THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

TRAINER'S GUIDE FOR HOME BASED CARE PROVIDERS

National AIDS Control Programme

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LIST OF ABBREVIATIONS

-	AIDS	-	Acquired Immune Deficiency Syndrome
-	AMREF	-	African Medical Research Foundation
-	CBHC	-	Community Based Health Care
-	CDC	-	Centres for Disease Control and Prevention
-	DHMT	-	District Health Management Team
-	G.V	-	Gentian Violet
-	GPA	-	Global programme on AIDS
-	HBC	-	Home Based Care
-	HIV	-	Human Immune deficiency Virus.
-	HSR	-	Health Systems Research
-	MCH Aides	-	Maternal and Child Health Aides
-	MOH	-	Ministry of Health
-	MTP	-	Medium Term Plan
-	MTUHA	-	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya.
-	NGO	-	Non Governmental Organization
-	PLHA	-	People Living with HIV/AIDS
-	PHC	-	Primary Health Care
-	PWA	-	People with AIDS
-	STDs	-	Sexually Transmitted Diseases
-	T.O.T	-	Training of Trainers
-	WHO	-	World Health Organization.
-	UNAIDS	-	Joint United Nations Programme on AIDS

1. INTRODUCTION

Tanzania is one of the countries most hit by HIV/AIDS in Sub Sahara Africa. The reported AIDS cases by December 1998 were 109,863 with an estimated number of 550,000 (NACP Surveillance Report No. 13 December 1998). Thus the Prevention and Control of HIV infection and care of AIDS patients including others with terminal illnesses rose a difficult challenge to the overall system of care for the sick within the institutional and community setting.

According to a survey done in the country, about 40 - 60% of hospital bed capacity is allocated to AIDS patients or to patients with AIDS related diseases (Demographic and Health Survey 1996). This shows that, the need for care is already enormous and will continue to increase. The overcrowded hospitals and health centres are striving to cope with this new challenge, on strained health budgets.

Hospitals in particular are unable to deal with the huge load of patients with HIV/AIDS and others terminally ill in need of medical and nursing care. Thus, the need for an appropriate and cost effective Home Based Care Programme to support the hospital services.

TRAINER'S GUIDE

This trainer's guide has been prepared to assist the trainer/facilitator of HBC in identifying the main areas of emphasis while training.

It may not be complete on its own but requires more information from other resources (references) stipulated in the course content outline.

The Trainer's Guide will be useful in:

- orienting the trainer and trainees to the National Health Policy, other policy guidelines and strategies relevant to HBC.

- directing the trainer on how to go about planning, organising, conducting and evaluating HBC teaching and learning activities.

- assisting the trainer in teaching each unit of the National Course Plan for training HBC providers at T.O.T. level, and after some modification, to suit the trainees at community level.

- stipulating the scope and roles of HBC, tasks which the HBC provider has to learn, and competencies for HBC.

This Trainer's Guide covers on all the areas of quality HBC services, HBC supervision guidelines and monitoring tools, strategies and tools for community involvement and participation, guidelines on referral of chronically ill patients, to mention but a few.

Some similar information may be found both in the Trainer's Guide and in the National Course Plan. This is done for the sake of emphasis rather than repetition.

The National Course Plan for T.O.T and the Course Plan for Training Community HBC Providers have almost the same content but differ in focus and levels at which they are set; reflecting the background/characteristics of the learners (trainees).

UNIT: 1.0

INTRODUCTION TO HOME BASED CARE (HBC)

INTRODUCTION

Home Based Care for the sick in Tanzania is not a new thing, has been there since time immemorial.

The increasing number of HIV/AIDS and other chronically ill patients, who cannot be taken care of in the existing health facilities, prompted the need of establishing HBC services in Tanzania. Since the scope of HBC was not clearly defined, patients with HIV/AIDS and other chronic illnesses were discharged from the health facilities without any proper referral system for continuum care at home. Hence there was a need to train HBC providers who would be responsible for training and supporting the patients' families, who in turn will continue taking care of these patients at home.

The need for establishing HBC services in Tanzania was also revealed by various studies that were conducted in various parts of the country. In these studies, patients with HIV/AIDS prefered being taken care of in their homes, close to relatives, friends and loved ones, especially during the last days of their lives. Further more, the Demographic and Health Survey done in the country in 1996 showed that about 40% to 60% of hospital bed capacity is allocated to AIDS patients or to patients with AIDS related diseases.

Formal HBC services by Ministry of Health (MOH) were initiated in 1996 as a pilot study in 8 district of Rukwa and Coast regions. The main objective of this pilot study was to train HBC providers, who in turn would train the family members who are the main actors in the HBC services. Between 1996 and 1998, 51 HBC providers had been trained, in the two pilot regions. They have proved to be very useful and their services are very much needed and appreciated by communities.

HBC should therefore be integrated into the District Health Care Delivery System, and be part and parcel of the District Health plans.

- **OBJECTIVES**

By the end of the unit the trainee will be able to:

i. discuss the overview of Home Based Care.
ii. utilize the concept of the National Health Policy and PHC Strategies relevant to HBC.
iii. outline the roles and responsibility of key actors in HBC services .
iv. utilize the principles of competences for HBC.
v. explain the concept of Health Sector Reform.

- **SUMMARY OF CONTENTS**

i. Overview of Home Based Care.
ii. National Health Policy,and PHC strategies.
iii. Health Sector Reform.
iv. Roles and responsibilities of key actors in HBC.
v. Competences for HBC.

CONTENT

1 [redacted]

INTRODUCTION

The National Health Policy in Tanzania emanates from the Primary Health Care (PHC) approach proclaimed in 1978, but whose effective implementation started in 1983. The actual realization of what PHC is, was in 1978 after the Alma Ata Conference.

Before the Arusha Declaration of 1967, the priority was on curative services, centred mostly in urban centers leaving the rural areas completely neglected. From 1967, priorities for provision of health services changed and preventive services were rated as first priority. Health services were to be provided equitably in the whole country. Thus, priority in establishing and improving "health services, turned to the rural areas with great emphasis on preventive care, hence the establishment of health centers and dispensaries with Maternal and Child Health (MCH) services".

Other activities like community based health care, child survival programmes, and family planning are all part and parcel of the Primary Health Care strategy.

In an effort to improve the health services, health sector reforms have been introduced and are being implemented to facilitate the overall objective of the health policy. They are intended to facilitate increased productivity of quality health services in the most cost - effective way.

1.1 OVERALL OBJECTIVE OF THE NATIONAL HEALTH POLICY

The overall objectives of the health policy in Tanzania is to improve the health and well-being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people.

Specific Health Policy objectives:

- To mobilize the community on participation in terms of contribution, management and development of health services.
- To develop and sustain a health culture through safe life styles, dietary habits and environmental maintenance.
- To support and encourage research on communicable diseases traditional medicine, people's habits and customs towards improvement of health status.
- To improve the existing health infrastructure and facilities so that they render better health services.
- To promote multi-sectoral and inter-sectoral collaboration in strengthening provision of health services.

- To improve mother and child health with particular emphasis on preventive, curative and family planning.

- To be self sufficient in health personnel of all disciplines at all levels from village to national level.

- To improve the system of procurement and distribution of drugs and medical supplies to make sure they are available at all health facilities.

1.2 STRATEGIES TO ACHIEVE OBJECTIVES

- To devolve health services to the district level in line with the on-going Local Government Reforms, so that communities are directly involved in the improvement of health services and infrastructure.

- To improve health services and infrastructure to both urban and rural areas by utilizing the available resources.

- To ensure adequate supply of drugs and medical equipment.

- To control diseases that crop up as a result of poor nutrition and environment.

- To improve operational research on the health care system and make use of research findings to improve health services delivery.

- Monitoring and supervision of health activities to the public/government facilities, including those by Non-Governmental Organisations (NGOs) and the private sector to be carried out by central government, regions and districts.

- Rehabilitation and maintenance of existing infrastructure, replacement and equipping health facilities and placement of qualified personnel.

- Gradual shift of government/public resources from curative to preventive services, massive campaign on control of communicable diseases and strengthening of MCH services and health education on the importance of nutrition.

- Through cost-sharing there will be additional funds to supplement Government efforts in supply of drugs and hospital supplies to health facilities. The user-fees will be revised to reflect the actual proportion of costs to be shared.

- To enforce existing rules and regulations that safeguard health services provision in general, and in particular workers in industries and estate farms against health hazards.

- To continue training and retraining of health personnel at all levels. Emphasis will be put on correct strategies to ensure equal distribution of health personnel.

- To make follow-up and ensure that health guidelines are adhered to by Regions, Districts, NGOs, and private health facilities, who will be obliged to follow the standard, staffing levels recommended by MOH.

- To achieve health policy objectives in respect to resources, the policy therefore recommends:

- An increased role of the community in financing health services especially costs of curative services. Users fees will be enhanced in government health facilities and Ministry of Health training institutions, so that they render better health services.

- Encouragement of the private sector in providing health services and running of training institutions.

- Government concentrate on health services qualifying as public services. e.g. preventive health services that are not attractive to the private sector, but of interest to public e.g. health inspectors.

1.2 PRIMARY HEALTH CARE STRATEGY

Primary Health Care is essential health care, addressing the main health problems in the community, providing promotive, preventive, curative and rehabilitative services to all individuals and families with their full participation. It is an integral part of the country's health system of which it is the central function and main focus.

It should be emphasized that PHC is a vehicle for implementation of the health policy. PHC is applied at the first level of control of individuals, the family and community with the national health systems, be at village health post, dispensary, health centre or hospital.

Primary Health Care must start with the community and in the community providing care as close as possible to where people live and work.

2 [redacted]

- The community should first see the need for ownership of the model. If there is no felt need then the community must be sensitised, motivated and encouraged to establish and sustain the HBC services by the District Health Management Team (DHMT).

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

2.1 The Patient

A patient receiving HBC services will be expected to:

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

2.2 The Family

Patients with chronic illnesses will to a large extent be cared for in their homes. Since hospital

based staff do not usually provide care to such patients at home, family members will take over the responsibility of providing care at home. Indeed, it is envisaged that family members will be the main actors in providing HBC services.

(a) The family will be required to choose among themselves a person who will be trained on specific elements of care for their patient. However, it is essential that more than one member of the family knows about the general care of the patient so as to support each other and ensure continuity of care in case the primary care giver is absent.

(b) After the patient has given consent, the family should be counseled about their patient's illness; informed about the cause, signs and symptoms, treatment, possible complications and prevention. This should be done at the health facility where the diagnosis is made before referral for HBC.

