

# **Challenges of HIV and AIDS-related community home-based health care delivery system in Roma Valley, Lesotho**

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## **Abstract**

Community home-based health care plays a major role in the care of patients who take medication at their homes, and other vulnerable categories of people. This study investigates the problems and prospects of community home-based health care in the Roma Valley Maseru, Lesotho. The population of the study consists of health professionals at St. Joseph Hospital who are members of the Roma Valley Community Home-Based Health Care Organisation, local chiefs, and a team of women who are caregivers in Roma Valley villages. Two methods were used to collect the data: key informant interviews and in-depth interviews. The study revealed that the organisation is experiencing many problems, including lack of funds, shortage of working facilities, lack trained of personnel, and lack of incentives for volunteers. Among other possible attempts to substantiate and champion community home-based health care in Lesotho this study recommends a social policy that governs the system should be formulated. The government of Lesotho should allocate some budget for this kind of health care programmes. Furthermore, community-based food security projects supporting people living with HIV and AIDS and other home-care recipients could be of vital importance. Furthermore, full-time professionals participating in community home-based health care services should be employed.

**KEYWORDS:** health care, community support, HIV, AIDS, Lesotho, Southern Africa

## **Introduction**

In Lesotho, the burden of HIV and AIDS disease is overwhelming; the Ministry of Health and Social Welfare reported that more than 50% of outpatient visits to hospitals were for AIDS-related ailments, and that more than 60% of inpatient are in hospital due to AIDS-related illnesses. It is further reported that the number of orphans is rapidly increasing as a result of HIV- and AIDS-related deaths (GOL 2007). Some of the identified drivers of

the HIV and AIDS epidemic in the country include inadequate behaviour change despite widespread HIV and AIDS awareness, and stigma that prevents disclosure and responsible behaviour. Due to the present situation, the government of Lesotho along with other South African Development Community heads of state declared HIV and AIDS to be a national and regional disaster; since then, the issue of HIV and AIDS has remained a top priority on their agenda (Matobo, Obioha & Mpemi 2008).

The government of Lesotho officially accepted the Primary Health Care Strategy in 1979 and has set out implementing it in three-to-five-year plans. The country is divided into 18 health service areas (agencies), which can operate independently and which have a three-tier referral system (Dennill, King & Swanepoel 2004). The World Health Organisation (1998) defines Primary Health Care as essential care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation at a cost that communities and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination to promote proper health care for everybody.

With regards to the participation of communities and families, the concept of primary health care encompasses community home-based health care and at times it is referred to as “the Community Primary Health Care System”. In Lesotho, at the district level, the communities are given responsibility for their own health and health development, and elect their own committees. These committees are usually established according to legislation passed in 1981, and membership usually includes traditional leaders and healers (Dennill, King & Swanepoel 2004).

There is an increasing number of HIV and AIDS patients and patients with HIV and AIDS-related diseases in Lesotho, such as tuberculosis, gonorrhoea, cancer and many others. At present, Lesotho has a population of 1,880,661 (2006 national census) with an HIV infection prevalence rate of 23.2% (Ministry of Health and Social Welfare 2008). This results in large numbers of people queuing at hospitals for health services and congestion in hospital wards; therefore, community home-based health care, under the umbrella of the primary health care system, came as an intervention in which patients are taken care of at their homes and through community action (Van Dyk 2002). Moreover, according to Dennill, King and Swanepoel (2004), a shift in the emphasis of health care is necessary; from curative hospital-based care to community home-based health care. The above views correspond with the earlier position of Kimane (2002), who contends that community home-based health care has attracted significant attention in recent years in Lesotho.

This kind of health care is given to individuals in their own homes where they are supported by their families, their extended families or those of their choice as members of the community. It is a functional care system that assumes community action when units of community, such as nearby hospitals, spiritual leaders, traditional healers and professionals such as social workers, counselors, nurses and volunteers, work on an integrated perspective in caring for patients in their own home environment. Van Dyk (2005) states that in ideal circumstances, family community caregivers are supported by a multidisciplinary team that can meet the specific needs of the individuals living with HIV

and AIDS and others in critically ill health conditions. Van Dyk earlier (2002) contended that community home-based care programmes are meant to empower the community and families to cope effectively with the physical, psychosocial and spiritual needs of those living with HIV infection and AIDS, including those with other ill health conditions. Community home-based health care should constitute of different categories of people with diverse skills and exposure in social and health areas. This is so as to provide patients with care at their social, health spiritual, emotional and psychological levels. However in Third World countries such as Lesotho, home care is not provided at all necessary levels as it ideally should. Therefore, the delivery of this kind of health care is faced with a number of problems.

In previous Basotho generations, giving home care was not a social and health issue: it was simply the way people responded to a dependent family member. Nonetheless, HIV and AIDS make demands on the community and society that cannot be met by hospitals alone. Families, loved ones and the community all have indispensable roles to play in supporting and taking care of individuals with HIV and AIDS, orphans, and other categories of the chronically ill, including the elderly. However, the challenges are currently increasing, as the overwhelming rate of orphans proves that many people, especially productive middle-age parents, are dying of HIV and AIDS in Lesotho. As in some other countries in sub-Saharan Africa, many children live in homes and communities ravaged by the effects of HIV and AIDS (WHO 1995). Due to this situation, the demands on families and the community do not end with the death of the patients only, but the AIDS pandemic has left behind millions of orphans and other children made vulnerable by HIV and AIDS in Africa, and the conditions in which these children live are often appalling. This situation presents a challenge to the future of Lesotho and most African communities, especially amongst children who stand the risk of being killed by AIDS if communities do not reach out appropriately to help these children and secure their future.

In essence, contemporary community home-based health care is caring for HIV and AIDS patients so that they live longer, mainly through educational measures as its mandatory issue, asserted Van Dyk (2005); nevertheless, many people are dying at a higher rate than would be expected. This alarming situation is in distinct contradiction to observations that this kind of health care is a success in Lesotho (Dennill, King & Swanepoel 2004) and specifically in the Roma Valley axis of the country (Molale 2009). The present situation in Lesotho, therefore, leaves much to be desired in terms of addressing the problems of the community home-based care system. It is against this background that this study attempts to determine what hinders community home-based health care from meeting its mandate of ensuring a relatively longer life for HIV and AIDS patients and other related diseases, since a vast number of people is dying at a very high rate, as proven by high rate of orphans.

