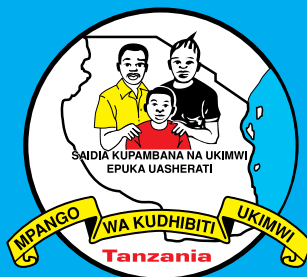


THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

**GUIDELINES FOR HOME BASED
CARE SERVICES IN TANZANIA**



National AIDS Control Programme

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TABLE OF CONTENTS

	<i>Page</i>
Foreword	i
Abbreviations/Acronomy	ii
Introduction	iii
PART ONE – QUALITY OF HOME BASED CARE	
1. Introduction	1
2. Scope of Home Based Care	1
3. Quality of Home Based Care	1
4. Role and Responsibilities at Different Levels and Institutions in HBC Services	5
5. Roles and Responsibilities of key actors in HBC Services	9
6. The Quality assurance cycle for Home Based Care	13
PART TWO – REFERRAL SYSTEM	
7. Introduction	15
8. Referral System in a District	15
9. District planning for HBC services	17
10. Criteria for discharge of admitted patients	19
11. Strategies to comply with referral	21
PART THREE – SUPERVISION GUIDELINE AND MONITORING TOOLS	
12. Introduction	22
13. Objectives	22
14. Levels and Scope of Supervision	23
15. Planning for Supervision	26
16. Check list	28
17. Annexes	30

**PART FOUR - COMMUNITY INVOLVEMENT AND PARTICIPATION IN HOME
BASED CARE AND ROLE OF TRADITIONAL HEALERS IN HOME
BASED CARE SERVICES.**

18. Introduction	40
19. Community Involvement and Participation	41
20. Strategies for Community involvement and participation in HBC	41
21. Community understanding of Home Based Care Services	43
22. Roles and Responsibilities of the Community in HBC Services	43
23. Roles and Responsibilities of Community actors	44
24. Financing and Sustaining HBC services	46
25. Training, monitoring and evaluation of community involvement and participation	49
26. Special Issues	50
27. The Role of Traditional Healers	51

FOREWORD

These guidelines put together the work of a team of professionals who have been working in the area of care including prevention and control of HIV/AIDS and other chronic conditions in different settings. Their formulation reflects experiences gained from work conducted in a few districts, namely Sumbawanga, Mpanda, Nkansi, Kibaha, Kisarawe, Rufiji, Mafia and Bagamoyo and from an operational research conducted in Bagamoyo district in Coast Region.

It is not the aim of these guidelines to replace the routine hospital services that are currently in use for managing patients with chronic illnesses. The intention is to provide guidance on what to do at the district levels, especially the District Health Management Team (DHMT) taking into consideration the limited resources available at that level. Furthermore, it aims at the community Home Based Care provider who will be the link between patients, family, and the community on the one side and the health facility on the other. We hope the book will be a valuable tool for DHMT and Home Based Care providers in providing quality care, guidance on when to refer, and how to supervise treatment for a patient in a family setting.

These guidelines are the first version and therefore not by any means exclusive. The Ministry of Health is open to dialogue and advice on any issue, which may help to improve them for the benefit of our patients. In that connection we welcome feedback from all the users of these guidelines.

The document is arranged in four parts namely: Quality of Home Based Care (part one), Referral System (part two), Monitoring and Supervision (part three), Community Involvement and Participation and the Role of Traditional Healers in Home Based Care (Part four).

We believe this book supported by other policy guidelines on HIV/AIDS/STDs will make a valuable contribution to the fight against HIV/ AIDS and other chronic illnesses in our community.

The Ministry of Health would like to thank all those who participated in one way or another in preparing this document. Special thanks go to DANIDA for providing both technical and financial support which enabled the production of these guidelines.



M . J. Mwaffisi
Permanent Secretary
Ministry of Health

ABBREVIATIONS/ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
DANIDA	-	Danish International Development Agency
DHB	-	District Health Boards
DHMT	-	District Health Management Team
HBC	-	Home Based Care
HIV	-	Human Immunodeficiency Virus
Ke	-	Mwanamke
Me	-	Mwanaume
Mk	-	Miaka
MOH	-	Ministry of Health
MTP	-	Medium Term Plan
NACP	-	National AIDS Control Programme
NGO	-	Non Governmental Organization
No	-	Number
PLHA	-	People Living with HIV/AIDS
PTB	-	Pulmonary Tuberculosis
RHMT	-	Regional Health Management Team
STDs	-	Sexually Transmitted Diseases
USA	-	United States of America

INTRODUCTION

Infection with Human immunodeficiency virus (HIV) almost invariably ends with chronic illnesses often accompanied by development of opportunistic infections and other clinical conditions that are usually amenable to treatment. The number of patients with HIV/AIDS related diseases have continued to increase steadily since the first cases were reported in 1983. Indeed, by late 1990's, about 50 – 60% of adult patients admitted to medical wards were on account of HIV-related diseases. Similar trends of HIV infections have been reported among other patient population.

The impact of disease due to HIV/AIDS and other chronic illnesses on the already overburdened health care system has been enormous and continues to grow. Consequently it is increasingly becoming impossible to give quality care in many of the government health facilities. Furthermore, results from studies done among patients with advanced HIV disease showed that many of them preferred dying at home rather than in hospital settings. In response to this, the government has introduced a continuum of care which extends from the health care system to communities, households and families. To this end, the government plans to establish Home Based Care (HBC) services for people with chronic illnesses including HIV/AIDS.

HBC service is being developed to mitigate the impact of increased morbidity and mortality from HIV/AIDS and other chronic illnesses. Family members will be expected to play a major role in provision of HBC services. Consequently they should get training guidance and support to enable them provide quality care at home. This approach to patient care is in line with the National Health Policy which aims at:

- a) Ensuring that health services are available and accessible to all people wherever they are in the country, both in urban or rural areas.
- b) Moving towards self sufficient in manpower by training all the cadres required at all levels from village to national.
- c) Sensitizing the community on common preventable health problems and improve the capabilities at all levels of society to assess and to analyse problems and to design appropriate action through genuine community involvement.
- d) Promoting awareness in Government and community at large, that health problems can only be adequately solved through multisectoral co-operation, involving such sectors as education, agriculture, water and sanitation, community development, women organizations, political parties and non governmental organizations.
- e) Creating awareness through family health promotion that the responsibility for ones health rests squarely with the able–bodied individual as an integral part of the family.
- f) Reducing infant and maternal morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion, control of communicable diseases and treatment of common conditions.

PART ONE

QUALITY OF HOME BASED CARE

1. INTRODUCTION

Recently the government introduced reforms in the health sector which aims at empowering districts in decision making on all health issues with the objective of improving the quality of health services at all levels of care. HBC services aim at improving the quality of care for chronically ill patients within the health facilities and at their homes. However, for the HBC services to have the intended outcome and impact, it is imperative that both the quality and standards to be expected from such a service be clearly defined. These Guidelines aim at ensuring a continuum of quality care from the health facilities to the household level.

2. SCOPE OF HOME BASED CARE

The HBC aims at providing a continuity of care for persons with chronic conditions from any level of health care facility to the home environment. It shall be linked and integrated in the existing district health care delivery services. It is important to realize that inputs from the family, community and the health care system will be necessary in provision of HBC services.

- a) The family shall be the main actors of implementing HBC.
- b) The HBC provider could be a public servant, private person, volunteer from the community or NGO whose duties are as on pg. 10 - 5.3
- c) The health facility will have at any one time at least one member of its staff trained in HBC she/he will be the “**CONTACT PERSON**” whose functions will be as on pg. 10 - 5.4
- d) The District Health Management Team (DHMT) will be responsible for the integration of the HBC services in the health care system, monitoring and evaluating implementation as stipulated on pg. 5 & 6 - 4.1C

As the number of chronically ill patients is increasing fast both in the institutions and the community, HBC is recommended to all chronic illnesses. Also as most of the terminally ill patients prefer to die at home, there is a need to bring hope to all of them. A well integrated, planned and implemented HBC will serve this purpose.

3. QUALITY OF HOME BASED CARE

3.1 Definitions

In order to be able to measure the quality of HBC, it is important to define clearly both the quality and standards to be expected.

Quality

Quality is a measure of how good something is, or the degree of excellence or superiority which a thing possesses. A service is said to be of quality if it meets or exceeds the expectations of the user. Quality HBC is defined as delivery of care for patients at home following the standards, which have been set.

Quality at the health facility level

For a health facility to have the potential to provide quality services there should be adequate and conducive space; equipment, supplies and drugs adequate for the provision of quality care; and acceptable number of competent personnel to provide the minimum intervention package of HBC services.

Quality during the Process of Care provision: Includes the services or the performance of a procedure with available resources, the knowledge and skills that a health worker should have in order to perform a

quality care.

Quality at the output/Outcome level: Level at which the expected results of the care, such as reduction in dissatisfaction, discomfort, disability, morbidity and mortality have been achieved.

Standard

Standard can be defined as the level of quality against which others are measured/ judged. It is a statement of expected quality and makes clear the organisations expectation for quality. Hence HBC services will have to be measured against set standards of care

Chronically ill patients

A patient is defined as having chronic illness if she/he continues to be ill for more than one month. Such patients include those with diseases that take long to be cured (leprosy) or those known to be life long e.g. HIV/AIDS and sickle cell disease. Adults and children with the following chronic diseases/illnesses should be considered for HBC:

Children or Adults
HIV/AIDS
Asthma
Tuberculosis
Leprosy
Cancers
Epilepsy
Stroke
Diabetes.
Cerebral Palsy
Sickle cell disease/Anaemia

3.2 Minimum intervention package for Quality HBC

Minimum intervention package is the collection of activities and resources (equipment, drugs supplies and personnel) required for providing the expected HBC to most of the chronically ill patients at the set levels of quality and standards.

The aim of the minimum intervention package for HBC is to provide a continuum of care for chronically ill patients, from health facility to their homes, using existing resources within the current health delivery system and communities.