What the family needs to do:

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

Requirements at the family/household level

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

2.3 The Community HBC provider

The community HBC provider could be a public servant, or an individual volunteer from the community or NGO whose duties shall include:

i. Linking the family with the local health care facility and other services in the community by reporting and referring patients to the appropriate places.
ii. Conducting community sensitisation in order to establish and sustain HBC financially.
iii. Implementing the HBC policy guidelines by:

(a) providing health care support to families with chronically ill patients.
(b) training families on how to care for the chronically ill patients including:
    - nursing care ;
    - feeding;
    - providing comfort;
    - alleviating pain;
    - preventing infections; and

- detecting complications and danger signs.

iv. Reporting on the state of the patients to the health facility contact person monthly.
v. Raising the community awareness on new developments concerning chronic illnesses and prevention of infectious ones including HIV/AIDS and PTB.

vi. Make available to the patient needed equipment, supplies and drugs from the health facility and other material support provided by the community.

Requirements

The community based HBC provider should be provided with a first aid kit containing the following items:

- Gloves, Gauze, Bandages, Thermometers, Mackintosh, Hypochlorite, Antiseptics, Plastic Apron, washing soap;
- Simple reading materials on different diseases;
- Register for recording patients receiving HBC services; and
- Stationary.

Quallfication

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

- based in the community they are serving;
- literate know how to read and write;
- able to build good interpersonal relationship;
- interested in caring for sick people;
- willing to volunteer;
- accepted by the community they are going to serve;
- reliable and do not easily despair; and
- able to maintain confidentiality.

2.4 Contact Person

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

i. train, supervise, support the community HBC provider and evaluate the quality of care being provided in their catchment area.
ii. keep a register of clients receiving HBC services with a track of their whereabouts, their health status, and report to DHMT by MTUHA system.
iii. ensure availability of equipment supplies and drugs for HBC and continuity of care.
iv. educate and provide support to the family to implement the HBC policy guideline.
v. follow up patients discharged from their health facility and from hospitals.
vi. raise awareness of the community and mobilize them for involvement in the provision and sustainability of quality HBC services.
vii. network with other health care providers in the community.
viii. keep patients' records and report to the health facility contact person.
ix. participate in HIV prevention activities.

Requirements

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

2.5 NGOs and Religious groups.

NGOs and religious groups with an interest in provision of care to patients should be encouraged to:

(b) provide HBC services to chronically ill patients including HIV/AIDS patients according to the National Guidelines for HBC.
(b) link with the health facility contact person for referrals, training and supervision.
(c) provide counseling and spiritual support to patients/families and communities.
(d) continue providing social support as per their objectives.
(e) raise community awareness on various health issues and educate them accordingly aiming at prevention and control of communicable disease including HIV/AIDS, STDs, tuberculosis, leprosy etc.

Religious Leaders
The role of religious leaders may include providing spiritual, pastoral care, guidance, counselling, moral and social support to patients and families. The religious leaders identified should be those respected by the patient. Where appropriate such leaders should be encouraged to:

(a) continue giving spiritual support and counseling to patients.
(b) sensitize the community on health issues to keep them healthy.
(c) sensitize the community on the importance of supporting the sick through HBC services.
(d) refrain from claiming to cure AIDS through prayers
(e) encourage patients to seek medical care.

2.6. Traditional health practitioners

i. not to engage in activities which enhance transmission of infections.
ii. refer patients through a home based care referral system.
iii. give correct information to patients and refrain from claiming to cure AIDS.
iv. encourage patients to obtain medical care.

Requirements

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

2.7.The DHMT

Functions of the DHMTs shall include:

i. Integrating HBC in the district health plans as one of the methods of implementing the national health intervention package.
ii. Creating awareness, and conducive environment for the community, on the need and importance of establishing and sustaining HBC services.
iii. Conducting training of trainers, training of trainees and training of supervisors of HBC.
iv. Monitoring the implementation of HBC services in the district.
v. Conducting supervisory visits to health facilities.
vi. Making available equipment, supplies and drugs to be utilised for HBC services including:

- Equipment for dressing.

Gallipots	- for nursing procedures
Receiver (Kidney) dishes	- for nursing procedures
Scissors	- for cutting
Dressing forceps	- for dressing

- Supplies

Candid oral paint	- for oral thrush for children
G.V paint	- for ulcers
Savlon solution	- for disinfecting wounds and equipment
Hypochlorite solution (Bleach)	- for disinfection of linen/hands.
Calamine lotion	- for herpes zoster
Gauze and Cotton	- for dressing.
Bandage and adhesive plaster	- for fixing dressing
Microscope slides	- for taking blood for malaria
Lancets	- for pricking
Apron and mackintosh	- for barrier protection
Gloves	- for barrier protection
Thermometer	- for temperature taking
Washing soap	- for general hygiene

- Drugs

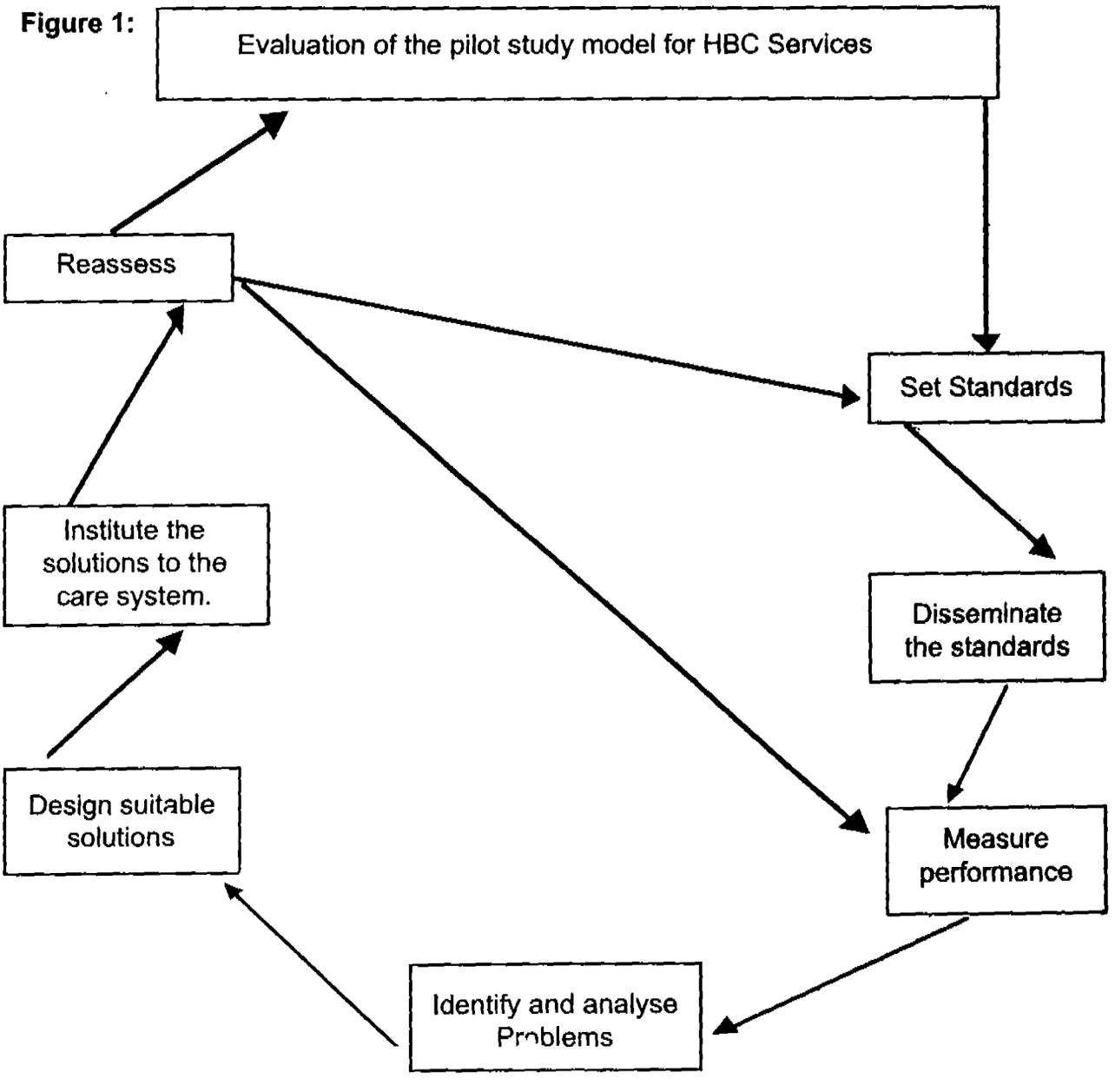
Chloroquine	- for malaria
Aspirin	- for pain relief and temperature regulation
Chlorpheramine	- for itching, allergic condition
Promethazine	- for itching and vomiting
Cotrimoxazole	- for infection
Ampiclox Tablets	- Antibiotic
Ampiclox syrup	- Antibiotic
Vitamin IBî Complex	- for replenishing nutrient deficiencies.
Multivitamin	- for replenishing nutrient deficiencies.
Paracetamol-tablets and syrup	- for pain relief
Oral Rehydration salt sachets	- for rehydration
Hydrocortisone ointment 1%	- for eczema
Benzyl Benzoate Emulsion (BBE	- for scabies
Whitfield ointment	- for skin fungal infection
Sodium benzoate solution	- for oral thrush in adults

3 THE QUALITY ASSURANCE CYCLE FOR HOME BASED CARE SERVICES

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

- The family shall be the main actors of implementing HBC.
- The health facility shall have one member of staff to act as the Contact Person whose competencies shall include:
- An understanding of the health policy objective; the concept of primary health care strategy; and the purpose of health sector reforms, especially the essential health intervention packages.

Figure 1:



The competencies for HBC provider, the trainer and supervisor shall be centred on the following:

i. alleviating chronic pain;
ii. managing different clinical conditions;
iii. educating and supporting families on nursing care of their patients; and
iv. counselling families and patients on managing pain, crisis and stress associated with HIV/AIDS and other chronic illness.

- The DHMT shall train the health facility workers (the contact person for district and facility level). The TOT shall be a Medical Officer and a Nursing Officer.

- The health facility worker shall train the community HBC provider.

- The community HBC provider shall train and support the family in providing care to their patients.

TRAINER/TRAINEE ACTIVITIES

- Lecture / Discussion
- Plenary sessions
- Demonstration
- Group work
- Brainstorming

RESOURCES

1. MOH: National Health Policy
   PHC Strategies
2. NACP 1999 - National Course Plan for Training HBC providers for persons with HIV/AIDS and other chronic illnesses.
3. NACP 1999 - Guidelines on Home Based Care Services in Tanzania.
4. Updated Health System Research findings.
5. NACP 1998 - Surveillance Report No. 13
6. NACP 1999 - Mwongozo wa Kuhudumia Wagonjwa Majumbani.
7. Charts, Posters.
8. WHO - Weekly Epidemiological record No.29 of 20th July 1990.
9. Relevant WHO Materials
10. NACP 1999 - Manual for Trainers of Hospital Based Counsellors

EVALUATION

- Questions and answers.
- Evaluation group work.