## **Objectives and framework of the study**

This study investigated the problems and prospects of the community home-based health care system in Roma Valley. Specifically, the study investigated the operations and functionality of the system in the study area; it investigated the objectives of the system; and it assessed the challenges and problems facing the community home-based health care system in Lesotho.

According to Dennill, King and Swanepoel (2004), the overall objective of a community home-based health care system is to deliver health services efficiently and effectively through infrastructure that covers the health needs of communities at the grassroots level. According to the authors, this process needs to be dynamic, as it will be influenced by the political, cultural, technical and financial factors of the country. They further state that it will also require the consideration of available resources to meet this new structure, with a shift of resources going to the community for health care. Moreover, they assert that the concept of the community home-based health care promotes an approach to health care based on principles that allow people in their communities and families to receive the care that enables them to lead socially and emotionally productive lives. This means that community home-based care is not only concerned with the health statuses of patients, but is also concerned with the emotional and social well-being of the whole clientele.

WHO (1988) points out that this kind of health care is viewed as the first level of contact with individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care services. Furthermore, Spencer (1990) refers to community home-based health care as a means of ensuring the optimal health levels of physical, mental, social and environmental circumstances that can be attained for any given community; this author further states that community circumstances will not be static but will always be changing, as will the needs of the people and the methods of fulfilling those needs. Therefore, the state of the community's health has to be constantly measured so that its needs and priorities can be met. According to Kaye (1990), the range of potential community home-based health care service recipients is exceedingly large and diverse, encompassing mainly HIV/AIDS patients, the developmentally disabled, post-hospitalisation patients, the chronically and physically impaired of all ages, the mentally ill requiring home-based hospice care, new-born infants and their mothers and, finally, abused older adults and children. However, currently community home-based health care predominantly concentrates on caring for chronically ill patients living with HIV/AIDS. This is inevitably so since HIV/AIDS has dramatically taken the lead in the cause of other health problems; therefore, community home-based health care is a holistic concept.

Kaye (1990) contends that funding for community home-based health care services is open-ended: there is no cap on the amount that may be expected, but utilisation patterns reflect low levels of expenditure. Reimbursable home health care services must be provided by a certified community home health care agency in a manner similar to that of hospital-insurance companies; similar fiscal intermediaries assist in the administration of

the program, processing claims determining eligibility, and reimbursing “reasonable costs”. Of greater importance is that the funding of health care services depends on whether the care giving organisation is run by a governmental or by a non-governmental body.

According to Spencer (1990) community home-based health care entails that the medical profession is no longer the only group responsible for health care. Rather, a community home-based health care team consists of doctors, nurses, laboratory and diagnostic experts, physiotherapists, occupational therapists, social workers, health inspectors, welfare and voluntary workers, auxiliary health workers, educators, and many others. Each of the aforementioned members contributes to care provision on the basis of their area of specialisation through a multidisciplinary approach.

In the operation of this kind of health system Spencer (1990) emphasises what he calls “community medicine”, which is directed to the care of whole communities. Therefore, in this case, the whole community is the client. In diagnosing an individual patient’s condition, various methods are employed, such as measuring pulse rate, temperature, blood pressure, listening to the sounds of heart and lungs, feeling for abnormalities of the organs and many other diagnostic considerations. It is clear that the practice of good community medicine requires the best comprehensive medical care of patients and families that can be obtained in all circumstances for a particular community. A community home-based health care organisation is, therefore, responsible for the entire running of the care provision system. Through the elected committee members, the care organisation is responsible for the following: recruitment of caregivers, coordination of care provision activities, controlling of resources, and the general implementation of policies guiding the provision of care.

There are many problems associated with community home-based health care operations. Taking the case of Lesotho, although Health and Social Welfare policy (2003: 11) emphasises community involvement ‘through ownership of community projects, communities will be masters of sustainable primary health care programs in their own areas,’ there is no properly organised system of community home-based health care, except by non-governmental organisations, (NGOs) and none is even proposed in the recently proposed National Welfare Policy (2002), observed Nyanguru (2002). The Department of Social Welfare, which under normal circumstances would be vested with a mandate to develop such a system is understaffed to cope effectively with providing support to such a system as community home-based health care, observed Kimane (2002), Nyanguru (2002) and Chisepo (2001). Nyanguru (2002) points out that incidence of HIV/AIDS evident in the country at the moment makes it imperative that a system like community home-based health care be developed as quickly as possible to take care of (among others) the swelling numbers of orphans. He notes, however, that extremely limited numbers of social workers makes this kind of health care options less effective. In addition, Dennill, King and Swanepoel (2004) believe that that since resources are limited, priority is given to providing new services to rural areas that have previously received little or no service. They further point out that inaccessibility of the mountainous areas and the wide distribution of people in these areas make the satisfactory distribution of services almost impossible.

Apart from the particularities of Lesotho, there are other general problems encountered by community care organisations. Other barriers to effective health care services relate to official policy and the nature of health care services (*ibid.*). Factors such as fragmentation of health care services, inadequate referral systems, the inequitable distribution of health personnel, the approach to health strategy development and general resistance to change in the health endeavour may adversely affect teamwork and multidisciplinary approaches. In the long term, this may give rise to improper management of community home-based health care as a form of primary health care provision at grassroots levels. Furthermore, reluctance to recognise the many changes taking place in society and in the health care area will negatively affect intersectoral co-operation and teamwork.

Furthermore, some barriers are related to the training of health workers. Dennill, King and Swanepoel (*ibid.*) observe that training of professional health care workers in public health is largely compartmentalised and very rarely integrated. This makes the current training of members of the community health care team inappropriate for a multidisciplinary and intersectoral approach to health.

Home health care – Kaye (1992) uses the term synonymously with community home-based health care – creates an unusually heavy demand on the service team to work together in a collaborative manner by its very nature. This could be achieved through an integrated approach. According to Kaye (*ibid.*), the challenge grows out of the intrinsic nature of community home health care teams combined with the unique structure and characteristics of health care services. Unlike many intervening teams in the health and human services, Kaye (*ibid.*) observes home-care teams are frequently composed of both professional and paraprofessional staff as well as an exceedingly wide range of disciplines that consider themselves to be members of the group. Therefore, with this kind of membership, the author argues that team practice in home health care carries with it the risk of conflict, competition and poor coordination.

