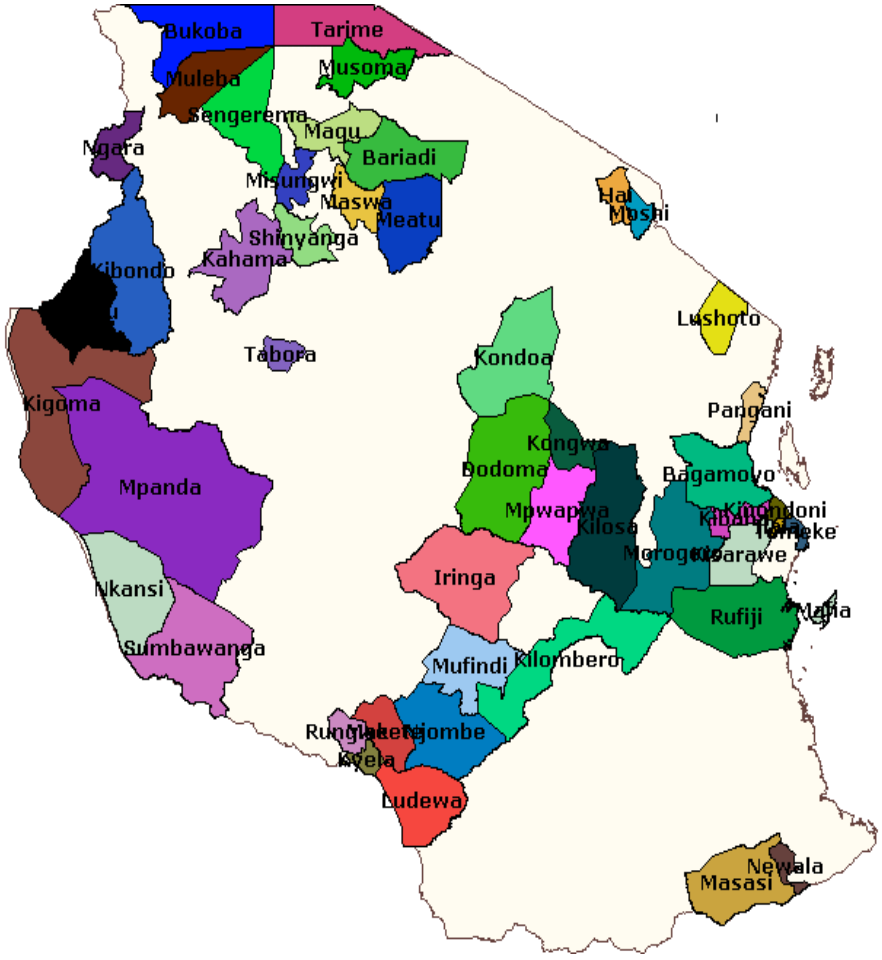
REPORT ON THE EVALUATION MISSION OF THE BELGIAN GOVERNMENT SUPPORTED HOME BASED CARE PROJECT IN TANZANIA: 8-22 JANUARY 2006.



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The author accepts sole responsibility for this report commissioned by UNAIDS. The report does not reflect the views of UNAIDS.

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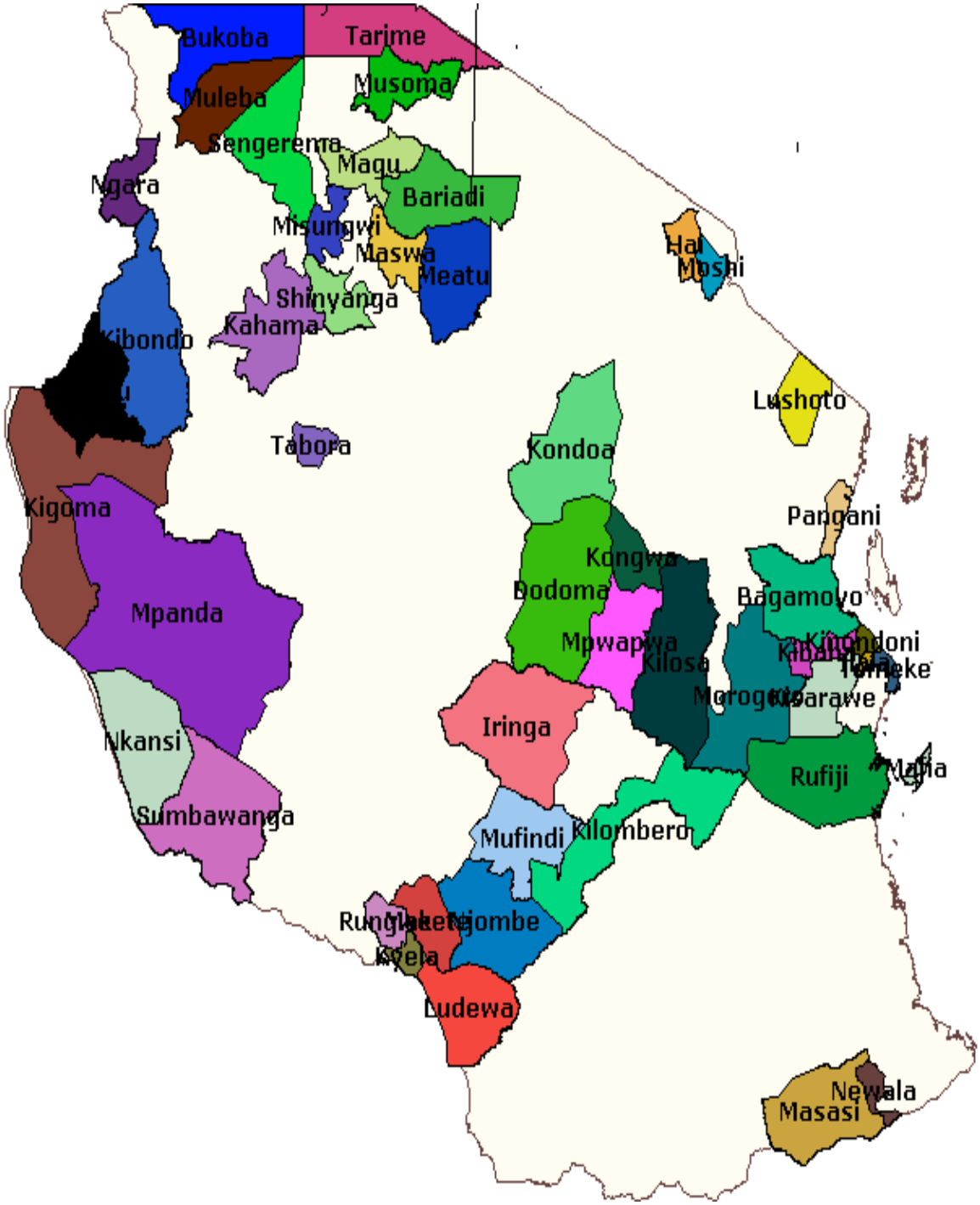
A map of the United Republic of Tanzania showing the districts that are providing Home Based Care. 39 were funded by the Belgian Government from 2001-2005.



ABBREVIATIONS AND ACRONYMS

AFRO	African Regional Office (WHO)
AIDS	Acquired Immuno-Deficiency Syndrome
ARVT	Antiretroviral Treatment
CBO	Community Based Organisation
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CDC	Centre for Disease Control
CHMT	Council Health Management Team
CMOH	City Medical Officer of Health
CTC	Care and Treatment Clinic (ARVT Site)
CO	Clinical Officer
CORP	Community Own Resource Person
CPA	Country Programme Advisor (UNAIDS)
DANIDA	Danish International Development Agency
DCT	Diagnostic Counselling and Testing
DED	District Executive Director
DMO	District Medical Officer
DOT	Daily Observed Therapy
EPI	Expanded Programme of Immunisation
FBO	Faith Based Organisation
FHI	Family Health International
HARP	Holistic HIV/AIDS Related Programme
HBC	Home Based Care
HIV	Human Immunodeficiency Syndrome
IMCI	Integrated Management of Child Illnesses
MOH	Ministry of Health
NGO	Non-governmental Organisation
PASADA	Pastoral Activities and Services for people with AIDS in Dar es Salaam Archdiocese (National NGO involved in HBC)
PMTCT	Prevention of Mother-to-Child Transmission
PHC	Primary Health Care
PLWHA	Person/People Living with HIV and AIDS
NACP	National AIDS Control Programme
MSD	Medical Stores Department
TACAIDS	Tanzanian Commission for AIDS.
TFDA	Tanzanian Food and Drug Administration Agency
TOT	Trainer of Trainers
Tsh	Tanzanian Shilling (Tanzanian currency: 1USD=+-1 000 Tsh)
UNAIDS	United Nations AIDS (UN AIDS Programme)
USAID	United States of America International AID Agency
VCT	Voluntary Counselling and Testing
VEO	Village Executive Officer
WEO	Ward Executive Officer
VHC	Village Health Committee
WHO	World Health Organisation (Un Agency with the Health Mandate)
WR	WHO Country Representative
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control [Programme
ZAPHA+	Zanzibar Association of People Living with AIDS.

Introduction.

In 2001, within the framework of the international Partnership Against AIDS in Africa, the Belgian Government granted financial support to UNAIDS to provide a standard basic kit to facilitate home and community care to people living with HIV and AIDS. The Ministry of Health of Tanzania in collaboration with the Tanzanian UN Theme Group developed a Project on "**Improving Access to Basic Drugs for Home and Community Care".** This project was approved by UNAIDS and an agreement was signed on October 10th 2001 between UNAIDS and the World Health Organisation (WHO). The project was conceived (Sept 2001- Sept 2002). Due to the delay in starting the project , a no cost extension was requested (Sept 2002- Dec 2003). A second No- cost extension was requested and granted by UNAIDS for the period covering December 2003 to June 2005. A new work plan was proposed and approved by the project steering committee and by UNAIDS for this period. The total financial support to the project was US$ 2,306,628, 50% of which was to be utilised for Home Based Care (HBC) activities at the country level whilst the rest of the funds was kept at WHO Geneva for procurement of drugs and supplies. The Belgian HBC Project covered 39 districts.

The overall responsibility for the implementation and coordination of the project was with the Ministry of Health (MOH) through its National AIDS Control Programme (NACP) for the mainland, and with the Zanzibar Ministry of Health and Social Welfare through the Zanzibar AIDS Control Programme (ZACP). For the Dar es Salaam Region districts, the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) ran the project in collaboration with the City Council in 3 districts of Kinondoni, Ilala and Temeke.

WHO Tanzania provided technical support, including monitoring of the project through a National Project Coordinator. The District Health Management Teams (DHMT) would monitor implementation in the Project Districts. In each Project implementing district, there were at least two trained Home Based Care (HBC) trainer of trainers (TOTs) who were responsible for training, coordination and supervising HBC Providers at the Health Centre and Dispensary level. The HBC Providers at the Health Centre and Dispensary levels would in turn train and supervise the family caregivers and volunteers at the community level.

EXECUTIVE SUMMARY.

The Belgian HBC Project brought many benefits to the care and support services of the chronically ill people of mainland Tanzania and the Islands of Zanzibar. It gave many lessons that could be used for the development of a comprehensive HBC project in Tanzania and beyond.
Our observations showed that it was accepted and appreciated at all levels from the central to the district levels, community and individual client levels.
Health care workers feel that the Project relieved them of the congestions at health facilities. Further the training offered gave them a new insight into the epidemic of HIV and AIDS. This training also prepared them indirectly for the coming of ARVT. Several of them actually said that they learnt facts about HIV and AIDS they had never heard before. At the community level it was felt that this project brought services nearer to the people. This alleviated a lot of problems such as transporting people from homes to hospitals or other health facilities, which could be very costly. The supplies including food, washing commodities and protective clothing such as gloves helped communities cope with the epidemic. Many communities also learnt a lot about HIV and AIDS and how to take care of the infected including universal precautions. At the individual level, clients appreciated being cared for in their home surroundings. Many felt health facilities, good as they may be, cannot replace family surroundings and, friends and relatives.

