Republic of Kenya
Ministry of Health

HOME- AND COMMUNITY-BASED CARE IN KENYA

An Implementation Framework for

HOME- AND COMMUNITY-BASED CARE IN KENYA
This publication is one of a series of materials that reflect the Government of Kenya’s concern for and commitment to the fight against the HIV/AIDS epidemic. Books in the series are:

- National Home-Based Care Policy Guidelines
- National Home-Based Care Programme and Service Guidelines
- Training Home-Based Caregivers to Care for People Living with HIV/AIDS at Home – A Curriculum for Training Community Health Workers
- Home Care Handbook
- Home-Based Care Orientation Module for Health Service Personnel and Programme Managers
- National Voluntary Counselling and Testing Guidelines
- Training Curriculum for Voluntary Counselling and Testing
- National Guidelines on Prevention of Mother to Child Transmission of HIV
- National Policy Guidelines on the Use of Anti-Retrovirals
- An Implementation Framework for Home- and Community-Based Care in Kenya
HOME- AND COMMUNITY-BASED CARE FOR PEOPLE LIVING WITH HIV/AIDS

An Implementation Framework
for
HOME- AND COMMUNITY-BASED CARE IN KENYA

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<th>Full Form</th>
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<tbody>
<tr>
<td>ACK</td>
<td>Anglican Church of Kenya</td>
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<tr>
<td>AIDS</td>
<td>Acquired immune-deficiency syndrome</td>
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<td>AOP</td>
<td>Annual operational plan</td>
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<td>ART</td>
<td>Anti-retroviral therapy</td>
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<td>ARVs</td>
<td>Anti-retroviral drugs</td>
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<tr>
<td>CBD</td>
<td>Community-based distributor / distribution</td>
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<td>CBO</td>
<td>Community-based organization</td>
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<td>CCC</td>
<td>Comprehensive care clinic</td>
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<td>CHW</td>
<td>Community health worker</td>
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<tr>
<td>CHEW</td>
<td>Community health extension worker</td>
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<tr>
<td>CORP</td>
<td>Community-owned resource person</td>
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<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>DASCO</td>
<td>District AIDS/STD Control Coordinator</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHBCC</td>
<td>District Home-Based Care Coordinator</td>
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<td>DHP</td>
<td>Division of Health Promotion</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>DMOH</td>
<td>District Medical Officer of Health</td>
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<tr>
<td>DOTS</td>
<td>Directly observed therapy short course</td>
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<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>HBC</td>
<td>Home-based care</td>
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<tr>
<td>HCBC</td>
<td>Home- and community-based care</td>
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<tr>
<td>HIV</td>
<td>Human immuno-deficiency virus</td>
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<tr>
<td>JHPIEGO</td>
<td>Johns Hopkins Program for International Education in Gynaecology and Obstetrics</td>
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<tr>
<td>KANCO</td>
<td>Kenya AIDS NGOs Consortium</td>
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<tr>
<td>KENWA</td>
<td>Kenya Women with AIDS Consortium</td>
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<tr>
<td>KMTC</td>
<td>Kenya Medical Training College</td>
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<tr>
<td>KNH</td>
<td>Kenyatta National Hospital</td>
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<tr>
<td>KRC$</td>
<td>Kenya Red Cross Society</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MIPA</td>
<td>Meaningful involvement of people with AIDS</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NASCOP</td>
<td>National AIDS/STD Control Programme</td>
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<td>NEPHAK</td>
<td>Network of People with HIV/AIDS in Kenya</td>
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<tr>
<td>NGO</td>
<td>Non-government organization</td>
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<tr>
<td>OI</td>
<td>Opportunistic infection</td>
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<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>PHMT</td>
<td>Provincial Health Management Team</td>
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<tr>
<td>PITC</td>
<td>Provider initiated testing and counselling</td>
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<td>PLHA</td>
<td>Person/people living with HIV/AIDS</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother to child transmission (of HIV)</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<td>WEHMIS</td>
<td>WEM Integrated Health Services</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WOFAK</td>
<td>Women Fighting AIDS in Kenya</td>
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The preparation of this Home- and Community-Based Care Implementation Framework has come at a time when the Ministry of Health is shifting its focus through the Community Strategy towards strengthening health care provision at level 1 (the community – villages, households, families, individuals). HCBC is an integral part of the Ministry’s Community Strategy. Care for people living with HIV/AIDS is continually evolving as health service providers respond to the changing needs of clients, families and communities.

More bedridden patients are also recovering and graduating from debility to mobility, thereby becoming active members of their community on life-long anti-retroviral treatment. This calls for the extension of comprehensive care beyond the health facility to the home and community level. The framework presented here reflects that critical change of focus from home-based care to home- and community-based care.

The HCBC framework is a guide to implementers, supervisors and donor agencies. The goal is to ensure the provision of quality care for the HIV infected and other chronically ill people at the home and community level. International and local donor agencies as well as HCBC implementing partners will be required to use this framework for the implementation of HCBC activities in line with the relevant priority areas of their respective districts. Government officials at the various levels will also use the framework to monitor, guide and supervise the implementation of HCBC programmes. With a recommended minimum package for HCBC, rolled out according to a nationally recommended HCBC implementation model, the Ministry expects that standards and quality of care will be upheld.

Through the use of this HCBC guiding framework, implementing partners will reflect the Government’s commitment to ensure that those with debilitating illnesses and those infected and affected by HIV receive a sustainable continuum of care of the highest quality in their homes and in their communities.

**Dr. Francis Kimani**  
Director of Medical Services  
Ministry of Health
NASCOP – National AIDS/STD Control Programme of the Ministry of Health – wishes to acknowledge the efforts put into the preparation of this HCBC implementation framework by various stakeholders. Among others, these include the National AIDS Control Council (NACC) and the Ministry of Health’s Department of Sector Planning and Management, and the divisions of Nursing, Health Promotion and Clinical Medicine. Ministry of Health representatives from Nyanza, Coast and North Rift Valley provinces, Kisumu town, and Siaya, Nakuru and Mwingi districts also made significant contributions.


