GUIDELINES FOR PROVISION OF SOCIAL SAFETY NET FOR COMMUNITY HOME BASED CARE PATIENTS 2005

DEPARTMENT OF SOCIAL SERVICES

MINISTRY OF LOCAL GOVERNMENT

Private Bag BO 180 Gaborone, Botswana
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>List of acronyms</td>
<td>4</td>
</tr>
<tr>
<td>Definition of terms</td>
<td>5</td>
</tr>
<tr>
<td>1.0 Introduction</td>
<td>7</td>
</tr>
<tr>
<td>2.0 Backgrounds</td>
<td>8</td>
</tr>
<tr>
<td>3.0 Goal</td>
<td>9</td>
</tr>
<tr>
<td>3.1 Objectives of the CHBC SSN</td>
<td>9</td>
</tr>
<tr>
<td>4.0 Definition of CHBC</td>
<td>9</td>
</tr>
<tr>
<td>5.0 Purpose for the CHBC Social Safety Net</td>
<td>10</td>
</tr>
<tr>
<td>6.0 Eligibility for Registration under CHBC Social Safety Net</td>
<td>10</td>
</tr>
<tr>
<td>7.0 Types of assistance</td>
<td>12</td>
</tr>
<tr>
<td>7.1 Food basket</td>
<td>12</td>
</tr>
<tr>
<td>7.2 Transportation</td>
<td>13</td>
</tr>
<tr>
<td>7.3 Repatriation</td>
<td>13</td>
</tr>
<tr>
<td>7.4 Counseling</td>
<td>13</td>
</tr>
<tr>
<td>7.5 Rehabilitation</td>
<td>14</td>
</tr>
<tr>
<td>7.6 Burial</td>
<td>15</td>
</tr>
<tr>
<td>8.0 Management of resources</td>
<td>15</td>
</tr>
<tr>
<td>8.1 Budgeting</td>
<td>15</td>
</tr>
<tr>
<td>9.0 Responsibilities and Obligations</td>
<td>16</td>
</tr>
<tr>
<td>9.1 Responsibilities of the patient</td>
<td>16</td>
</tr>
<tr>
<td>9.3 Responsibilities of Care Givers</td>
<td>16</td>
</tr>
<tr>
<td>Steps for failure to adhere to CHBC SSN Guidelines</td>
<td>15</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

This publication was compiled by the Department Social Services (DSS) with contribution from the CHBC reference group members. (Annex A).

The Department would like to take this opportunity to thank all who have contributed to the development of these implementation Guidelines for CHBC Social Safety Net with special acknowledgement to:

- CHBC reference group members.
- CHBC consensus building workshop participants.
LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti- Retroviral</td>
</tr>
<tr>
<td>CHBC</td>
<td>Community Home Based Care</td>
</tr>
<tr>
<td>CHBCSSN</td>
<td>Community Home Based Care Social Safety Net</td>
</tr>
<tr>
<td>DHT</td>
<td>District Health Team</td>
</tr>
<tr>
<td>FCARM</td>
<td>Family Care Assessment, Registration and Monitoring Tool</td>
</tr>
<tr>
<td>FCM</td>
<td>Family Care Model</td>
</tr>
<tr>
<td>HBC</td>
<td>Home Based Care</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IARF</td>
<td>Inter Agency Referral Form</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MLG</td>
<td>Ministry of Local Government</td>
</tr>
<tr>
<td>OC</td>
<td>Orphan Care</td>
</tr>
<tr>
<td>S&amp;CD</td>
<td>Social and Community Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
</tbody>
</table>
DEFINITIONS OF TERMS

1. **Antiretroviral Therapy** – Treatment given to people who are HIV positive with CD 4 Count of 200 and below to boost their immune system and able to fight opportunistic diseases.

2. **Community Home Based Care** – is the care provided to patients (bedridden or ambulant) at home or in the community with the support of the professional health care workers.