Many lessons were learnt from the Belgian Project. It was learnt that without proper training at all levels, the success of such a project is limited. Further, community participation in all phases of a project is essential for its success. Communities need to partake in the whole project cycle; planning, prioritisation, implementation, monitoring and evaluation. They should also be involved in reviews of the project. The burden of care of the chronically/terminally ill in the community falls mainly on only one gender, the women. Communities should be made to realise this and allow for gender equality in care and support of clients of HBC. In Zanzibar the reverse was observed, men do most of the chores such as fetching water, bringing firewood and going to the market for shopping amongst other duties. Generally, the project revealed the importance of bringing services nearer to the communities.
A needs assessment preferably with participants from all levels, donor community, PLWHAs, health care workers and communities should be done before starting such projects. It helps to show precisely what the requirements of the clients could be. A few requirements were missed out at the beginning of the project but were realised along the way.

One of the most important lessons learnt from the Belgian Project was lack of a sustainability strategy at the initial stage of the project. All participants should be part of the project development including a sustainability strategy that should be part of the project memorandum.

A list of recommendations is added at the end of the report.

Background Information.

The United Republic of Tanzania covers and area of 945,087 spare kilometres. It is divided into 26 administrative regions and 121 districts.
21 administrative regions on the mainland and 5 on the Island of Zanzibar. It has a population of 34,569,232 (2002 Census), with 23% of the population living in the urban areas and 77% in the rural areas. 46% of the population is aged less than 15 years, life expectancy is 49 years for males and 51 for females. Infant mortality rate is 99 per 1 000 live births (Regional Health Survey 1999) and maternal mortality ratio is estimated at 529 per 100,000 live births. The annual population growth rate is estimated at 2.9% and GNP per capita is around US$280 (2000)

The first three cases of HIV in Tanzania were diagnosed in 1983 in the Kagera Region. The epidemic grew steadily and by 1986 all 26 regions had reported cases. The Tanzania HIV/AIDS Indicator Survey (2003-2004) reported that in 2003, Tanzania Mainland was estimated to have 1, 820 000 people living with HIV (840 000 females and 960 000 males).
Tanzania has a prevalence rate of 7%, making it one of the 25 countries with the highest HIV prevalence globally (UNAIDS 2004). More than 80% of the people are infected through heterosexual transmission. The youth and women are the most vulnerable groups.

In response to the growing epidemic, a National AIDS Task Force was established in 1985. It developed a health sector response, mobilised communities, trained health care workers and developed a safe blood service. In 1988 a National AIDS Control Programme (NACP) was established. The NACP coordinated the development and implementation of the first and second national medium term plans (MTPI and MTPII) covering the period 1987-1996. The two medium term plans focussed on prevention, care and mitigation of HIV and AIDS. Despite increased awareness of HIV and AIDS among the population, there has been no significant behaviour change. The third national medium term plan (MTPIII), focused on a multi-sectoral approach to combating HIV and AIDS and Behavioural Change Communication (BCC).

The Ministry of Health through NACP developed a health sector strategy on HIV and AIDS (2003-2006). This strategy was launched in February 2003. A National Care and Treatment Plan (2003-2008) was also developed in collaboration with the Clinton Foundation and adopted by the government of Tanzania in October 2003. Implementation of the care and the treatment plan started in 2004; by June 2005, 91 sites were providing Antiretroviral Treatment. The Plan, identified 91 sites in which to provide ARVT in 2004/5. ARVT should have started by October 2004 but it was delayed and only started by March 2005. However, by October 2005, close to 18 000 people living with AIDS (PLWA) had benefited from the programme.

Several sources of funding have contributed towards care, support and management of AIDS in Tanzania. These include amongst others: The government of Tanzania, The Global Fund for AIDS, Tuberculosis and Malaria (GFATM), The Tanzania Multi-sectoral AIDS Programme (TMAP), United States President's Emergency Plan for AIDS Relief (PEPFAR), the Belgian, the Canadian and the Norwegian governments and other bilateral and multi-lateral donors.

Project Implementation

The Belgian project was initiated in response to the increased spread of HIV and AIDS epidemic in Tanzania and its strain on the Health sector. Health facilities had become overburdened with AIDS patients and could not cope adequately. These AIDS clients needed comprehensive care at all levels, health facility, home and at the community level. Experience in other countries such as Uganda, Zambia and Zimbabwe has shown that clients living with AIDS and AIDS related illness which took a long period of time, want to be cared for at home close to their families and relatives. The Tanzanian NACP decided to support HBC with help from different partners. Before the beginning of the Belgian project, HBC had already been established in 28 districts with support from the Danish International Development Agency (DANIDA), United Nations Development Programme (UNDP) and the Italian Government Initiative. By December 2005, a total of 66 districts were providing HBC services in the country.

The Belgian HBC Project had three major objectives:

- Strengthening the continuum of care for people living with HIV and AIDS (PLWHA), involving Districts, Mission Hospitals, Health Centres, dispensaries, NGOs, PLWHA support groups and Families & Communities
- Developing a sustainable Home Based Care system, which included training, drug supplies, supply of equipment and support for home visiting by health care workers and volunteers.
- Mobilisation of People living with HIV and AIDS Associations for care activities.

The activities for this project were divided into two phases:

PLANNED PROJECT ACTIVITIES for 2001-2003.

These activities included the following.

- Development of an HBC drug kit with the help of the Steering Committee with the Chief Pharmacist and Tanzania Drug Authority as members and procurement of the drugs through WHO Geneva.
- Preparation of guidelines, training and advocacy materials; booklets, brochures etc
- Training of trainer-of-trainers (TOTs) at the district level; these in turn trained health care workers, volunteers and community members.
- Procurement and distribution of Home Based Care kits
- Sensitisation of the districts and communities on Home Based Care.
- Training of trainer-of-trainers (TOTS) at the district level; these in turn trained health care workers, volunteers and community members.
- Supervision and monitoring of the Project activities.
- Procurement and distribution of bicycles to be used by HBC Providers.
- Provision of Care services to HBC clients through home visits
- Support of Information, Education and Communication (IEC) activities in the districts.
- Development, production and distribution of standard patient management and home visiting monitoring tools.

ACTIVITIES DURING THE NO-COST EXTENSION PERIOD (July 2004-June 2005)

These included most of the activities above with a few additions such as:

- Provision of HBC Services in Dar es Salaam CCBRT in collaboration with the City Council.
- Provision of food to the needy patients
- Orientation workshops to prescribers in the Project health facilities
- Supporting HBC carers through supportive meetings.
- Provision of HBC services through support visits by people living with HIV and AIDS (PLWHAs)

N.B. CCBRT was involved in the project from its inception in 2002.

Objectives of the Evaluation:

Overall Objective:

Documentation of implementation experience of the Belgian HBC Project with a view to better defining the way forward of scaling up community and home based care services in Tanzania. This looks at the progress made and lessons learnt.

Specific Objectives:

- Evaluate whether the objectives of the project have been met
- Evaluate the use of drugs included in the drug kits
- Document positive experiences
- Document and discuss the constraints in implementing the project
- Determine the available opportunities
- Provide recommendations for scaling up community and home based care services in Tanzania
- Suggest best model for implementation of HBC in Tanzania.

Methodology

A convenience sample of 4 districts chosen by the National Project Coordinator and Ministry of Health were visited and different approaches which included use of a questionnaire, face-to-face interviews, focus group discussions and debriefings. There were questionnaires for the following officers (see appendix for samples of the questionnaires.)

- National Project Coordinator based at the World Health Organisation Tanzania Office.
- Programme Manager/Coordinator Counselling and Social Services Unit of the Tanzania Ministry of Health
- District Medical Officer or Council Health Management Team member/s
- Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)
- District Home Based Care Coordinator (Based at District Office)
- Health Facility HBC Provider (at Health Centre or Dispensary)
- Ward Executive Officer or Village Executive Officer included in this questionnaire were other village community leaders such as Traditional Healers/Leaders of Faith Based Organisation.
- Head of family: Carers at the Community/Family Level of the Client.
- Client (Person who is chronically ill and under HBC Services.

Other methods used were:

- Face to face interviews
- Focus group discussions
- Observation
- Debriefing of CHMTs and other stakeholders at Districts and facilities

After every evaluation process a debriefing session was held at the Health facility and/or at the District office with CHMT members. The debriefing at the district level included all facilities visited and was to give District Managers a chance to comment and also give their suggestions and observations. At all levels providers were asked for means of verification (MOV); these included copies of reports, statistics and strategic and operational plans. A final debriefing was held for the steering committee of the Project and identified partners.

There were a few flaws in this methodology. First of all there was a language barrier between the evaluator and most of the people interviewed and a translator was used in most cases. The translator in most cases was an HBC provider who could be biased. A professional translator not associated with the project would have been better. There was not enough time for the whole exercise and a random sample would have been much better than a convenience sample. However with the time given a convenience sample was the most appropriate.

The external evaluator was accompanied on the mainland by the National Project Coordinator HBC (WHO Tanzania) and the Coordinator Counselling and Social Services Unit from the Ministry of Health of Health Tanzania. On the Island of Zanzibar the evaluator was accompanied by the National Project Coordinator (WHO Tanzania) and the Coordinator Counselling and Social Services Unit and Her Assistant from the Ministry of Health and Social Welfare of Zanzibar. At district levels, the district home based care coordinators accompanied the team. A list of all people met and interviewed is in the appendix

OBSERVATIONS AND FINDINGS.

The evaluation team visited 6 districts out of the 39 districts where the Belgian Project was implemented, four on the mainland namely Dodoma Rural, Dodoma Urban, Kilosa and Kinondoni districts.. Two were on the Island of Zanzibar namely Zanzibar Urban and Zanzibar North A. In all these districts, clients, caregivers, HBC Providers/Trainers at facilities, District HBC Coordinators and Council Health Management Team (CHMT) members were interviewed. The opinion of communities was sought through community leaders and opinion influencers such as Political Leaders, Traditional Leaders, Traditional Healers and Faith Based Organisation leaders. Where NGOs were working these were also interviewed for their opinion over the Belgian Project.

Acceptability

People at every level from the District Head Quarters to the lowest levels; families and the clients accepted The Belgian Project enthusiastically. **Clients and their families praised the project for bringing services nearer to the people.** Many clients due to poverty could not afford fares to travel to the Health facilities that usually are more than 20 or more kilometres away. The provision of commodities such as food, soap and drugs brought relief to many families since they could not afford these commodities. Most of the families of HBC clients are very poor. The illnesses put even more stress on the family economics. Families were also very grateful that most bed-ridden **clients were now productive** and could do their own chores without much help due to the management of opportunistic infections by the HBC providers. There was so much appreciation to the programme that in many villages and facilities we visited people would come to talk to us in praise of the project without invitation. In Dodoma Urban district for instance we met a client who is now a community own resource person (CORP). These are community members who help families at the community level and provide HBC and are supervised by the HBC Providers from the health facilities. CORP are chosen by communities and trained by the Project. They are usually volunteers working at community levels under the supervision of a trained health facility HBC provider at the health centre or dispensary. Walking out of the District Health facility we were asked to go through the TB outpatient ward to meet a person who had come in the morning just to meet 'this angel' who had brought such a wonderful programme that had made her life so enjoyable. This is her testimony: *"Two years earlier, her sister had pronounced her dead, and sent her home on a bus from Morogoro 200km away, unaccompanied with a letter to her father, asking him to receive his dead child. The sister believed she could not survive a week. The sister even wrapped her in clothes that people usually use to wrap the dead. Her father picked her up and took her to a health facility in Dodoma Urban. Later she was referred to an HBC service, which she says revived her and made her life normal again."* The day we met her she looked very healthy and she praised God for bringing the Belgian Project to her area. She said when she recuperated she decided to contribute by volunteering as a CORP to help others who are chronically ill like herself.

The team observed that there was a clear bond between the HBC providers at the community level with clients and their families.

Community leaders also showed their appreciation of the Project by their enthusiastic welcome. They agreed to meet us at even odd hours including weekends.

In Kilosa we met the District Executive Director (DED) and her team on a Saturday morning and again in the evening when we came for debriefing. Such was the commitment of the community leaders and officials to the Project.
We listened to so many positive testimonies from families, clients and community leaders on how the HBC services had helped the chronically ill.

Accessibility
Every one felt that the **HBC services were easily accessible** especially in areas where there were CORPs. Virtually everywhere when we asked clients and families whom they would call in an emergency they either pointed at the service providers or mentioned them by name. People said they preferred to go to the health facilities with or be referred by the local HBC providers. The HBC providers had become the primary health care service providers in most communities. Communities testified that **the providers were accessible 24 hours a day**. The providers gladly obliged as well. In Zanzibar for instance the CORPs were of the opinion that, to them it was their contribution to community development. In some facilities HBC services and other related services t such as VCT had been brought closer to each other so that patients did not have to spend time moving from one building to the other for services which could be confusing at big facilities. In Hanete, a Health Centre under Dodoma rural, VCT and HBC had been brought to the same room.

