



**ZIMBABWE**

# **Republic of Zimbabwe**

## **NATIONAL COMMUNITY AND HOME BASED CARE STRATEGIC PLAN 2010 - 2015**



## **NATIONAL CARE AND SUPPORT PROGRAMME**

NOVEMBER 2010

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## Foreword

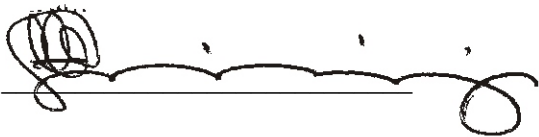
For the past 25 years Home based care has been offered to clients with chronic and terminal illnesses in Zimbabwe. Due to the mature nature of HIV in the country, most clients including children under C&HBC have HIV related illnesses. The C&HBC programme has evolved to ensure a continuum of care to adult and children with chronically and terminally illnesses such as cancer, hypertension and its complications, diabetes, epilepsy, mental illness and HIV and AIDS. The elderly have also been catered for under C &HBC.

The introduction of ART in 2004 and the increase in chronic conditions such as mental illness and cardiovascular conditions has expanded the focus of C & HBC from purely care of the terminally ill to include prevention, treatment and psycho-social support. Similarly due to the increasing child morbidity and mortality C&HBC has integrated child and adolescent care into the programme.

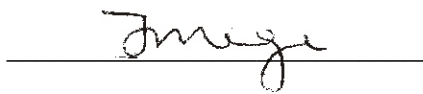
Homed based Care has been called upon to utilize all available resources in the home and community as well as the health institutions in its endeavour to provide comprehensive services to clients hence a change in terminology to community and home based care .

To achieve national commitments towards universal access to HIV prevention, treatment, care and support the government of Zimbabwe has continued to foster collaboration and support among C&HBC stakeholders in the implementation of innovative community and home based care interventions. The National C&HBC Strategic plan has been developed with a focus of strengthening a community and human rights based care approach that is gender sensitive to all through active participation of all appropriate key stakeholders at all levels including children and young people. It is only through the strategic partnerships of key stakeholders that clients including children and young people with chronic and terminal conditions will access comprehensive services to improve quality of life and reduce mortality.

It is hoped this strategy will provide the Zimbabwean Government and its C&HBC stakeholders a useful framework through which the C&HBC programme will be implemented monitored and evaluated. We call upon all C&HBC stakeholders to use this strategic framework so as to make C&HBC in Zimbabwe a success.



Brigadier General (Dr) G. Gwinji  
Secretary for Health & Child Welfare



Dr T. Magure  
CEO National AIDS Council

## Definition of Key Terms

Key Term	Definition
<i>Antiemetic</i>	Drug that is effective against vomiting and nausea
<i>Communicable Diseases</i>	An infectious disease that can be transmitted from one individual to another either directly by contact or indirectly by fomites and vectors.
<i>Community</i>	A specific group of people, often living in a defined geographical area, who share a common culture, values and norms.
<i>Community Based Care</i>	Care that the consumer can access nearest to home, which encourages active participation by the community, responds to the needs of people, encourages traditional community life and creates responsibilities.
<i>Continuum of care</i>	Comprehensive multi-level response from the hospital to the home and vice versa, covering a wide range of medical, emotional and social support needs of chronically ill clients and their families. To establish a continuum, diagnosis has to be made that provides for further care and support.
<i>Evaluation</i>	The systematic collection of information about program activities, characteristics, and outcomes that determines the merit or worth of a specific program. Evaluation studies provide credible information for use in improving programs, identifying lessons learned, and informing decisions about future resource allocation.
<i>Goal</i>	The higher order aims of the program or project, to which the intervention is intended to contribute.
<i>Home Based Care</i>	Any form of care given to sick people in their own homes.
<i>Monitoring</i>	Routine tracking and reporting of priority information about a program and its intended outputs and outcomes.
<i>Narcotics</i>	Drugs that relieve pain.
<i>Need</i>	These are necessary requirements for a Community and Home Based Care (C&HBC) client such as and vocational training, food, health, shelter, water and sanitation, psychosocial support, and basic care.
<i>Non Communicable Diseases</i>	Illnesses caused by something other than a pathogen. It might result from hereditary factors, improper diet, smoking, or other factors. Others are as a result of affluence for example hypertension, diabetes, cardiovascular disease, cancer, and mental health problems, asthma, atherosclerosis, allergy to mention a few.
<i>Operational Research</i>	The application of systematic research and evaluation techniques to improve programs and service delivery. This application analyzes only factors that are under the control of program managers, including indicators of program success, such as improving the quality of services, increasing training and supervision of staff members, and adding new service components. It is designed to assess the accessibility, availability, quality, and sustainability of programs.
<i>Opioids</i>	Chemical substance that has a morphine mainly used for pain relief.
<i>Primary Caregiver</i>	Often a volunteer or family member who works with the C&HBC client to share information about health practices, provides some basic care and work closely with the secondary caregiver for other services.
<i>Programme</i>	A system of projects or services intended to meet C&HBC client needs.
<i>Pruritis</i>	Relates to itchiness which might be due to a rash, diabetes mellitus or other infection.
<i>Secondary Caregiver</i>	A trained person, often a volunteer who works with communities and families to share information about health practices, provides some simple treatments and refer clients to clinics/ service providers for other services.
<i>Strategy</i>	A long term plan of action designed to achieve a particular goal.
<i>The Three Ones Principles</i>	These are the principles which were identified through a preparatory process at global and country levels, initiated by <b>UNAIDS</b> in cooperation with the World Bank and the Global Fund to respond to AIDS, Tuberculosis and Malaria and have been further refined in dialogue with other key donor partners. The three ones consist of: <ul style="list-style-type: none"> <li>• <b>One</b> agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners.</li> <li>• <b>One</b> National AIDS Coordinating Authority, with a broad based multi-sector mandate.</li> <li>• <b>One</b> agreed country level Monitoring and Evaluation System.</li> </ul>
<i>Village Health Worker</i>	These are trained to offer primary health care at the village level.
<i>Volunteer</i>	Someone who works for a community primarily providing any service of one's own free will, without solicitation or compulsion because they choose to do so.
<i>Volunteer Management</i>	It is an effective process through which volunteers are engaged. The process starts from planning of a volunteer programme, recruitment and selection and volunteer support such as orientation & training, supervision & evaluation and recognition.

## **Acknowledgements**

The National Community and Home Based Care Strategy is a collaborative effort of national Community and Home Based Care stakeholders who were consulted at various stages. The coordination of the development of the Strategic Plan was spearheaded by the Ministry of Health and Child Welfare (MOHCW) and the National AIDS Council (NAC) with technical support from the World Health Organization and UNICEF.

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## **Acronyms**

AIDS:	Acquired Immuno-Deficiency Syndrome
ART:	Antiretroviral Therapy
CBO:	Community Based Organisation
C&HBC:	Community and Home Based Care
CSO:	Civil Society Organisations
DAAC:	District AIDS Action Committee
DHE:	District Health Executive
DHT:	District Health Team
DNO:	District Nursing Officer
FBO:	Faith Based Organisation
HBC:	Home Based Care
HIV:	Human Immuno-deficiency Virus
IEC:	Information Education and Communication
M and E:	Monitoring and Evaluation
MoHCW:	Ministry of Health and Child Welfare
NAC:	National AIDS Council
NATF:	National AIDS Trust Fund
NEDICO:	New Dimension Consulting
NSAID:	Non-Steroidal Anti-Inflammatory Drug
NGO:	Non Governmental Organisation
OI:	Opportunistic Infection
PHC:	Primary Health Care
PWD:	People With Disabilities
PLHIV:	People Living With HIV
VHW:	Village Health Worker
STEPS:	STEPwise approach to Surveillance
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
TBA:	Traditional Birth Attendant
WFP:	World Food Programme
WHO:	World Health Organisation
ZNASP:	Zimbabwe National HIV and AIDS Strategic Plan

## **Executive Summary**

In Zimbabwe, C&HBC plays a significant role in the response to HIV and other chronic illnesses. C&HBC provides the much needed continuum of care for chronically ill clients including those with HIV related illnesses. With the introduction of antiretroviral therapy and treatments for other chronic conditions C&HBC no longer focuses only on palliative care for the terminally ill but also provides prevention, treatment, care and psycho-social support for both children and adults. For C&HBC programmes to provide comprehensive services it is essential that strategic partnerships are maintained amongst stakeholders who include clients, their families, the community, the MOHCW and other relevant government departments, donors, FBO, private sector and civil society. C&HBC programme should provide gender sensitive services utilizing a community and human rights based care approach which prioritizes involvement of the clients including children and young people in their care.