3. **Community Home Based Care Social Safety Net**

   “Care given to individuals who are terminally ill in their own homes supported by the social welfare support system. It is intended to meet spiritual, material and psychosocial needs of patients and their significant others.

4. **Counselling** – is a professional helping process that involves a case worker and a client. It can be provided either one to one or group counselling.

5. **Family Care Model** – is a strategy that seeks to integrate the CHBC and OC programmes into a family focused support system and facilitate referrals of customers from agency to another.

6. **Food Basket** – food items given to different beneficiaries on a monthly basis. In this instance it is based on the level of need (means testing).

7. **Psychosocial** – is a process of meeting patients and their relatives’ psychological and emotional needs. It also seeks to help them cope with emotional trauma, grief and stress associated with terminal illness, death etc.

8. **Referral System** – is a structure set up to assist beneficiaries/patients to access services provided by different stakeholders in a less cumbersome and cost effective manner.
9. **Rehabilitation** – is a process of empowering individuals socially and economically to enhance their social functioning and attain self-sustenance.

10. **Repatriation** – An act of transferring an individual/client from one place to another with the view to reconcile him with his place of origin and significant others who can provide care and support. In this instance to facilitate speedy recovery. Repatriation could also refer to moving a corpse of an individual who has to be buried at an appropriate place.

10. **Terminal Illness** – is an active and progressive disease which can not be cured.

11. **Vulnerable Children (Potential Orphans) for the purpose of the CHBC SSN**, these are children of the patients registered in the CHBC SSN aged below 18 years, and are assisted as needy children as per the Revised National Policy on Destitute Persons.

12. **Confidentiality** – Refers to keeping secret information concerning the client disclosed in a professional relationship.
1.0 INTRODUCTION

These guidelines are intended to provide guidance for implementation of the Community Home Based Care food basket. Since the inception of the programme, the Department has been guided by the Destitute Policy of 1980, which was revised in 2002. These guidelines are designed to provide direction and to serve as a standard tool to be used specifically for CHBC. They are meant to address the discrepancies observed regarding the implementation of the food basket.

1.1 Gaps

It has been observed that;

- There have been no consolidated guidelines and standards on the provision of the CHBC social Safety Net.
- There was no uniformity and implementation varies from district to district.
- There was no consistency in implementation of the CHBC food basket.
- Programme lacked consistent monitoring and evaluation techniques.

1.2 Justification

There is need to develop CHBC Social Safety Net guidelines and standards for the implementation of programme so that;

- They guide officers during the implementation of CHBC SSN.
- They guide stakeholders during referral of the clients to avoid unnecessary referrals to Social and Community Development departments for food basket.
- To provide uniformity implementation of the CHBC programme.
- Enhance optimal use of the already strained resources.
2.0 BACKGROUND

Botswana has made major economic stride since independence and the country is now regarded as a middle-income economy. However the HIV/AIDS threatens to reverse the successes realized over the years. The first AIDS case was reported in Botswana in 1985 and since then Botswana featured among the countries with high infection rate in Sub Sahara. There is therefore a mounting pressure placed on the health facilities, as a result of the impact of HIV/AIDS. The Botswana 2003 Second Generation HIV/AIDS Surveillance Survey on pregnant mothers indicated that the prevalence of HIV was 36.2% in 2001, 35.4% in 2002 and 37.4 % in 2003. The numbers of terminally ill patients has been increasing to be absorbed in the health care facilities.

The Government of Botswana adopted Community Home Based Care strategy in 1995 as response to HIV/AIDS epidemic. The epidemic resulted with the increased number of terminally ill patients cared for at home because the hospitals could no longer accommodate all patients. The overall goal of community Home Based Care programme is to provide comprehensive care services at home and at community levels in order to meet the physical, Psychological, social and spiritual needs of terminally ill patients including PLHWAS and their families. CHBC is increasingly preferred as method where patients can be looked after by loving family members in a more familiar home environment. Services provided include medical care, nursing care, psycho-social support, information, education and communication for behavior change, counseling and spiritual support.