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This document describes a systematic framework for establishing and maintaining home- and community-based care (HCBC) in Kenya. The framework is intended to guide governments, national and international donor agencies, and civil society organizations in developing or expanding HCBC programmes. Approaches to HCBC are continually evolving in response to the changing needs of patients/clients and their families. In the beginning, most home-based care programmes focused on the care of the sick and family caregivers. As the AIDS epidemic continued to grow, orphan care became a critical concern. And now with the availability of highly effective anti-retroviral drugs (ARVs), more and more people are graduating from being bedridden to being active members of the community on lifelong ARV treatment and in need of comprehensive care.

This poses a major paradigm shift from home-based care (HBC) – the care of a single sickly family member at home – to home- and community-based care (HCBC), which is a broad-based approach rooted in a community’s concern for friends and neighbours in need. The framework is an integral part of the community strategy for strengthening health care at level 1 of the Kenya Essential Package for Health (KEPH) developed by the Ministry of Health. This document describes the elements of a comprehensive HIV/AIDS care package, the minimum care package, the national model for HCBC implementation and actions for strengthening the systems that support the model.

Comprehensive Care Package
People with HIV and other chronic and terminal illnesses have multiple needs that can only be addressed through comprehensive care. Such
Care is continuous from the health facility to the home and community level, and is not simply restricted to treatment. The key elements of comprehensive care include clinical care, nursing care and palliative care. Other aspects are psycho-social support, counselling and HIV testing, and spiritual support. Underlining these are family care and support of orphans and vulnerable children (OVC), and care of the caregivers. Finally, food and nutrition support and education, as well as programme monitoring and evaluation, are critical components.

**Minimum Care Package**
To ensure that the patient and family receive quality care regardless of organizational constraints, a minimum care package has been identified that includes: nursing and palliative care, clinical care that emphasizes treatment literacy and sustainability of care, family care and OVC support, capacity building, and monitoring and evaluation. To ensure that all the elements of the minimum care package are addressed, a strong referral and networking system linking the patient and family to other services is required.

**Strengthening Support Systems**
Strong systems will strengthen and support the implementation of the minimum package for HCBC and therefore maintain the provision of a high quality continuum of care. Personnel, administration and quality control are among the essential systems. For example, it is necessary to maintain an optimal number and quality of staff, strengthen administration and supervision, and provide consistent monitoring and evaluation. Other systems are quality assurance and accreditation, leadership, coordination, integration of services, logistics and supplies. Referral, linkages and networking at all administrative and health care levels are other essential contributors to the system.

**Target Audience**
This framework targets three levels of audiences:
- Policy makers and senior administrators, middle managers, and those who develop and run HCBC programmes.
- Government officials at the various levels who will need the framework to monitor, guide and supervise the implementation of HCBC programmes.
- Civil society implementing partners, who will be required to use this framework for the implementation of HCBC activities in line with the relevant district’s priority areas.

With this framework for a recommended minimum package for HCBC and a nationally recommended HCBC implementation model, it is anticipated that standards and quality of care will be maintained and the quality of life of all those affected will be improved.

All partners implementing HCBC programmes should adhere to the standards and criteria stipulated in either the comprehensive or the minimum health care packages.
1 Introduction

Services for the care of Kenya’s sick at home and in the community are numerous, but are often established without full awareness of what is expected of them at a minimum. Despite the existence of the Programme and Service Guide for Home-Based Care, different models of care have been implemented without adherence to an agreed upon standard. This Implementation Framework for Home- and Community-Based Care (HCBC) intends to bridge that gap by setting out the minimum standards of care for HCBC programmes. The framework is a guide to implementers and supervisors with a goal of ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level.

Initiated by the Ministry of Health’s National AIDS/STD Control Programme (NASCOP), the framework is the result of the collaborative effort by a wide array of organizations and agencies working in or supporting HCBC programmes that were committed to improving the quality of care under these programmes. (Refer to Annex A for a list of the participating stakeholders.)

International and local donor agencies, along with civil society, faith-based and non-government organizations (CSOs, FBOs, NGOs) will be required to use this framework for the implementation of HCBC activities in line with the relevant districts’ priority areas. Government officials at the various levels will also use the framework to monitor, guide and supervise the implementation of HCBC programmes. It is anticipated that the use of this recommended minimum package for HCBC will raise the standards of care and improve the quality of life for individuals, families and communities.

1.1 Definition and Vision of HCBC

Home- and community-based care is an integrated, comprehensive, continuum of care for people infected with HIV as well as other disabling or terminal diseases.
The vision is to integrate HCBC into other health services so as to provide a holistic, sustainable, stigma-free and high quality continuum of care that is accessible to all those in need and supported by motivated community and health facility care providers.

1.2 Purpose and Rationale of the HCBC Framework

Coming at a time when the Ministry of Health is shifting its focus through the Community Strategy\(^1\) by strengthening health care provision at level 1 (the community – village/households/families/individuals), this framework addresses HCBC as an integral part of the Community Strategy. HCBC is continually evolving as health service providers respond to the changing needs of clients, families and communities.

For example, with the availability of highly effective anti-retroviral drugs (ARVs), more and more bedridden patients are recovering and regaining their health, thereby graduating from debility to mobility and returning to active roles in the community. With such patients being on life-long ARV treatment and requiring comprehensive care, the need to go beyond the home to community level care is critical. This is the root of the change of focus from home-based care to home- and community-based care. According to the Kenya Essential Package for Health (KEPH),\(^2\) there are six levels of care at which HCBC would be integrated for different care provision activities. These are:

- Level 1: Community: village/households/families/individuals
- Level 2: Dispensaries/clinics
- Level 3: Health centres, maternities, nursing homes
- Level 4: Primary hospitals – District and sub-district hospitals
- Level 5: Secondary hospitals – Provincial hospitals
- Level 6: Tertiary hospitals – National hospitals

The rationale for the HCBC implementation framework is to guide programme implementers by defining the minimum standards and a model of care that best serves the needs of clients, families and communities. The minimum package and model of care will be supported by strong systems of capacity building, linkages, networking, M&E, coordination and supervision.