The package should include the following range of services to ensure the required standards, including:

- (a) Nursing Care
- (b) Counselling
- (c) Rehabilitation Care e.g. physiotherapy and occupational therapy
- (d) Terminal Care
- (e) Social support

- (f) Training and providing appropriate information concerning specific conditions/illnesses
- (g) Continuity of treatment for the specific diseases as per diagnosis and prescription
- (h) Referral and networking among the care providers
- (i) Supervision and Monitoring
- (j) Evaluation and re-planning

Drugs, supplies and equipment required for HBC

1	Chloroquine tablets	-	For malaria
2	Aspirin tablets	-	For pain, inflammation & raised temperature (fever)
3	Paracetamol tablets	-	For relieving pain & fever
4	Chlorpheniramine	-	For itching (allergy)
5	Promethazine	-	For itching and vomiting
6	Hydrocortisone ointment 1%	-	For eczema
7	Ampiclox capsules	-	For bacterial infection
8	Ampiclox syrup	-	For bacterial infection in children
9	Multivitamin	-	For replenishing deficiencies
10	B complex	-	For replenishing deficiencies
11	Oral rehydration salts	-	For dehydration
12	Benzyl Benzoate Emulsion (BBE)	-	For scabies
13	Whitfield ointment	-	For skin fungal infections
14	Nystatin oral suspension	-	For oral thrush
15	Sodium Benzoate solution	-	For oral thrush in adults
16	Gentian Violet Paint	-	For superficial ulcers
17	Savlon Solution	-	For cleaning wounds
18	Gauze	-	For dressing
19	Cotton wool	-	For dressing
20	Bandage	-	For dressing
21	Adhesive plaster	-	For dressing
22	Microscope slides	-	For making slides for malaria
23	Lancet prickers	-	For pricking
24	Plastic Apron	-	For prevention of getting dirty
25	Mackintosh	-	For avoiding soiling during procedures
26	Scissors	-	For cutting
27	Gallipot	-	For putting antiseptics.
28	Kidney dishes	-	For dressing procedures
29	Thermometer	-	For taking temperature
30	Gloves	-	For preventing infection during procedures
31	Hypochlorite solution	-	For disinfecting
32	Washing soap	-	For washing hands
33	Calamine lotion	-	For itchy skin rash
34	Cotrimoxazole	-	For chest infections and infective diarrheas

3.3 The following need to be available for the success of HBC Services.

Since HBC is a new service to be integrated in the existing health care system, the following need to be done to ensure its success:

a) Raising Awareness

Raising awareness of the health care providers at all levels would provide opportunity to expand utilization of HBC services by patients with chronic conditions of diverse nature.

b) Discharge of patients from health care facilities

Chronically ill patients should be registered with the HBC services at the time of discharge from a health facility. To ensure a continuum of care patients should be directed to a HBC contact person at the health facility closest to their domicile or to HBC provider based in their community.

c) Referral of patients

It is essential that there is a well-structured referral system that will enable patients getting HBC in their homes to have easy access to health facility based care when in need.

d) HBC personnel

It is essential that all persons involved in HBC service provision, training or supervision get adequate training for the tasks. They should also be able to have good interpersonal relationship with colleagues at the health facility, the Community Home Based care Providers and other sectors that affect the HBC service in that respective community.



4. ROLES AND RESPONSIBILITIES AT DIFFERENT LEVELS AND INSTITUTIONS IN HBC SERVICES

4.1 Administrative level:

(a) The Central level - Ministry of Health

- i. Develop policies to ensure good quality care.
- ii. Develop the HBC policy guidelines which will be used for implementation, quality control and monitoring of the services.
- iii. Develop and review clear guidelines for HBC services.
- iv. Develop and frequently review training guidelines.
- v. Evaluate reports on HBC service provision aiming at its improvement from time to time

Requirements

- Two trained technical people at NACP
- A technical Advisory Team
- Monitoring and evaluation instruments and plans
- Resources.

(b) The Regional Level

The responsibility of the Regional Health Management Team (RHMT) will be to:

- i. Interpret the HBC Guidelines and ensure their implementation
- ii. Co ordinate:
 - The link between the districts, Ministry of Health and Donor Agencies
 - Monitor and evaluate HBC plans and budgets in all the districts
 - Assess training needs for HBC contact persons in the districts
- iii. Supervise data collection, processing, analysis and utilization in all districts
- iv. Maintain quality assurance of HBC
- v. Provide HBC technical support to districts
- vi. Carry out operational research to improve on HBC services
- vii. Compile and analyze HBC data, quarterly/annually and submit reports to the MOH and give feedback to districts.
- viii. Oversee the implementation of HBC guidelines in districts.

Requirements

- At least two HBC contact persons at each district hospital (preferably, a medical Officer and a Nursing Officer).
- HBC guidelines for service provision, training and supervision
- HBC sensitization campaigns
- Relevant monitoring and evaluation tools

(c) District Level

Within the health sector reform policy, HBC services are planned to be integrated in the primary Health Care programme. Therefore, the District Health Management Team will be responsible to:

- i. Implement the HBC policy guidelines.

- ii. Create awareness of the community on the need and importance of HBC aiming at their involvement.
- iii. Conduct a needs assessment and plan for HBC to be integrated in their health care delivery system.
- iv. Establish a networking and referral system for the patients from the community to the health facilities and discharging to the HBC providers in the community.
- v. Conduct the required training for personnel to ensure provision of effective HBC services in the district.
- vi. Ensure community involvement and participation.
- vii. Monitor and supervise the services.
- viii. Provide the necessary equipment, supplies, drugs and transport for HBC.
- ix. Identify the health center/dispensary contact persons for HBC and monitor/supervise their work.
- x. Evaluate the services every two years aiming at its improvements.
- xi. Allocate resources needed for HBC in the district
- xii. Compile and analyze HBC data quarterly and annually and submit reports to the region and give feed back to the health centres and dispensaries.

Requirements

- The HBC guidelines for:
 - Service provision
 - Training of trainers and community HBC providers.
 - Supervision
- Drugs and equipment for HBC services as per suggested list.
- Transport for supervision
- HBC awareness campaigns
- Resource allocation for HBC.
- Competent personnel at least two for each health facility

4.2 Health Care Facilities.

For the HBC to be functional, it is vital that good lines of communication be worked out between the different levels of patient care. Hence, the health care facilities would be required to make diagnosis, initiate treatment and provide appropriate counselling services. At the time of leaving the health facility, patients should be given adequate discharge summary information to enable the next care provider to take over. Patients would take such information to a health facility nearest their place of domicile or to the community HBC provider. This would ensure continuum of quality health care from the health care facility to the household

(a) Consultant Hospitals

Only patients with difficult and/or complicated problems would be attended at this level. Once the clinical problems have been sorted out, patients may be referred back to the respective regional or districts hospitals for further management.

Consultant hospitals are therefore responsible for:

- i. Making diagnosis and initiating treatment until the patient is stable.
- ii. Providing counseling.
- iii. Referring patients in stable conditions to their respective districts where they will be channelled in the home based care system.
- iv. Teaching students about HBC.
- v. Providing technical support for district/regional hospitals in their zones
- vi. Keeping liaison with other hospitals by contact persons.

Requirements

- Hospitals should have at least two people trained in HBC. The two will be responsible for channelling patients in need of HBC services back to their respective districts and receive them when they are referred from a lower level. (A Medical Officer and Nurse are recommended).
- Drugs, supplies and equipment for HBC services.
- Guidelines for discharge, record keeping and referral.

(b) Regional Hospitals

The responsibilities of the regional hospitals will include:

- (i) To provide technical support to the districts
- (ii) To compile records from all the District hospitals ready for reporting to the Ministry of Health.
- (iii) Supervise the district Hospitals.

Requirements

- Supervision guidelines
- Drugs and equipment for discharged patients
- Discharging system
- Two people as contact persons

(c) District Hospitals

The district hospitals should be able to make diagnosis for most patients suffering from chronic illnesses referred from the lower levels. Once diagnosis has been made and appropriate management initiated/instituted patients with chronic illnesses would be discharged from hospital through the HBC system.

The tasks of the District Hospitals will include the following:

- i. To implement the HBC policy guidelines:
- ii. To train the trainers for HBC personnel at the health centres and dispensaries
- iii. To supervise and monitor HBC staff at lower health facilities monthly
- iv. To Keep record of the patients cared according to the guidelines
- v. To mobilize and allocate resources as per DHMT guidelines
- vi. To evaluate HBC services in each health facility

Requirements

- Training guidelines and manuals
- Supervision guidelines and tools
- Two persons trained in HBC per hospital (preferably a Clinical Officer and a Nursing Officer).
- Drugs and equipment as per recommended list
- Resources mobilization and allocation.

(d) Health Centres

The responsibilities of the health centres will be to:

- i. Implement the HBC policy guidelines
- ii. Train the community HBC providers in their catchment areas.
- iii. Follow up patients discharged from the health centres or from other hospitals residing in their catchment areas

- iv. Supervise the Community HBC providers, at least one visit per week.
- v. Raise community awareness on HBC and mobilize the same to get involved in provision of quality HBC in their community
- vi. Provide horizontal supervision for the dispensary contact persons
- vii. Mobilize resources for HBC
- viii. Keep records for HBC

Requirements

- Training manual and guidelines
- Supervision instruments and guidelines
- Drugs, supplies, equipment and other resources as per recommended list
- Trained HBC contact person

e) Dispensaries

- i. Should implement the HBC policy guideline
- ii. Should have trained HBC contact person(s). At least one-trained staff (preferably MCH Aide/ Public Health Nurse).
- iii. Should monitor HBC services as per guidelines and report to the district contact person monthly
- iv. Should have the required supplies, drugs and equipment as per recommended list
- v. Should supervise the Community HBC Providers with at least one visit per week.

Requirements

- Training manuals and guidelines
- Supervision instruments and guidelines
- Drugs, supplies and equipment and other resources as per recommended list
- Trained HBC contact person

4.3 The Community

It is the duty of the DHMT/health facility leadership to introduce the concept of HBC to communities, thereafter each community should identify and express their need for HBC and plan for it. However, communities should be guided in the planning by DHMT/staff in the nearby health facility. It should nevertheless be made clear that the ownership of HBC services to a large extent belongs to the Community.

For implementation of HBC services, communities should be assisted to:

- (i) Identify needs for HBC services
- (ii) Identify resources for HBC services
- (iii) Make appropriate decisions on health issues
- (iv) Look for solutions for the prevailing health problems.
- (v) Identify the community HBC provider(s) to be trained by the contact person at the health center or dispensary. The number of HBC providers trained may vary from community to community, depending on the needs and available resources.
- (vi) Determine modalities of remuneration for the community HBC provider.
- (vii) Identify patients with chronic illnesses to be reached by the service and a system of registering new ones
- (viii) Plan for home visits, community awareness meetings and support for referrals (e.g. transport)
- (ix) Plan for continuing community involvement in the improvement and sustainability of the service.

5. ROLES AND RESPONSIBILITIES OF KEY ACTORS IN HBC SERVICES.

Several factors are likely to affect provision and quality of HBC services. Such factors may be related to the patient, family, community HBC provider, health facility contact person, and community based organizations or groups involved in patient care. In order to get optimum benefits from HBC services each of the players will be required to perform their respective roles as indicated hereunder:

5.1 The Patient

A patient receiving HBC services will be expected to:

- i. Take his/her medicines accordingly
- ii. Report on the complications.
- iii. Cope with the illness.
- iv. Prevent transmission of their infections to others.

