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Field-testing Costing Guidelines for Home-based Care: The Case of Uganda

July 2005

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Order No TE 070

Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- *Implementation of appropriate health system reform.*
- *Generation of new financing for health care, as well as more effective use of existing funds.*
- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

July 2005

Recommended Citation

Musau, Steve, Catherine Chanfreau, and Lennie Bazira Kyomuhangi. July 2005. *Field-Testing Home-Based Care Costing Guidelines: The Case of Uganda*. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

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Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: USAID/Uganda

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United States Agency for International Development

Abstract

There is a growing acknowledgment of the importance of the continuum of care and support services to people living with HIV/AIDS outside of health facilities. Greater reliance on communities to provide care and support to people living with HIV/AIDS as well as non-complex maintenance and adherence support for treatment of those who are under antiretroviral treatment is seen as a way to alleviate the burden placed on traditional health systems in countries highly affected by HIV/AIDS. This report presents findings from the field-test of the Partners for Health Reform*plus* (PHR*plus)* guidelines developed for costing home-based care (HBC) programs, with cases drawn from nine HBC programs in Uganda. Findings The guidelines help the user to define the core HBC activities and to collect appropriate cost and service data.

The guidelines were found to accommodate diversity in HBC service configuration and modes of delivery. Questionnaires were easy for data collectors to implement and respondents to comprehend. The data collection process benefited from respondent sensitization to which data are needed prior to the actual data collection visit. The questionnaire was expanded during the field-test and question order will be modified to expedite future data collection. Importantly, the guidelines' costing boundaries were found to effectively limit what is to be counted in the HBC costing exercise.

Regarding the cost findings themselves, costs vary greatly among Ugandan HBC providers depending on staffing patterns, types of medical care provided, and other support to families, especially nutritional supplementation. Staff costs are the most significant cost item; for five of the programs, it is costliest item and, for another two programs, it is the third costliest. The next five costliest items are transport, training, medical supplies, food, and capital costs. Support to orphans and families of AIDS patients are not widespread: only four of the programs studied have an orphan care component. However, direct assistance to orphans, especially school fees and supplies, is a significant cost for the programs that provide it. Volunteer incentives are the lowest cost.

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Acronyms

ARV	Antiretroviral Therapy
HBC	Home-based Care
OI	Opportunistic Infection
PHR*plus*	Partners for Health Reform*plus*
PLWHA	People Living with HIV/AIDS
TASO	The AIDS Support Organization
TB	Tuberculosis
Ushs.	Ugandan Shillings
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Acknowledgments

The authors are grateful for the support of numerous people who participated in this field-test in Uganda of the home-based care (HBC) costing guidelines developed by the Partners for Health Reform*plus* (PHR*plus*) project.

We are especially indebted to the Ministry of Health, Uganda, for the support received from Dr Elizabeth Madraa and her staff, Margaret Muwonge and Domitilla Odongo-Aginya. This study would not have been possible without the participation of the HBC programs that so kindly agreed to be part of this field test. We are indebted to the following HBC programs: Hoima Hospital Home Care Program (Giorgia Saporetti, Stephano Antonetti); Hospice Africa Uganda, Kampala (Dr Ekiria Kikule, Fatia Kijange, Catherine Nawangi, Tom Duku, Manjit Kaur); Kitovu Mobile Home Care and Orphan Support Program (Madinah Nantumbwe, Nabakooza Afisah, Joseph Kamya, Robert Yiga); Meeting Point Namuwongo, Kampala (Noel Namukisa); Mengo Hospital Home Care Department (Alex Bogere, Dorothy Nansubuga); Nsambya Home Care Department (Lawrence Sekimpi-Kirwana); Reachout Mbuya Parish (William Stanley, Dr Margaret Junker); Rubaga Hospital Home Care Department (Freda Kisa, Christine Namusisi, Sr. Resty), and The AIDS Support Organization (TASO) Mulago (Grace Oling, Peter Banuwera Kapere).

Susan Scribner, PHR*plus* chief of party in Uganda, provided invaluable help in advice, report review, and logistical support. Technical review of the report was provided by Gilbert Kombe, also of PHR*plus*, Abt Associates Inc.

This study was made possible with funding from the United States Agency for International Development through the PHR*plus* Project, contract number HRN-C-00-00-00019-00.