\(^1\) Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES, published by the Ministry of Health, June 2006 (hereafter referred to as the Community Strategy).

All partners implementing HCBC programmes should adhere to the standards and criteria stipulated in either the comprehensive or the minimum health care packages.

1.3 Guiding Principles and Core Values of the HCBC Framework

In fulfilling the purpose of the HCBC Framework, partners will adhere to and promote the following principles and core values:

- **Empowerment:** Helping patients/clients to help themselves by providing them with the skills and opportunities to develop their potential and continuously improve.

- **Integrity:** Treating others as we want to be treated.

- **Partnership:** Working together with patients/clients, collaborators and beneficiaries of HCBC to achieve more sustainable and efficient outcomes.

- **Teamwork:** Harnessing the benefits of synergy to enhance performance and provide learning and development opportunities.

- **Quality care:** Ensuring that we fully understand and meet patient/client needs, with the understanding that quality of care is the responsibility of every care provider.

- **Respect for the basic human rights of PLWHAs:** Using the HIV/AIDS Act of the Government of Kenya to uphold the rights of all those who are infected and affected by HIV. All implementers should be familiar with this Act (Cap 14 of the laws of Kenya, 2006).

- **Mainstreaming gender:** Defining complementary gender roles and responsibilities, promoting women’s empowerment, addressing traditional inequitable gender-related cultural practices, and addressing gender imbalance in home- and community-based care and service delivery.
People with HIV/AIDS and other chronic and terminal illnesses have multiple needs that can be addressed effectively only through comprehensive care. Such care is continuous – from the health facility to the home and community level – and not simply restricted to treatment. It is recognized that not all HCBC providers will be able to meet all the needs of the infected and affected. Nevertheless, by understanding the comprehensive care package, and through it generating a wider community response and participation, they will be able to implement the minimum HCBC package and any additional elements for which resources are available. (For a list of additional reading materials related to HCBC refer to Annex B.)

2.1 Elements of Comprehensive Care

Here we are discussing the ideal approach to HCBC – the full range of care and referral services needed for the delivery of optimum care at the community level. The continuum includes clinical and nursing care, pain relief, and counselling and spiritual support, among others.

2.1.1 Clinical Care

Clinical care focuses on diagnosis and treatment to meet the health needs of the patient/client. Action here includes:

- Assessing the patients’/clients’ needs through physical examination, observation and history taking.
- Planning to meet identified needs.
- Providing clinical services including drugs.
- Developing treatment literacy and providing adherence counselling.
- Recognizing and acting on needs requiring appropriate referrals.
- Drawing up a discharge plan.
- Following up on the implementation of the discharge plan and the welfare of the patient/client.

The comprehensive HCBC package includes:

- Clinical and basic nursing care
- Palliative care, pain relief
- Psychosocial support and counselling
- Life skills development
- Family care and support
- Food and nutrition
- Prevention of HIV transmission
- Linkage, coordination, referral, networking
2.1.2 Basic Nursing Care

Basic nursing care refers to the day-to-day maintenance of a person’s health. Nursing care includes the assessment of the client’s needs and problems on the basis of the requirements of activities of daily living and the subsequent preparation of caregiver plans. These plans are implemented, monitored and evaluated in accord with the identified needs, including appropriate referrals.

Nursing care also includes care of pressure areas for bedridden patients and help with maintaining mobility, bathing, wound cleansing, skin care and oral hygiene. It covers adequate ventilation in the home, as well as guidance and support for proper nutrition. Prevention of infections through the use of antiseptics and disinfectants along with the use of protective materials like gloves and encouraging the use of condoms are also part of the basic nursing care provided. Other activities include hand-washing, cleaning linen with soap and water, homestead hygiene, and burning or safe disposal of human and other waste materials.

2.1.3 Palliative Care, Pain Relief and Symptom Management

Palliative care is the combination of active and compassionate long-term therapies intended to comfort and support individuals and families living with a chronic life-threatening illness. Pain relief is an essential element of palliative care. Symptom management runs from interventions for reducing fever and relieving pain, to treating diarrhoea, vomiting pain, and cough.

2.1.4 Psychosocial Support

Psycho-social support is an integral part of comprehensive care. It responds to the total well-being of the person and the family affected by the illness, particularly HIV/AIDS, through interventions that focus on the emotional, mental and social aspects. These aspects will be addressed through counselling, spiritual support and guidance, as well as issues relating to confidentiality as described below.

2.1.5 Counselling

Counselling is an essential element of care for the sick person, family members and care providers to enhance their capacity to cope with the disease and provide care. Counselling, as a professional skill, can be provided through individual, family or group counselling approaches. Group counselling affords an opportunity for people with similar needs to share their
experiences on how they have managed and coped with their condition.

The process must integrate structured counselling principles and should engage people living with HIV/AIDS as key partners, making reference to the Meaningful Involvement of People with AIDS (MIPA) guidelines. The outcome of counselling will be to promote positive living and prevention of further HIV transmission and re-infection. This may be achieved through individual or group counselling. Key elements to be incorporated include good interpersonal communication with respect and dignity, a non-judgemental attitude, empathy and cultural sensitivity, and respect for positive traditional practices.

2.1.6 Spiritual Support and Guidance

Spiritual support and guidance have proven effective in providing hope and consolation to the affected individual and family. This kind of support should be sensitive to different beliefs, whether traditional or conventional faith. Spiritual leaders play a vital role in this area and may assist when and where possible.

2.1.7 Confidentiality

Confidentiality is one of the many challenges in HCBC, particularly because of the fear of stigmatization and discrimination associated with HIV/AIDS. It is therefore paramount that HCBC providers be sensitive to the concerns of the individual and the family affected. The providers should encourage shared confidentiality, bearing in mind that the rights of the sick person or person living with HIV/AIDS are respected. The process must enable the person and the household to cope with the situation effectively.