Furthermore Van Dyk (2002) argues that one of the greatest dangers that besets community home-based health care is that the caregivers might sometimes retire from the care-giving process because of exhaustion and burn out occasioned by the extreme demands of caring for a terminally ill patient. This distorts the operation of the care system since the system would always have to make some rearrangements to fit well in its functioning. She further contends that, as a result of the nature of care organisations and their bureaucratic red tape, caregivers as volunteers and professionals may be frustrated. Therefore, they do not have a voice in the decisions that affect them and their work and often do not get the necessary support from superiors. They often experience role ambiguity due to role expansion; for instance, they have to counsel AIDS patients at times although this was not previously part of their duties. In addition to too having little autonomy and responsibility, finances for voluntary caregivers and important prevention projects are often drastically cut. This often results in people developing some mistrust towards community home-based health care.

In reviewing the problems associated with community home-based health care Van Dyk (2002) points to isolated patients, especially when they are confined to

homes or beds. Again, many people in communities are fearful because of ignorance, superstition and a fear of stigma by other members of the community. Consequently, people might reject the concept. More importantly, community home-based health care organisations often experience a problem of gender imbalance that is common in the caregiving activity: only a few men are willing to be caregivers. UNAIDS (2000) study in Uganda and in South Africa found that the caregivers who battle with HIV/AIDS in their communities are mainly women and girls, which demonstrates that the burden of caring for the sick is mostly on females.

However, the least acknowledged caregivers within the home are children (Klukow 2004). According to Klukow (*ibid.*), as their parents became more heavily afflicted with the disease and dependent on them, children find their roles changing from child to primary caregivers, as they have to care for the parents. This often results in loss of childhood, which Klukow states has series of implications for normal childhood development. With this regard, therefore, one might argue that community home-based health care contributes to child abuse. Furthermore, the element of child abuse is further reflected when children who take care of their sick parents are faced with the trauma of nursing and watching their parents die of AIDS. Even with help from outside agencies, Klukow (*ibid.*) argues that it should be recognised that children are not emotionally equipped to deal with the roles they take on as caregivers to their dying parents. In some traditional cultures, talking about death is taboo, and this further complicates lives of many children.

Caregivers often experience stress because they lack or do not have transport to be there for clients when needed because, they feel inadequate, lack useful material and often feel guilty when they do no more to help. 'There is not enough time to do what needs to be done.... training skills and preparation for the work are often inadequate' (Van Dyk 2002: 325). She also observes a lack of medication and health care material and of the resources for observing universal precautions as another problem that can hinder the care system from meeting its mandates.

Finally, caregivers feel a great loss when clients die and have a lasting anxiety about the family left behind, especially if there are children (UNAIDS 2000). Personal identification with suffering of people with HIV/AIDS often complicates the work of many caregivers. Because many caregivers are HIV-positive themselves, they observe first hand while caring for people with AIDS how they too will become sick and die; therefore, caregivers seldom allow themselves time to grieve for their patients when they die. In fact, there is usually no time to work through a patient's death because the caregivers have to come for other critically sick people. (UNAIDS 2000).

Furthermore, Van Dyk (2005) observes that non-compliance with treatment often occurs because patients or caregivers do not know how or when to administer the medication they require. This problem coincides with a lack of knowledge about the disease and its treatment; emergency situations and community resource, which often hampers the community home-based health care.

In addressing issues of burnout as problems facing most of caregivers, Van Dyk (2002) points out that it is absolutely vital for caregivers to have support systems and

necessary training as well as to care for themselves: 'Community Home-Based Health Care can only be successful if caregivers are well trained and if ongoing support and advice are available' (Van Dyk 2002: 320). This means that community home-based health care organisations with relevant specialists such as doctors, social workers and nurses, are responsible for the training of caregivers if they are to fit well into home-care systems.

From a different perspective, Kaye (1992) emphasises knowledge, skills and attitudes as determinants of successful community home-based health care, requiring the thorough blending of relevant information, effective methods and enlightened values and personal orientation to service delivery. Kaye recommends the following principles as a specific mix of the knowledge, skills and attitudes that should be held by community home-based health care professionals: firstly, a steadfast commitment to maximising the capacity for independent functioning on the part of the impaired older adult or AIDS patients; secondly a genuine concern for satisfying the needs of the patient who is experiencing decline, whether it be permanent or temporary, in his or her physical and/or mental capacities; thirdly, a firm confidence that home health care can delay and prevent the institutionalisation of patients; and finally, an unfaltering willingness to safeguard the health and safety of home-care clients through adherence to established standards of care.

At this juncture, it is important to note that these principles of orientation to community home-based health care assume the equal importance of knowledge and compassion in meeting client objectives in the care system, combined with a good decision-making capacity make a creative staff person. According to Frohlich cited in Van Dyk (2005), a number of factors to be considered when selecting volunteers include age, gender, accessibility, willingness, commitment, dedications, time, understanding of the problem involved, reliability, honesty, the ability to relate well to people, and the necessary integrity to respect people's confidentiality and basic rights. This point of view entails that, as a result of a poor model of the selection of caregivers by health care organisations, the delivery of care probably will suffer from some uncertainties imposed by the individual caregivers. Therefore, the good selection of caregivers is a proactive tool to ensure effective home health care. Moreover, proper and suitable deployment is required; volunteers should be used wherever they fit best in terms of their personalities, qualities, expertise and interest (Heron 1998). Heron gives an example of language, i.e. speaking the language of the patient and his or her family and being able to read and write.

Kaye (1992) also puts great emphasis on the demand for appropriately trained personnel. According to him, skills include such activities as the assessment plans. The knowledge base, in an ideal sense, should include an understanding of the organisational nature of home health agencies and the recognition of the importance policy plays in their operation and how policies affect the delivery of care. Similarly, Van Dyk (2005) notes that good supervision of community home-based care is of critically valuable consideration. She contends that home health care supervisors function to encourage staff accountability, increase coordination, and promote effective implementation of the service plan. To perform these tasks, supervisors should have considerable knowledge and expertise in direct service delivery to the frail and home-bound elderly, a thorough understanding of the home health care agency policies and procedures and, finally, advanced skills

in communication, training, organisational process evaluation and problem solving. This argument had previously been advanced by UNAIDS, (2000), where it was suggested that if caregivers are to perform their functions with effective results in the long run, managers should consciously attempt to ensure that every effort is made to keep the caregivers' stress within reasonable limits. Moreover, volunteer and home-based care organisation hospitals and clinics cannot afford to lose the caregivers caring for people with HIV/AIDS, because caring at home has alleviated pressure on health professionals. UNAIDS (ibid.) also included organisational support to the caregivers as a prerequisite to better results. It argued succinctly that caregivers at every level need to know that their work is recognised and valued and that they are supported for the sake of their morale and confidence.