UNIT 2.0

BASIC FACTS ABOUT HIV/AIDS/STDs

INTRODUCTION

- Globally the AIDS situation continue to be alarming. According to reports by UNAIDS, in 1998 alone, 5.8 million people were infected with HIV worldwide, 5.2 were adults, 590,000 were children below age of 15 years and 2.1 million were women. Cummulatively, there were 33.4 million people living with HIV/AIDS worldwide as of December 1998.

- In Tanzania, the first three cases were first observed in 1983. Generally, the fewer cases are reported due to inaccessibility of Health Care Services, problems of diagnosis in most health care facilities and poor reporting. The current total number of estimated AIDS cases in Tanzania stands at about 550,000 of which only 109,863 cumulative AIDS cases had been reported by December 1998. The overall prevalance of HIV infection among blood donors was 9%. More shocking data in 1998 showed the prevalance of 11.8% in women is significantly higher as compared to 8.5% in men.

- HBC providers dealing with persons with HIV/AIDS should be able to give basic facts about HIV/AIDS, specifically, to ensure that they understand that having the virus is different from having AIDS. Correct definitions, causes, modes of transmission and prevention and control should be well explained so as to minimise or prevent further spread of the infection.

- Clear explanations of clinical features of HIV/AIDS will enable patients to identify and manage opportunistic infections early in order to prevent further complications. It will also enable the affected persons to know in which stage they are. Furthermore, the HBC provider should be able to provide accurate and clear information on STDs, their symptoms and the importance of early and proper treatment. Studies have shown that early and proper treatment of STDs reduces the rate of HIV transmission by 40%.

OBJECTIVES

By the end of this unit the trainee will be able to:

i. explain the magnitude, trends, patterns and impact of HIV/AIDS epidemic.
ii. define the terms HIV/AIDS.
iii. describe causes and mode of transmission.
iv. diagnoses HIV/AIDS.
v. mention the methods of prevention and control of spread of HIV/AIDS.
vi. counsel on breast feeding and HIV infection (counselling on informed choice)
vii. counsel on mention stages and main clinical features of HIV infection (according to WHO classification)
viii. correct misconception about HIV/AIDS modes of transmission and prevention.
ix. describe common types of Sexual Transmitted Diseases (STDs)

SUMMARY OF CONTENTS

i. Overview of HIV/AIDS Situation.
ii. Magnitude, trends, patterns and impact of HIV/AIDS epidemic.
iii. Definitions of HIV/AIDS.
iv. Causes and mode of transmission.
v. Diagnosis of HIV/AIDS.
vi. Prevention and control of spread of HIV/AIDS.
vii. Breast feeding and HIV infection (counselling on informed choice).

vii. Common types of Sexual Transmitted Diseases (STDs).
- Correct misconception about HIV/AIDS modes of transmission and prevention.
- Stages and main clinical features of HIV infection (according to WHO classification)

CLINICAL FEATURES AND STAGES OF HIV/AIDS *(as classified by WHO)*

There are 4 clinical stages of HIV/AIDS.

1. CLINICAL STAGE: I
- A symptomatic
- Persistent generalised lymphadenopathy (PGL)

2. CLINICAL STAGE: II
- Weight loss <10% of body weight.
- Minor mucocutaneous (seborrheic dermatitis, prong, fungal nail infections, and recurrent oral ulceration's, angular.
- Herpes Zoster, within the last 5 years.
- Recurrent upper respiratory tract infection (i.e. bacterial sinusitis).

3. CLINICAL STATE: III
- Weight loss > 10% of body weight.
- Unexplained prolonged diarrhoea > 1 month.
- Unexplained prolonged fever (intermittent or constant) > 1month.
- Oral candidiasis (thrush).
- Pulmonary tuberculosis within the past year.
- Serve bacterial infections (i.e. pneumonia, pyomyositis).

4. CLINICAL STAGE: IV
- HIV wasting syndrome.
- Pneumocystic carinii pneumonia.
- Toxoplasmosis of the brain.
- Cryptospodiosis with diarrhoea > 1 month.
- Cryptococcosis extra pulmonary.
- Cytomegalovirus (CMV) disease of an organ other than liver, spleen or lymph nodes.
- Herpes simplex virus (HSV) infection mucocutoneous > 1 month or visceral any duration.
- Non typhoid salmonella septicaemia.
- Extra-pulmonary tuberculosis.
- Lymphoma.
- Kaposi's Sarcoma.
- Candidiasis of oesophagus, trachea, bronchi or lungs.
- Atypical mycobacteriosis, dissemination.
- HIV encepalopathy.

TRAINER/TRAINEE ACTIVITIES
- Lecture/Discussion
- Group Work
- Plenary sessions
- brainstorming

RESOURCES
1. NACP 1999 - Guidelines on HBC
2. NACP 1998 - Surveillance Report No. 13
3. UNAIDS 1999 - Surveillance Reports
4. Relevant WHO Materials
5. NACP 1999 - STDs Training for Clinicians

EVALUATION
- Question and Answers
- Evaluation of group work

UNIT 3:

CONCEPTS OF HOME BASED CARE

INTRODUCTION

HBC CONCEPT

- HBC is perceived as assisting the individual, sick or well, in the performance of those activities contributing to health or its recovery or to a peaceful death. The individual can perform those activities unaided given the necessary, and adequate, strength, will or knowledge; and to do this in such a way as to help gain independence, as rapidly as possible.

- The scope of HBC involves continuous caring for chronically ill patients from the health care facility to the home.

- The environment is part of medical care and is linked to the health support and referral system.

- HBC shall be established at all levels in the district as part of existing health care system. The community has to be sensitised on the importance of this service and should own it.

- The main actors for implementing HBC services (care providers) shall be the family members who will be trained by the community HBC provider.

- The community HBC provider will continuously assist, support, supervise, monitor and evaluate HBC activities involving the patient and family members (the carers) at all stages of implementation of the caring model. The community HBC provider shall be a link between the patient/family and contact person stationed at a Health facility.

- The contact person stationed at a health facility will train the community HBC provider to implement HBC guidelines. He / She will report to the contact person at district level, who will report to the DHMT all HBC activities within the district including services provided by NGOs/Volunteers, and relatives of patients.

- The HBC provider (contact person) must have accepted qualities of the profession such as adequate knowledge and specific norms. She / He should adhere to the code of professional ethics related to HBC.

- The HBC provider (contact person) must be familiar with the National Health Policy guidelines and strategies relevant to HBC in Tanzania, while providing HBC services.

OBJECTIVES:

By the end of this unit, the trainee will be able to:

i. discuss the HBC Concept.
ii. adhere to the code of Ethics related to HBC.
iii. identify the key roles, qualities and characteristics of an effective HBC provider.
iv acquire knowledge and skills in improving the well being of persons living with HIV/AIDS and other chronic conditions.
v. list the conditions that should be managed by the HBC provider.
vi. explain tasks, which HBC provider can learn.

SUMMARY OF CONTENTS

i. definition of HBC.
ii. professional code of ethics related to HBC.
iii. quality and characteristics of an effective HBC provider (contact person).
iv. tasks which HBC provider (contact person) has to learn.
v. conditions that should be managed by HBC provider.

CONTENT

1. DESCRIPTIVE DEFINITION OF HBC

- HBC perception
  - Philosophy related to HBC
  - Scope of HBC
  - Implementation of HBC.

2. PROFESSIONAL CODE OF ETHICS RELATED TO HBC

- Descriptive definition of ethics.
- Ethical considerations in HBC.

3. QUALITIES AND CHARACTERISTICS OF AN EFFECTIVE HBC PROVIDER, (CONTACT PERSON)

- Knowledgeable in HIV/AIDS and other chronic illnesses.
- Competent in her/his work.
- A good listener.
- Empathetic and understanding.
- Accepts differences in people, tolerance, good will.
- Flexible and genuine.
- Respects other people's opinions and professions.
- Knowledgeable of values, activities and social systems in their community
- Works in harmony with others.
- Ensures that confidentiality is maintained.
- Reliability and royalty.
- Confident and goes not easily give up.
- Ability to identify and recognise one's limitations.
- Not involved in illegal personal profit gain.

4 TASKS WHICH HBC PROVIDER (CONTACT PERSON) HAS TO LEARN.

- Establish and sustain interpersonal relationships.
- Initiate a relationship in an attempt to allow knowing each other by greeting, introducing onesself and giving general information about the aim of the encounter and testing to see if the visit is acceptable.
- Show the family and patient empathy and real concern without reacting in a highly personalised way.
- Manage pain, stress and crisis.
- Recognise that pain is a complex mysterious phenomenon that cannot be completely or simply understood and is expressed as experiences that a person finds unpleasant and would like to avoid.
- Recognise that bodily pain is an uncomfortable sensation that can be localised in some part of the body while mental pain is an uncomfortable feeling that is difficult to localise in any specific part or parts of the body.
- Recognise that some people will report pain, as no pain, mild, moderate or severe even though the degree of physical trauma is similar, due to individual pain thresh hold.
- Observe the patient's behavioural response to the pain experience, whether or not pain is present, duration of the pain, meaning of the pain in terms of the amount of anxiety, the intensity of the pain sensation, tolerance of pain and the characteristics of the pain.

- Establish a therapeutic interpersonal relationship with the patient and family when handling the pain whether anticipated, present or when it is over.
- Administer prescribed pharmacological agents that enclave pain.
- Continue to assess and obtain accurate assessment often-precipitating event and the resulting stress and crisis.
- Collaborate with community leaders and other key people in the community.
- Prevent and control transmission of HIV/AIDS by educating patients, family, and community the following:
  - Hand washing with soap and water after handling soiled linen, clothing having contact with body fluids and before and after performing procedures.
  - Covering all open wounds with dressing bandage or clean cloth on both his/her body and that those of the patient.
  - Washing and cleaning of clothing and equipment stained with blood, diarrhoea or other body fluids after soaking them in Hypochlorite solution.
  - "No sharing" of sharp skin-piercing instruments, toothbrushes, razors, needles or anything which can cut or come into contact with blood.
  - HIV is not spread during normal social contact, but that it is important to avoid other common infections that are spread by normal social contact, such as diarrhoea and respiratory tract infections.

- Acquire knowledge and skills in improving the well being of persons living with HIV/ AIDS. Strategies to be used:-
  - Encourage and support counselling and voluntary testing services.
  - Create a favourable environment to ensure availability of relevant and affordable drugs for management of HIV/AIDS.
  - Expand and improve HBC services in districts with high HIV prevalence.
  - Reduce stigma and discrimination against people living with HIV/AIDS and their families.

