

Exploring the Effectiveness of Community Home-Based Care (CHBC) Programs in Africa with Examples from Some African Countries

S. M. Kang'ethe¹ and Vongai P. Mangwiro²

*University of Fort Hare, Department of Social Work and Social Development,
Private bag X1314, Alice 5700, South Africa
E-mail: ¹<skangethe@ufh.ac.za>, ²<200909461@ufh.ac.za>*

KEYWORDS IGA (Income-Generating Activities). HIV/AIDS. Resource-Constrained Countries. Sustainability. Developing Countries. Communities. Psychosocial Support

ABSTRACT Incontrovertibly, CHBC programs in developing parts of the world can be a panacea if their efficiency and effectiveness are enhanced or strengthened. The aim of this paper is to raise debates and discourses on the effectiveness of CHBC programs in some developing countries. The paper has relied on a review of literature methodology. Findings indicate that CHBC are generally made ineffective by: inadequate public support, inadequate government support, lack of human and materials resources, and lack of financial resources. The following have been suggested to bolster CHBC programs: increase public awareness and support, fostering a strong government-NGO partnership, mobilizing local funding, mobilizing adequate human and material resources, and adopting various ways of strengthening the effectiveness of the programs. The paper has theoretically been premised on the Sustainable Livelihood Approach (SLA).

INTRODUCTION

Internationally, the number of people living with HIV/AIDS is increasing alarmingly especially in resource strapped countries of the developing part of the world (WHO 2002). This also means that the resources to help the PL-WHA go on decreasing as the number burgeons (Ramphela 2008; Barnett and Whiteside 2006). However, the response of community members to volunteer and manage and run community home-based care programs is commendable. This is considered a panacea especially in countries where the bed capacity is low to cater for the increasing number (WHO 2002). The rationale behind the current expansion of CHBC programs in low- and middle-income countries partly reflects a pragmatic response to the lack of human resources and financial resources required to provide HIV care for diagnosed persons. People especially those on ART need adequate care and if the hospitals and hospices cannot provide the care, then community home-based care remains to be the only solution. They are therefore considered a panacea in finance-constrained countries (Marhal et al. 2004; Van Damme et al. 2006).

Conceptually, Community Home-Based Care is the care provided to chronically or terminally ill patients and other with debilitating sickness-

es, such as those with HIV and AIDS, TB, and cancer by friends, family and community members (Kang'ethe 2010a). This care takes place either at the home of the sick person, or at the home of the caregiver or the party giving care and assistance (Ministry of Health 2005; Muchiru and Florich 1998). The core objective of CHBC is to extenuate the effects of HIV/AIDS, reduce pain and suffering of the clients so that they can have a better social functioning (Kang'ethe 2006).

The CHBC program enables the society and families to cope effectively with the physical, psychosocial and spiritual needs of those living with life threatening illnesses and prepare patients for a dignified death. However, according to Southern Africa AIDS Information Dissemination Services (SAFAIDS) (2008), most CHBC programs and services have fallen short in terms of the quality and effectiveness of their service provision. Unfortunately, CHBC programs in these developing countries are facing challenges, which hamper them to fully accomplish their desired goal even if the programs have been implemented to aid people. The challenges include lack of public support, poverty, lack of government support, lack of funds and lack of human and material resources. In these researchers' opinions, the effectiveness of CHBC programs in a few countries of the developing world

would be successful if people are educated more on how to reduce the impacts of HIV/AIDS, improve the patient's ill health and if more funds and resources are made available. These researchers therefore consider it pertinent to explore the effectiveness of CHBC programs and recognize the challenges that these programs are facing as they try to ameliorate the impacts of HIV/AIDS. This paper, therefore fuels arguments and criticisms on the effectiveness of CHBC programs in a few countries of the developing world.