Affordability
To the communities HBC services were affordable in the sense that they paid with what they could offer such as labour and their time.
Communities also gained in the sense that they saved money since there was no more paying for transport as services were nearer home, and the fact that the drugs for opportunistic infections and supplies were offered for free through the HBC kits provided in the project.
Benefits
Every level felt that there had been many benefits during the implementation of the programmes.

- The **HBC providers at the local health facility and at the district level were glad for the training they had received**. All felt that they had learnt many new ideas about HIV and AIDS and were more confident than before the project. They also had educational materials to refer to in case of difficulties, and these had been supplied to them by the Project. They had guidelines and policies to follow.

- **Families and clients felt that they had gained a lot**: they had **been educated** on how to care for their sick relatives and on different health issues. They had information packages that helped them understand the ailments much better. They also had learnt about HIV and AIDS and **could pass prevention messages** for instance to other family members, friends and relatives. A client in Zanzibar became so motivated that he went hunting for documents on HIV whenever he was in Zanzibar town. He would bring the information home and sit with his family and together they would digest the new information. HBC services can therefore become vehicles for prevention and education. Food rations, medications and other commodities improved the welfare of the clients. One client in the village of Ulaya (Kilosa district) said he was grateful

because he saved 5000 Tsh. per month, which he used to spend on bus fare to travel to town for services.

Some clients said that they appreciated the psychosocial support services they received from the HBC providers because it always improved their moral and self-esteem.

- The Project also **improved social and family support** at the household and community levels.

- At the central level, the employment of the Project Coordinator contributed greatly towards the improvement in the Project coordination. It would have been difficult for the Counselling and Social support Unit at NACP that remains understaffed to coordinate the Project..

Participatory approach

This was found to be different depending on the level interviewed. Communities might not have been involved at the initial planning stage but with time they felt they had been brought on board. Most community leaders felt that the HBC providers had informed them right from the start and that they had participated in most of the activity plans at their level. They felt that they owned the project.

It is however disturbing to note that all communities were ignorant about when the project was coming to an end. The district level coordinators had been involved much more in the planning process. Virtually all of them knew the project had come to an end on the 30th June 2005 and that what they were still using, especially the drugs, were from the final supply which was slowly getting finished. Some districts however had put HBC service activities in their plans and had budgeted for them. In Dodoma Urban even communities leaders had created a fund for the sustainability of the project. Community leaders contributed Tsh 300 per month towards the fund.

Implementation modalities

In all implementing districts, health facilities HBC providers, provided the services as well as performing other duties in their respective facilities. HBC services were often provided on part time and on a voluntary basis, with the majority of the providers conducting home visits after their usual facility activities. **However HBC providers at district level employed different modalities.** Whereas most of them only allowed their health care workers to do HBC after their normal facility duties, in Dodoma Rural HBC providers took three days of the week from their work schedules for HBC service provision. In other places health care providers were allowed to go after lunch having worked in the clinics in the morning from7.30 am to between 12.30 and 13hrs. Most of the facilities have many patients to consult in the mornings and with the shortage of nursing manpower the burden is much heavier. Giving them special days may be the best option but may not be possible unless there is adequate manpower. Most of the HBC providers are not worried about this and believe they are coping well. Their dedication to the HBC service is outstanding, they feel that it is their contribution to fighting back debilitating illnesses. In all districts except the 3 districts under Dar es Salaam Region there are CORPs. They probably relieve the facility HBC providers from many chores.

Incentives
In all districts except the three districts under Dar es Salaam Region, health facility HBC providers were not given any incentives. However, in the No Cost Extension Budget, two CORPS per health facility were paid Tsh.1 000 per visit for a maximum of 13 visits per month. In reality the CORPs conduct a lot more visits than the number they are paid for. In the three districts under Dar es Salaam region the HBC providers are paid of Tsh 1,000 per patient visit towards transport.

It was also reported that some NGOs in Dodoma Urban are paying health facility HBC providers Tsh 30,000 monthly, CORPs Tsh. 10 000 and also giving Tsh 5,000 as money for bicycle maintenance. The providers under the Belgian project were given one bicycle per facility with no funds for the bicycle maintenance .
This has lead to other HBC providers and CORPS asking why they get no incentives. It is unfortunate that this discrepancy occurred. There is a need for standardisation of the incentives as this may lead to demoralisation of those who do not get any or get fewer incentives. This is a problem that must be dealt with and standardised as soon as possible before starting a new programme. Ironically the providers and CORPs at Zanzibar were not interested in incentives. Authorities should also think of alternative incentives besides cash .

Community Mobilisation.
For such a service to succeed not only is **community participation is a pre-requisite**, the community also needs to be well informed. **Many avenues were utilised to mobilise the public**. These included village meetings through community leaders, educating clients who had visited health facilities for consultation. It was gratifying to see that most of the HBC Providers and CORPs where they are available, use every avenue to mobilise communities, faith-based organisations meetings and services, schools, any official meeting, etc. When people are sensitised about a service and what it offers, more people will seek its services. Many clients are referred for HBC services by community leaders or by other clients who are already enrolled in the HBC programme.
This shows the confidence the community leaders and the clients have in the Belgian Project and what it offered. The HBC provider in Ulaya, Kilowa District must be recognised for outstanding innovation; on arrival from his training he met with all influential community members. Then he requested faith-based leaders from both the Muslim and Christian faiths to help him with giving spiritual and pastoral care to all his clientsThis is working impressively and should be seen as another way of how communities can contribute to this programme. Even the traditional healer of the village commented that he was the best person he had ever worked with. And they met regularly to discuss HBC services. The traditional healer offered his assistant to be trained as a CORP as he himself was too old to become one. He found the programme very helpful to members of his community including his own clients. He also said he referred clients to the health facility and the HBC provider where necessary. This could be seen as a motivative community mobilisation approach that needs to be explored further in other areas and by other service providers.
Districts were advised to use forums such as District and Regional Meetings to solicit for support from other sectors. These meetings could also be used to encourage other sectors to mainstream HBC. An example of the agricultural sector was given: it is the sector that has the comparative advantage of knowing most about food security, and

could help in production of foods and expertise in income generating activities related to agriculture.
Districts were also advised to bring information about such services to the Council meetings so that the politicians are made aware and could map out their roles in the HBC services. This could include mobilising communities, and resources, etc.

Information management system
The Project had facilitated **the development of monitoring tools** for the implementing districts.

All districts followed these protocols except for a small deviation in the three districts under Dar es Salaam Region where CCBRT and the city council collaborate in the HBC services. A previous evaluator also observed that these three districts were not adapting the developed monitoring tools.

It is possible that with time they will be forced by circumstances to do so if an integral HBC system is introduced in the country where a standardised reporting system will have to be adopted by all HBC service providers. **Despite the problems of transport especially in the rural districts, the reporting system seems to be functioning well.** HBC providers send reports monthly to the District HBC Coordinator who in turn compiles a quarterly report, which is sent to the central, level where a national report is compiled. The biggest problem is between the HBC providers and HBC coordinators especially in rural areas where faxes and telephones do not exist and very few facilities have radio communication. There are some delays here and there but otherwise the system is functioning although there has not been a time where all districts submitted reports to the central level. This is very commendable and clearly shows the dedication of all those involved in the HBC programme. Here also a few innovations were observed. In Haneti, Dodoma Rural District, the health facility sends its monthly report with public transport. They have developed a system where information is sent through the public bus system: the driver or the assistant of the bus is given an envelope which on arrival in Dodoma he/she drops into a special box (kind of pigeon hole) which has been mounted at the main bus terminus at Dodoma Town. The District office empties this box every day after work or even more than once. This is an outstanding public and private partnership. This service is free of charge. CCBRT has an elaborate system which goes all the way to the lowest level with means of verification at most levels. They also have regular meetings to discuss the reports.
The central level on the mainland must be congratulated for **developing a feedback system.** Whenever they receive the quarterly reports they compile all of them into one document, make some comments and send a compiled report to all implementing districts. This is a very good incentive for those who are collecting data for these reports. It seems however that this report back system is lacking between districts and their HBC facilities. We encouraged districts to develop such a system. Even if they have regular meetings with their HBC providers it is advisable to also send back compiled reports from all participating facilities so that others learn from what others are doing and also have a good picture of how services are running in the entire district. The central level in Zanzibar holds regular meetings but does not send a report; they were advised to develop a written feedback system that is a compilation of reports from all participating facilities.
It was disappointing to realise that **lower levels were not aware that the Belgian project had ceased in June 2005,** it seemed as if only central and district level

officials had this important information. This might be one setback of the lack of feed back from the district to the lower facilities and the community.
However, this lack of transparency is regrettable and may cause the loss of trust between these levels and the facility and community levels. HBC providers, CORPS, clients, their families and community members had a right to know everything about the project. After all they were partners in the Project. How would HBC providers explain to clients if suddenly drugs and other commodities were no more available or were in short supply? All levels were advised to be transparent, because this could also help in motivating community leaders and communities in developing ways of sustaining a project while there was still ample time.

Collaboration between HBC service organisations.
This is the most problematic issue in the HBC services provided at all levels. **There are many independent groups working at both national, regional, district and community levels. There is no proper coordination system.**
In some districts it was mentioned that there were also many community based organisations (CBOs) springing up and district officials could not control them.
To make matters worse they have their own different approaches and functional modalities. Each organisation has its strengths and weaknesses, which could be put together to develop a positive approach to solve the problems in the districts. Each could pull in its comparative advantage and resources without losing its identity for the benefit of the quality of services in the districts. **The TUMAINI example** in Dodoma Urban District could be taken as a step in the right direction. Six organisations with different comparative advantages came together to offer diverse services such as income generating activities, technical support, stigma reduction education, financial and project management etc. This was after a needs assessment of the communities in the area showed that communities were short of food and generally very poor, lacked information on chronic illnesses, still stigmatised people living with HIV and did not understand concepts of good nutrition. The six organisations therefore formed a group called TUMAINI that offered these services to communities and families. The experiment is working very well and should be explored further. It is not understood why they did not invite the Belgians who also were very strong in the district to join them. It is interesting to observe that they were 'poaching' CORPS HBC providers and CORPS that had been trained by the Belgian project, which means they recognised the strength of their Belgian, supported counterparts. **Lack of collaboration has caused problems in many areas**. Not only are clients sometimes getting confused messages, the situation is also definitely having an impact on community confidence in NGOs etc. In a small village in Dodoma Urban we were told by an elder that**. "***These days when an NGO comes to visit, we ask what type of NGO it is, if it is one that offers food we accept them gladly". However if it is one of those that just come to talk we find a good reason for them not to come talk to us on that day".*
A client in one of the districts was visited by two different NGOs, who not only offered conflicting information but also medication that should not have been mixed. There are many other stories of how organisations are literally 'fighting' for turfs.
Districts were advised to create inventories of all AIDS service Organisations in their areas of jurisdiction. This inventory will have the contact person for the organisation, the services the organisation offers, what population target it serves, how it works (using what modalities) etc. This inventory could be used to avoid duplication, fighting for territory and allow organisations to work together and share

resources and skills in a complementary manner. It also allows district officials to find out what areas are neglected both geographically and programmatically.
For instance TUMAINI would have collaborated with the Belgian project by offering the stigma reduction , income generating activities expertise to help the clients it had recruited instead of competing with it.
But this a very good lesson that has come from this evaluation exercise. Further it was clear in some instances that vertical health sector programmes were also going separately to clients instead of collaborating in their efforts. It is not cost effective for instance to send an ARVT provider to a client, then next a TB provider and later an HBC provider to the same client.
This is a clear duplication, which could be avoided if at all levels the programme would collaborate in their planning and implementing of their different programmes. It is also cost effective and in this era where there is shortage of manpower, it is maximising use of meagre resources.

Referral system
This is another area that needs to be addressed as a matter of urgency. **There is not yet a system that allows the referral of the chronically ill from facility to HBC providers and CORPs or vice-versa.** A good referral system would help improve the HBC services although that would probably mean more clients for the limited number of HBC Providers and CORPs presently in the service. A good referral system may also require a good discharge criterion. Clients should not just be discharged until certain criterions have been fulfilled. These could include a good HBC service where they are going, a family prepared to accept the client etc. In this era of ARVT and DOTS treatment, a good referral and discharge system would enhance the HBC programme. Several cases were witnessed where the HBC provider only realised that the client was on ARVT through interviewing or conversing with him. In a proper referral system, the HBC provider would have known this beforehand through the system. As already been mentioned clients and communities seem to be developing their own referral systems, This is a good initiative when there is no system in place, however it is most important that the national programme develop a standardised system.