- Fever.
- Skin conditions.
- Wound, abscesses and boils.
- Pressure sores or bed sores.
- Allergies
- Mouth and throat conditions.
- Coughing, difficult in breathing, chest tightness and rapid respiration's -**refer.**
- Tuberculosis.
- Pain.
- Anxiety and depression.
- Tiredness and weakness.
- Nausea and vomiting.
- Genital, ulcers and discharges - **refer.**
- Kaposis Sarcoma - **refer.**
- Herpers Zoster - **refer.**

* **In all the above conditions, patients should be referred to a health facility if condition does not improve.**

TRAINER / TRAINEE ACTIVITIES

- Pretest.
- Brainstorming.
- Lecture/Discussion.
- Role-plays.
- Group work.
- Plenary sessions.
- Demonstration

RESOURCES

1. NACP 1999 - Guideline for Home Based Care Services in Tanzania
2. WHO 1993 - HIV/AIDS Prevention and Care: Teaching Module for Nurses and Midwives
3. NACP 1999 - National Multisectoral Policy Guidelines on HIV/AIDS and STDs
   NACP 1998 - Strategic Plan (MTP-III 1998 - 2002)

EVALUATION

- Questions and answers.
- Evaluation of group work.

UNIT: 4.0

BASIC CONCEPTS OF COUNSELLING

INTRODUCTION

- While teaching this unit the facilitator should keep in mind that some patients receiving HBC services have already received pre and post counselling on HIV/AIDS. There may be some with chronic conditions (diseases) e.g. cancer, stroke with paralysis, and diabetes who have also been counselled on their conditions but need supportive counselling for existing problems/complications of their diseases. However, pre test and post-test counselling may be required for new cases.
- A Hospital Based Counsellor may be invited to come and teach this unit (as an area of her/his speciality)
- The counsellor /or HBC provider should be knowledgeable on HIV/AIDS and other chronic illnesses, and should use counselling skills in giving accurate information on diseases to avoid causing unnecessary anxiety to the patient and family.
- Confidentiality is the cornerstone of counselling.

OBJECTIVES

By the end of this unit the trainee will be able to:

i. define and differentiate counselling and advising.
ii. describe types of counselling.
iii. identify the key qualities and characteristics of an effective counsellor.
iv. describe the different counselling techniques.
v. practice key client-counsellor interacting skills.
vi. mention the Characteristics of a person living positively with HIV /AIDS.
vii. assist a person with HIV/AIDS live positively through proper counselling.

SUMMARY OF CONTENTS

I. Definition and functions of key terms.
ii. Types of counselling.
iii. Qualities and characteristics of an effective counsellor.
iv. The different counselling techniques.
v. Key client-counsellor interacting skills.
vi. List characteristics of a person living positively with HIV /AIDS.
vii. Living positively with HIV /AIDS.

CONTENT

- Counselling is a professional activity of helping a person/client to cope or make informed decision. It can easily be confused with advising especially in our society where advising is a major means of support.
- Advice is provided by a person who knows the other well while counselling is done where the people interacting may not know each other well but are bound by professional relationship.
- A counsellor rarely uses his own experiences but on skilful exploration of strength,

experiences and opportunities.

[redacted]

- Individual counselling.
  - Client centred
  - Counsellor centred
- Family counselling.
- Group counselling.
- Couple counselling.
- Nutritional and dietary counselling.
- Supportive counselling.
- Pre - test counselling.
- Post- test counselling.
- Coping with loss and bereavement.

[redacted]

- Knowledge : Committed to specialized knowledge in the field of counselling.
  - Knowledgeable of values, activities and social systems in their community.
  - Basic knowledge of common health problems in the working environment.

- Attitude and values:
  - Respecting other persons and their opinion.
  - Accepts differences in people (open mindness).
  - Tolerance.
  - Goodwill.
  - Recognition of worth of each individual.

- Behavioural
  - Flexible.
  - Genuine and non-dominant.
  - Concern for others
  - Acknowledges his or her limitations.

[redacted]

- **Joining**
  This is establishing a relationship with the client. It is a process, which starts when a counsellor meets a client and it continues right through the session.

- **Listening**
  Every client has a story to tell and the way you respond effectively depends on how you listen. It involves attending carefully to the client's verbal and not verbal messages. It is very important for counsellors to be in touch with their own thoughts and feelings and how these are interacting with those of the client. Are your own thoughts and feelings influencing your response?

  Listening occurs in two parts:
  - Listening to contents: this involves listening to the story as the client is giving it to you.
  - Listening to the process: this involves listening to the feelings, concerns, worries etc.

- **Empathy**
  Is an ability to see between the word through the other's eyes without judging them. One can only empathise when he/she has listened to the other's story and understood it.

  It is important to distinguish between empathy and sympathy. Sympathy involves feeling sorry for, while empathy involves feeling with the client. While sympathy disables empathy enables.

- **Questions**
  This is the primary tool counsellors use to obtain information or seek clarification.
  There are two types of questions
  - ***Closed questions*** -These demand short or one word answers e.g. what is your name? Where do you live? Are you married? etc. They are very useful for obtaining demographic data and at the opening stage of the session i.e. when joining. However, when over used closed questions may lead to interrogation rather than counselling, and makes the counsellor overworked.
  - ***Open-ended questions***-They demand long explanatory answers. These are the best to use in a session because they allow the client to talk more and also come up with their own solutions. Examples of such questions are: "can you tell me more about your relationship with your father?", or could you explain that? and how did you feel?

- **Clarifying**
  Counsellor checks his/her understanding of what the client has said by seeking clarification e.g. Are you saying that .....?
  Did I get you right.....?
  Correct me if I am wrong?
  Never make assumption in counselling, always seek to clarify. If you are not sure of the meaning check it out.

- **Commenting on the process**
  Sometimes the counsellors sense the client's change of mood when a particular topic is raised, or the client seems to get angrier and angrier by the minute. It helps to comment on the process. e.g. 'I notice that each time we talk about your father your voice drops to a whisper?, or You seem to be getting angrier and angrier as we are talking?'
  Sometimes the counsellor comments on the process when there is a discrepancy between the verbal and non-verbal e.g. client says, " I love my father very much" then promptly starts crying.

- **Summarising**
  This is a way of shifting out the less relevant material and also summing up the client's main concerns or issues discussed so far. Summary is used to check whether that counsellor has understood clients story, especially when changing topics e.g. moving from family system to school system.

- **Widening the system**
  When people are in crisis they usually forget the other people who can be there for them. Thus, widening the system is looking for support from any of the given systems sorrounding a person.

- **Taking a one down**
  This is a way of acknowledging the client's expertise in a certain area e.g. after talking to a person for 30 minutes; a counsellor cannot become an expert on the client's family or culture etc. A good counsellor would take a one down and say something like how are

such problems solved in your family or according to your culture?; or "what is expected of you at this age?"

- **Use of exceptions**
  Usually when there is a problem, it is not present 24 hours a day. There are times when it does not happen. When exceptions have been identified, what would be happening when the problem is not there? Can the exception be implified in order to eliminate the problem?

- **Externalising**
  Very often when we speak of a person with a problem, we attach a problem so firmly to a person that we make that person the problem, i.e. we often speak of an alcoholic, a schizophrenic, a bully, a delinquent, a bed wetter a liar etc.
  In counselling, the counsellor should externalise the problem by always talking about it as something separate from the client,s e.g. the problem is the problem and not the person.

- **Enactment**
  This is a technique used to make a counselling session different form being merely a talking session and is done by asking the client to act or show what happens when the problem arises. Clients can be asked to act out both the problem situation and the solution. Enactment gives the counsellor and the individual considerable information and helps in the formulation of intervention strategies.

- **Reframing**
  Involves taking a set of events described by the client and giving them back in a different frame. A reframe is best regarded as a different perspective rather than the truth. The aim is to shift the client's view but not necessarily to make him/her accept the counsellor's opinion.

  The purpose of reframing is to change the meaning that an individual or family attaches to certain behaviour or interactions, in such a way as to make the situation easier to change; e.g. nagging wife may be reframed as a caring wife. It is much easier to deal with a caring wife than a nagging one. Reframes are used to normalise situations which a client thinks are abnormal.
  There are four types of reframes

- **Normalising reframe**
  This involves normalising pathology for the developmental difficulties.
  - Coping reframe
    This is news of a difference. Counsellor picks up small things that the client did well and praises him/her for it.
  - Positive innovation
    Counsellor commends the individual or family for coming to seek help.

- **Scaling**
  Instead of asking clients to describe intensity of feelings or behaviours, scaling can be used and it gives more accurate information. For children scaling is best done using the hand show e.g. "Last time you were this angry, show me how angry you are today". With adults it is better to use a number scale of 0 -10 where 0 is not angry at all and 10 is extremely angry.

- **Empty chair**
  Empty chair technique is used to symbolically bring in an absent member of the family or significant persons. The counsellor might say to the client, "If your husband was sitting in

this chair, what would you say to him? How would he respond to that?, or if Mr. Kassim was sitting in that chair how do you think he would respond to what you have just told me?". The empty chair helps the counsellors to hear the voices of the absent people.

- **Use of silence**
  A counsellor needs to be comfortable with silence. Silence forces the clients to speak and share more. When a counsellor poses a question and the client does not respond immediately, the temptation is to simplify the question or ask another one.

5. THE KEY CLIENT-COUNSELLOR INTERACTING SKILLS

- **Basic skills**
  - Relationship building
  - Exploration
  - Understanding
  - Action plan.

- **Use of confidentiality and ethical consideration in counselling.**
  Confidentiality has two meanings:
  i. It means privacy i.e.
  - The right to protect from:
    - physical search, or
    - use of picture for advertising without consent.
  - To control information about oneself by:
    - restricting or preventing data collection,
    - restricting the use of personal information, and
    - imposing obligations of confidentiality to prevent un warranted disclosure of collected information

  ii. Confidentiality also means:
  - The obligation owed by one person to another, not to disclose information given by or about another, or the obligation to disclose it only in limited circumstances.

6. LIVING POSITIVELY WITH HIV/AIDS

Counselling of persons with HIV/AIDS is very important. The objective of counselling is to assist an individual with HIV/AIDS understand the problem he/she has and find ways and means of facing it. It also assists the individual to make the correct and best decision on how to continue living with the problem positively after accepting the situation. Proper counselling helps the affected person in reducing the psychological and physical effects, which would otherwise increase stigma.

Characteristics of a person living positively with HIV/AIDS.
- Not blaming anyone for the problem he/she has.
- Not feeling guilty or ashamed.
- Having positive attitude towards one-self and others.
- Following medical advice by seeking medical care quickly in case of infections such as bronchitis, thrush and skin sores.
- Eating plenty of foods rich in protein, vitamins, minerals and carbohydrates.
- Getting enough sleep and not getting overtired.

