- Ongoing psychosocial support and counselling through periodic support group or individual sessions;
- Staff rotation; and
- Periods of respite, vacation periods and recreational outings.

Honouring CHBC team members through a system of rewards and incentives may include: further education; honouring CHBC team members at community gatherings; providing awards for outstanding service; honoraria and in-kind payments to volunteers; recognition and support for the work of CHBC team members especially from higher health officials; presenting the CHBC team members with t-shirts, uniforms, bags, umbrellas, badges etc.

Training and Development of CHBC Personnel

Need Assessment

CHBC team members have different levels of literacy and therefore different learning needs. Assessing learning needs are pertinent to ensure that educational sessions are relevant and appropriate to the learners. CHBC programmes are continually evolving in response to the changing needs of PLHIV and families. Previously a CHBC programme was primarily focused on the care of PLHIV and family caregivers. As the AIDS epidemic increases globally, care and support of children affected by HIV and AIDS is becoming a major concern. A continual training program for CHBC staff would help them abreast latest developments in the field. It is also important for PLHIV to be part of all training/ sensitization sessions (especially for the training on stigma and discrimination).

Training needs assessments can be carried out by either a professional such as nurse/paramedical or a social worker or by a multidisciplinary team. A single professional should do the assessment only if the training criteria are well-established through input of key stakeholders, narrow in focus and the assessment tools and guidelines clearly structured.

Curriculum Development

The core CHBC team must be appropriately trained to effectively deliver the CHBC. The core content of the CHBC curriculum should focus on:

- Basic information on HIV transmission and how to prevent it
- Basic comfort measures and nursing care for adults and children
- Managing symptoms and administering medication
- Use of traditional remedies
- Universal precautions
- Palliative care, including counselling terminally ill people, bereavement
- Counselling and pain relief
- Nutrition
- Psychosocial support and counselling for PLHIV, caregivers, children affected by HIV and AIDS, health, social welfare workers and volunteers
- Training the trainers for continued in-service education
- Supervising and managing CHBC, including motivating staff
- Stress management and care for caregivers
- Managing referrals and resources

Educational sessions involving all members of the CHBC team (including PLHIV and their families) help in reducing stigma and encourage open communication. Separate sessions can be given arranged for meeting specific training requirements of different cadres/levels of CHBC staff. Members of the CHBC team should educate PLHIV, their families in their homes, and take sessions with the community, as and when required.

CHBC Team: Roles, Responsibilities, Essential Training and Skills Required

Designation	Minimum Qualifications and Requirements	Key Responsibilities	Training Requirements
Doctor: Part time position	• MBBS or equivalent • Registration with the Pakistan Medical & Dental Council	• Consultation in CHBC clinic – once in a week or in every two weeks depending on the patient workload • Being the first point of contact for the client, examines and then further counsels or refer to the HIV specialist	• Basic familiarity with HIV medicine • Orientation of CHBC • Clinical management of HIV
Project Manager	• Preferably Masters in Business Administration • Diploma in Public Health	• Experience with Monitoring & Evaluation • Coordination with sub-office • Ability to produce capacity building plans	• Report writing, managerial, and presentation skills • Communication skills
Admin & Finance Officer	• Preferably Masters in Business Administration • Minimum degree Bachelors in Business Administration	• Data and document verification • Accuracy of data and documents	• Donor Funding and reporting mechanisms • Proposal Development and Report Writing • Financial Skills • M&E Skills • Logistic Management
Health Assistant	• Certificate level in General Medicine from the Pakistan Health Professional's Council	• Consultation of clients who visit for STI Services • Follow up of CHBC clients • Prescribing medicines for minor ailments	• STI Case Management • Clinical management of HIV • Orientation of CHBC • Nutritional Counselling • Basics of ART

Staff Nurse/ Paramedical	• Diploma in General Nursing, Midwifery or other paramedical • Registration with the Pakistan Nursing Council or other relevant authority	• Assist the Doctor or Health Assistant as required • Manage the drug store • Maintain drug expiry chart • Provides nursing care to PLHIV	• Competency based VCCT • Nursing care of PLHIV • Nutritional Counselling • Basics of ART
HIV Counsellor	• Certificate (10+2) in General Medicine/ Nursing/Social Work or equivalent	HIV Related counselling for: • HIV testing • Antiretroviral therapy (ART) adherence • Other types of counselling in the SOP	• HIV/STI testing • Basics of ART • Counselling Skills
Laboratory Technician/ Assistant	• Certificate in Medical Laboratory or equivalent • Lab Assistant course completed from & Vocational Training Institute	• Diagnostics for HIV & STI • Preparing & sending samples for External Quality Assurance Scheme	Lab testing for HIV and STI
Outreach workers	• Preferably from the positive community (as per GIPA principle)	The responsibilities of the outreach workers are as follows: • Provide care and support to PLHIV at the CHBC and in the home • Undertake field visits to verify the address of the person who has been enrolled on ART and sent to the CHBC for counselling support • Undertake follow-up visits to ensure adherence to ART • Establish rapport with the PLHIV community and NGO's working in the area • Provide information to the community regarding the	

		Community Care Centre and the services offered • Mobilize pregnant women for PPTCT services and liaison with other health functionaries.	

Training Outline for Outreach Workers on HIV/AIDS & TB

Topics to be covered

HIV Epidemiology

- What is HIV?
- What is AIDS?
- How is HIV diagnosed?
- How is AIDS diagnosed?
- What are opportunistic infections associated with HIV and AIDS?
- How does childhood HIV and AIDS differ from adult HIV and AIDS?

TB Epidemiology

- What is TB?
- How does TB spread?
- How is TB diagnosed?
- How is TB managed?
- How does childhood TB differ from adult TB?

TB HIV Epidemiology

- HIV TB interaction
- HIV and TB interactions
- Prevention of HIV related TB
- Interventions to control TB
- Interventions to control TB

I**nterventions to control combined TB & HIV/ AIDS Epidemics**

- Interventions responding to TB: TB case finding and cure: TB preventive therapy, immunization
- Transmission, intervention against other HIV-related morbidity and mortality among TB patients
- Home and community care of HIV and AIDS and TB patients

Monitoring and evaluation

- Basic TB control indictors: Case finding and treatment outcome indicators
- Basic HIV prevention, care, and support indicators
- Process and impact indicators for collaborative TB/HIV/AIDS activities

Proposed Training Plan for Home-Based Caregivers

TRAINING	STAFF TO BE TRAINED	TRAINING DURATION	TRAINING FREQUENCY	MAIN TRAINING TOPICS
Sensitization Programme for all staff in the CHBC	All staff	1 day	Yearly	• Basic information on HIV and AIDS • Myths and misconceptions about HIV and AIDS • ICTC • PPTCT • ART • HIV-TB coordination • Package of services for prevention and control of HIV and AIDS • Care and support for people living with HIV and AIDS
CHBC Team Training	All CHBC Staff	5 days	Yearly	• Basic information on HIV and AIDS • Basic information on NSF-III, Provincial AIDS Control Programmes and the package of services for prevention and control of HIV and AIDS • CHBC Operational Guidelines • Reporting formats and monitoring • Team Building
Counsellor Induction Training	Counsellor	12 days	Once at the time of appointment	• Basic information on HIV and AIDS, HIV testing and counselling • Basic counselling Techniques Counselling on reproductive choices and infant feeding • Counselling for specific target groups • Counselling for care and treatment • Counselling on treatment literacy and adherence • Counselling for other issues • Advanced counselling skills

Counsellor Refresher Training	Counsellor	5 days	Yearly	• Review of counselling skills • Review of pre-test and post-test counselling process • Review adherence counselling, technical updates, administrative issues, M & E
Laboratory Technician Induction Training	Laboratory Technician	5 days	Once at the time of appointment	• Basic information on HIV and AIDS • Laboratory bio-safety and standard work precautions • Collection, transport and storage of specimens for HIV testing and related diagnostic tests • SOP for routine investigations • Quality Assurance • Lab management • Lab infrastructure • Equipment maintenance and calibrations
Laboratory Technician Refresher Course	Laboratory Technician	3 days	Yearly	• Same as above
OW Induction Training	Community Health Worker	3 days	Once at the time of appointment	• Basic information on HIV and AIDS • ICTC, PPTCT & HIV-TB • Continuum of care for PLHIV • Functions of an OW • Home visits as part of outreach • Skills related to home based care • ART adherence requirements
OW Refresher Training	Outreach Worker	2 day	Yearly	• Same as above
Nurses Induction/ Refresher Training	Nurses	5 days	Yearly	• Updated Module for Nurses training on HIV and AIDS

Doctors induction/ Refresher Training	Doctors	5 days	Yearly	• Standardized training module developed by NACP

Educational Management and Curriculum Delivery

The educational sessions should be regular and well managed. CHBC Project Manager is responsible for planning and managing the session. This includes assessing needs, planning periodic training sessions, training the trainers, on-site training and offering different educational methods such as role-plays.

Planning Periodic Training Sessions

Learning must be reinforced and updated. The CHBC team should therefore receive continuing education on regular basis. This also includes training of the PLHIV and family. The needs for the periodic training will depend upon the need requirement and the capacities of the PLHIV and family.

Training the Trainers

Training the trainers is mandatory so that education is a continuous process. Refresher courses are required for education to be effective. This results in assimilation of new knowledge and consolidation of previous learning.

On-Site Training

Learning is often more relevant and realistic when it is delivered on site or within the home.

Offering Different Instructional Strategies

To cater to the different learning needs, a mix of teaching and learning methods should be used. These methods might include lectures, group discussions, role plays, simulations, repeat demonstrations, visual learning aids, story-telling, dramas, songs, games and the use of information pamphlets, posters and leaflets. These educational materials must be in the local language and at the literacy level of the learners.

Outreach

In general the community should be educated about the transmission, prevention and care of PLHIV. Education sessions can be held at schools, gatherings, religious meetings, local celebrations, the workplace and in any area or feasible occasion. Members of the CHBC team may be asked to present information at these meetings. CHBC team members should therefore be trained and encouraged to provide public education.

Education to Reduce Stigma

In different cultures and societies, people attribute HIV and AIDS to be the consequence of sin, witchcraft, karma etc. Moreover PLHIV are being stigmatized, rejected and discriminated

all over the world. The only effective way of fighting against this stigma is through education. Such education should be the integral part of outreach education to the community.

Mass Media Involvement

The print and electronic media are a robust mechanism in educating the public. However, they must first be educated. The CHBC team might be involved in helping to educate the mass media about home care and how to support ill people and families at home. In particular, CHBC team members might be invited to provide examples of HIV and AIDS stigma and discrimination and to highlight the problems of children affected and infected with HIV on national TV and radio.

Evaluation of Education

Session evaluation is essential. Evaluation should include: the core content, the level of student learning, the credit given to learners, the number of education sessions and teacher performance assessment. First and the foremost is to determine the learning needs of the community, then the learning outcomes should be specified and mechanisms to evaluate the level of student learning designed. Educational strategies can therefore be customized to the local needs.

8.0 FINANCING AND SUSTAINING OF THE CHBC INTERVENTIONS

8.1 Local Resource Mobilization

Program sustainability depends upon identification of local resources in order to reduce dependency and empower communities. Moreover interventions must be in line with the proven government strategies. Duplication or replacement of services must be avoided at all cost.

8.2 Alternate Sources of Funding

One of the major burning issues in any CHBC program for PLHIV is the care and support of children infected or affected by HIV. This requires long term planning and alternate sources of funding. Therefore The CHBC must be developed for a minimum time period of three years to recognize and tap other funding sources. The sources may be demand in next GFATM proposal R-II with different dimensions for continuation of care and support services for PLHIV.

8.3 Public-Private Partnerships

CHBC programs are usually funded by governments, international or national donor agencies, NGOs and religious organizations. In essence public-private partnerships must be developed to ensure sharing and pooling of financial resources. In case the CHBC is funded by the government, in many developing countries, the funds allocated have been found to come through public taxations, community based social insurance schemes or revenue provided for general health care. CSOs/NGOs should also contribute a suitable proportion of funding to inculcate ownership and sustainability.

8.4 Cost Sharing

However, the costs of CHBC can be shared between the Federal, Provincial and the District Governments. If so, the proportion of funds available from all three tiers should be pre-determined. The percentages of CHBC funds invested in developing/ maintaining, and in running the CHBC program should also be calculated.

In case if NGOs, religious organizations and the private sector are the active players in delivering CHBC, the government and the donor agencies should support these organizations with funding. In rare instances, CHBC programme might itself is responsible for its own funding. If NGOs, religious organisations and the private sector are responsible for genesis of their own funding, systems should be ensured for sustainability of funds over a prolonged period of time. This should take place with a partnership of NGOs and Government agencies to inculcate ownership and sustainability

Similarly if the local community is expected to be responsible for a proportion of the funds, mechanisms must be there for funds generation and sustenance. In this context community-based insurance schemes might be an option. However, issues of introduction, management and maintenance of such schemes must be dealt with. If a fee for CHBC services is introduced the mechanisms of waiver for poor and destitute should be determined. Moreover, cost-curtailment methods should be decided upon.

8.5 Community Ownership

Sustainability of any community program largely depends upon the commitment and ownership by the people of the said community. Indirect approaches to ensure sustainability are:

- Community mobilization
- Development of effective community leadership
- Participation in developing and managing local CHBC programs, Utilization of local human resource
- Expertise in preparation, management and monitoring of CHBC budget and its equitable and transparent allocation.

8.6 Social Support Networks

Under-resourced settings substantially burden CHBC programmes. Prioritization of needs is therefore mandatory. More over long-term support of infected and affected children would require linkages with other NGOs for nutrition support, related health services, provision of school fees and uniforms, and access to micro finance schemes, vocational training and job placements. Income-generating activities such as community gardens and farms, craft markets, community fairs, contributions from local businesses, religious organizations are all a means to provide funds for CHBC.

8.7 Revolving Funds

Systems of revolving community funds can be established. Money is provided to buy the drugs, supplies and equipment necessary for CHBC. PLHIV and family members then pay a small fee for these services. These payments go into a revolving fund to help in sustaining the program. However a payment waiver system for those in abject poverty should be established to ensure access to care.

8.8 Retention of Volunteers

Induction of volunteers in CHBC programs is critical for its running. Many volunteers respond to a call for help because of their religious convictions and beliefs. However, retention of volunteers would require group support activities, education, honoring them, providing

recognition awards, honoraria and other incentives. The choice of incentives depends on the financial status of the CHBC program.

8.9 Shared Resources

Furthermore, sharing resources such as supplies, equipment, information and education across sites with other health-related NGOs, community-based organizations, religious organizations and community health facilities can help to cut the CHBC costs.

9.0 MONITORING AND EVALUATION OF CHBC PROGRAM

The CHBC team and the stakeholders at the district and provincial level (external members) are responsible for monitoring and evaluating the CHBC program. The CHBC team will be responsible for monitoring, quality assurance, formative evaluations, and external evaluators will perform formal summative evaluation. The standards and regulations for CHBC programming are established through these National Guidelines. The CHBC team will be responsible for ensuring that its practice portrays the standards, policies and regulations.

CHBC quality assurance framework thus includes:

- Determining CHBC goals, objectives and sub-objectives
- Determining CHBC practice guidelines, determining the roles and responsibilities of CHBC team members
- Developing the standards, policies and regulations for CHBC
- Developing standards for monitoring performance
- Developing outcome measures for CHBC
- Ensuring adequate resources: staff, supplies and equipment, education and financing

9.1 Quality of Care Indicators

These indicators will be assessed by PLHIV, their families and members of the CHBC team. In addition, external evaluators will assess the quality of care during outcome evaluation. Following quality of care indicators are therefore used:

For PLHIV:

- The level of knowledge on provision of care
- Access to health care (free or affordable)
- Access to transport (free or affordable)
- Access to medicines, including homeopathic remedies (affordable or free)
- Access to medical supplies and equipment (affordable or free)
- Adequate symptom relief
- Use of universal precautions
- Adequate nutrition
- Provision of basic nursing care and comfort measures such as personal hygiene of PLHIV, house cleanliness
- Availability of clean clothes and bedding

- Mobility of PLHIV (where appropriate)
- Adequate heat and ventilation
- Access to psychosocial support and counselling, including voluntary counselling and testing
- Willingness to disclose positive HIV Status
- Adequate referral and access to community resources
- [13]Satisfaction with the quality of care
- Improved quality of life for PLHIV
- Improved coping and empowerment of PLHIV

For Family members:

- Adequate family education on the provision of care
- Access to affordable or free health care
- Access to medication
- Access to treatment
- Access to transport
- Access to supplies and equipment
- Access to community funds for destitute people or participation in income generating activities
- Access and referral to community resources
- Access to psychosocial support and counselling, including voluntary counselling and testing
- Disclosure promoted
- Reduced family and community stigma associated with HIV and AIDS and care
- Respite from care giving
- Satisfaction of family members with the quality of care and family support
- Improved quality of life for family members
- Improved family coping and empowerment

For CHBC team members:

- Satisfaction of CHBC team members with providing high-quality care for PLHIV
- Satisfaction of CHBC team members with providing high-quality care for family members

[13] Satisfaction criteria are subjective and should be based on field experience of CHBC team after implementation of the program for quality of care improvement.

- Adequate educational preparation of nurses
- Adequate educational preparation of outreach workers
- Adequate educational preparation for doctors
- Adequate educational preparation of other complementary health and social service personnel involved in CHBC
- Continuing education of CHBC team members
- Psychosocial support and counselling for CHBC team members
- Acceptable quality of life for CHBC team members
- Adequate supervision and monitoring for effective care of PLHIV and their families
- Adequate and effective case management for care of PLHIV and their families
- Adequate and effective referral to other needed resources[14]
- Access to transport to visit homes
- Access to adequate drugs
- Access to adequate supplies
- Access to adequate equipment for care in the home
- Access to community funds to support destitute families

9.2 Reporting And Documenting Formats for Monitoring and Evaluation Activities

The attached reporting formats in the Annex shall be used to monitor activities. They include

- Checklist for Community Needs Assessment
- Checklist for Planning of CHBC
- Checklist for Implementation of CHBC for PLHIV
- Waste Management Checklist
- Documenting format for Partnerships at community level
- Recording format for monthly services being provided at the CHBC
- Recording Format for Monthly Staff details
- CHBC Staff Appraisal Form
- Documenting format for assessment of health status (Health Assessment Forms)
- Documenting format for counseling services (Counseling Form)
- Documenting format for the needs assessment of PLHIV (Membership Form)
- Documenting format for monthly home visit form (Monthly Home Visit Form)
- Documenting Format or making Referrals (Referral Form)

9.3 CHBC Program Evaluation

[14] Timely referral for any service needed by PLHIV but not included in CHBC program with provision of transport to the referral site as well as facilitation at the site.

During the community development process, at the end of each step evaluation is done to see what has been accomplished, what went right, what went wrong, and how the process can be further improved. After program implementation the evaluation becomes an evolving process. Evaluation has two important aspects:

1. Formative continuous evaluation occurs on an ongoing basis and is usually undertaken by the CHBC team
2. Summative evaluation is usually carried out by an external third party on periodic basis

9.4 Formative Evaluation

Informal formative evaluation monitors the program on a regular basis. This form of evaluation is usually done by checking with the target group (PLHIV, family members and members of the CHBC team) about how the CHBC program is working and whether it is meeting the needs of the target group.

Such informal evaluations can take place during home visits and at team meetings. The outcome of these evaluations should be recorded and plans established to improve services and care where necessary. Issues related with formative evaluation are: the criteria of informal evaluation and frequency of evaluation.

Evaluation related to funding of CHBC includes information on sources of funding, CHBC budget, fund raising and resource mobilizing activities. The CHBC supervisor is usually responsible for regular informal evaluation in this context.

9.5 Summative Evaluation

The summative form of evaluation is undertaken by external/third party evaluators. The purpose is to evaluate the outcomes of the CHBC program and the focus should be on the quality of care indicators for the CHBC program. It should be conducted annually and its schedule, requisite funding and identification of potential external evaluators should be decided at the inception of the program.

Evaluation is a continual part of the CHBC program. Without this continual feedback loop, the CHBC program would lose its effectiveness. The results of both the informal and formal evaluations should be shared with the stakeholders involved in CHBC.

9.6 Monitoring Of CHBC Activities

The CHBC activities are subject to monitoring and evaluation by external evaluators. CHBC Project Manager would be responsible for submitting quarterly and annual progress report on CHBC activities against pre-determined targets for review. This will help establish the performance of the CHBC Centres and benchmark best practices.

Constant monitoring is essential for ensuring the proper implementation of the continuum of care activities. In order to ensure a comprehensive monitoring system, the CHBC Project Manager must ensure a monitoring and supervision schedule for periodic assessment of performance and quality of care being provided. It is essential to respond to the training needs of the professionals involved in the provision of care, as identified during the monitoring process. The various monitoring tools attached in the annex could be used for recording and reviewing information as and when required. This data can further be used for providing regular feedback on CHBC Performance along various dimensions, in stakeholder meetings and for submitting formal reports to external evaluators.

9.7 Supervision and Support of CHBC Activities:

Regular monitoring of CHBC activities by the relevant stakeholders is vital for the effective implementation of the program. To facilitate the supervision of CHBC activities, it is important for the external evaluators to:

- Determine supervision, monitoring and evaluation methods for assessing the implementation and impact of CHBC services.
- Develop and use:
    1. Appropriate schedules for supervising and supporting providers of CHBC activities.
    2. Effective supervision tools such as checklists.(Please refer to Annex)
    3. Effective monitoring indicators for assessing the outcomes of the CHBC program.
    4. Establish an information system for recording, monitoring, supervising and evaluating CHBC activities
- Conduct:
    1. Supervisory visits to care givers, family members and community groups providing CHBC services.
    2. Continuous evaluation of CHBC activities
    3. Regular scheduled studies on HIV and AIDS and CHBC to determine the impact of the program on PLHIV, families and communities.
    4. Review CHBC activity records and provide support as needed.
    5. Conduct regular performance appraisals of the CHBC providers in terminal care.
    6. Develop responsive CHBC policies based on the findings of the assessments.