Feedback from the field
Despite the acceptability and accessibility and other positive qualities, providers and client alike felt that it needed some improvements.
HBC providers and CORPS requested refresher training courses. These courses should be institutionalised, two or three times a year since new developments on HIV/AIDS occur fast. HBC providers also requested more information in terms of pamphlets, brochures, etc on all subjects associated with chronic illnesses.
HBC providers at facilities also requested incentives or honorariums. This was more so on the mainland than on the Island of Zanzibar. CORPS mentioned the provision of transport namely bicycles. Only HBC providers were provided with bicycles although the CORPS are allowed to utilise them sometimes. Due to the limited numbers of CORPs some HBC providers travel long distances to perform their duties. District HBC Coordinators requested their **own transport** for supervision and services. Presently they depended on pool vehicles, which were scarce and overburdened by the health system. This made it hard for them to perform their duties adequately.

In the No Cost extension budget, needy patients got food rations once per month. Communities and clients wanted the **food rations to be given more often** instead of only once a month . At the same time they also asked for help in developing income-generating projects to boost their economic power and help them be self-sufficient. Most of them felt that illnesses of their relatives put pressure on their economic base and drained in some cases the meagre saving they have. In Ulaya the village health committee (VHC) requested transport at the facilities, a vehicle for the district HBC coordinator, a motorcycle for the HBC provider and a bicycle for the CORPS They had observed that at these three levels lack of transport or provision of wrong transport was hindering services sometimes. They gave the example of the HBC provider who they said cycled sometimes to places as far as 8 km away which made it 16km on return, this was tiresome using a bicycle especially when he sometimes found clients wanting his services on returning to the facility. This also clearly shows how communities are observing the burden to providers. Many clients also requested **more information and reading materials** on their ailments.

Coordination:

Coordination of HBC falls under the mandate of the Ministries of Health in Mainland and Zanzibar through the National AIDS Control Programmes. This is a critical aspect of the fight against HIV and AIDS. Both Ministries should have a clear feel of what is happening on the ground. They need as a matter of urgency to develop an **AIDS Service Organisations Inventory** including the contact persons, where the organisation serves geographically, what they do and how they do it. This inventory includes all sectors including government, non-governmental organisations and the private sector. Secondly both Ministries should compile an inventory of the plans of HBC service organisations and when the planning process for the coming year begins encourage joint planning. All service organisations should follow policies and guidelines. This can only happen when the Ministries know who is who and everything about the organisations. It can also help the commissions to map out what strengths and weaknesses lie in the current response. They can then advise in-coming organisations or those already in the country which are duplicating services or have no territory where to go and what services to offer. It was clear from the senior government officials that **coordination of AIDS activities was a great problem** and the Belgian Project also clearly showed this by what is happening in certain districts like Dodoma where so many NGOs are doing Home Based Care disjointly. To succeed in providing good home based care the MOH , TACAIDS and ZACAIDS should address this issue quickly.

HBC is part of a health sector response to HIV and AIDS. It is therefore the mandate of the Ministry of Health to coordinate all HBC activities in Tanzania. Further the same ministry already coordinates all health activities including all Health care worker activities. It probably will be an easy task for it to add the coordination of HBC. It however needs to work hand in hand with other stakeholders such as other ministries (Ministry of Local Government is an important stakeholder), non-governmental organisations (NGOs) donors etc.

Steering Committee:

- One of the positive aspects of the Belgian project was the creation of a Steering committee. The aim of this committee which had terms of references (TORs), was to oversee the implementation of the project.The steering committee had a broad membership comprising of representatives of the different parties involved:

Ministry of Health (MOH): Directorate Preventive Services

- Programme Manager National AIDS Control Programme Mainland
- Programme Manager Zanzibar AIDS Control Programme
- Tanzanian Commission or AIDS
- CCBRT (NGO)
- PASADA (NGO)
- Members of Association of PLWHAs (Mainland and Zanzibar)
- The Belgium Embassy
- UNAIDS
- WHO
- PORALG
- TFDA (Tanzania Federal Drug Administration)

The committee met at least twice a year, but during the No Cost Extension period a small group composing of the Belgian Embassy, WHO, UNAIDS and MOH met once every 3 months, whilst the big steering committee continued to meet twice a year. The idea of a committee is advantageous in the sense that it gives every stakeholder a say in monitoring thus giving ownership to the beneficiaries. However, the institution of the steering committee was delayed because the project proposal was silent on the issue. It would be welcome if this is sustained during the initial phases of the HBC programme envisaged. The committee should be made of people with diverse comparative advantages, which when put together will help the programme and give good technical support.

Drugs and use of drugs.

The main strength of the project was the availability of HBC kits that included drugs for the management of opportunistic infections and palliative care. These included antifungals, analgesics, antipyretics, antibiotics, prophylactic drugs, disinfectants as listed below :

- Cotrimoxazole
- Cloxacilline
- Paracetamol
- Codeine phosphate
- Oral morphine sulphate
- Miconazole
- Iodine solution

Supplies that included bandages, cotton wool, soap, disinfectant and gloves were also part of the standardised drug kit. All the facilities visited had received kits between September and October 2005, and there was still enough supplies for three to six months. **The drug logistics at the local level was very good; they followed the First expiry first out** (FEFO)policy. Our observations showed that this was being adhered to at all levels. **Even at the family levels we never had a case where a**

client went without drugs for a day. The HBC providers were supplied with bags to carry the drugs in and an umbrella to protect them if and when it rains. **Only qualified personnel prescribed the drugs from the drug kit.** Every facility had a special place to store the drugs. These storage facilities were adequate and our quality control showed they were well protected from damage etc**.**

It must be noted however that where too many NGOs competed for clients there was a tendency of over prescription in the sense that every NGO which had drugs would give their own drugs if and when they consult a client. There was evidence of this in the Dar es Salaam Region.

Drug Distribution

There were **some delays in procuring drugs from Geneva through WHO and UNAIDS**. **However at the country level things moved very fast**. Clearing drugs at the ports of entry took less than three weeks. The country also had a policy of not allowing drugs nearing expiry, in fact the expiry date should range between 3-5 years otherwise the drugs would not be accepted. The Tanzania Federal Drug Administration (TFDA) also make sure that only registered drugs are utilised. The TFDA however reviews its Drug list at least twice a year.

Logistics in the country was also very well planned and executed. The Medical Stores Department transported the drugs to the different districts which then transported them to the relevant facilities. There was a person assigned at every level to make sure that the system runs smoothly.

Lessons Learnt

From observations and interviews in the districts visited, it was clear that a lot of lessons could be learned from the Belgian project. The following are a few but most critical ones. They are presented in any order:

- **A comprehensive needs assessment has to be done before a service is started**. This should include planners, providers and recipients of the service. Planning should be done jointly involving all players and beneficiaries. It was only realised for instance that the project required a coordinator, people needed food and providers required transport after the project had started. Further there was also a hitch with prescription practices by Health Care workers who were not used to the drugs. If planners had done a comprehensive Needs Assessment with the HBC Providers, CORPs and clients and their families some of these issues would have been detected and taken care of but it is also a very good lesson learnt for future projects.
- **The project also showed that the communities in Tanzania mainland and Zanzibar are eager to participate in developments in their areas**. This is an opportunity that should be utilised to the maximum. Community participation is a pre-requisite to the success of any service. It should be noted that the communities need to be well informed and should be part of the planning, implementation and evaluation of any service.
- **A joint supervision** including joint field visits by all key players is necessary during the implementation of a project. This would facilitate a clear understanding of problems and successes and also help in solving problems of the project on the ground.
- **A sustainability strategy** should be developed at the same time a project is being planned. A good service as was offered by the Project cannot be abruptly stopped. Even where a Pilot is being planned there should be a sustainability strategy in case the pilot is successful as is in this case. If planning had been done with all levels involved Districts and communities may have helped in creating a sustainability strategy; this is evident in Dodoma where communities set up a fund and the District put HBC in its district annual plans.
- **There is need for the Public and Private Partnership** (PPP). This was evident in this project where we saw for instance how private bus operators help in transporting reports from the rural areas to the district offices for no charge. The Private Sector has an important role to play and should be mobilised to use its comparative advantage and mainstream HIV and AIDS.
- **The Project showed how committed the Health Care staff is and also those who were volunteering**. This is another opportunity that could be utilised fully to improve health standards of the communities. There were cases where health care workers use their own funds for repairing bicycles, paying bus fares and buying commodities for patients in need. The fact that most health care workers go for HBC after their normal duties and working hours also shows great commitment.

However they **need incentives**, not monetary but such things as availability of working tools, training and getting certificates etc. This would encourage more health care workers to volunteer for service provision beyond their normal call of duty.

- **Self-help is possible in most of the communities.** There was evidence of communities getting involved in implementation and in some cases contributing to funds. This realisation is of great importance, it shows that where communities are willing, a good government and community partnership (GCC) could be developed. Communities have abundant resources, they sometimes just need guidance on how to utilise these resources. In some cases they have built shelter for their chronically ill neighbours who had no shelter or food.
- **Having forums or steering structures to the Project were helpful**. These should be made up of stakeholders and people with technical know how. They can regularly monitor progress and also guide the project. The fact that there were for instance pharmacists in the steering committee helped the Project to buy the right drugs and follow the right channels of importing the drugs and distributing them. In other projects donors import their own drugs without going through the central authority.
- **There are too many vertical programmes that need to be integrated**; most of the programmes of the MOH are vertical, VCT, ARVT, TB-DOTS to name a few. These services could easily be integrated to improve services and cut down on human resources and other costs. In some districts this had been realised and rooms just next to one another had been created to ease the walking distance for the patient. Further the different programmes had started working together and referring patients to one another. This needs to be strengthened and standardised nationally.
- **There is no clear referral system** of clients from facilities to HBC programmes or vice versa. Most clients were being picked up by communities and referred to HBC or clients were referring other clients. Putting a referring system into operation will improve the quality of services and will allow clients to be picked up much earlier.
- **Training service providers before the start of a service** is very important. Health care workers (HCW), CORPs and family members were all grateful that they had been trained which helped them perform their duties better. HCW and CORPs understood the epidemic of HIV/AIDS better than before the project. Families were glad that they could now take care of their own and were well informed.
- **HBC can help reduce stigma**. The fact that all levels are mobilised and trained to deal with chronically ill patient helped those who discriminated these clients. Education made them get rid of some of the myths they had about HIV in particular. There were many testimonies of people whose relatives shunned them but after the introduction of HBC the family members were even helpful. HBC also helped health care workers pick up hidden stigma; one health care worker said the best way to find out whether family members are stigmatising or not is to ask who the clients eats with, whether they are using the same utensils for eating, bathing etc.

Sometimes on the surface one can think there is no stigma but such detail would not have been picked up if it was not for going to families and observing certain behaviours. These are tools many HCWs are using to check about stigma and use the information to educate families through dialogue.