The government adopted an integrated and Multi-sectoral approach for the implementation of the CHBC programme. The programme is implemented by the government in collaboration with Non Governmental Organizations and Community Based Care Organizations. The Ministry of Health is responsible for the development of policies and standards and for provision of professional guidance and support on the health care including counseling issues. The Ministry of Local Government (Department of Social Services) on the other hand, has the mandate for development of policies and standards for provision of technical guidance on the social welfare component. It is for this reason that the Department of Social Services found it necessary to develop guidelines on CHBC Social Safety Net. Further more, the department has observed that different districts have been implementing the CHBC social net safety differently. As a result of
differing implementation strategies employed by the Local Authorities in executing the activities of CHBC programme, it has been necessary to come up with the guidelines complementing those implemented under the Ministry of Health.

3.0 GOAL

The goal of CHBC SSN is to provide quality care through provision of material, psychosocial, counseling and spiritual support to the patients and their families in a home setting.

3.1 Objectives of the CHBC SSN

3.1.1 To provide guidance on material support to the chronically and terminally ill patients within their home environment.

3.1.2 To provide guidance on Psychosocial support services to the deserving patients and their family members in their homes.

3.1.3 To increase the level of HIV/AIDS awareness to the patients, their family members and the community members.

3.1.4 To enhance the social functioning of the recovering patients through rehabilitation.

3.1.5 To provide guidance on how to refer to appropriate stakeholders for relevant action.

4.0 DEFINITION OF COMMUNITY HOME BASED CARE

Community Home Based Care is the care given to individuals who are terminally ill in their own homes cared by their families; supported by Social Workers and other Social welfare providers to meet spiritual, material and psychosocial needs with the individual playing the crucial role.

This definition is adopted from the CHBC Operational Guidelines of 1996, and adapted to these Guidelines.
It may be defined as the care provided to patients (bedridden or ambulant) at home or in the community with the support of the professional health care workers.

5.0 PURPOSE FOR THE CHBC SOCIAL SAFETY NET (CHBC SSN) GUIDELINES

These guidelines serve to provide standardized implementation of the CHBC programme in the local authorities. They should be used as a guide that:

5.1 spells the criteria for assisting patients placed on CHBC.

5.2 for determining who qualifies to be given the CHBC food basket.

5.3 For establishing a referral system that avoid confusion in what has to be done.

5.4 In resource mobilization and utilization.

6.0 ELIGIBILITY FOR REGISTRATION UNDER HOME BASED CARE SOCIAL SAFETY NET (CHBC SSN).

REFERRAL SYSTEM

6.1 Both the Ministry of Local Government and the Ministry of Health have developed various client and family assessment and referral tools that are used in CHBC programme. Three of these tools will be used for assessment, registration and referral of clients for CHBC Safety Net. These are as follows:

- 6.1.1 Home Based Care (HBC) Programme Referral Form (MH 2071)
- 6.1.2 Family Care Assessment, Registration and Monitoring Tool (FCARM)
- 6.1.3 Inter Agency Referral Form (IAR)
- Statistics and monitoring tool
6.2 Patients who will benefit under the CHBC SSN programme will be those referred to the programme by the Government Medical Doctor. However patients who require emergency assistance will be assisted by Social Workers... The form used is MH 2071 which is in quadruplet (H/Facility, DHT, Patients File and S/Worker). The original is left in the patients file. Two copies are for District Health Team and the local health facility respectively. The health facility will refer the patient to the area Social Worker for Psychosocial support. The Social Worker therefore has to assess the socio-economic status of the patient as per the Operating Manual for the Revised National Policy on Destitute Persons to determine whether he/she qualifies.

6.3 Assistance under CHBC food basket is means tested. Provision of services such as counseling is mandatory. The criteria for assistance is based on the definition of a Destitute Person, as defined in the Revised National Policy on Destitute Persons of 2002, that is,

“An individual who due to disabilities or chronic ill health conditions is unable to engage in sustainable economic activities and has insufficient assets and income sources”.