Monitoring indicators are essential in assessing the progress and outcomes of CHBC Program Activities. Indicators should be selected in accordance with the activities that are being implemented in the communities. Some core indicators to be monitored include:

9.8 Monitoring Indicators for HIV & AIDS Activities:

- Number of clients who received pre-test counselling at the CHBC Centre

- Number of clients referred for CD 4 Test
- Number of clients referred for Viral Load Test
- Number of clients who received post-test counselling at the CHBC Centre·
- Number of clients that were put on ARVs
- Number of PLHIV who have maintained adherence at >95% for 6 months/1 year
- Number of outreach workers trained in HIV & AIDS program policies and guidelines
- Number of Health Care Organizations referring PLHIV to the CHBC Centres
- Number of affected households with at least one family member trained in CHBC, out of the total number of households registered with the CHBC Centre
- Number of community groups who have been trained to provide CHBC services out of the total number of community groups targeted for training
- Number of home visits carried out by CHBC Staff (outreach worker, nurse/paramedic, counsellor or doctor) out of total number of outreach visits targeted to be conducted

9.10 Monitoring Indicators for OI, TB, STI & HEP. C Activities:

- Number of CHBC Staff trained in management of OI, TB, STI and Hepatitis C and their related program policies and guidelines
- Number of PLHIVs referred for diagnosis of OI, TB, STI and Hepatitis C
- Number of PLHIVs receiving treatment for OI TB, STI and Hepatitis C against those diagnosed for the disease
- Number of PLHIVs OI cured of TB, STI and Hepatitis C against those receiving treatment for the disease

9.11 Monitoring Indicators for IEC (Information, Education, & Communication) Activities:

- Number of IEC sessions held by the CHBC Centre for the affected families and community groups against the scheduled number of IEC sessions
- Number of families and community groups working with PLHIV and their families after the IEC sessions against the total number of families and community groups who attended the sessions
- Pre and post assessment of basic knowledge [15] about HIV and AIDS infection and control amongst the families and the community groups following the IEC Sessions
- Pre and post assessment of reduction in stigma and discrimination for PLHIV amongst the families and the community groups following the IEC Sessions

[15] Please refer to Annex (Baseline knowledge indicators for Aids and HIV)

9.12 Monitoring Indicators for Counselling and Psychological Support:

- Number of PLHIV receiving counselling and psychosocial support services in their homes against total number of PLHIVs registered.
- Number of PLHIV receiving counselling and psychosocial support services at the CHBC Centre against total number of PLHIVs registered
- Number of counselling sessions provided to affected families against the total number of counselling sessions planned
- Number of support group meetings held against the total number of meetings planned

9.13 Monitoring Indicators for PPTCT:

- Number of pregnant mothers provided VCCT services
- Number of pregnant mothers referred for screening for HIV AIDS
- Number of pregnant mothers diagnosed as HIV positive against the total number of pregnant mothers who underwent screening
- Number of HIV positive pregnant women on ART Therapy against the total number of HIV positive pregnant women registered with the CHBC centre
- Number of health care organization referring HIV positive pregnant women, mothers and/or children to CHBC Centre
- Number of support groups formed by communities to provide social support to mothers and their families participating in PPTCT programs
- Number of infants born to HIV positive mothers who are tested on PCR within 8 weeks
- Number of infants found HIV negative on PCR against the total number of infants tested on PCR at 8 weeks
- Number of infants found HIV negative on PCR against the total number of infants tested on PCR at 18 months
- Number of HIV positive mothers exclusively breast feeding their infants

9.14 Monitoring Indicators for ART

- Number of PLHIVs referred for initiation of ART
- Number of home visits made to PLHIV on ART therapy against total number of registered PLHIVs on ART
- Number of PLHIV and families requesting for home based care while on ART
- Number of health care organizations offering ART referring PLHIV to CHBC Centre
- Number of PLHIV >95% adherent to ART
- Number of PLHIV with signs of ARV related complications referred to ARV centre

9.15 Monitoring Indicators for Terminal Care

- Number of PLHIV registered for receiving terminal care in their homes
- Number of home visits carried out for provision of terminal care to PLHIV
- Number of terminal patients who made end-life arrangements against the total number of terminally ill patients
- Number of support groups formed by communities to provide physical, spiritual and social support to terminally ill patients and their families affected by HIV and AIDS

9.16 Monitoring Indicators for Resource Mobilization Activities

- Number of PLHIV and families receiving social support against the total number of PLHIV registered with the CHBC
- Number of collaborations established with the community groups and NGOs for provision of resources to support CHBC services to the infected and affected.
- Number of activities undertaken by CHBC Centre for fund generation and resource mobilization

9.17 Monitoring Indicators for Human Resource Development Activities

- Number of trainings conducted for various levels of the CHBC staff on HIV and AIDS against the total number of trainings planned
- Number of in-house training programs implemented at the CHBC Centre for improving the skills of the CHBC staff and family caregivers
- Pre and post training assessment of the CHBC Staff

Standard Services at the CHBC Centre

10.0 STANDARD SERVICES AT CHBC SITE

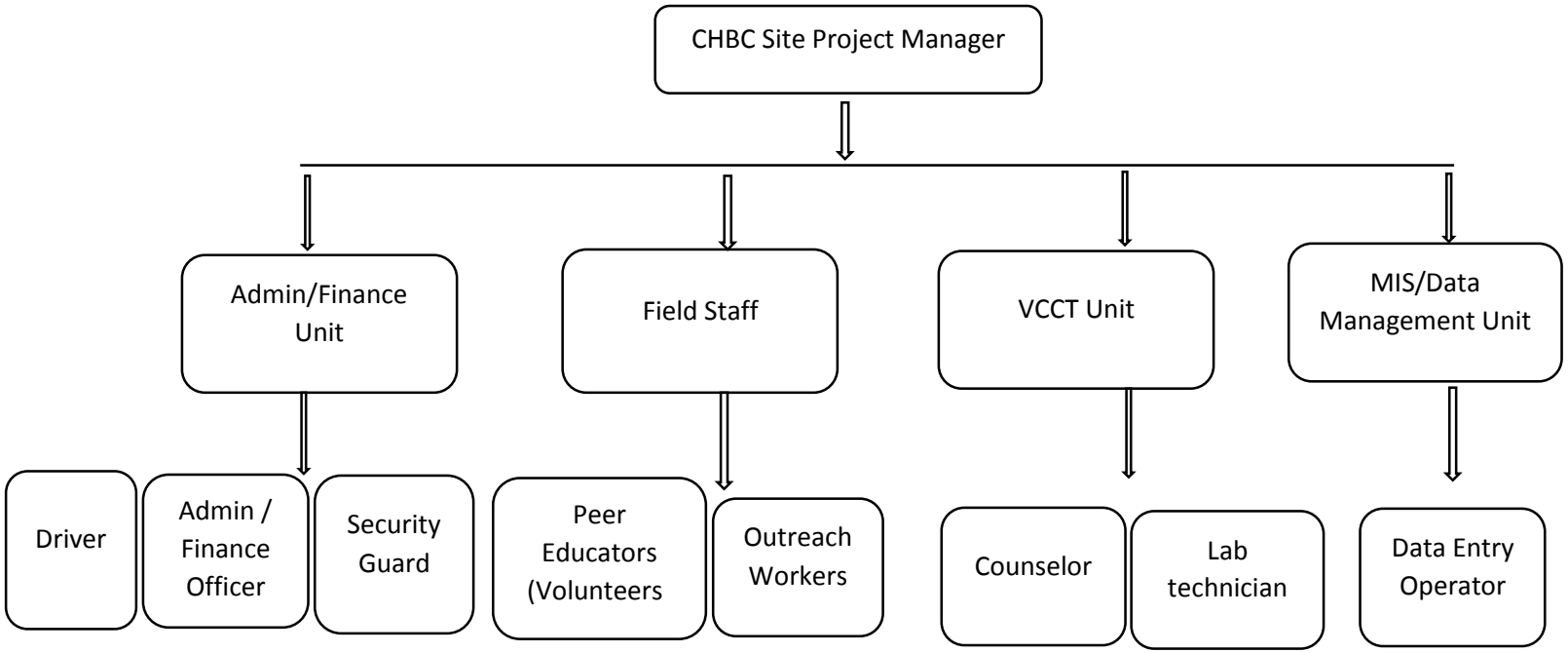
This document provides a quick “how-to” guide to CHBC staff regarding standardized operating procedures of all CHBC activities, data management, reporting and coordination amongst the stakeholders. This document is an auxiliary to the “National Guidelines for CHBC” and the “National guidelines for VCCT counseling”. It should also be used in coordination with the Tangible Support Guidelines and the budget line items per activity.

CHBC is defined as any kind of care or support provided through a center or at the person’s home or in their community for person(s) living with HIV/AIDS (PLHIV) or their affected family members. Care and support service provision through a CHBC model is not a substitute for hospital care, but supports treatment, including such activities as psycho-social support, medical support through referrals, food/nutrition support, livelihood support, and rehabilitative/palliative support, etc.

Key things to consider with care and support service provision for PLHIV and family member:

1. Maintaining client confidentiality and
2. Treating all clients with dignity and respect.

10.1 Standard Structure of a CHBC under the Global Fund HIV/AIDS Grant



10.2 Key CHBC Activities

Expand VCCT to increase detection and uptake of PLHIV

- Promote VCCT as the entry point into the continuum of care
- Conduct VCCT using rapid test kits as per protocols
- Risk assessment
- Pre/posttest counseling along with rapid testing
- Registration and need assessment of PLHIV and family members, as relevant

Provide psychosocial and nutritional support

- Counselling provided at CHBC
- Counselling provided to family through household visits
- Quarterly support group meetings
- Nutritional counseling provided to individuals, families and children
- Provide food security package to vulnerable families
- Support the development of peer educators (volunteers from within community)
- Promote additional referrals by engaging existing clients to reach out “snowball” effect

Improved livelihoods via socioeconomic support and job creation for PLHIV

- CHBC staff members build relationship with local business community, establish database of prospective employers, conduct assessment of client skills, build confidence and presentation skills of clients, link and support clients to avail of job opportunities and relevant employment training programs, support entrepreneurial ventures which show a promising business plan.
- Support vocational/business skills training for improving livelihood
- Business support tool kit for PLHIV or family members who have successfully completed a training course (or already possess a marketable skill) who wish to start up their own activity or business and require a toolkit to initiate their work

Provide referral support to clients for HIV-treatment related services

- Regular medical referral to local district hospitals and follow up for possible adverse effects/complications of ART and opportunistic infections, including support for logistics and meals
- Supportive medical investigations including Complete Blood, LFTs, Blood Sugar Random (BSR) and Hepatitis B&C antigens to be done twice a year/PLHIV on ART
- Special investigations like CT and MRI scans
- Collaborate with TB sentinel sites in TB/HIV case-finding, referral, and treatment support
- Establish effective links with proximate TB sentinel sites

Support ARV treatment adherence for adults and children

- Travel for ART registration

Care for children infected/affected by HIV/AIDS

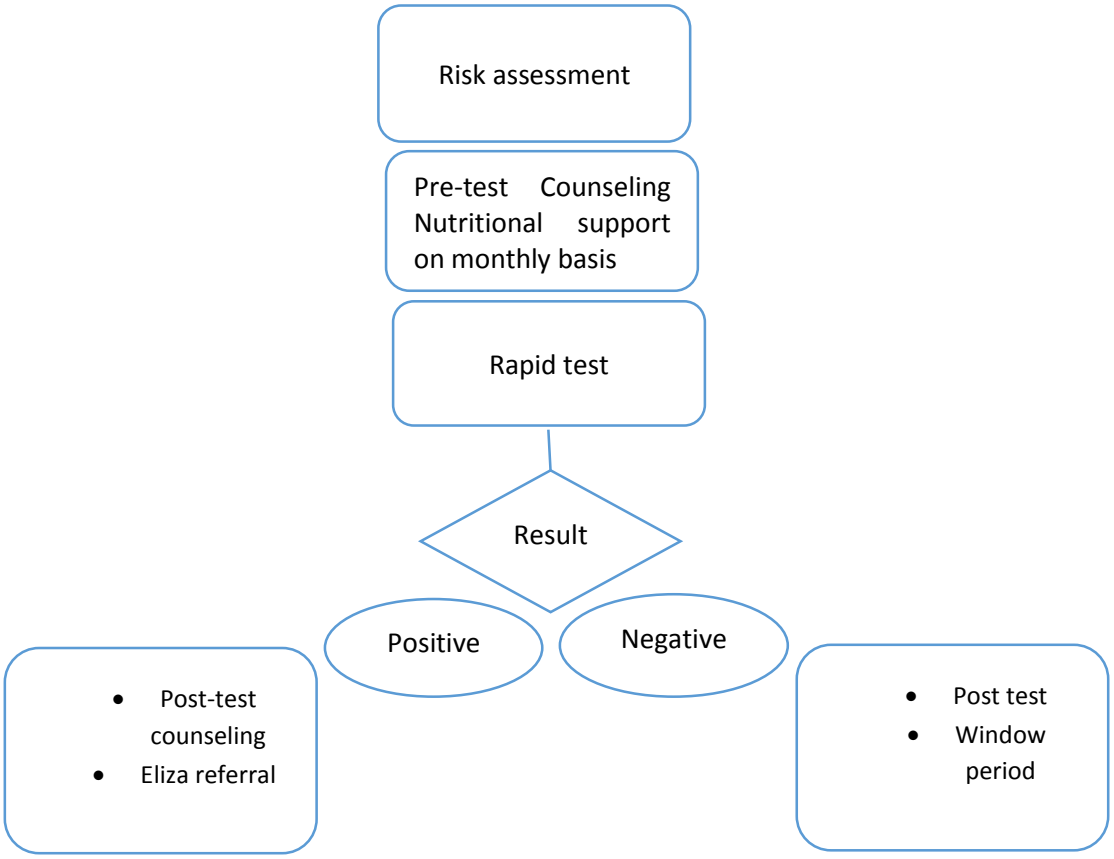
- Refer infected children (who require intervention) to UNICEF for nutritional support
- School Package (uniform, books and stationery cost) once yearly
- School Package (tuition fee) monthly

CHBC sites liaising with other stakeholders

- CHBC build supportive relationship with local community and faith-based group working with high-risk populations – MSM, transgender (Hijras), sex workers, migrants
- Quarterly district strategy meetings between proximate CHBC sites

10.3 Voluntary and Confidential Counseling and Testing (VCCT)

VCCT Counselor is the person who will attend the client first and will conduct risk assessment after risk assessment the VCCT process will be initiated. Whole process is structured below.



It is good to conduct a risk assessment in your first interaction no matter if a test has already been done or not because you may reach the last exposure and frequency of at-risk behavior and you will be in a better position to suggest window period and have further discussions with that person.

Risk Assessment

To whom: Any person who comes to CHBC for VCCT or for registration

When: In the first interaction with any person who is interested in VCCT or registration

How much time should it take? 30 to 45 minutes time is ideal for risk assessment

Who: VCCT Counselor is the best person who should first interact with client and conduct risk assessment however experienced outreach worker (ORW) can also conduct risk assessment

Documentation and record keeping: HIV-consent form and risk assessment forms should be filled and kept in the appropriate file for record

How: Welcome and introduction of you and CHBC and then asking to have brief introduction from client is the good method to start. Some tips to conduct good risk assessment are given below.

- Good repute building with client at the start so that s/he can share the things without any fear.
- Assure client that information collected will be kept 100% confidential
- Standard risk assessment form should be used for further probing as it covers all aspects of risks, so you will never miss any information.
- Give client the time to think, remember and then response
- Try to find out window period as close as possible by probing for information about the last risk exposure.

Pre-/Post-test Counseling

To whom: The person who is willing to conduct a rapid test for HIV/AIDS and whose risk assessment have been done.

When: Just before and after conducting rapid test

How Much time should it take? 30 to 45 minutes

Who: VCCT Counselor will conduct the pre/posttest counseling

Documentation and record keeping: Counseling form will be used for recording pre-/post-test counseling. It should be stapled together with risk assessment and rapid test report and should be kept in appropriate file. In case of family member put the forms in family files; for other general community put the forms in general VCCT file. In case if a client identify HIV+ and a client wants to register at the site then all record should be shifted to newly open PLHIV file. Enter data into VCCT register and MIS.

How: Creating a link with previous interactions is a good start for pre-/post-test counseling. Consequences of rapid test should be fully covered during pre-test counseling session. Similarly information sharing about HIV/AIDs should be shared in post-test counseling, no matter if the test result is positive or negative.

Some tips to conduct good pre-/post-test counseling:

- Give client a chance to speak and listen carefully
- Pay full attention when client is speaking and cover all fears of client.
- Calculate the window period and give a concept to client in posttest counseling.

- Do tell client to keep status remember that their test result is confidential information and should not be shared lightly.
- Prepare a counseling plan based on risk assessment for future communication and keep continuous link with client.

10.4 Registration and Need Assessment

To whom: The person who has a confirmation report from any Provincial AIDS Control Program (PACP)-recognized diagnostic center and willing to get registered at CHBC site.

When: After getting confirmation report from CHBC and having well knowledge about CHBC services

How Much time should it take? 1 to 2 hours

Who: ORW or any other CHBC staff

Documentation and record keeping: Fill out the registration form with complete signatures of beneficiary, witnesses and head of organization/project manager (PM). Need assessment form should also be filled along with registration form and put together. Eliza report and copy of CNIC is necessary to attached with registration form. Enter the data into PLHIV register and MIS.

How: Once a person has got confirmation report the registration process will be started. Registration could be done by either ORW or VCCT counselor. Explain well about CHBC services before registration so that one should have enough knowledge about CHBC services before registration.

Need assessment (by using need assessment form) is necessary just after registration. Any staff member from CHBC can conduct need assessment and manager will be the final authority to review and approve the services recommended by assessor.

Some important points to keep follow while registration of client.

- Readout terms and conditions for registration thoroughly in front of client and then give them a chance to read their self if s/he want.
- Do ask for CNIC copy and make sure that client has confirmation report and willing to provide a copy of both.
- Get signatures carefully and use probing questions when working with the client to fill the need assessment form
- Pay more time for need assessment as this will be the basis of service provision to beneficiary.
- Allot the registration number carefully by checking the last number allocated
- Create a file just after completing the registration process and put all documents in to it.

- Enter the registration in appropriate register and also into MIS for smooth recording.

It is important to re-do a client needs assessment when a person's socio-economic situation has changed, in order to ensure that the most vulnerable and marginalized clients are being served appropriately.

10.5 Counseling at CHBC Site and During Home Visit

To whom: registered PLHIV and family members.

When: at least once in a quarter with each PLHIV and family member

How Much time should it take? 30 to 45 minutes

Who: VCCT counselor will conduct the counseling

Documentation and record keeping: counseling form will be used for recording. It should be filed together with home visit tool if counseling is done during a home visit and be kept in appropriate file. Enter data into MIS as well.

How: creating a link with previous interactions is a good start for counseling.

Some tips to conduct good counseling could be:

- Facilitate a well-structured, open-ended discussion
- Maintain a respectful, non-judgmental attitude
- Promote active listening, including accurate reflection of the issues or concerns
- Ask supportive questions that raise important issues, in caring, nonjudgmental ways
- Be aware of their verbal and non-verbal behaviors
- Encourage the PLHIV and caregivers to make their own decisions
- Create an encouraging and caring atmosphere
- Pay full attention when client is speaking and cover all fears of client.
- Prepare a counseling plan for future communication and keep continuous link with client.

10.6 Home Visits to PLHIV and Family Members

To whom: For all registered PLHIV and family members who are willing for home visit on Quarterly basis or need base.

When: Once in a quarter is necessary, but it could be done more than once on need based (with justified documentation).

How Much time should it take? 60 to 90 minute.

Who: ORWs are mainly responsible for home visits. VCCT Counselor and PM on need basis

Documentation and record keeping: Proper home visit check list for PLHIV and Family members home visit reporting form should be filled just after the visits. It will be counter signed by site PM. Data should be entered into appropriate register and MIS.

How: Home visit is the health monitoring visit so one should keep it in mind that s/he is going to evaluate the intermediate level results of care and support activities provided to client. Beneficiary should be previously informed about the planned visit. Involving family members in home visit and providing need based counseling to family members is necessary during the home visit. Some tips to conduct a good home visit are given below.

- Inform your client at least one day prior to visit so that he can make sure the availability
- Make sure that family members have also been informed for the visit
- Take care of confidentiality and disclosure to family members. Don't meet with those members whom PLHIV did not disclose his status.
- Use home visit form as a guideline to cover all kind of topics which are expected for home visits
- Use IEC material for better understanding while providing counseling to family members.

10.7 Support Group Meeting

To whom: registered PLHIV

When: on monthly basis for each CHBC site at least 1 support group meeting should be held

How Much time should it take? 90 to 120 minutes

Who: lead role will be VCCT counselor. Other CHBC staff will also participate in it including PM

Documentation and record keeping: group activity reporting format should be used for each meeting. Participant's attendance sheet must be filled for each meeting. Signatures of participants are necessary to be taken. Entry in MIS will also be required for each meeting.

How: Support groups are the platform for PLHIV to share their experiences and concerns amongst each other and learn from each other. These should be conducted at CHBC office or any place where participants can easily share their problems in a friendly environment. Some of the tips to conduct good support group meetings are given below. Minimum participants should be 8 and maximum 15.

- Prepare well and proper session plan for the meeting
- Introduce yourself and CHBC with participants and share objectives of support group meeting.