2.1.8 Life Skills Development

People living with HIV/AIDS should be encouraged to adopt positive life styles to strengthen skills that enable them to effectively prevent further infection. Involvement in community groups gives them a sense of belonging, hence promotes responsible behaviour and sustainable positive lifestyles. Making them aware of relevant reproductive health services will help them access dual protection against re-infection and unplanned pregnancies.

2.1.9 Family Care and Support

This is a holistic approach to providing care and support beyond the sick individual. A person with a chronic illness is a member of a family unit, hence care and support should be provided within the context of the family. Family care and support
should therefore take into consideration the inter-relationships among family members and family roles in providing the necessary care and support. Among others this involves psycho-social and spiritual support, planning for the children’s future, bereavement counselling, mobilization of family support, and the use of a memory book, which is encouraged where appropriate.

Other important aspects to consider under family care and support are care for orphans and vulnerable children (OVC) and care for caregivers.

**OVC Care and Support**
Care and support for OVC must encompass children’s rights as stipulated in the Children Act (cap 586 of 2001) and the Kenya National OVC Policy Guidelines. Such support includes child health services, immunization, nutrition, education, legal protection and inheritance rights, and shelter. The HCBC providers, who are often the first to come in contact with OVC, need to link them with the specific organizations or institutions that offer the necessary services as stipulated in the Kenya National OVC Policy Guidelines.

Children must be regarded as key players and not just as beneficiaries of care and service delivery. They should therefore be empowered to participate actively in various care and support interventions, particularly those related to issues of inheritance.

**Care for Caregivers**
Caring for caregivers and family members is important to avert burnout, a condition brought about by excessive emotional stress and physical strain. Caregivers should be linked to relevant support systems that address their needs appropriately. Friends, spiritual leaders, neighbours and community volunteers can provide support to help both the sick and the family caregivers. Special attention should be given to child and elderly caregivers because of the enormous challenges they face in offering quality care. To ensure quality of care and support services, caregivers should be supplied with appropriate information on self-care and given supportive supervision and other capacity building services.

**2.1.10 Food and Nutrition**
Proper food and nutrition are essential for improving the health of the sick and for maintaining the well-being of PLWHAs and those with other chronic illness. Providing nutrition support should involve short-, medium- and long-term interventions. Short-term interventions may come in the form of food by prescription to meet immediate urgent needs. In the medium term, interventions are more likely to entail palatability issues and consumption for the purpose of recuperation and recovery, while the long-term services may involve

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Children are key players and not just beneficiaries of care and service delivery, especially in matters related to inheritance.

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Comprehensive Care Package
ensuring food security for sustenance. Long-term interventions will call for multi-disciplinary approaches that build community capacities for food production, safety and security. The *Kenya National Food and Nutrition Guidelines* provide details on food and nutrition. Maintenance of proper food hygiene through the entire process of preparation, cooking, serving and storage helps to prevent food-borne diseases.

2.1.11 Prevention of HIV Transmission

Prevention of HIV transmission is an important aspect of reducing new infections. Services here include voluntary counselling and testing (VCT), provider initiated testing and counselling (PITC), and prevention of mother to child transmission (PMTCT) of HIV. These are services through which clients are supported to make informed decisions relating to testing, treatment and care. In addition, caregivers must maintain standards of care to avoid infection, hence the importance of observing infection prevention steps when providing care (see Section 2.1.2).

**Prevention with Positive Initiative**

The involvement of people living with HIV and AIDS through the MIPA principle is a key element for abating stigma and promoting prevention and positive living. MIPA should be encouraged at all levels. Behaviour change promotes behaviours that reduce the risk of either acquiring or transmitting HIV infection. Actions here may entail peer education and the participation of “expert patients”. These are HIV-positive patients who are living positively and are involved in outreach to encourage others to live positively, prevent HIV transmission and adhere to treatment. Among other measures are condom promotion, reproductive health and HIV integration. In all our interventions, efforts must be made to address the issue of prevention among discordant couples.

**Counselling and Testing**

Counselling and testing services provide an entry point to the provision of care and accurate information on HIV/AIDS. Such services are available in many communities through VCT centres, PITC, home testing and counselling, PMTCT, and diagnostic testing and counselling.

2.1.12 Linkage, Coordination, Referral and Networking in HCBC

The purpose of strengthening linkage, coordination and referral is to ensure continuity of care. Roles and responsibilities of service providers at all levels must be defined. It is also necessary to identify, map and
harmonize a database of services available in line with the comprehensive care services. The information available in the database will facilitate follow up and referral to services at different levels. Through the supportive supervision structures of the provincial and district health management teams (PHMT and DHMT, respectively), equitable distribution of services and gaps in service provision will be identified and addressed.

2.2 Monitoring and Evaluation of Comprehensive Care Services

Essentially based on reports from routine supervisory field visits and periodic reviews, monitoring and evaluation in HCBC is an important aspect of quality control in the implementation of HCBC activities. Key considerations in M&E are documentation, quality of care monitoring, supportive supervision and operations research.

2.2.1 Documentation

Data should be kept on activities carried out to deliver the components of comprehensive care services at all levels of the care continuum. This allows feedback on such activities and will facilitate planning, implementing and improving HCBC. The information should be captured effectively.

Serving Communities with Special Needs

People with special needs include nomadic communities, internally displaced persons, refugees and the disabled. This service approach is characterized by special arrangements made to reach and serve these hard-to-reach groups. The following are some of the possible arrangements:

• Training members of the community as community service providers.
• Providing satellite or outreach services at designated points for easy access by the community.
• Providing mobile services to either move or reach such communities.
• Ensuring services provided are captured through the use of relevant data collection tools.

Long-term nutrition services may involve ensuring food security for sustenance. They call for multi-disciplinary approaches that build community capacities for food production, safety and security.
and recorded using standardized tools designed for the collection of data on HCBC activities.