Previous scholars have observed that the multidisciplinary approach adopted by many community home-based health care organisations plays an essential role in the care system as referral systems are made easy. In this regard, Miller (2000) adds that working in a multi-disciplinary team is an effective way of protecting staff from undue stress, because it spreads the burden of care and responsibility. For instance, it is very helpful to spread the emotional burden when a patient is dying by extending the team of caregivers who sit with the patient. Focusing on the problems emanating from the multidisciplinary approach and addressing the problem of lack of co-operation between professionals in a multidisciplinary team work, some scholars suggest that there should be a common team objective that is accepted and understood by all members. This entails a clear understanding of each team member of his or her role, functions and responsibilities, and mutual respect for the role and skills of each team member, allied to a flexible approach.

Furthermore, Phillips emphasises community participation as a key catalyst in enhancing community home-based health care: 'The reliance at local levels on health worker/caregivers; trained, partly trained and untrained personnel can be a source of strength, although it can also place great strain on some communities' (1995: 154). Moreover, he asserts that community development is a key element concerning community participation in health planning itself. Similarly, McBeth and Schwer (2000) view community participation as an essential catalyst in effective community home-based health care. They further say that appropriate technology facilitates community participation, and this includes an integrated information infrastructure, diagnostic and treatment modalities, transportation, communications networks and other existing and emerging technologies. These technologies are tools that communities use to assess their needs, provide interventions, and evaluate outcomes in relation to the established goals of health care for all.

## **Methodology**

This study was carried out at Roma, in the district of Maseru, Lesotho. The name Roma Valley is derived from the landscape of the area. It consists of a group of 16 villages in the Roma area, a valley located between two ranges of plateaus. The concept of community home-based health care was initiated there in 2001, with the purpose of caring for HIV and AIDS patients so as to alleviate burden and pressure on health professional at hospitals.

The establishment of the community home-based health care in the Roma Valley was facilitated by the Lesotho Catholic Bishop's Conference with support from the health professionals of St. Joseph's Hospital located at Ha-Mafefooane. The team comprises a group of nurses, doctors, HIV and AIDS patients, a social worker, a counsellor, Catholic pastors and groups of women as caregivers from the various villages within Roma Valley. Furthermore, volunteers from various places, agencies and NGOs are welcome. As caregivers, the abovementioned groups of women receive professional training and health care materials from St. Joseph's Hospital. The care system team works hand in hand with members of families with HIV and AIDS patients and other vulnerable groups of people, such as orphans, pregnant young girls, the elderly and other chronically ill people.

The study population consists the abovementioned people as well as village chiefs. A sample of 12 interviewees was drawn from the population as follows (one medical doctor, one social worker, one HIV and AIDS coordinator, one Catholic priest, one nurse, one counsellor, three community caregivers, and three village chiefs). This sample was drawn from a combination of purposive<sup>1</sup> or judgmental sampling in which the snowball procedure was adopted to reach the respondents.

Two methods were used to collect the data: the key informant interview and the in-depth interview. Local chiefs were identified and they, in turn, helped to identify and locate the caregivers. Then, through snowball method, the identified caregivers helped to identify other caregivers, and in-depth interviews were used to obtain responses to the research questions. Moreover, the Roma Valley home-care coordinator assisted significantly in the identification of health professionals who are also members of the home-care organisation. The professionals were interviewed using the key informant interview.

The use of the health care workers instead of the patients themselves as the interviewees makes ethical consideration unnecessary. The interviews conducted with various members of the home-based health care organisation in the study area were not intrusive and did not require the precise personal information of the interviewees with regard to their health problems and status. Therefore, the information gathered from them neither exposed participants' personal health history nor their concern about their health status.

The data generated from the interviews were analysed by using open codes. This means that the responses were recorded as notes and were expanded during spare periods outside the field. Selective coding was useful in the organisation of data to present it in a manner that is in line with objectives of the study. Therefore, key interrelated categories (themes) were selected and coded while the unnecessary and unrelated categories and subcategories were eliminated.

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<sup>1</sup> Purposive sampling was considered appropriate for this study since the health professionals and other individuals in the sample are knowledgeable and informed about the subject of this research. Similarly, snowball sampling fits well in this study since the identified caregivers were required to help locate others through the assistance of the village chiefs.

## **Findings and observations of the study**

### **Organisation**

The Roma Valley Community Home-Based Health Care Organisation was established in 2001. Its establishment was facilitated by Lesotho Catholic Bishop Conference with professional support from St. Joseph's Hospital located at Ha Mafefuoane, Roma. The organisation was aimed at alleviating the burden of caring for HIV/AIDS patients and at decongesting the beds in the hospital. Congestion makes it difficult to provide proper care for other patients with curable diseases. The hospital management and the Roman Catholic Church thus found it better to utilise the Roma community to care for their patients in their own home environment with medical support from the hospital. 'Like in other developing countries, most of the citizens of Lesotho are poor and cannot afford hospital costs, so the concept of Community Home-Based Care is a cheap alternative,' said the coordinator.

In the community, relatives from both the nuclear and extended families of the sick, other community members of goodwill, and other bodies such as churches, youth clubs etc. care for people living with HIV and AIDS, the elderly, orphans and other categories of people in need of special care. These patients could be provided with some food packages, clothing or they could be helped otherwise using the locally available resources. Roma Valley Community Health Care Organisation targets the following categories of people within the community: people living with HIV and AIDS, chronically ill people the elderly, orphans, the disabled all ages, and other groups of people who need critical health care.

The rationale for the integration of various skills, including those of the health professionals in the home-based care for the affected individuals and families, is intended to act as checks and monitoring mechanisms, especially for the informal caregiving system. This is done through the provision of some personal care and occasionally skilled services, assessment of the adequacy of informal caregiving, patient/family self-care instruction, and respite services. Equipping the volunteers who are also non-trained health professionals with the basic know-how that may be necessary, especially where there is no doctor, also forms part of the justification for the continued existence of this home-based care structure in Lesotho.