5.2 The Family

Patients with chronic illnesses will to a large extent be cared for in their homes. Since hospital based staff do not usually provide care to such patients, family members should take over the responsibility of providing care at home. Indeed it is envisaged that family members will be the main actors in providing HBC services.

- (a) The family will be required to choose among themselves a person who will be trained on specific elements of care for their patient. However, it is essential that more than one family member knows about the general care of the patient so as to support each other and assure continuity of care in case the primary care provider is absent.
- (b) With the patient's consent the family should be counselled about their patient's illness and informed about the cause, signs and symptoms, treatment, possible complications and prevention. This should be done at the health facility where the diagnosis is made before referral for HBC.

What the family needs to do

- i. Feed the patient appropriately.
- ii. Nurse the patient according to her/his prevailing condition.
- iii. Prevent complications
- iv. Prevent transmission of infections e.g. HIV, PTB.
- v. Link with the community HBC provider for support and referrals.
- vi. Alleviate pains as much as possible.
- vii. Provide comfort to the patient.
- viii. Make sure that the patient takes his/her medicines according to doctor's instructions.
- ix. Make sure that the patient keeps appointments and observes medical advice appropriate for his/her disease.
- x. Support the patient in order to avoid risk situations for infections and complications.
- xi. Provide emotional support and spiritual care to the patient.

Requirements at the family/household level

- Patients take drugs according to prescription
- Equipment (locally available) for avoiding infection
- Disinfectant at the household (hypochlorite solution for households with AIDS patients).
- Food and other basic needs of the patients.

5.3 Responsibilities of Community HBC provider

The principal responsibility of the community HBC provider is to implement the HBC policy guidelines by:

- (a) Providing health care support to families with chronically ill patients.
- (b) Training families on how to care for the chronically ill patients including.
 - Nursing care
 - Feeding
 - Providing comfort
 - Alleviating pain
 - Preventing infections
 - Detecting complications and danger signs
- (c) Linking the family with the health facility and other services in the community by reporting and referring patients
- (d) Reporting on the state of his/her patients to the health facility contact person monthly
- (e) Raising the community awareness on new developments concerning the chronic illnesses and prevention of infectious ones including HIV/AIDS and PTB.

Requirements

The community HBC provider should be provided with a First Aid kit containing the following items:

- Gloves, gauze, bandages, thermometers, mackintosh,
- Hypochlorite solution, antiseptics, plastic apron, washing soap
- Simple reading materials on different diseases
- Register for recording patients receiving HBC services
- Stationery

Qualification

Community HBC providers will have access to sensitive and confidential information while performing their duties. In addition they will be expected to work under difficult conditions and for long hours. Consequently, only persons of sound integrity should be considered for the position. Communities are therefore advised to consider persons with the qualities listed below:

- Should be based in the community she/he is going to serve
- Should know how to read and write
- Should be able to build good interpersonal relationship
- Should be interested in caring for sick people
- Should be willing to volunteer
- Should be accepted by the community he/she is going to serve
- Should be reliable and does not easily despair
- Someone who can maintain confidentiality

5.4 Contact Person

The contact person for the community HBC provider should be stationed at the nearest health facility and would be expected to:

- i. Educate and provide support to the family to implement the HBC policy guideline
- ii. Train the community HBC providers in their catchment areas.
- iii. Follow up patients discharged from their health facilities and those from hospitals.
- iv. Supervise the Community HBC providers in their catchment areas.

- v. Raise awareness of the community and mobilize them for involvement in the provision of quality HBC.
- vi. Network with other health care providers in her/his community
- vii. Keep patients' records and report to the district contact person.
- viii. Participate in HIV prevention activities.
- ix. Provide counselling service to the patients/families

Requirements

- Drugs as per recommended list
- HBC guidelines
- Supervision guidelines and tools
- Training manual

5.5 NGOs and religious groups.

Non Governmental Organizations (NGOs) and religious groups that have interest in provision of care to patients should be encouraged to:

- (a) Provide HBC to chronically ill patients according to the national guidelines for HBC.
- (b) Link with the Health facility contact person for referrals and supervision.
- (c) Provide counseling and spiritual support to patients/families and communities.
- (d) Continue providing social support as per their objectives.
- (e) Raise community awareness on various health issues and educate them accordingly, aiming at prevention of communicable disease including HIV/AIDS, STDs, tuberculosis, leprosy etc.

Religious Leaders

Religious leaders are often called upon to provide guidance, counselling and spiritual support to patients and families. Where appropriate such persons should be encouraged to:

- (a) Continue giving spiritual support and counseling to patients.
- (b) Continue sensitizing the community on healthy issues to keep them healthy and
- (c) Sensitize the community on the importance of supporting the sick through HBC services.
- (d) Refrain from claiming to cure AIDS through prayers
- (e) Encourage patients to obtain medical care.
- (f) Continue providing social support.

5.6. Traditional health practitioners.

Traditional healers/health practitioners may be found in most communities in Tanzania. In addition, many patients and in particular those with chronic illnesses do seek the services of this group of practitioners. Consequently, where appropriate communities should work out modalities of getting cooperation of traditional health practitioners with the main objective of providing effective and safe health services to the individual person and community in general. Traditional health practitioners should therefore be asked to do the following while performing their practice:

- (a) Not to do activities which enhance transmission of infections.
- (b) Refer patients through a Home Based Care referral system.
- (c) Give correct information to patients and refrain from claiming to cure AIDS.
- (d) Encourage patients to obtain medical care.

Requirements

- Mobilization for their positive involvement.
- Education.
- Community information and awareness of proper treatment of common diseases.
- A Referral system in place for patients to get medical care and home based care

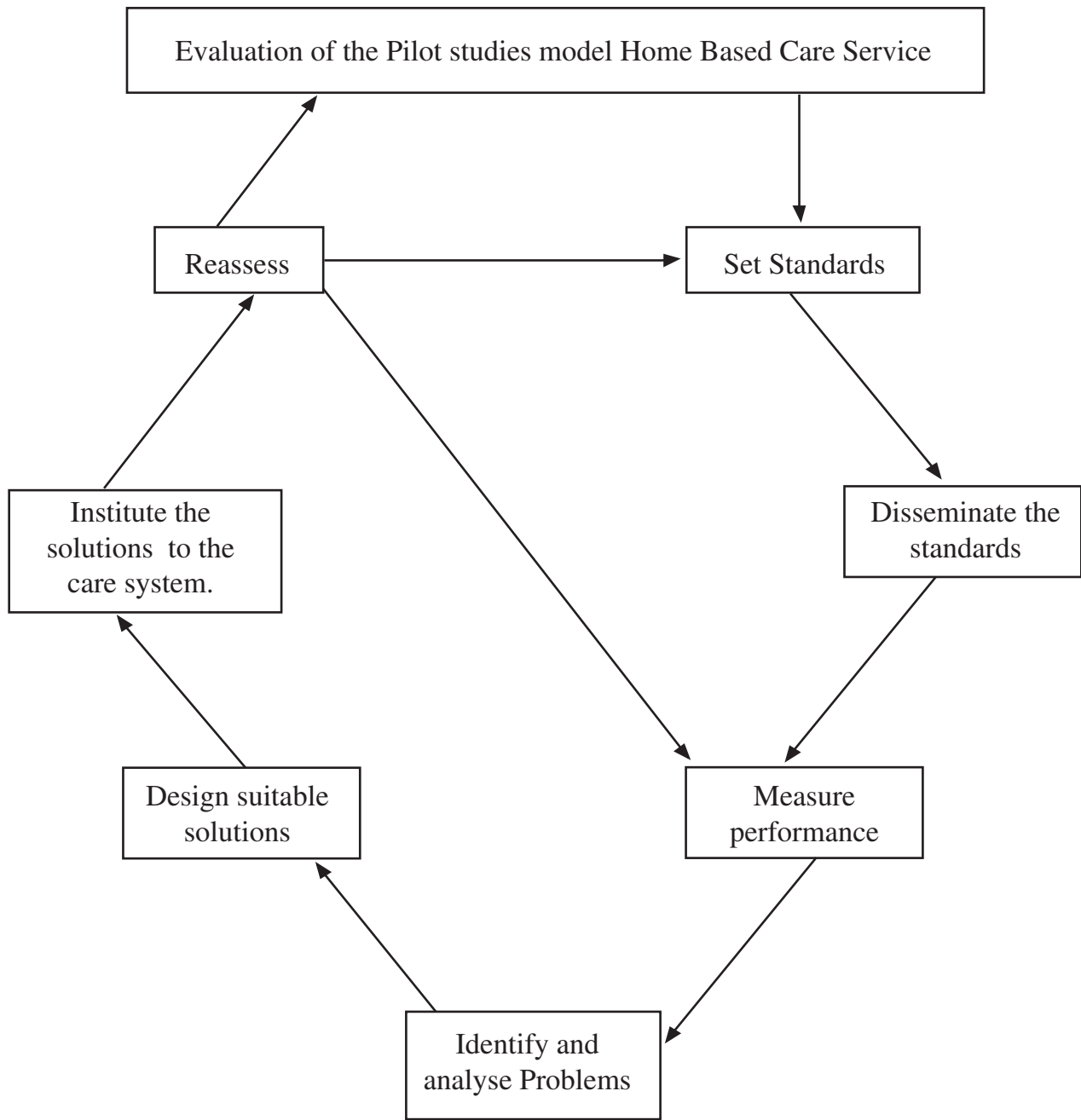
6. SUPERVISION AND MONITORING.

Supervision and monitoring of activities planned under the HBC are essential in order to ensure that quality services are being given to those in need. Supervision aims at monitoring, developing and supporting individuals providing home based care. Hence, it is expected to result into skill development as well as prevention of burn out and aging professionally.

It is important that all levels of the service provision from the household to the Ministry level conduct supervisory activities. Furthermore, supervisory activities should be both administrative and technical in order to have maximum impact.



7. THE QUALITY ASSURANCE CYCLE FOR HOME BASED CARE SERVICES



The aim of the proposed cycle is to ensure that the services have a process for continuously improving the quality. The circle should be reviewed annually, especially at the beginning of the HBC strategy for care of the terminally ill patients - DHMT and each health facility.