The National Review of C&HBC of 2006 highlighted the disparities of the services that were being provided in the different districts of the country in terms of coverage and, comprehensiveness. MOHCW and NAC set up to develop the National C&HBC Strategic Plan to provide a framework through which C&HBC will be provided to all chronically ill clients in the country. The strategy was developed through a consultative process involving all key Community and Home Based Care (C&HBC) stakeholders and service providers in the country. In addition a documentation review was done that provided background information on C&HBC and various chronic illnesses in Zimbabwe.

The strategy focuses on chronic illnesses caused by both communicable and non communicable diseases such as, HIV related illnesses, TB, cancer, hypertension, epilepsy, stroke, cardiovascular conditions and mental illnesses. The strategy also recognizes the special needs of children and adolescents living with chronic conditions including those with HIV

The implementation timeframe of this strategy is from 2010 to 2015.

The C&HBC Strategy is presented as follows:

**Goal**

To contribute towards an improved quality of life for chronically ill clients including children and adolescents and their families through the provision of standardized and comprehensive care at community and home level in Zimbabwe.

**Objectives of the Strategy**

- To improve access to C&HBC services by chronically ill clients including children and adolescents in Zimbabwe from 35% to 85% by 2015;
- To improve the quality of care for C&HBC clients through use of minimum standards and comprehensive services
- To support and motivate secondary caregivers
- To facilitate evidence based C&HBC programming in Zimbabwe

**Guiding Principles**

- Multi-Sectoral Approach
- Participatory Approach
- Holistic and Comprehensive Care
- Sustainability
- Ethical and Human Rights Based Care
- Accountability
- MIPA
- Gender equity
- Child & Youth Friendly Approach

**Implementation**

- Implementation Strategies
- Coordination & Implementation
- Implementation Plan
- Resource mobilization
- Monitoring and Evaluation
- Strategy Budget

**Strategies**

*Supportive operating environment and Volunteer Management*

*Adoption, Dissemination and Implementation of national C&HBC guidelines and policies*

*Coordination and Strategic Partnerships*

*Operational Research and Documentation*

## I. Introduction

The practice of Community Home Based Care (C&HBC) has been in existence for several decades. In Zimbabwe structured community home based care targeting individuals with chronic illnesses such as cancer, hypertension and its complications, diabetes, epilepsy, mental illness and , etc has existed for over twenty five years. . The National AIDS Policy of 1999, The National Review of CHBC of 2006, The National ART Review called for concerted effort to ensure that HIV clients get comprehensive care in the community and in the home. In response to the increase in non communicable diseases which are now one of the major cause of death among Zimbabweans (National Health Strategy for Zimbabwe 2009-2013, National Step wise Survey for Zimbabwe of 2005, the World Health Report of 2000), it was critical that the community home based care programme be strengthened in order for the people living with these conditions to benefit from community services and to get support from the home/family. In line with the Global trends Zimbabwe's focus is Community and Home Based Care (C&HBC) to maximize on available care and treatment resources

The mature nature of the HIV epidemic as it progresses to its fourth decade in the country; and with the availability of treatment and as we move towards universal access of care and treatment it is thus critical to revisit the national care and treatment strategies to bring them up to date with current evidence based knowledge and practices which include community and home based care. As non communicable diseases reach epidemic levels, the Zimbabwe StepWise Survey showed a high prevalence of modifiable risk factors of NCDs. It is therefore prudent to learn from the experience of the HIV & AIDS epidemic to bring to the fore practices that offer the best quality of care for chronic diseases so that they take responsibility for their lifestyles behaviour and care and management of their condition within the spirit of primary Health Care (PHC)

The ART programme, increase in cancer, mental health, diabetes mellitus, cardiovascular conditions such as hypertension has revolutionized C&HBC, creating more demand for C&HBC as this has become an entry point for prevention, treatment, care and support. In view of the above occurrences the Ministry of Health & Child Welfare and NAC have developed this strategy in consultation with other stakeholders to guide implementation of the programme. The strategic plan draws from the present programmatic situation and draws from experiences of various implementers hence it will ensure the provision of quality C&HBC services to clients.

### **The present Community and Home Based Care Situation**

The Community and Home Based Care in Zimbabwe plays a significant role in the response to HIV and other chronic illnesses. The majority of care at community and home levels is provided by women and more recently children who perform care duties with limited training and resources. Commonly provided C&HBC services include provision of nutritional support to clients, training of caregivers and access to AIDS related treatment.

Community and Home Based Care Programmes focus on ensuring that communities have capacity to provide care for their chronically ill. These programmes emphasise the need for community involvement and participation to foster community support and ownership in all service areas. Male involvement in C&HBC activities has been increasing over the past years. However, there have been some areas of concern raised, which include domination of male caregivers in leadership, men demanding better incentives compared to women on the basis that they traditionally are breadwinners. Children and youth involvement has also been on the increase; however this group is often left out in C&HBC training and other relevant programmes. People living with chronic conditions play a significant role in C&HBC. Furthermore People Living with HIV (PLHIV) facilitate in lobbying and advocacy and contribute positively to the reduction of stigma and discrimination for the affected and infected (HDN and SAfAIDS, 2008). Findings from the National Review of Community Home Based Care and Access to Treatment Services in Zimbabwe (2006) highlighted the following areas from which the Strategy is informed; *Training and Capacity, Volunteer Management, C&HBC Guidelines, Male and youth involvement, C&HBC and Testing and Counselling linkages, C&HBC Coordination Mechanisms, Information Sharing and Dissemination, Standards of C&HBC, Monitoring and Evaluation.* These findings play a significant part in informing this strategy.

Meanwhile funding for C&HBC remains low and this has been exacerbated by the socio economic decline experienced in the last decade affecting the health care delivery systems. In addition issues on C&HBC activities coordination, monitoring and evaluation need to be addressed. It is the intention of this strategic Plan to address these challenges. Furthermore issues surrounding advocacy and understanding of the programme will inform the strategic plan

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<sup>1</sup>MoHCW ,NAC, WHO (2006) National Review of Community Home Based Care and Access to Treatment Services in Zimbabwe

*The Government of Zimbabwe with the support of civil society organisations has created an enabling policy environment to address provision of C&HBC services. In the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010, C&HBC has been identified as a key component. In addition, the National AIDS policy recognizes C&HBC as an extension of the health-care delivery system that has to be fully developed and supported as an essential component of the continuum of care for People Living with HIV (PLHIV). Zimbabwe continues to witness a decline in the prevalence of HIV from 24.6% in 2003 to 13.7% in 2009 in adults aged 15 to 49 years. To date over 247000 are accessing ART. In this light, the National Plan for the nationwide provision of antiretroviral therapy (2008-2012) acknowledges the role played by communities in Antiretroviral Therapy (ART) follow up. The plan identifies the need to harmonize Community Health Workers training materials into a national standard Community Health Worker training programme. Furthermore to implement the C&HBC programme other related policies and guidelines that the country has produced such as The National Plan of Action for Orphans and Vulnerable Children (2005), The National Behavioral Change Strategy: For prevention of Sexual Transmission of HIV (2006-2010) and The National HIV Testing and Counselling Strategic Plan (2008-2010) will be tapped into.*