Executive Summary

Home-based care (HBC) is recognized as a key form of care and support, especially in resource-limited settings. HBC extends the reach of care from the facility to the household, which is critical for populations unable to access facility-based care, and for facilities overburdened by patients in need of care. Understanding HBC is essential to guide the efficiency and reach of programs working to care for those coping with HIV/AIDS.

The Partners for Health Reform*plus* (PHR*plus*) Project is in the process of developing HBC costing guidelines and the Uganda Ministry of Health kindly agreed to collaborate in this effort by field-testing the guidelines in HBC programs in that country. The objective of the fieldwork was to test the costing principles developed in the costing guidelines and apply them to a range of HBC programs targeting people living with HIV/AIDS (PLWHA). This document presents the field-test methodology and findings of the fieldwork conducted in March 2005 in nine study sites.

Research questions of the fieldwork exercise were:

- Are the costing guidelines and study instrument flexible enough to accommodate various HBC models and range of activities delivered? Were the steps to conduct the costing exercise described in the costing guidelines easy to implement?
- Are program managers and respondents able to understand the HBC guidelines' working definitions and appropriately answer to the questionnaires during data collection?
- Do costing boundaries developed in the costing guidelines demarcate limits for what is counted in the costing exercise? What are the main strengths and weaknesses of setting costing boundaries?
- What are HBC total costs, unit costs, and main cost drivers?

HBC programs included in this report were selected with Ministry of Health assistance to answer these research questions. The selection of HBC programs did not intend to provide a representative sample of the universe of HBC programs in Uganda. Study sites were selected on a convenient basis to provide a sample of HBC programs with various operating and administrative structures, services delivered, population eligible for services, geographical location, and size of HBC coverage.

PHR*plus* applied an integrated methodological approach to test the costing guidelines. Comprehensive data on organization of the HBC programs, nature of essential HBC services provided, HBC coverage, program personnel, drugs and medical supplies, home-based care kits, program expenditures, training and education, family benefits, food supplementation, capital costs, and funding sources were captured from program records and from interviews with program coordinators, logistical officers, and accountants and, where necessary, community health workers and volunteers. Responses were entered into an Excel spreadsheet for analysis.

The field-test found the need for some minor modifications to the costing guidelines but, overall, the guidelines are robust enough to guide the costing of HBC programs

In regard to costs of HBC programs studied, results show wide variation in both total costs and costs per patient. There is great diversity in the resources used by the different programs and this is to some extent linked to the programs' diversity in their range of services and service delivery approaches. The delivery of services also varies in terms of means of transportation, frequency of home visits by clinicians, and the use of community health workers. There are five main findings regarding costing:

First, staff costs are the most significant cost item. For five programs, staff costs are highest cost item and, for another two programs, they are the third highest cost item. The next five cost items in order of significance are transport, training, medical supplies, food, and capital costs.

Second, support to orphans and families of AIDS patients are important costs in programs that offer these services, but the services are not universally offered. Four of the nine HBC programs have an orphan care component. The annual cost per orphan supported ranged from Ugandan shillings (Ushs.) 66,000 (US$ 39) to Ushs. 455,000 (US$ 268). It is important that there is clear separation of costs for orphan support to include only those costs that are part of the HBC service as defined in the guidelines. Other aspects of orphan support can be shown under non-HBC services in order not to distort the costs of the HBC program.

Third, volunteer incentives rank seventh among the 10 items costed. The highest ranking for volunteer incentives in the individual HBC program cost profiles is fifth place in one program. This is not an indication that volunteer workers are not important. On the contrary, it appears that they play a very important role in the delivery of care to patients at home. This is an area that requires attention for its long-term viability as a part of the HBC strategy for care delivery.

Fourth, unit costs of HBC vary a great deal from program to program. Unit costs per patient per year excluding orphan support range from Ushs.1,240 million (US$ 729) to Ushs.72 million (US$ 42). The HBC programs with the highest total costs also appear to have higher unit costs. This means that the higher-cost programs do not necessarily have much higher patient volumes than the lower-cost ones. A straight comparison of costs is, however, not possible when there is such diversity in the package of HBC services and differences in the quality of care provided.