REFERENCES:

1. Ministry of Health 1990, *National Health Policy*
2. Ministry of Health, January 1999, *National Primary Health Care Supervision Guidelines.*
3. Wizara ya Afya 1990 *Mwongozo wa kuwahudumia wale wenye viini na ugonjwa wa UKIMWI, Mpango wa Taifa wa Kudhibiti UKIMWI.*
4. Ministry of Health March, 1999, *Quality Assurance Training Guidelines for Health Workers.*
5. Ministry of Health 1990, *Guidelines on Community Based Health Care activities in Tanzania.*
6. AMREF 1995, *Huduma kwa wenye UKIMWI Majumbani. Elimu kuhusu UKIMWI kwa Wafanyakazi wa Afya Tanzania, Somo la Tano.*
7. Blinkhoff P. Bukanga E. et al. Jan. 1999 *Strategies for Hope No. 14. Under the Mupundu Tree Volunteers in Home Care for people with HIV and TB in Zambia Copper Belt.*
8. Glen Williams 1990; *Strategies for Hope No. 1 AIDS Care and prevention at Chikankata hospital Zambia.*
9. Ministry of Health .June, 1998, *Guidelines and Standards for Counseling and Supervision.*



PART TWO

REFERRAL SYSTEM

I. INTRODUCTION

Since the beginning of the AIDS epidemics in the late seventies, Tanzania has experienced a gradual increase in the number of patients being admitted into hospitals with chronic or long duration illnesses. The situation is compounded by the limited resources whereby the public and private expenditure per capita on health is about 7.0 US\$. This level falls far below the optimal per capita expenditure that has been estimated at about 12US dollar.

From this, it can be seen clearly that by keeping chronically ill patients in hospitals for a long time after being stable, will overstretch the health budget and the already impoverished human resources. Furthermore the hospital set up is not best place to deal with spiritual and family needs of a terminally ill patient.

The HBC services for chronically ill patients is expected to:

1. Ensure continuation of care for those discharged from hospitals
2. Provide appropriate and timely care for those at home and
3. Refer chronically ill patients timely and appropriately.

The proposed referral for chronically ill patients will be done within the district health care referral system. The health referral system in Districts has four levels that can be utilised. These include Community, Dispensary, Health Centre, and the District hospital levels.

Referral follows these levels in ascending order and similarly when referring back. The referral system provides for a by-pass of these levels to higher levels in emergency conditions and accidents. The aim of this document is to assist the districts to set up a functional cost-effective referral flow within the existing health care delivery system for the chronically ill patients.

This part is organised in four sections. The first is describing the levels and functioning of a referral system in a district. The second deals with district planning and implementation, suggesting ways of integrating HBC service in the district health plan. The third is suggesting general criteria for discharging patients. It also describes general criteria for referral of patients to higher levels as well as guidance to be used by the community HBC provider to refer patients to the dispensary. The fourth section highlights the criteria that may be used to ensure compliance with the referral system.

2. REFERRAL SYSTEM IN A DISTRICT

2.1 Current referral system

Under normal circumstances a patient from a household will refer himself/herself or be sent by relatives to a nearby Dispensary or health centre (if a dispensary is far away). From these two levels if the condition is not manageable, the patient will be given a letter of referral to the next higher level describing the condition and the treatment given so far. Therefore the order of referral is from Household (or community) to dispensary, then to health centre and lastly to District hospital. For a proper working referral system, a critically ill patient at the health centre would expect to be transported to the district hospital by an ambulance of the health centre; but this system is not working in most districts because the cars have broken down.

In the current system a provision is in place for emergency conditions requiring surgery, deliveries etc. to be sent directly to the district hospital. On being discharged from district hospital, patients have to go home and start afresh if condition or other disease occurs.

2.2 Proposed integrated referral system for chronically ill patients

In line with the National Multisectoral Policy guidelines on HIV/AIDS/STDs on care for PLHAS which requires to establish a referral and discharge system which links the Hospital to community services, the

Government proposes the following:-

- i. From the District hospital a chronically ill patient will be discharged directly to the nearest catchment health facility, in most cases a dispensary, where a HBC service contact person is situated. Records should be kept at the district hospital by a HBC contact person.
- ii. All the relevant information, including diagnosis and instructions on the current management and treatment of the condition should be provided to this contact person and kept at the catchment dispensary.
- iii. The contact person at the dispensary will in turn introduce this patient to the community HBC provider for follow up and supervision at the level of household.
- iv. In case of a situation that requires referral to the higher level, the community HBC provider will refer the patient to the dispensary. At the dispensary if they are not able to provide needed care the patient will be referred to health centre. Similarly at the health center, if they are not able to provide the needed care the patient will be referred to district hospital. At District Hospital the HBC contact person will facilitate the management of this patient. On the event that the district hospital are not able to provide the needed care the patient will be referred to higher levels of health care.
- v. Like in a normal referral system, in case of emergency the chronically ill patient may be referred straight to the District hospital with a note to the contact person at the District to facilitate easy management.

2.3 Requirements for a functional referral system

i Finance

Districts and respective local communities should be sensitised and mobilised to set up funds to meet referral costs.

ii Training

1. Health care providers in all facilities should be trained on how to properly implement referrals
2. Subject of referral in the medical and allied health training curricula should be emphasised.
3. Communities and their leaders should be sensitised on how the referral system functions and need for compliance.
4. Periodic in-service training should be organised to enable health care providers to provide quality care.

iii Record keeping and data collection

1. Registers to be kept at all levels
2. The HMIS to include information on HBC services.
3. The information collected in the HMIS will be analysed at all levels of health care to enable evidence based planning.
4. Actors at all levels should be able to make the necessary analysis relevant to their level of health care provision.

iv Reporting

1. The District Health Management Team (DHMT) will manage the referral system.
2. There are four levels in a district which are, community, dispensary, health centre and district at the top. Districts are to report to higher levels and give feedback to lower levels.
3. A back referral register should be established at the district hospital, the health centre and the dispensary. The register will keep record of all those who have been discharged or referred back. This register will contain information on demographic characteristics of the chronically ill patient, diagnosis, place of back referral in case of a district hospital or discharging hospital, if it is a health centre or a dispensary. The register will also contain information on recommended management while in the care of community HBC provider.
4. A copy of discharge summary to be made available to the HBC provider and the discharging facility.

v. Monitoring, supervision and evaluation.

1. Every level should supervise the immediate lower level.
2. Supervision of HBC should be integrated within the district supervision activities.
3. Supervision checklist should be developed and revised regularly.
4. The referral system should be evaluated regularly and the information gathered be utilised to improve the referral system

vi Personnel management and administration

1. Where the number of staff in a health facility are adequate, there will be no need of employing new staff. Two of the dispensary key staff (Clinical Assistants, Maternal and Child Health Aide or Public Health Nurse B) will be trained on how to provide HBC services.
2. DHMT members will be responsible for HBC services in the district.

vii District strategies to sustain HBC services

1. Staff at peripheral health facilities should be trained.
2. The quality of health facilities should be improved so that they are able to offer quality services.
3. Out reach consultative clinics should be organised within the supervisory schedule.

viii Communication

1. Communities should be encouraged and mobilised to share the costs of communication including transport
2. Communication between the public and private sectors should be enhanced by sharing information through seminars, dialogue, workshops and meetings.
3. Where geographical inaccessibility exists, local arrangements may be made with the private sector to offer the required services, or else alternative means should be sought by the district.

3. DISTRICT PLANNING FOR HBC SERVICES.

i. District Health Boards and DHMT should be sensitised on the following:-

1. Assessment for the need of establishing HBC services for the district.
2. Establish a cost- effective functional referral system of the chronically ill patients within the prevailing social economic environment.
3. Integrate referral for chronically ill patients within the district health care delivery system.

ii Planning context

Planning for referral of chronically ill patients should be an integral part of district health plans. The aim is to have a functional cost effective referral system for chronically ill patients.

iii Sources of information/data for planning

1. Community HBC providers
2. Health facilities
3. Surveys
4. Experience from other districts with functioning referral system
5. Review of documents
6. Others

iv Assessment of Health Service Inputs

The District Health Boards and DHMT need to answer the following questions in detail so that the resulting information can be used for better planning and identification of appropriate cost-effective interventions:-

1. What is the quality of current referral services for the chronically ill patients in the district?.
2. What are the weaknesses and strengths of the current referral services for chronically ill patients?.
3. Are there possibilities to have contractual understanding with the private providers?.
4. Are the referral services reaching all who need it?.
5. Are the referral services being delivered in line with given standards?.
6. What efforts are being made to involve the community?.
7. How much are the communities willing to contribute to running of the HBC services?.
8. Are the communities participating in decision making?.
9. Is the referral system acceptable by the community?.
10. Are resources available? (human, equipment, drugs and other supplies).

v. Developing interventions

1. Identify additional components and activities that are required to strengthen the referral system for chronically ill patients.
2. Plan solution to identified constraints and limitations to the referral system for chronically ill patients.

vi. Resources

1. Deployment of existing staff.
2. Drugs to be procured through the established procedure.
3. Other materials such as sundries, stationery, postage and transport to be purchased according to laid down procedures.

vii Plan of operation

1. At each level of health care, a list of all referral activities will be prepared.
2. All activities will be assigned to various members in each facility.
3. DHMT should participate in the allocation of tasks and timing.

viii Monitoring of activities

1. Regular visits
2. Periodic check on the transport availability
3. Assess and evaluate staff performance periodically
4. Regular checks on the community HBC provider and assess their performance
5. A supervisory schedule of the DHMT members should include supervision of HBC services.
6. The peripheral health facility contact person for HBC should have a supervisory schedule for HBC services.

ix Plan for community mobilisation

1. Education to the public
2. Involve community leaders
3. Program to enable communities meet the various needs of referral should be worked out given the prevailing local environment.

4 a. CRITERIA FOR DISCHARGING OF ADMITTED PATIENTS.

The general guiding criteria for discharging patients should be based on the following factors.

1. Improvement of the patient's general conditions judged by its own merits
2. Ethical consideration and professional discretion of the discharging officer.
3. When laboratory and radiological investigations or examinations have revealed significant improvement compared to the initial findings which warranted the admission.
4. Family should be involved when planning for discharge of the patient. This will make family members participate adequately in the care of the chronically ill patient at home, thus ensuring continuity of patient's care.
5. Patient's wishes to be discharged should be considered on its own merit.

Issues to consider during discharge

1. Discharge card should be issued to all discharged patients. The discharge card should contain necessary and adequate information which is understandable to those who will be caring for the patient without violating the patients confidentiality.
2. The patients discharge should be documented in the discharge register and should contain the date of discharge, condition on discharge, where discharged to and name of discharging officer.
3. The patient should be referred back to his/her home catchment health facility as well as to the community HBC provider.

4 b. CRITERIA FOR REFERRING PATIENTS TO A HIGHER LEVEL

i. Within the district health care delivery system one should make sure that referral for chronically ill patients fulfils the following:-

1. Referring facility unable to provide required care.
2. There is an agreed system of referral within a district.
3. The referred individual is treated preferentially.

ii. General criteria for referral to higher level

1. Patient whose condition is deteriorating.

2. Patient's condition does not improve despite treatment
3. Emergency conditions which need surgery or specialist attention.
4. If the diagnosis cannot be established.

iii Private referral

1. Nearly all referrals to private health facilities are self referrals
2. Private hospitals should be encouraged to discharge their patients to HBC services. Referral from HBC to a private health facility will depend on patient's request. For those who cannot pay for their back referral to a private facility should be referred to the public health facility. The following criteria are suggested to guide the HBC provider to refer patients under their care to a higher level. The table below, left column, shows condition of the chronically ill patient while on the right column are criteria matched to the condition. If any of the criteria in the right hand column occur, the chronically ill patient under care of the HBC provider should be referred to the higher level.