Other communicable diseases such as Tuberculosis and STIs will continue to increase, with TB having been reported to 138,866 cases (new and lapsed). TB is the commonest cause of death among PLHIV (Health Information Department, 2004). Community home based care needs to have a strategy of reducing the high burden from TB through prevention of TB and support for clients on DOTS, infection control in the home and provider initiated testing and counselling in relation to the co infection of HIV and TB

## **I.1 Rationale for the National C&HBC Strategy**

The Zimbabwe National Strategic Plan (ZNASP) of 2006- 2010 acknowledges the need for comprehensive community and home based care as a continuum of care for clients with chronic illnesses. The review on C&HBC programmes conducted by Ministry of Health and Child Welfare (MoHCW) and National AIDS Council (NAC) found out that there was at least one C&HBC programme in each district with differences in quality and distribution of services. The disease status and the developments in treatment have called upon the C&HBC programme to provide prevention, treatment, care and support services that include palliative care to deserving clients. The Plan for Nationwide Provision of Antiretroviral Therapy (2008-2012) has highlighted the importance of strengthening of community participation and C&HBC as an essential strategy for supporting clients in the communities that they reside in. The MOHCW and NAC has developed the C&HBC strategy in order to provide a framework from which stakeholders will be guided in the provision of quality and standardised services to all deserving clients in the country while ensuring strategic partnerships with all critical stakeholders.

### **The Strategy Development Process**

The development of this strategy was done through a participatory and consultative process with all key C&HBC stakeholders involved in workshops. The workshops provided a platform to discuss key issues on C&HBC that needed to be addressed. Following the workshops C&HBC guidelines were developed with the aim to standardize C&HBC programmes nationally. A documentation review was also done to provide background information on C&HBC and various chronic illnesses in Zimbabwe. The strategy was developed using key themes that had been identified in the guidelines and gaps identified by the C&HBC assessment, and guided by the National Health Strategy (2008-2013).

## 2 The Strategy

### 2.1 Goal

The overall goal of this strategy is; “*To contribute towards an improved quality of life for chronically ill clients and their families through the provision of standardized and comprehensive care at community and home level in Zimbabwe.*”

### 2.2 Strategic Objectives

The **objectives** are:

- i. To improve access to C&HBC services by chronically ill clients in Zimbabwe from 35% to 85% by 2015
- ii. To improve the quality of care for C&HBC clients through use of minimum standards and comprehensive services ;
- iii. To support and motivate community home based caregivers/secondary caregivers to provide C&HBC to all chronically ill clients in Zimbabwe
- iv. To facilitate evidence based programming in the C&HBC programme in Zimbabwe

### 2.3 Guiding Principles

The implementation of this strategy is guided by the following principles;

- **Human Rights Based Care Approach:** All chronically ill clients should have equitable access to a minimum package of support regardless of their condition, background and circumstance. Human rights and client confidentiality in the provision of C&HBC services should be observed.
- **Multi-Sectoral Approach:** A multi-sectoral approach and the establishment of strategic partnerships will be utilized to ensure an effective national response to address C&HBC services.
- **Participatory Approach:** active participation of families, communities and C&HBC clients and stakeholders in decision making and other processes that affect provision of health care at home and community level will be promoted. People living with chronic illnesses including PLHIV shall be empowered to play an active role in the planning, monitoring and implementation of C&HBC programmes. The elderly, male and youth/ children involvement will be given a deliberate emphasis in the whole process of implementing this strategy.
- **Holistic and Comprehensive:** In order to improve quality of life; physical, mental, psychological, social and spiritual aspects of care shall be provided to the client and family in a holistic manner where all age groups and gender are involved. Prevention will be part of comprehensive care, targeting both the HIV negative and positive.
- **Sustainability:** Community ownership, through active participation of clients, communities and other key stakeholders recognizing their various needs and capabilities will be the prerequisite for sustainable C&HBC service provision.
- **Accountability:** Promoting accountability in C&HBC .
- **Complementarity:** C&HBC will compliment public health delivery systems to the community in order to ensure a continuum of care.
- **Gender Equity:** there will be equal access, responsibilities and opportunities to women and men, girls and boys.
- **Child and youth friendly services:** the C&HBC programme should be sensitive to the needs of children and youths and ensure appropriate services are provided

### 2.4 Priorities

#### Priority Diseases for C&HBC

There are several communicable and non communicable diseases that require C&HBC services that include;

- HIV related illnesses

- TB;
- Cancer;
- Hypertension;
- Epilepsy;
- Stroke;
- Cardiovascular conditions;
- Mental Illness;

## 2.5 Strategies

### 2.5.1 Strategic Objective I:

**Improve access to C&HBC services by chronically ill clients including children in Zimbabwe from 35% to 85% by 2015**

#### **Strategies and Activities**

#### 2.5.1.1 Mapping of the national C&HBC Programme

Mapping of the C&HBC programme will be done to identify C&HBC partners and their activities and identify those with comparative advantage to establish strategic partnerships. Mapping will focus on both geographical coverage and programmatic services provided to the clients. Mapping will also enhance referral facilities and pathways and identify gaps in coverage and service provision and facilitate extension of services to areas of need. Regular updates of the intervention mapping will be done on a two yearly basis to continuously guide on progress and highlight needy areas. The C&HBC Atlases will be distributed to the varied stakeholders who include implementers, donors and policy makers.

#### **Outputs**

1. C&HBC Intervention Atlases updated regularly and distributed to stakeholders
2. Increased coverage of programmes through increased strategic partnerships

#### 2.5.1.2 Capacity Building of the service Providers in Community and Home Based care

Due to the change in focus of C &HBC, caregivers are called upon to deliver quality prevention, treatment care and support programmes. C&HBC programmes therefore need to upgrade the training that is offered to caregivers. To be able to offer the more comprehensive training, a harmonized training package will be developed for use in training of caregivers. The training package will be printed and distributed widely to ensure that C&HBC training becomes standardized. Distribution of the National C&HBC Training Package will be preceded by an orientation meeting for stakeholders and supervisors of C&HBC programme. The Training Package will be reviewed regularly to ensure updates on emerging issues.

Training of Trainers (TOT) will include community nurses and personnel from Community Based Organisations and will be done utilising the newly developed training package. The strategy will ensure that every district of the country has at least three trainers. To ensure that comprehensive training is provided to the clients, trainers will cascade training to the grassroots level secondary caregivers to include the new emerging issues. Training will be expanded to the primary caregiver to be assured of correct treatment and care 24 hours a day even in the absence of a secondary caregiver.

Various C&HBC service providers are supervising the caregivers at diverse intervals using different methods. This strategy focuses on ensuring that there is constant supervision and mentoring among service providers so that clients receive the expected comprehensive services. The C&HBC programme will;

- Develop standard tools for supervision and mentoring;
- Identify supervisors for Community Health Workers (CHW) and caregivers;
- Capacity build supervisors of community health workers regarding the C&HBC programme and
- Develop plans to support, supervise and mentoring through provision of resources and other logistical support.

## Outcomes

1. Increased caregivers with up to date knowledge on C&HBC services
2. Increased number of clients receiving comprehensive services

### 2.5.1.3 To Mobilise Resources for C&HBC Programme Support and implementation

The National Review of C&HBC of 2006 highlighted resource shortages that are faced by the C&HBC programmes. Due to lack of these resources some programmes have not been able to provide comprehensive services as is expected. It is therefore essential that the programme develops fund raising strategies to ensure that the programme gets well resourced and is supported by both local and international funders.

This strategy will seek to conduct regular mapping updates of the C&HBC programme to highlight programme coverage and type of services provided by the different implementing partners. This will inform the programme on gaps in terms of geographical and service provision and give an indicator of what the programme needs to raise funds for.