Statement of the Problem

Worldwide, CHBC programs have increased as the cases of HIV/AIDS continue to burgeon in many countries especially those of the African continent hardest hit by the epidemic. This phenomenon has disastrous and perfidious outcomes, especially of phenomenal increase in the number of orphans and vulnerable children. Although considerable commitment has so far been demonstrated by many countries hardest hit by the epidemic, apparently delivering comprehensive CHBC programs is often hindered by weak linkages with other HIV services. Top-down donor policies and a lack of sustainable and consistent funding strategies present a formidable threat to these programs in the long term (Wringe et al. 2009). Therefore, these researchers consider it central to explore the effectiveness of CHBC programs in a few countries of the developing world in an endeavor to work out some sustainable solutions to the quagmire. People living with HIV/AIDS need effective services as they battle with the disease.

Rationale of the Study

The main aim of this paper is to analytically raise arguments and discourses on the effectiveness of CHBC programs in a few countries of the developing world with an endeavor to work out modalities and strategies of improving the conditions of HIV/AIDS patients and those with debilitating sicknesses.

METHODOLOGY

The paper uses a review of literature methodology quoting various CHBC journals, books

and has benefitted from the researchers' experience in working in the HIV/AIDS domain.

OBSERVATIONS AND DISCUSSION

The Challenges that Impede the Effectiveness of Community Home-Based Care Programs in Selected African Countries

Inadequate Public Support

Since community home-based care programs are usually run and managed by volunteers, community and public support is critical for their sustenance (Kang'ethe 2010b). However, even public and community support face challenges in that communities have different values, norms, and beliefs, which makes it more difficult for most CHBC programs to encourage people to work together in the fight against HIV/AIDS pandemic. This situation is exacerbated by the state of stigma that makes people fear that those infected can easily infect them. This is serious because it has led some families to abandon their children, parents, and brothers. In some extreme cases, those who discover they are sero-positive and who are not exposed to HIV/AIDS knowledge have even committed suicide (Barret-Grant et al. 2001). Subjectively, there are therefore many stumbling blocks especially of attitudinal nature that besets optimal support of people living with HIV/AIDS. Other structural challenges include poor communication, poor referral system and lack of knowledge and skills among health staff (Wandwalo et al. 2004; Kang'ethe 2008). In a Kenyan study, researchers noted that a failure to include community members in discussions relating to the implementation of HBC programs resulted in a local campaign against the organization to prevent potential beneficiaries from participating in program's activities (Waterman et al. 2006).

Religious belief systems also present a formidable challenge to the public support of PLWHA. To this end, Pindani (2008) contend that what is surprising is that even now some churches and church members believe that HIV and AIDS is a punishment from God. This has led to such church followers distancing themselves from people living with HIV/AIDS. Similarly, in Ecuador and Zambia, some PLHIV have reported personal experiences of stigma and discrimination because of their visible involvement in

delivering services or working with an NGO providing HBC services (Cornu and Attawell 2003). Other perfidious effects associated with stigma and stigmatization include reluctance by PLWHA to disclose their HIV status, sometimes creating a stumbling block to effective CHBC delivery (SAFAIDS 2008). Due to stigma, some PLWHA in Botswana and their caregivers have been reported to going far away from the nearby clinic to fetch medication or treatment for fear of being known and stigmatized by their communities (Kang'ethe 2010c).

Inadequate Government Support

Although community home-based programs are run through community volunteerism and goodwill (Kang'ethe 2010b), communities may not have adequate resources needed to make the programs run successfully. Although immense progress in support of CHBC programs is in record, but still many programs are skeletal and lacking in many professional tools and resources. For community home-based care programs to be effective, the government has to provide all the requisite tools that the sick people require. Unfortunately, some research on the provision of requisite CHBC tools has shown that such support has not been adequate. For example, a research in Botswana by Kang'ethe revealed that out of the tools that the government had promised or considered necessary for community home-based care programs, there was not enough to competently and effectively run the program (Kang'ethe 2009). Perhaps the phenomenon in Botswana prompted some community members to view the program as a dumping process. However, Akintola (2004) argued that CHBC is largely being sustained by the work of non-governmental and community-based organizations, with minimal support from the government.