4 c. CRITERIA FOR REFERRAL FOR HBC PROVIDER

HBC care provider should refer patients with conditions on the Left associated/complicated by those on the Right column

Condition	CRITERIA
Fever	Persistent cough Persistent fever >38°C Sharp chest pain Difficult in breathing Neck stiffness and severe headache Mental confusion Fits/convulsions Loss of consciousness Diarrhoea and vomiting
Mental confusion	Mental confusion of any degree
Chest pain/difficulty breathing	Fever >38°C Sharp pain Blood stained/rusty sputum Greenish/yellowish sputum
Oral/throat sores	Difficulty in swallowing Bleeding
Oral thrush	Difficult swallowing Bleeding No response to treatment Hard swelling in the mouth or on the skin Cause unknown
Nausea and vomiting	Fever>38°C Severe nausea and vomiting

Condition	CRITERIA
Diarrhoea	Severe diarrhoea Unable to drink oral fluids Frequent/severe vomiting Severe body weakness/severe dehydration Fever >38°C
Boils	Fever >38°C Big boils
Allergy	Cause unknown
Vaginal/penile discharge	Pus discharging ulcer Enlarging ulcer
Bed ridden	Fever >38°C Diarrhoea Vomiting Difficulty in swallowing
Tuberculosis (TB)	Oral lesions/body itching Worsening body condition
Other conditions	Worsening patient's condition

5. STRATEGIES TO COMPLY WITH REFERRAL

1. Improve the physical and service quality of health facilities.
2. Empower DHMT to implement own evidence based plans.
3. Educate both the public and health care providers, on the importance of a cost effective functional referral system.
4. Introduce referral guidelines for peripheral health workers.
5. Facilitate proper documentation of back referral.
6. Introduce appropriate penalties for self referrals.
7. Establish community fund which could also be used to meet the costs of referral.
8. Encourage private health facilities to refer back patient to HBC services.
9. Initiate dialogue with private health care providers on how they can fit in the district health care referral system.

REFERENCES

1. MOH (1998) *National District Health Planning Guidelines*.
2. Ministry of Health Tanzania (1997) *Health Sector Reform Program of Work 1998/99-2000/2001*.



PART THREE

SUPERVISION GUIDELINE AND MONITORING TOOLS

1. INTRODUCTION

The AIDS epidemic is escalating rapidly in Tanzania. Medical services are experiencing growing demand because of AIDS and hospital services are being over stretched owing to increased case load and continued budget reductions. In addition to medical requirement of AIDS patients, psychological, economic, practical and other needs arise for the patient and family. Home care for AIDS patients is being developed in response to the rising economic costs of hospital care, shortage of beds, and in recognition of the limited benefits of hospitalisation for chronically ill patients. Home based care (HBC) also presents the possibility of providing a holistic service to meet different patient and family needs together with promoting awareness and HIV prevention in the family and community.

With the general increase in public expectations for quality health care, supervision guidelines have to be prepared in order to:

- Have a standard supervision tool to judge quality of HBC services.
- Have standard supervision strategies for HBC services to ensure that the national objectives are accomplished.

1.1 The objectives of these guidelines are to:

- Provide guidance to supervisors on how to carry out supervision of HBC activities more effectively and efficiently at all levels of health care delivery system.
- Make supervision as an effective tool for on the job learning and professional updating of HBC provider's skills at all levels of health care.
- Promote objectivity, consistency and impact of supervision on quality of HBC service delivery in the country.
- Determine the performance of HBC providers in relation to quality and standard in implementing HBC activities.

1.2 Definition of Supervision

Supervision in the context of HBC services is a management function planned and carried out in order to guide, support and assist HBC providers in carrying out their tasks. It involves on job transfer of knowledge and skills between the supervisor and the one being supervised through opening of administrative and technical communication channels.

1.3 Supervisory visits aim at:

- Assisting the HBC providers to improve their performance.
- Ensuring uniformity to set performance standards.
- Identifications of problems and solving them at appropriate time.
- Maintaining and reinforcing the administrative and technical link between higher and lower levels
- Follow up decisions reached during previous supervision visits.
- Identification of the HBC provider's needs.

2. LEVELS AND SCOPE OF SUPERVISION

Supervision roles will be undertaken at five levels: National, Regional, District, Health Centre/Dispensary and at community .

Level of service delivery	Activities	How to carry out the activities	Time frame	Responsible person	Feed back
Ministry of Health	Developing and reviewing HBC supervision guidelines and monitoring tools. Monitoring and evaluating HBC rendered by public, NGOs and private health institutions. Training supervisors	Analysis of reports from supervisory visits. Receiving service reports from regions to compare achievement with set standards. Evaluation of the services using developed tools for data collection.	Quarterly Annually	-Two technical officers/professionals will be identified and trained in HBC services and supervision. - They will be based at NACP but will also collaborate with the training directorate and other relevant units in the MOH.	Give feed back to RHMT
Regional	To co-ordinate and support the district in planning, implementation, supervision, monitoring and evaluation of HBC services.	Supervising DHMT's data collection, processing, analysis and utilisation in all the districts. Receiving service reports from districts to compare achievement with set standards. Co-ordinate training of HBC supervisors in the district Compiling reports to MOH .	Quarterly Annually	- Supervision team will be RHMT: may co-opt or commission their roles of supervision to relevant technical officers/professionals as may deem necessary.	Give feed back to DHMT

Level of service delivery	Activities	How to carry out the activities	Time frame	Responsible person	Feed back
District level	Monitoring and evaluating HBC services rendered by public, NGOs and private health institutions within the district. Training of supervisors.	Evaluation of the services using HBC monitoring tools. To compare service achievements against set standards and targets. Supervision of HBC services in the district. To monitor adherence to service standards and policies. - Assess competence of HBC providers - Compile reports to RHMT.	Quarterly Annually	- DHMT [may co-opt/ commission its supervision role to technical officer/ professionals from within the health sector such as district hospital, voluntary agencies and private practise].	Give feed back to Health centre/ dispensary
Health Centre/ Dispensary	Supervision and Monitoring of HBC services in their catchment areas.	- Supervisory visits to all community HBC providers in their catchment areas. - To monitor adherence to service standards and policies. - Compile reports to DHMT.	- Supervising community HBC providers weekly - Compiling reports monthly	Contact person at Health Centre / Dispensary	Give feed back to community HBC providers

3. PLANNING FOR SUPERVISION

Supervision must be included in the annual health plans at each health facility level. These include routine and focus supervision. Routine supervision is carried out to check how daily activities are being performed. Focus supervision addresses specific areas that need more time and thorough examination. Emergency supervision is carried out in the event of changes or divergence from performance and ethical standards in health care delivery.

3.1 Areas to be supervised in HBC services include

1. Planning, monitoring and evaluation:
 - Routine recording and reporting.
 - Evaluation procedures.
2. Materials management
 - Established procurement system and adequacy.
 - Maintenance of supplies records.
3. Facilities and equipment management.
 - Adequacy of equipment and supplies.
 - Condition of equipment and supplies.
4. Human Resources management
 - Placement of staff according to qualification
 - Norms, ethics and standards of performance.
5. Clinical package
 - Clinical management of patients and nursing care.
 - Referral support.

3.2 How to supervise

Before the supervision team conducts supervision it should familiarise itself with:

- The understanding of HBC services.
- The understanding of HBC services supervision and monitoring through training.
- Main objectives of supervision
- The meaning of quality health care
- The roles and responsibilities of staff to be supervised.

The process of supervision can be divided into 3 stages: preparatory, actual supervision and immediate feedback.

In the preparatory stage - the necessary tools for supervision are assembled, the problems at that level identified and objectives for supervision set. Transport, schedule of supervision arranged.

At the actual supervision stage - the supervisors study the performance of HBC providers at work place and identify support needs. Lastly, the supervisors meet with the management teams to discuss findings from the respective areas.

3.3 Supervision Report

The purpose of making supervision reports is to inform the supervised HBC providers and those who have authority to make decisions.

3.4 Composition of the supervision reports

Supervision report may be structured as follows:

- Title page.
- Acknowledgement
- Acronyms
- Executive summary
- Background
- Main report – Analysis of findings/observation/situation analysis, needs, service and systems.
- Conclusion and recommendations
- Appendices

Explanation of the above contents

Acknowledgement:

Word of appreciation to individuals and organisations, which participated and assisted in the supervision.

Acronyms:

Elaborate meaning of short forms.

Executive Summary (if required):

This section may be important if the report has to be sent to top officials who often do not have time to read the whole report. The Executive summary is not supposed to be more than one page.

It needs to disclose to the reader the most essential points of the whole report. Most of the essential points are Aims of the supervision, objectives of the supervision, how supervision was conducted, what were the constraints, what are the conclusions and recommendations. In the report, the summary comes first, but it is written after all the sections of the report have been completed.

Introduction:

Describes the objectives of the supervision, places visited and people met. A brief description of the methods used to do the supervision should be included in this section.

Main report:

Analysis of findings/observations/situation analysis: This section describes all the constraints and weaknesses and strengths observed during supervision.

Conclusions and recommendations:

Recommendations include action taken on the spot and action to be implemented based on conclusions. There will be action taken on the spot and actions to be implemented by the supervised health workers and those which will need in puts from the higher level.

Appendices:

This section may be included in every report. It will include all the references, which are not reflected in the main text.

4. CHECK LISTS

The purpose of a checklist is to guide the supervisor on areas to be addressed during supervision. It also serves as a reminder to the supervisors on areas which would otherwise be overlooked. A well-filled checklist will act as a good reference in the future for the supervisors and the health staff who are supervised in the subsequent visits.

4.1 Checklist of issues for HBC supervision

Questions

1. Are the HBC forms 1,2 and 3 filled in correctly? (Annex 1 – 3)
 - 1 a. Does the HBC provider enter all the necessary information in the HBC form 1 (Annex 1)
 - 1 b. Are the HBC forms not in use kept in appropriate place?
 - 1 c. Are the quarterly summaries up to date? (Annex 2)

Equipment, drugs and supplies

2. Is there a record of drugs and medical supplies? (Annex 3)
 - 2 a. Are the equipment maintained in good condition?. Check the standard list. (Annex 3)
 - 2 b. Are drugs/supplies ordered in time according to needs and resources?
 - 2 c. Are there adequate supplies of drugs?