NAC and MOHCW in conjunction with the national C&HBCTWG will define the resource gaps. The resource gap should be comprehensive enough to cover the programme coverage as well as the material and human resources to address the gaps.

Advocacy meetings will be conducted with the legislators especially targeting the Parliamentary Portfolio on Health for increased public support for the programme. The advocacy meetings will share both the funding gaps as well as the costed C&HBC National Strategic Plan

Meetings with partners will be conducted to share the costed National C&HBC Strategic Plan and this should include funding partners who are already partnering with C&HBC implementers such as ESP, Global Fund and other such donors.

## Outputs

1. Increased funding base for the C&HBC programme

### 2.5.1.4 To improve linkages between C&HBC and other key services in the provision of prevention, treatment, care and support to chronically ill clients

Chronic illnesses that include HIV produce negative effects that go beyond the health sector and also beyond the client's family. It is therefore important that partnerships be fostered in C &HBC programmes to harness those partners who can support clients with varied expertise and resources. C&HBC is considered as a continuum of health service hence the programme has to be well linked to the MoHCW for technical support, supervision, guidance and referrals. The partnership with public sector is not limited to MoHCW as other public sectors also contribute to the success of C &HBC. Such public sectors include the Ministry of Agriculture and Public Service & Social Welfare among others who can assist with food security issues and orphans and vulnerable children's (OVC) issues as well as social welfare services respectively as appropriate. C &HBC programmes can engage the private sector in issues of support for treatment as well as provision of HBC support for their workers and families among other issues. PLHIV associations are also essential for emotional support and expert patients' services among other services that they provide.

There are various sectors providing C&HBC services in the country at various levels. However, there is lack of linkage among service providers resulting in services provided not standard and comprehensive to clients. Thus this strategy seeks to identify key C&HBC service providers in the country and harmonize national plans of actions on C&HBC in order to identify the key priority areas.

#### 2.5.14.1 Strengthen Partnerships and Coordination Structures at District Ward and village levels

- **Mapping of C&HBC partners and their activities** will be done and identification of those with comparative advantage to establish strategic partnerships. Mapping will also enhance referral facilities and pathways

- The programme will seek to review the activities of the DHT, the DAAC, WAAC and VAAC in relation to the C&HBC programme. The strategy will foster closer linkages of the different coordination mechanisms in relation to programme support.
- Facilitating meetings between the DHT members and DAAC for planning and fostering of strategic partnerships for support of the programme
- Facilitate regular meetings for WAAC that prioritizes the C&HBC programme as part of their agenda.
- Convene regular partners/stakeholders forum at all levels for joint C&HBC programme planning, and monitoring and evaluation

#### **2.5.1.4.2 Strengthen Referral Systems**

For the C&HBC programme to provide comprehensive prevention treatment, care and support services there is need for referral to varied appropriate services within the communities where the HBC programme is based as well as to health institutions. The programme will create awareness among all stakeholders on the need for referral and facilitate referral services

- The programme will map out referral facilities that include health institutions and community based services including the resources that are needed to facilitate smooth referral of clients amongst the varied stakeholders
- The strategy will facilitate the provision of resources for support of referral activities
- The strategy will ensure that community health workers are trained for support of the C&HBC programmes
- Community based caregivers to be capacity built with reference to referral of C&HBC clients
- The Discharge Planning Guidelines will be reviewed and updated
- The strategy will facilitate the expansion and strengthening of implementation of the Discharge Plan
- C&HBC programme to foster strategic partnerships and linkages with health centres for ART, HTC, PMTCT, STI, Nutrition and TB & HIV management that are critical in ensuring clients receive comprehensive services. A system to be established for referral of ART, PMTCT and other such to the C&HBC. Linkages will also be fostered with the BCC programme. A system of monitoring referral and linkages to be established
- The strategy will create strong linkages with programmes that provide nutrition support. The programme will seek to strengthen the relationship between C&HBC and major food donors such as WFP. The programme will present the identified needs on nutrition supplementation to WFP and other nutrition supporting donors or CSOs. Plans for clients' nutrition supplementation will be done in collaboration with MOHCW Nutrition department who will provide the technical support.
- The programme will strengthen linkages or link up clients for support with food security initiatives through The Ministry of Agriculture and Rural development, Food and Agricultural Organization and other relevant CSOs.
- The strategy will advocate for support of clients by communities and family members through community mobilization. Community participation and involvement will ensure programme sustainability. The strategy will ensure that the community is informed about the programme and how their support is valued.
- The programme will strengthen the Involvement of PLHIV & Chronically Ill in C&HBC programmes. There is some evidence to the effect that the involvement of PLHIV and chronically ill in programme management yields some positive results especially on issues of advocacy and lobbying and for reduction of stigma and discrimination in communities where clients live. Patient experts can also share experiences and support other clients in a more appropriate way. The national Review of C&HBC of 2006 highlighted that a great number of secondary caregivers were PLHIV. There is need for involvement of PLHIV in strategic positions to ensure their needs are addressed while they participate in programming

#### **2.5.1.4.3 Support of primary care givers**

A primary caregiver who is often a family member lives with the sick person and looks after the client for twenty four hours of the day. A friend or neighbour can also be a primary caregiver when the sick person does not live with their family members. Lately children and adolescents have also become primary caregivers as they care for their sick parents and guardians. Even though the C&HBC programme does not encourage children to become caregivers, it is evident that a number of children are doing care work and hence the need to ensure that the needs of these children are met by the programme and to provide infection control measures for them.

- The programme will conduct a needs assessment for primary caregivers with a special focus on child and adolescent caregivers

- The programme will seek to provide for the needs of the caregivers as outlined by the needs assessment and taking into consideration the human rights for both adults and children
- The programme will strengthen the training of primary caregivers on how to care for clients to ensure that clients get qualitative care during the 24 hours of the day
- Primary caregivers will also be trained on counselling and psychosocial support
- Advocacy of the families to avail more than one primary caregiver so that they can exchange in looking after the clients to avoid burn out

#### **2.5.1.4.4 Community mobilization and participation**

The C&HBC programme is built upon the premise that communities own the programme in their areas hence its focus on community mobilization and participation. Communities should be involved in the programme from the planning stage and throughout all the other stages up to monitoring and evaluation. Community mobilization and participation empowers communities to be able to assist their sick and to come up with strategies for sustainability of the projects when donors pull out. Communities will also need to be strengthened to ensure that they are able to cope with programming even without donor support

- Communities will be sensitized on the new focus of C& HBC which encompasses prevention treatment, care and support. A relaunch the programme will be done to ensure stakeholders understand the new focus of the programme
- Advocacy meetings will be conducted with communities for support of primary caregivers of clients on C & HBC and for secondary caregivers assisting clients on the programme-
- CMEIAST
- Support VSO, support volunteer day, palliative care day
- CSOs and community based organizations will be assessed and capacity building will be based on identified gaps

#### **Outcome**

- C&HBC district planning among all key stakeholders;
- Improved coordination among C&HBC service providers
- Community ownership and participation

#### **2.5.2 Strategic Objective 2:**

**To improve the quality of care for C&HBC clients through use of minimum standards and comprehensive services**

##### **2.5.2.1 Operationalisation of national C&HBC guidelines and standards**

The Government of Zimbabwe with the support of civil society organizations has created an enabling policy environment to address provision of C&HBC services. Key national C&HBC policies, standards and strategies include;

- *Curriculum Guidelines for the Training of C&HBC volunteers: June 1997;*
- *Discharge Planning Guidelines for the Chronically ill/ terminally ill patients: 1998;*
- *Community Home Based Care Policy for the Republic of Zimbabwe: 2001;*
- *National Community Home Based Care Standards: 2004;*
- *National Home- Based Care Training Manual 2005; and*
- *National Guidelines on Community and Home Based Care for HIV and other Chronic Conditions, 2009.*