- Apart from exceptional cases, **there is little collaboration between different HBC service organisations at the community level.** Confusion has been created in some places where many different organisations go to the same homestead to give service but coming at different intervals and sometimes with conflicting information.
- **It is essential to clarify right at the beginning whether a project is a pilot or a long-term service**. This is important especially to district planners, politicians and communities and clients. Some officials felt that this information was not well transferred to authorities and communities, families and clients.
- The burden of caring for HBC clients in the families falls more on women than men. **Men especially on the mainland are not involved**, they feel it is a woman's Job. Zanzibari men are the opposite, they help their womenfolk

Challenges

- **Lack of coordination** is an issue that will be problematic for some time unless something is done now to create a functional coordination mechanism. It should be the role of the Ministry of Health and other relevant government structures to create this coordinating mechanism.
- **Transport** is problem at all levels. For any envisaged HBC co-service the issue of transport should be thought about seriously at the level of the district, facility and even at the community level.
- **Sustainability** of HBC services that at to a large extend relies on volunteerism. Such issues as incentives to health care workers and food rations to clients must be clearly thought through. Expanding HBC to every district in the country would require a huge fund to sustain these incentives. This needs better coordination, standardisation and partnering with other stakeholders.
- **A collaboration mechanism** of all the different HBC providers in the country needs to be created. This is a mammoth task which is however possible with good planning and bottom up approach.
- **Standardisation** of materials, reporting systems etc; with so many players with their own material and approaches, it would be necessary to standardise everything before a new national HBC service is developed.
- **Recruitment of personnel** for a service of this nature especially professionals where there is already a shortage of them is a daunting task. However the present system could not be sustained especially if the service has to be rolled out countrywide. HBC needs its own manpower to make it a core service in the health care delivery system rather than an extra activity performed on a part time basis.
- **VCT and ARVT services are still wide and apart**. HBC encourages people to seek these services; if they are not developed at the same time as HBC there might be a disruption in the continuum of care. Already communities were complaining about the distance of VCT centres from villages.
- Funding should also be available and this is a very expensive but necessary service. Is it possible to mobilise the required funds that also allow medical kits?
- **Supply of drugs** may be problematic when the purchasing moves from a donor to government. The government tendering system may be cumbersome and may take too long. A good quality control system must also be in place; this needs equipment and manpower
- How to deal with the **clinical waste** generated by clients on Home based care, where do people throw away the soiled material and solid waste? Clinical waste management is critical
- **Transfer of trained manpower**, this was witnessed in several occasions. Trained TOTs, HBC providers are moved from one facility to the other without recognising their rare skills. In one area an HBC provider was transferred from a place where he was the only HBC provider to a place where there were two HBC providers already. The

other place was therefore left with no one to offer this essential service. Officials should therefore, before transferring personnel look at the needs of facilities and availability of the skilled staff.

- Low income status at the household level (no food etc)
- **Retention and sustaining of volunteers**.

Opportunities

- **Many partners who are in the HBC core-service including NGOs.** There are presently many different organisations working on HBC in Tanzania. There is a good opportunity to use their collective efforts to help in developing a comprehensive HBC model. The organisations could pool their resources and skills and use each other's comparative advantage. This has already worked in the TUMAINMI experiment. It just needs to be expanded and developed further with the collaboration of everyone on board. The organisations presently working in the HBC field have first knowledge, skills and experiences on the field in Tanzania. Pooling these resources together will be a great asset for a proposed HBC co-service.
- **Dedication of the government personnel.** What normally impedes development of programmes is the shortage on manpower. However in a situation like Tanzania where the health personnel has shown such dedication, their support and commitment to work is a good opportunity for the country.
- **Enthusiasm of the communities.** The fact that communities have accepted this programme and have been participating enthusiastically is a great opportunity for the government. It should use this opportunity to expand the programme. Communities including political and traditional leaders in many areas that had not been covered in the implementing districts were asking when the services were coming to them. Please note that the project was supposed to cover 3 districts in each region and only a number of wards and villages were covered. This clearly shows how eager they were to have HBC services in their own areas.
- **Introduction of ARVT.** Many people had given up hope on their chronically ill relatives despite management of opportunistic infection. With the introduction of ARVT many bedridden clients are now up and about and even productive again. This was mentioned many times during our visits. People are therefore eager to help HCW in taking care of their relatives because they know their lives have been prolonged.
- **PPP and GCP.** There has been encouraging partnerships between the public and the private sector (PPP) and also the government and communities (GCP). Both have been sensitised about the problem facing the country and have shown willingness to join the fight.
- **Existence of such structures as TACAIDS, ZAC and Regional Facilitating Agencies** can help in resource mobilisation, advocacy, coordination of programmes and many other issues related to HIV, AIDS and other debilitating illnesses. If these structures are functional they could take a lot of pressure away from the Ministry of Health and Local Government and leave them concentrate on technical issues only.
- **Examples of a good working organisation of People Living with the virus in Zanzibar**. HBC requires the support and participation of people living with HIV and AIDS. On the mainland there is still a problem of creating a strong organisation for people living with the virus. However a lesson could be learned from the Zanzibar Association of People with AIDS (ZAPHA+). This organisation is also very helpful in all programmes for people with debilitating illnesses such as HIV and AIDS. The mainland has a great opportunity to learn

from ZAPHA+ and let people living with the virus be part of the HBC core-service providers.

Many individuals living with HIV are CORPs, with a strong organisation more would be part of the struggle.

- **Committed community leaders.** All community leaders met during the evaluation were very proud of the HBC programmes in their areas. Some leaders had even gone to the extend of creating sustainability fund for the projects. In some areas councillors and other politicians & traditional leaders wanted the services brought to their areas that were not yet covered. If community leaders show such a commitment they will easily encourage their followers to partake in a programme or service, which is a great opportunity here.

- **Dialogue between Government and other partners:** There have been meetings among many organisations involved in HBC services in Tanzania convened by the government. This is a great opportunity to map out the way forward. This would improve services tremendously and would reduce duplication of resources and therefore cut costs.

- Lessons learnt from the Belgian Project and other HBC services in Tanzania are an opportunity to develop a function and qualitative co-service.

- Existence of Policy, Guidelines and Training manuals that are important for awareness, education, implementation procedures and evaluation.

PROPOSED MODEL FOR THE UNITED REPUBLIC OF TANZANIA.

There is no doubt that HBC services are essential for the welfare of chronically ill Tanzanians. Presently there are many players with different modalities of approach. The first step would be to consolidate the different experiences of all players and come to a consensus on the way forward. These steps have already started and should be continued.

Many programmes under the Ministry of Health are still vertical programmes. This is not conducive to good service provision. Integration of programmes is a step the Ministry has to take. Integration of programmes will be beneficial to both clients and health care providers. Clients will not have to move from one programme to another for services that could easily be put together. With the shortage of manpower in the health services , integration will create a multifaceted health worker who can deliver different kinds of services at a time. ARVT, Management of Opportunistic Infections (OI), Prophylaxis using cotrimoxazole, TB-DOTs, syndromic management of STIs to name a few, are all grouped under care and support of HIV/AIDS, it would therefore be logical to put them under one roof. This does not mean they lose their individual identity.

HBC services should become a core-service in the health care delivery system. The Ministry of Health has to create a properly integrated system at all levels: centrally planning should be done jointly; at the regional and district levels, services should beadapted to deal with HBC and to be responsive to the need of the referred patients. At the health facilities, communities and households levels structures need to be strengthened to work hand in hand with districts level structures. It is necessary to develop a good and functional follow up system to make sure that things are working. A balanced HBC service where every partner has a contribution and a say has to be strived for, it should not be imposed from top downwards, but should be developed after a consensus among all stakeholders including people living with HIV and AIDS, the government, donors, non-governmental organisations and other interested parties. It is necessary to create new structures for the HBC core-service to function optimally. Below is a proposed structure:

Proposed Structure for An Integrated HBC Model for the United Republic of Tanzania.

It is proposed that the Ministry of Health creates at Head Quarters (HQ) a Care and Support Unit. This unit should be made up of a multi-disciplinary team. The unit must jointly plan with other service providers at HQ, thus making sure there is collaboration at the central level by all disciplines. The same unit will also be responsible for all HBC services in the country regardless of who is running them. It will develop guidelines and policies, and will be advising the Ministry on licensing any organisation proposing to do anything associated with HBC. The Unit will also responsible for training and developing training curricula and guidelines. It also makes sure that no materials, equipment etc, on HBC gets into the country without its approval. The Unit will for any National Organisations involved in HBC, that is, making sure they work within the stipulated guidelines, legal framework and policies. It should have powers to investigate where necessary and advise the Ministry of Health accordingly.

At the Regional and District levels, multi-disciplinary teams should also be created to oversee the functioning of HBC services in their jurisdiction. They are responsible for the lower levels of the Health facilities and Community levels.
They make sure that all partners in HBC services follow the stipulated guidelines and policies. They should keep an inventory of all the partners in the respective areas. They advise Regional and District authorities on HBC provision. Regional Teams supervise the District teams whilst District teams are responsible for training the Health Facility and Community HBC providers and supervising them. District health teams are also responsible for the monitoring and evaluation of HBC programmes in their areas. Information must flow from top to bottom but with feed back from the top. Any organisation in a District should if it has queries go through the District Office that then takes the matter further. The HBC Providers and Trainers at the facility are responsible for the services at the community levels. They are the ears and eyes of the Council Management Team. They make sure that communities are served well by any organisation and should report to higher authorities if an discrepancies occur.
A good and functional referral system should be developed between facilities and the HBC providers and CORPS at the local level. Discharging facilities such as the Care and Treatment clinic (CCT), TB clinic, Diabetes Clinic, Cancer clinic (just to name a few), should have the contact details of the facilities where the client stays. They should then inform the HBC providers about the patient so that services if need be are started without delay. The HBC providers should also do the same when the refer clients to heath facilities. There should also be a criterion for referring clients from home to facilities, these could include:

- symptoms that cannot be managed at home,
- change in the patient's home circumstances (no one to take care of client)
- need for further investigations
- sudden deterioration of the client's conditions etc.

It might be necessary to develop a special form for this referral system; Zanzibar already has such a system and has developed a form for this purpose. The referral system should incorporate adequate caption of information on when the client is referred and/or discharged. There should also be a discharge criterion. Some of the discharge criterion may include:

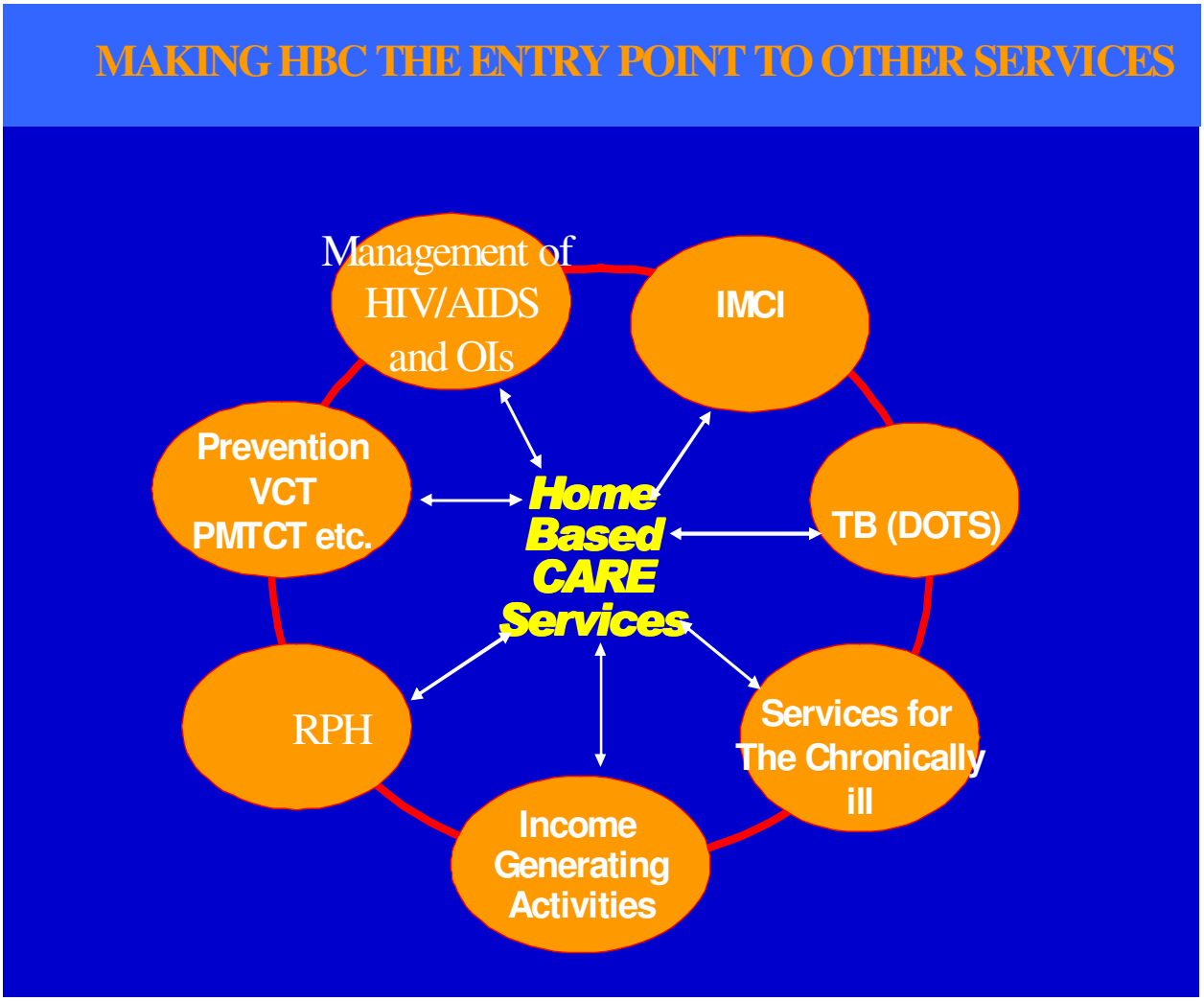
- Informed consent of the client
- The client has been adequately counselled,
- Client has social support available where he/she is going
- A follow up plan including who does the follow up e.g. which facility.
- Complete assessment of the home where the client is going
- Family members have been counselled and agreed to care for the client
- Family members trained on how to care for the client
- Schedule for regular check ups by the doctor or other health workers.