- Use appropriate IEC material for more clarity and to create a comfortable environment for participants for sharing of their thoughts and problems
- Involve participants in sessions to provide them a peer atmosphere for better learning
- Introduce group works, role plays and demonstrations to make it interactive for participants
- Follow up plan should be prepared at the end of meeting consist of use of knowledge and further spread of learning

10.8 Food/Nutrition Packages

- **To whom:** all registered clients who fulfill the criteria of food recipient
- **When:** Package will be provided on monthly basis. After six months need assessment will be reviewed again (unless a person's socio-economic situation has changed before that, in which case it should be revised at that time, not waiting for six months) and package would be provided to identified members for next six months. This is to ensure that the most vulnerable are consistently receiving the nutritional support.
- **How Much time should it take?** Nutritional counseling should be provided along with provision of food/nutrition package based on need. This counseling should takes 30 to 40 minutes. Counseling could be done in a group.
- **Who:** ORWs are primarily responsible for food distribution. Other CHBC staff can also participate in it.
- **Documentation and record keeping:** food/nutrition form should be filled for each package and signatures must be taken from recipient. Contact numbers and copy of CNIC should also be attached.
- **How:** Food package could be distributed individually or in a group by taking care of the dignity of PLHIV. Package could be modified according to the needs of beneficiary but no cash would be provided against food package to any beneficiary. Package could also be delivered during home visits of PLHIV which can save the transportation cost of beneficiary. Counseling along with package is necessary where it needed so that PLHIV could realize the real objective of food provision is for nutritional support for maximum health benefits.

10.9 Development of Peer Educator

To whom: any volunteer from the PLHIV or MARP community (with similar geographical location/ similar community i.e., MSM/ transgender/ SW/ IDU)

When: once in a month i.e., three peer educators per quarter

How much time should it take: Job description and responsibilities of a peer educator should be explained to him/her at the time of selection, this could take 60 to 90 minutes

Who: PM CHBC is primarily responsible to finalize the selection of peer educator

Documentation and record keeping: one page JD of peer educator, filled activity template tool and record day sheets of peer educator should be properly filed in an appropriate file

How: PM CHBC would clearly explain the role and responsibilities of a peer educator to the selected person, specifically mentioning the ways of working, working hours and reporting requirements of this activity.

Here are some of the tasks that peer educator would undertake

- Work to identify PLHIV in the area
- Encourage and refer members of the community to undertake VCCT if they have been in vulnerable situations
- Encourage identified PLHIV to register with the CHBC site
- Encourage the identified PLHIV to encourage their family member to undertake VCCT
- Encourage the PLHIV to maintain regular contact with the CHBC site and staff
- Support in following up with PLHIV clients, especially those who had been lost to follow up

10.10 Business skill training

To whom: registered PLHIV or family members who show their interest in any skill development activity and s/he is physically appropriate and able to implement the training learning

When: quarterly as per budget availability

How Much time should it take? Trainings could be 10 days to 90 days based on nature of the training.

Who: Managers will coordinate the vocational institutes at district level and ORWs recommend trainings for any PLHIV or family member. Managers will be in follow up with institute in terms of attendance and progress in trainings and after completion of trainings ORWs will follow up with beneficiaries for implementation of trainings. A PLHIV or family member client would need to fill out an application to enroll in the proposed course.

Documentation and record keeping: There should be a client's application for enrolling in the proposed course, with the project manager's remarks after assessing the client's request. Also the training referral forms needs to be filled at the time of referral, and then after three (first follow up) and six months (second follow up) the outcomes will be recorded by using the same tool. Registration/admission forms copy must be attached with training referral form. Entry into training/loan register and MIS is also compulsory. Each case will be reported only once no matter the training goes longer to next reporting period.

How: This activity is basically for livelihood support to PLHIV and their family members. Each CHBC manager needs to search out the relevant institutes which are providing the vocational /language trainings. A liaison will be established with this institute and then CHBC will send clients for trainings. Attendance monitoring will be done by manager or any authorized person during the trainings.

These trainings could also be done through local practitioners by making a MoU with them specially tailoring, electrician, mobile repairing, welding etc.

Business skill trainings could be arranged in office or any appropriate place by hiring a technical skilled trainer to depart training for a group of members who wants to establish small enterprise.

10.11 Business support

To whom: A members who receive vocational skill training or business skill training from CHBC.

When: after successful completion of training by registered member. Support will be provided according to the funds availability at CHBC.

Who: ORWs and managers are responsible to provide, record and report the support

Documentation and record keeping: The client's application for the proposed business should be attached, including the project manager's remarks after assessing the client's request. Also, training/loan referral form will be used for recording of this support. Photocopies of the client's certificate if already skilled or any evidence showing his/her knowledge to start the particular business or work should alos be attached. Signatures of recipient must be taken while providing this support. Entries in training/loan register and MIS will also be necessary. Training completion certificate needs to be attached along with the form.

How: after successful completion of training the CHBC staff will start providing business support for needy members. The support will only be provided in kind. No cash will directly be given to members instead the CHBC staff will facilitate the members to purchase the tool kits. A follow up plan needs to be deciding while the time of provision of package so that tool kit could be used purposefully.

10.12 Referral for medical/emergency/nutrition/supportive/special investigation

To whom: Any registered client (Only PLHIV) who is eligible according to criteria provided in tangible support guidelines.

When: Need basis whenever a member required any kind of referral it could be provided as per budget provision.

Who: Any one from CHBC who can facilitate the referral should take the charge for referral and facilitate the members. Managers and counselor are the key persons for referral but ORWs are also encouraged to facilitate in referral.

Documentation and record keeping: for each kind of referral a referral form is available which needs to be filled while the time of provision of this support. For medical/emergency/ supportive/special investigation referrals there is a need to attached the OPD or emergency departments slips for a complete referral. Supportive/special investigations reports should also be attached with the form. All other lab test reports should be attached with the forms. Doctor's recommendations will be required for every referral from one city to other. In nutritional referral it is required to fill food/nutrition form by mentioning the exact items which a particular child received in a result of referral along with membership slip or any evidence of receiving institute.

How: To fulfill the medical /nutritional requirements of members these referrals will be made by CHBC. Managers and counselors will have to search out the institutes which are providing the services and they will have to develop strong coordination with PACPs, ART centers and other institutes at district level. Site will try to provide maximum referral support to their clients to fulfillment of their requirements. CHBC will provide the travel, accommodation logistics costs for each kind of referral.

Process for referral will be initiated whenever a client contact with CHBC for any medical/nutritional problem. Site will have a look at budget availability and then take members to any nearby institute for required support. referrals does not mean just to provide financial assistance but member should properly be facilitated throughout the checkup and after completing checkup s/he should be provided financial support.

10.13 Travel for ART registration

To whom: PLHIV who is registered at CHBC site but not at any ART center

When: Need based, any client who get registration at CHBC site but is not registered at ART center

Who: ORWs are primarily responsible for this activity however other CHBC staff can also participate in it.

Documentation and record keeping: A referral slip from CHBC to ART center is required to get the registration done. Afterwards, there is a need to attach client confirmation report, coding slip/ MRN (medical record number) assigned by ART center in appropriate file. Recording of this activity in PLHIV register (in "referred to" column) is also required, to track the activity progress.

How: Initially CHBC staff will identify PLHIV who are not registered at ART center (that could be new registrations or any transferred case etc.), on the next step ORWs would take those PLHIV to ART center with written referral for registration. ORWs will ensure that PLHIV get their registration at ART center by getting them an MRN/ or any confirmation slip from the center. CHBC will provide the travel costs to PLHIV for registration at ART center, as per budget.

Nutritional packages for infected children *(no defined/ finalized mechanism – does not exist yet)*

To whom: Registered infected children (40% percent malnourished children of 5% infected in total population), as per eligibility criteria

When: Refer infected children (who require intervention) to UNICEF for nutritional support on need basis (first time referral only)

Who: ORWs are primarily responsible for this activity however other CHBC staff can also participate in it.

Documentation and record keeping: A referral prescription/ recommendation from pediatric doctor would be required if any child is referred to UNICEF by CHBC site to get nutritional support. Other important documents include referral slip by CHBC manager to UNICEF, confirmation slip/ record number provided by UNICEF, and NIC copy of guardian/ caretaker of child would be collected and placed in the appropriate file at CHBC site. Recording of this activity in PLHIV register (in "referred to" column) is also required, to track the activity progress.

How: Initially CHBC staff will identify registered infected children who meets the eligibility criteria. On the next step ORWs would take the guardian/ caretaker of that child to UNICEF site with written referral (from both pediatric doctor and PM CHBC) for registration at UNICEF. ORWs will ensure (by following up) that infected child get his/her registration at UNICEF by getting them any record number/ or any confirmation slip from UNICEF. CHBC will provide travel costs to caretaker/ guardian for registration at UNICEF site, as per budget.

10.14 School Package

To whom: All infected and affected registered children who fulfill the eligibility criteria of this activity.

When: school fee should be given on monthly basis, however complete package (uniform, shoes, stationary) will be provided to each child once in a year.

How Much time should it take? N/A

Who: ORWs are primarily responsible for school package distribution. Other CHBC staff can also participate in it.

Documentation and record keeping: school support tool should be filled for each package and signatures must be taken from recipient. Contact numbers and copy of CNIC should also be attached. Entry in MIS will also be required against each package distribution.

How: School support would be given upon receiving of original receipts (fee slips, items purchased receipts). Counseling along with package can be given where it needed so that PLHIV could realize the real objective of this support.

Supportive relationships with local community and faith-based group working with high-risk populations:

To whom: With faith based or influential groups working with high risk populations - MSM, transgender (Hijras), sex workers, migrants

When: once in a quarter with any of the above mentioned group.

How Much time should it take? 90 to 120 minutes is the appropriate time for the session

Who: PM CHBC is primarily responsible for this activity while ORWs and counselor should also be participating in this meeting.

10.15 Home Based Care

The care that is provided to PLHIV can be at three levels:

1. Physical Care
2. Palliative Care
3. Terminal Care

Physical Care

Physical care in the home setting involves the following:

Providing basic nursing care which is the same for HIV-related illness as is for any person who is ill

- Positioning and mobility
- Bathing
- Wound cleansing, skin care
- Oral hygiene
- Adequate ventilation
- Guidance and support for adequate nutrition

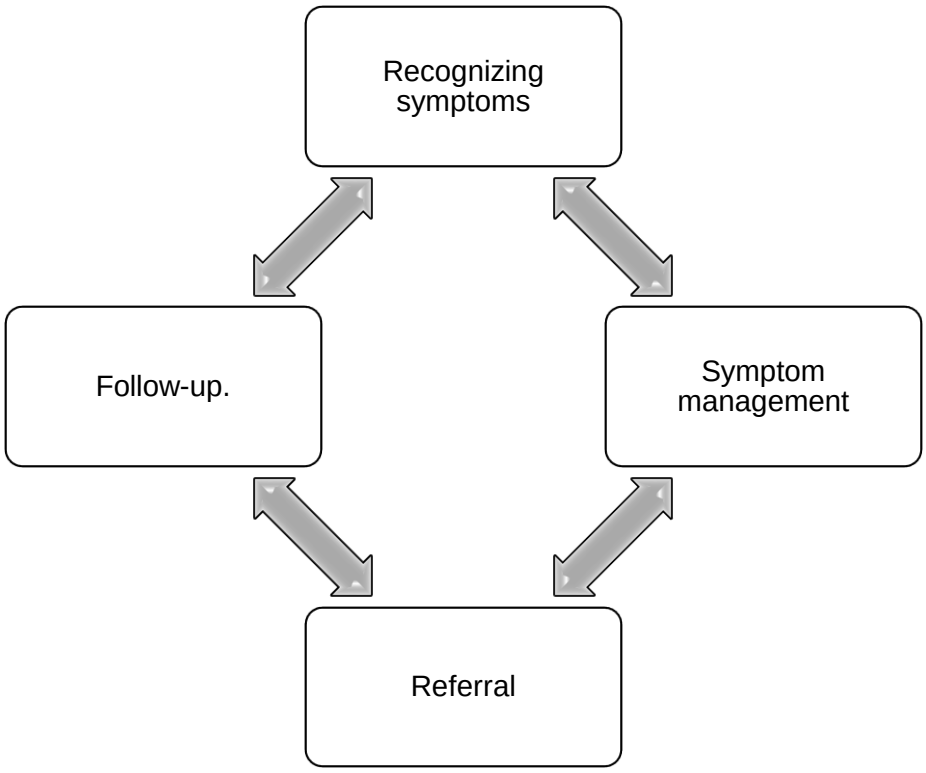
Undertaking measures to comfort PLHIV

- Recognizing symptoms
- Symptom management
- Referral
- Follow-up

10.16 Educating on the use of universal precautions for infection control

These are critical in the care and prevention of HIV and are to be taken regardless of the PLHIV's condition and include:

- Hand-washing
- Avoiding contact with blood or body fluids by using gloves and diapers etc.
- Cleaning linen with soap and water
- Using disinfectants and detergents and
- Burning or safely disposing of the waste.



10.17 Management of Opportunistic Infections

Opportunistic infections are those that invade the body when the immune system is not working adequately. Progressive HIV infection results in reduced immunity making PLHIV more vulnerable to opportunistic infection.

Tuberculosis being the commonest opportunistic infection, other infections affecting PLHIV includes septicaemia, pneumonia, fungal infections of the skin, mouth and throat, unexplained fever, chronic diarrhoea with weight loss.

Anti-tuberculosis drugs are equally effective in PLHIV as in those not infected with HIV. The therapy is cost effective and widely available even in the developing countries. Adherence and compliance to the therapy are major challenges where CHBC workers can play an effective role.

10.18 Symptom Management

Symptom management depends on the PLHIV's condition. However, basic symptom management includes:

- Reducing fever
- Relieving pain

- Treating minor ailments like diarrhoea, vomiting, cough; skin, mouth, throat, genital problems, general tiredness/ weakness
- Treating neuro-physiological symptoms.

These treatments might include pharmaceutical preparations or the use of traditional remedies and herbal treatments. The CHBC team should have basic home care kits that contain the basic medicines and supplies for home care. For people with HIV or AIDS, various treatments may be given for opportunistic infections, the most common being tuberculosis. Tuberculosis medication is usually administered through a directly observed therapy, a short course (DOTS) programme. However, these medicines might be given as part of the CHBC programme or through a separate community service. Treatment for preventing opportunistic infections can be made available through CHBC referral.

10.19 Pain Relief

Pain relief is an essential element of CHBC care. In resource-limited settings, medicines can be scarce. Aspirin and Paracetamol are often available but not given in adequate doses to relieve pain. Trained OWs can administer Class A controlled drugs. Such Class A drugs includes morphine injections, tablets, oral mixture and other narcotics. These drugs must be provided in accordance with the national laws on dangerous drugs and with the national drug policy. Members of the CHBC team should be familiar with these policies and guidelines. A doctor should prescribe these analgesics, and at least one member of the CHBC should be qualified to administer Class A drugs. Herbal remedies and traditional therapies can also be effective in relieving pain.

10.20 Palliative Care

Palliative is defined as an approach that improves the quality of life of PLHIVs and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

Palliative care is the combination of active and compassionate therapies to comfort and support PLHIVs and their families. During periods of illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual needs, while remaining sensitive to personal, cultural, and religious values, beliefs and practices.

Palliative care should start at the time of diagnosis and can be combined with therapies for treating opportunistic illness; or it may be the total focus of care. Palliative care requires a team approach including PLHIV, the families, caregivers and other health and social service providers and considers the needs of the whole person. It includes:

- Medical and nursing care
- Social and emotional support
- Counselling
- Spiritual care

It emphasizes living, encourages hope, and helps people to make the most of each day. The palliative caregiver must treat PLHIV with respect and acceptance, acknowledge their right to privacy and confidentiality, and respond caringly to their individual needs. An essential part of effective palliative care is the provision of support for caregivers and service providers. Such support will enable them to work through their own emotions and grief related to the care they are providing.

Palliative Care Benefits

Palliative care helps in improving the quality of life for the PLHIV, as it:

- Offers relief from pain and other worrisome symptoms
- Affirms the right of the PLHIV and family to participate in informed discussions and make treatment choices
- Affirms life and regards dying as a normal process
- Neither quickens nor slows down death
- Provides relief from pain and other distressing symptoms
- Integrates psychological and spiritual aspects of care
- Provides a support system to help PLHIV live as actively as possible until death
- Provides a support system to help the family and loved ones cope during the PLHIV's illness and/or bereavement.
- Combines the psychological and spiritual components of PLHIV care
- Offers a support system to help PLHIVs live as actively as possible until death
- Offers a support system to help the family cope during the PLHIV illness and in their own bereavement
- Uses a team approach to address the needs of PLHIVs and their families, including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness

Palliative care is more effective in the early course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

10.21 Terminal Care

Terminal care aims to improve the quality of life at the end of life, by relieving symptoms and enabling a person to die in comfort, with dignity, and in keeping with their wishes.

Terminal Care for PLHIV

In the developed world, the end stage of the illness might occur in a hospice or a special terminal care facility. In most cases in Pakistan, however, dying at home is the only available and or viable option for the PLHIV. The primary concern in terminal and palliative care is to make PLHIV as comfortable as possible by providing medical, spiritual, emotional, practical, and psychosocial support both to the PLHIV and to his/her loved ones. Even where resources are severely limited, good palliative care can be given.

The decision to stop medical treatment must be made by PLHIV (if this is possible) and the family or loved ones and in conjunction with the community workers. Care then shifts to make the dying person as comfortable as possible, and to prepare emotionally and spiritually for death. Such care includes both practical and nursing care issues, as discussed below.

Principles of Terminal Care

- Provide spiritual and emotional/ grieving support for PLHIV and their loved ones
- Prepare PLHIV, their families, and caregivers for death. This includes advice concerning avoiding any traditional death rites which would spread infection
- Ensure appropriate provision is made for the children involved and that their rights are respected
- Provide bereavement support to the family and loved ones following death.

Practical Issues

PLHIV (if able) should make the choice about a suitable place to die. This choice might include hospital or their own home. In most instances, PLHIV remain at home till they die.

In developed countries hospice and terminal care centres usually have specially trained staff to care for both the person who is dying and the loved ones. In Pakistan's context, where the PLHIV mostly opts to remain at home, the family, and other caregivers will require special training to provide appropriate terminal care to him/her.

The following considerations for providing good palliative/terminal home care will be dependent upon adequate resources. However, whenever possible, care should include:

- **Health support services**: The local or nearby health centre must be briefed about the person's condition, so that staff can provide the caregivers advice and appropriate medical supplies.
- **Guaranteeing adequate family and social support**: This will help reduce the pressure on the caregivers, who are usually the women in the family. It will mobilize relatives and friends to help in household or related tasks, and hence build support for the sick person. The OWs should discuss how to mobilize the support of local community leaders, outreach agencies, neighbours, and members of community or religious associations. This might be an important time to facilitate reconciliation with estranged family and/or friends.
- **Placing PLHIV in a light, well-ventilated room:** The room should ideally be quiet, comfortable, and yet close enough to the rest of the family to remain involved in family life.

With HIV and AIDS, there is a growing realization that comprehensive care must include care associated with death and dying. Caring for PLHIV in the terminal stages of AIDS puts a great strain on everyone involved. For individuals who choose to die at home, where resources are scarce, care for the dying has traditionally been provided by communities and families, and might involve spiritual support. Families, friends, communities, OWs, volunteers, and others will be affected in this process.

One of the most difficult aspects of caring for PLHIV is deciding when to stop active treatment and to begin to prepare the person and his/her family for dying. In practice, the boundary between the two activities is often indistinct, with both terminal and interventional care continuing in tandem. The decision to stop treatment requires considerable skill, and sensitivity. Whenever possible, the decision should be taken by health care professionals, PLIHV, family members and loved ones.

It is often difficult to decide when aggressive medical treatment should end and when palliative care might begin. Palliative care would begin when: medical treatment is no longer effective, the side-effects outweigh the benefits, the PLHIV opts to discontinue aggressive therapy, or the PLHIV’s vital organs begin to fail.

Challenges in Terminal Care Of PLHIV:

HIV poses a unique set of challenges to the caregivers, PLHIV, the families, the communities and OWs. Those specific to terminal care of PLHIV include the following:

- AIDS may affect whole families when parents and children become infected.
- People who die from AIDS usually die at a young age.
- The stigma and fear associated with HIV and AIDS often means that the diseases and death are not openly spoken of and suitable arrangements for death might not be made.
- Estrangement of family and friends often occurs.
- Sometimes PLHIV lose contact with families and friends due to conflicting values related to sexuality or lifestyle choices.
- Community and family support might be lacking because of the stigma, fear and isolation associated with HIV.
- The care of the PLHIV is often left to the family (and to women in particular), who are often both unprepared and untrained.
- The course of terminal care for PLHIV is unpredictable. Opportunistic infections and illnesses are often unpleasant and difficult to manage. These can include: foul odour, chronic diarrhoea, vomiting, skin lesions, seeing the person in pain, dementia, confusion, aggression, and depression.
- The caregiver can develop feelings of powerlessness and helplessness.
- Caring for someone who is dying at home is expensive. The caregiver must consider the loss of income, the cost of medical and pharmaceutical supplies, and the expense of a funeral.
- Problems or complications with inheritance can further increase the poverty of women and children.
- The physical burden of caring for PLHIV.
- The emotional burden for the care-givers of seeing a loved one dying.

10.22 Funeral Support

- Provide support to the bereaved family in arranging the funeral of the deceased patient.

10.23 Specific Services Rendered By CHBC Team

Actively Identify and Register PLHIV in the Community

- Work to identify PLHIVs in the area

- Encourage and refer members of the community to undertake VCCT if they have been in vulnerable situations
- Encourage identified PLHIVs to register with the CHBC centre
- Encourage the identified PLHIV to encourage their family to undertake VCCT
- Encourage the PLHIV to maintain regular contact with the CHBC centre and staff

Note: Please refer to the annexure for the Membership Form

Provide Prevention Information

- Promote the "ABCDs" (abstinence, being faithful, using condoms, and do not share needles). Remember that "abstinence-only" can cause more transmission because many people are unable to stay abstinent. Therefore, when they do have sex, they are not prepared to practice safer sex. Because of this, everyone needs to know about condoms.
- Encourage discussions about HIV risk and vulnerability among groups of women, men, girls, boys, and elders.
- Work to reduce stigma and increase awareness about HIV and AIDS.
- Explain to people why they may be vulnerable to HIV.
- Refer people for STI diagnosis and treatment.
- Provide condoms and information on how and why to use them.
- Provide information on other Family Planning methods and where to get them.
- Identify pregnant women for PPTCT and help them get services and follow-up.
- Involve the community in CHBC efforts and advocate for more attention and resources for care and support

Provide Nursing Care, First Aid, and Other Health Services to PLHIV

- Identify the immediate nursing care needs.
- Assess condition of PLHIV for medical referral if necessary.
- Provide the basic nursing care needed.
- Refer for further care, as needed.
- Support PLHIV adherence to ART, as necessary.