The National C&HBC Strategy has been developed with the aim of providing implementers with guidance for improving the quality of care of C&HBC clients with consideration of the new developments that are occurring in the area of HIV illnesses as well as that of the other chronic illnesses

## Activities

- **Review of C&HBC documents:** The National Review of CHBC&ART Services of 2006 recommended a review and update of the guiding documents. Ministry of Health and Child Welfare and National AIDS Council together with the C&HBC stakeholders will conduct a review of Curriculum guidelines for C&HBC training manuals, discharge plan (1998) and develop the Care giver policy. In developing and updating of the documents, evidence based and upcoming issues will be considered. The C&HBC Training Package will integrate issues of prevention, treatment care and support in line with the new focus of C&HBC.
- **Information Dissemination:** Standardized documents will be distributed to C&HBC providers at all levels. Sensitization and education will also be done providing measures upon which the guidelines and strategy can be used by various stakeholders in providing C&HBC services. It will be prudent that supervisors of community health workers get oriented on the guiding documents including the new focus of C&HBC for them to be able to provide the needed support to the programme.
- **Repackaging Policies and guidelines:** Repackaging will ensure that the guidelines and policies are user friendly at all levels. The Participant training manual will be translated in two main vernacular languages (Shona and Ndebele)
- **Lobbying and Advocacy:** The government will be actively lobbied to ensure enforcement of policies. Regular meetings will be conducted with the legislators to update them of the progress in the programme and to seek for support as appropriate
- **Supportive Operating Environment to** ensure effective C&HBC service provision to chronically ill clients. A communication strategy will be developed to ensure the adoption of guidelines and policies. The communication strategy will encompass the following activities: advocacy, social mobilization and programme communication. The communication strategy will not only focus on programme actors but will also target policy makers, development partners and donors

## Output

1. C&HBC documents revised/developed (The National C&HBC Training Manuals, The Discharge Planning Guidelines, National Volunteer Caregiver Policy)
2. Number of documents printed and distributed to key stakeholders;
3. Number of people reached through sensitisation and education meetings

## Outcomes

1. Improved use of C&HBC guidelines and policies by all key stakeholders;
2. Improved user friendly policies on C&HBC that can be used by stakeholders at all level;
3. Increased understanding of C&HBC policies among key stakeholders.
4. Increased usage of C&HBC policies and guidelines by stakeholders

### 2.5.2.2: To improve the procurement and supply management systems of C&HBC commodities highlight the issue of HBC supplies, procurement and utilization

There is need to ensure that the relevant C&HBC commodities are readily available to the clients through service providers. The C&HBC commodities include Home Based Care Kits, Food Packs, bicycles, motor cycles, writing materials and uniforms are available. Issues of constant supply and maintenance need to be addressed.

The C&HBC TWG has set up a Standard National HBC Kit which guides programmes on what items are critical for the support of clients and their caregivers. The standard kit will be reviewed to be in line with the comprehensive care to be provided. This programme will ensure that:

- C&HBC programmes are mapped and updated regularly,

- Quantification of the HBC Kits needed for all clients will be done on a regular basis
- Research on utilization of kit items will be conducted to facilitate the revision of the Standard Kit
- A plan for distribution of kits will be put in place
- Quantification of the other needs such as bicycles , motor cycles and their spares will also be done according to the C & HBC Mapping results

The programme will develop a system for procurement, distribution and coordination of these C&HBC resources which should be linked to the National Pharmacy procurement and distribution.

- Most of the clients and community need nutritional support for
- Mobilise for support for nutrition support from donors who support the nutrition component and food security initiatives. MOHCW and NAC will conduct meetings to present the gaps in terms of nutrition support as highlighted by the regular mapping of the programme.
- Train health care workers, secondary and primary caregivers on nutrition and food security
- Provide/link clients to nutritional support linkages for children, clients and their families including for therapeutic feeding

## Outputs

- Increased C&HBC supplies
- System in place for procurement and distribution of C&HBC supplies
- Nutritional support for clients on the programme

### 2.5.3 Strategic Objective 3

#### **To support and motivate the community home based caregivers/secondary caregivers to provide C&HBC to all chronically and terminally ill clients in Zimbabwe**

Various responses are available that address C&HBC to chronically and terminally ill clients. The C&HBC programmes are manned mainly by volunteer caregivers. There is no National Volunteer Policy for standardized management of these caregivers.

### 2.5.3 Strategies and Activities

This strategy will be addressed through the following activities:

**2.5.3.1 Volunteer/Caregiver Policy Development and Management:** The programme will develop a Caregiver/Volunteer Policy. The Volunteer/Caregiver Policy will address issues of recruitment, standardisation of training and incentives for volunteer caregivers.

**2.5.3.2 Advocacy and Lobbying** for policy implementation will be done by all key C&HBC stakeholders through the Ministry of Health and Child Welfare to ensure adoption of the Volunteer/Caregiver Policy by government. Advocacy meetings will be conducted with the legislators to facilitate the adoption of the policy. Campaigns will also include putting emphasis on continuous review of policies to be in line with the current changes nationally, regionally and internationally. Advocacy and lobbying will also be conducted with the varied C&HBC stakeholders for their adoption and implementation of the policy.

**2.5.3.3 Capacity Building of Caregivers** will be done in accordance with the National Training Package to ensure that caregivers are able to provide comprehensive prevention, treatment, care and support services. The strategy will

seek to recognize the trained caregivers through accreditation

**2.5.3.4 Caregiver Recognition:** The programme will commemorate caregiver and volunteer days on a regular basis as recognition of the importance of services provided by the caregivers

### Outputs

- National volunteer/caregiver policy developed and disseminated to stakeholders
- Advocacy meetings held with legislators and adoption of policy
- Increased number of trained caregivers with up to date knowledge on C&HBC ;
- Regular commemoration of Caregiver days

### 2.5.4 Strategic Objective 4

**To facilitate Evidence based programming in the C&HBC programme in Zimbabwe**

#### Strategies and Activities

##### 2.5.4.1 Operational Research and Documentation

Several stakeholders participate in C&HBC programmes. The National C &HBC National Review of 2006 highlighted that it was difficult to verify quality of interventions that are being provided by different stakeholders due to non standardization of services. There is need to strengthen operational research and documentation in order to be able to share good practices and to implement evidence based practices. The strategy will also strengthen the monitoring and evaluation of C&HBC initiatives in line with the three ones principle.

##### 2.5.4.1.1 Facilitation of Evidence Based C&HBC Programming

- Identification and documentation of good practices will be promoted
- Regular reviews of the C&HBC programme will be conducted at the national, provincial and district levels
- **Promote conducting of operational research** and delivery of evidence based C&HBC services. Baseline surveys on C&HBC services for chronic illness will be conducted to identify priority interventions. Surveys will target chronically ill clients, C&HBC service providers the government and other key stakeholders through MoHCW. The programme will also focus on strengthening and facilitating researches on C & HBC. Relationship between mental illness and HIV is one area of focus in the research plan .

##### 2.5.4.1.2 Routine Monitoring and Evaluation

- Review and revise existing monitoring, documentation and reporting tools and develop up to date tools for collection of primary data that reflect services provided to clients Data collection tools should feed into the National Monitoring and Evaluation system
- Information from stakeholders to reflect areas that are agreed upon for the programme Indicators should be clear and the programme will promote the use of both quantitative and qualitative data collection tools
- Capacity build the community members on documentation, monitoring and evaluation
- Capacity building of C&HBC key stakeholders to include community health workers, CSO programme officers, on documentation, monitoring, evaluation, record keeping and operational research
- Reporting by stakeholders to be on a quarterly basis and feedback mechanism established

- Strengthening record keeping by capacity building of stakeholders, providing resources for safekeeping of records and setting up electronic database on programme

## **Output**

- Presence of functional and effective C&HBC monitoring, evaluation, research and documentation systems; and
- Improved knowledge on the relationship between PLHIV and other conditions that include mental health assisting programming.
- Programme implementers reports submitted on quarterly basis.
- Mechanism for feedback to implementers functional
- Operational researches carried out and good practices identified and disseminated

### **3. Coordination and Implementation**

#### **3.1 Coordination**

Coordination will be done collaboratively by NAC and MOHCW and will be cascaded down through their structure down to the grassroots level.