- Taking enough exercises to keep fit.
- Continuing to work, if possible.
- Occupying oneself with different activities.
- Receiving both physical and emotional affection.
- Sociallsing with friends.
- Receiving counselling to maintain positive attitude and express his/her feelings, whether angry, sad, blaming or hopeful.
- Always using a condom during sexual intercourse, even if both partners are HIV positive in order to prevent pregnancy and STDs.
- Avoiding pregnancy because it lower the body's immunity and hastens the outset of AIDS in HIV positive women.

TRAINER / TRAINEE ACTIVITIES.

- Brain storming.
- Lecture / discussion.
- Role-play.
- Demonstration
- Testmonies
- Video Shows
- Group work

RESOURCES

- NACP 1999 - A guide for AIDS Counsellors in Tanzania.
- NACP 1999 - Curricular for Training Hospital Based Counsellors and Supervisors.
- NACP 1999 - Skills manual for Hospital Based Counsellors.
- CONNECT- Zimbabwe Institute of Systemic Therapy 1998 - Systemic Counselling manual -1
- Janie Hampton - The AIDS Support Organization (TASO) Uganda
- AMREF 1990 - Living with AIDS: Strategy for Hope No. 2
- Ruth Sims and Veronica A. Moss 1995 - Palliative Care for People with AIDS - 2nd Edition

EVALUATION

Questions and answers.
Evaluation of role-play.

UNIT: 5.0

CARE OF THE HIV/AIDS AFFECTED CHILD.

INTRODUCTION

The problems of orphaned and sick children in Tanzania have considerably increased due to the HIV/AIDS epidemic. Many of the orphans in the country are left by a parent or both who had AIDS. Some who are more unfortunate are also infected with the HIV virus or are already sick due to AIDS.

Rarely do mothers know that they are HIV positive when pregnant, and that they can infect their unborn baby. When a child gets ill after birth or fails to thrive, blood tests are done and the parents may at times be told that their child is HIV positive. The child is the 'bad news bearer' .

OBJECTIVES

By the end of this unit the trainee will be able to:

i. identify the basic needs of a child affected by HIV infection.
ii. assist the mother / family in providing care to an HIV affected child.
iii. identify the basic needs of an orphan.
iv. identify the appropriate authorities in the community where orphans can be referred for assistance.

SUMMARY OF CONTENTS

i. Providing care to HIV infected child.
ii. Providing orphan support.
iii. Utilization of the referral system used in the community/district.

CONTENT

1. PROVIDING CARE TO HIV INFECTED CHILD

The basic needs of a child affected by HIV infections are: -

- breast feeding (after counselling on informed choice) and safe weaning.
- maintaining good nutritional status and safe weaning and provision of nutritious foods.
- maintaining and interpreting growth monitoring card.
- providing recreation for the child. (i.e. play)
- prevention of illness through immunization, safe environment and good hygiene.
- educating parents and caregivers on how to care for such a child.
- providing early and vigorous therapy for common paediatric conditions.
- ensuring the child has a good quality life.
- providing supportive care at home.

2. PROVIDING SUPPORT

Identify the basic needs of an orphan.

The basic needs of an orphan are: -

- proper feeding (breast or artificial feeding);
- love and affection;
- security;
- safe environment and clothing;
- proper feeding and weaning;
- growth monitoring through MCH clinic;

- quantity and quality of food;
- prevention of illnesses including immunisation and good hygiene; and
- psychological support through counselling and education to care takers.

3. UTILIZATION OF THE REFERRAL SYSTEM USED IN THE DISTRICT

- Assist the family with referral of orphans to appropriate authority/organisation according to the need and existing facilities in the district e.g. NGO.
- If a child is underfive, advise caretakers to take the child to MCH clinic for further advice and monitoring growth and development.

TRAINER/TRAINEE ACTIVITIES

- Lecture/Discussion
- Demonstrations
- Group work
- Plenary session

RESOURCES

Janie Hampton - The AIDS support Organisation (TASO) Uganda .
AMREF 1990 - Living Positively with AIDS - Strategy for Hope No. 2.
Ruth Sims and Veronica A. Moss- 1995. - Palliative Care for people with AIDS - 2nd Edition
WHO 1993 - Global Programme on AIDS/HIV prevention and care: Teaching modules for Nurses and Midwives.

EVALUATION

Questions and answers
Evaluation of clinical performance

UNIT: 6

THE CONCEPT AND PRINCIPLES OF HOME BASED CARING MODEL

INTRODUCTION

In giving care to anyone there are principles of care which, if adhered to, ensures appropriate care in a given situation. In HBC, a model has been derived where by the HBC provider be a professional, a family member or a community volunteer can follow and provide appropriate and quality care to the client/patient. This is known as the "Caring Model".

OBJECTIVES

At the end of the unit the learners will be able to: -

i. explain 'Quality Care' and its components.
ii. list categories of patients for Home Based Care.
iii. describe the Caring Model.
iv. list the common procedures done in HBC services.

SUMMARY OF CONTENTS

i. Definition of quality HBC.
ii. Components of Quality Care and its components.
iii. Categories of patients for HBC.
iv. Caring Model Process.
v. Common procedures in HBC.
vi. Infection control in HBC.

CONTENT

1. MEANING OF QUALITY HBC

The word Quality is used as a judgement of excellence in various situations. It can also be considered as doing the best with available resources, or expressed as doing the right thing in the right way at the right time.

Definition of Quality

Quality can be defined as a measure of how good something is. Something has quality if the object or the service meets or exceeds the expectation of the user.

Components of Quality Care

There are 10 components of quality.

i. **Policy:** The government has the responsibility of protecting the public from poor-quality. Therefore it has to have sound policies to protect the poor, unprivileged and the risk groups as one aspect of quality of care.

ii. **Technical competence**
This is the knowledge and skills which a health worker needs to have in order to do a good job. These are obtained through formal training, experience, on the job training and in continuing education.

iii. **Efficiency**
Efficiency refers to using the minimum amount of effort or resource needs to achieve intended results. It involves making the best use of the available resources. Efficiency minimises wasted time, drugs and other materials.

iv. Interpersonal relationship

The working relations between health workers, managers, patients, community and other sectors affect the quality of service provided. Good interpersonal relationships are essential in health services to build respect, confidentiality, trust, credibility, courtesy, responsiveness and empathy.

v. Effectiveness

Effectiveness is achieving the intended results (from the planned objectives). Since quality is measurable, methods of determining effectiveness are important as a way of monitoring performance.

vi. Access to service

This refers to the proportion of the people in a catchment area who are able to utilize the services e.g. in HBC:

- Some people may not be reached because of long distances from a health facility, the existence of bad roads, rivers, and mountains etc.
- Cultural barriers due to cultural beliefs and attitudes.
- Attitudes of the community HBC providers who may have negative attitude and lack confidentiality.
- Ignorance community should be educated on the HBC services provided in their area.

vii. Continuity

A good referral system, good record keeping, and keeping the patient informed about their conditions help to maintain continuity of care.

viii. Safety

HBC activities should be safe and able to produce desired results. The HBC provider must consider the safety of the patients, communities and themselves. The HBC provider should make correct diagnosis, give correct treatment and prevent cross infection while providing care to patients.

ix. Acceptability

Acceptability is interpersonal relationship. The patient, family and community will accept the services provided if there is satisfaction of the care given.

The attitude of HBC provider and time spent will influence the acceptability and utilization of the services.

x. Equity

There are two dimensions in ensuring equity in health care i.e. the issue of density and geographical distribution of health services. In HBC equity should be considered for all citizens irrespective of their gender orientation, colour, race, income and social status.

2. CATEGORIES OF PATIENTS

- Patients living with HIV/AIDS and other chronic illnesses may be categorised into 4 categories.
  - Those who can perform full range of activities.
  - Those who can perform limited activities.
  - Seriously ill and confined to bed.
  - Terminally ill.
- From the above categories, the care required differs;
  - The patient who is completely independent requires no or minimal caring help.
  - The patient who is totally dependent requires maximum caring help.

3. THE PROCESS OF THE CARING MODEL

The caring model should be used to identify and solve the problems of persons with HIV/ AIDS and other chronic illnesses.

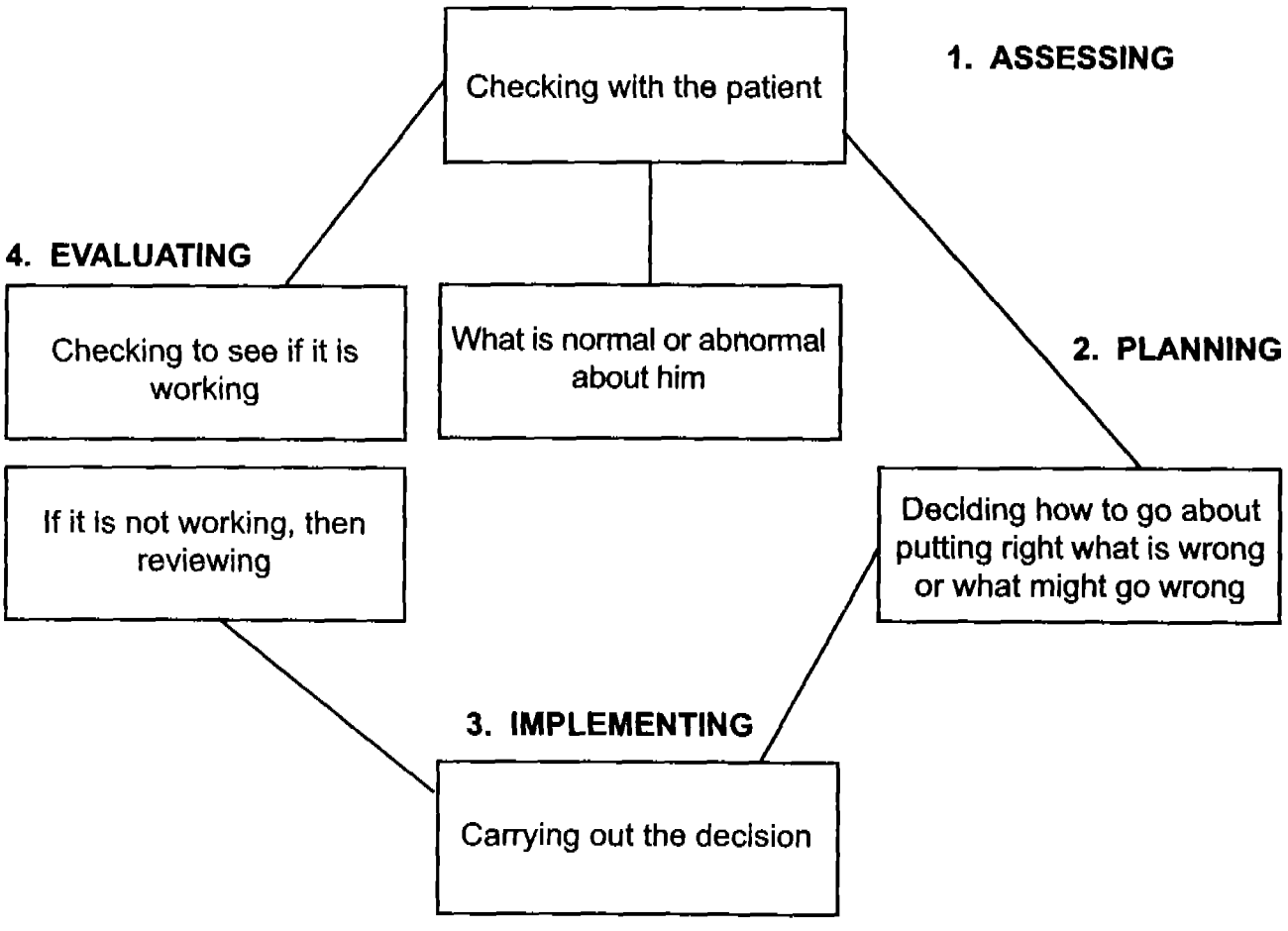


Figure 1: ILLUSTRATION SHOWING THE CARING MODEL

The process of caring has the following 4 steps:

I. Assessing.

* Assess the patient's health status/condition in order to identify her/his needs (physical, psychological, social, and spiritual) and problems and detect what is not normal.