Note: Please refer to the annexure for the Medical Health Assessment Form

Transfer Knowledge & Nursing Care Skills to Primary Caregivers

- Identify the learning needs of caregiver and PLHIV.

- Plan and organize the transfer of knowledge and skills.
- Give knowledge and skills to caregivers and self-care skills to PLHIV.
- Make a plan of care with the caregivers and PLHIV.
- Always have a caring attitude.
- Keep confidential records related to CHBC activities

Provide Supportive Follow-Up to the Trained Primary Caregiver(S) and PLHIV

- Conduct regular follow-up visits to the trained caregiver and PLHIV.
- Help PLHIV and caregivers follow action plans and solve problems.
- Keep records of actions taken.

Note: Please refer to the annexure for the Monthly Home Visit Form

Provide Referrals and Links to Specialized Care and Support Services

- Help PLHIV and caregivers to identify the support needed (medical, nursing spiritual, emotional, psychological, economic, nutritional, and legal).
- Identify the individuals/groups/organizations that can provide the support.
- Link PLHIV and families to the identified groups.
- Help plan for transportation if needed, or help set up home visits.
- Follow-up to assure coordination of services along the entire continuum of prevention and care.
- Be involved in social/ economic schemes to support PLHIV and family members. Tap into resources such as food aid, kitchen gardens for nutritional support.
- Find religious, civic, government, and NGO sources to support education, housing, clothing, and feeding needs. Provide basic community level counselling to help PLHIV and family members make decisions, cope, and seek the care and support they need.
- Identify factions that offer legal support and assistance with writing a will, planning for surviving children and family members, protection against loss of property, and other legal issues faced by PLHIV and their family members.

Note: Please refer to the annexure for the Referral Form

Mobilize the Community for Chbc Services

- Organize education activities within communities to create a supportive environment for CHBC and PLHIV.

- Participate in community level advocacy activities to create a supportive policy environment.
- Combat stigma in the community in general as well as in everyday relationships with friends, family, and households of PLHIV.
- Encourage the community to start and participate in CHBC activities for PLHIV.

10.24 Adherence Support Services

Adherence refers to ensuring the drugs are taken exactly as they have been prescribed and also at the correct time. Any diet restrictions must be followed carefully alongside with the medicine. HIV drugs only show their affects if they are constantly present in the patient's system. If the level of the drugs drops to a significantly low level, then it is possible for the virus to start resisting the drugs and their effect will be minimized.

Role & Responsibilities of CHBC Staff

- PLHIVs must be advised to seek medical advice for their infective symptoms prior to initiating any treatment.
- On initiation of treatment, PLHIV is to be advised on how many tablets are to be taken and how often do they need to take them, and if there are any food or storage restrictions.
- PLHIV must be encouraged to discuss openly any difficulties or side effects when on the medication with the CHBC staff. CHBC Staff should facilitate them in seeking medical help for additional medication or replacing a particular medicine causing serious side effects.
- The dosage of drugs can be sorted for each day, or a pill-box can be utilized. This will help in checking if any dose has been missed out.
- Extra drugs should be kept in handy if PLHIV is travelling so that he does not run out of them.
- Some medicines for pain relief and wound care can be provided to PLHIV.
- Adequate support should be acquired from family members or friends to ensure that the treatment plan is being followed. Constant reminders can be provided by the support group.
- CHBC staff can help PLHIV share experiences of other PLHIVs on similar treatment.
- Medicines to counteract nausea and diarrhoea should be kept handy even before treatment is started as these are the most common side effects once the therapy is started. Most combinations are twice-daily regimens. This usually means taking them every 12 hours. However, several drugs only need to be taken once a day. This usually

means taking every 24 hours. PLHIVs must be counselled that completely forgetting to take a once-daily dose may be more serious than forgetting a twice-daily one.

- OWs/Counsellors should make use of available adherence materials for both children and adults available at the provincial level such as calendars, wrist-bands, games, booklet on ARV side-effects, etc.

10.25 Treatment Plans

The OWs/Counsellors at the CHBC can help develop a treatment plan as per the instructions of the prescribing doctor. This will consist of the following:

- Which pills to take?
- How many to take?
- When to take them?
- Whether to take them with food or an empty stomach?

Treatment plans can also be obtained from the local clinic or can be developed by the CHBC Team and usually have information as depicted below:

My Treatment Plan			
Name of ARV	Number of Pills	When	Comments
D4T	1	8 am to 8 pm *(every 12 hours)*	
3TC	1	8 am to 8 pm *(every 12 hours)*	
EFV	2	8 pm	*Avoid taking pills with a high carbohydrate meal*

Treatment Helper

A caregiver such as a family member, friend or relative can be taken on board before starting the ART. He/she can act as PLHIV's 'treatment helper'. This helper shall be responsible for the following:

- Constant reminders for taking the medicines as prescribed
- Helping PLHIV if she/he is encountering any side effects
- Accompany PLHIV when visiting the CHBC or Health Facility

Treatment Record

A treatment record is used for verifying what pills were taken and when exactly. In this manner, ART medicines can be recorded at the same time every day. This will help ensure that the virus is kept under control. A sample treatment record is depicted below. A calendar can be used for this purpose as well.

Treatment Record							
Did I take any ART medicines							
Yes/ No	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning							
Evening							
How ART medicines made me feel today?							

10.26 Centre Based Care

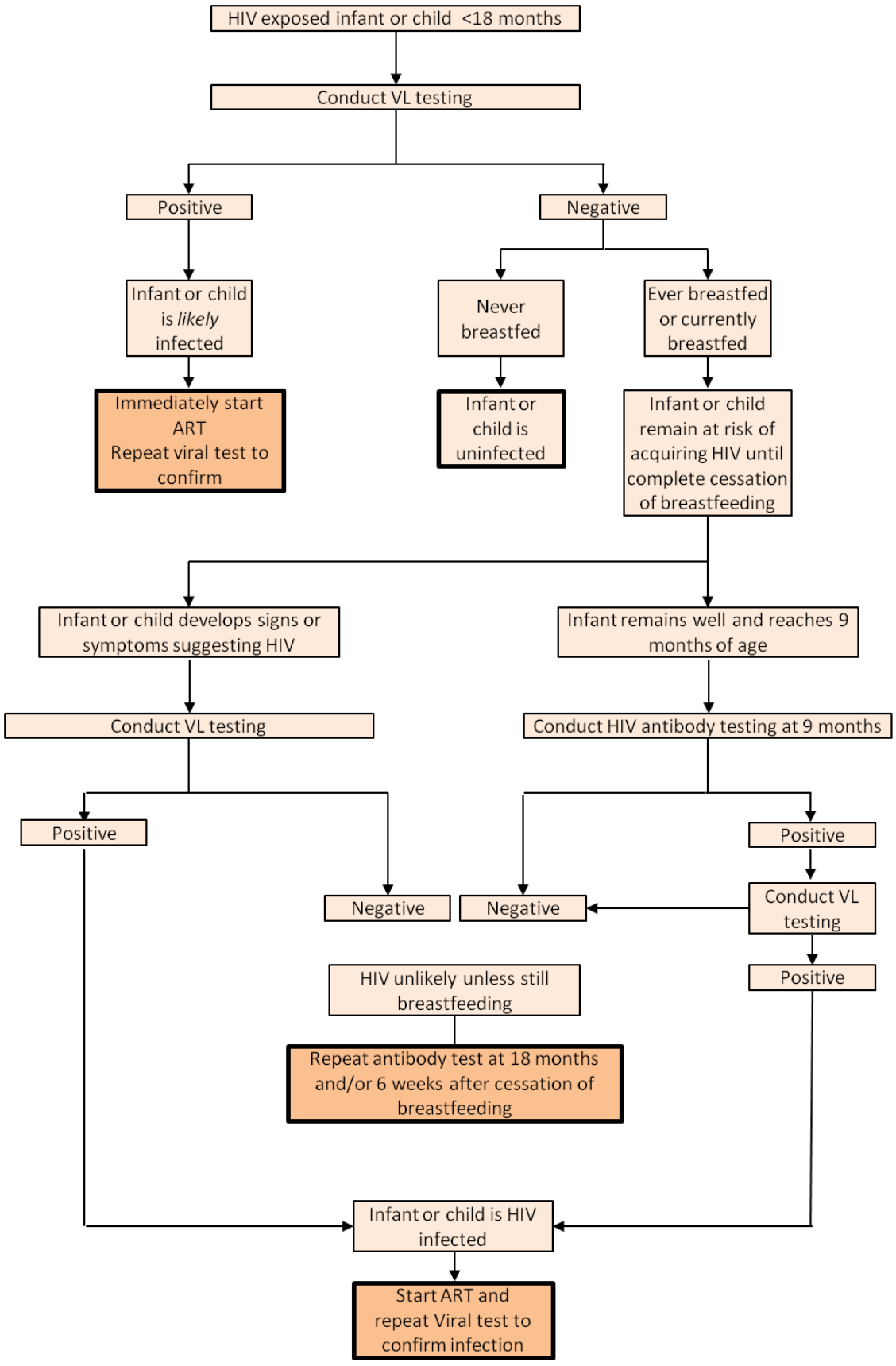
- All CHBC service sites provide services to all PLHIV in the catchment area.
- All PLHIV found are offered VCCT services.
- All PLHIV are screened for tuberculosis (TB) using the standard questionnaire, and referred for further TB diagnosis and treatment at least every three months.
- All PLHIV are referred for CD4 testing.
- All PLHIV are assessed for OIs and treated accordingly.
- All enrolled PLHIV undergo World Health Organization clinical staging at every visit.
- All enrolled PLHIV receive regular follow-up health checks: Stage 1 every three months; Stage 2, 3 and 4 every month.
- All PLHIV clients with a CD4 count <500 are started and continued on Cotrimoxazole prophylaxis.
- All ART eligible PLHIV are referred to ART sites. Children are referred to paediatric AIDS clinicians.
- All HIV positive pregnant women are referred for PPTCT.
- All PLHIV have gender and age appropriate growth charts (height, weight, head circumference) in their medical record files, updated at each visit.
- All adult PLHIV are asked about family planning and contraception needs at each visit.
- All PLHIV receive positive prevention counselling as appropriate (harm reduction, PPTCT, condom use, conception) at each visit

10.27 Guidelines, Equipment and Commodities Kept At All CHBC Sites Includes;

- The National CHBC Guidelines
- IEC materials for PLHIV Counselling
- STI and OI drugs
- CHBC Essential Tool kit
- National ART, OI, PPTCT, VCCT and Paediatric Guidelines
- National Paediatric Desk Reference Tool for clinical care and ARV dosing
- World Health Organization STI Management Flow Chart
- World Health Organization Clinical Staging Chart
- Growth Charts

- IEC materials for STI and HIV positive counselling for PLHIV
- Other equipment and commodities as necessary
- HIV Counselling and Testing Guidelines
- Confidential records of HIV-positive patients
- Rapid Tests for VCCT – **National Testing Algorithm**
- Membership Form (First Home Visit Form)
- Medical Assessment Form
- Counselling Form
- Referral Form

National HIV Testing Strategy



Summary of Services Provided at the Chbc and Requirements for the Same[16]

Types of Services	Activities	Human Resources	Infrastructure Required and Supplies
Counselling Services	• Drug and treatment adherence, treatment education • Couple counselling/ Family planning • Counselling for infant feeding • Reproductive health (e.g. use of contraceptives, condom demonstration and distribution, family planning for HIV positive couples etc) • Nutritional counselling • Psychological Support	• Trained counsellors	• Separate facilities for integrated counselling services(for males and females) • Audio Visual equipments DVDs etc • Patient education tools, posters, health promotion material etc
Nutritional Counselling and support for in patients	• Balanced diet for PLHIV • Provision of nutritional supplements • Nutritional education to PLHIV and caregivers.	• Cook • Helpers • Nurses trained in Nutritional Education	• Kitchens with utensils and facilities • Dining room • Nutritional Supplements
Treatment and Patient Management	• Provision of comprehensive care for prevention and treatment of OI and other illness in PLHIV • Basic Laboratory services • Coordination with ART centre and other Basic laboratory services for forward and back referral • Transfer of referral data and information	• Doctor • Nurses • Lab Technician	• Out-patient Services • Availability of in-patient care • Basic laboratory facilities and facilities for minor surgical procedures • Drugs and treatment for minor OI • Transportation facilities for patients movement-ambulance • PEP Kits • Personal protection kit

[16] Operational Guidelines for Community Care Centres, National Aids Control Program, India 2007

			e.g. gloves, goggles, plastic apron etc • Infection control and waste management equipment e.g. colour coded buckets, needle destroyers. • IT equipment for communication and reporting e.g. computer, fax/printer, scanner, broadband internet connection. MIS Systems
Referral and Outreach	• Outreach for follow up of PLHIV for ART adherence • Trace and retrieve defaulters • Conveyance to referral centres • Facilitation of home based care • Coordination with referral centres for support	• Outreach workers for providing health services	• Transportation facility-Vehicle Hire • Telephone line for patients to call up
Other Support Services	• Support for PLHIV who face social rejection • Link with legal services • Offer of spiritual services and fitness programs such as yoga • Recreational facilities • Advocacy with various stakeholders • To provide linkage to PLHIV with PLHIV peer support networks • To empower income generation and self help groups • To facilitate PLHIV to access available resources provided by government and NGO agencies • To facilitate linkages between other service providers and patients, like educational help for the children and Income generation programmes	• Community Volunteers	• Recreation facilities e.g space to run peer support activities, lounge for education and recreation etc • Audiovisual equipment e.g. TV, DVD, CDs, Radio etc. • Motivate other service services and fitness providers and agencies programmes such as youth volunteers, peer Yoga groups, community support etc

10.28 Coordination at District and Provincial Level

To achieve high level of outcomes through CHBC services, coordination and liaison with other stakeholder is very important. Here are some tips to accelerate the coordination:

- Find out and create a list of relevant stakeholders including ART centers, PPTCT centers, PACP DHQ hospital, private hospitals, laboratories, NGOs, CBOs, associations networks working on HIV, etc.
- Include contact persons, address and contact numbers of landline and cell numbers in contact list
- Conduct liaison meetings with stakeholders on bi monthly/quarterly basis as per agreed upon schedule
- Prepare clear agenda and relevant agenda points for each liaison meeting
- Always keep minutes of the meeting and share these minutes with stakeholders no later than 1 week
- Conduct progress sharing meetings with respective PACP and keep update him on activities being carried out at CHBC
- Involve the PACP, ART center in charge and PPTCT center in charge in your activities by inviting them to participate in meetings, food distributions and support group meetings etc.
- Always share your issues with relevant stakeholder and ask them to support your clients
- Offer them to utilize your outreach resources to support their clients
- Share your IEC material with ART centers and ask them to share CHBC services information to potential clients (After consent of client refer them for CHBC services).

Documentation and record keeping: Group activity reporting format should be used for each meeting. Also, the correspondence emails between the organizations should be filled. Participant's attendance sheet must be filled for each meeting, and signatures of participants are necessary to be taken, along with the meeting agenda.

How: This meeting is the platform to talk about the rights of PLHIV and to discuss stigma and discrimination made by society to PLHIV. Participants may be influential community persons, religious scholars, local politicians, stakeholders and government officials.

Invitations for participants should be made at least three days before meeting. Necessary IEC material and banners should be prepared for display which should highlight the main agenda of meeting.

Ideal start of this meeting is to introduce the goals and objectives of CHBCs. After that, topic of session should be introduced and a link between CHBC objectives and topic should be clarified. Then proceedings of the session by key facilitators would take place.

Participants should be given a chance to participate and share their thoughts about the topic and these should be documented carefully. An environment should be created where all stakeholders have a chance to participate and share their thoughts. It is better to use local and simple language for participants so that everybody could understand and participate actively.

Relevant examples and case studies should be shared so that participant could be motivated and mobilized for suitable actions.

Make sure that all aspects of the topic are covered and an action plan is formulated at the end of the meeting. Action plan should consist of the key issues needs to be address, key activities to solve these issues, lead role to solve and time frame for a particular action.

Quarterly district strategy meetings between proximate CHBC sites

To whom: With another functional CHBC site

When: once in a quarter.

How Much time should it take? 90 to 120 minutes is the appropriate time for this meeting

Who: All staff of CHBC (at least key CHBC staff).

Documentation and record keeping: Group activity reporting format should be used for each meeting. Also, the correspondence emails between the CHBC sites should be filled. Participant's

attendance sheet must be filled for each meeting, and signatures of participants are necessary to be taken, along with the meeting report.

How: In order to conduct this activity in an organized and benefiting manner, following steps are suggested

- Identify the nearby CHBC which is doing well and can be of learning for your team. Engage in proper communication with its management so that the visit does not surprise the management of visiting CHBC.
- Propose your objective of the visit i.e. what actually you want to learn/ observe at that specific site.
- Communicate with the selected CHBC and work together to develop a proper visit plan/schedule. This should include tentative plan of your visit including date, timings and different sharing activities/sharing which will take place during the visit. Better to agree this schedule with the management of visiting CHBC.
- Make sure to have it be a one pager concept covering all above areas, share it with the management of the CHBC site which you intend to visit. This will help clarify the whole process and provide proper justification for the budget spending as well.
- Regarding budget, both sites can utilize their budgets for this activity as this will be a two way learning process and will be considered achievement of both

10.29 Data Management at CHBC Site

- Remember that 17 tools are being used for CHBC data collection
- There are 5 registers for data recording including, PLHIV register, Family register, VCCT register, Group activity register and training loan register (Business support)
- An online Management Information System (MIS) is also in place parallel to these registers and tool
- Managers should have copy of agreement, performance framework, and budget breakdown document, and guidelines and targets sheet.
- Make sure all guidelines are displayed in notice board and all staff is well aware about these guidelines

10.30 Necessary documents to open a file of PLHIV

Ensure that:

- You have the copy of Eliza report/CD4 test report/MR# of client in his file
- You have collect a copy of his/her CNIC or his spouse (if not available then do report to SR regarding acceptable form of identification)

- Registration form has been shared with client and filled properly by CHBC staff, duly signed by client and witnesses
- Risk assessment has been properly done and MARP category has been identified and duly marked
- Need assessment form has properly been filled and all necessary information has been collected. Make sure no single column is unfilled or unmarked and all socio-economic aspect has been assessed
- Please take enough time to fill all kinds of assessment as these are the basis for tangible and non-tangible supports.

10.31 Updating and maintaining the files, registers and MIS

Ensure that:

- All the services provision tools have been placed into clients' respective file after filling and signed by manager.
- Before putting the tool into clients respective file, check whether its entry have been made into all relevant registers and MIS
- All the files are placed in a confidential placed with proper locked cupboard and in systematic order
- Registers are duly counter signed by manager and up-to-date and placed into safe place
- Check on random basis that dates on tools, registers and MIS are matching each other
- Other necessary files includes, group activity (Support group meeting) report file, VCCT file and Monitoring reports (Monthly/Quarterly reports to SR, SR monitoring report form and email communication file. These files should be created and updated
- Create an electronic library of folders for each kind of data with appropriate name so that you can find out the information easily.

10.32 Reporting at CHBC

Programmatic

- Indicator table is being used for CHBC reporting which consist of 35 indicators , sub indicators and qualitative part of reporting
- Build understanding on indicator table and give equal attention to quantitative as well as qualitative part of that standardized format
- Use registers to compile the report instead of counting the copy of tools
- Involve the whole team to compile the report especially qualitative part should be completed with consultation of staff as they can explain better about success stories, issues and support required.

- Make sure you have put relevant explanatory comments in comment column
- Make sure your reference column is matching with your registers (Ensure the most up to date indicator table is being used)
- Check that you have changed the reporting date and reporting period (especially at the top of indicator table)
- Generate report from MIS and match them before sending it, find mismatches and make certain corrections (if problems are in entry then fix it otherwise report it SR)
- Give the appropriate name to each report e.g. Q7-final-reprot or Feb-final-report etc.
- Keep the most updated version of your reports clearly indicated as final which have been communicated to other stakeholders (suggestion is to delete all unnecessary previous version)

Reporting Timeline: As per agreement each CHBC is required to send their progress report before 5th of each month. The report consists of a quantitative part and Narrative section.

Steps for monthly/quarterly report submission:

	What	When	Whom
1	Preparation of monthly/Quarterly report by using monthly/Quarterly report format (Indicator table) (Counting the figures from registers and put against each indicator)	29th of every month	Counselor and ORWs
2	MIS report generation for comparison with indicator table manual report	29th of every month	DEO
3	Reconciliation of report with MIS generated report (Indicator wise comparison of figures in both reports)	29th of every month	PM+DEO
4	Reconciliation of report with recording registers (PLHIV, Family, VCCT, Group and Training/Business Support register)	29th of every month	PM
5	Review of supporting documents (M&E forms, referral slips, medical reports, vouchers etc.)	30th of every month	PM
6	Discussion on narrative section of report with CHBC team	30th of every month	PM
7	Reconciliation of report with financial report (Comparing the indicator values with expense report to verify the expenses of each activity)	30th of every month	PM+AFO
8	Sharing of report with SRs through email	Before 5th of every month	PM

Steps for monitoring and report verification at SR level:

For monthly report verification and feedback

- SR will review the monthly reports of SSRs at office level and share the feedback through email.

- Need based visits to CHBC sites could be planned by SR

For quarterly report verification and feedback

- On quarterly basis the report will physically be verified through a random spot check monitoring visit by SR staff.
- SR staff will prepare the visit plan and share the travel plan with CHBC PM at least one week before the visit.