Fifth, it was apparent that most organizations with an HBC program do not monitor the HBC costs separately from those of their other activities. This made it difficult to accurately identify the costs of the HBC programs. For best monitoring of resource use and efficiency, it is important that major costs are tracked by program. This will help to provide data to support arguments for scaling up HBC as a viable, long-term strategy for HIV/AIDS patient care.

1. Introduction

More than 95 percent of people living with HIV/AIDS (PLWHA) live in lower-income or developing countries and nearly two-thirds of them live in sub-Saharan Africa (UNAIDS 2004). As the number of patients increases, health systems face increasing pressure to expand health care services to combat a growing burden of disease and they are challenged to provide new types of services to those under treatment. Relying on ancestral strengths of family and community networks, home-based care (HBC) has emerged as a promising effective method of providing care to those infected and affected by HIV/AIDS, especially in sub-Saharan Africa. The Ugandan government has always been at the forefront of HIV/AIDS programming in Africa, and it regards HBC as "a viable mechanism for delivering services because it has important benefits for everyone on that continuum" (Ministry of Health 2004). Uganda recently drafted a national policy on home-based care for PLWHA, which sets up a framework for the implementation of HBC activities nationwide.

Understanding the cost of home-based care is essential to guide the efficiency and reach of programs working to care for those coping with HIV. HBC has been recognized as a key form of care and support, especially in resource-limited setting. It extends the reach of care from the facility to the household, which is critical for populations unable to access facility care and for facilities overburdened by patients in need of care. Given the current diversity of program interventions implemented by HBC entities, it is critical to define the services and clarify the inputs that drive costs.

In collaboration with the government of Uganda, the Partners for Health Reform*plus* project (PHR*plus*) field-tested the costing guidelines for home-based care in nine HBC programs in March 2005.[1] The objective of the fieldwork was twofold: first, to test the costing principles developed in the costing guidelines and, second, to apply them to a range of HBC interventions targeting PLWHA. This report details the field-test research questions, methodology, and findings including costing estimates of HBC services in the study sites. Based on field-test findings, the PHR*plus* HBC costing guidelines will be refined for broader application by U.S. Agency for International Development (USAID) SO4 partners, other U.S. government partners working in care, host country counterparts, and program managers in the public nonprofit and faith-based sectors.

[1] Publication of the PHR*plus* costing guidelines for home-based care is forthcoming, in Fall 2005.

2. Concepts of HBC Guidelines

Because the definition and boundaries of what constitutes home-based care varies from stakeholder to stakeholder and from country to country, the PHR*plus* project in collaboration with USAID developed a standardized methodology that aims at determining the costs of HBC services and providing comparisons across HBC program types. Ultimately, application of the PHR*plus* costing guidelines for home-based care will provide information to help inform policy- and program-level recommendations to effectively plan and allocate financial, human, and commodity resources for HBC programs.

2.1 Costing Principles

The PHR*plus* HBC costing guidelines provide a systematic framework for costing HBC services. The objectives of these guidelines are to clarify costing principles and apply the standardized principles to classic HBC interventions. This will allow programs and countries to determine credible and comparable cost information for diverse HBC approaches and better inform efficiency options of those approaches. As such, these guidelines are a first step in the development of an internationally acceptable costing approach for HBC services.

To ensure comparability, definitions and essential elements of HBC services are extracted from or in line with the World Health Organization (WHO) terminology of home based-care (WHO 2002). Particular effort has been made to clearly limit boundaries of the HBC costing exercise to all the forms of care given to ill people in their homes, while being flexible, i.e., allowing in some way the inclusion of activities not delivered at home, so that manager's of organizations that offer HBC programs can ensure the continuum of care for people under treatment.

2.2 Working Definitions and Boundaries

In 1989, WHO defined home-based care services to PLWHA as a program that offers health care services to support the care process **in the home of PLWHA** (WHO 1989). Such care includes physical, psychosocial, palliative and spiritual activities (WHO 2002)

In carrying out a costing exercise, it is critical to define boundaries of the activities that are to be included in the exercise. In reference to the HBC costing exercise, understanding HBC terminology and identifying all of the HBC-related activities of an organization prior to beginning the costing itself is key. Table 1, adapted from WHO (2002), enumerates the "core" activities that may be provided by an organization as part of an HBC program. It is these core activities – all in support of services delivered in the home of PLWHA – that are costed in the current study of nine Ugandan HBC programs.