### **Streaming and recruitment of caregivers into the system**

In specific terms, recruitment into the home-based caregiving system is on voluntary basis. Community members who are willing to volunteer are trained as caregivers and counsellors by the coordinator with the help of other professionals within the hospital. From the findings, Roma Valley Community Health Care Organisation consists of a coordinator, a counsellor, and para-professionals (group of caregivers and volunteers) from various villages in the Roma Valley community. Among the caregivers are HIV and AIDS counsellors whose duty is to offer counselling and to test people at their homes in conjunction with providing some care to the identified home patients. Other parties, such

as hospital social workers, doctors and some nurses, are indirectly involved in the system. They thus contribute to activities, such as workshops, training of volunteers or through consultations. Otherwise, the major work of providing home care is performed by the trained volunteers.

Other than the St. Joseph Hospital's management authorities, the Roma Valley home caregiving body consists of a coordinator at the top of the hierarchy, a counsellor who assists the coordinator, then the para-professionals as trained volunteers, i.e. caregivers, HIV and AIDS counsellors. Relatives of the home-care recipients also play a major role in caring for their sick relatives through guidance by caregivers. Furthermore, other community members as individuals and as community-based organisations, such as support groups, churches and traditional healers, contribute significantly towards home care.

### ***Operational modalities and functioning of the organisation***

The local chiefs, people as individuals, and local government councils help the caregivers to identify home patients. The caregivers visit families with the patients and offer some guidelines to the relatives on how to care for them. They also care for them, especially those patients who are living alone or live with their children. Furthermore, they make some referrals for critically ill patients to St. Joseph's, which is the nearest hospital. They usually lobby to the hospital to refer the patients to Thusong where they are encouraged to undergo some counselling and testing for proper and suitable medication treatment. This is because most of the patients who seem not to recover despite the medical treatment they undergo usually test HIV positive. Therefore, it has gradually become a routine to encourage home patients to know their HIV status. Other than the referral system, the trained caregivers in HIV testing and counselling, and HIV and AIDS counsellors usually offer some counselling to the identified home patients and test them.

The home-based voluntary counselling and testing are carried out to help people know their HIV status through the Know Your Status campaign, which is a program under National AIDS Commission. Through educational counselling, those who have tested HIV positive are referred by the counsellors to the hospital where they undergo CD<sub>4</sub> count examination and, if eligible, they are given anti-retroviral medication. The caregivers also supervise these people taking these medications at their homes.

In terms of community mobilisation, Roma Valley Community Health Care Organisation also conducts some public gatherings in the various villages constituting the Roma Valley. The gatherings are made successful by local chiefs and local government councils in some of the villages. In some cases, the gatherings are organised by the caregivers with other representatives of the organisation from the hospitals, such as nurses and social workers. At the gatherings, people are usually sensitised about the HIV and AIDS pandemic and are encouraged to participate in community home-based health care, since it is the responsibility of every member of the community to care for people living with HIV and AIDS and other vulnerable categories of people using locally available resources. At the gatherings, community members are counselled and tested by HIV and AIDS counsellors.

Furthermore, it is through the help of the chiefs in cooperation with caregivers that distribute donations whether from government or international organisations such as WHO and World Vision in the form of food packages to people living with HIV and AIDS as identified by the caregivers.

At fixed periods of time, caregivers submit their monthly reports on their work and the limitations and difficulties they encountered. There is a monthly meeting held at St. Joseph's hospital at which a coordinator and Thusong HIV and AIDS counsellors (as volunteers) together with a team of community home-based health caregivers discuss problems they encounter during their practice at homes and possible resolutions for the problems.

### ***Infrastructure, resources and facilities***

The main facility for the effective running of the organisation is the element of voluntarism, which is the willingness of a person to perform a certain task without expecting to be paid or given something in return. Despite the role played by some of the hospital employees, the caregivers and HIV and AIDS counsellors work as volunteers. They are trained and provided with some caregiving materials such as testing kits, bandages, cotton, and toiletries, and First Aid medication. However, it should be mentioned that these provisions are not sufficient because there is no guaranteed source for them, except that the hospital management provides when it can.

Other provisions are occasionally obtained from organisations, such as Know Your Status campaign, Care Lesotho, and New Start; otherwise, there is a serious shortage of working material. Moreover, Roma Valley home-based care is enshrined in Roman Catholic Church, which forms the backbone of St. Joseph's Hospital management. That being the case, the church plays its best role in supporting the organisation not only in spiritual needs but in the supply of working material such as testing kits. At some other times, the church representatives such as Lesotho Catholic Youth Society, and even priests visit home patients to counsel and attend to their spiritual needs.

Furthermore, the involvement of family members eases the workload of caregivers since they usually provide them with some guidelines and advice on how best they could care for their sick relatives. The other facilitating factor in the home caregiving process is that some of the community members usually provide home patients with food and other needs, such as clothes. The other provisions are from some of the local NGOs such as youth clubs, Lesotho Catholic Youth Society, etc.

### ***Mission and objectives***

According to the coordinator, the Roma Valley Community Health Care Organisation was established to reduce the congestion of patients at St. Joseph's hospital beds, which is mostly as a result of HIV and AIDS pandemic by caring for them in their own homes. According to the coordinator of programme:

It was realised by most of the countries that community home-based health care could serve as an alternative to care for patients of the HIV/AIDS epidemic who could not be cured even when hospitalised since the disease is

incurable. Therefore, it was found to be convenient to care for the patients at home for them to live relatively longer.

Therefore, the organisation accomplishes its mission of integrating families and community members in community home-based health care; training families and volunteers about caring for home patients; counselling and testing people at their families; educating HIV and AIDS home patients including other categories of patients on how to care for themselves in terms of hygiene, the prevention of further infection, taking medication as prescribed by doctors, and the importance of eating a balanced diet. Furthermore, for those patients who are entirely dependent because of their adverse health conditions, including the elderly, home caregivers do some manual cleaning in their homes, help them to bathe, prepare some food for them and assist them in many other ways.

### ***Operational challenges and problems***

Inadequate or a lack of instruments or materials were identified as one of the main problems of the organisation. 'We only depend on the hospital resources which are not meant to cover the practice of home care, so definitely they are not sufficient to meet our goals,' said the coordinator. She pointed out that there are not even gloves to touch clients during HIV testing, let alone handling patients with some sores. The problem of the lack of gloves is further emphasised by most of the caregivers, which makes them feel reluctant to visit patients at their homes; for some, there is no point in visiting since they cannot touch them with their bare hands in the process of helping them to go to toilet, bath them, or assist them in turning on the beds. This accounts for why some of the patients, especially those with HIV and AIDS, feel neglected and discriminated against as even their relatives are encouraged not to touch them with their bare hands. Furthermore, handling them with gloves has its own psychological interpretation, as some of the patients (especially the illiterate) often feel discriminated and stigmatised when they are handled with gloves worn. This lack of working material decreases the willingness of the caregivers to help, as the patients have put hope on them while they cannot efficiently help them. 'Sir, We are eager and find it Christian to help these disadvantaged home patients since majority of them could not afford hospital costs, but we do not have proper and enough working facilities,' said one of the old women in the group, who looked emotionally moved.