2.2.2 Quality of Services

The minimum HCBC package (see Chapter 3) will form the basis for monitoring the quality of care. Service quality should include performance of care providers according to their skills and satisfaction, client satisfaction, and family and community participation and empowerment. Emphasis is placed on the principle that quality is the responsibility of every caregiver. Involvement of other disciplines and sectors in health care provision through linkages and networking is essential.

2.2.3 Supportive Supervision

Supportive supervision is an essential part of norms for improving quality of care at all levels. Multi-disciplinary supervisory teams from the DHMT are expected to ensure that standards of quality and quantity of care are met during service delivery. Supervision should aim at assessing performance and promoting good communication and discussion. The broader aspect of supervision includes appropriately trained supervisory teams established at national, provincial, district, divisional and location levels.

2.3 Operations Research

There is need for periodic operational research on HCBC activities at all levels of care provision. Information gathered and analysed at different care levels will help in the identification of best practices for replication. The data should also be used to provide immediate feedback to HCBC providers, supervisors and key stakeholders and to facilitate monitoring of the progress of planned activities.
Ensuring that the sick person and the family receive quality care regardless of organizational constraints requires a minimum level of care. Although the comprehensive care package described above may seem enormous for implementers with limited resources or those in their early stages of development, the minimum package will guide such implementers in the delivery of quality care.

It is important to – without compromising the quality of care given to patients and clients – set priorities from among the minimum package elements to be implemented, and then work towards achieving the full complement of services beyond the minimum to the comprehensive package. A strong referral and networking system is essential to ensure that all the elements of the care package are addressed by linking the patient and family to needed services.

3.1 Elements of the HCBC Minimum Package

Basic human needs form the core of the minimum HCBC package. Among these are health care, education and shelter, as well as social and psychological support.

3.1.1 Nursing Care and Palliative Care

This aspect of the package includes all basic nursing care, the care of the dying, counselling and psycho-social support, and pain relief. Palliative care is the combination of active and compassionate long-term therapies intended to comfort and support individuals and families living with a chronic, incurable life-threatening illness.

3.1.2 Clinical Care with an Emphasis on Treatment Literacy and Sustainability

Client education is the essential element here, to ensure adherence to the prescribed drug regimens for

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**The minimum HCBC package includes:**
- Nursing and palliative care
- Clinical care emphasizing treatment literacy and sustainability
- Family care and support
- Capacity building
- Linkages, referral and networking
ARVs and other drugs for opportunistic infections, as well as other condition medication. Sustainability of the drug supply ensures that the client will not have unplanned treatment interruption. Clinical care also helps to promote positive living and prevent infection and re-infection. Another important component of care for people living with HIV in the community is instilling awareness of the need to seek treatment in case of any ailments no matter how minor.

3.1.3 Family Care and Support

Care services must extend to the family in addition to the individual patient/client and other caregivers. This element includes psychosocial support, reproductive health services, nutrition advice and food security for the family.

3.1.4 Capacity Building

HCBC capacity building targets the various cadres at all levels of service and care provision. Training for health care professionals varies from short courses to diploma and degree levels in HCBC. Once trained, these professionals in turn train others at the health facility and community level using the NASCOP curriculum. Since level 1 (the community) of KEPH is considered to have the largest number of service providers, both formal and on-the-job training approaches should be used to address knowledge and skill gaps. A crucial point here is the necessity for quality training by NASCOP accredited trainers for all levels and cadres of HCBC personnel.

3.1.5 Establishing Linkage, Referral and Networking Systems

Knowing where to go for additional help is key to maintaining a comprehensive continuum of care. A continuum of care is a system that involves a network of resources and services that provide holistic and comprehensive support for the sick person, family and caregivers. The goal is to provide an affordable range of services in various settings, from home, community and clinics to hospitals, and vice versa. (See also Section 4.5.)

3.2 Monitoring and Evaluation of the Minimum HCBC Package

An effective working M&E system will have appropriate structures in place that include M&E literate staff, a good network and linkages, and standard reporting procedures, formats and tools. M&E constitutes a system for keeping activities on track towards achieving the goals of the HCBC programme. M&E should be carried out for all programmes implementing HCBC at all levels, from the centre to the community. The results should be shared among partners and the best practices replicated among implementing programmes. (Refer to Chapter 6 for more details.)
Strong support strategies are necessary to strengthen the implementation of the national HCBC model aimed at providing a high quality continuum of care. Among the systems that need strengthening are administration, supervision, monitoring and evaluation, and quality assurance and accreditation. Others are leadership, coordination, integration of services, logistics and supplies, referral, linkages, and networking at all administrative and health care levels. Maintaining the optimal number and quality of staff is essential.

Concerted action to strengthen the administrative and health care levels from the national, regional, provincial, district and division levels, to the community, will ensure a strong and sustainable system that supports the individual and affected family. This links directly with the KEPH, which focuses on strengthening systems right from the lowest level of service provision.

The following sections summarize actions needed to strengthen HCBC systems.

4.1 Systems Strengthening

Health systems consist of all people and actions whose primary purpose is to promote, restore or maintain health. These systems may be integrated and centrally directed, or more loosely connected. They consist of:
- Formal health services.
- Traditional medicine.
- All use of medication whether prescribed by a provider or not.
- Home care of the sick.
- Health enhancing interventions like disease prevention, environmental sanitation, road safety.

4.1.1 National Level Actions

- Develop and review policy guidelines and training curricula.
- Facilitate relevant training for staff.
- Formulate and review HCBC strategy.
• Enhance the capacity of PHMTs to supervise HCBC activities.
• Provide overall direction for HCBC implementation.

4.1.2 Provincial Level Actions

• Effectively implement policies, guidelines and strategies.
• Facilitate quarterly provincial stakeholder review/consultative meetings.
• Supervise HCBC activities in the province.
• Provide HCBC training to relevant PHMT members.