#### **3.2 Implementation Modalities**

The C&HBC strategy recognizes that there are several players supporting C&HBC including the Government, FBOs, Private Sector and Civil Society. The implementation of the C&HBC strategy requires strong multi-stakeholder partnerships to ensure comprehensive, integrated and holistic service delivery to C&HBC clients, their families and the community.

The roles of the various stakeholders are presented in the table below.

<b>C&amp;HBC Stakeholder</b>	<b>Roles</b>
<b>Ministry of Health and Child Welfare and National AIDS Council</b>	<ul style="list-style-type: none"> <li>• Coordinate the integrated C&amp;HBC programmes</li> <li>• Develop an overall programme strategy for planning, resource allocation, implementation, and monitoring, evaluation and reporting.</li> <li>• Create partnerships and networks and coordinate with key national partners including networks of PLHIV and the national C&amp;HBC coordination committee.</li> <li>• Ensure the development, implementation and review of C&amp;HBC policies.</li> <li>• Ensure programme operation is within the scope of the ZNASP and national key strategies on chronic illnesses.</li> <li>• Identify communication strategies that will facilitate coordination of all key stakeholders at various levels.</li> <li>• Develop and coordinate the M&amp;E framework</li> <li>• Resource mobilisation</li> </ul>
<b>National C&amp;HBC TWG</b>	<ul style="list-style-type: none"> <li>▪ Provide policy input, guidance and conceptual strategies on C&amp;HBC programme development, management, implementation, monitoring and evaluation</li> <li>▪ Provide analytical review of related C&amp;HBC policies regularly.</li> <li>▪ Provide support on capacity development of partners on the state of the art issues in C&amp;HBC</li> <li>• Provide technical assistance on appropriate resource mobilization strategies in relation to the National CHBC Programming</li> </ul>
<b>Provincial and District Office (Ministry of Health and Child Welfare and National AIDS Council)</b>	<ul style="list-style-type: none"> <li>• Consolidation of an integrated C&amp;HBC community based action plans</li> <li>• Develop a monitoring plan for the C&amp;HBC programme</li> <li>• Convene C&amp;HBC Task Force meetings .</li> <li>• Create and sustain active partnerships at provincial level with private, public sector and CSOs to support the C&amp;HBC Programme</li> </ul>
<b>Rural Health Centre</b>	<ul style="list-style-type: none"> <li>• Develop and implement action plans.</li> <li>• Provide technical support and supervision to implementing partners</li> <li>• Monitor C&amp;HBC programme</li> <li>• Produce programme report and submit to the district office.</li> <li>• Supervision &amp; support to all levels</li> </ul>
<b>NGOs, Private Sector and other implementing partners</b>	<ul style="list-style-type: none"> <li>• Resource mobilization</li> <li>• Develop and implement action plans.</li> <li>• Monitor C&amp;HBC programme</li> <li>• Produce programme report and submit to the district office.</li> </ul>
<b>Secondary Caregivers</b>	<ul style="list-style-type: none"> <li>• Identify chronically ill people in the community.</li> <li>• Mobilize and sensitize the community in order to reduce stigmatization on chronically ill clients.</li> <li>• Conduct home visits.</li> <li>• Provide family members with caring skills</li> <li>• Disseminate information in the community.</li> <li>• Liaise with health and social service providers for referrals where necessary.</li> <li>• Collect community based data and compile reports</li> <li>• Support primary caregivers</li> </ul>
<b>Clients including children and adolescents and their primary caregivers</b>	<ul style="list-style-type: none"> <li>• Participate in care planning</li> <li>• Adherence to treatment;</li> <li>• Infection control;</li> </ul>
<b>Community including community leaders</b>	<ul style="list-style-type: none"> <li>• Identification of community needs</li> <li>• Social mobilization</li> </ul>

The implementation plan is designed to accommodate different partners at national, provincial, and district down to ward levels to play their roles and responsibilities based on their mandates and comparative advantages in addressing various needs of chronically/terminally ill clients including children and young people. Partnerships may take various forms and these will be collaborated within the national health services. Partnerships may include:

- Jointly planning and executing activities . This will include sharing calendar of events and synchronizing common activities with various C&HBC Stakeholders.
- Quarterly meetings and reports will be done at all levels.
- Integration /mainstreaming activities into ongoing programmes.
- Using one national monitoring and evaluation framework

### **3.4 Resource Mobilization**

Resource mobilization is essential for the successful implementation of the C&HBC programme. Funding gaps will be identified and resource mobilisation will focus on filling the existing gaps. All C & HBC stakeholders will play a role in mobilizing resources for the programme.

3.4 The strategy implementation plan is provided in the table below;

Strategy	Broad Activities	Specific Activities	Target	Indicator	Responsible Authority	2010	2011	2012	2013	2014	2015	Budget
<b>Strategic Objective 1 : To improve access to C&amp;HBC services by all chronically /terminally ill clients from 35% to 85% in 2015</b>												
1. Mapping of the national C&HBC Programme	Mapping and /Updating current C&HBC Atlas (assess coverage, trained personnel and type of services)	Revise and develop tools for data collection Collect data Compilation of the atlas Dissemination of atlas to stakeholders nationwide Extend services to areas with identified gaps	3 updates	Atlases printed and disseminated C&HBC coverage by ward determined Number of clients reached by C&HBC	NAC, MOHCW		x		X		X	
2. Capacity Building of Service Providers	Capacity building of service providers	Development and reproduction of training manuals Conduct training of trainers as well of secondary and primary caregivers utilizing the new training package Develop tools for supervision and mentoring Identify supervisors of community health workers and secondary caregivers Conduct training of	Training Manual revised every 2 years Train 850 trainers & refresh 680 trainers 51,000 secondary caregiver s trained	Number of Training Manuals printed Number of community health workers and caregivers trained Number of support and supervision conducted	MOHCW, NAC, C&HBC TWG, C&HBC Implementin g Partners	X	X	X	X	X	X	X



<p><b>4. Coordination and Strategic Partnerships</b></p>	<ul style="list-style-type: none"> <li>• Mapping C&amp;HBC partners and their activities &amp; Resources</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct a nationwide mapping of C &amp; H B C partners</li> <li>• Review and strengthen the operations of the DHT, DAAC, WAAC and VAAC</li> <li>• Convene Partners/Stakeholders forum on C &amp; H B C at various levels</li> <li>• Support a structured establishment of support groups including PLHIV support groups</li> <li>• Map out the referral facilities and referral pathways</li> <li>• Identify the referral needs provide the resources and other support for referral.</li> <li>• Strengthen the implementation of the discharge planning</li> </ul>	<p>various levels Support a structured establishment of support groups including PLHIV support groups Number of structured support groups established and supported</p>	<p>Number of structured support groups established and supported MOHCW, NAC, Implementing partners</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>
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**Strategic Objective 2:  
To Improve the quality of care for C&HBC clients through use of minimum standards and comprehensive services**