Lack of Human and Material Resources

In most African countries, human and material resources are very essential components to ensure a successful CHBC program and in improving the conditions of all the patients under CHBC programs (Kang'ethe 2009). Although community members need to be commended for their spirit of volunteerism, it is a naked fact that

it is usually the poor and the illiterate who usually volunteer their services. With HIV/AIDS becoming a complex disease especially due to complexity of opportunistic diseases such as tuberculosis, this requires knowledgeable human resource. Some illiterate caregivers in Botswana indicated that sometimes they are not in a position to perfectly track the disease progression of their clients due to the limited knowledge pertaining to the disease (Kang'ethe 2006). Due to meager human and material resources, to run community home-based care programs, many countries especially of Africa face a multitude of challenges and limitations, which not only adversely affect their ability to carry out their activities, but also have the potential to exacerbate poverty and existing gender inequalities among affected families and communities (Mohammad and Gikonyo 2005). According to Mohammed and Gikonyo (2005), there is a lack of careful assessment of the needs of the communities' capacities to support the programs. It is imperative to identify these needs and recognize how and which ones the CHBC program can address. Pessimistically, when patients are referred to home to receive CHBC services without adequate assessment of their domestic environment, caregivers often find themselves struggling to accommodate patients in a home lacking adequate shelter, food, safe water, proper sanitation, and clothing (Ngwenya and Kgathi 2006; Shaibu 2006). In some cases, minors have been left to provide human resource to assist the sick people. This has been reported to endanger their physical, social and psychological wellbeing (Kang'ethe 2010d).

As a result, CHBC programs are unable to implement and adequately deliver services to their clients due to insufficient resources, such as overhead funds, CHBC kits and educational materials (Mohammad and Gikonyo 2005). According to MOCHW (2010), there is lack of a national strategy or policy addressing food and nutrition insecurity in vulnerable households with PLHIV. However, critiques argue that many CHBC services in southern Africa have been developed through unsystematic, needs-based efforts and debate that more emphasis must be placed on taking a more formalized, organized, and programmatic approach in establishing these programs (Ogden et al. 2004).

Lack of Financial Resources

Availability of financial resources remains one of the drivers of health infrastructure the world over. Since most governments of the developing world suffer a weaker financial base, funding from either local or overseas donors has been an important factor in funding community home-based care programs in many resource strapped countries of the world (WHO 2002; Kang'ethe 2010e). In Africa, the lion's share of the funds for running or bolstering HIV/AIDS programs have usually been sourced from abroad (WHO 2002). However, this source of funding has increasingly dwindled especially after the western world experienced the state of economic meltdown at the close of the first decade of the 21st century. Some countries such as Botswana have received enormous financial support from the Bill and Melinda Gates Foundation especially through the African Comprehensive HIV/AIDS Program (ACHAP), a government-public collaboration. Precisely, ACHAP was in the first decade of the 21st century holistically involved in financing the antiretroviral (ARV) roll-out program and putting in place a formidable infrastructure pertaining to testing and distribution of ARVs (ACHAP 2005; Kang'ethe 2010e). Lack of funding has severely affected many countries of Africa. For example, in Zimbabwe, if the current funding does not improve, the quality of community home-based care programs will continue to weaken. Zimbabwe has been affected by bad political governance that has slammed the country with economic sanctions. This means that donors and erstwhile donor agencies have pulled out leaving CHBC programs to rely on unreliable community support. Even if this is forthcoming in various instances, this has not promised significant quality of care. If then the current quality of care is anything to be accounted for in many countries of Africa such as Botswana, it means that the countries will not score significantly in the health-related MDGs (UNDP 2004). This calls for an analysis of the national policy on community home-based care, for standards and guidelines on internal funding. The home-based care programs require strengthening for enhanced efficiency and effectiveness with regards to management, and resource utilization. According to Mohammad and Gikonyo (2005), reduced donor support is currently undermining the ef-

fectiveness of CHBC programs as organizations either scale down or reach out to clients with very limited services. Chela et al (1994) is of the view that although the survival of the programs in many African countries reflects their sustainability in the medium term, their dependence on foreign funding, and their sustainability in the long run may not be ensured.