It is also necessary to know where the client is going to get drugs from when the need arises, and how the adherence is going to be monitored. Some clients end up without help either because they cannot afford to travel to facilities, or because of lack of knowledge. A home-based care service would discover such problems and solve them and improve the quality of life of the client.

Many programmes are related one way or another to each other and involves several sectors. At the Regional and District levels, it is advisable to address meetings called

by the District Executive Directors where every sector is represented. This will encourage other sectors to mainstream HBC if need be.
Further other sectors might give advice using their comparative advantages; agriculture for instance could help in establishing yard gardens with nutritious foods and vegetables as well as income generating projects associated with its mandate.
It is also necessary to get political support and commitment; politicians can help in advocacy and resource mobilisation.

HBC should be made an entry point for other services, since it involves communities, families and clients. This would be a great opportunity to educate communities and provide other services for which they might not be getting for a variety of reasons, but mostly because they cannot afford travelling to facilities where the services are usually available. The diagram below shows an example of services that could be provided through HBC.



A waste management strategy at the community level is also an important component of an HBC service. Solid waste produced by clients needs to be disposed off securely. Community members need to be educated on how to get rid of this waste. There is need develop ways and means of getting this waste from the households. This is the

duty of the Districts and Health Facilities but the Ministry of Health and Environmental Health Institutions need to be involved from the onset.

In some countries there are special containers for disposal waste from household of people living with HIV. This however may increase discrimination, but a safe way has to be found which also protects the status of the client.

There is need to educate the public and communities on waste management. This might be included in education given during the training of family and community members, but also as part of education through environmental and hygiene visits. Education should include how waste is collected from the homes, where it has to be deposited and in what containers it should be packed. It has been suggested that clinical waste from HBC should be classified as dangerous waste and should be collected in red bags so that environmental officers know and are protected. It is the duty of the government to decide what approach to use, however the communities need to be part of this important decision.

Besides solid waste, other waste generated from HBC may include syringes and injections; there should be adequate disposal methods for these such as availability of sharps containers. It might be necessary to do an inventory of all possible waste generated by HBC. The best way would be to consult all other stakeholders and community and family members in compiling this list, then working out modalities to manage the suggested waste.

Sustainability of the Project:

Presently sustainability is a problematic issue. Since this was not part of the original plan, most districts had not planned for the continuation of project. Some innovative approaches however were observed in different regions. Most districts had put the HBC programme in their 2006-2007 operational plans and budgets. Others like in Dodoma had actually created funds to sustain the project.

It is recommended that HBC services becomes a programme and thereby integrated into the services provided by District Heath Teams. This has implications in terms of human and financial resources. The HBC programme should be reviewed and manpower specifically for the programme allocated accordingly. It is necessary to create human resources at the district, health facility and community levels. In the meantime, it would be suggested that the MOH encourages all participating districts develop budgets and plans for the continuation of this project. Even supplementary budgets could be encouraged. There is also the possibility of the government sourcing for funds from donors to sustain the project for a year or two till government can take over. The Belgian government could be asked to continue supporting the programme where the project was running, with funds going directly to the Ministry of Health and not through other channels.

For monitoring purposes the Belgian government could create a post for someone to oversee the programme they are funding .e.g. A Junior Programme Officer (JPO) etc. This person could be attached to the Ministry of Health. The Ministry of Health should also start budgeting for a programme on HBC and creating the necessary structures and human resources. During the transitional period the MOH would try mobilise funds for the sustenance of the project. – a proposal to submit to the GFATM may be a very good option to consider - This should be done as soon as possibly especially as the drugs will run out soon. It also means that the Medical Stores Directorate (MDS) has to budget for these drugs and make sure there are enough stocks in the country. Districts also have to start planning for the required

human resources and the district offices, the health facilities and at the community levels. They also have to train the cadres including community mobilisation.

Recommendations and Conclusion.

- The evaluation has demonstrated the strong benefit of HBC for the PLWA and for their families
- Ways to ensure sustainability of HBC are to be examined carefully.
- Taking into account the lessons learned, it is recommended that HBC service become part of the national services and is progressively scaled up.
- There is an urgent need to improve the availability of Voluntary and counselling services beyond the District Hospitals especially in the rural districts. Communities and community leaders also expressed these sentiments. Most VCT services are at health facilities that people cannot reach because they are too far away. With the advent of rapid testing, it might be advisable to start mobile VCT services and ensure that services are available in health centres and dispensaries.
- There have been many HBC Projects in Tanzania for the last 10 years or more. The MOH should compile all these practices to-date and call a consensus meetings of all participants and other interested parties to map out the way forward.
- There is need to strengthen Greater Involvement of People Living with HIV/AIDS (GIPA) on the mainland. PLWHAs are an important stakeholder who should not be missing from an HBC programme. Zanzibar has already a strong association that is actively involved in provision of HBC and other services to PLWHAs, the mainland may learn from it.
- The national level, the Regional levels and the Districts should develop an inventory of all HIV/AIDS Organisations in their area of jurisdiction. This inventory should include the contact person, where they work in Tanzania, their area of work and what expertise they offer. This inventory could have multiple purposes including sharing of skills and experiences. It would also help the authorities to map where services are lacking and what services are also lacking. It helps reduce duplication of efforts.
- TACAIDS, ZAC, MOH and Other Ministries sit and help in developing a coordination mechanism. It is the duty of the CHMTs, commissions and Regional Facilitating Agencies to coordinate all AIDS Activities in Tanzania. They also are responsible for Advocacy, Resource Mobilisation, and Promotion of Research amongst others. Where these institutions need capacity it might be necessary for the Ministry of Health to find experts to help them.
- TACAIDS, ZAC, Regional Facilitating Agencies with the help of the Ministry of Health to develop policy guidelines of how NGOs, donors etc work in Tanzania. These guidelines should include rules on how equipment, drugs, training materials etc, should be approved first by relevant authorities.
- The Ministry of Health to have the Mandate to control all issues surrounding HBC services such as approval of requests to work on HBC in Tanzania etc.
- It might be helpful to divide the country, regions and districts into zones for particular NGOs. Currently most of the NGOs are in the urban areas only leaving rural areas that make the majority of the country. It would also be easy to evaluate and monitor these organisations, when there is a zoning system.

Together with the inventory the quality of service provision would be greatly improved.

- All HBC service organisations to use materials developed by the country authorities unless their materials have been approved and can be adapted for Tanzania. Some materials might not be culturally sensitive.
- Districts to develop an inventory of the local foods. These should include wild fruits, insects and other edible flora and fauna, including the seasons of variation. The list can then be divided into the four food groups with help from experts.
  The list could help donors or who ever wants to provide foods to clients, instead of buying refined foods it is advisable to give foods that people are used to and are locally available.
- Districts to also develop an inventory of all the drugs and remedies that locals use. Some of these remedies may be harmful if taken together with whatever is being provided through health facilities. The Ministry of Health with its expertise could develop a country pharmacopoeia that detains, ingredients, side effects and reactions to other drugs of these local drugs and remedies. Remember whether we like it or not 70% of our clients still visit a traditional healer before, during and after our consultation (Chipfakacha 1997)
- The country to start developing IEC materials that are cultural sensitive and reflect the environment of Tanzania. It might be necessary to decentralise the development of IEC materials. Some materials observed during the evaluation did not reflect the environment of the communities visited; food posters for instance showed foods that were alien to most communities.
- The MOH and the Districts to develop roll out plans for the HBC service. Even if the funds are not yet available it is necessary for districts to explain how they will roll out when the time comes. Some districts actually had very good roll out plans e.g. Dodoma Rural.
- Districts to start including HBC in their strategic and operational plans.
- All providers of HBC need refresher courses and training whenever a new programme is introduced. There was no training when ARVT was introduced and this has created some anxiety. It might be necessary to hold to refresher courses annually. The other alternative is in-service-training but this also needs refresher courses for the trainer-of-trainers (TOTs)
- Transport is definitely a major problems. The HBC service has to seriously debate on how to solve this problem, because without transport service provision quality is compromised.
- Develop a policy of shared confidentiality. Many caregivers do not know what their relatives are suffering from. HBC is supposed to protect both the client and family members, a family member ignorant of the status of the person he/she is caring for rarely uses universal precautions. We witnessed a case where the carers did not know despite the fact that two organisations were servicing the family and client, and none had counselled the family and informed them. Ironically they had cautioned the carer to use gloves at all times, but she did not know why.
- HBC service providers to provide caregivers with protective clothing especially gloves, and napkins/incontinent pads for those clients with diarrhoea. The following could be used as a guideline for the CORPS' and family carers' at the community package:

    - Gloves (Heavy duty and disposable)
    - Bed-pans re-usable
    - Catheter and urinary-bags or condom catheters
    - Mackintosh and draw sheets
    - Cotton wool, gauze & swabs, bandages
    - Disposable pads/incontinent pads
    - Soap and washing detergents
    - Liquid bleach, disinfectant iodine
    - Syringes and needles
    - Disposable towels
    - Crutches and wheel chairs
    - Plastic apron
    - Dressing pack
    - Normal saline for dressing
    - Red plastic bags for disposing clinical waste
    - Sharps boxes where necessary, for needles and syringes.
- All HBC services should have a CORP at the community level; Dar es Salaam Region for instance does not have these important cadres.
- At the operational level, there should be regular meetings of service providers to exchange ideas. This could range from 2-4 times a year.
- A decision has to be made whether to give incentives to HBC providers and CORPs or not. The situation has to be uniforms in all places in the United Republic of Tanzania.
- Districts to train District HBC Providers and Facility HBC Providers in mapping techniques so that they show their statistics on the walls include a map of the area with pins showing where their clients are.
- It might be necessary to have a technical advisory committee on HBC at the initial stage of rolling out; this could have a life span of 3-5 years.

APPENDIX

TERMS OF REFERENCE FOR THE EVALUATION OF THE BELGIUM GOVERNMENT HBC SUPPORT – TANZANIA

A. OVERVIEW AND INTRODUCTION

A project for scaling up community and home based care for people living with HIV/AIDS was developed in the year 2000 within the framework of the International Partnership against AIDS in Africa, funded by the Belgium Government in Burundi, Mozambique and Tanzania.

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Through the project, a home care kit containing basic medicines and supplies was provided, focusing on ameliorating the most distressing symptoms of AIDS, namely; pain, diarrhoea, fever and lesions caused by fungal infections through home care. The kit also provides for adequate supplies of Co-trimoxazole for the prophylaxis of the commonest opportunistic infections. In Tanzania, the project implementers are the Ministries of Health on the Mainland and Zanzibar, the Dar es Salaam based NGO, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT). WHO is the Executing Agency on behalf of the UN Theme Group on HIV/AIDS. The total support provided is US$2,306,628 for the period between October 2001 when the Agreement was signed and December, 2003. Half of the budget, US$1,153,314 is allocated for purchasing the medicines and supplies while the remaining balance is for implementing the country activities.

The project that was intended to reach 43 districts, started in 5 initial districts (Mpanda, Bagamoyo, Ilala, Temeke and Kinondoni). Then moved to 12 districts and by December 2004 the services had been fully established in 39 districts where training of providers, distribution of drugs and supplies and bicycles has been completed. The project was supposed end on 31st December 2003, but its implementation was delayed by one year. A No Cost Extension was requested and approved for the project to end on 30th June 2005.

The initial proposed activities included:

i. To develop management guidelines,
ii. To train C/HBC trainers and service providers,
iii. Deliver home care to PLHAs
iv. To undertake sensitization, advocacy and service promotional activities
v. Procure and distribute HBC drugs and nursing supplies
vi. To conduct monitoring and supervision activities

The No Cost Extension work plan included additional activities as follows:

i. Provision of food support to needy patients
ii. Orientation of prescribers to the HBC kit
iii. Support home visiting by community's own resource people including PLHAs

OBJECTIVES

The overall objectives of the evaluation are the documentation of implementation experience with a view to better defining the way forward in scaling up community and home based care services in Tanzania. Specifically, the review will address the progress made and lessons learnt. The evaluation review will seek to provide answers to the following questions:

- What are the positive experiences?
- What are the constraints in implementing the project?
- What are the available opportunities for solving the identified constraints?
- What are the recommendations for scaling up community and home based care services in Tanzania?
- What is the best model for implementing HBC in Tanzania?