5. Operationalisation of C&HBC Guidelines	Review, adoption, dissemination and implement the national C&HBC Guidelines, training packages and standards	Review and Revise the National C & HBC Discharge Guidelines, National Training Package and Volunteer Policy  Repackaging of policies and Guidelines Develop and disseminate the C & H B C communication Strategy Sensitize stakeholders on the revised C&HBC Guidelines Sensitize policymakers and community leaders on the new C & H B C Guidelines	1 of each	# of copies guidelines reviewed revised Number of documents printed and distributed to key stakeholders Communication strategy in place and disseminated  Number of stakeholders sensitized Number of community leaders sensitized	MoHCW and NAC	X	X				
6. Logistics Supply and Management	<ul style="list-style-type: none"> <li>Procure and supply the C &amp; H B C commodities</li> </ul>	Conduct research to review and update the national HBC kit  Quantify the amount of H B C kits and replenishment supplies required  Procure and distribute HBC kits utilizing a distribution plan Procure and distribute bicycles, bicycles spares  Procure and distribute motorcycles for C&HBC supervisors Procure and distribute caregiver uniforms		National HBC Kit updated Quantification of HBC kit supplies records in place Number of HBC kits procured and distributed  Number of bicycles , bicycles spares and motorcycles distributed Number of caregiver uniforms supplied  Maintenance	MOHCW, NAC, National C&HBC TWG, CSOs	X	X	X	X	X	X



**Strategic Objective 3:  
To support and motivate community home based caregivers**

Caregiver motivation	<ul style="list-style-type: none"> <li>To support and motivate caregivers in C&amp;HBC</li> </ul>	<ul style="list-style-type: none"> <li>Production and dissemination of caregiver policy to Varied stakeholders</li> <li>Integrate caregiver incentives in C&amp;HBC Programme</li> <li>Standardize criteria for volunteer caregiver recruitment</li> <li>Standardize incentives for caregivers</li> <li>Conduct meetings with MOHCW and Parliamentary Portfolio on Health &amp; other stakeholders to lobby for support of caregivers. Utilize caregiver Policy document</li> <li>Provide standard Training for all caregivers utilizing the National C&amp;HBC Training Package</li> </ul>		<p># of caregiver policy copies disseminated</p> <p>Number of meetings conducted with legislators &amp; motion moved in support</p> <p>Number of C &amp; H B C programme recruiting and complying with Caregiver Policy</p> <p>Number of caregivers receiving standardized training</p>	MOHCW, NAC, C&HBC TWG	X	X	X	X	X	X	
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### **3.5 Monitoring and Evaluation**

The National Community Home Based Care Strategy aims at providing comprehensive and coordinated response in the provision of preventive, care, support and treatment to chronically ill clients through supporting the already existing health service structures.. Monitoring and Evaluation will be done in line with the national M and E framework. The overall goal of monitoring and evaluation is to provide a comprehensive tracking system to collect, enter, analyze, and share information on C&HBC services in Zimbabwe. The national MoHCW office and NAC secretariat will assist district offices to develop and maintain district C&HBC databases. In addition, the national MoHCW office and NAC secretariat will assist the C&HBC stakeholders at national, provincial and district level to establish regular M and E Dissemination and data use mechanisms, including website, electronic and print distribution and annual M&E dissemination meetings, at district, provincial and national levels. The M and E framework will therefore;

- Ensure there is equity, transparency in service provision and access;
- Identify lessons learnt and gaps (programmatic, geographic and financial);

Track implementation of activities that are outlined in the National C&HBC Strategy and determine whether objectives have been achieved

## National Community and Home Based Care Strategy (2010-2015) M and E Plan

Outcome Indicators	Outputs	Output Indicators	Broad Activities	Means of Verification/D ata Source	Partners Responsible	Time Frame (in Years)					
						2009	2010	2011	2012	2013	2014
<b>Strategic Area I: Supportive operating environment &amp; caregiver management</b>											
<b>Outcome:</b> Improving Access to C&HBC Services by chronically ill clients from 35% to 85% in 2015											
Determination of coverage of the C&HBC programme to include number of clients served and type of services provided	<ul style="list-style-type: none"> <li>National C&amp;HBC Atlas of who is doing what and where including resources available</li> </ul>	<ul style="list-style-type: none"> <li>National C&amp;HBC Atlas printed &amp; disseminated &amp; coverage determined</li> </ul>	<ul style="list-style-type: none"> <li>C&amp;HBC Mapping Updates</li> </ul>	<ul style="list-style-type: none"> <li>National C&amp;HBC Atlas in place</li> </ul>	MOHCW, NAC, National C&HBC TWG			X	X	X	
Service providers receiving competencies to provide comprehensive services	<ul style="list-style-type: none"> <li>National Training Package developed &amp; updated on a two yearly basis</li> <li>Training of 850 new C&amp;HBC Trainers</li> <li>Refresh 680 Trainers</li> <li>Training of 51,000 Caregivers</li> <li>Refresher Training for 56,625 Caregivers</li> <li>Training of 85 District Mentors</li> <li>Conduct 765 mentoring visits</li> </ul>	<ul style="list-style-type: none"> <li>Number of Service providers trained</li> </ul>	<ul style="list-style-type: none"> <li>Training Package updated on a 2 yearly basis</li> <li>Training of different service providers</li> </ul>	<ul style="list-style-type: none"> <li>Updated National C&amp;HBC Training Package in place</li> <li>Training Reports</li> <li>Mentoring reports</li> </ul>	MOHCW, NAC, National C&HBC TWG, CSOs		X	X	X	X	X



Outcome Indicators	Outputs	Output Indicators	Broad Activities	Means of Verification/ Data Source	Partners Responsible	Time Frame (in Years)					
						2009	2010	2011	2012	2013	2014
<b>Strategic Area 2: Adoption, dissemination and Implementation of C&amp;HBC national Guidelines and documents; Coordination &amp; strategic partnerships</b>											
<b>Outcome: Improved quality of care for clients through use of minimum standards and comprehensive services</b>											
Proportion of C&HBC Service Providers implementing programmes in line with the national C&HBC guidelines and policies	<ul style="list-style-type: none"> <li>• Repackaged C&amp;HBC policies and guidelines on a 2 yearly basis</li> <li>• Increased knowledge of available policies and guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• No. of repackaged policies and guidelines</li> <li>• No. of dissemination workshops conducted</li> <li>• No. of advocacy workshops conducted</li> </ul>	<ul style="list-style-type: none"> <li>• Information Dissemination</li> <li>• Repackaging Policies and guidelines</li> <li>• Lobbying and Advocacy</li> </ul>	<ul style="list-style-type: none"> <li>• Repackaged policies</li> <li>• Reviewed policies</li> <li>• National C&amp;HBC Quarterly Reports</li> <li>• Workshop Reports</li> <li>• M and E Reports</li> </ul>	MoHCW, NAC, CSOs, UN Agencies and Private Sector	X	X	X	X	X	X
Procurement and distribution of C&HBC commodities	<ul style="list-style-type: none"> <li>• Research on and review national standard CHBC Kit</li> <li>• Procure and distribute a total of 305,200 CHBC kits in 5 years</li> <li>• Procure &amp; distribute 85 motorcycles for supervisors</li> <li>• Mobilize for nutrition support and train households on nutrition</li> <li>• Link up clients with IGAS</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>							

Outcome Indicators	Outputs	Output Indicators	Broad Activities	Means of Verification/ Data Source	Partners Responsible	Time Frame (in Years)					
						2009	2010	2011	2012	2013	2014
<b>Strategic Area 3: Supportive operating environment and Volunteer Management</b>											
<b>Outcome: Improved C&amp;HBC operating environment and Volunteer Management</b>											
Improved C&HBC operating environment	<ul style="list-style-type: none"> <li>Production and dissemination of Caregiver Policy &amp; updating on a 2 yearly basis</li> <li>Standardized Training Package for caregivers</li> <li>Advocacy meetings with MOHCW &amp; Parliamentary Portfolio on Health &amp; other stakeholders on a yearly basis</li> <li>Standardized incentives for volunteers</li> <li>Commemorative days</li> </ul>	<ul style="list-style-type: none"> <li>Caregiver Policy in place &amp; updated</li> <li>National Training Package in place &amp; updated on a 2 yearly basis</li> <li>No of implementers utilizing policy</li> <li>No of caregivers capacity built</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy and lobbying of policy implementation and review</li> <li>Volunteer Management; Issues of standardisation of incentives for caregivers</li> <li>Capacity Building; Training of caregivers to include new emerging issues.</li> </ul>	<ul style="list-style-type: none"> <li>Reviewed policies</li> <li>Policy implementation Reports</li> <li>Caregiver Capacity building Reports</li> <li>Monitoring and Evaluation Reports</li> <li>National Harmonized Training Package developed and updated</li> </ul>	Government, CSOs, Private Sector, UN Agencies, C&HBC clients, Volunteers	X	X	X	X	X	X
Improved Volunteer Management											