10.3 Steps involved in monthly /quarterly report programmatic verification process:

1. CHBC overall environment assessment (as per CHBC monitoring checklist)
2. Random spot check for the reconciliation of report with recording registers (PLHIV, Family, VCCT, Group and Training/Loan register) (random spot check means few indicators will be selected on random basis and reconciled with registers)
3. Random spot check for the review of supporting documents (M&E forms, referral slips, medical reports, Vouchers etc.)
4. Reconciliation of report with MIS generated report (all indicators will be cross checked on both reports)
5. Discussion on narrative section of report with PM and relevant staff
6. Reconciliation of report with financial report (Budgeted activities will be compared with financial report)
7. Beneficiary verification (Beneficiaries who received tangible support services during the quarter will randomly be selected and contacted Physical or telephonic by using beneficiary verification checklist)
8. Observation of any running activity at CHBC site (during the site visit the SR staff will monitor activities which are already planned and feedback will be provided by using appropriate monitoring checklist (Support group monitoring checklist, counseling session monitoring checklist etc.)
    - Overall feedback will be shared with SSR through debriefing meeting
    - Monitoring/observation checklist will be shared with SSRs through email after the visit and after it is reviewed by the SR Program Manager

10.34 Standard Financial Reporting Procedures

- SSR must provide to SR the following forms and documentation in order for a liquidation to be processed:
- Quarterly Expense Details
    - Journal ledger (complete detail of transactions for the reporting period that includes reference to account codes by transaction).
    - Cash Book
    - General Banking Information (bank account numbers and names, signatories)
    - Bank Statements
    - Bank Reconciliation Statements
    - Original Expenses, Receipt and Journal Vouchers
    - Documentation supporting all expenses shown in liquidation (including timesheets and pay slips).
- SR reviews expense reports and supporting documents
    - **SR project and finance staff review the original records supporting the reported expenditures** to ensure that the reported amounts are properly supported and deemed allowable.
    - **SR must notify SSR in writing of all disallowable costs with recommended actions for correction**. Factors affecting the eligibility of an expense are as listed below:
        - Expenses are not reasonable and consistent with level of programming;
        - Expense not in original budget
        - Costs exceed 10% of the approved cost category and do not have prior approval; and
        - Financial documentation is not in compliance with SR requirements (e.g. insufficient number of bids; lack of contracts; missing evidence of delivery of materials).
    - Other factors that will be considered when reviewing supporting documentation and determining allow ability include:
        - Value (i.e. larger scale purchases requiring 3 bids)
        - Intent (i.e. misuse or misappropriation of funds; differential between actual vs. reported)
        - Level of deviation (i.e. disregard for procurement procedures; expenses clearly unrelated to programming)

11.0 TANGIBLE SUPPORT GUIDELINES

11.1 Introduction

Purpose of the guidelines

The guidelines define tangible support activities for service providers primarily aimed at ensuring provision of quality care and support to people living with HIV and AIDS (PLHIV) at centers/sites providing HIV medical treatment, food security and livelihoods improvements services for vulnerable PLHIV communities. The guidelines further provide a standardized approach to tangible care and support for PLHIV in diverse conditions and try to emphasize the importance the importance of proper need assessment of PLHIV for prior provision of any tangible support.

Tangible support for PLHIV and Global Fund project R9 Phase II

The economic indicators in Pakistan are very poor, further the prevalence of HIV is found to be most acute in marginalized communities. In many limited resource setting PLHIV and their family members have to pay for health care including medicine and supplies, which further enhanced the economic burden. The grant is expected to play an important role in ensuring the PLHIV and their family members have access to health and social welfare regardless of their ability to pay.

Some of the proposed measure to tackle their challenge includes providing an adequate food basket that fulfill the nutritional needs of PLHIV and affected family; skill development for generating some economic activity for PLHIV and affected family members through vocational training and the importance of having access to startup capital for entrepreneurial ventures should also be promoted; ability to access medical referrals; and care for children.

11.2 Areas of tangible support

- Food security package
- Improved livelihoods via socioeconomic support and job creation of PLHIV
- Medical referrals and special investigation support
- Support for ART treatment adherence for adults and children
- Care for infected /affected children

11.3 Proper need assessment

Before the delivery of any tangible support service mentioned above, CHBC staff must conduct a detailed, unbiased and realistic need assessment of each registered clients. This will help the CHBC staff to choose the appropriate client for appropriate service.

11.4 Description of Tangible Support

Food security support

People living with HIV or AIDS need different foods from people with good health conditions. The disease in itself and its medication can make them lose a lot of weight, feel cold all the time and get serious stomach problems. This will make them weaker and more vulnerable to serious infections. Because PLHIV get more susceptible to contract infections easily compared to people without HIV, it is of paramount importance that they use hygienic and properly cooked food and drink clean water. Since all PLHIV regardless of their age, sex, and physiological status, require more energy than uninfected individuals of the same status in order to meet the elevated nutritional needs that result from the infections and changes in metabolism caused by HIV, sub-recipients and other such organizations plan to address specific food needs of these people.

Service package description/budget line explanation

Procure and distribute food support monthly (15 % of registered PLHIV @ $ 24/month/family, always in line with the approved budget)

Eligibility criteria for providing this support

- Beneficiary is a registered PLHIV at CHBC site and at ART center.
- Beneficiary is aged above 15 years
- Household income is less than PKR 7,000/month.
- Family size comprises of more than 05 members.
- Living in rented or poorly furnished or comprises of one room home.
- Don’t get livelihoods support service from the CHBC site
- Preference is given to those families where more than 01 member is HIV positive
- CHBC sites should provide it on a fixed basis for 6 months at a time for the most vulnerable families, after 6 months (or sooner if there are changes in a family’s socioeconomic status) the needs assessment must be redone in order to ensure that the most vulnerable are receiving the support.
- At least 80% of the packages must be done on a fixed basis, in order for the vulnerable families to gain the most consistent nutritional benefit from the package. Up to 20% of the packages may be supplied on a rotational basis, in order to ensure that the most vulnerable clients are always being served. It should still be considered to be a consistent support; however, for their nutritional needs.

Note: *All PLHIV and their family members shall be counseled for regular food intake including variety of fruits and vegetables, and for physical exercise unless restricted by a physician. Livelihood support should be provided to such family for breaking this poverty cycle and establishing sustainable livelihood income, and then the family may no longer qualify for food support as its socio-economic situation should be improved.*

Improved livelihoods via socioeconomic support and job creation for PLHIV

Poverty and lack of adequate employment opportunities is a common phenomenon in Pakistan whereas this further implicate the conditions of majority of PLHIV (IDUs, sex workers, migrant workers, street youth, and deportees from UAE, for example). Many of them have either lost their employment or are threatened to lose it for their health and social conditions. It further pushes them in the worse economic conditions. Therefore there is a dire need to explore/grow opportunities for their employment (including self-employment) where they can earn their living in respectable manner, free from fear and discrimination. The focus of the support is to help clients/beneficiaries receive skill development training/business which will allow them to return quickly to work and earn their livelihood.

Composition of this package/budget line explanation

This support consists of two areas:

Vocational and Language Training/Business Skill Training: Comprises of $90/course for 4 people per quarter (always in line with the approved budget). This is now combined with business training skills. (Business trainings skills would be aimed for those who would be starting their own business).

- It may be used to support beneficiaries for any vocational, language, computer or technical course that is expected to improve their income generation capacity. The choice of the course should be based on previous educational and professional background of the beneficiary as well as the local market for the skills covered in the training.
- Since the beneficiaries may belong to geographically distant locations, and have different educational backgrounds and interests, CHBC site managers should preferably support them for individually for the most appropriate courses, instead of grouping them together for a single course.
- The maximum amount to be spent in support of a single beneficiary is $90 per quarter. This may include incidental costs such as traveling, in addition to course fee.

- It may be used to support beneficiaries for any courses that impart business/sales/marketing skills required for effective use of the skills possessed or gained by the beneficiaries. In instances where the distinction between these and vocational courses is not strict, or when these are not available in the locality, this budget may be utilized to cover more beneficiaries under the vocational course line item.
- This may include incidental costs such as traveling but only if the total support does not exceed the per person course fee amount and only allowable to those clients who are facing difficulty to access the vocational centers due limited transportation facilities, distant location of center/living in villages etc.

Business support packages: This is provided @ $100/person/quarter for 3 people per quarter (always in line with the approved budget). Conditions for this support are set as under:

- The business support to be used to purchase toolkits or business startup kits (in kind) for beneficiaries who have successfully completed a training course and show strong motivation to setup their own work/business.
- The IPs will ensure that proper business plan is prepared and the businesses thus set up are properly monitored in accordance with the already developed monitoring plan.

11.5 Eligibility criteria for providing this support

- The beneficiary for this support must be a registered PLHIV or a registered family member (dependents only) of PLHIV.
- In case of a family member being selected, the following two conditions must be fulfilled:
    a. The PLHIV in that family is unable or unwilling to enroll in a training course him/herself, for physical or any other reason, and nominates a family member for receiving this support
    b. The family member is living in the same household as that of PLHIV and is expected to contribute the earnings to the same household
- Household income less than PKR 7,000/month AND the beneficiary does not own a house or the home comprises of one room
- Physical and mental condition of the beneficiary is suitable for the vocational training and continuing independent work after the training
- Minimum requirements for vocational training are fulfilled (e.g. basic education if required)
- Should be active and willing to participate throughout the training course cycle
- PLHIV or his/her substitute (mentioned as above) agrees to go under the needs assessment process and is willing to participate in the training.

- Preference will be given to vulnerable families. (such as female headed household, families with person(s) having physical or mental challenges etc.)
- In order to receive support for business, the beneficiary or his/her substitute is liable to show 95% attendance in the training.
- Business support will be provided only after successful completion of the training to those individuals who are motivated to independently work towards establishing their own practice/business

NOTE: *The CHBC staff should follow up after 3 months and 6 months, with every beneficiary who receives any of these benefits, to assess:*

a. Whether s/he is making good use of the training/support provided
b. Whether she /he has been to increase household income using this support.

11.6 Medical referrals and special investigation support

Provision of comprehensive care for prevention and treatment of OIs (Opportunistic Infections) and other HIV-related illnesses in PLHIV is very important. Basic laboratory service, coordination with ART center, laboratory services for forward and back referrals is the right of each PLHIV.

The aim of this support is to create and strengthen referral mechanisms for ARV/CD4/TB/OI/Hepatitis B and other HIV/AIDS related health concern of PLHIV. Coordinate within and between different levels of the health system in order to expand access to care and treatment. CHBC sites are responsible for arranging the vehicle/transportation and meal during the facilitation of such services for vulnerable PLHIV.

11.7 Service package description/budget line explanation

- **Referral Support:** Regular Medical Referral and follow up for possible adverse effects/complications including logistic and meals @ US$ 10/encounter/month for 20% of registered PLHIV (always in line with the approved budget). Special Emergency support to look after logistic and accommodations needs of PLHIV. Under combined "Medical Referral" category. Support includes logistic and accommodations needs of PLHIV in case of emergency. Support includes the travelling and meal cost of PLHIV in case of regular medical referral or for the follow up of adverse effect /complication of PLHIV.
- **Supportive medical investigations:** It includes Complete Blood, LFTs, Blood Sugar Random (BSR) and Hepatitis B&C antigens to be done twice a year/PLHIV on ART.

Special investigations like CT and MRI scans, if occasions arise can also be covered under Supportive Medical Investigations line item).

11.8 Eligibility criteria for providing this support

For Medical /Emergency:

- Registered PLHIV and requires immediate medical/surgical attention
- Household income less than PKR 10,000/month AND does not own a house
- Written prescription by a registered medical practitioner on a legal medical document for evidence of particular support, which mentions that this is medical referral case or emergency case, OPD slip in case of medical referral and emergency department slip in case of emergency or doctor prescribe document which Indicate the nature of case.
- Preference should be given to the most vulnerable families.
- No discrimination on basis of gender, sex, race, ethnicity, sexual orientation, occupation
- After fulfilling the above criteria, the support should be provided on first come first serve basis.

For Supportive/Special investigation:

- Registered PLHIV who is currently on ARV treatment (documentary proof needed)
- Household income is less than PKR 10,000/month AND does not own a house or poor living.
- Prescribed by a registered medical practitioner (at CHBC site, ART Center or other health facility)
- Preference should be given to the most vulnerable families.
- S/he has received this support less than twice in last one year.
- No discrimination on basis of gender, sex, race, ethnicity, sexual orientation, occupation
- After fulfilling the above criteria, the support should be provided on first come first serve basis.

11.9 Support ARV treatment adherence for adults and children

Service Package description/budget line explanation

This is the first & one-time travel referral to the registered PLHIV. It includes the travel cost of client to ART center for registration @ of 10 US $ /person (always in line with the approved budget)

Eligibility Criteria for providing this support:

- PLHIV is registered at CHBC site.

- Any Existing/ new registration who are not registered at ART center.
- S/he has vulnerable economic condition and not able to bear the travel cost of referral.

11.12 Care for infected and affected children

HIV has increased the number of vulnerable children and families to unprecedented numbers some of the most complex and interrelated problem of these children and families are following. Added financial and physical burden on care givers in instance when children are cared for by other family members, after their parents death children can lose their rights to their property of home, an increased dropout rate from the schools in children being infected or affected by HIV/AIDS without education, skills work and family support, children may end up extremely vulnerable situation like living in street, and increased vulnerability to the drug abuse due to lack of adult care. CHBC team is therefore often responsible for initiating the process of providing of comprehensive, planned care for these vulnerable children, this can do CHBC team by linking those with the poorest health conditions to nutritional support and for linking others to school and by providing educational material.

11.13 Service package description/budget line explanation

This supports also consist of three areas:

- **Child nutritional referral:** Refer infected children (who require intervention) to UNICEF for nutritional support (40% mal nutritional children of 5% of infected total population. This is the first time referral only) @10 US $ per children (always in line with the approved budget)
- **School package:** book, stationary, uniform, shoes and jersey@ 38.46$ (always in line with approved budget)
- **Tuition fee:** @ 9.62Us $ for the period of 12 months. (always in line with approved budget)

11.14 Eligibility criteria for providing this support

For Nutrition Referral:

- A PLHIV child is registered at CHBC site.
- Parents are unemployed poor financial conditions.
- Having worst/critical health conditions.
- Preference will be given to those children whose age is less than 5 years.
- A physician's (preferably pediatrician) prescription for such support.
- No discrimination on basis of gender, sex, race, ethnicity, sexual orientation, occupation.

For School Support:

- Orphans, preference to infected children, maximum 2 children per family; package available for 10% of all registered PLHIV
- Either parent of this child is a registered PLHIV (alive or dead) OR the child him/herself is PLHIV
- If this child is not infected, and has another infected sibling, then that sibling will be preferred
- Child is less than 18 years of age
- Parents/guardians are unemployed and have no other source of income
- Parents do not own a house
- Not more than two children (infected or affected) can be supported per family
- No discrimination on basis of gender, sex, race, ethnicity, sexual orientation, occupation

Summary

Draft SOP Table by Activity with Supporting Documentation Requirements						
S#	Name & definition of activity	Eligibility criteria (see tangible support guidelines)	Tangible/ Intangible Support	Supporting documents needed for program	Supporting documents needed for finance	M & E requirements
Expand VCCT to increase detection and uptake of PLHIV						
1	Expand VCCT services at CHBC sites	All individuals those want to test their self.	Intangible	Filling of HIV consent form. Filled risk assessment form Filled Pre - test counseling form. Filled Post- test counseling form. Filled lab testing form. Recording of activity in the VCCT register Recording of activity in MIS.	Invoiced of hand gloves, syringes and lab items purchased during particular quarter.	Recording of activity at MIS and hard registers
2	Pre & Post-test counselling	All individuals who wanted to get tested his self.	Intangible	Filled pre & post-test counseling form. Filled lab test referral form. Recording of activity at VCCT register. Eliza confirmation report for reactive individual.	Bills/invoices of hand gloves, syringes and running items.	Recording of activity at MIS and hard registers.
Provide psychosocial and nutritional support						
3	Counseling at CHBC site	All registered PLHI V & family members (as per guidelines)	Tangible for PLHIV And intangible for family members	Filled counseling form. Recording of activity at PLHIV register.	Acknowledgement receipt from the clients for the amount he/she received for fare/travel to CHBC site	Recording of activity in MIS system and hard register. Providing fare to deserving client.

4	Counseling during home visit (average 1 to 2 visit to each registered family per quarter.	All register PLHIV & families.	Intangible	Filled counseling form for PLHIV and families. Recording of activity on PLHIV and Family register Filled home visit tool. Recording of home visit activity at Family/PLHIV register.	Vehicle log book. Fuel bill. Detailed Excel Sheet document in which they recorded the detail of activity by date.	Recording of activity in MIS and hard registers.
5	Support group meeting (1 meeting per month)	All registered PLHIV	Intangible	Filled activity report tool. Participant attendance list. Recording of activity at group register. Recording of activity in MIS.	Examine invoices. Participant attendance list. Activity narrative tool.	Recording of activity at MIS and hard registers
6	Food security support for individuals and families who fall below poverty line (15% of registered PLHIV)	Registered PLHIV who meet the tangible support guidelines	Tangible	Filled food security support tool. Recording of activity at PLHIV register. Recording of activity at MIS. NIC copy of recipient.	Examine procurement procedure. (Quotation, invoices of procured items).	Recording of activity at MIS and hard registers
7	Support in the development of peer educator (volunteer from the community)	Volunteer from the PLHIV community. peer similarity of HIV status, or MARP group, or geographical location or age group	Tangible	1 page JD of peer educator. Filled activity template tool. Record day sheets of peer educator who serves in the community.	Acknowledgment receipt of stipend from peer educator. Filled activity report tool.	Recording of activity with all supporting documents.
Improved livelihoods via socioeconomic support and job creation for PLHIV						

8	Support vocation/business skill training to improve livelihood (90 USD/person @ 4 people per quarter (together w/ business skill training)	Registered PLHIV and possibly their families members	Tangible	Client application for enrolling in proposed course. Project manager remarks after the assessment of client's request. Photocopy of admission form. Filled training referral tool. Recording of activity in training loan register.	Receipt/ admission invoice. Training referral filled tool.	Recording of activity at MIS and hard registers.
9	Support business /start up tool kit for skilled members (100 USD/person at 3 people per quarter)	Registered PLHIV and possibly their families members	Tangible	Client application for proposed business. Project manager remarks after the assessment of client's request. Photocopy of certificate if already skilled or any evidence showing his knowledge to start the particular business or work. Filled training referral tool. Recording of activity in training register. Recording of activity in MIS	Receipt/ invoice of tool kit or purchase items. Training referral filled tool.	Recording of activity at MIS and hard registers
Provide referral support to clients for HIV-treatment related services						

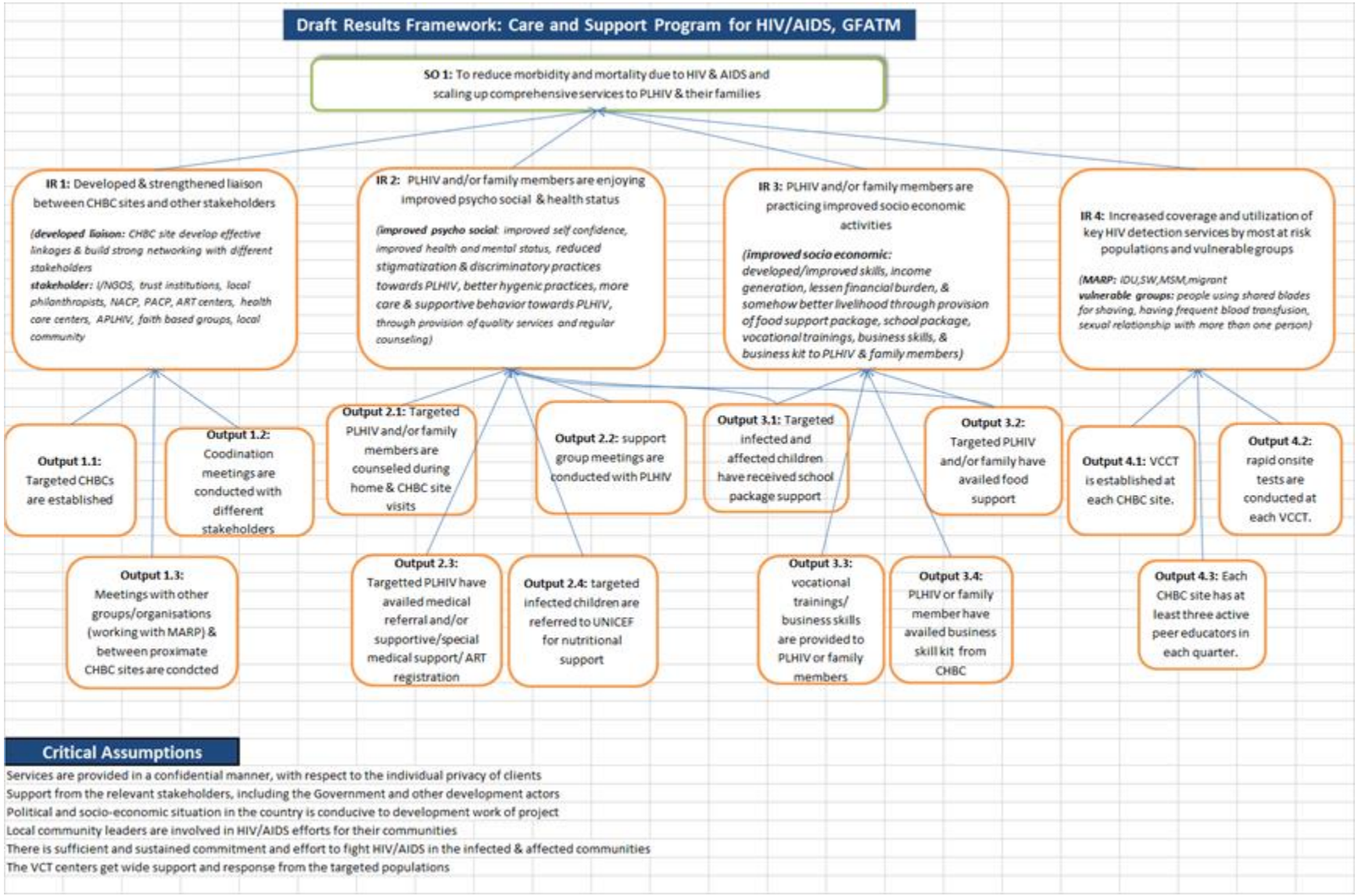
10	Regular medical referrals to local hospitals and follow up for adverse effect/complications of ART, opportunistic infection /emergency support to look after the logistic and accommodation needs of PLHIV combined under this category	Registered PLHIV	Tangible	OPD/Emergency admission slip. Doctor prescription for the evidence of activity performed. Filled regular/emergency referral tool. Recording of activity in PLHIV register. Recording of activity in MIS.	Client visit slip. Amount Received invoice of clients. Filled medical referral tool.	Recording of activity at MIS and hard registers
11	Supporting medical investigation including complete blood ,liver function test(LFT), blood sugar random(BSR), hepatitis B & C antigens and CT.MRI, this support is 5% of registered PLHIV at a given CHBC site per six month	Registered PLHIV.	Tangible	OPD admission slip. Doctor prescription as evidence of activity performed or not. Filled supportive/specialized investigation reports. Test reports Recording of activity in PLHIV register. Recording of activity in MIS	Client visit slip/ doctor prescription. Amount Received invoice of clients. Filled supportive /specialized tool. Lab test receipt.	Recording of activity at MIS and hard registers