Conversely, the list in Table 1 helps to exclude activities that should not be included in an HBC costing exercise; for example, **community-based care and support,** which refers to all forms of care given to ill people at the community level and is not limited to in-home activities.

Table 1: Home-based Care Core Activities

Core Elements	Core Activities
Provision of care	Basic physical care Palliative care Psychosocial support and counseling PLWHA Treatment for tuberculosis and opportunistic infections Antiretroviral therapy (ARV) drugs Food supplementation
HBC administration	Network of services and resources Ensuring access to referral services Transportation to referral services Payment waivers (ability to pay) Coordination with facilities Discharge planning Written referral Benefits to families: cash allowances, caregiver compensation (in-kind, honorarium) Supply and storage of home-base care kits, necessary drugs and commodities, and equipment Staffing: supervision, recruitment, staff rotation, and community clinic to avoid burn-out Budget and financial management including income-generating activities
Education/training	Target groups: ill people, family members, community health workers, community volunteers, and administrative people Curriculum development Educational management and curriculum delivery Outreach activities Education to reduce stigma Mass media involvement Evaluation of education
Monitoring and evaluation	Quality assurance Monitoring and supervision Evaluation

Source: WHO 2002

When setting boundaries for the costing exercise, close attention should be given to distinguish home-based care from community-based care and support. Community-based care and support entails the following activities (Russell and Schneider 2000):

- That are based outside conventional health facilities (hospitals, clinics, health centers), but which may have linkages with the formal health and welfare sector; and
- That address any aspect of the "continuum of care and support," from time of infection through to death and impact on survivors.

For example, two activities commonly part of community-based care and support are advocacy and community mobilization; neither should be part of the HBC costing exercise.

As alluded to above, to meet the needs of managers whose organizations provide a broad continuum of HIV/AIDS care, the PHR*plus* costing guidelines allow inclusion of the costs of

activities that do not meet the above definition of HBC; they are presented as "addendum" or "below the line" costs to make it clear that they are outside the core HBC program. This allows for credible and comparable cost estimations of diverse HBC approaches across regions and countries and to better inform efficiency options.

2.3 Costing Approach

The PHR*plus* HBC costing guidelines follow the basic principles of activity-based costing, i.e., the guidelines break down the HBC services provided by an organization into discrete activities and cost the inputs needed to implement each activity. Each activity comprises recurrent and capital costs, and direct and indirect costs. Direct costs are those that can be directly linked to the activity; indirect costs are shared across many activities, e.g., an administrator's salary, or rent.

To calculate the cost of individual components of a service, the unit cost of each component must be estimated and volume consumed of that item must be quantified. For example, to calculate the labor cost of a health worker, the number of days worked by that worker is multiplied by the daily cost of the worker. Both unit cost and volume information are collected from secondary data sources, such as payroll records, or from primary sources, such as interviewing the health worker. Depending on the maturity of the HBC program, most data can be gathered from secondary data sources; some information, such as the prevalence of certain opportunistic infections (OIs), requires primary data collection.

3. Field-testing Methodology

In collaboration with the government of Uganda, PHR*plus* field-tested the PHR*plus* HBC costing guidelines in March 2005. With the support of PHR*plus* Uganda, the team tested the costing principles, applied them to a range of nine HBC programs targeting people living with HIV/AIDS, and estimated the cost of HBC services delivered in the nine sites.

3.1 Research Questions

The approach to this activity was to field-test the PHR*plus* costing framework for HBC programs to ensure that it can be applied to a range of HBC typologies and adequately capture HBC costs while remaining flexible enough to accommodate the needs of HBC program managers who must capture the cost of other activities carried out by their organizations.

The research questions of the fieldwork exercise are:

- Are the HBC costing guidelines and study instrument flexible enough to accommodate various HBC models and range of activities delivered? Were the steps to conduct the costing exercise described in the costing guidelines easy to implement?
- Are program managers and respondents able to understand the guidelines' working definitions and appropriately answer the data collection questionnaires?
- Do costing boundaries developed in the costing guidelines adequately demarcate limits for what is counted in the costing exercise? What are the main strengths and weaknesses of setting costing boundaries?
- What are HBC total costs, unit costs, and main cost drivers?