Similarly, the hospital matron contended that lack of working materials, including medication, also promotes the relapse of home patients whom she said are better off being taken care of at home than hospital since they could get the support they deserve within their home communities: 'A patient should be cared for socially and medically but due to this drastic shortage of medication patients who seem to recover often relapse, and in the long run they die unnecessarily,' said the matron.

Lack of transport also forms another major obstacle to the operation of the organisation as a whole. The matron stated that due to shortage of vehicles, community home-based health care public gatherings are not as successful as expected, since professionals such as nurses, social worker, counsellors, and even the coordinator herself

are unable to make it to the gatherings due to shortage of vehicles. This again hinders measures by the hospital management to conduct some evaluation and assessment of the organisation at the grassroots, despite the monthly reports submitted by the volunteers. The matron further emphasised that the hospital management still feels it is necessary to work with people at grassroots level and support such vitally beneficial practice as community home-based care.

Furthermore, the caregivers indicated that they could not reach villages in the rural communities, and yet these are the most remote and lack important information about crucial issues such as community home-based health care and HIV and AIDS. Therefore, this results in the centralisation of home-based care delivery at the villages surrounding St. Joseph's Hospital.

Another major problem adversely affecting home-care provision in the Roma Valley is the lack of incentives for the volunteers. According to the coordinator, the caregivers and HIV and AIDS counsellors who work as volunteers are mostly people living with HIV and AIDS; they would be motivated if they were given some incentives, such as traveling allowances and food.

Similarly, almost all the interviewed caregivers pointed out that they are not given anything as a reward or incentives, not even lunch boxes. This forms the major reason why most of the trained caregivers had dropped out. 'Initially we had a considerably large number of volunteers trained but, surprisingly, less than a half are showing up and submitting their monthly reports,' said the coordinator. In the long run, this negatively affects the functioning of the organisation, since most of them have dropped out. The volunteers also highlighted that their relationships with their families' members are under tension, since they spend money for traveling for service without any external support. 'It would be better if we were not promised anything instead of promising our children things which we could not buy for we are not given even a single cent,' said one of the HIV/AIDS counsellors. This inherently discourages others to volunteer themselves in community home-based health care.

Little or the absence of support and corporation from local chiefs and families is another factor against the system. In this case, most of the volunteer caregivers indicated that they are not welcomed in some of the families, while some of the family members seemed to be frightened of them and hide their patients. In some families, it was discovered that some of the household members discriminate against the patients and neglect them. This results in many patients developing a negative attitude towards community home-based health care. As a result, they also find it better to be fully hospitalised rather than being neglected by the very same people from whom they are expecting some love, support and emotional uplift. Similarly, there is also a problem where some of the local chiefs tend to show a lack of corporation and reluctance in matters of home care. Sometimes, they refuse to help in the organisation of public gatherings.

According to most caregivers, another problem that community home-based health care faces is widespread household poverty among caregivers and the patients. This situation makes it difficult for the patients to take their medication as prescribed by doctors, especially ARVs, as they require patients to eat a proper diet at regular intervals

before the medication is taken and to enable it to work well. As a result, most patients prefer being cared for at hospitals where they would have access to relatively better meals on a more regular basis. This greatly affects the effective functioning of the organisation. The element of poverty is mostly also expressed in situations in which a patient is living alone. In some cases, such patients end up dying because there is nobody to cook for them, let alone to assist them in taking medication and bathing.

### ***Mitigating the operational challenges and problems***

In addressing the problem of lack of working materials, the matron suggested that the issue of community home-based health care be allocated some finances by the government of Lesotho through the Ministry of Health and Social Welfare. This should, according to them, be implemented rather than merely being discussed. They pointed out that community home-based health care is currently in demand due to the HIV and AIDS epidemic. The disease should no longer be considered as a disease but a condition that only requires proper health care maintenance and appropriate diet. Therefore, the government should understand that it should invest in community home-based health care for making a healthy nation.

With regard to remuneration, the respondents asserted that it is true that community home-based health care depends on voluntarism, but this does not mean that the volunteers should go without some basic materials that workers need in order to carry out their work effectively. Such materials are food and transport and, of course, care kits, including testing kits. They emphasised the fact that home care can be a success only if the caregivers are sufficiently provided with these facilities as incentives for them to be motivated and thus work effectively. Apart from the government, which is considered by almost every person as having an answer to everything and every problem, international organisations (UNICEF, WHO, and World Vision to name a few) are better at targeting the community home-based health care aspect in ensuring healthier nations while attempting to combat the HIV and AIDS threat worldwide.

Caregivers and HIV and AIDS counsellors as volunteers seemed to have the general suggestion that if community home-based health care is to fulfil its mandate of caring for the sick and the disadvantaged, they (as volunteers) should be equipped with working material and provided with some incentives. They stated that this would serve as motivating aspect and as a safeguard against the complaints of their relatives that they depend on the income of the families to do their voluntary work.

The volunteers further suggested that if home-based care recipients could be provided with food packages for a sustainable period, the caregiving process would be effective, since a lack of proper diet adversely affects medication for most patients. Regarding the problem of poverty facing many home patients, most of the local chiefs proposed that it would be of vital importance to have a sort of food security project supporting home patients. They suggested that the project could be based on the locally available resources while other facilities such as seeds, insecticides, gardening tools and some general capital are provided by a donor if possible. The same idea was reported by the caregivers as one of the major opinions by most of the care recipients.

Furthermore, the hospital social worker suggested that the concept of community home-based health should be boosted with community coalitions. This refers to a joint effort by various units found within the Roma community in supporting the care given at homes. Therefore, the caregiving system should target different churches, youth clubs, other CBOs, schools and other associations found in tertiary institutions, such as the National University of Lesotho and colleges (Roma College of Nursing), to name a few. These bodies could play a major role in mobilising the Roma community and sensitising it to the importance of the concept of community home-based health care. In other words, he emphasised the holistic approach in community home-based health care provision. Moreover, the hospital matron pointed out that government of Lesotho has launched a program to integrate community home-based health care, under Primary Health Care policy, in the budget for the Ministry of Health, but there had been little interest in it until recently.