This is done by:

- History taking.
- Physical examination (head to toe examination)
- Using the observation skills.

II. Planning

After identifying the needs and problems:

- Set objectives of care.
- Plan patient's care in priority order and involve him/her and family members in planning care and decisions making .

iii. Implementing

- Implement the planned decision (care) involving the patient and family.
- Use the principles of care to provide the basic nursing care to the patient based on the needs and problems of individual patient. The needs may be physical, psychological social and spiritual.
- The HBC provider/caregiver should remember that he/she is caring for a person, not just a body. Their feelings (patients) are important. Since every person is different, there are no rules about what to do or say. Here are some ideas that may help:
  - Respect the patients' independence and privacy
  - Keep them involved in their own care, dont do everything for them or make all their decisions. Nobody likes feeling helpless.
  - Have them do what they can. Everybody likes to feel useful, they want to be part of the group and contributing what they can.
  - Include them in the household e.g. make them part of the normal talk. Many people will want to feel involved in the things that are happening around them.
  - Talk about things. Sometimes patients may need to talk about their own situations/ illness e.g. AIDS as a way to think out loud.
  - Having chronic illnesses such as AIDS can make a person angry, frustrated depressed or scared. Listening, try to understand, showing you care and helping them work through their emotions is very important in HBC services.
- Meeting all the patient's needs, physical, psychological, social and spiritual is of prime importance in HBC.

iv. Evaluating

- Evaluate the care given using the objectives set.
- If objectives are not met, find out why and then replan.

4. COMMON PROCEDURES/ACTIVITIES DONE IN HBC

- Observation of vital signs (temperature, pulse, respiration)
- Bed making and methods of changing bed linen.
- Positions used in nursing
- Keeping the patient's environment clean and safe.
- Bed bath, Oral hygiene, care of hair and nails.
- Prevention of pressure sores.
- Feeding of helpless patients.
- Wound dressing.
- Administration of medicines.
  - Oral.
  - Injections (sub-cutenuous and intramuscular.
- Providing exercises (active and passive).
- Elimination maintaining bladder and bowel integrity.
- Recreation.
- Providing rest and sleep.
- Giving Health Education.
- Recording and reporting.

5. INFECTION CONTROL IN HOME BASED CARE.

In preventing the infections; the HBC provider educates the patients, family, and community by doing the following:

- Emphasizes hand washing with soap and water after handling soiled linen, or clothing having contact with body fluids and before and after performing procedures.
- Emphasizes covering all open wounds with dressing bandage or clean cloth - both HBC provider's and those of the patient.
- Uses a piece of plastic paper, gloves or big stick or leaf to handle soiled items.
- Washing and cleaning of clothing and equipment stained with blood, diarrhoea or other body fluids after soaking them in Hypochlorite solution.
- "no sharing" of sharp skin-piercing instruments, toothbrushes, razors, needles or anything which can cut or come into contact with blood.
- Emphasizes on practices which ensure good hygiene and proper disposal of wet and dry waste (dressings and excreta).
- Emphasizes on the use of clean linen and clothes.
- Avoidance of pricks needles and other sharp instrument used by the patient.
- Avoidance of mouth to mouth resuscitation.
- Protects AIDS patients from Malaria.
- Attends a patient who may be a source of cross infection last. (e.g. those with septic wounds)

TRAINER / TRAINEE ACTIVITIES.

- Lecture / Discussion.
- Role-play.
- Group work.
- Demonstration.
- Plenary session.

RESOURCES

- MOH 1999 - Quality Assurance Training Guideline for Health Workers
- U.S. Department of Health and Human Resources - Caring for someone with AIDS at home. A Guide
- WHO 1999 - HIV/AIDS prevention and care: Teaching module for Nurses and Midwives.
- NACP 1999 - Guideline on HBC services in Tanzania.
- NACP 1999 - Mwongozo wa Kuhudumia Wagonjwa Majumbani.

EVALUATION

- Questions and Answers.
- Evaluation of role-play.
- Evaluation of trainees during field practice.

UNIT: 7.0

COMMUNITY PARTICIPATION AND INVOLVEMENT IN HBC

INTRODUCTION

The community is the key actor in HBC activities. It is therefore important for the community to have a clear understanding of the nature and functions of HBC; that HBC is part and parcel of their daily activities. The community has the responsibility for planning, management and maintenance of the HBC services.

In order to achieve community understanding of HBC, it is important to sensitise and raise the awareness of medical personnel and other professionals, government leaders, non-governmental organisations and community leaders e.g. religious leaders.

OBJECTIVE

By the end of this unit the trainees will be able to:

i. explain the concept of community participation and involvement.
ii. describe the strategies for community participation and involvement in HBC services.
iii. mobilize the community in support of HBC activities for persons living with HIV/AIDS and other chronic illnesses.

SUMMARY OF CONTENTS

I. Overview of community involvement and participation.
Ii. Collaborate with community leaders and other key people in the community.
Iii. Network in the community.
iv. Modalities for sensitisation.
v. The community actors to be involved in the sensitisation.

CONTENT

CONCEPT OF COMMUNITY PARTICIPATION & INVOLVEMENT

Since time immemorial people have lived and worked together in certain situations to attain specific goals on self help basis. Situations where people work together include:-

- initiation function e.g. in *Jando* and *Unyago,*
- marriage ceremony,
- resolution of family quarrels,
- road construction,
- school/dispensary construction , and
- burial ceremonies.

For HBC to succeed there should be active community involvement and participation in the promotion of the services, the community is the key actor in HBC activities. It is therefore important for the community to have a clear understanding of the nature and functions of HBC. The community needs to understand that HBC is part and parcel of its daily activities, along with the responsibility for planning, management and maintenance of the HBC services.

Forms of Participation:

i. Spontaneous (empowering) - This is based on local initiatives which have little or no external support and which from the very beginning have the capacity to be self sustaining.
ii. Induced (Contribution) - This is the most common which results from external initiative seeking support or endorsement from external plans.
iii. Compulsory - People are mobilized or organised to take part in activities in which they have had no say or control.

OBJECTIVES OF COMMUNITY PARTICIPATION AND INVOLVEMENT IN HBC SERVICES

* To assist communities to identify their health and development problems through understanding of HBC as an essential part of the health care system.
* To assist the communities to identify and mobilize resources available locally and else where for HBC services for chronically ill patients.
* To assist communities to plan and implement HBC activities aimed at supporting chronically ill patients in the communities.

- Community education, sensitization to raise awareness, mobilization for action to solve their problems and organization.
- Identify and train HBC providers and patient care providers on the house based care model and its operation.
- Strengthening home based care management information system which is appropriate and efficient.
- Inter sectoral coordination and collaboration of actors from village level to district level.
- Identification and supporting of economic groups conducting income generating activities.
- Identification and utilization of resources available locally as well as resources from else where.
- Identification and utilization of community organizations and structures.
- Availability of essential and appropriate medicines.
- The district to strengthen community health care service delivery systems and integration of vertical programmes.
- Conduct operational research on HBC and use the findings for re-planning and implementing HBC activities.
- Find ways and means to be used by the community to reward or remunerate the community HBC providers.

Community sensitization is a process of creating awareness to the community. Awareness is defined as ability to understand, to realise, to know or to appreciate.

- The community actors to be involved in the sensitization include:-
  - Community development officials from village to district level,
  - District PHC committee and District Health Management Team,
  - Religious leaders,
  - Teachers,
  - Politicians - Members of Parliament, Ward councillors,

- The Media,
- Other relevant people and institutions.

- Modalities for Sensitization:-
  - Meetings,
  - Preaching,
  - Seminars,
  - Newspaper, TV, leaflets, brochures, Posters,
  - Cultural Youth and Women groups,
  - Drama,

- **COMMUNITY SENSITIZATION PROCESS**

1. Adoption of correct attitude	Professionals who have positive attitude towards the community and primary health care can positively sensitize the community.
2. Identification of problems of concern to the community	Sensitization should revolve around health and development problems that are of concern to the community; if not based on relevant problems or concerns of the community, sensitisation will not be effective.
3. Correct identification of entry points	Proper entry point to the community should be sought. The entry point will vary from community to community eg. it may be chiefs, or Traditional leaders. It should be realised that leadership of any community must be sensitized. Leadership can be a bottleneck if not involved.
4. Utilization of community resource people	it is important to utilise community resource people in the process of sensitization. These are people who have shown some leadership or qualities, or are charismatic and can mobilize the community. A careful analysis of the community to identify these people is important.
5. Planning, patience and persistence	The process of sensitization is a process towards attitude change. This can be slow and frustrating at times - careful planning, assessment and patience is needed. Care is required in the process of dealing with peoples attitudes; it is slow and should not be taken for granted. One community meeting or one awareness workshop does not mean that people have been sensitized or their attitudes changed. A number of discussions and dialogue with the community and professionals need to take place.

4. ROLES AND RESPONSIBILITIES OF THE COMMUNITY IN HBC SERVICES

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

TRAINER / TRAINEE ACTIVITIES

- Lecture / Discussion
- Role-play.
- Group work
- Plenary session

RESOURCES

- NACP 1999: District Guideline for Community involvement and participation in HBC for chronically ill patients and the role of Traditional Healers.
- 1997 UNAIDS Technical Upadate. UNAIDS Best Practice Collection: Community Mobilization and AIDS
- NACP 1999: - Guideline for Home Based Care Services in Tanzania.