6.4 Insufficient Income sources are:

Earning or receiving an income of less than P120.00 per month without dependants or less than P150.00 per month with dependants.

6.5 Chronic and/or terminal illness

6.5.1 Chronic and/or terminal illness in these guidelines refers to all illnesses that are not curable including but not limited to:

6.5.2 Cancer

6.5.3 All opportunistic diseases resulting from HIV infection, cumulatively causing AIDS.

6.5.4 Illnesses that have been resulted in patients being bedridden.

6.6 CHBC Vulnerable Children
6.6.1 These are the children of the patients registered under the CHBC SSN who are below 18 years, and are assisted as needy children as per the Revised National Policy on Destitute Persons.

6.6.2 These children should be assessed to determine their psychosocial, material and emotional needs as opposed to those of their parents.

6.6.3 They should be assisted in their own rights. The assistance should be family focused to cater for the nutritional needs of the patient and his/her dependents, that is, the number of food items issued should be determined by the number of the family members. The assistance should include school requisites as stated in the Revised National Policy on Destitute Persons of 2002.

7.0 TYPES OF ASSISTANCE

7.1 Food Basket

7.1.1 Patients receive food basket monthly that should be prescribed by government Dietician or otherwise be derived from the existing CHBC standard food basket based on the condition of the disease and the nutritional needs of an eligible patient determines it. There are mainly two types of patients, those on oral tube feeding and those not on oral tube feeding.

7.1.2 Patients on oral tube feeding require frequent feeding and their food basket is therefore more expensive.

7.1.3 The cost of the food basket for patient differs from patient to patient because of the different dietary requirements recommended by the Dietician. The costs for the two types of patients, that is those on oral tube feeding and those not on oral tube feeding are as follows:

7.1.4 The cost of prescribed food basket for patients on oral tube feeding will be up to P1200.00 per month.

7.1.5 The cost of food basket for patients not on oral tube feeding will be up to P500.00 per month.
7.1.6 The food basket determined by the Dietician/Medical Doctor should be reviewed after every 3 (three) months, to monitor progress.

7.2 Transportation

Transportation of needy CHBC patient's checkups is coordinated and managed under the programme. Vehicles purchased under the programme should be used for all transportation of the beneficiaries under this programme, through a joint venture of core service providers (Nurse/ Social Worker) under the programme.

7.3 Repatriation

CHBC Coordinator and Social Worker should undertake repatriation of patients jointly. A terminally ill patient should be accompanied by either a Nurse or a Social Worker depending on the condition of the patient.

7.4 Counseling

Counseling is a crucial aspect of the Community Home Based Care Social Safety Net Programme. It is therefore embedded into the programme and must be carried out by the CHBC Social Worker at all costs. This involves providing continuous counseling including HIV counseling. The objective of which is to assist, the patients accept their status and to live positively with the status. It should embrace preventative issues to reduce the risk or incidence of infecting the caregiver and significant others.

7.4.1 Social Work principles especially "confidentiality" should be adhered to when providing counseling.

7.4.2 It is defined as keeping secret information concerning the client disclosed in a professional relationship. This is an ethical obligation on your part as a professional. The client has to know however that his right in this regard is not absolute, that is, decisions are taken within the framework of the law and the operations of the agency.
Immediate family members of the patient are very crucial in the counselling and care of the patient, therefore sharing the confidentiality of the status of the patient with the immediate family (husband, wife, children old enough to provide care 10 year+) is necessary. However the patient’s consent of disclosure to significant others is necessary.

As already mentioned the client’s right to confidentiality is limited, for instance when there is a clear indication that:

- There is conflict within the client himself or
- this confidentiality conflicts with the rights of another individual or
- There is conflict with the rights of the professional, the agency or of the society as a whole.

7.4.3 The general principle to the above situations is that the secret of the client should not cause any harm to anyone else or agency

7.4.4 The above principle gives a guide to you as a professional of what to do when entering into a professional helping relationship.