Support ARV treatment adherence for adults and children						
12	Travel for ART registration	Registered PLHIV at CHBC sites. Clients who are not registered at ART center.	Tangible	Client confirmation report. Referrals slip from CHBC to ART center. Coding slip/MRN (medical record number) assigned by ART center. Recording of activity in PLHIV register by clearing mentioned in the remark Column.	Client visit slip. Amount Received invoice of clients. Filled medical referral tool.	Recording of activity at MIS and hard registers
Care for children infected/affected by HIV/AIDS						
13	Referral to UNICEF for nutritional support of infected children. (40% percent malnourished children of 5% infected in total population) **Mechanism does not exist yet**	Registered infected children	Tangible	Referral slip of Pm/pediatric doctor Confirmation slip/ record number provided by UNICEF. Filling of nutritional support tool. Recording of activity in PLHIV register. NIC copy of guardian or recipient who received the support.	Invoice of received items or fare slip Filled tool NIC copy of guardian or recipient.	Recording of activity at PLHIV register and MIS

14	School package includes (Uniform, books, bags and stationary) 10% of total registered PLHIV.	Infected children and if savings available then affected children	Tangible	Filled school support package tool. Copy of NIC of recipient. Recording of activity in PLHIV register in case of infected children and family register in case of affected children. Recording of activity in MIS	Invoices of purchased items Filled school packs tool.	Recording of activity at MIS and hard registers
15	School fee quarterly tuition fee	Infected children and if savings available then affected children	Tangible	Filled school support package tool. Copy of NIC of recipient. Recording of activity in PLHIV register in case of infected children and family register in case of affected children. Recording of activity in MIS	School invoice for tuition fee Filled school packs tool.	Recording of activity at MIS and hard registers.
CHBC sites liaising with other stakeholders						
16	Build supportive relationship with local communities and faith based organization working with high risk populations, MSM, transgender (Hijras), sex worker, Migrants(1 meeting per quarter)	All functional CHBC sites	Intangible	Copy of Correspondence email among faith based organizations. Copy of Agenda of meeting. Attendance list of participants. Meeting report.	Invoices of expense. List of participant. Filled activity narrative tool.	Recording of activity at MIS and hard registers

17	Quarter district strategic meeting between proximate CHBC sites	All functional CHBC sites	Intangible	Copy of Correspondence email between both CHBC sites. Copy of Agenda of meeting. Attendance list of participants. Meeting report.	Invoices of expense. List of participant. Filled activity narrative tool.	Recording of activity at MIS and hard registers

12.0 RESULTS FRAMEWORK: CARE AND SUPPORT PROGRAM FOR HIV/AIDS, GFATM



Annexures

Annexure I

Universal Precautions

Universal Precautions are simple standards of infection control practices to be used in the care of all PLHIV, at all times, to reduce the risk of transmission of blood borne infections. They include:

Safe Handling and Disposal of Sharps

- Careful handling and disposal of “sharps”
- Hand washing with soap and water before and after all procedures; use of protective barriers such as gloves, gowns, aprons, masks, goggles for direct contact with blood and other body fluids
- Proper disinfection of instruments and other contaminated equipment
- Proper handling of soiled linen

The greatest hazard of HIV transmission in health care settings is through skin puncture with contaminated needles or "sharps". Most "sharps" injuries involving HIV transmission are through deep injuries with hollow bore needles. Such injuries frequently occur when needles are recapped, cleaned, disposed of, or inappropriately discarded.

Although recapping needles is to be avoided whenever possible, sometimes recapping is necessary. When this is the case, a single-handed scooping method should be used. To do this, place the needle cap on a hard, flat surface and remove your hand. With one hand, hold the syringe and use the needle to scoop up the cap. When the cap completely covers the needle, use the other hand to place the cap firmly on the hub of the needle.

Puncture-resistant disposal containers must be available and readily accessible for the disposal of "sharps".

Many easily available objects, such as a tin with a lid, a thick plastic bottle, or a heavy plastic or cardboard box, can work as suitable "sharps" containers. These can be burned in a closed incinerator, or can be used to transport the "sharps" to an incinerator. It is important to empty containers when they are 3/4 full, to wear heavy-duty gloves when transporting "sharps" containers, to incinerate used equipment at a hot enough temperature to melt the needles. Where the sharp container is not burned, bury it in a deep pit. Added precautions to prevent "sharp" injuries include wearing gloves, having an adequate light source when treating patients, locating sharps containers directly at the point of use, never discarding "sharps" in general waste, and

keeping "sharps" out of the reach of children. Whenever possible, needle holders should be used when suturing.

Sharp Accidents

Each CHBC should follow the Universal Precautions in case of "sharps" injury or other exposure. Many concerned people neglect to report such injuries. This can lead to inaccurate data on health care worker exposure and more importantly, to a lack of follow-up counseling, testing, treatment and care. Following a "sharps" injury, immediate first aid should be given, such as flushing the site with running water, hand washing with soap and water, and, where there is bleeding, allowing the site to bleed briefly. Any exposed mucous membranes should be flushed with large amounts of water. Antiseptic solutions can have a caustic effect and have not been proven to be effective. However, in the absence of water, antiseptic solutions should be used. Following exposure, the type of exposure and the actions taken should be recorded and the Treatment and Care Centre notified so that PEP can be obtained if relevant. Voluntary confidential counseling should be available immediately, and HIV testing and follow up counseling made available. Post exposure prophylaxis (PEP) with antiretroviral treatments (ARV) can reduce the risk of becoming infected. PEP is available at the Treatment and Care Centres and is guided by local policies and is dependent upon the availability of drugs. If available, a combination of ARV should be taken as soon as possible after the accident (within 24 hours) and for four weeks following exposure. Many health care workers find reporting and undergoing voluntary testing and counseling stressful, and some chose to remain silent. This silence is often due to the fear, stigma and discrimination associated with HIV.

Evaluating Sharp Practices

If the same accident occurs more than twice, "sharps" practices must be evaluated. Methods for avoiding "sharps" use should be considered, for example, drugs might be given by methods other than injection; stapling rather than suturing; using adhesive tape or skin closure strips; and avoiding unnecessary incisions such as episiotomies.

Safe Decontamination Of Equipment

Efficient cleaning with soap and hot water removes a high proportion of any microorganisms. All equipment should be dismantled before cleaning. Heavy gloves should be worn for cleaning equipment and if splashing with body fluid is likely, and then additional protective clothing such as aprons, gowns, and goggles should be worn. The following table helps in selecting the method for decontamination:

LEVEL OF RISK	ITEMS	DECONTAMINATION METHOD
High risk	Instruments which penetrate the skin/body	Sterilization, of single use of disposables
Moderate risk	Instruments which come in contact with non-intact skin or mucous membrane	Sterilization, boiling, or chemical disinfection
Low risk	Equipment which comes in contact with intact skin	Thorough washing with soap and hot water

Sterilization and Disinfection

All forms of sterilization will destroy HIV:

Recommended methods of sterilization include steam under pressure (e.g.. autoclave or pressure cooker), or dry heat such as an oven. Disinfection will usually inactivate HIV. Two commonly used disinfection methods are boiling and chemical disinfection. If boiling, equipment should be cleaned and boiled for 20 minutes at sea level, and longer at higher altitudes. Chemical disinfection is not as reliable as sterilizing or boiling. However, chemical disinfection can be used on heat sensitive equipment, or when other methods of decontamination are not available. Equipment should be dismantled, thoroughly cleaned and rinsed after disinfection. Chemicals that have been found to inactivate HIV include chlorine-based agents (for example, bleach), 2% glutaraldehyde, and 70% ethyl and isoproyl alcohol.

Cleaning:

Detergents and hot water are adequate for the routine cleaning of floors, beds, toilets, walls, and rubber draw sheets. Following a spillage of body fluids, heavy-duty rubber gloves should be worn and as much body fluid removed with an absorbent material. This can then be discarded in a leak proof container and later incinerated or buried in a deep pit. The area of spillage should be cleaned with a chlorine-based disinfectant and the area thoroughly washed with hot soap and water. All soiled linen should be handled as little as possible, bagged at the point of collection and not sorted or rinsed in patient care areas. If possible, linen with large amounts of body fluid should be transported in leak proof bags. If leak proof bags are not available, the linen should be folded with the soiled parts inside and handled carefully, with gloves.

Safe disposal of waste contaminated with body fluids

Solid waste that is contaminated with blood, body fluids, laboratory specimens or body tissue all should be placed in leak proof containers and incinerated, or buried in a 7 foot deep pit, at least 30 feet away from a water source. Liquid waste such as blood or body fluid should be poured down a drain connected to an adequately treated sewer or pit latrine.

Planning And Management

Proper planning and management of supplies and other resources are essential in reducing the occupational risk of HIV infection. Such measures should include risk assessment, setting of standards and protocols that address safety, risk reduction, post-exposure follow-up and first-aid. In addition, occupational risks can be reduced by introducing measures to prevent or reduce stress, maintain an optimum workload, orientate new staff and provide education and supervision. Staff burnout, characterized by feelings of depletion, loss of vitality, energy, and motivation is a major occupational hazard and can lead to increased risk for occupational exposure to HIV. In addition, fear of occupational exposure to HIV in health care settings may discourage potential recruits from pursuing nursing and midwifery as a career, thus reducing the future supply of trained professionals. Strategies that address these concerns include:

Gaining and maintaining adequate supplies and resources Nurses/midwives need to explore different approaches to meet their resource needs, such as:

- Finding out what can be obtained from government and nongovernmental sources, through regular distribution
- Finding out what is locally available and what can be bought. To what extent can patients and their relatives contribute
- Reviewing the quality of available supplies
- Developing or improving systems for ordering, transporting, and storing, and ensuring there is not an oversupply that will be wasted
- Developing a schedule for obtaining and maintaining supplies which includes taking into consideration travel, delivery time, and weather
- Establishing sustainable acquisition and payment procedures

In resource poor settings, some supplies may not be available. In such cases, nurses/midwives must creatively about how to manage care. Can plastic bags or condoms be used instead of gloves; can cooking utensils be used for boiling equipment; are there herbal and traditional alternatives to detergents and soaps? Can leaves, thimbles, or plastic wrap be used instead of band aids to protect cuts? Are the resources that are available being used appropriately? For example, if gloves are in short supply, prioritize -- they are less necessary for giving routine injections and making beds than for deliveries and suturing.

One way to assign priorities is to classify the commonly performed procedures into low, medium and high risk, and allocate resources accordingly. Consideration should be given to cost effectiveness as opposed to cost containment noting that the cheapest equipment is not always the safest or most cost effective in the long run. In home care settings, nurses/midwives will need to be even more creative in finding solutions to infection control. Wherever possible, a home care kit should be available to all health care personnel working in the community and in homes. This kit should include disinfectants, soap, utensils for boiling, gloves, protective garments, and containers for safe disposal of equipment and waste.

Setting and Maintaining Standards, and Political Action

Nurses/paramedics should be active in developing and maintaining quality assurance programs, and in developing and participating in infection control committees. Nurses and midwives must also develop, maintain, and evaluate standards, procedures and protocols for safe, adequate and effective control of infections. In addition, nurse managers should exert political pressure upon employers and upon national and international agencies to provide funds for essential supplies and equipment for providing safe quality care.

Care for the Care Giver

Understandably, many nurses/paramedics fear becoming infected with HIV. Stigma, prejudice and discrimination surrounding HIV and its life threatening effect may compromise their ability to provide quality care, and even their commitment to remain in the profession. There should be adequate insurance and compensation for HIV-infected health workers. However, such compensation will depend upon the country's ability to pay, the place of employment and the employer. Particular attention should be given to:

Continued Employment

Being HIV-infected is not a cause for termination of employment, regardless of whether HIV was acquired on the job or not. As with any other illness, HIV-infected nurses/midwives should be allowed to work as long as they are fit, provided they practice universal precautions. HIV infected health care workers can make considerable contributions to care by helping to educate others, reducing the stigma and discrimination associated with HIV, and providing sensitivity training, support and counseling. Employers should provide work assignments that both support the HIV infected worker's ability to perform tasks and enable them to avoid infections (particularly TB).

Work Place Issues

Health care workers, like the general population, may feel fear, stigma and discrimination towards HIV infected individual. In fact, HIV- infected health care workers are often subjected to severe sanctions from their colleagues. As a result, many care workers are reluctant to be tested and to enter into counseling, treatment and care. This is problematic, because if nurses/midwives do not know their HIV status, they can put themselves and others in the health care setting at risk. Therefore, employers should develop policies that:

- Convincing employers, managers and insurance agencies not to discriminate against HIV positive personnel
- Providing support legal assistance and referral
- Fostering networking with other HIV positive employees
- Counseling on career change and job retaining opportunities
- Advising about continued practice and the disclosure of their HIV status
- Developing and disseminating position statements on issues such as mandatory testing (not supported), ethical obligations for HIV positive personnel, and ethical treatment by health care workers for people living with HIV
- Providing up to date and accurate information about compensation benefits, occupational risks, and follow up care
- Clarifying professional ethical norms and obligations in regard to health care and HIV

Initiating a Package of Services

Depending on the stage of the disease and the resources that are available, HIV positive nursing/paramedic care/midwifery personnel require a package of services that might include:

- Protect the privacy of the HIV-infected employee
- Prevent social isolation of the HIV infected employee by co-workers
- Keep HIV positive personnel in a supportive occupational setting as long as possible
- Educate all employees, management and union leaders about the rights and care of HIV-infected health care workers

Annexure 2.

Baseline knowledge about HIV and AIDS

The indicators for assessing the baseline knowledge about HIV and AIDS are:

- Basic definition of HIV
- Basic definition of AIDS
- Difference between HIV and AIDS
- Basic information on HIV transmission
- Basic information on HIV prevention
- Basic Knowledge of the symptoms of HIV
- Basic Knowledge of the symptoms of AIDS
- Basic knowledge of comfort measures and nursing care for adults and children
- Managing symptoms and administering medication
- Use of traditional remedies
- Knowledge of Universal precautions
- Basic knowledge of the symptoms of the common STI's, OI's, TB and Hep. C

Annexure 3

Recommended CHBC KIT

1 Why the Kit

1.1 Advantages to the patient and care provider:

- Facilitates access to essential drugs for treating major diseases including HIV and AIDS opportunistic infections such as diarrhea, tuberculosis, and childhood illness
- Reliable sources for ensuring adherence to treatment and drug quality

Advantages to the health care system:

- Limits the range of essential drugs to those necessary
- Simplifies budgeting, procurement, storage, transport and supply management
- Facilitates equitable availability of supplies and drugs
- Contributes to more rationale prescribing, dispensing and use of drugs

1.2 What does the Kit contain?

The KIT contains Care items and basic drugs (see attached list). The use of the Kit in the monitoring tool is meant to provide direction towards a systematic approach to rendering patient care in a holistic manner. The care items and drugs in the Kit act as a checklist for comprehensive patient management.

Pain Medication Class 'A' Drugs

The care provider is a professional who is trained and licensed to handle class 'A' or Dangerous Drugs. Under the Dangerous Drug Act and in accordance with the National Drug Policy, the professional must hold a current license to acquire and administer these drugs. Within the c/HBC programme, it is advisable to have such a professional covered by a registered palliative/long term care facility. In this case, she or he can administer:

- Morphine injections, Morphine mixture
- Morphine tablets and Doxyeyeline Caps

Pain Medications over the Counter

- A trained professional may administered advanced pain medications, such medications include: Voltaren, Ibuprofen, Valoid and Metoeloperamide

Wound Cleanser

Liquid betadine with instructions for mixing and usage

Cleaning Liquid

Disinfectant with instructions for mixing and usage

NOTE: the following is recommended for guiding programmes in the acquisition, and administration of medicines found on the recommended list:

1. Essential items and drugs recommended for basic nursing care by a trained nurse:
   - Item numbers 1 to 17 are essential items;
   - Item numbers 21, 22, 27, 28 and 29 are optional. This is administered based on the national policy and training received by the healthcare worker or HCG.

2. Essential items and drugs recommended for the extension of medical/clinical care in the delivery of Community Home Based Care Services by a professional health care worker/outreach worker:
   - Items number 18 to 59

RECOMENDED LIST
MEDICINES AND SUPPLIES FOR COMMUNITY/HOME BASED CARE KITS

NO	ITEM	PRESENTATION
1	Home Base Care Bags (for nurse/paramedic, outreach worker & volunteer)	
2	Home visit reporting forms (country specific)	Amend existing referral/follow-up form to accommodate C/HBC
3	Ball Pen	
4	Soap and container with holes for water drainage	
5	Disposable Towels	Pack of 10
6	Heavy duty gloves	
7	Non-sterile disposable gloves	
8	Plastic Apron	
9	Mackintosh sheets/incontinent reusable protective pads	
10	Draw Sheets	
11	Adult diapers	Small, Medium and Large sizes

12	Skin Protection Cream	Jars 200mls size preferred
13	Skin Wash	
14	Gauze Swabs	Pack of 100
15	Bandages – crepe 75 mm roll+100mm roll	
16	Bowls (for cotton wool and solutions)	
17	Cotton wool	100g
18	Wooden tongue depressor	
19	Towel Forceps	
20	Clip Forceps	
21	Blood pressure apparatus and stethoscope	
22	Auxiliary thermometer	
23	Hand Flash light + battery	
24	Scissors	
25	Skin antiseptic with dispenser (appropriate packs for wound and foley catheter care)	
26	Condom male and female (optional but highly recommended)	
27	Umbrella (foldable)	
28	Bicycle with carrier	
29	Calamine Lotion	Lotion 50ml vial
30	Oral rehydration salts	Powder 27.9 g (sachets)
31	Nystatin	Tablet 500 mg or pessaries 100000UI
32	Paracetamol	Tablet 500 mg or syrup 125 mgs/5mls
33	Acetylsalicylic Acid	Tablet 300 mgs
34	Ferrous sulphate and folic acid	Equiv, 60 mgs iron + 400 mierog folic acid
35	Ferrous sulphate	Oral solution equiv.25 mgs iron (a sulphate)/ mls
36	Retinol Palmintate (Vitamin a)	Suger coated tablets 10,000 IU : 5 mgs
37	Foley catheters x 2 way x size 16 & 18 and catheter care (betadine swabs or alcohol solution) for cleaning the skin	
38	Ketoconazole	Tablet 200 mg
39	Ketoconazole	Oral suspension 100 mg/5ml
40	Griseofulvine	Tablet 250 mg
41	Metronidazole	Tablet 500 mg
42	Metronidazole	Oral suspension 200 mg/5ml
43	Acriflavian	Tablet 200 mgs
44	Amoxycillin	Tablet 500 mgs
45	Doxycycline	Tablet 100 mgs

46	Sulphamethoxazole + trimethoprim	Tablets 480 mgs + 80 mgs
47	Sulphamethoxazole + trimethoprim	Oral suspension 20 mg + 40 mg/5ml
48	Erythromycin	Tablets 250 mgs
49	Ascorbic acid	Tablet 50 mg
50	Vitamin B Complex Inj	10 ml Ampoule
51	Chloroquine	Tablet 100 mg base
52	Chloroquine	Syrup 50 mg (as phosphate or sulphate)/5ml
53	Sulfadoxine Pyrimethamine	Tablet 500 mg + 25 mg
54	Promethazine	Tablet 10 mgs
55	Feeding Tubes and containers/bags for food	Medium and Large (1 of each size)
56	Tetracycline	Tablets or syrup
57	Ringers Lactate + set	Intravenous solution 500 MLS
58	Disposable needles and syringes	Various sizes for intramuscular injections
59	Tuberculosis medication as recommended by clinical team	
60	ARV prophylaxis	
61	HAART	
62	Class “A” analgesics for use by professional palliative care team members	

Food Supplements

These include food rations, nutritional packets etc. The HCG and professional may want to source these items from community groups, NGOs or any other food-based organization. It is important to give the patient some food before serving medication if indicated.

Annexure 4

Assessment Form for PLHIV

Membership Form

1. Personal Information

Name: _____

NIC#: _____

Contact #: _____

Address: _____

_____

_____

Sex: ☐ Male Female ☐

Age: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

HIV Status: +ve since: …… Number of HIV +ve persons in family: Male …….. Female ……

Relation……..

Date of joining CHBC: ……..……

Family Registration No: ……

In case of emergency who should be contacted:

Name: ……

Address: ……

Relation: ……

Contact #: ……...

Education:

☐> Matric ☐ Matriculation ☐ Intermediate ☐Graduation

☐Masters ☐Illiterate ☐ Technical Education

Technical Skills:

☐Vendor/ Shopkeeper ☐Driver ☐Mechanic ☐Tailoring

☐Electrician ☐Farmers ☐Welder ☐Embroidery

☐Beautician ☐Other Technical Skill

How long have you been using this skill?