4.1.3 District and Divisional Level Actions

• Coordinate HCBC activities and put monitoring systems in place.
• Integrate services and develop best practices in HCBC.
• Provide logistics, where possible, for HCBC activities.
• Provide HCBC training to implementers, community health workers and care providers.
• Facilitate quarterly district stakeholder review meetings.
• Strengthen collaboration and linkages with other HCBC stakeholders/organizations.
• Conduct supportive supervision for all HCBC implementing organizations.

4.1.4 Community and Family Level Actions

• Provide HCBC training to care providers in the community and the household.
• Provide logistics for delivery of HCBC services, e.g., HCBC kits (see Annex C).
• Facilitate quarterly stakeholder meetings.
• Facilitate quarterly meetings of community health workers.
• Provide technical support to CBOs involved in HCBC.
• Establish monitoring, referral and networking systems.

4.2 Capacity Building

Health professionals, volunteers, the sick and family members require adequate education and training in prevention, treatment and care. In addition, managers at higher levels and senior staff at health facilities need to be sensitized on home- and community-based care in order to institutionalize HCBC at all levels in the health care system. To strengthen institutionalization, health care facilities need to participate in the training activities and supervise practical attachments to the facilities. The following paragraphs provide a brief guide for the HCBC training programme.

4.2.1 Standardizing the Training Curriculum and Length/Duration of Training

All HCBC training should be conducted using the national curriculum prepared and approved by NASCOP. Since the curriculum is modular, training can be phased over a period, but it is not complete until all the modules have been covered.
Community health worker training requires 11 days of classroom sessions combined with a period of supervised practical training spread over two to three months and with performance reports. Only after completion of both theory and practical sessions will certification be approved. The training must be carried out by individuals and institutions approved/accredited by the relevant DHMT. Different levels of training will be in line with the capacity building objectives described in Section 3.1.4.

Additional training content may be identified to meet the needs of specific target audiences, for example materials for treatment literacy, adherence to anti-retroviral therapy (ART), stigma reduction, or domestic hygiene and sanitation. The Kenya Medical Training College (KMTC), if adequately prepared, has the institutional potential to facilitate the roll-out of HCBC training countrywide in liaison with NASCOP and DHMTs.

4.2.2 Identifying/Appointing Qualified Trainers/Facilitators

A high standard of training cannot be maintained without qualified trainers. Since the key care elements in HCBC have a clinical orientation and involve nursing care, a trainer with a clinical background and relevant training skills from an accredited training institution is required.

4.2.3 Harmonizing Training Venues and Monitoring of Trainings

Training venues will be established and approved by the relevant DHMT. Different venues are suitable for different groups of trainees. Assessing learning needs and determining the training content for the various levels will ensure that sessions are relevant and appropriate. On-site training has been found to be most effective in HCBC activities and notable in cutting costs, hence facilitating larger numbers to be covered through training.

4.2.4 Formalizing Certification of Trainees

A systematic serialization of all HCBC certificates awarded to successfully trained health professionals and community health workers is mandatory. This will ensure that certification is limited to individuals and cadres who are properly trained using the approved curriculum and training materials. DHMTs in all districts in the country, in collaboration with NASCOP, are currently implementing this requirement to ensure identification of authentic qualifications.

4.3 Financing and Ensuring Sustainability

Sustainable financial support for HCBC is very challenging for communities. These programmes are often vulnerable to inconsistent and sporadic sources of funding. The following strategies can
help to promote the sustainability of the HCBC programme.

4.3.1 Preparing Annual Operational Plans

Preparing, managing and reporting on the HCBC budget for the fiscal year will focus attention and reflection on the district priorities and therefore facilitate sourcing of funds for recurrent expenditures.

4.3.2 Promoting Public–Private Sector Partnerships (PPP)

In many instances, HCBC programmes come about through partnership and joint sponsorship of the programme. The Government, NGOs, CBOs and the private sector can join forces in the “public–private sector partnership” initiative to help in supporting HCBC activities.

4.3.3 Pooling Resources

All HCBC programmes require a range of resources such as supplies, equipment, and information, education and communication (IEC) materials. Sharing resources with other health-related NGOs, CBOs, FBOs and community health facilities can help to reduce HCBC programme operational costs and burden of care. Joint development of resources like IEC materials can also contribute to consistency and quality control.

4.3.4 Mobilizing Community Resources

Community leaders, spiritual leaders and political leaders within the community can facilitate the mobilization of community resources for care. Resources can also be mobilized to support/sustain HCBC activities through income-generating activities such as community gardens, granaries and farms, craft markets, community fairs, and recreational, sport and artistic events, as well as contributions from local businesses and FBOs.

4.4 Encouraging Volunteerism

HCBC can not be sustained without the enormous contribution of volunteers. Volunteers have one thing in common – a desire and ability to help others. Many volunteers respond to a call for help through their places of worship. Others offer to help when they see how HCBC volunteers have helped their own family, neighbours or friends. Retention and encouragement of volunteers may be achieved through group support activities, training opportunities, honouring volunteers, and providing awards, honoraria and payment in kind.
4.5 **Linkages, Referral System and Networking**

The primary intention of HCBC is to provide a continuum of holistic care that is supported by strengthening referral linkages, follow up, monitoring and case management. The following actions provide a guide for maintaining the continuum of care.

4.5.1 **Integrating Services**

This refers to the mix of care, treatment, psycho-social support and preventive services in proportions that maintain a continuum of care. The continuum involves an integrated network of resources and services to provide holistic, comprehensive support for the sick person, the family and caregivers from home, community, hospitals and vice versa.

4.5.2 **Strengthening Linkages and Networking**

Linkage is networking with important service contributors to the HCBC programme. It can be with business people, NGOs, FBOs and other resource people at the local level. Such relationships should be strengthened through shared activities of staff, service provision, training, monitoring and supervision, and a two-way referral and follow up system.

Community network meetings among the different practitioners, organizations and agencies involved in caring for the sick and families at home are important. Networking facilitates discussions on different issues and possible solutions to problems such as transport and access to certain services.