Strategies to Bolster CHBC Programs in Selected Countries of the Developing World

Increase Public Awareness and Support

The governments in a few countries of the developing world should take the initiative to engender community participation. This will strengthen these programs' community goodwill and therefore ownership (Kang'ethe 2006). This could be one of the approaches that can enhance their sustainability. This calls for grass-roots leadership to be involved in mobilizing their constituents to embrace, accept and assist in the running of these programs (Kang'ethe 2006). This will encompass conducting regular meetings with the leaders and groups (Mohammad and Gikonyo 2005). An extension of 'sensitization' and 'mobilization' activities has often been identified as a strategy to overcome the apparent lack of community ownership for CHBC activities in some settings. These researchers would like to see a more active involvement of faith-based organizations. Because of their position of power and the people's loyalty towards them, faith-based organizations can be good agents of marketing the need for communities to assist community home-based care programs, financially, human resource wise and through volunteerism (Kang'ethe 2010b; Byamugisha et al. 2002). Faith-based organizations would especially be strong launching pads to campaign against stigma and discrimination. Thus, they will counter the erstwhile doctrines, ideologies and stereotypes from faith-based bodies that viewed those living with HIV/AIDS as sinners that people should have no concern of (Byamugisha et al. 2002).

Governments should Partner with NGOs to Support CHBC Programs

These researchers contend that the government should work hand-in-hand to form formi-

dable partnerships with the NGOs and other private bodies to finance CHBC programs or provide the much-needed human resource, especially to effectuate management. Objectively, CHBC programs need financial and technical support from governments, NGOs and development to enhance various care activities with the potential to positively impact the health and social status of the PLWHA and prolong their need for additional complex medical care (PATH 2001). Subjectively, the government should undertake a bigger role in CHBC delivery to make sure that HIV/AIDS patients and their families have all the necessary available quality of care, treatment and support they need. To this end, a few countries in the developing world should make efforts to have a budget to finance CHBC programs in order for them to be effective.

Mobilize Local Funding

The developing countries in the world should mobilize their business communities and the general populace to embark on raising funds to support the running of community home-based care programs (WHO 2002; Kang'ethe 2006). This is because donors have been exhausted with the developing countries habit of ever expecting assistance from them. Donor assistance has also created a dependence syndrome that is not developmental in nature. To this end, countries need to rise to the challenge usually presented by the World Health Organization, for them to look for their economic solutions in their backgrounds (WHO 2002). This means recognizing and exploring different indigenous ways of raising funds. This is why many social work gurus such as Mupedziswa and Osei Hwedie are increasingly advocating for a paradigm shift in the way countries' social work is carried out using foreign curriculum and ideologies. They are advising countries to take the route of indigenization as a plausible and rational way of approaching problems (Mupedziswa 2005; Osei-Hwedie and Rankopo 2008). Perhaps an apparent sustainable approach will be to have these CHBC programs initiate income-generating activities (IGA) in order to increase their level of sustainability (Kang'ethe 2010e). The NGOs in collaboration with the government should help CHBC programs initiate their own income-generating projects to enable them to financially sustain themselves. However, caution needs to

be taken because such IGAs are only likely to be successful and sustainable if they correspond to the interests and skills of local people. The projects should be people driven and their design should enlist adequate community participation (Kang'ethe 2006, 2010e)

Mobilizing Human and Material Resources

Even though CHBC programs are playing a greater role in the fight against HIV/AIDS, there is need to ensure that CHBC programs are run or managed by a cadre of well-qualified personnel. This is to ensure effective and efficiency utilization of the meager resources (WHO 2002). Lindsey et al. (2003) assert that receiving preparatory information, continued training and support from the health workers might be important components in influencing coping and provision of quality care among home-care providers.

However, quality services can be effective if caregivers have sufficient resources and other support infrastructure to enable them manage health problems more effectively and therefore reducing deaths and mitigating the effects of other debilitating illnesses.