Performance assessment

3. Is there a qualified HBC provider?
 - 3 a. Does he/she has job description?
 - 3 b. Check – Is the HBC provider patient relationship good?
 - 3 c. Does the HBC provider allow enough time for the patient to explain herself/himself?
 - 3 d. Is history taking adequate?
 - 3 e. Is the patient given correct treatment?
 - 3 f. Is the patient counselled properly?

4.2 Monitoring and Evaluation

Does the RHMT/DHMT assess the performance / check progress reports and action plans to determine the degree of implementation vis-a-vis planned level?

- a. Are there any operational research carried out? Check if the district used the results and how?

- b. Does the RHMT/DHMT evaluate their performance?

4.3 Scoring system

There are several methods that can be used in assigning a score on the performance of various activities observed during supervision. Numerical scoring method was chosen as a standard scoring method for HBC services as this scoring method allows calculating average score through time and across facilities.

In this method each performance category is assigned a number as shown in the example below:-

- | | | |
|---|---|--------------|
| 1 | - | Excellent |
| 2 | - | Very good |
| 3 | - | Good |
| 4 | - | Satisfactory |
| 5 | - | Poor. |

At the end of this exercise average score for a health facility or district can be calculated using the numeral scoring chart annex 6.

REFERENCES

1. Ministry of Health, Tanzania (1999) *National Primary Health Care Supervision*.
2. Ministry of Health, Tanzania (1996) *Health Sector Reform Plan of Action 1996*.
3. Franklin A. et al. *Supervision of Health Personnel at District Level, WHO*.
4. Ministry of Health, Tanzania (1998) *Guidelines and Standards for Counselling and Supervision*.
5. The United Republic of Tanzania, Ministry of Health, NACP, (1989), *Guideline Testing Control and Management of AIDS/HIV*.



5. ANNEXES

Annex 1 a

MINISTRY OF HEALTH

HBC Form I: Home Based Care Monthly Report

Month _____ Year _____

Village _____ District _____ Region _____

Name of HBC provider _____

No	Name of Patient	Age	Gender	Visiting Dates				Remarks
				Date	Date	Date	Date	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
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31								

Copy at the Health Facility
Copy to the HBC Provider

WIZARA YA AFYA

HBC Form I: Taarifa ya mwezi ya huduma za wagonjwa majumbani

Mwezi _____ Mwaka _____

Kijiji _____ Wilaya _____ Mkoa _____

Jina la Mhudumu _____

No.	Jina la Mgonjwa	Umri	Jinsia	Tarehe za Kumtembelea Mgonjwa				Maoni/ muhimu
				Tarehe	Tarehe	Tarehe	Tarehe	
1								
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3								
4								
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31								

Nakala kituo cha Afya

Nakala kwa mhudumu

MINISTRY OF HEALTH

HBC Form 2: Home Based Care Quarterly / Annual Report

Village.....Dispensary/Health Centre.....

District..... Region:.....

Name of HBC provider.....Date.....

	January – March		April – June		July – September		October – December			Total				
	Male		Female		Male		Female		Male		Female			
	<5yrs	>5yrs	<5yrs	>5yrs	<5yrs	>5yrs	<5yrs	>5yrs	<5yrs		>5yrs			
Total No. of clients														
No. of new clients														
No. of deaths during the period														

Copy at the Health Facility

WIZARA YA AFYA

HBC Form 2: Taarifa ya robo mwaka ya huduma kwa wagonjwa majumbani

Kijiji:.....Zahanati/Kituo cha afya.....

Wilaya.....Mkoa.....

Jina la mhudumu.....kutoka tarehe.....hadi tarehe.....Mwaka.....

	Januari – Machi		April – Juni		Julai – Septemba		Octoba – Desemba			Jumla	
	Me	Ke	Me	Ke	Me	Ke	Me	Ke	Ke		
	<5mk	>5mk	<5mk	>5mk	<5mk	>5mk	<5mk	>5mk	<5mk		
Idadi ya wagonjwa wote											
Idadi ya wagonjwa wapya											
Idadi ya wagonjwa waliofariki											

Nakala kituo cha Afya

MINISTRY OF HEALTH

HBC Form 3: Monthly Report From Dispensary/Health Centre

Date filled in:.....Month:.....Year:.....

District:.....Dispensary/Health Centre:.....

Supplies/equipment/ drugs	Goods in stock	Goods received	Goods used	Goods remained	Goods need to be supplied	Remarks
Tabs Chloroquine						
Tabs Aspirin						
Hydrocortisone Ointment%						
Tabs Chlopheniramine						
Tabs Paracetamol						
Ampiclox capsules						
Cotrimoxazole tabs (Septrin)						
Multivitamins tabs						
Vitamin B complex						
Savlon solution						
ORS sachets						
Benzyl Benzoate Emulsion						
Thermometer						
White field ointment						
Mackintosh						
Forceps dressing						
Adhesive plaster						
Scissors; straight						
Cotton wool						
Microscope slides						
Blood lancet						
Sodium benzoate solution						
Gallipot						
Hyporchlorite solution						
Calamine lotion						
Washing soap						
Cotton gauze						
Receiver (Kidney dishes)						
Gloves						
Plastic apron						
Bandage						
G V paint						
Ampiclox syrup						
Promethazine tablets						
Nystatin oral paint						

Copy at the Health Facility

WIZARA YA AFYA

Fomu 3: Taarifa ya mwezi ya Dawa / Vifaa kutoka Zahanati / Kituo cha Afya

Tarehe:.....Mwezi.....Mwaka.....

Wilaya:.....Zahanati / Kituo cha Afya.....

Dawa / Kifaa	Idadi iliyopo	Idadi iliyopokelewa	Idadi iliyotumika	Idadi iliyobaki	Idadi inayohitajika	Maoni
Vidonge vya Chloroquine						
Vidonge vya Aspirin						
Hydrocortisone ointment 1%						
Vidonge vya Paracetamol						
Vidonge vya ampiclox						
Vidonge vya Paracetamol						
Promethazine						
Chlopheniramine						
Ampiclox syrup						
Vidonge vya Seprtrin						
Vidonge vya Multivitamin						
Vidonge vya Vit. B. Complex						
Savlon solution						
ORS Sachets						
Benzyl Benzoate Emulsion						
Thermometer						
Whitefield ointment						
Mackintosh						
Forceps dressing						
Adhesive Plaster						
Scissors / Straight						
Cotton wool						
Cotton gauze						
Microscope slides						
Blood lancet						
Sodium benzoate solution						
Gallipot						
Receiver kidney dish						
Callamine lotion						
Hypoclorite solution						
Sabuni ya mchi						
Plastic apron						
Nystatin oral paint						
G. V. paint						
Gloves						

Nakala kituo cha Afya

MINISTRY OF HEALTH

HBC Form 5: Patient's Referral Form

Date:.....

Patients Name:.....

Age:.....Sex:.....

Village.....Tencell Leader.....Division.....

To:.....

Dispensary/Health centre/District hospital.

Reason for referral:.....

.....

Services rendered:.....

.....

Name of the person referring the patients:.....

Signature:.....

Title:.....

Address:.....

WIZARA YA AFYA

HBC Fomu 4 : Fomu ya Rufaa ya mgonjwa

Tarehe.....

Jina la Mgonjwa:.....

Umri:.....Jinsia.....

Kijiji:.....Balozi.....Tarafa.....

Kwenda kwa:.....

Zahanati/Kituo cha Afya/Hospitali ya wilaya

Sababu ya Rufaa:.....

.....

Huduma iliyotolewa:.....

Jina la anayetoa rufaa:.....

Sahihi:.....

Cheo:.....

Kituo:.....

MINISTRY OF HEALTH

HBC Form 5: Patient’s Consent to pass information to third party

I.....the undersigned, do hereby give permission.....

.....to inform the following person(s) about my sero status:

1.....

2.....

3.....

Name

Signature.....

Date.....

WIZARA YA AFYA

HBC Form 5: Kibali cha mgonjwa, Taarifa yake itolewe kwa mtu mwingine

Mimi.....ninaye husika ninatoa ruhusa kwa

.....amweleze/ awaeleze wafuatao kuhusu hali/ ugonjwa wangu

1.....

2.....

3.....

Jina.....

Sahihi.....

Tarehe.....

Numerical Scoring Chart

Name of District:.....

Question	Name of the Health facility	Name of the Health facility	Name of the Health facility	Name of the Health facility	Average score for district
1.					
1.a					
1.b					
1.c					
2					
2.a					
2.b					
2.c					
3.					
3.a					
3.b					
3.c					
3.d					
3.e					
3.f					
Average score of Health facility.					



PART FOUR

**COMMUNITY INVOLVEMENT AND PARTICIPATION AND THE
ROLE OF TRADITIONAL HEALERS IN HBC SERVICES.**

1. INTRODUCTION

The National Health Policy has elements of community based health care. The objective is to improve the health and well being of the people. The aims of the health policy are to:

- (i) Make health services more accessible to all people in Tanzania
- (ii) Promote community participation and involvement in healthy life styles.
- (iii) Promote multisectoral action in health care.
- (iv) Promote family health.
- (v) Reduce mortality and morbidity by providing preventive and promotive health care services
- (vi) Train manpower from village level to the national level.

The Guidelines on Community Based Health Care Activities are developed on the basis of these aims of the health policy.

The health policy accommodates home based care (HBC) for chronically ill patients in that HBC brings health services to chronically ill individuals in their homes. However, for the HBC to be successful it is vital that there be active community involvement and participation in the promotion of the service.

These guidelines have been prepared to assist stakeholders (planners, policy makers, partners) in implementation; and communities in establishing and strengthening their involvement and participation in HBC services.

A. GUIDELINES ON COMMUNITY INVOLVEMENT AND PARTICIPATION IN HOME BASED CARE FOR CHRONICALLY ILL PATIENTS

1. Definition of concepts

- (a) A community is a group of people living together in the same geographical area under one administrative leadership, sharing more or less common social and economic conditions. In a community, the majority of members know one another, have close or wide interaction and they ought to act together in their common interests. A community is known as a village in rural areas and a hamlet (Kitongoji) in urban setting.
- (b) Community involvement is defined as a process by which partnership is established between the Government and local communities in the planning, implementation, monitoring and evaluation of development projects and activities which are executed in the community. Genuine community involvement is the most essential prerequisite for successful implementation of community based HBC activities. To be genuine, the involvement must be on voluntary basis and there should be a real devolution of authority and power as well as responsibility. Involvement must be generated and maintained from village to national level.
- (c) Home based care (HBC) refers to basic medical and counselling services, material and social support provided to chronically ill patients including AIDS patients and their families in the households.
- (d) Community participation in HBC is the involvement of the community in taking care of chronically ill patients and provides social and material support to patients and their families in the household.