## **Discussion of findings**

It was discovered that the Roma Valley Community Health Care Organisation functions, not autonomously but under the umbrella of St Joseph Hospital, whose authorities are affiliated with Roman Catholic Church. It is an inevitable fact that the organisation operates from the hospital, even though it is imperative that the organisation should have some autonomy, thereby having its own professional staff and facilities.

Van Dyk (2002) contends that lack of autonomy creates an atmosphere of frustration since the organisation workers always have to work within strict bureaucratic protocols, causing their creativity capacity to be distorted. This does not mean that the hospital management should not exercise its power to monitor and evaluate the organisation's operation. In an ideal sense, home care should be allocated full-time formally trained and fairly paid workers. In contrast, in Roma, the professionals directly involved are the coordinator as a nurse, and a counsellor, even though they are obliged to perform other hospital duties. This is likely to cause role conflict. The other professionals assist in home care to a very minimal degree. Similarly, Spencer (1990) argued that a community home-based health care team should consist of doctors, nurses, laboratory diagnostic experts, physiotherapists, occupational therapists, social workers, health inspectors, welfare and voluntary workers, auxiliary health workers, educators and many other units.

Spencer points out that with the above personnel, home-based care will entail the following practices: measuring pulse rate, temperature, blood pressure, listening to the sounds of heart and lungs, feeling for abnormalities of the organs and many other diagnostic considerations, for which the community at large forms the clientele. According to the findings, in the case of the Roma Valley Community Home-Based Health Care, none of these technical practices are carried out during home-care provision due to lack of trained professionals. Nevertheless, one may argue that such technical caring activities are suitable for those countries that are fully developed where health programs such as community home-based care operate fully on government expenditure. Despite this, the idea is that the standard of community home-based health care in Lesotho should, to a larger extent, be improved.

Moreover, it was discovered that the delivery of this kind of health care in Roma Valley pays more attention to the health of people living with HIV and AIDS than other categories of patients and people in need of special care. This was determined during the in-depth interviews with caregiver and also from their monthly reports. The reports mainly outline the number of people tested and their HIV status and number of families of people living with HIV and AIDS visited, and very little is said about other vulnerable groups deserving home care. For instance, Table 1 shows a summary of reports of nine caregivers for February 2008:

*Table 1: Summary of February, 2008 reports of 9 caregivers*

Caregiver	Number of people tested		Their HIV status				# people living with HIV and AIDS' families visited
	Males	Females	Males		Females		
			+ve	-ve	+ve	-ve	
A	4	8	2	2	3	5	4
B	6	4	2	4	1	3	7
C	3	9	0	3	4	5	3
D	1	7	0	1	3	4	6
E	5	6	3	2	2	4	5
F	3	8	1	2	3	5	4
G	2	6	1	1	4	2	3
H	4	5	1	3	3	2	5
I	1	7	0	1	3	4	3

According to Kaye (1990) the range of potential community home-based health care service recipients is exceedingly large and diverse. It encompasses the following: mainly HIV and AIDS patients; the developmentally disabled; post-hospitalisation patients; the chronically and physically impaired all ages; the mentally ill requiring home-based hospice care; newborn infants and their mothers and finally, abused older adults and children. Nonetheless, Van Dyk (2002) has pointed that the concept of the community home-based health care is predominantly focusing on the issue of HIV and AIDS since the pandemic is a “mother” of many diseases and gives rise to yet many other social problems.

Another gap identified was that the organisation is very much concerned with health matters but it also has to be concerned with people’s social, emotional and psychological wellbeing as Spencer observed (1990). Consequently, there is a need for personnel such as professional counsellors and psychological therapists in community home-based health care.

The findings further revealed that the major problem facing the organisation is the lack of funds. This was alluded to by almost all the respondents. In this case, there are two things that can be done as to counteract this problem. Firstly, since community home-based health care is a non-income generating phenomenon and depends on the

aspect of voluntarism and donations, international organisations that are concerned with global health, such as WHO, should be targeted and sensitised to the importance of the concept. The other alternative is that potential authorities such as local government councils and the Ministry of Health and Social Welfare should be better of lobbying to central governments to realise essential role played by community home-based health care in the sphere of supporting the causalities of HIV and AIDS pandemic. Therefore, the governments are better at financially supporting this phenomenon.

The absence of a national social policy governing the concept of community home-based care in Lesotho is one of the barriers to the success of the concept, as Nyanguru (2002) argues. The Department of Social Welfare, which under normal circumstances would be vested with a mandate to develop such a system, is too understaffed to effectively cope with providing support to a system such as community home-based health care, observed Kimane (2005), Nyanguru (2002) and Chisepo (2001). Therefore, health and social welfare authorities should lobby to the government of Lesotho about the formulation of a social policy governing the home-care system. This could be facilitated by academic research on community home-based health care, which could yield the information necessary for policy construction.

With better financing, home care would be a success, since the securing of working materials and incentives for the volunteers would be guaranteed. This would safeguard against other problems, such the volunteers dropping out, poor relationships between the volunteers and their immediate relatives. Similarly, the problem of lack of transport could be addressed through finances.

Moreover, with some help, especially financial aid, the Roma Valley Community Health Care Organisation could gain some autonomy and minimise its dependence on St. Joseph's Hospital. Such autonomy could be promoted by the employment of more professionals necessary for the effective home-care delivery services. Moreover, there is a saying that "knowledge is power", thus with enough professional personnel, the organisation can efficiently meet its goals.

Apart from the apparent shortcomings and impediments to community home-based health care in Roma Valley, the initiative possesses some qualities, such as community participation and integration, which could make any health distribution system work very effectively. Community participation is conceived as a key catalyst in enhancing this kind of health care. The reliance at local levels on health worker/caregivers; trained, partly trained and untrained personnel can be a source of strength, although it can also place great strain on some communities. More important in this regard is the aspect of visible community participation in health planning itself, which is a key to overall community development. Similarly, McBeth and Schwer (2000) view community participation as an essential catalyst in effective community home-based health care. They go further to say that appropriate technology facilitates community participation and that this includes an integrated information infrastructure, diagnostic and treatment modalities, transportation, communications networks and other existing and emerging technologies. These technologies are tools communities use to assess their needs, provide interventions, and evaluate outcomes in relation to established cases.