EVALUATION

- Questions and answers.
- Evaluation of role-play.
- Evaluation of trainees during field practice.

UNIT: 8.0

TREATMENT AND MANAGEMENT OF THE MOST COMMON CONDITIONS IN HBC

INTRODUCTION

The Home Based Care provider will manage and treat common conditions of patients with HIV/ AIDS and other chronic conditions in the home together with the family. This will enable the patient to live a healthier life.

OBJECTIVES

By the end of this unit the trainee will be able to:

i. provide treatment and management of the most common conditions seen in persons with HIV/AIDS and other chronic illnesses.
ii. refer the patient to a health care facility if the condition worsens or those conditions which cannot be managed at home.

• SUMMARY OF CONTENTS

i. Common opportunistic infections due to lowered body immunity after HIV infection.
ii. Treatment and management of the most common conditions seen in persons with HIV/ AIDS and other chronic illnesses.

CONTENT

1. TREATMENT AND MANAGEMENT OF THE MOST COMMON CONDITIONS SEEN IN PLHAs AND OTHER CHRONIC ILLNESSES

- Refer to:
- NACP 1999: *Mwongozo wa Kuhudumia Wagonjwa Majumbani.*
- NACP 1999: Guideline for Home Based Care Services in Tanzania.

2. COMMON CONDITIONS SEEN IN PLHAs AND OTHER CHRONIC ILLNESSES

The most common conditions seen in Persons Living with HIV/AIDS (PLHAs) and other chronic illnesses include:

- Fever - which may be caused by bacterial infection, viral infection and malaria.
- Diarrhoea - which may be caused by contaminated food or water, worm infestation, some drugs and viral infection of the G.I.T. (HIV enteropathy).
- Skin conditions - such as dry peeling skin and itching skin caused by poor nutrition, and skin diseases.
  - Skin rash, bruises and small wounds - caused by skin disease and drug allergies.
  - Boil caused by infection and poor skin hygiene.
  - Pressure sores - caused by pressure on the pressure points seen in bedridden patients.
  - Herper Zoster caused by zoster virus.
- Mouth and throat conditions e.g. candidiasis or thrush and herper simplex (caused by high fever).
- Nausea and vomiting - caused by - viral infection, malaria, gastro enteritis, and some drugs taken by patient.
- Cough - caused by: - common cold or "flu"
- Chest tightness, dyspnoea and rapid respiration caused by:
  - Pneumonia, Tuberculosis and Cardiac diseases.

- Tuberculosis - caused by Kochís Bacillus (AFB).
- Pain -caused by HIV/AIDS opportunistic infections and other chronic illnesses.
- Anxiety and depression - caused by psychological effect of the HIV/AIDS and other chronic illnesses or brain involvement by the virus.
- Genital ulcers and discharges caused by - sexually transmitted diseases, candida, and other diseases.
- Tiredness and weakness - caused by - anaemia, poor nutrition, infections and depression.
- Kaposi's Sacroma - cancer of the skin (Kaposi's)

TRAINER / TRAINEE ACTIVITIES

- Lecture discussion.
- Demonstration.
- Group work.
- Plenary session.

RESOURCES

- NACP 1999: *Mwongozo wa Kuhudumia Wagonjwa Majumbani.*
- NACP 1999: Guideline for Home Based Care Services in Tanzania.
- 1995 Gimenez Lambert A: Module 3: Nursing Care. A comprehensive Guide for the Care of Persons with HIV Disease.
- WHO/GPA HIV Prevention and Care: Teaching Modules for Nurses and Midwives
- U.S. Department of Health and Human Service, CDC: Caring for someone with AIDS at Home. A GUIDE

EVALUATION

Questions and answers
Evaluate work performance during fieldwork.

UNIT 9.0

CARE OF THE TERMINALLY ILL AND THE DIEING PATIENTS IN HBC

INTRODUCTION

In life dieing is inevitable. To the family caring for their dieing relative in the home it is a difficult time but has to be prepared for. As patients with chronic illnesses prefer being in the home, so do they prefer dieing in the familiar surroundings of their homes. In HBC, it must be remembered that there is no clear line of when a person will die - life maintenance and even hospitalisation is advocated.

OBJECTIVES

i. Assist the patient and family in providing care to the terminally ill person or patient with HIV/AIDS and other chronic illnesses.
ii. Describe the stages of terminal illness and dieing.
iii. Assist the dieing patient / family in caring for the dead body.

SUMMARY OF CONTENTS

I. The stages of terminal illness and dieing.
ii. Care of the terminally ill and dying patient.
iii. Care of the dead body.

CONTENT

1. STAGES OF TERMINAL ILLNESS AND DYING

Like grief the dying patient passes through 5 stages.

- **Stage of denial:** "No, Not me"
- **Stage of anger:** "Why me?"
- **The stage of bargaining:** "If I live oh God...."
- **Stage of depression:** "Poor me"
- **Stage of acceptance**

* Note that the 5 stages of dieing may occur rapidly but in some cases each stage may take a few hours or up to several days.

2. CARE OF THE TERMINALLY ILL PATIENT

- allow the patient to live as full a life as possible.
- relieve his discomfort and distress.
- provide for his needs in the different stages.
- help the patient achieve death with dignity.

3. CARE OF THE TERMINALLY ILL/DOING PATIENT

Those caring for the terminally ill or dying patient should know that even the uncounscious patient can hear and also feel pain. So care should continue to the very end; including hygiene, grooming, nutrition, love and attention.

- The person can be encouraged to talk about death if he/she wishes.
- Counselling of the patient and family members is essential, during the different stages of dieing.
- Cultural norms are followed on planning for:-

- whom to inform after death.
- place of burial.
- what is to be done to the patient after death. ie. cleaning the body, dressing, prayers and the burial ceremony.

- Use the HBC caring process to identify the patients needs and problems to plan for his/ her care.
- Verbal communication is encouraged throughout the care, so that the patients dignity is maintained.
- You dont always have to talk, just being there is sometimes enough.

The following are some of the nursing care needed for the terminally ill and dying patient:

A. PROVIDE COMFORT

Comfort can be physical, mental, spiritual and social. The following are some of the interventions to meet these needs.

I. Physical

- Respiration: a clear airway must be maintained.
  - Position the patient comfortably so that breathing is not interfered with.
  - Removal of excess mucus/sputum from the month by available means; to enable free passage of air.
- Nutrition is promoted to the optimum level possible. Rehydration is done when needed.
- Pain relief is promoted through position, cold/warm compresses, medications etc.
- Elimination is maintained safely and the patient is left clean and dry.
- Personal hygiene and grooming makes him feel good.
- Pressure areas are cared for to prevent pressure sores.

II. Mental:(emotional, and pschological)

- The family should support the dieing patient emotionally.
- Many like companionship and feel relief on being touched.
- The patient should be encouraged to hope - It is therapeutic. Hope goes away after the acceptance stage. The family or HBC provider must avoid reinforcing hope after the patient has accepted dieing (Given up hope).

iii. Spiritual

- The patient may need prayers, so a religious leader may be requested to attend to his/ her spiritual needs.
- Some request for scripture reading.

iv. Social Needs (Be close to relatives and friends)

- HBC encourages the family to be together.
- Companionship is needed by the terminally ill patient.
- Activities e.g play cards could help him take his mind off his condition.
- He/she may want to tell stories and needs attentive listeners who encourage him to continue.

B. AUTONOMY

Independence is encouraged:

- Those activities he can perform are encouraged.
- If he refuses eg. food, getting up he is not forced.

- Requests: Wishes are respected and requests are met to the best ability of the family.
- Personal feelings are accepted as they are, although they can be quite strange.
- Writing a will:
  - When a dying patient has accepted his condition he may wish to leave his estate in order. e.g. Will writing should be encouraged.
  - Counselling for writing a will should be done and the written document be duly signed and witnessed. This will make it into a legal document.

C. COPING WITH LOSS AND BEREAVEMENT

- Support - the patient and relatives may feel relief when they are able to talk about their feelings.
- Since the HBC provider will deal with clients/patients with chronic illnesses, it is essential that she knows how to deal with the family members, relatives and friends. She/he should remember that people are undergoing a very difficult time for it is not easy for them to cope with the loss of the loved one. Bereavement is a state of acute distress which is a company with a sequance of emotional reactions. It is important that a HBC provider understands this and supports them to move from one stage to another. Though in the later stages, they can work out what to do next and find a new integrity, they need to voice their ideas to check with another person.

4. PREPARATION FOR DEATH

The family should be prepared for the death of their relative, although it is customary to hope and not to give up.

Those caring for the terminally ill or dying patient should know that even the uncouncious patient can hear and also feels pain. So care should continue to the very end; including hygiene, grooming, nutrition, love and attention.

- The person can be encouraged to talk about death if he wishes.
- Counselling of the patient and family members is essential, during the different stages of dying.
- Cultural norms are followed on planning for:-
  - Whom to inform after death
  - Place of burial.
  - What is to be done to the patient after death. ie. cleaning the body, dressing, prayers and the burial ceremony.

5. CARE OF THE DEAD BODY

Precautions and care the family need to take of the dead body of a person who died after HIV/AIDS e.g.

- Wearing gloves when handling the body.
- Not touching blood, faeces, urine and other body secretions with bare hands, always wear gloves.

- Cover all open wounds/ulcers with plaster or bandage.
- Pack with cotton wool all body orifices (opening).

TRAINER/TRAINEE ACTIVITIES

1. Lecture/Discussion.
2. Demonstrations.
3. Group work.
4. Plenary session.

RESOURCE

- Janie Hampton - The AIDS support Organisation (TASO) Uganda
- AMREF 1990 - Living Positively with AIDS - Strategy for Hope No. 2.
- Ruth Sims and Veronica A. Moss 1995. - Palliative Care for people with AIDS - 2nd Edition
- WHO/GPA 1993 - HIV prevention and care: Teaching modules for Nurses and Midwives.
- NACP 1999 - Trainer's Guide for Home Based Care Providers

EVALUATION

- Questions and answers.
- Evaluation of clinical performance while caring for terminally ill patients during fieldwork.

UNIT: 10.0

SUPERVISION AND MONITORING OF HBC ACTIVITIES

INTRODUCTION

All HBC activities must be supervised so that the service objectives are met to the highest level possible. Supervision in HBC is done at both health facility level to the community level. Standards that have been set will be the parameters in guiding both the supervisor and those being supervised. Monitoring forms for HBC have been intergrated into the MOH Health Management Information System [MTUHA]

OBJECTIVES

By the end of this unit trainees will be able to:

i. define the terms supervision standards and monitoring,
ii. discuss the importance of supervision in HBC,
iii. describe the process and stages of supervision, and
iv. utilise the supervision forms and the data collected for planning future HBC activities in the district.