Coordinating committees and local leaders, especially the chief who is responsible for resolving local conflicts and problems at community level, should be involved in strengthening community level networking.

4.5.3 **Establishing Referral Systems**

Not all programmes are able to meet all care needs of the patient, family members and caregivers. Establishing referral systems is important for access to care services such as hospice care, or caregivers’ access to counselling and rehabilitation services. In addition, access to support groups, voluntary counselling and testing, ART and laboratory services, spiritual support and guidance services, and other forms of community-based care may also be needed. Effective referrals should be made from health facilities to the home and back again, highlighting treatment and care plans to be implemented. A well organized discharge plan ensures a strong referral system and maintenance of the continuum of care.

Orphans will need access to child support services through the Children’s Department of the Ministry of Home Affairs, education facilities, child protection programmes and legal services. Accessing these forms of support require strengthening linkages and referral systems.
4.5.4 Handling Logistics and Supplies

This system will need to be strengthened to ensure a reliable supply of home care kits developed locally under the guidance of the national standard content list (see Annex C). The standard list (revised in 2006) provides the minimum type/number of supplies that should be in the kit and which a community health worker can use comfortably in the community, without clearance of the MOH especially drugs. Additional items may be added depending on local needs, but with the supervision of the professional health worker.

4.5.5 Ensuring Food Security, Supplements and Food for Prescription

Measures have to be taken to provide supplements, prescription foods and emergency food supplies in the short term. Long-term measures must be put in place to ensure food security that is sustainable and appropriate.

4.6 Quality Assurance and Quality Control

The HCBC Programme and Service Guidelines and the National HCBC Policy Guide set standards and regulations that govern HCBC implementation. This HCBC implementation framework further emphasizes the need for quality in the provision of care. In order to discourage “briefcase” HCBC organizations and to uphold high standards, DHMTs will accredit HCBC implementers in their districts. This will be based on the requirements for quality training, the use of skilled workers – whether volunteer or paid – and implementation of the approved minimum care package. The DHMT, through the HCBC supervisors or coordinators, will be responsible for ensuring that these policies, standards and regulations are upheld.

4.7 Supervision and Coordination

Quality of care requires that the individual involved be supervised effectively. It also demands the proper supervision and coordination of the various agencies and organizations involved in HCBC.

4.7.1 Supportive Supervision

All levels from national (central) to province and district will ensure that policy guidelines, administrative arrangements and overall management frameworks published by the Government are adhered to. Such supervision is facilitated through face-to-face forums and establishment of effective communication among all levels of administration and within different government agencies. There is need to share reports of supportive supervision with other collaborating HCBC implementers.

4.7.2 Coordination

The Government through NASCOP and the National AIDS Control Council (NACC) has set up coordinating committees at all
administrative levels, the lowest of which is the Constituency Coordinating Committee. Close supervision by DHMTs, and the PHMT’s coordination of HCBC activities within various districts, should be achieved. Any organization implementing HCBC activities must make its activities known to these teams right from the planning stage through all the implementation, monitoring and evaluation phases.

The DHMT should keep an inventory of all organizations undertaking HCBC activities in each district with a goal of strengthening stakeholder participation.

4.7.3 HCBC Organogram

The various players in HCBC, from MOH to the communities, are shown in Figure 1.

Figure 1: Players, stakeholders and relationships in HCBC
The Ministry of Health’s Community Strategy for the delivery of level 1 services has as one of its main objectives the strengthening of health facility-community linkage through the effective decentralization and partnership. It is through the stipulated community structures that HCBC will be implemented. This structure emphasizes the focus on catchment areas within a specific sub-location. Each area serves 5,000 people through 50 community health workers (CHWs) and 2 supervisors (Community Health Extension Workers – CHEWs). Each supervisor supervises 25 CHWs and each CHW is expected to serve 20 households (approximately 100 people). All HCBC implementers should therefore work closely with the relevant DHMTs and PHMTs in identifying priority areas to ensure equity in service delivery.

Steps in implementing such a programme include assessing needs, planning and organizing the programme, actual implementation, and comprehensive monitoring and evaluation. The steps are itemized below.

5.1 Assessment

5.1.1 Situation Analysis
- Delineate geographical catchment area.
- Define the target population, their demographic data and their care needs.

5.1.2 Logistic Analysis
- Consider availability of the workforce including training gaps.
- Assess other available resources including HCBC kits and funds.

5.1.3 Networking, Referral and Linkage
- Identify other organizations serving this population and services they offer.
• Determine the availability of resources/services for possible referral of clients to ensure comprehensive care provision.

5.2 Planning and Organizing

• Ensure adequate personnel trained in HCBC, e.g., CHWs, supervisors and coordinators.
• Formulate both short-term and long-term budgetary and workplans for sustainability.
• Ensure appropriate planning for logistics to last at least two years.
• Plan to offer quality care covering at least three components of the minimum HCBC package and a strong referral for other care services.
• Identify care networks to link and refer for components not directly offered using standard referral tools.
• Be familiar with and make use of HCBC documents from the Ministry of Health, NASCOP and NACC that guide the provision of quality care at home and community level. (Refer to Annex B for a selection for relevant documents.)
• Plan for the motivation, appreciation and sustainability of CHW caregivers.

5.3 Implementation

• Seek acceptance and ownership by community-owned resource persons (CORPs), e.g., leaders.
• Provide services as planned ensuring quality care and linkage with health care systems.

5.4 Monitoring and Evaluation

• Conduct continuous monitoring of planned activities, midterm and end term evaluation of programme activities.
• Use standard tools for data collection and reporting, such as CHW diaries, CBO registers, form 726 annex and others.
• Carry out organizational data analysis for use in improving weak areas and supporting strong areas for continuity.
6 Monitoring and Evaluation

Monitoring and evaluation (M&E) is an essential component of any programme that is implementing an HCBC programme. The purpose of M&E is to keep activities on track towards programme goals. An effective M&E system comprises appropriate structures that include M&E trained staff, good reporting procedures and appropriately detailed reporting tools.