## **Linking the community home-based care system to functionalist social theory**

Functionalist theory is rooted in the sociological writings of Parsons (1971) and the work of scholars, such as Spencer, Durkheim, and Merton (Tischler 2000). The theory views society as a system of highly interrelated structures or parts that function or operate together harmoniously. Furthermore, the proponents of the functionalist perspective analyse society by asking what each different part contributes to the smooth functioning of the whole. For instance, one may assume that the educational system serves to teach students specific subject matter. Nonetheless, functionalists might note, according to Tischler (*ibid.*), that it also acts as a system for the socialisation of the young and as a means of producing conformity.

In addition to the assumption that society is a system of highly interrelated units functioning harmoniously, functionalists also view society as quite stable and self-regulating, like a biological organism. Thus, most members of the society share a value system and know what to expect from one another. This is in line with Parsons' functionalist observation that there are certain social systems involving major areas of social life, such as the family, religion, education, health, politics and economics. Parsons evaluated these systems according to functions they performed both for society as a whole and for one another.

Furthermore, the functionalist theory is a very broad theory in that it attempts to account for the complicated interrelationships of all the elements that form human societies, including the complex societies of the industrialised world. It, therefore, follows that one could view it as the potential of being employed to explain such concept as a community home-based health care system. This becomes clearer with the contention that home-based health care assumes community sense when different units of community such as nearby hospital, spiritual leaders, traditional healers and professionals such as social worker, nurses, counsellors and voluntary workers, through integrated perspective, take the initiative to care for their sick neighbours in their own home communities. As proposed by the functionalist perspective, societal units, community units in this case, complement each other in harmony; therefore, those units work hand in hand to offer care and support for the sick community members. In this regard, the multidisciplinary approach adopted by many community home-based health care organisations, play an essential role in the care system as referral systems are made more easily. Furthermore, working in a multi-disciplinary team is an effective way of protecting staff from undue stress because it spreads the burden of care and responsibility (Miller 2000). For instance, it is very helpful to disperse the emotional burden when a patient is dying by extending a team of caregivers rather than an individual member of the team who sits with the patient.

Moreover, the functionalist theory also views society as normally being in a condition of dynamic or near equilibrium by constantly making small adjustments in the response to shifts or changes in its internal parts or units (Tischler 2000). Sometimes, changes can be as a result of problems encountered by the units of the main system either on an individual basis or as the whole system. For instance, the case of community home-

based health care system may experience a lack of funds and/or shortage of relevant technical know-how, and that inevitably results in some changes in the care system operations. Just as the sub-units of the society ought to adapt to new encounters for the sake of harmony, the sub-units of the community home-based health care system are supposed to adapt to and deal effectively with new encounters if the system is to continue to flourish. This idea is further strengthened by Spencer's observation that community circumstances will not be static but will always be changing (Spencer, 1990). This concerns, the needs of the people and the methods of fulfilling those needs, therefore the state of the community's health have to be measured, and its needs and priorities met. Through the lens of the functionalist theory, the operation of a community home-based health care system could be understood and explained, especially its dynamics and the system's adjustments and adaptations to the new encounters that are of course potential hindrances to the expected running of the system, which has the mandate of providing proper health care to ill community members.

## **Conclusions and recommendations**

Based on the findings of this study, the following recommendations arise, which if appropriately applied will lead to more successful operation of the community home-based health care in general. Firstly, there should be the formulation of a social policy governing community home-based health care in Lesotho. Secondly, the government of Lesotho should allocate some budget for community home-based health care programmes. Thirdly, there should be some community-based food security projects supporting people living with HIV and AIDS and other home-care recipients. Fourthly, there should be the employment of full-time professionals participating in community home-based health care services. Fifthly, there should be a strong and firm attempt to integrate men in community home-based health care since gender inequality appeared to be one of the controversies. Finally, community home-based health care programs should encompass the concept of community coalitions with the affected families being targeted at most.

Community home-based health care plays an essential role in improving the health conditions of people living with HIV and AIDS and other vulnerable sick poverty-stricken people of Lesotho. Indeed, it is one of the internally generated responses by the communities in the study area towards increasing rate of HIV and AIDS and related ailments. Moreover, this aspect is inexpensively achieved in comparison to institutional care, which has led most authors to suggest that it may probably be the last resort, especially for communities with poor health infrastructure. Despite its enormous problems and obstacles, there appears to be hope and future for this practice in Lesotho. That being the case, the government of Lesotho is urged to invest more in this system if the disadvantaged and vulnerable poor and sick people are to feel cared for and socially included in their own home communities.

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## Povzetek

Skupnostna zdravstvena oskrba na domu igra pomembno vlogo pri oskrbi bolnikov, ki se zdravijo doma in drugih ranljivih skupin ljudi. Pričujoča študija raziskuje težave in možnosti skupnostne zdravstvene oskrbe na domu v naselju Maseru, ki se nahaja v dolini Roma v Lesotu ter predstavlja mogoče rešitve za identificirane težave in možnosti napredka. V študijo so bili vključeni zdravstveni delavci na St. Joseph Hospital, ki delujejo v Organizaciji zdravstvene oskrbe na domu doline Roma, lokalni poglavarji in skupina skrbnic v vaseh doline Roma. Za zbiranje podatkov smo uporabili metodi intervjujev in poglobljenih intervjujev s ključnimi informant, pri analizi zbranih podatkov pa smo uporabili metodo kodiranja. Študija je pokazala, da se organizacija srečuje z veliko težavami, vključno s pomanjkanjem sredstev, pomanjkanjem delovnih sredstev, pomanjkanjem usposobljenega osebja in pomanjkanjem spodbud za prostovoljce. Da bi lahko v Lesotu lahko podpirali in razvijali zdravstveno oskrbo na domu, bi bilo potrebno izoblikovati socialno politiko, ki bi upravljala tak sistem. Vlada Lesota bi morala nameniti nekaj proračunskih sredstev za tovrstne zdravstvene programe. Poleg tega bi bili

bistvenega pomena tudi projekti skupnostne prehranske varnosti ljudi, ki živijo z virusom HIV in AIDSOM ter drugimi prejemniki oskrbe na domu, pa tudi zagotavljanje polno zaposlenih strokovnjakov, ki bi sodelovali pri zagotavljanju skupnostne zdravstvene oskrbe na domu.

**KLJUČNE BESEDE:** zdravstvena oskrba, podpora skupnosti, HIV in AIDS, Lesotho, Južna Afrika

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