7.4.5 Skills such as interviewing, listening and other intervention skills are requisite in executing this counselling process.

7.4.6 Dealing with human behaviour is not carved in stone; therefore provision of counselling services will be contextual and circumstantial.

7.5 Rehabilitation

7.5.1 Patients registered under this programme, recovering as a result of proper counseling, eating correct diet, adhering to the ARV therapy and responsible living are obligated to enroll in rehabilitation programme as described under the “Guidelines for Implementation of the Rehabilitation Programme for the Destitute Persons”. The medical doctor report will determine participation on the rehabilitation programme.
7.5.2 Registration for rehabilitation should be facilitated by routine reassessment of the patient to determine their recovery level. If the health status of the patient has improved, he/she will be required to enrol for his/her rehabilitation. Rehabilitation is required for improving the socio-economic functioning of recovering patients, so that they could take charge of their own lives by engaging in income generating activities.

7.5.3 Patients recovering should be referred to the Medical Doctor for review. This should be facilitated by the CHBC Coordinator.

7.6 Burial

Where there is a need registered CHBC patients who die while in the programme may be buried by council. The conditions of the provision should be as per the Revised National Policy on Destitute Persons of 2002. Budgeting for the funeral expenses of the CHBC patients is the responsibility of the CHBC Social Workers.

8.0 MANAGEMENT OF RESOURCES

CHBC resources should be coordinated and managed under the programme. These include:

8.1 Budgeting

The budgeting of the CHBC SSN should be prepared by the CHBC Social Worker for submission to National AIDS Coordinating Agency (NACA) through the Council Economic Planner and the Ministry of Local Government AIDS Coordinating Unit. This budget includes food basket and any other requirements for the patient based on assessment. Other office equipments and materials such as furniture, computers etc.

8.2 Upon approval of funds NACA will indicate the funds for CHBC SSN for proper accounting of the funds.
9.0 RESPONSIBILITIES AND OBLIGATIONS

9.1 Of the Patients

Patients are expected to:

9.2.1 Take responsibility for their own lives by honoring appointments for counseling sessions either in their homes or in the office

9.2.2 Honor appointments for medical check ups.

9.2.3 Collect treatment on scheduled dates, and to adhere to the treatment.

9.2.4 To adhere to the recommended diet

9.2.5.1 Not sell food issued to them

9.2.6 Take part in their rehabilitation and ensure enhancement of their social functioning.

9.3 Of the Care Givers

9.3.1 Care Givers are expected to provide basic needs of the patients and to ensure provisions under 9.0 of these guidelines.

9.4 Steps for failure to adhere to these Guidelines

The following steps for adherence were adopted from the Revised National Policy on Destitute Persons of 2002(6.10.5) and adapted to these Guidelines and they include:

a) The CHBC patients will be counseled to adhere to their responsibilities.

b) Members of the patient’s household will be counseled and enlisted to urge the patient to adhere.
c) The patient will be informed in writing and advised verbally that failure to adhere will result in loss of the benefits for three successive months.

d) Steps (a and b) will be repeated during the three months the benefit is being withheld.

e) The mental and psychological state of the patient will be assessed.

f) A recommendation to suspend the benefits will be submitted to the responsible council committee through the Chief Executive Officer.
ANNEX A

Reference Group Members
1. Hamilton Mogatusi
2. Motshedisi Sebipe
3. T. Omphitlhets
4. B. B. Mudanga
5. Delic Sehunwe
6. M. Selwe
7. L. N. Onneile
8. O. Morwalela
9. Francinah Moeletsi
10. C. K. Mareka
11. B. P. Mabilo
12. S. Sebetso
13. K. e. Ralekgobo
14. A. Mothobi
15. David Ngele
16. Edith Wabo
17. Keneilwe Mogomotsi
18. N. T. Lebani
19. M. N. Matsetse
20. J. Sebele