6.1 Importance of M&E

All programmes implementing HCBC at all levels, from the centre to the community, should have an effective monitoring and evaluation system in place, and should ensure that it is used. The results should be shared with partners and best practices replicated appropriately.

Community health workers should be guided on how to report the activities they carry out in the community and their specific catchment areas to minimize cases of reporting overlap and duplication of reports. Information collected at this level is very important because it constitutes the basic data that inform the programme at higher levels and for future planning of activities.

6.2 Link between MOH and NACC M&E System

Proper linkages of home- and community-based care programmes and health facility information systems must be in place. There must be a focal point at the health facility to link the facility with the CHW or CBO. The focal point can be an office or desk with a list of all CHWs, all CBOs involved in HCBC, an HCBC client register and contacts for care providers.

It is through the focal point that data collected in the community will be channelled upward. At divisional level, the divisional home and community care coordinator will compile data for onward flow to the district level. The coordinator will also analyse and interpret the data for local consumption and work closely with the Constituency AIDS Control Committee.

The District Home- and Community-Based Care Coordinator (DHCBCC), with the supervision of the District AIDS/STD Control Coordinator (DASCO), will compile the district data for onward flow to the province and analyse and interpret it for consumption at district level. The provincial HCBC Coordinator, with the supervision of the PASCO, will...
compile data for onward flow to NASCOP and will work closely with the NACC regional representative to analyse and interpret the data for regional use. At national level, NASCOP and NACC will compile, analyse, interpret and disseminate data to support planning and to inform national and international partners appropriately through regular forums and publications. There should, in fact, be regular forums at every level to inform every player of any changes made in the monitoring and evaluation system.

6.3 Tools

The reporting tools used at every level of implementation should be the same nationally, i.e., CHW diary, CBO register, MOH forms and NACC’s community-based programme activity reporting (COPAR) form. These tools are to be prepared (or modified) with consultation or support from other partners though NASCOP and NACC, and then distributed to all implementers.
**Annex A: Contributing Stakeholder Organizations**

1. National AIDS Control Council (NACC)
2. Ministry of Health
   - Department of Sector Planning and Management
   - National AIDS/STD Control Programme (NASCOP)
   - Division of Nursing
   - Division of Health Promotion
   - Nyanza Province, North Rift Valley Province, Coast Province
   - Siaya District, Kisumu District, Nakuru District, Mwingi District
3. Pathfinder International
4. St. John Ambulance
5. Family Health International
6. Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO)
7. Women Fighting AIDS in Kenya (WOFAK)
8. Network of People with HIV/AIDS in Kenya (NEPHAK)
9. Kenya Women with AIDS (KENWA)
10. WEM Integrated Health Services (WEHMIS)
11. Kenya Medical Training College (KMTC)
12. Kenya Red Cross Society (KRCS)
13. Mildmay International
14. Kenyatta National Hospital VCT centre
15. Kenya AIDS NGOs Consortium (KANCO)
16. Catholic Diocese of Kitui Home-Based Care Project
17. Catholic Diocese of Nakuru Home-Based Care Project
18. Maua Methodist Church Palliative and Community-Based Care Project
19. Anglican Church of Kenya (ACK) Diocese of Eldoret HIV Care Project
20. Karatina Home-Based Care Project
21. Health Policy Initiative
Annex B: Additional Reading

2. National Home-Based Care Policy Guidelines, NASCOP, 2002
3. National Home-Based Care Programme and Service Guidelines, NASCOP, 2001
6. Monitoring and evaluation tools: MOH form 726/7, COPAR, CBO register, CHW diary
8. Training Curriculum for Voluntary Counselling and Testing, MOH/NASCOP, 2003
19. Community Reproductive Health Package, MOH/DRH, 2006
20. Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE
SERVICES (The Community Strategy), MOH, 2007


25. AIDS control and prevention projects AIDSCAP, HIV/AIDS care and support projects – Family Health International, Project 936-5972.31-4692046
## Annex C: Standard Minimum HCBC Kit Content (Revised 2006)

<table>
<thead>
<tr>
<th>Item description</th>
<th>Quantity</th>
<th>Unit</th>
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<td>2 Condoms</td>
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<td>Box</td>
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<tr>
<td>3 Scissors</td>
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<td>Pair</td>
</tr>
<tr>
<td>4 Bar soap</td>
<td>3</td>
<td>Pieces</td>
</tr>
<tr>
<td>5 Paracetamol</td>
<td>60</td>
<td>Tabs</td>
</tr>
<tr>
<td>6 Multivitamins</td>
<td>30</td>
<td>Tabs</td>
</tr>
<tr>
<td>7 Clopheniramine (piriton)</td>
<td>30</td>
<td>Tabs</td>
</tr>
<tr>
<td>8 Gentian violet (GV) paint</td>
<td>1</td>
<td>Bottle</td>
</tr>
<tr>
<td>9 Chlorine bleach (Jik) 250 mls</td>
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<td>Bottle</td>
</tr>
<tr>
<td>10 Waste disposal bags 14 x 9</td>
<td>50</td>
<td>Pieces</td>
</tr>
<tr>
<td>11 Cotton wool 100 grams</td>
<td>2</td>
<td>Rolls</td>
</tr>
<tr>
<td>12 Gauze</td>
<td>25</td>
<td>Pieces</td>
</tr>
<tr>
<td>13 Cotton bandages</td>
<td>6</td>
<td>Rolls</td>
</tr>
<tr>
<td>14 Oral rehydration salts</td>
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<td>Sachets</td>
</tr>
<tr>
<td>15 Vaseline (petroleum gel) 50 grams</td>
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<td>Bottles</td>
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<tr>
<td>16 Zinc oxide plaster 1 x 2.5</td>
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<td>Rolls</td>
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<tr>
<td>17 Antiseptic lotion (Hibitine) 125mls</td>
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<tr>
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An Implementation Framework
For Home- and Community-Based Care in Kenya

National AIDS/STD Control Programme
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