Never ☐ 1 yr ☐ 2-5 yrs☐ 5=10 yrs 〉10 yrs☐

How many years of experience do you have?

Nil ☐ 1 yr ☐ 2-5 yrs☐ 5=10 yrs 〉10 yrs

Family Profile

Who is head of the family?: ……..……..……

Is he/she working?: Yes☐ No ☐

Relation: …… Sex: Male ☐ Female: ☐

Number of family members: …….

Did any family member passed away with HIV: Yes☐ No ☐

Number of Children: _____

Sr.	**Age**	**M/F**	**School going:**
			Yes ☐ **No** ☐
			Yes ☐ **No** ☐
			Yes ☐ **No** ☐
			Yes ☐ **No** ☐

			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Dependents with age:

☐Spouse Age _____

Has your spouse been tested for HIV: ☐Yes ☐No

☐Children Ages (as per birth order)

Age	**M/F**	**Tested for HIV:**
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

☐Mother Age _____ ☐Father Age _____ Brother _____ Age _____
Sister_____ Age _____

Family system:

☐Single Unit ☐Joint Family ☐Single Parent

☐Other: …….

Infrastructure

House: ☐Own ☐Rented ☐Paying Guest ☐ With Relative

Rooms: ☐One ☐Two ☐Three ☐Four ☐Five

Please explain the housing facility:

……

……

Utilities

☐Electricity ☐Natural Gas ☐Water ☐ Telephone

2. Income Status

Employment status:

☐Government Job ☐Private Job ☐Business ☐Unemployed

☐Dependent ☐Other: ……

In case of dependents please specify age and sex:

……

……

Source of monthly Income

☐Job _____ ☐Business _____☐Relative's Support _____

☐Spouse/children Support _____ ☐ Other : _____

Total Income per month:

☐< 3000 ☐3001 – 5000 ☐5001 – 7000 ☐7001 – 10000

☐10001 – 12000 ☐12001 – 15000 ☐ < 15001

Who is responsible for the home expenses (mention relation)?

……..……...

……..……

3. Health Status

Weight: ……. (kg)

Are you on ART: ☐Yes ☐No

Ailments:

☐TB ☐Diabetes ☐Blood Pressure ☐HBV

☐HCV ☐Cardiac Problem ☐Cancer ☐Other: ……

4. Support receiving from the CHBC

Are you registered with any care and support services organization/NGO"?

☐ Yes ☐ No

If yes, please write the name of the Organization/NGO and address:

……

……

If yes what services are you already receiving?

☐Nutritional support ☐School Fee for children ☐ ARV ☐ General Medicine

☐Vocational Training ☐Microfinance ☐ Others

5. Existing Level of Knowledge of Client about HIV & AIDS

What is HIV?

☐Disease ☐Virus ☐Illusion

What is AIDS?

☐Disease ☐Virus ☐Illusion

How does HIV spread?

☐Touching ☐Breathe ☐Blood

How to prevent HIV from spreading?

☐Practicing safe sex ☐Using clean disposable syringes only ☐Using only pre screened blood for blood transfusions

Is it safe to perform the following activities with PLHIV?

☐Sharing utensils ☐Sharing clothes ☐Sharing food ☐Sleeping ☐ Hugging

Is there any treatment for the HIV?

☐Yes ☐No

Can we assess a person by observing that he is HIV positive or not?

☐Yes ☐No

Is AIDS is the disease of aged persons?

☐Yes ☐No

Is HIV a communicable disease?

☐Yes ☐No

Can we sit, eat and live with PLHIV or an AIDS patient?

☐Yes ☐No

Do you think HIV and AIDS is a problem of a specific place/area?

☐Yes ☐No

Do you think an HIV positive person can live a normal life like others?

☐Yes ☐No

How long a person with HIV and AIDS can live?

☐1 year ☐5 years ☐10 years ☐More than 10 years ☐No specific time

Results/Recommendations form

Comments and Recommendations by assessor:

……

……

……

……

……

……

Cost Calculations/ Analysis

Sr. #	Services	Amount	Per person cost	Per child	Per Adult
	Total				

Assessed by: ***Dated:***

_____ _____

Checked and Recommended by: ***Approved by:***

_____ _____

Dated: *Dated:*

_____ _____

Annexure 5

Referral Form

(For use by CHBC Staff)

Patient Code: _____

Name: _____

Age: _____ (yrs) Sex: _____

Family Serial No: _____

Location: _____

Date of Referral: _____ (mm-dd-yy)

PLHIV Referring Unit: _____

Present Complaints:	**Past Complaints:**
i) _____ ii) _____ iii) _____ iv) _____ Comments:_____ _____ _____	i) _____ ii) _____ iii) _____ iv) _____ Comments: _____ _____ _____
Present investigations required: _____ _____ _____	Results of the Past Investigations: _____ _____ _____

Reasons or the Referral:

- ☐ Medical check-up
- ☐ Medical management
- ☐ TB Screening
- ☐ TB treatment
- ☐ Home care assistance
- ☐ ART Services
- ☐ STI Case Management
- ☐ VCCT
- ☐ Financial Support
- ☐ Social Support
- ☐ Essential Package of Care
- ☐ Support Group/post test club
- ☐ Drugs and Alcohol Counselling
- ☐ Family Planning Services
- ☐ Psychological Support
- ☐ Emergency Management
- ☐ PPTCT
- ☐ Others Specify.....

TREATMENT HISTORY:

Sr.	Name of Medicine	Strength	Dosage

Referred To

Referral for	Name of the site	Complete Address	Telephone Number/Email (optional)	Focal Person
HIV Specialist Clinic				
Treatment Centre				
TB Diagnostic Centre				
TB Dots Clinic				
Higher STI Services				
CD4 Count				
Viral Load Test				
ART Services				
Family Planning Services				
PPTCT Services				
Emergency Management				
Inpatient services				
Other services				

Purpose of Referral:

_____

_____

_____

Name:

Signature:

Date:

Annexure 6

Assessment of the Health Status

(To Be Filled In By the Doctor or a Nurse)

Signs and Symptoms:

Patient Code: ……..

PRIMARY INFECTION*:*

No symptoms □

Fever □

Sore throat □

Skin infections □

CLINICAL STAGE 1:

No symptoms □

Swollen or enlarged lymph nodes □

CLINICAL STAGE 2:

Moderate unexplained weight loss □

Recurrent respiratory infections □

Herpes zoster □

Oral ulceration □

Papular pruritic eruptions □

Seborrheic dermatitis □

Fungal nail infections □

CLINICAL STAGE 3:

Unexplained severe weight loss (>10% of presumed or measured body weight) □

Unexplained chronic diarrhea for >1 month □

Unexplained persistent fever for >1 month (>37.6ºC, intermittent or constant) □

Persistent oral candidiasis (thrush) □

Oral hairy leukoplakia □

Pulmonary or extra pulmonary tuberculosis (current) □

Severe presumed bacterial infections □

(e.g., pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteremia)

Acute necrotizing ulcerative stomatitis, gingivitis, or periodontitis □

Unexplained anemia (hemoglobin <8 g/dL) □

Neutropenia (neutrophils <500 cells/µL) □

Chronic thrombocytopenia (platelets <50,000 cells/µL) □

CLINICAL STAGE 4:

HIV wasting syndrome, as defined by the CDC □

Pneumocystis pneumonia □

Recurrent severe bacterial pneumonia □

Chronic herpes simplex infection (orolabial, genital, or anorectal site for >1 month or visceral herpes at any site) □

Esophageal candidiasis (or candidiasis of trachea, bronchi, or lungs) □

Pulmonary / Extrapulmonary tuberculosis □

Kaposi sarcoma □

Cytomegalovirus infection (retinitis or infection of other organs) □

Central nervous system toxoplasmosis □

HIV encephalopathy □

Cryptococcosis, extrapulmonary (including meningitis) □

Disseminated nontuberculosis mycobacteria infection □

Progressive multifocal leukoencephalopathy □

Candida of the trachea, bronchi, or lungs □

Chronic cryptosporidiosis (with diarrhea)	□
Chronic isosporiasis	□
Disseminated mycosis (e.g., histoplasmosis, coccidioidomycosis, penicilliosis)	□
Recurrent nontyphoidal *Salmonella* bacteremia	□
Lymphoma (cerebral or B-cell non-Hodgkin)	□
Invasive cervical carcinoma	□
Atypical disseminated leishmaniasis	□
Symptomatic HIV-associated nephropathy	□
Symptomatic HIV-associated cardiomyopathy	□

Annexure 7

Counsellor Form

(To Be Filled In By the Counselor)

Name: _____

Family no: _____

Complete address: _____

AREAS OF HIV AND AIDS COUNSELLING PROVIDED

- Risk Assessment and Preventive Counselling
- HIV counselling and testing
  - Pre-test Counselling
  - Post-test Counselling
- Counselling for behavioural change
- Supportive Counselling – Client, Couple, Group & Peer counselling
- ART Adherence Counselling
- Spiritual Counselling
- Counselling for disclosure to partner/husband and/or family
- Counselling for STI prevention and treatment
- Counselling for safe sex practices
- Nutritional Counselling
- Terminal Stage & Bereavement Counselling
- Rehabilitative Counselling
- Counselling support for those with suicidal tendencies

Comments of Supervisor:

……

……

Name:

Signature: Date:

Annexure 8

Monthly Home Visit Form for Registered PLHIV

Name: _____

Family no: _____

Location: _____

Age: _____ Sex: _____

1. Physical Condition
Assessment of the Health Status for HIV:

Do you feel you have improved over the last month?

☐ Yes ☐ No

Please explain?:

……
……
……

Was any referral to a health facility made during the last month?

☐ Yes ☐ No

If yes for what:
.....……

From where:
……

Were any emergency referral services provided to you during last one month?

☐ Yes ☐ No

If Yes For what:
.....

From where:
……

Are there any new complaints during last one month?

Yes ☐ No ☐

If yes please Explain:

……

……

2. Physical Care

Was any of the following basic nursing/care provided to you during the home visit?

- Positioning
- Mobility
- Bathing
- Wound cleansing, skin care
- Oral hygiene
- Adequate room ventilation
- Guidance for adequate nutrition
- Nutritional Support Package

Were any of the following measures undertaken to comfort you during the last one month?

- Recognizing symptoms

  Details:

  ……

- Symptom management

  Details:

  ……

- Referral

  Details:

  ……

- Follow-up

  Details:

……

Are Universal precautions being practiced by you?

Yes ☐ No ☐

Are Universal precautions being practiced by your family?

Yes ☐ No ☐

If yes, then please specify which one:

- ☐ Hand-washing
- ☐ Avoiding contact with blood or body fluids by using gloves and diapers etc
- ☐ Washing bed linen with soap and water,
- ☐ Using disinfectants and detergents
- ☐ Burning or safely disposing of the waste
- ☐ All wounds sores, grazes or lesions (where the skin is split) are kept covered at all times.
- ☐ Bathrooms and toilets are clean, hygienic and free from blood spills.

Is any medication given for the following ailments?

- ☐ Pain
- ☐ Fever
- ☐ Diarrhoea
- ☐ Dehydration
- ☐ Cough
- ☐ Nausea & vomiting
- ☐ Fungal infections e.g. oral thrush
- ☐ Skin conditions
- ☐ Mucosal conditions like mouth ulcers, abscesses, wounds, pain, rash, itchiness

If yes, what medicines have been given?

……

Were any of the following types of counseling provided to you during the last one month?

- ☐ Voluntary counselling and testing provided to any of your family members?
  - Pre-test counselling
  - Post test counselling
- ☐ Emotional counselling
- ☐ Health counselling

- Hygiene counselling
- Nutritional counselling
- Making plans for the future of family members
  - Writing of Will
- Protecting Inheritance rights
- Bereavement counselling on loss of a family member

Was any form of support services offered to the PLHIV or their children?

- Support for schooling e.g. school fee, books, uniform etc
- Spiritual support
- Nutritional support
- Support for Vocational Training and Skill Enhancement
- Financial Support
- Referral Support
- Funeral Support

3. Psychological Condition:

Willing to talk: ☐ Yes ☐ No

Compliant to therapy: ☐ Yes ☐ No

Support being provided by family members? ☐ Yes ☐ No

Positive support being provided by neighbors/community: ☐ Yes ☐ No

Comments:

……..……

……

ARV Adherence

Have you taken ART before? ☐ Now ☐ Before

When was ART started? …….. Month……. Year

Are you still taking ART? ☐ Yes ☐ No

Are you adhering to the ARV Therapy?

☐ Yes ☐ No ☐ To some extent

Comments:

……..……

……

Can you show us the medicines you are taking?

Comments:

……..…….

……

What time do you take ART each day? ☐ In the morning ☐ In the evening

Are you having any problems remembering to take ART? ☐ Yes ☐ No

Do you have any side-effects from these medicines? ☐ Yes ☐ No

If yes, please explain:

……..……

……

Traveling Time: …… Meeting Time: ……..

Visitors name and signature

(1): …… ……..

(2): …… ……

Date and day of Visit: ……

1. EMPLOYABILITY

Employable skills

Have you received any skill development training?

Yes ☐ No ☐

If yes, are you employed after the skills were developed?

Yes ☐ No ☐

TO BE FILLED IN BY THE CHBC STAFF MAKING THE HOME VISIT:

Type of services needed by the PLHIV:

- ☐ CHBC based Counseling
- ☐ Home Based Counseling
- ☐ Medicines for pain relief
- ☐ Medicines for OI
- ☐ Dressing for wound care
- ☐ Home based kits
- ☐ Referral for CD4 /Viral load
- ☐ Referral for HIV treatment centre for complicated OI
- ☐ Emergency Referral
- ☐ School Package support
- ☐ Nutritional support
- ☐ Vocational Training support
- ☐ Funeral support

Comments:

……

……

……

……

Name: ……

Signature: ……

Date: ……

TO BE FILLED IN BY THE SUPERVISOR AT THE CHBC CENTRE

Type of services approved:

- ☐ CHBC based Counseling
- ☐ Home Based Counseling
- ☐ Medicines for pain relief

- Medicines for OI
- Dressing for wound care
- Home based kits
- Referral for CD4 /Viral load
- Referral for HIV treatment centre for complicated OI
- Emergency Referral
- School Package support
- Nutritional support
- Vocational Training support
- Funeral support

Comments of Supervisor:

……

……

……

……

……

……

……

……

Name:

Signature:

Date:

Annexure 9

Staff Details at the CHBC

Details of Staff at CHBC					
Staff type	Full Time / Part Time	No. of positions sanctioned	No. of positions filled	No. of positions vacant	No. of staff trained during the month
1. Project Manager					
2. Doctor (Male)					
3. Doctor (Female)					
4. Nurse / Paramedical (Male)					
5. Nurse / Paramedical (Female)					
6. Admin and Finance Officer					
7. Counsellors					
8. Outreach Workers					
9. Laboratory Technician					
10. Driver					
11. Janitorial Staff					

Annexure 10

Community Need Assessment for establishment of CHBC Program for PLHIV

Sr.	DATA COLLECTION	Done	Not done
1	No. of PLHIV enumerated in the community		
2	PLHIV categorized according to gender (Males, Females)		
3	PLHIV categorized according to age (Children, Adolescents, Adults, Old Aged)		
4	Type of Community (Urban, Rural, Slum) determined		
5	Health Facility (Government, Private) utilization by PLHIV determined		
6	Existing referral systems (Hospital/Treatment and Care Centres/PPTCT/laboratories etc) if any for PLHIV determined		
7	Attitudes of Community toward HIV and AIDS determined		
8	Attitudes of Community toward CHBC determined		
9	Socio-economic status (upper , middle or lower class) of the community determined		
10	Educational level (Literate, Illiterate) of the community determined		
11	Health needs (Physical, Social, Psychological, Spiritual) of PLHIV determined		
12	Information & Educational needs (on PLHIV management & CHBC) of the families of PLHIV determined		
13	No. of caregivers at home determined		
14	Ages of caregivers at home determined		
15	Attitudes of families toward outside caregivers determined		
16	Attitudes of families toward home based care determined		
17	Availability of resources for home based care assessed		
18	Accessibility for advanced medical care for PLHIV determined		
19	Availability of supplies for clinical care & infection control determined		
20	Availability of medicines for symptoms relief especially for pain control determined		
21	Training needs (in patient management & referrals) of community groups assessed		
22	Socio-cultural issues (stigma attached with HIV, isolation, abuse, drug addiction) within the families studied		
23	Level of community participation & support for adults and children infected & affected with HIV assessed		
24	Community's perceptions regarding HIV and AIDS assessed		
25	Community's perceptions regarding CHBC assessed		
26	Potential to form community support groups for PLHIV assessed		
27	Traditional & cultural beliefs of the community for HIV that may compromise quality of care studied		

*PLHIV: Persons living with Human Immunodeficiency Virus

Annexure 11

Checklist

Planning for Establishment of CHBC Program for PLHIV

Sr.		Have done	Have not done
1	Statement of need with background information and prioritization formulated		
2	Mission/value statement developed		
3	Goals and objectives of the CHBC program set		
4	Existing policy guidelines on patient management (HIV & TB treatment) reviewed		
5	Existing policy guidelines (CHBC for PLHIV & TB) reviewed		
6	Existing policy guidelines for diagnostic services (HIV & TB laboratory services) reviewed		
7	Existing policy guidelines for case finding (HIV testing & TB screening) reviewed		
8	Existing policy guidelines for HIV & TB surveillance reviewed		
9	Existing policy guidelines for medicines & supplies (HIV & TB CHBC) reviewed/revised		
10	Existing guidelines for referrals (PLHIV & TB patients) reviewed/revised		
11	Availability of essential drugs for CHBC (patient management, OI, symptom relief) assessed		
12	Availability of referral system & support networks for PLHIV determined		
13	Guidelines for health, nutritional, emotional & bereavement counseling reviewed/developed		
14	Guidelines for legal support (inheritance, will writing, child placement) reviewed/developed		
15	Guidelines for referrals to Family planning services reviewed/developed		
16	Guidelines for staff training in CHBC reviewed/developed		
17	Time frames for implementation of CHBC determined & timelines/Gantt charts developed		
18	Budget for CHBC developed		
19	Guidelines for Community sensitization for CHBC developed		
20	Guidelines for providing technical support to medical personnel, community leaders, program managers, international and national partners developed		
21	Guidelines for monitoring of CHBC program developed		
22	Guidelines for end of year evaluation of CHBC program developed		
23	Guidelines for Community sensitization for CHBC developed		

PLHIV: Persons living with Human Immunodeficiency Virus.
OI: Opportunistic Infections
IEC: Information, Education & Communication
TB: Tuberculosis
HIV: Human Immunodeficiency Virus

Annexure 12

Checklist

Implementation of CHBC Program for PLHIV

Sr.	Implementation Steps	Done	Not done
1.	Care supply list (Essential drug/ supplies) for CHBC developed		
2.	Ordering schedule for supplies/medicines/equipment for CHBC developed		
3.	Delivery plan for CHBC services developed		
4.	Monitoring system for CHBC services developed		
5.	Community support groups involved/consulted in decision making during implementation		
6.	Referral systems and support networks in placed		
7.	Management decisions made at operational level adapted		
8.	Detailed budgeting with resource allocations made		
9.	Human resource plan followed- recruitment/ hiring & pay-roll structures determined		
10.	Pre-service, In-service and continued education plan for CHBC team, PLHIV & home care givers implemented		
11.	Skills development of CHBC personnel, home-caregivers in home care service delivery done		
12.	Educational & Informational material for CHBC developed/ adapted		
13.	CHBC coordinator identified for monitoring, reporting, holding meetings, ordering supplies for CHBC kits and obtaining financial support		
14.	Site location for CHBC program identified		
15.	Area and equipment for storage of CHBC supplies/medicines procured		
16.	Networks built for community resource sharing, mobilization and participation in CHBC activities		
17.	Public-private partnerships/linkages established for CHBC program		
18.	Monitoring plan for CHBC followed		
19.	Evaluation plan for CHBC in placed		

CHBC: Community & Home Based Care
PLHIV: Persons living with Human Immunodeficiency Virus.

Annexure 13

CHBC Activities Monitoring Check List for Project Managers

Sr.		Yes	No	Comments
1.	Minimum staff available (doctor/health assistant, staff nurse, counselor and laboratory technician/assistant) for running STI/VCCT clinic			
2.	Doctor/health assistant, staff nurse with STI/EPC training, counselor with VCT training and laboratory technician with training on HIV/STI testing			
3.	STI/EPC/VCCT SOP and STI/VCCT National Guidelines available at service sites			
4.	HIV counseling is provided by trained health personnel			
5.	Clinic and registration areas ensure visual and auditory privacy			
6.	Clinic room and laboratory have running water supply			
7.	All STI clients are offered RPR and HIV testing			
8.	All VCCT clients found HIV-positive are offered EPC services			
9.	All female clients are treated for STIs following positive laboratory results			
10.	All STI clinics provide monthly screening to FSWs and H/MSW			
11.	All laboratory flow charts/procedures are displayed on the wall			
12.	All service sites have PEP flow charts displayed on the wall, with focal person contact information			
13.	All service site staff know the exact procedure and mechanism for PEP referral			
14.	Referral directory exists and service sites staff know where to refer PlHIV's			
15.	The refrigerator temperature is monitored using the temperature monitoring chart			
16.	All service sites have The Commodity Expiry Tracking Chart for test kits displayed on the wall			
17.	The laboratory register is regularly maintained			
18.	Samples for quality control test are collected, sent to the National Public Health lab, and results recorded.			

CHBC site: Date of Visit:

Annexure 14

Waste Management Checklist

Name of CHBC Center: ……..