Increase the Effectiveness of CHBC Programs

Although mitigating the effects of HIV/AIDS remains both an arduous and an uphill task in many resource constrained countries of the developing part of the world (WHO 2002), research findings show that there has been some improvements in tackling cases of HIV/AIDS generally. Nevertheless, the programs continue to face challenges in providing better services, which means that although implemented, there are myriad gaps that continue to impede the process of qualitative care (Kang'ethe 2008, 2009; WHO 2002). This is important for the care process to be benchmarked with cases of best practice experience in other care settings of the world. To this end, UNAIDS (1999) defines best practice as the continuous process of learning, feedback, reflection and analysis of what works or does not work, and identifies effective programs based on research and evaluation. Such programs present lessons in strengths and weakness, and information useful for programs and policies.

Moreover, UNAIDS explains that the effectiveness of a program or practice is the extent to

which it produces the defined outcomes and meets its objectives, which includes relevance, ethical soundness, sustainability, effectiveness and efficiency relevant to the program. This means that all the HIV/AIDS hit countries should take note of the best practice, the objectives and strategies of the best practice programs. Despite some efforts to cost HBC interventions in Zimbabwe, Rwanda and Uganda (Hansen et al. 1998), there has been little work on exploring the relative costs or cost-effectiveness of different HBC strategies across settings. Therefore, further research is needed in this field. According to WHO (2002), the first step in providing effective CHBC is to assess the patient's environment and make sure that the basic needs of the patient and family are being met. This includes ensuring that families have adequate shelter, food, safe water, proper sanitation and clothing. Subjectively, observation on the ground shows that most CHBCs have not been able to follow-up on the patient's environment before they discharge them. This points to the importance of careful planning of CHBC programs. It is also critical that operational partnerships and referral mechanisms are established at local, regional, and national levels upon implementation of the program (Defilippi 2005). Mohammad and Gikonyo (2005) also argue that effective CHBC programs for people living with HIV/AIDS can only be achieved through a "continual cohesive commitment between communities, governments, organizations, and development agencies/donors".

Theoretical Frame

The Sustainable Livelihoods (SL) Approach

The Sustainable Livelihoods was advocated by Robert Chambers in the mid 1980's (Kolmar and Juli 2002). The theory embraces that livelihood should be sustainable when it can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation, and which contributes net benefits to other livelihoods at the local and global levels both in the short and long term. The SL approach serves primarily as a programming framework to devise a set of integrated support activities to improve the sustainability of livelihoods among poor and vulnerable groups,

including those living with HIV/AIDS by strengthening the resilience of their coping and adaptive strategies (UNDP 1997). The approach is a people-centered approach and it recognizes that people have certain rights but also certain responsibilities to each other and to the society. It recognizes the enormous diversity among the people living with HIV/AIDS, the extremely poor people in the world, and stresses the strengths of these people.

According to Hussein (2002), the SL approach integrates environmental, social and economic issues into a holistic framework for analysis and programming from the beginning. This is especially true in identifying not only the types of assets which people use, but also how existing livelihoods can be strengthened with new and appropriate technologies and corresponding social and economic investments. Nevertheless, the SLA can be used both, as an instrument in CHBC programs to establish and evaluate data, and as a program to design and explain interventions to address the various challenges that CHBC faces as they try to extenuate the impacts of HIV/AIDS. Even though they are many theories that can support this paper hypothetically, Robert Chambers' SL approach accentuates that people who are in poverty, including the HIV/AIDS patients and other chronic patients have the strength to build and sustain themselves if only they receive guidance and have enough resources to equip them. Consequently, HIV/AIDS patients, the government, NGOs and the public in a few countries of the developing world should be sophisticated and enabled through the principles of SL approach in order for CHBC programs to be effective and improve the conditions of HIV/AIDS patients.

CONCLUSION

The fight against HIV/AIDS can only be achieved if various organs involved in the fight such as community home-based care programs, are well implemented and operationalized with adequate human resources as well as being equipped with requisite material and financial resources. This is to make the programs run both, efficiently and effectively. However, many programs in the developing part of the world lack necessary financial, material and human resources to make them effective. It is critical therefore, to challenge the government, the NGOs and the

private care friendly organizations to come together and craft a workable modality to strengthen both the efficiency and the effectiveness of CHBC programs. Helping them initiate income-generating activities will strengthen their sustainability.