SUMMARY OF CONTENTS:

i. Definition of terms related to supervision, standards and monitoring.
ii. Importance of supervision.
iii. Process and stages of supervision.
iv. Supervision forms and the data collected for planning future HBC activities in the district.

CONTENTS

1. SUPERVISION

i. Definition of supervision in HBC

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

ii. Importance of supervision

- Assisting the staff to improve their performance.
- Ensuring uniformity to set performance standards.
- Identification of problems and solving them at appropriate time.
- Maintaining and reinforcing the administrative and technical link between high and lower levels.
- Follow-up decision reached during last supervision visit.
- Identification of staffing needs.

iii. Process and stages of supervision

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

- **Stage one: Preparation,**
  - Identify priority issues for supervision.
  - Review objectives, standards and level of performance.

- Prepare a checklist to be used for the supervision.

- **Stage two: The Supervision visit**
  - Introduction of supervisor (s).
  - Explain purpose and objectives of the visit.
  - Observe the health workers performing their duties and tasks using a prepared checklist (standards).
  - Determine performance gaps and problem.

- **Stage three: Immediate feedback**
  - Findings are discussed immediately by giving results of evaluation of performance to the workers i.e. good points, weak points and suggestions for improvement.
  - Workers should be encouraged to think on how to solve their problems instead of relying on the supervisors.
  - Both the supervisors and workers must agree on the course of follow-up action.

- **Supervision Report**
  The purpose of writing supervision reports is to inform the supervised HBC provider and those who have authority to make decisions.
  - Checklist of issues for HBC Supervision.

This includes questions related to:

1. Monitoring forms (tools)
2. Equipment, drugs and supplies
3. Performance assessment of the HBC provider.

2. STANDARDS

- **Definition of standards**
  Standards can be defined as a quality measure serving as a basis to judge the level of excellent performance. It is a statement of expected quality and makes clear the organisation expectation for quality. (A checklist is a type of standards used in supervision to ensure that a task is carried out properly and is complete).

- **Characteristics of standards**
  - Clear - should be clear and easy to follow by the user.
  - Realistic and applicable - set standards should be achievable within the available resources including staff, equipment, finance etc.
  - Reliable - they should be based on sound principles, scientifically, socially and culturally accepted. When they are followed they should produce similar results and outcome.

- **Use of standards**
  - The uses of standards are to:
  - Improve health services delivery.
  - Help self assessment.
  - Support supervision.
  - Inspect (evaluation).

- **Standards should be:**
  - Communicated adequately to those who are responsible for implementation. Understood and accepted by users.
  - Displayed at service delivery point. (work place)

[redacted]

Refer to: NACP 1999 - Guideline for Home Based Services in Tanzania (Under: Levels and Scope of Supervision)

[redacted]

Refer to: Guideline for Home Based Services in Tanzania: (Under Guidelines for referral.)

[redacted]

- Using HBC Monitoring form integrated into the Health Management Information System (MTUHA).
- The HBC provider has to use the HBC monitoring forms in order to monitor HBC activities. These forms will be used at community level and at health facility level.

Types of HBC monitoring forms

1. Form No. 1: Home Based Care Monthly Report.
   - Copy at the Health Facility.
   10 Copy to the HBC provider.
2. Form No. 2: Home Based Care Quarterly/Annual Report.
   11 Copy at the Health facility.
3. Form No. 3: Monthly Report from Dispensary/Health Centre. (For Supplies/equipment/ drugs) - Copy at the Health Facility.
4. Form No. 4: Patient's Referral Form.
5. Form No. 5: Patient's Consent to pass information to third party.
6. Form No. 6: Numerical Scoring Chart. (used in Supervision)

TRAINER/TRAINEE ACTIVITIES

- Brief lecture/Discussion.
- Trainees to practice filling in each form.

RESOURCES

- NACP 1999 - Guideline on HBC services in Tanzania.
- HBC Monitoring and Evaluation instruments.

- **EVALUATION**
  Trainer to check how the forms are being filled in.
  Questions and Answers.

UNIT: 11.0

PRINCIPLES AND THE CONCEPT OF TEACHING AND LEARNING

INTRODUCTION

- This unit will assist the facilitator (T.O.T) in the process of teaching and learning.
- The T.O.T is assumed to be a person who has been described in the National Course Plan. He/she could be a Nursing Officer, Clinical Officer or Medical Officer with some experience in teaching/training activities.
- The T.O.T will revise the knowledge of principles of learning and teaching acquired during her/his basic training and adds on the principles stipulated in the National Course Plan for training HBC providers.
- The trainees will have to be taught on how to prepare lesson plans and conduct micro - teaching in class before field practice.
- Evaluation and grading of each micro - teaching has to be done. Evaluation will continue during field practice, when the trainee will be giving health education to patients, families and community.

OBJECTIVES

By the end of this unit the trainee will be able to:

i. describe principles of learning,
ii. explain how learning can be promoted by the facilitator.
iii. describe different teaching methods/aids
iv. utilize the principles of teaching and learning when giving health education to the patient, family and community.

SUMMARY OF CONTENTS

i. principles and concepts of teaching and learning.
ii. domains of learning i.e. Knowledge, Attitude and Skills.
iii. how facilitators can promote learning.
iv. teaching methods.
v. teaching learning aids.

CONTENT

1. TEACHING AND LEARNING

- Review principles and concepts of teaching and learning.
- Review the three domains of learning i.e. Knowledge, Attitude and Skills.
- Motivation.
- Motivation accelerates learning especially self-motivation, thus a motivated person learns faster than the one who is not motivated.
- Readiness to learn.
- General Education background, intellectual ability and individual attitude makes one ready to learn and accept responsibility.
- Age of the trainee (too young or too old) will affect learning.
- Setting of realistic goals.
- Realistic goals, which are achievable, enhance effective and efficient learning.

Learners capacity to learn

- Learners learn in different ways and at different rates and speed. (Always consider individual differences when teaching).

- Learning situation
- Knowledge is useful when learned in a situation similar to where it will be applied.

[illegible]

- Learning takes place at different paces in different individuals.
- Learning must be rewarded or reinforced.
- People learn by selective perception.
- Active participation promotes learning.
- Practice/repetition are essential.
- Things are learnt better if they are sequenced from simple to complex or known to unknown.
- Objectives are essential for effective learning.
- Feedback on performance is important in learning.

[illegible]

- Establish good facilitator/participant relationship.
- Consider participants as individuals with different needs and abilities.
- Motivate participants by providing a conducive physical and social environment.
- Give feedback to participants (Tell them how they are doing).
- Help participant to learn relevant materials.
- Organise what is to be learned systematically.
- Use different teaching methods/skills which make the learner be active.

[illegible]

- Must have a command of theoretical knowledge about learning and human behaviour.
- Display of attitudes that foster learning and genuine human relationships.
- Command of knowledge in the subject matter to be taught.
- Control of technical skills of teaching that facilitate learning.

[illegible]

- **LECTURE** (Some times knows as Telling Method)
  Is a form of classroom activity where the teacher in his role as a communicator or informer during a lesson, talks to his students in an autocratic way. In its pure form, student have no opportunity to ask questions or offer comments during the lesson.

- **DISCUSSION**
  A discussion is a leaning activity where a teacher and his students talk together in order to share views, ideas and information about a topic or problem. They talk together in order to solve a particular problem. The discussion can be a guided one where the teacher uses a number of questions related to the topic under discussion in order to control its direction.

  As a teaching method in a modern classroom, it allows the teacher to give some room to his students to take part in a lesson through sharing ideas and points of view on a particular topic.

- **DEMONSTRATION**

  This is a teaching method where by a teacher performs an instructional activity in the presence of his students in order to show them how to do it; for example dressing a wound.

- **THE ROLE-PLAY**

  It is a teaching method involving a spontaneous portrayal of a situation, condition or circumstances by selected members of a learning group.

B: TEACHING AND LEARNING AIDS:

These are materials which a teacher uses in a lesson in order to help him teach effectively. They also help students to understand what they are being taught more easily.

There are many different types of aids. Some examples of teaching - learning aids are:-

- Chalkboard;
- Flip chart;
- Posters;
- Overhead projector; and
- Slide projector.

Effective teaching and learning aids should be:-

- acurate and relevant;
- appropriate for a particular age group;
- attractive so that they can attract learners attention; and
- brief, clear and simple.

CATEGORIES

- Visual aids:- These are aids which help pupils to learn through seeing. e.g. chalkboard, and posters.
- Audio aids:- Are materials which produce sound and therefore help learners to learn through hearing eg. tape recorders.
- Audio - Visual aids:- These are materials which help student to learn by using both the senses of sight and hearing e.g. sound films, Television, and Video.

THE IMPORTANCE OF TEACHING AND LEARNING AIDS

- They arouse student curiosity and motivation and at the same time sustain student attention throughout the lesson.
- They help the teacher to clarify points.
- They reinforce memory.
- Aids help students in acquiring listening and observational skills.

TRAINER AND TRAINEES ACTIVITIES

- Lecture / Discussion.
- Practice microteaching.

RESOURCES

- Ford and Morgan 1976 -Teaching in the Health Professions.
- Leaky, Cobb, Jones1972 - Community Health Nursing.

3. NACP 1999 - National Course Plan for training HBC providers.
4. Dr An Browne - Course guide for administrators and trainers for the health service research.

EVALUATION

- Questions and answers.
- Evaluation of micro-teaching.
- Evaluation of Health Education Sessions during field practice.

UNIT: 12.0

FIELD WORK, FEEDBACK, REVISION AND EVALUATION:

SOME GUIDELINES

1. The 3rd and 4th week of training is allocated to field practice on HBC in patient's homes.
2. Clinical objectives will be prepared by the trainer and given to each trainee before they depart of the fieldwork.
3. This practice will be supervised by the trainer (s) until such a time the trainees can work on their own.
4. The work performance of each trainee will be evaluated continuously.
5. Daily work plans, objectives and daily diary will have to be prepared by each trainee.
6. At least three assessments should be done and graded for each trainee.
7. Assignments (individual and group) should be given in time and they should be graded at the end of fieldwork period.
8. Guidelines should be given to trainees to guide them with report writing.
9. There will be report presentation of all HBC activities done during the period of field practice on the application of theory learned during the 1st and 2nd weeks of training (feedback).
10. Patient's relatives (caregivers) and community leaders should be invited to attend report presentation sessions in order to have their inputs, and have feedback.
11. All procedures of community nursing should be followed and applied throughout the period of fieldwork.
12. During the 5th week, trainees will report back to the training centre ready for revision and a POST-TEST will be administered at the end of training period.