2. Objectives of Community Involvement and Participation in HBC Services

- (a) To assist communities to identify their health and development problems through understanding of HBC as an essential part of the health care system.
- (b) To assist the communities to identify and mobilize resources available locally and elsewhere for HBC services for chronically ill patients.
- (c) To assist communities to plan and implement HBC activities aimed at supporting chronically ill patients in the communities.

3. Strategies For community Involvement and Participation in HBC Services

- (a) Community education, sensitization to raise awareness, mobilization for action to solve their problems and organization.
- (b) Identify and train HBC providers and patient careproviders on the home based care model and its operation.
- (c) Find ways and means to be used by the community to reward or remunerate HBC providers.
- (d) Strengthening home based care management information system which is appropriate and efficient.
- (e) Intersectoral coordination and collaboration of actors from village level to district level.
- (f) Identification and supporting of economic groups conducting income generating activities.
- (g) Identification and utilization of resources available locally as well as resources from else where

- (h) The district to strengthen community health care service delivery systems and integration of vertical programmes.
- (i) Identification and utilization of community organizations and structures.
- (j) Availability of essential and appropriate medicines and supplies and advice on the treatment of some diseases.
- (k) Conduct operational research on HBC and use the findings for re-planning and implementing HBC activities.

4. Strategies for implementation of Home Based Care Services in the Community

Patient care takes place both in the community and in established health and related institutions. HBC is an integral part of Community Based Primary Health Care. It should be initiated and implemented in the community by the community.

4.1 Essential/Basic elements of Home Based Care and Implementation activities in the community.

Elements of HBC	Implementation of Activities in the Community
(a) Education on Home Based Care	Community education on Home Based Care.
(b) Promotion of food production and	<ul style="list-style-type: none"> • Food Production, processing, distribution, preparation and good nutritional practices utilization. • Community education on good methods of food production, processing, distribution, preparation and utilization.
(c) Adequate supply of safe water and basic sanitation	<ul style="list-style-type: none"> • Identification and protection of water source • Fetching, storage and utilization of safe water and utilization of sanitary facilities (latrines etc) • Community education on safe water and sanitation.
(d) Prevention and control of endemic diseases	<ul style="list-style-type: none"> • Community education on prevention and control of endemic diseases. • Personal and household hygiene • Utilization of safe water and food hygiene
(e) Adequate treatment of common diseases and injuries.	<ul style="list-style-type: none"> • Community education on recognition of common diseases and injuries and on First Aid. • Community education on prevention of common diseases and injuries and early and complete treatment.
(f) Provision of essential medicines and supplies	<ul style="list-style-type: none"> • Community education on proper use of drugs and medicines • Acquisition and use of medicines and supplies

4.2 Community Understanding of Home Based Care (HBC)

The community is the key actor in HBC activities. It is therefore, important for it to have a clear understanding of the nature and functions of HBC.

The community needs to understand that HBC is part and parcel of its daily activities and it has the responsibility for management and maintenance of the HBC services.

- (a) In order to achieve community understanding of HBC, it is important to sensitize and create awareness to medical personnel and other professionals, government leaders, non - governmental organizations and community members.
- (b) The community actors to be involved in the sensitization include:
 - (i) Community development officials from village to district level
 - (ii) District Primary Health Care Committee and District Health Management Team.
 - (iii) Religious leaders
 - (iv) Teachers
 - (v) Politicians - members of parliament, ward councillors and influential people.
 - (vi) Non - governmental organizations (NGOs)
 - (vii) The media
 - (viii) Other relevant people and institutions
- (c) Modalities for sensitization
 - (i) Meetings
 - (ii) Preaching
 - (iii) Seminars
 - (iv) Newspapers, TV, leaflets, brochures, posters.
 - (v) Cultural , youth and women groups.

The sensitization and creating awareness are on going activities.

5. Roles and Responsibilities of the Community in HBC Services

A community has a variety of roles and responsibilities in HBC. Effective implementation of HBC activities rests on the community's understanding that chronic illness among community members is not a problem of one individual but rather a problem of the whole community. On this basis, the community has to undertake broad and specific action to address the problem of providing care to chronically ill patients.

5.1 The major roles and responsibilities of the community on HBC services.

Roles	Responsibilities
(i) Situation analysis	<ul style="list-style-type: none"> - Collect data or information on chronically ill patients in the community. - Assessment of needs and problems of Chronically ill patients in the community. - Review what is being done about the Situation of chronically ill persons. - Determine the number of orphans in the Community and their problems - Outline what should be done to the Situation
(ii) Developing HBC program	<ul style="list-style-type: none"> - Identify planning team - Set aims of HBC on what should be achieved - Determine target groups and criteria for their selection - Outline strategies i.e. the approach to be taken - Set out activities to be done - Identify the material and human resources required. - Set time frame for monitoring and evaluation. - Identify collaborators and resources available in the community
iii) Plan of action	<ul style="list-style-type: none"> - Decide on major activities to be undertaken - Determine who should do what, how, when and where. - Resources needed - Need for training - How to fill gaps of the required resources
(iv) Implementation	<ul style="list-style-type: none"> - Determine management and organization i.e. how the programme will be managed and administered - Make decision on supervision of HBC activities: Follow up and reporting. - Supply requirements, storage and utilization.
(v) Monitoring and Evaluation	<ul style="list-style-type: none"> - Make assessment on achievement of HBC activities: Resource utilization and community involvement and participation
(vi) Re - Planning activities	<ul style="list-style-type: none"> - Set new objectives and targets.

6. Roles and Responsibilities of Community actors in HBC.

Community actors are the people and other structures and institutions that play essential roles and have responsibilities in the implementation of HBC.

6.1 Roles and Responsibilities of the Community Actors.

Actors	Roles	Responsibilities
(i) Family/Household	Care provider and protection	<ul style="list-style-type: none"> - Provide shelter, food, clothing, bath and dressing - Administer medicines - Pay costs of drugs and supplies.
(ii) Community HBC provider	Provider of basic health services including HBC services in the community	<ul style="list-style-type: none"> - Monitor patients' medication - Visit chronically ill patients/families - Provide basic health education to patients and families - Make referral to dispensary and health center - Report to village government - Report to health facility.
(iii) (a) Village government	<ul style="list-style-type: none"> - Community organizer - Management, supervision and evaluation of HBC. 	<ul style="list-style-type: none"> - Mobilization of the Community on HBC. - Resource allocation - Implementation of HBC Services - Monitoring and Evaluation of HBC Services.
(b) Dispensary	<ul style="list-style-type: none"> - Provide technical support, coordination and supervision. Train community HBC providers 	<ul style="list-style-type: none"> - Treatment of diseases - Counseling patients and their families - Referral and discharge of patients - Follow - up HBC activities - Supervision of Community HBC Provider - Submit report to higher level.
(iv) (a) Ward Development Committee	<ul style="list-style-type: none"> - Advocacy on HBC services - Coordination of social and economic development including HBC activities in the ward. - Plan for HBC services 	<ul style="list-style-type: none"> - Mobilization of Communities on HBC - Allocate resources. - Submit report.
(b) Health Centre	<ul style="list-style-type: none"> - Provide health services - Provide technical support to community HBC 	<ul style="list-style-type: none"> - Provide technical support To communities for HBC activities - Diagnosis and treatment - Counselling patients and families - Referral and discharge of patients - Monitoring and Supervision of HBC Activities.

Actors	Roles	Responsibilities
(v) (a) District leadership.	<ul style="list-style-type: none"> - Advocacy on HBC services. - Coordination of social and economic development including HBC activities. - Plan for HBC services. 	<ul style="list-style-type: none"> - Mobilization of communities on HBC activities. - Policy matters on HBC - Resource mobilization and allocation. - Administrative matters on health including HBC
(b) District hospital	<ul style="list-style-type: none"> - Advocacy, and coordination of HBC services - Provide technical support 	<ul style="list-style-type: none"> - Implement policy issues on HBC. - Mobilization on HBC - Resource allocation - Administrative matters on health including HBC - Treatment and counselling - Training, monitoring and evaluation of HBC services. - Supervision and submission of report.
vi) Non - governmental organizations and Community Based Organizations (where available)	<ul style="list-style-type: none"> - Community empowering for social and economic development. - Support for HBC services 	<ul style="list-style-type: none"> - Support to communities on <ul style="list-style-type: none"> • Mobilization for HBC • Training needs • Supplies • Income generating activities.
vii) Traditional healers and Traditional birth attendants	<ul style="list-style-type: none"> - Healing practices - Ensure safe baby <p style="text-align: center;">Delivery</p>	<ul style="list-style-type: none"> - Assist deliveries - Treatment of illness - Counselling patients and families - Referral to health facilities

7. Financing and Sustaining HBC services

Sustainability of an activity is the ability of that activity to remain functioning after withdrawal of external funding. In order to bring this about, it is necessary to establish funding mechanism right from the beginning of establishing HBC activities in the community.

7.1 Models of financing and sustaining HBC

- (i) Household/Family is responsible for the financial cost of patient care. This is in line with the cost sharing policy of the Government.
- (ii) Community should support patients /families unable to pay for the costs and expenses of their patient care.

7.2 Possible options for the community support of HBC services

- (a) Establishment of community health fund, that is owned, managed and controlled by the community.
- (b) Contributions by community members in form of cash, material and in kind in order to address specific problems of patients.
- (c) Non-governmental organizations/community based organizations can support communities to establish income generating activities which will enable them pay for the financial requirements for HBC activities and services.
- (d) District support in terms of funds, medicines and other necessary resources.
- (e) Contributions from individuals on voluntary basis and other financial sources identified by the community.

7.3 Integrating the home Based Care into the District Health Care System.

This implies that these services should be part and parcel of the district health care delivery system.

Approaches to Integration

- (i) The training on HBC should be incorporated/included in the training curriculum in medical, paramedical and nursing institutions.
- (ii) The key actors in the management (planning, implementation, monitoring and evaluation) include the following:
 - (a) District Nursing Officer under the cover of District Medical Officer.
 - (b) Nurse midwife/Public Health Nurse under Clinical Officer incharge of Health Centre.
 - (c) Nurse assistant/Attendant under dispensary incharge who is the Assistant Clinical Officer.
 - (d) Community HBC providers under health facility HBC contact person.

The actual implementation of this line of management will depend on the staffing situation in the health facilities.

7.4 Possible people to be involved in HBC at community level include

- (a) Community volunteers
- (b) First Aiders
- (c) Traditional birth attendants
- (d) Traditional healers
- (e) Religious leaders
- (f) Other suitable people selected by the community.
- (g) Village health worker – revival

7.5 Criteria for Selection of HBC Providers.

The community should consider the following criteria when selecting candidates for HBC

- (a) Literate person.
- (b) A person who is willing to volunteer to do the work.