3.2 Field-test Approach

Field-testing was conducted in Uganda in collaboration with and the support of the Ugandan Ministry of Health. Field-test activities were the following:

- Sensitization of program managers (or other program representative) to concepts set out in HBC guidelines during a stakeholder meeting
- Adaptation of HBC data collection questionnaire to the draft of the Ugandan HBC policy framework of December 2004
- Pretest of HBC costing instrument in one HBC program and refinement of questionnaire
- Administration of costing instrument in selected HBC programs
- Analysis and interpretation of results for each study site

3.3 Site Selection

HBC programs for PLWHA were selected to participate in the field-test with the assistance of the Ministry of Health. The programs selected were not intended to be a representative sample of the universe of HBC programs in Uganda. Rather, they constituted a convenient sample of HBC programs with various operating administrative structures, services delivered, geographical location, and size of HBC coverage. The willingness of HBC teams contacted by the ministry and PHR*plus* Uganda to give time to data collectors also influenced the composition of the final study sample.

Nine HBC programs were selected; seven were located in the Kampala district and two were outside the Kampala area. Table 2 lists the study sites and their geographical location by district.

Table 2: Geographical Location of HBC Study Sites

Study sites	District
Hoima Hospital Home Care Department	Hoima
Hospice Africa Uganda, Makindye	Kampala
Kitovu Mobile Home Care and Orphans Program	Masaka
Meeting Point Namuwongo,	Kampala
Mengo Hospital Home Care Department;	Kampala
Nsambya Home Care Department	Kampala
Reachout Mbuya Parish	Kampala
Rubaga Hospital Home Care Department	Kampala
The AIDS Support Organization (TASO) Mulago	Kampala

Table 3 shows the types of HBC services offered to PLWHA by the participating programs.

Table 3: HBC Range of Services

Services	Hoima	Hos-pice	Kitovu	Mtg Point	Mengo	Mbuya	Nsambya	Rubaga	TASO
Palliative care	x	x	x	x	x	x	x	x	x
ARV therapy			x			x	x		x
Basic physical care	x	x	x	x	x	x	x	x	x
Psychosocial support and counseling	x	x	x	x	x	x	x	x	x
Treatment for opportunistic infections	x	x	x	x	x	x	x	x	x
Food support	x	x	x	x	x	x	x		x
Orphan support			x	x	x			x	
Other family support*		x	x	x	x	x		x	x
Education and training	x	x	x	x	x		x	x	x

* Includes clothing, sanitary items, payment of hospital bills

Service delivery also varied in terms of means of transportation, frequency of home visits by clinicians, and the use of community health workers. Some programs make home visits on a daily basis while others send out a team only twice a week.

3.4 Study Instrument

Comprehensive data were collected on the following aspects of the HBC programs: organization of HBC program, nature of essential HBC services provided, HBC coverage, program personnel, drugs and medical supplies, home-based care kits, program expenditures, training and education, family benefits, food supplementation, capital costs, and funding sources. Data were captured from HBC programs' records and from interviews of HBC program coordinators, logistical officers, and accountants and, where necessary, community health workers and volunteers. Data were collected using the using the questionnaire in Annex A.

3.5 Data Collection and Analysis

The team of data collectors consisted of a public health physician with experience in HIV/AIDS, a health economist, and one Ministry of Health staff involved in HBC supervision. On average, a half day per study site was needed to collect data if the HBC staff member who attended the sensitization meeting did preparatory work. In each program visited, a mix of respondents was needed to complete the data collection. The data collection team followed the steps listed below:

- Prepare an organizational chart that shows all departments in the organization providing HBC, including those not directly involved in providing HBC services. This is particularly important if the organization is engaged in services other than HBC and will help in deciding which costs are shared across departments.
- Choose the reference period of fiscal year 2004 that will be used for the collection of data for costing exercise.
- Determine the primary activities of the HBC program.
- For direct client services, identify the package of services offered during home visits.
- Identify necessary data, unit costs, and volume for each input.
- Set up a data collection plan.
- Review secondary data sources.
- Identify data gaps left by secondary sources, and fill those gaps with using primary sources of data.
- Collect primary data.
- Enter data from responses to the questionnaires into an Excel spreadsheet for analysis.