Outcome Indicators	Outputs	Output Indicators	Broad Activities	Means of Verification /Data Source	Partners Responsible	Time Frame (in Years)					
						2009	2010	2011	2012	2013	2014
<b>Strategic Area 4: Operational Research and Documentation</b>											
<b>Outcome: Evidence based C&amp;HBC programming</b>											
Proportion Stakeholders using evidence based C&HBC programming	<ul style="list-style-type: none"> <li>Robust operational research agenda</li> <li>Documented C&amp;HBC processes/activities, good practices and lessons learnt</li> </ul>	<ul style="list-style-type: none"> <li>No of operational studies conducted</li> <li>Number of C&amp;HBC documentation produced</li> </ul>	<ul style="list-style-type: none"> <li>Research, documentation and delivery of evidence based C&amp;HBC services.</li> </ul>	<ul style="list-style-type: none"> <li>Operational research reports</li> <li>C&amp;HBC processes/activities, best practices and lessons learnt documents</li> <li>C&amp;HBC Intervention Strategies</li> </ul>	Government, CSOs, C&HBC clients, UN Agencies, Community Representatives	X	X	X	X	X	X

### 3.6 Strategy Budget

Strategies	Activities	Proposed Budget (US\$)	
<b>1. Adoption, Dissemination and Implementation of national guidelines and policies</b>	<b>C&amp;HBC</b>	• Development of Communication Strategy. Technical support for 30 days	9,000.00
		• Printing of 200 copies of the communication Strategy	3,000.00
		• Mapping C&HBC partners and their activities & Resources to be done in 2011, 2012 & 2014 with Technical support for 60 days at each time	54,000.00
		• Printing of 3000 copies of C&HBC Atlas	30,000.00
		• Information Dissemination will include one day sensitization meetings with Health Portfolio committee for 50 people yearly for 5 years	6,250.00
		• Lobbying and Advocacy with donors at a day's meeting with 50 people and to be done yearly for 5 years	6,250.00
	• Updating of National C&HBC Training Package & National C&HBC Guidelines 2010, 2012 & 2014. Consultancy for 60 days each year	54,000.00	
	• Printing of 3000 National C&HBC Training Package	75,000.00	
	• Printing of 30,000 Participant Handbook in shona & ndebele	30,000.00	
	• Printing of 3000 National C&HBC Guidelines	30,000.00	
	• TOT of 850 officers: 24 workshops of 5 days duration each with 35 participants and 3 facilitators	414,900.00	
	• TOT refresher for 680: 23 workshops of 30 people for 3 days with 3 facilitators per workshop	186,300.00	
	• Training of 51,000 secondary caregivers for 10 days: 1700 workshops with 30 participants and 3 facilitators	2,797,200.00	
	• Refresher training of 31125 caregivers: 1038 x 3 days workshops with 3 facilitators	2,241,405.00	
	• Training of 85 district mentors in 2 workshops x 5 days with 3 facilitators	204,750.00	
	• 765 mentoring visits for 1530 for 2 trainers for 2 days per person in pairs	45,950.00	
	• Needs assessment with 60 days consultancy	18,000.00	
	• Printing of 3000 Needs assessment reports	15,000.00	
<b>2. Coordination and Strategic Partnerships</b>	• National Level One day Forum meetings quarterly with 25 people	12,500.00	
	• Participation in Provincial Partners/Stakeholders 1 day forum on C&HBC for 20 people conducted on a quarterly basis	10,000.00	
	• District 1 day forum meetings on C&HBC for 15 people conducted on a quarterly basis	3,000.00	
	• Participation in Ward Level Quarterly Meetings for WAAC with 15 people	3,000.00	
<b>3. Supportive operating environment and Volunteer Management</b>	• Advocacy and lobbying of policy implementation and review (costed above)		
	• TOT CMEIAST for 218 trainers: 3 day training with 3 facilitators each for the 7 workshops	64,530.00	
	• CMEIAST Training for 3,880 community leaders: 186 workshops each with 3 facilitators x 3 days	179,820.00	
	• Formation of 1314 support groups of 30 per group. Maintenance of the following support groups per year: 263 in 2011; 526 in 2012; 789 in 2013; 1052 in 2014; 1314 in 2015	315,520.00	
	• Conduct training for 5256 support group members. 131 workshop s x 5 days duration with 4 facilitators per workshop	289,000.00	
	• Training of 170 participants in capacity assessment with 3 facilitators for 6 workshops	51,000.00	
	• Capacity assessment for 680 ASOs: consultancy for 60 days per year for 5 years. Participations of assessment teams in 30 days per year of collecting data	123,750.00	
	• Training of 1275 people x 5 days duration: workshops with 30 participants & 3 facilitators	152,325.00	
	• IEC Material for treatment support: Production of 89,000 ART Tool kits for children	4,450,000.00	
	• Production of 500,000 pamphlets. Will need consultancy for 15 days	600,000.00	
	• Production of 4,500 posters	4,500.00	
	• Cash vouchers for 300,000 PLHIV Households	3,000,000.00	

	<ul style="list-style-type: none"> <li>• Production of 15,000 copies of Caregiver Policy</li> </ul>	150,000.00
	<ul style="list-style-type: none"> <li>• Launch of Caregiver Policy: 1 day national level event with 100 people</li> </ul>	2,500.00
	<ul style="list-style-type: none"> <li>• Volunteer Management; Issues of standardisation of incentives for volunteers and caregivers : Payment of US\$15 per month for the following: 19,950 year 1; 30,150 year 2; 37,350 3<sup>rd</sup> year; 44,550 4<sup>th</sup> year; and 51,750 5<sup>th</sup> year</li> </ul>	33,075,000.00
	<ul style="list-style-type: none"> <li>• Capacity Building; Training of caregivers budgeted in above rows</li> </ul>	
	<ul style="list-style-type: none"> <li>• Procurement of a total of 345,200 HBC Kit: 40,000 in 2010, 63,000 in 2011; 66,000 in 2012; 65,000 in 2013; 60,000 in 2014 &amp; 51,200 in 2015</li> </ul>	11,746,000.00
	<ul style="list-style-type: none"> <li>• Procurement of 85 motorcycles for supervisors of caregivers in 2011</li> </ul>	212,500.00
<b>4 4. Operational Research and Documentation</b>	<ul style="list-style-type: none"> <li>• Promote operational research, documentation and delivery of evidence based C&amp;HBC services. Conduct 5 Operational researches on C&amp;HBC per year from 2011 to 2015. Consultancy for 60 days per year</li> </ul>	85,500.00
	<ul style="list-style-type: none"> <li>• Documentation of 425 good practices per year from 2011 to 2015. 5 good practices per district per year</li> </ul>	22500.00
	<ul style="list-style-type: none"> <li>• Mid Term Review of the National C&amp;HBC Programme in 2013: Needs 60 days consultancy</li> </ul>	72,000.00
	<ul style="list-style-type: none"> <li>• Conduct End of Term Review of the C&amp;HBC Programme in 2015. Will need consultancy for 60 days</li> </ul>	72,000.00
<b>5. Preliminary Budget before M and E</b>		<b>60,926,900.00</b>
6. Monitoring and Evaluation (at 15% of Item 5)	Monitoring by 3 national level staff for 5 days per quarter; provincial level staff monitoring for 3 for 5 days per quarter and district level staff monitoring by 3 people for 5 days per quarter	747,000.00
<b>7. Total Budget</b>		<b>61,673,900</b>