METHODOLOGY

The evaluation team will apply the following methods to gather data:

- Review of official project documents including progress reports
- Interview stakeholders; service providers and service beneficiaries,
- Visits to sampled project districts

THE EVALUATION TEAM

It is proposed that the evaluation be conducted by internal and external consultants, who will work with the following stake holders/partners:

- The MOH,
- NGOs – e.g. CCBRT,
- CHMTs from the implementing districts,
- Representatives of organizations of PLWHA
- WHO
- UNAIDS

The evaluation team will work in selected districts for at least 10 days in order to collect data on the evaluation indicators.

DURATION

The evaluation will take 15 days, during which the team will collect data on the evaluation, and present preliminary findings in a debriefing meeting of the steering committee and other co-opted members to get comments before finalization of the report.

LIST OF KEY PROJECT DOCUMENTS

The following key project documents will be made available to the evaluation team:

The signed Project Document
Project progress reports,
Monitoring and evaluation tools,
Service delivery guidelines and training manuals,
Project consultancy reports.

SCOPE OF THE EVALUATION

A sample of districts to be visited will be drawn. In each district, the consultants will tract the evaluation indicators shown in the table below.

TABLE: PROGRAM EVALUATION INDICATORS

Narrative Summary	Measurable Indicator	Means of Verification
GOAL: To improve the quality of Community & Home Based Care Services	Increase access to C&HBC services by 25% in 17 districts by December 2002 and in 43 districts by December 2003	Project Reports
OBJECTIVES:		
1. Revise and produce AIDS case management guideline for paramedical staff.	Number and percent of participating health facilities with revised clinical AIDS management guidelines	Facility survey
2. Revise and produce counseling guideline for paramedical staff	Number and percent of participating health facilities with revised counseling guidelines	Facility survey
	Number and percent of health care providers receiving training on clinical AIDS management guidelines	Facility survey
3. Establish C&HBC services	Number and percent of community and home-based care givers trained under the project	1. Reports 2. Survey in selected communities
4. Procure, distribute and provide drugs and needed supplies to AIDS patients and the chronically ill in communities and homes.	Number and percent of community and home-based care clients receiving drugs and supplies provided under the project.	Survey in selected communities
5. Deliver C&HBC services	Number and percent of community and home-based care clients receiving at least one home care visit by participating C&HBC organizations	Selected community survey
6. Stimulate demand for C&HBC services	Service utilization trends.	Project reports
7. Provide technical and administrative support to project.	Supervision, monitoring, evaluation and reporting according to schedule	Project review

EXPECTED OUTPUT

The main output of the evaluation will be the report elaborating the following:

i. Identified strengths of the project.
ii. Identified weaknesses.
iii. Identified opportunities
iv. Recommendations on:
- How to improve future project implementation,
- How to improve programme management (coordination, supervision, monitoring and reporting)

- Proposed content and quantities of the C/HBC kits
- How to facilitate the involvement of PLWHAs in the project.
- Model for implementing HBC in Tanzania

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT
Evaluation Form No. 1 for WHO Country Office
Respondent: National Programme Officer

Evaluation Objective	Discussion points/guides	Response/Findings
Objective 1. To assess the level of implementation of planned project activities within the existing operational environment.	Have you received all the necessary activity reports from project areas? (*If yes How often? Describe the reports and provide copies)*	
	Have you conducted supportive supervision according to the schedule? *(If yes describe and provide copies of the supervision reports, If not why?)*	
	Did you review the project during its implementation? *(If yes provide copies of review reports. If not why?)*	
	Have you provided technical support [training, meetings etc.] according to the expectations? (If yes give details)	
	How many HBC kits were procured and distributed to the project sites?	
	Were the HBC kits received on time? How adequate were supplies of HBC kits?	
	If not explain	
Objective 2. To	How many districts	

assess the project's achievement in terms of HBC service availability, functioning and utilization in the project districts.	established HBC through the project? How many health facilities were supported to establish HBC in the project districts? How many health workers were trained to provide HBC in the project districts? How many community volunteers were trained to provide HBC? How many clients did receive HBC services in these districts	
Objective 3. To assess project's contribution to the development of policies, guidelines and training materials for HBC in Tanzania Mainland and Zanzibar.	How did the project contribute to the development of normative tools, IEC, guidelines, training materials, supplies etc? *(Please explain)*	
Objective 4. To determine the cost of scaling up and CHBC services at district level to reach the recommended national targets in Tanzania Mainland and Zanzibar.	How much money in total has been spent on the project? Did you receive budget from AFRO timely?	
	Have you provided budgets to the project areas timely? And how is the mechanism?	
	How much money was spent as ***direct costs*** for establishing and maintaining HBC services e.g. training, and supplies?	
Objective 5. To document the level of involvement of various partners in ownership and implementation of programme	What was the role of WHO in the project?	

	Who were other in-country partners in the project and what were their roles? ***(Please refer to other UN organizations, government, civil society organizations and communities)*** Did the various partners play their roles adequately? ***(If not explain)***	
Objective 6. To assess the potential for sustainability of programme achievements at the national and district levels.	What do you think will happen to the services that have been established after the project closes?	
Objective 7. To generate recommendations for the future use by all stakeholders who were involved in the programme.	What lessons, experiences and products of the project need to be taken up by WHO and partners for future actions? ***(Explain in terms of do's and don'ts)***	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT
Evaluation Form No. 2 for MOH
Respondent: Programme Manger/Coordinator Counselling and Social Services Unit

Evaluation Objective	Discussion points/guides	Response/Findings
Objective 1. To assess the level of implementation of planned project activities within the existing operational environment.	Did you receive activity reports from project areas quarterly? ***(If yes describe and provide copies of the reports, If not explain)***	
	What was the mechanism of reporting? Did you encounter any problems in receiving reports from the districts? Explain	.
	How many supportive visits did you make to the project districts during the project life? ***(check reports if available)***	
	How many project reviews were conducted during over the project life? ***(check minutes if available)***	
Objective 2. To assess the project's achievement in terms of CHBC service availability, functioning and utilization in the project area.	What are the national targets for the provision of HBC services? What has been the contribution of the project towards these targets in the country and project districts?	
Objective 3. To assess project's contribution to the development of policies, guidelines and training materials for HBC in Tanzania Mainland and Zanzibar.	What gaps in terms of policies, guidelines and training materials had you in the implementation of HBC programs before the starting of the project (2002)? What were then the complements or gaps filled by the Belgian	

	supported HBC project? ▪ *Policy & guidelines* • *Training materials* • *Financial and material Resources*	
Objective 4. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	Do you feel you had ownership and leadership of the project? • *In what capacity level* • *In what mandate level* • *What did you do as leader of the project?* Were you involved in monitoring and follow up of funds and supply management [distribution, utilization, report etc.]? *(If yes explain the mechanism of the management of funds)*	
Objective 5. To assess the potential for sustainability of programme achievements at the national and district levels.	In which ways do you expect the services that have been established will be sustained? What will be the role of the Ministry?	
Objective 7. To generate recommendations for the future use by all stakeholders who were involved in the programme.	What lessons, experiences and products of the project need to be taken up by the MOH and partners for future actions? ***(Refer your response for: policies, guidelines and standards, capacity building, up-scaling and/or research)***	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT
Evaluation Form No. 3 for CHMT
Respondent: DMO/CHMT

Evaluation Objective	**Discussion points/guides**	**Response/Findings**
Objective 1. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	Are you aware of the project, program areas and participating partners in the district? Do you feel you had ownership and leadership of the project? • *In what capacity level* • *In what mandate level* • *What did you done to own the leadership of the project?* Were you involved in monitoring and follow up of funds and supply management [distribution, utilization, report etc.]? *(If yes explain the management of funds)*	
Objective 2. To assess the level of implementation of planned project activities within the existing operational environment.	Did you receive activity reports from project areas quarterly? *(If yes describe and provide copies of the reports, If not explain)*	
	What was the mechanism of reporting and how often? When did you submit activity reports received from the project sites to the ministry of health?	

	How many supportive visits did you make to the implementing sites during the project life? ***(check reports if available)***	
	How many project review meetings did you hold over the project life? ***(check minutes if available)***	
Objective 3. To assess the project's achievement in terms of CHBC service availability, functioning and utilization in the project area.	What are the district targets for the provision of HBC services? What has been the contribution of the project towards these targets in the region and project districts? What mechanisms did you use to sensitize the community to access the services? Has the project implementation been able to create demand for HBC services? ***Explain***	
Objective 4. To assess project's contribution to the development of policies, guidelines and training materials for and HBC in Tanzania Mainland and Zanzibar.	What gaps in terms of guidelines and training materials had you in the implementation of HBC programs before the starting of the project (2002)? What were then the complements or gaps filled by the Belgian Govt projects? Specially in terms of • *Guidelines* • *Training materials* • *Financial and material Resources*	

Objective 5. To determine the cost of scaling up and CHBC services at district level to reach the recommended national targets in Tanzania Mainland and Zanzibar.	From the expenditures that were done in implementing the project, are you able to estimate the cost of scaling up HBC to reach national targets in the district? ***(Make estimates for each intervention*** Have you included HBC services in the district plans? If yes, what items are being funded through the district budget?	
Objective 6. To assess the potential for sustainability of programme achievements at the national and district levels.	In which ways do you expect the services that have been achieved will be sustained? What will be the role of the district?	
Objective 7. To generate recommendations for the future use by all stakeholders who were involved in the programme.	What lessons, experiences and products of the project need to be taken up by the MOH and partners for future actions? ***(Refer your response for: policies, guidelines and standards, capacity building, up-scaling and/or research)***	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT

Form No. 4 for Implementing NGO

Respondent: CCBRT

Evaluation Objective	**Discussion points/guides**	**Response/Findings**
Objective 1. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	What was your role in the project? Were you able to make critical decisions about project implementation? ***(If not, explain)*** What has your organization benefited from the project? Do you feel like participating in similar partnerships in future? What needs to be improved in such partnerships?	
Objective 2. Objective 1. To assess the level of implementation of planned project activities within the existing operational environment.	Do you feel you had ownership and leadership of the project? • *In what capacity level* • *In what mandate level* • *What did you do to own the leadership of the project?* Were you involved in monitoring and follow up of funds and supply management? *(If yes explain the management of funds)*	
Objective 3. To assess the project's achievement in terms of CHBC	What do you feel about the availability and utilization HBC in the districts that you	

service availability, functioning and utilization in the project area.	supported? What lessons have you learnt during the implementation of the project	
Objective 4. To assess project's contribution to the development of policies, guidelines and training materials for HBC in Tanzania Mainland and Zanzibar.	Did the project influence any policies and guidelines for HBC services in the country and districts? If yes, how? If no, why not?	
Objective 5. To assess the potential for sustainability of programme achievements at the national and district levels.	How will the services and achievements be sustained?	
Objective 6. To generate recommendations for the future use by all stakeholders who were involved in the programme.	What recommendations can you make about: • Use of lessons and experiences gained through the project? • Improving the implementation of similar projects in future?	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT

Evaluation Form No.5
Respondent: District HBC Coordinator

Evaluation Objective	Discussion points/guides	Response/Findings
Objective 1. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	Were you involved in the planning of activities, if yes at what level? Were you involved in implementation of planned activities, if yes at what level? Were you involved in funds and other resource utilization arrangements?[administration] (If yes explain the management of funds and supplies)	
Objective 2. To assess the level of implementation of planned project activities within the existing operational environment.	In terms of implementation what were the targets and how much did you achieve in terms of: • Health facilities providing HBC • HBC provider training • HBC kits distribution • Supervision of HBC services What was the mechanism of reporting and how often did you report? Did you receive activity reports every quarter? • If yes describe and provide copies of the reports • If not explain When did you submit the reports you received from project areas to the higher level) How many supportive supervision visits do you conduct per quarter?	