REFERENCES

- ACHAP 2005. *ACHAP (African Comprehensive HIV/AIDS Partnership) Update*. December.
- Akintola O 2004. *A Gendered Analysis of the Burden of Care on Family and Volunteer Caregivers in Uganda and South Africa*. Health Economics and HIV/AIDS Research Division (HEARD). South Africa.
- Barnett T, Whiteside A 2002. *AIDS in the Twenty-First Century- Disease and Globalization*. Hampshire: Palgrave Macmillan.
- Barret-Grant K, Fine D, Heywood M, Strode A 2001. *HIV/AIDS and the Law: A Resource Manual*. 2nd Edition. Johannesburg, South Africa: AIDS Law Project and the AIDS Legal Network.
- Byamugisha G, Steinitz LY, Williams G, Zondi P 2002. *Journeys of Faith: Church-based Responses to HIV and AIDS in Three Southern African Countries*. Oxford: G and A Williams.
- Chela CM, Msiska R, Sichone M, Mwinga B, Martin A, Yamba CB, Anderson S, Van Praag E 1994. *Impact of Home-Based Care for People Living with HIV/AIDS in Zambia*. Zambia: Ministry of Health, Zambia and Global Program on AIDS World Health Organization.
- Cornu C, Attawell K 2003. *The Involvement of People Living with HIV/AIDS in Community-based Prevention, Care and Support Programs in Developing Countries*. New York: Population Council/International HIV/AIDS Alliance.
- Defilippi Kath 2005. Integrated community-based home care: Striving towards balancing quality with coverage in South Africa. *Indian Journal of Palliative Care*, 11(1): 34-47.
- Hansen K, Woelk G, Jackson H 1998. The cost of home-based care for HIV/AIDS patients in Zimbabwe. *AIDS Care*, 10: 751-759.
- Hussein Karim 2002. *Livelihoods Approaches Compared: A Multi-Agency Review of Current Practice* [PDF]. October.
- Kang'ethe SM 2006. *Contribution of Caregivers in Community Home Based Care Programmes: The Case of Kanye, Botswana*. PhD Thesis, Unpublished. South Africa: University of North West.
- Kang'ethe SM 2008. Challenges that referral system poses to care giving in Botswana. *Social Work Maatskaplike Werk*, 44(4): 355-368.
- Kang'ethe SM 2009. Challenges impacting on the quality of care to persons living with HIV/AIDS and other terminal illnesses in Botswana. *Journal of Social Aspects of HIV/AIDS (Sahara)*, 6(1): 24-32.
- Kang'ethe SM 2010a. Exploring the psychosocial palliative caregiving position associated with Kanye HBC Programme. *Botswana Notes and Record Journal*, 42: 112-153.
- Kang'ethe SM 2010b. Exploring states of panacea and perfidy of family and community volunteerism in palliative care giving in Botswana. *Indian Journal of Palliative Care*, 16(1): 15-22.
- Kang'ethe SM 2010c. The perfidy of stigma experienced by the palliative community home based care (CHBC) caregivers in Botswana. *Indian Journal of Palliative Care*, 16(1): 29-35.
- Kang'ethe SM 2010d. The dangers of involving children as family caregivers of palliative care and home based care to advanced HIV/AIDS patients in Botswana. *Indian Journal of Palliative Care*, 16(3): 117-122.
- Kang'ethe SM 2010e. Evaluation of the support to caregiving by local Non- Governmental Organizations (NGOs) support in the Kanye care programme, Botswana. *Social Work Maatskaplike Werk*, 46(2): 209-223.
- Kollmair M, Juli G 2002. *The Sustainable Livelihoods Approach*. Zurich: University of Zurich.
- Kgathi DL, Ngwenya BN 2006. HIV/AIDS and access to water: A case study of Home-based care in Ngamiland. Botswana. *Physics and Chemistry of the Earth*, 31(15): 669-680.
- Lindsey E, Hirschfeld M, Tlou S 2003. Home-based care in Botswana: Experiences of older women and young girls. *Health Care Women Int*, (6): 486-501.
- Muchiru S, Florich J 1999. *HIV/AIDS Home Based Care*. Gaborone, Botswana: Macmillan, Botswana Publishing Co (Pty) LTD.
- Ministry of Health 2005. *Malawi Community Home Based Care Policy and Guidelines* 2005. Lilongwe: Malawi.
- Marchal B, Kegels G, De Brouwere V 2004. Human resources in scaling up HIV/AIDS programmes: Just a killer assumption or in need of new paradigms? *AIDS*, 18(15): DOI: 10.1097/00002030-2000410210-00023.
- Mohammad N, Gikonyo J 2005. *Operational Challenges Community Home Based Care (CHBC) for PLWHA in Multi-Country Aids Programs (MAP) in Africa*. Washington DC: World Bank.
- Mupedziswa R 2005. Challenges and prospects of social work services in Africa. In: JC Akeibunor, EE Anugwon (Eds.): *The Social Sciences and Socio-economic Transformation in Africa*. Nsuka: Great AP Express Publishing, pp. 271-317.
- Ogden Jessica, Simel Esim, Caren Grown 2004. Expanding the Care Continuum for HIV/AIDS: Bringing Careers into Focus. *Horizons Report*. Washington, D.C.: Population Council and International Center for Research on Women.
- Osei-Hwedie K, Rankopo M 2008. Developing culturally relevant social work education in Africa: The case for Botswana. In: M Gray, J Coates, MY Bird (Eds.): *Indigenous Social Work Around the World*. Cornwall: Ashgate, pp. 203-219.
- PATH 2001. Outlook/Volume 19, Number 2. From <outlook@path.org>
- Ramphele M 2008. *Laying Ghosts to Rest- Dilemmas of the Transformation in South Africa*. Cape Town: Tafelberg.
- SAFAIDS 2008. *Caring from Within: Key Findings and Policy Recommendations on Home-Based Care in Zimbabwe*. Harare: Health and Development Networks (HDN) and Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS).