- (c) Someone the community really wants because he/she has shown interest in caring for the sick or people in trouble.
- (d) A person who has good interpersonal relationship.
- (e) One who maintains confidentiality.
- (f) A reliable person and who does not despair.
- (g) Preferable middle aged.

7.6 Training

Communities must be educated on HBC operation and services. HBC providers and patient care providers must be trained on how to administer HBC services to chronically ill patients.

The communities should use their own resource persons. The communities should select community members to be trained by selected trainers and HBC providers. These people, after their successful training should work as community resource people. The communities should decide on how to pay them, in kind or in cash, based on the abilities of the communities themselves.

Extension workers and other professional employees in the communities should also be educated, sensitized and eventually mobilized to support HBC in the communities.

The management and administrative staff at the District, Regional and National levels (Ministry of Health) will be required to facilitate the training of HBC providers identified by the community.

Training Needs for Actors in HBC.

Actors	Roles	Training needs
Community Resource People <ul style="list-style-type: none"> • Community leaders • HBC providers • Traditional healers • Traditional birth attendants • Any other person selected by the community. 	<ul style="list-style-type: none"> • Educate and sensitize on nutrition, and HBC • Mobilize community to implement HBC • Provide HBC services of treatment, counseling and basic human needs 	<ul style="list-style-type: none"> • HBC model and its operation. • Community modalities of involvement and participation • Basic first aid and management of common illness • Methods of collecting, reporting and utilizing information.
Community Extension Workers and Health facility contact persons.	<ul style="list-style-type: none"> • Technical support to The community to improve Health and development Activities • Train community resource people • Community change agents. 	<ul style="list-style-type: none"> • HBC model and its operation • Community modalities of involvement and participation • Functional duties for development • Collection, reporting and use of information
Facilitators/Supporters at district, regional and National levels.	<ul style="list-style-type: none"> • Policy formulation • Coordinate planning of community projects • Training and supervision 	<ul style="list-style-type: none"> • HBC model and its operation • Community involvement and participation • Management and supervision

8. Monitoring and Evaluation of Community Involvement and Participation

8.1 People Responsible

- i. At village level.
 - The Community HBC provider will monitor and report to the village government and to the contact person at dispensary level.
 - The village Health Committee also will monitor and report to the village council.

- ii. The Dispensary will report to the health centre.

- iii. Health centre will report to district level.
 Hence the reporting chain should be from Village, Dispensary, Health Center and District level. In addition the reports should be sent through people incharge of those units. Supervision, monitoring and evaluation of HBC activities should be participatory. To facilitate supervision, monitoring, evaluation and control, there should be regular collection and analysis of relevant service management information. The communities should be given feedback so that they can re-plan their activities on HBC.
 Appropriate and adequate organizational support should be set up at all levels from the community to the national levels with responsibilities and logistic support for HBC.

8.2 Check list for Monitoring and Evaluation of Community Involvement and Participation

- a) Education on HBC.

- b) Promotion of food production and nutritional practices.
- c) Supply of safe water and basic sanitation
- d) Prevention and control of endemic disease.
- e) Treatment of common diseases and injuries.
- f) Provision of essential medicines and supplies.
- g) Prevention and control of deformities related to bed-ridden patients.

9. Special Issues

9.1 Code of Ethics for HBC providers

Ethics is associated with morality and professional conduct. Professional ethics in the health sector in the context of home based care activities require the actors to perform their activities in accordance with health professional requirements in a community context. The ethics deal with the methods employed in the process of executing activities in the communities. In doing HBC services to chronically ill patients, it is absolutely necessary to abide with the following ethical requirements:

- (a) Confidentiality
 - (b) Respect other people
 - (c) Commitment and volunteer to work on HBC
 - (d) Reliable person.
 - (e) Have confidence and does not give up.
 - (f) Ability to identify and recognize ones limitations
 - (g) Respect and cooperate with professional orders
 - (h) Should not be involved in illegal personal profit gain.
- HBC services require patients and their relatives to reveal personal information about the patient and home conditions in order to be able to assess the problem and the needs required. Such information should be provided voluntarily and the information should not be used in any way that may inflict harm or injury or embarrassment to the patient and the family.
 - HBC providers must be reliable people who respect and cooperate with professional orders as well as work well with other actors in home based care activities. Information on patients problems should not be revealed to people who are not concerned with the HBC activities. Thus the HBC providers should maintain anonymity and confidentiality on the patient identity and the problems involved. The patient has right to privacy.
 - HBC providers have confidence and willingness to work with the community.
 - They must at the same time be able to recognize their limitations on their ability to provide services to patients.
 - In monitoring, supervision and evaluation the reporter must be faithful and honest to the information which is reported. It is absolutely not acceptable to lie or give wrong information about the patient care activities. The HBC provider should not in any way engage in illegal personal profit gain in the communities.
 - Ethical issues in the health sector can become political when for example infringements on the rights of individuals, communities or even countries become a source of controversy or demand

for regulations. Both ethics and politics hinge on ideological point of view. What is acceptable from one point of view might be unacceptable from another. Watch and take precaution when political issues are involved.

9.2 Gender issue on Home BBC services

HBC for chronically ill patients is a responsibility of the household/family as well as a responsibility of the community.

The current practice shows that the females have bigger workload of the production and household activities and even in patient care at the household the females provide most of the patient care services. The HBC model requires fair distribution of gender roles and responsibilities. The families/communities should address the gender issues in HBC to ensure that:

- Females are relieved of some of their routine activities.
- Males participate fully in HBC activities.

Decisions on the gender division of labor in HBC activities should be made by the families and communities in their local conditions and environment.

B. THE ROLE OF TRADITIONAL HEALERS

1. Definition of Traditional healers.

Traditional health practices are characterized with conflicting terminologies. Terms such as traditional health practitioners, herbalists, spiritualists, bonesetters, medicine sellers, faith healers, magicians, traditional birth attendants and traditional medicine man/woman have been used to identify categories/types of traditional health practices. Even people who study traditional medicine mix terms, confusing practitioners with malpractitioners, the trained with the untrained, established healers with non-healers.

The Regional (Africa) Expert Committee of the World Health Organisation (WHO) on traditional African medicine defined traditional medicine as, the sum total of all knowledge and practices, whether explicable or not used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing.

On traditional African medicine, the committee observed that it involved the sum total of practices, measures, ingredients and procedures of all kinds, whether material or not, which from time immemorial had enabled the African to guard against disease, to alleviate his suffering and to cure himself.

According to the same source (WHO) a traditional indigenous healer is a person recognized by the community one lives in, to provide health using plant, animal and mineral substances and other methods based on social, cultural and religious backgrounds as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and well - being and the causation of diseases and disability.

The term traditional medicine does not denote a uniform or clearly identifiable medical practice nor is it used in the sense of being backward, unscientific and static. Traditional healers can be classified on the way they were trained, their methods of healing or the disease they treat.

Focusing on the role of traditional healers in patient treatment and care in the communities, these are people who use their own environment and knowledge of diagnosing diseases and treating them using plants, minerals, insects and animal products. In this context traditional healers include herbalists, bonesetters and traditional birth attendants.

2. Areas of Concern on the Role of Traditional Healers

2.1 Existence of Traditional healers

- (i) Traditional healers have practiced in most African communities since time immemorial and may continue to do so for a long time to come.
- (ii) Need for traditional healers.
 - (a) People seek traditional treatment.
 - (b) Communities accept traditional healers and their practices
 - (c) Traditional healers have high credibility in the community because they manage some illnesses.
 - (d) Traditional healers have legal recognition and some are members of registered associations of traditional health practitioners.
The Government is currently developing policy document on traditional medical practice.
- (iii) Involvement of traditional healer in patient care.
Traditional healers give treatment and counseling to patients on illness which the patient considers respond well to traditional healing. The service is given at the home of a traditional healer or at the house of a patient. Traditional healers lack scientific explanation of their treatment. Nevertheless, they enjoy wide acceptance of the community.
- (iv) Relationship of Traditional healers and medical personnel.
The role of traditional healer in the existing health care system is yet to be defined. However there is need to explore the possibility of working with them to care for patients in the communities. This can be done by doing the following:
 - (a) Medical practitioners should educate traditional healers on basic health education to enable them handle patients safely.
 - (b) Medical personnel should sensitive traditional healers on the importance of referring patients to health facilities as early as possible if the condition of patient does not respond to traditional therapies.



REFERENCES AND OTHER SOURCES OF INFORMATION

1. Community Participation – *Current Issues and Lessons Learned*. UNICEF 59/60 No. 2 1982
2. *New Approaches to Health Education in Primary Health Care*. Report of a WHO Expert Committee No. 690 Geneva 1983.
3. Semali, I. A. J. and F. F. Lyimo *Home Based Care for Terminally ill Patients due to AIDS and other causes. Baseline studies from Rukwa, Coast and Kagera Regions in Tanzania*, Ministry of Health (NACP and DANIDA) Dar es Salaam 1998.
4. Lyimo F. F. *Community Participation and Role of Traditional Healers in Home Based Care Services in Bagamoyo District*. Ministry of Health (NACP/DANIDA) Research Report. Dar es Salaam. 1999.
5. Ngweshami J. et al. *HIV Prevention and AIDS Care in Africa*. Royal Tropical Institute 1997.
6. *Community Development Policy*. Dar es Salaam June, 1996.
7. Ministry of Health, *Guidelines on Community Based Health Care Activities in Tanzania*. Dar es Salaam.
8. Ministry of Health, *Primary Health Care Strategy 1992*.
9. Ministry of Health, *Strategic Framework for The Third Medium Term Plan (MTP III) for prevention and control of HIV/AIDS/STD 1998 – 2002*, July, 1998.
10. Ministry of Health, *National District Health Planning Guidelines 1998*.
11. “*The Traditional Healer in Tanzania*” in Issue Vol. ix (3) 1979 Page. 2 –5.
12. Beck, A. “*Traditional Medicine and its Role in East Africa Today*”. *Medicine, Tradition and Development in Kenya and Tanzania*. Cross roads Press Waltham Ma. Brandies University 1981.
13. Green .E. C. *Indigenous healers and the African State. Policy Issues concerning African Indigenous Healers in Mozambique and Southern Africa*. Pact Publications. New York 1996.
14. Green. E. C. “*Traditional Healers in African Countries*” in National Council for International health. Global AIDS Network Newsletter No. 46 July/August 1977 Page 14 – 15.
15. Heggenhougen, K. et al *Community Health Workers. The Tanzania Experience*. Oxford and Nairobi. 1987.
16. Ministry of Health, *National Health Policy*. Dar es Salaam. February, 1990.
17. *Interviews and Discussion sessions with people from the Ministry of Health, Ministry of Local Government and Regional Administration and Ministry of Community Development, Gender and Children*.