Activities	Yes	No	CHBC staff Responsible	Remarks
Training of Staff				
All CHBC staff are aware about the waste management procedures described in the Universal Precautions and SOPs				
All CHBC staff are aware on their specific roles on management of all waste				
Collection of waste				
Separate waste bins are available for collection of infectious and non-infectious waste in the laboratory as well as examination room				
Strong leak-proof plastic bags are kept in the wastes bin for easy handling of wastes				
Sharps containers are available in the laboratory and examination rooms (this is required only if the laboratory and the CHBC Centre need to dispose of sharps)				
A jar with sufficient amount of 0.5 % hypochlorite solution is kept on the laboratory bench to collect and decontaminate pipette tips and other infectious equipment				
Disposal of wastes				
Utility gloves are available and being used by CHBC staff and family care givers for handling of waste				
All burnable infectious and non-infectious waste is burned in a local incinerator. The waste is burned completely.				
Serum and whole blood specimens are disposed of only after decontamination with sufficient amount of 0.5% hypochlorite solution				
Clinic staff and helpers uses personal protective equipments (apron, Goggles and Mask) while disposing of decontaminated liquid wastes into the drainage				
Needles are destroyed using needle destroyer immediately after use in the laboratory				

Annexure 15

Partnerships at Community Level

1. Number of working hours provided by the Community this quarter: ( )
2. Number of additional NGOs supporting CHBC in the district this quarter: ( )
3. What types of services did they provide?

   You may take as many options as necessary.

   - Food supplements
   - Food rations
   - Kit Items for replenishments
   - Money for school fees
   - Other: Specify: _____
4. What were the constraints to CHBC activities this quarter?
   - Transport difficulties
   - Stock-out of medicines
   - Inadequate support from supervisors
   - Inadequate support from community
   - Other: Specify: _____
5. What are your recommendations for improved CHBC?

_____
_____
_____
_____
_____

Name:

Designation:

Signature:

Date:

Annexure 16

Monthly Record of Services being provided by the CHBC

Parameters		Values in Numbers					
		Male	Female	TS/RG	Children Male	Children Female	Total
Numbers of PLHIV receiving counseling on ART adherence (New Registrations)	On ART						
Number of PLHIV whose families have been counseled (New Registrations)	On ART						
	Not On ART						
Number of PLHIV receiving counseling on ART adherence (Old Registrations)	On ART						
Number of PLHIV whose families have been counseled (Old Registrations)	On ART						
	Not On ART						
	On ART						

Numbers of PLHIV receiving counseling on other issues (New Registrations)	Not On ART						
Numbers of PLHIV receiving counseling on other issues (Old Registrations)	On ART						
	Not On ART						
Number of support group meetings held for PLHIV	On ART						
	Not on ART						
Number of PLHIV receiving additional nutritional support	On ART						
	Not On ART						
Number of children receiving support for schooling	Affected Children						
	Infected Children						
Number of PHIV receiving palliative care	On ART						
	Not On ART						
Number of PLHIV homes during the month on ART	On ART						
	Not On ART						
	On ART						

Number of PHIV receiving treatment for OI	Not On ART						
Number of PLHIV medical referrals made	On ART						
	Not on ART						
Number of PLHIV referrals made for psychosocial support	On ART						
	Not on ART						

CHBC Monitoring Tools

PLHIV Closing/Transferring Form

Case Type: Registration # of PLHIV: _____

☐Closed

☐Transferred # of family members transferred/closed: _____

Reason for Closing: *(To be filled in by verifying person, any one from CHBC staff)*

☐ Pass away ☐Migrated to other country ☐ Transferred to other site ☐ Lost to follow up ☐ Unwilling to receive CHBC Services ☐ any other reason _____

Remarks from verifying person:

_____

_____

Name of verifying person: _____ Signature: _____

Services Received by PLHIV & family members:

(In case of transfer receiving manager will check the entire documents for services)

Services	PLHIV	Repetition of the services	Family members	Repetition of the services
Counseling				
Regular medical referral				
Emergency support				
Supportive investigation				
Special investigation				
Food support adults				
Nutritional package pediatric				
School package				
Training referral				
Grants/business support				
Home Visits				
Funeral Support				
Any Other (Please specify)				

Acknowledgement from handing over PM:

This is to certify that PLHIV having above registration # has been closed from CHBC_____ from date___/___/_____ and the record of above beneficiary has also been closed properly in CHBC registers and MIS.

Name of PM: _____ Signature: _____

Consent from PLHIV: *(this section will only filled in case of client transfer to other CHBC site)*

I hereby agreed to transfer my registration from CHBC _____ to _____ for timely and effective services.

Name of Client: _____ Signature: _____

Acknowledgement from taking over PM:

It is acknowledged that above mentioned PLHIV registration #_____is registered at CHBC site_____ from date____/___/_____. S/He will be provided services as per CHBC guidelines.

New Registration#_____ Date of Transfer: _____/_____/_____

Name of receiving PM_____ Signature:_____

SUPPORTIVE/SPECIAL MEDICAL INVESTIGATIONS FORM

Date	Time	Name of Patient	Age	Gender	PLHIV Reg #

Brief description of the medical problem:

_____

_____

Date of last medical supportive/special investigations: _____

Supportive **Medical Investigations suggested:** (can be supported twice a year)

Complete Blood		Hepatitis B antigen	
LFTs		Hepatitis C antigen	
Blood Sugar Random		Others	

Details of any other support provided for this referral: _____

Special **medical investigations suggested:**

CT scan: _____ MRI scans: _____Others:_____

Any other support provided for this referral: _____

Referred By:

Name: _____

Signature: _____

Counter signature by Site Manager:

Name: _____

Signature: _____

REGISTRATION FORM FOR FAMILY MEMBER OF PLHIV

(Only to be filled first time)

1.	Date of registration: _____ / _____ / _____
2.	Name of Family member:
3.	Sex: ☐ Male ☐ Female ☐ Transgender
4.	Registration # allotted: _____
5.	Relationship with PLHIV:
6.	Name of PLHIV
7.	Registration # of PLHIV: _____
8.	Address (District):
9.	Age (in years):
10.	HIV status known? ☐ Yes ☐ No

Signature of Family member: (For adult family members only)

_____

Registered by:

Name/designation: _____ Signature: _____

COUNSELOR'S CHECKLIST

Registration # _____ Date of Counseling ___/___/_____

Note: VCT Counselor will conduct all types of Counseling.

AREAS OF HIV AND AIDS COUNSELING PROVIDED

- ☐ Risk Assessment and Preventive Counseling (Using Risk Assessment Form)
- ☐ HIV counseling and testing
- ☐ Pre-test counseling
- ☐ Post-test counseling
- ☐ Supportive Counseling – Client, Couple, Group & Peer counseling
- ☐ ART Adherence Counseling
- ☐ Counseling for disclosure to partner/husband and/or family
- ☐ Counseling for STI prevention and treatment
- ☐ Counseling for safe sex practices, including ABC approach
- ☐ Nutritional Counseling
- ☐ Terminal Stage & Bereavement Counseling
- ☐ Rehabilitative Counseling
- ☐ Counseling support for those with suicidal tendencies

Findings/recommendations from Counselor:

_____

_____

_____

_____

Name _____

Signature _____ Date _____

TRAINING REFERRAL FORM

SSR: _____ CHBC Site: _____

Registration Number of PLHIV or Family Member: _____

Name of the beneficiary: _____ Age: _____ (years)

Gender: ☐ Male ☐ Female ☐ TG

If a Family Member instead of PLHIV is provided support, give reason:

_____

_____

========== **TRAINING REFERRAL DETAILS**==========

Name of training institution referred to: _____

Address of the institute: _____

Phone No: _____Date of referral: _____ (*when the person was referred by CHBC site*)

Title of course:_____

Duration of course: _____ (months) from _____ (start date) to _____ (end date)

Total cost of the course (PKR): _____ Financial support provided (PKR): _____

Note: CHBC staff must register the individual for the course him/herself by going to the training institute. A copy of course registration voucher must also be attached with this form, once registration is done

Referred by (CHBC staff member): Name/Designation_____ Signature: _____

Countersigned by Site Manager: Name_____ Signature: _____

(FILL BACK OF THIS FORM FOR BUSINESS SUPPORT AND FOLLOW-UP DETAILS)

========== **BUSINESS SUPPORT DETAILS** ==========

Description and rationale of business support provided:

_____

_____

Date of providing business support: _____ Total value in PKR: _____

Name/Signature of beneficiary: _____ NIC # of Beneficiary: _____

Note: CHBC staff must take signature from the recipient of the support as a proof.

Support provided by (CHBC staff member): Name/Designation_____ Signature: _____

Countersigned by Site Manager: Name_____ Signature: _____

========== **FIRST FOLLOW-UP** ==========

Date of <u>first</u> follow-up (3 months after providing support): _____

Has beneficiary completed the training? ☐ Yes ☐ No

Is the beneficiary employed or started his/her own work or business? ☐ Yes ☐ No

Current monthly income from this business or employment (PKR): _____

If beneficiary has not started employment/business, give reason:

_____

Name & Signature of Site Manager: _____

========== **SECOND FOLLOW-UP** ==========

Date of <u>second</u> follow-up (6 months after providing support): _____

Is the beneficiary employed or started his/her own work or business? ☐ Yes ☐ No

Current monthly income from this business or employment (PKR): _____

If beneficiary is still unemployed or has not started work/business, give reason: _____

_____

Name & Signature of Site Manager: _____

FOOD & NUTRITIONAL SUPPORT FORM

PLHIV Registration # _____ Date _____Name of PLHIV _____

Type of support: ☐ Food support (Adult PLHIV) ☐ Pediatric nutritional Support (Child)

☐ Referral for pediatric nutritional Support (Child) (please specify items which client received)

Items provided in the package

Sr.#	Food item description	Quantity	Remarks
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Received by: Name _____ Signature _____

Phone No. of recipient: _____ Relationship with PLHIV: _____

Family registration # (if family member is receiving instead of PLHIV)_____

Attach photocopy of CNIC of recipient (or of guardian in case of child PLHIV)

Handed over by

Name _____

Designation _____

Signature _____

Counter Signature by Site Manager

Name _____

Signature _____

FAMILY MEMBERS HOME VISIT REPORT FORM

of family members registered: _____ # of family members met during visit: _____

Family Member Registration # (met during this visit) 1 _____ 2 _____ 3 _____

4 _____5 _____ 6 _____ 7 _____ 8 _____ 9 _____

Date of Visit __/__/_____

AREAS OF COUNSELING PROVIDED

☐ Supportive Counseling – Family, Couple, Group discussion

☐ Counseling for ART adherence by PLHIV

☐ Counseling for STI prevention and treatment

☐ Counseling for nutritional care of PLHIV

☐ Bereavement counseling for care of PLHIV

☐ Counseling for rehabilitative/palliative care of PLHIV

☐ Any other topic: _____

Key concerns/queries discussed/responded *(other than above mentioned counseling areas)*

1) _____

2) _____

3) _____

4) _____

5)_____

Personal Observation (personal/domestic hygiene, behavioral changes etc.)

1) _____

2) _____

3) _____

4) _____

5)_____

Recommendations/Action Plan:

_____

_____

_____

_____

_____

_____

Staff/visitor Name: _____

Signature: _____

Date: _____

Reviewed by PM

Name: _____

Signature: _____

Date: _____

Medical/ Emergency referral form

SSR: _____ **CHBC site**: _____

Date	Time	Name of PLHIV	Age	Sex	PLHIV Reg #	MARP Code

MARP Codes	
1	IDU
2	SW
3	MSM
4	Migrant
5	Others

Type of referral:

☐ Regular check ☐ Emergency referral

Problem description/Type of emergency :

_____

_____

_____

Referred to:

Name of Institute:
Address:
Telephone:
Focal person:

Referred by (Counselor/Outreach worker):

Name:_____Designation:_____Signature:_____

Verified by (Site Manager or designated in his absence):

Name:_____ Designation: _____Signature: _____

HOME VISIT CHECKLIST FOR REGISTERED PLHIV

Name:_____ Registration No: _____ Location: _____

Age: _____ (years) Sex: _____Date of visit: _____ Time: _____

On ARV: ☐Yes ☐No

Q No	Question	Responses
A: HEALTH		
A1	Do you feel you have improved over the last month?	1= Yes 2= No → skip to A5
A2	If yes what significance improvement have you noticed in your health? *Please circle all that apply*	1= Weight improvement 2= Feeling stronger 3= Able to work 5= Other (please specify) _____
A3	How you will rate the improvement compare to last month?	1= Small improvement 2= Medium improvement 3= Large improvement
A4	What are main reasons for these improvements? *Please circle all that apply*	1= Guidance and support during home visit 2= Counseling session on relevant problem 3= Family members care and support 4= Through use of regular and on time ARVs 5= Taking balanced diet 6= Food package support 7= Do not know 8= Other (please specify) _____
A5	If not what type of issues or illness did you face or notice? *Please circle all that apply*	1= Persistent fever 2= Diarrhea/loose motions 3= Loss of weight 4= Vomiting 5= Mental illness 6= Weakness 5= Other (please specify) _____

A6	Did you take any action to cope with these illness or problems? *Please circle all that apply*	1= Contacted CHBC for referral support 2= Contacted CHBC for emergency support 3= Medication by hospital or doctor by self-visit 4= Self medication 5= No action taken 6= Other (please specify)

B: PRECAUTIONS			
B1	What kind of universal precautions you and your family are following?		
	Precautions	*Client (Yes/No)*	*Family (Yes/No)*
	Hand washing through soap		
	Avoid contact with blood or body fluids by using gloves and diapers etc.		
	Washing bed linen with soap and water		
	Using disinfectants and detergents		
	Burning or safely disposing of the waste		
	All wounds sores, grazes or lesions are kept covered at all times		
	Bathrooms and toilets are clean, hygienic and free from blood spills		

C: ARV ADHERENCE		
C1	How frequently are you taking ARV?	1= Daily 2= Every two days 3= Every three days 4= More than three days (please specify) _____ 5= Not taking → skip to C3
C2	What time in a day, do you usually take ARV?	1= In morning 2= In evening 3= Both times
C3	If you are not taking ARV, please tell us why not?	1= Felt weak 2= Vomiting 3= Blood comes from mouth 4= Depressed 5=Weak memory 6= Other (please specify) _____
C4	Who supports you to take ARV?	1= Family members 2= Friends 3= CHBC staff 4= Other (please specify) _____

		5= No one
C5	Do you have any side effects to these medicines?	1= Yes 2= No → skip to section D
C6	If yes, what are those? *Please circle all that apply*	1= Vomiting 2= Diarrhea/loose motions 3= Stomach pain 4= Pain in body 5= Headache 6= Bleeding from mouth 5= Other (please specify) _____
D: Hygiene *To be filled through observation*		
D1	General condition of house/domestic hygiene	1= Clean 2= Dirty
D2	Personal hygiene condition	1= Clean 2= Dirty
D3	Utensils hygiene condition especially water containers	1= Clean 2= Dirty
D4	Latrine hygiene condition	1= Clean 2= Dirty 3=No latrine
E: FUTURE SUPPORT		

To be filled in by the CHBC staff making the home visit

Type of services needed by the PLHIV: *Please check all that apply*

☐CHBC based counseling ☐Home based counseling

☐Referral (name type_____)

☐Nutritional/food support

☐Vocational Training support

☐any Other (specify)_____)

Staff comments:

_____

_____

_____

_____

_____

_____

_____

Name:_____ Signature: _____

Date:_____

To be filled in by the supervisor:

Comments :

_____
_____
_____
_____
_____
_____

Actions decided:

1= _____

2=_____

3=_____

4=_____

5=_____

Name:_____ Signature: _____

Date:_____

NEED ASSESSMENT FORM FOR MEMBERSHIP

1. PERSONAL INFORMATION

Name _____Father/Husband name _____

CNIC # _____Phone No. _____

Address: _____

Sex: ☐ Male ☐ Female ☐ Transgender Age _____(Years)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

HIV Status: +ve since (date) _____

Number of HIV +ve persons in family: ☐ Male _____ ☐ Female _____ ☐ Transgender _____
☐ do not know

Relation (with positive family members) _____, _____ , _____, _____

Date of joining CHBC _____ PLHIV Registration No. _____

IN CASE OF EMERGENCY WHO SHOULD BE CONTACTED:

Name: _____ Relation: _____

Address: _____

Phone No: _____

EDUCATION

☐ Illiterate ☐ Technical Education ☐ Matric

☐ Intermediate ☐ Graduation ☐ Masters ☐ Other _____

TECHNICAL SKILLS (if any) (please tick all that apply)

☐ Farmer ☐ Electrician ☐ Beautician ☐ Driver ☐ Vendor/Shopkeeper

☐ Mechanic ☐ Welder ☐ Tailoring ☐ Embroidery ☐ Other Technical Skill

How long have you been using this skill?

☐ Never ☐ 1 yr ☐ 2-5 yrs ☐ 5-10 yrs ☐ 10 yr

Average monthly income through above mentioned skill?

☐No income ☐ < 3,000 ☐ 3,001 – 5,000 ☐ 5,001 – 7,000 ☐ 7,001 – 10,000

☐ 10,001 – 12,000 ☐ 12,001 – 15,000 ☐ > 15,000

Other sources of income (select all that apply)

☐No other source ☐ Job ☐ Business ☐ Relative's Support ☐ Spouse/children Support

☐any other (please explain) _____

Total monthly income:

☐ < 3,000 ☐ 3,001 – 5,000 ☐ 5,001 – 7,000 ☐ 7,001 – 10,000

☐ 10,001 – 12,000 ☐ 12,001 – 15,000 ☐ > 15,000

Family Profile:

Are you head of the family? ☐ Yes ☐ No

If no, name of head of the family: _____ Is he/she earning? ☐ Yes ☐ No

Relation with PLHIV: _____ Sex: ☐ Male ☐ Female ☐ Transgender

Total family members: _____ # family members dependent: _____

Detail of family members: (in case of more family members use extra page)

S. #	Name of family member	Age	Sex	Relation	Dependent	HIV test done
1.						☐ Yes ☐ No
2.						☐ Yes ☐ No
3.						☐ Yes ☐ No
4.						☐ Yes ☐ No
5.						☐ Yes ☐ No
6.						☐ Yes ☐ No
7.						☐ Yes ☐ No
8.						☐ Yes ☐ No

9.						☐ Yes ☐ No
10.						☐ Yes ☐ No
11.						☐ Yes ☐ No

INFRASTRUCTURE

House: ☐ Own ☐ Rented ☐ Paying Guest ☐ Living with relative

☐Other (Specify) _____

No. of Rooms in house: _____ Condition of house: _____

_____

UTILITIES:

☐ Electricity ☐ Natural Gas ☐ Water ☐ Telephone ☐ Cell phone ☐Other _____

3. <u>Health status</u>

Weight: _____(kg) Are you on ART: ☐ Yes ☐ No

Concurrent Ailments:

☐ TB ☐ Diabetes ☐ Blood Pressure ☐ HBV ☐ HCV ☐ Cancer

☐ Cardiac Problem ☐ Other: _____

4. <u>Support receiving form any other organization</u>

Are you registered with any care and support services organization/NGO? ☐ Yes ☐ No

If yes, please write the name of the Organization/NGO and address:

_____

If yes what services are you already receiving?

☐ Food/Nutritional support ☐ School Fee for children ☐ ARV ☐ General Medicine

☐ Vocational Training ☐ Microfinance ☐ Others _____

3. <u>EXISTING LEVEL OF KNOWLEDGE OF CLIENT ABOUT HIV & AIDS</u>

What is HIV? ☐ Disease ☐ Virus ☐ Illusion ☐ Do not know

What is AIDS? ☐ Disease ☐ Virus ☐ Illusion ☐ Do not know

How can one prevent HIV from spreading?

☐ Practicing safe sex ☐ Using clean disposable syringes only ☐ Using only screened blood for transfusion ☐ Any other_____ ☐ Do not know

Is it safe to perform the following activities with PLHIV?

Sharing utensils	☐ Yes	☐ No	☐ Do not know
Sharing clothes	☐ Yes	☐ No	☐ Do not know
Sharing food	☐ Yes	☐ No	☐ Do not know
Sleeping	☐ Yes	☐ No	☐ Do not know
Hugging/Touching	☐ Yes	☐ No	☐ Do not know
Breathing	☐ Yes	☐ No	☐ Do not know

Is there any treatment for the HIV? ☐ Yes ☐ No ☐ do not know

Can we assess a person by observing that he is HIV positive or not? ☐ Yes ☐ No ☐ do not know

Is AIDS is the disease of aged persons? ☐ Yes ☐ No ☐ do not know

Is HIV a communicable disease? ☐ Yes ☐ No ☐ do not know

Do you think HIV and AIDS is a problem of a specific place/area? ☐ Yes ☐ No ☐ do not know

Do you think an HIV positive person can live a normal life like others? ☐ Yes ☐ No ☐ do not know

RESULTS/RECOMMENDATIONS: (By assessor)

_____

_____

_____

_____

Assessed By:	**Checked/recommended by**	**Approved by**
Name:	Name:	Name:
Designation:	Designation:	Designation:
Signature:	Signature:	Signature:
Date:	Date:	Date:

LABORATORY TEST REPORT

SSR_____

CHBC site_____

Name_____

Age_____ Sex_____

Referred from _____ Referred by_____

Date_____

TEST	RESULT	
HIV	Reactive	☐
(Rapid test)	Non-reactive	☐

Lab Technician:

Name_____

Signature_____

Date_____

Stamp_____

ACTIVITY REPORT (Narrative)

SRR _____ CHBC Site _____

Name of the activity _____

Venue_____ Date_____ # of participants _____

# of PLHIV (with Family #) _____ _____

# of family members of PLHIV _____ Others_____ _____

Proceedings (supported by pictorial evidence): (Can stretch space to required # of pages)

Recommendations/Remarks/Next steps:

Name_____ Designation _____ Signature_____

Note: Kindly attach participants' attendance sheet

CHBC GROUP ACTIVITY ATTENDANCE SHEET

Name of the Activity_____

SSR _____ CHBC Site _____ Date _____

Sr.#	Name of participant	Category			Relation with PLHIV	Profession	Gender M/F/H	Age	Signature
		PLHIV	Family	Other					

Comments by the facilitator:

_____

_____

Activity conducted by:

Name _____ Designation _____ Signature _____

Verified by:

Name _____ Designation _____ Signature _____