- Shaibu S 2006. Community home based care in a rural village: Challenges and strategies. *Journal of Trans-cultural Nursing*, 17(1): 89 – 94.
- UNAIDS 1999. *UNAIDS Case Study: Comfort and Hope: Six Case Studies on Mobilizing Family and Community Care for and by People with HIV/AIDS*. UNAIDS Best Practice Collection.
- UNDP 2004. *Botswana Millennium Development Goals Status Report: Achievements, Future Challenges and Choices*. Gaborone: Government of Botswana and UNDP.
- UNDP 1997. *Promoting Sustainable Livelihoods: A Briefing Note Submitted to the Executive Committee*. June. (Mimeo).
- Van Damme W, Kober K, Laga M 2006. The real challenges for scaling up ART in sub-Saharan Africa. *AIDS*, 20: 653-656.
- Wandwalo E, Kapalata N, Tarimo E, Corrigan CB, Morkve O 2004. Collaboration between the National Tuberculosis Programme and a Non-Governmental Organization in TB/HIV care at a district level: Experience from Tanzania. *Africa Health Sci*, 109-114.
- Waterman H, Griffiths J, Gellard L, Olang G, O'Keeffe C 2006. *Action Research Project: Home-Based Care for People Living with HIV/AIDS*. Manchester: Mild May International.
- Wringe A, Cataldo F, Stevenson N, Fakoya A 2009. *Delivering Comprehensive Home-based Care Programmes for HIV: A Review of Lessons Learned and Challenges Ahead in the Era of Antiretroviral Therapy*. Centre for Population Studies. Keppel Street, London: London School of Hygiene and Tropical Medicine.
- World Health Organization (WHO) 2002. *Community Home-Based Care in Resource-Limited Settings: A Framework for Action*. Geneva: WHO.