

**Continuum of Care – Linkages**  
***General HBC reporting to Government Clinics***  
***November 4, 2005***

The following piece of information is written to give you a broad overview of how home-based care (HBC) programs are organized in Zambia, the role the Zambian government (primarily, the Central Board of Health and Ministry of Health) plays in supporting such organizations, the information passed between the government and private organizations, and the future linkages required as home-based care becomes recognized as an essential component of Zambian healthcare.

Home-base care began in Zambia 15-20 years ago, mainly through the work of Faith-based Organizations (FBOs). More recently, NGOs have joined the scene, but the FBOs throughout Zambia appears to be providing the majority of home-based care. With the arrival of ART in Zambia, a new realization of the importance of home-based care is beginning to motivate the government to increase its involvement in home-based care; the ART-related clinical challenges of adherence and managing side effects is bringing government health departments, now more than ever, to recognize home-based care as an essential community-level service for identifying, referring, and monitoring HIV positive patients. In reality, the government does not have the capacity to perform these services, and whether they admit it or not, they need the FBOs to be filling this gap. Similarly, because many of the clinics and hospitals from which HBC patients come and go are government run and funded, there must be an information linkage. As the government begins to be interested in obtaining the data from the HBC organizations, an additional challenge is arising: FBOs and NGOs are reluctant, or at best, unmotivated, to hand over such information due to lack of incentives and support by the government for their programs. Current support provided by the government for home-based care includes:

- ❖ Technical assistance and capacity building through training (although many FBOs have grievances about the cost and lack of quality)
- ❖ Staff support in the form of community nurses to oversee home-based care workers
- ❖ Home-based care worker kits, typically including pain killers, anti-malarials, bandages, and cotton swabs (on a minimal basis)

Provided their differences can be mended and that FBOs and NGOs start providing more information to the government, it will be helpful to understand how the government information chain is structured in order to develop a model for integrating HBC data into the government collection system. All data gathering is mandated on the national level by the Central Board of Health (CBOH). Information is passed from the District Health Management Teams to the Provincial office to the CBOH. Each District is further divided into zones or catchment areas, but there is not necessarily a dedicated health center in each zone. Information flow begins at District Health Centers (there are multiple Centers in each District). Tallies on critical indicators<sup>1</sup>, most of which are not

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<sup>1</sup> Critical indicators for districts and hospitals recorded per 1000 people include: Antenatal visits, institutional deliveries, trained deliveries, new family planning, fully immunized children, health care client contacts, malaria incidence, and measles. HBC-specific indicators need to be developed.

relevant to HBC, are kept in carbon copy record books. At the end of each month, these tallies are delivered by hand to the District's Data Collection Officer, who aggregates the District data in a computerized format. The aggregated data is delivered quarterly (typically by hand) to the Provincial Data Collection Officer, who then aggregates the Provincial data for the CBOH within the national Health Management Information System (HMIS). In the Ndola Province, the District has recently been connected over the internet, but hand delivery of records remains the practice namely because the face-to-face interaction becomes a way for ensure quality of data collection. As a result, HBC data collection most naturally begins at the health centers because that is where the information flow commences, and that is the level which most often interfaces with HBC programs either through referrals or overlap in nursing staff. Questions still remain, though, on how to provide incentives for data reporting; the critical indicators for HBC; and the logistics of extracting data from the home-base care workers' patient data.

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