	How many review meetings did you conduct during the project period? What were the challenges in implementing the project?	
Objective 3. To assess the project's achievement in terms of CHBC service availability, functioning and utilization in the project area.	What are the district targets for the provision of HBC services? What has been the contribution of the project towards these targets in the district?	
Objective 4. To assess project's contribution to the development of policies, guidelines and training materials for HBC in Tanzania Mainland and Zanzibar.	Did the project fill any gaps in HBC policy, guidelines and training material that existed before? If yes explain? What were then the complements or gaps filled by the Belgian supported HBC project Do you have any additional suggestions?	
Objective 5. To determine the cost of scaling up CHBC services at district level to reach the recommended national targets in Tanzania Mainland and Zanzibar.	Has the project helped you on how you could budget for scaling up HBC services in your district? Have you included HBC services in the district plans? If yes, what items are being funded through the district budget?	
Objective 6. To assess the potential for sustainability of programme achievements at the national and district levels.	Do you have any plan related to sustainability of services that were established and offered by the project? If yes, explain how and if not explain why?	
Objective 7. To generate recommendations for the future use by all stakeholders	What recommendations can you make about: • Use of lessons and experiences gained through and by the	

who were involved in the programme.	project at various levels? • Improving the implementation arrangements of similar projects in future?	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT

Project Evaluation - Health Facility
Form No. 6 Respondent: HBC Provider

Evaluation Objective	Discussion points/guides	Response/Findings
Objective 1. To assess the project's achievement in terms of CHBC service availability, functioning and utilization in the project area.	What is the total adult population of your service area? When did this facility start rendering HBC services? How many clients have accessed HBC services through this project? Do you think all patients in need are getting HBC? How many of them were HIV/AIDS patients? What did you do to sensitize the community about the availability of HBC services? Do you consider your HBC workload too heavy or quite manageable? What other services for PLHA exist in your service area? How are the HBC services linked to other social support services in the area?	
Objective2. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	Are community leaders involved in HBC services? If yes, how? If not, why? Are there NGOs or CBOs offering HBC in this area? If yes, how are they working with the project? Are community volunteers providing HBC? If yes, who trained them?	

	If not, why?	
Objective 3. To assess project's contribution to the development of policies, guidelines and training materials for VCT and HBC in Tanzania Mainland and Zanzibar.	Do you have tools/guidelines that guide you on how to manage your clients? If yes, who provided them? If yes, do you consider them as adequate? If not, what tools would you like to be provided with?	
Objective 6. To assess the potential for sustainability of programme achievements at the national and district levels.	How will the services continue to be provided without donor support? Are there any plans for sustaining the HBC services?	
Objective 7 To generate recommendations for the future use by the stakeholders who were involved in the project.	What did you learn from the implementation of the project? What do you recommend for the future use of the lessons learnt from the implementation of the project? Do you have any additional comments?	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT
Project Evaluation Form No. 7 Community Leader
Respondent: WEO/VEO

Evaluation Objective	**Discussion points/guides**	**Response/Findings**
Objective 1. To assess the level of implementation and monitoring of planned project activities within the existing operational environment.	Are you aware of HBC services being implemented in your community? If yes, who gives the services? When did the services start? How many times have you seen supervisors coming to see the services? How do patients managed at home get medical supplies?	
Objective 2. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	How have you personally been involved in the implementation of HBC? How is the community involved in supporting HBC services? **(Enquire about: support committees, contributions in form of human, financial or material)**	
Objective 3. To assess the project's achievement in terms of VCT and CHBC service availability, functioning and utilization in the project area.	Do you think VCT and HBC services provided to your community are adequate? Explain	
Objective 4. To assess the project's achievement in terms	Do you think HBC services provided in your are	

of CHBC service availability, functioning and utilization in project area	Adequate in terms of: - Service provision hours - Waiting time - Distance/ access - Number of providers	
Objective 4 To assess project's contribution to the development of policies, guidelines and training materials for HBC in Tanzania Mainland and Zanzibar.	Is HIV/AIDS part of agenda in your community meetings? If yes, have you discussed HBC services? What have been your resolutions so far?	
Objective 5. To determine the cost of scaling up CHBC services at district level to reach the recommended national targets in Tanzania Mainland and Zanzibar.	Do patients or relatives pay for HBC services? If yes, how much?	
Objective 6. To assess the potential for sustainability of programme achievements at the national and district levels.	What mechanisms has the community put in place for sustainability of this project after the donors leave? Who are other stakeholders who can be brought on board to support HBC?	
Objective 7. To generate recommendations for the future use by all stakeholders who were involved in the programme.	Please give your suggestions on how the HBC services could be improved	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT
Project Evaluation Form No.8 Head of the Family
Respondent - HOF

Evaluation Objective	**Discussion points/guides**	**Response/Findings**
Objective 1. To assess the level of implementation and monitoring of planned project activities within the existing operational environment.	How long has the patient been ill? Who from outside the family is helping to care for the patient? What is the assistance given by this external person? When did you start to get external assistance?	
Objective 2. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	Are you aware of other services that your patient could benefit from? ***(Probe for care and treatment services, TB, PMTCT, etc)***	
Objective 3. To assess the project's achievement in terms of CHBC service availability, functioning and utilization in the project area.	Does your patient receive services from HBC providers? Who are these providers? How often do they visit your patient? Are the services adequate? Explains In terms of: - Management of OIs - Supply of drugs and supplies Has the patient being referred to services that the provider cannot offer? If yes, explain In general, how can you	

	explain your satisfaction with the services?	
Objective 4. To assess project's contribution to the empowerment of families to care for patients at home	Have you received any IEC materials? Have you been trained on the care of your patient? If yes, by who? How has the training helped you to take care of your patient better? Have you or any other member of the family attended VCT? If No why? If yes, how do you find the services?	
Objective 5. To assess the potential for sustainability of programme achievements at the national and district levels.	Do you consider HBC as a programme that needs to be available in the community? If yes, what suggestions do you have for sustaining this project?	
Objective 6 To generate recommendation for the future use by all stakeholders who were involved in the project	What do you think need to be improved in improving such services?	

BELGIAN SUPPPORTED COMMUNITY HOME BASED CARE PROJECT
Project Evaluation Form No.9
Client

Evaluation Objective	**Discussion points/guides**	**Response/Findings**
Objective 1. To assess the level of implementation and monitoring of the project activities within the existing operational environment	How long have been ill? Who is taking care of you? What type of care are you receiving? How long have you been on HBC programme? Besides the regular care provider how often does the HBC provider visit you from the health facility? The community HBC provider? When were they here last? What services do they offer? How do you feel about the services? Were the services readily available when you needed them?	
Objective 2. To document the level of involvement of various partners in ownership and implementation of programme activities including government, civil society organizations and communities.	Are you aware of other services that you think can be of help to you? If yes are you linked with those services?	
To generate recommendations for future use by all	How did you feel about these services?	

stakeholders who were involved in the programme	What do you think could be done to make the services better?	

List of people of People the Evaluation Team met and interviewed.

NAME	Designation
Dr. Ronald Swai	Programme Manager NACP Tanzania
Dr. Cornelia Atsyor	WHO Tanzania EPI
Dr. Stefan Wiktn	CDC Tanzania
Mr. Geert Vanneste	Chief Executive Officer (CCBRT)
Dr. G. Chalamila	HBC Coordinator (Dar es Salaam City Council/ CCBRT)
Mrs.Teoodora Millinga	Counsellor Midwife (CCBRT)
Ms Fabiola Mponguliana	HBC Provider (CCBRT)
Ms Flora Makedya	Pharmacist (CCBRT)
Ms Marietha Njelekela	HBC Supervisor/HBC Provider (CCBRT)
Ms Faith Nchimbi	District HBC Provider PHN (CCBRT)
Cuthbert Kongola	District HBC Provider Dodoma Rural Council
Rosalia Moredi	District HBC Provider Dodoma Rural
Elishia Kishimbo	District Administrative Officer (Dodoma Rural)
Ambeseji Mawessor	District Health Officer .Dodoma Urban Council
Agnes Josep Mavere	Community HBC Provider
Mrs. V.J. Mtimba	District Nursing Officer/District HBC Trainer
Dr.C.F.Mahomera	Acting District Medical Officer
Mrs.Gedala Kalinga	District Cold Chain Officer Dodoma Urban Council
Ms Mary Masumbigan	ILS Focal Person Dodoma Urban
Mr. Said Shaban	Council Health Management Team (CHMT) Dodoma Urban
Dr Kelvin Mtavangu	Member of the CHMT Dodoma Urban
Mr. Benedict Temba	District AIDS Control Coordinator Dodoma Rural
Mr. Edwin Kongola	District HBC Coordinator (Dodoma Rural)
Dr.M.R. Ikapu	District HBC Coordinator and Assistant Medical Officer Dodoma Urban
Dr. Omar Makame Shauri	Permanent Secretary Ministry of Health and Social Welfare Zanzibar
Mr Juma Makame	HBC Provider/Trainer North A Zanzibar
Mr.Othman Omar	HBC Provider North A Zanzibar
Mr. Obeid Usi	Community Volunteer North A Zanzibar.
Mr. Amid Nasser	HBC Steering committee member /FBO Coordinator
Mr.S.I. Saadat	Zanzibar AIDS Commission Representative
Ms Amina Suleiman	ZAPHA Secretary/PLWHA.
Ms . Saide Hassan	Fulltime Counsellor at ZAPHA/ HBC Provider
Dr.Kalam Ameir	District Medical Officer Zanzibar Urban.
Mrs Saumu Saidi	Coordinator Counselling and Social Services Zanzibar AIDS Control Programme.
Stella Chale	NACP/WHO
Erasma A. Malekela	National AIDS Control Programme Tanzania
Sandra Cress	Clinton Foundation Tanzania
Dr Eunice Mmari	CDC Tanzania

Salma Jabir	ZAPHA+
Dr Caroline Mushi	Pathfinder International Tanzania
Mr Henry Meena	UNAIDS Tanzania
Katrien Meersman	Belgian Embassy Tanzania
Nassoro Kambenga	Village Executive Officer Ulaya (VHC)
Abdallahamani Mbiawe	Mjumbe (Member of the Village Health Committee)
Hamida Abduel	Member of the Village Health Committee
Shani Mnazali	Member of the Village Health Committee
Timotheo Mahembula	Member of the Village Health Committee
Adrus Kana	Member of the Village Health Committee
Ismail M. Dikaluka	Member of the Village Health Committee
Rashidi Kaona	Chairperson of the Village Health Committee (VHC)
Asha Saidi Kihongola	Member of the Village Health Committee
Zuena O.Mhinga	Member of the Village Health Committee
Salima Beda	Member of the Village Health Committee
Omari Mbwana	Member of the Village Health Committee
Hamisi Mjomba	Chair Person of the Village
Selemani Nyambweda	Member of the Village Health Committee
Tunu Mgawe	Member of the Village Health Committee
Emanuel Mulia	Member of the Village Health Committee
A.Rashidi Mlinga	Member of the Village Health Committee
Mariam Hassani	Member of the Village Health Committee
Ashura Hussein	Member of the Village Health Committee
Yasini A. Kidole	Member of the Village Health Committee
Stivin Putila	Member of the Village Health Committee
Stamili M. Liondo	Village Health Worker
Salehe Oman Mkundi	Ulaya Village
Client +Family carer	Dodoma Urban
Client + Family carer	Ulaya Village
Client + Family Care	Zanzibar North A District
Client	Dodoma Urban
Client	Zanzibar North A district
Client + Family Care	Kimbamba (Dar es Salaam Region)
Client + Family Care	Kimbamba, Kinondoni District
Ms Theresa Mmbando	District Executive Director (DED) Kilosa
Dr. Eliakia.G. Mapunjo	Acting District Medical Officer (Kilosa)
Dr. Wilbert Munuo	District Home Based Care Coordinator (Kilosa)
Dr. M. Mwemsanga	Medical Officer in Charge Kilosa Dist.Hospital
Ms Ruth Ghambanya	HBC Provider and Counsellor Kilosa District Hosp
Mrs.N. Kagama	HBC Provider Kilosa District Hospital
Mr.A. Mkunda	District Nursing Officer Kilosa District Hospital
Mr John Ngwina	Counsellor
Mr Emil Boma	Counsellor
Ms Priscila Maula	HBC Provider
Ms V. Mtimba	District Nursing Officer (DNO) Dodoma Urban
E Maembe	HBC Provider (Dispensary) Dodoma Urban
Mr. Celestine A.M. Haule	MSD Senior Sales Manager.
Bernadette Olowo-Freers	Country Programme Advisor (CPA)UNAIDS

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