4. Field-test Findings

This chapter discusses the findings of the field-test the PHR*plus* HBC costing guidelines, first regarding the guidelines themselves, and then the costs of the nine HBC programs.

4.1 Findings about the HBC Costing Guidelines

4.1.1 Accommodation to Various HBC Models

The field-test in Uganda showed that the HBC costing guidelines and study instrument are flexible enough to be used with various HBC models and range of activities delivered as long as agreement on working definitions and costing boundaries was reached with HBC program managers before the costing exercise was begun. The data collection steps described in the costing guidelines (and above in Section 3.5) also are easy to implement no matter the program.

4.1.1.1 Activity Boundaries

Of particular value to setting the stage for data collection – and to the entire costing exercise – was the step that called for preparation of a chart showing all departments and activities in the organizations providing HBC, including those departments and activities not directly involved in delivering HBC services. This allowed the data collectors and program managers to agree on what should be costed. Determining the primary activities of the HBC program was easily performed according to the draft of Ugandan national policy and guidelines for HBC.

In setting activity boundaries, particular attention should be given to (1) delineate which activities are provided in-home, (2) estimate number of people eligible for those activities (especially if preferences are given to certain disease-specific activity categories such as Directly Observed Therapy, Short-Term **(**DOTS), and (3) identify criteria of eligibility for services provided (degree of disability of people eligible for in-home services, transient families not included, or others)

As noted above, the continuum of care for HIV/AIDS, which encompass the provision of both health care and non-medical activities in and outside a patient's home, is broader than the HBC core of the costing exercise, which focuses on the costs to support the care process **in the home of the sick person**. Nevertheless, the guidelines' strategy for taking into account as addendum items the non-HBC costs that are part of the continuum care process maintains the integrity of the HBC costing exercise.

When implementing the costing methodology, attention should be given to the provision of food or food supplements. The precise nature of food delivery should be identified, and the data collection team must ensure that the food delivered is part of the package of services offered during home visits, even double-checking coverage data for such distribution.

With community-based organizations that assist orphans, particular attention should be given to identify where services are provided as well as to the children's HIV status. Health care services to support the care process **in the home of sick children will be a core cost of HBC.** Assistance

provided through home visits to orphans not infected by HIV (even though their parents were) can be included in the costing exercise as an addendum item if so needed by program managers.

4.1.1.2 Time Boundaries

The time boundaries of the costing exercise must be made clear to the respondents because some governments and organizations report expenditures by calendar year while others report by fiscal year. The field-test exercise clearly demarcated the time period it covered: data collection for each program was done for the 12-month period ending in 2004 that coincided with the program's report expenditure format.

4.1.1.3 Space Boundaries

Services to support the care process **in the home of PLWHA** must be clearly identified. Aggregated numbers that are available during the data collection exercise usually refer to the percentage of the population to be covered by all community-based care activities. When costing HBC programs, it is necessary to disaggregate coverage data of the proportion of the population that is covered "at home," i.e., received care via home visits.

4.1.1.4 Eligibility Boundaries

HBC services are often delivered on the basis of eligibility criteria such as disability, age, and others. If preferences are given to certain disease categories such as tuberculosis (TB), coverage data related to the targeted population should be collected or estimated. Field-test findings show that it is extremely difficult and time-consuming to disaggregate costs for specific diseases such as opportunistic infections, the exception being TB.

4.1.2 Administration of Questionnaire

As noted above, sensitization sessions were held prior to the costing exercise to introduce HBC program managers to the HBC guidelines and boundary definitions. The clear definition of HBC expenditures is particularly important for programs, such as Hospice Africa Uganda, that provide home care for both HIV and non-HIV patients. In addition to encouraging the managers' cooperation, the sessions saved time during the data collection process, enabling program managers to know which program records to collect in advance of the data collectors' visit. Sensitization also helped mangers to identify respondents qualified to properly answer the questions, and they scheduled appointment with key respondents in advance.

As the PHR*plus* team administered the costing instrument at study sites, the team assessed respondents' understanding of questions and their capacity to easily perform the tasks required to supply answers to questions, e.g., fill out cost tables in the questionnaire. Respondent understanding of the questions was good as long as the working definitions and costing approaches were clearly stated to them at the outset.

Expenditure categories listed in the questionnaires were found to be inadequately comprehensive and new lines had to be added; this made data entry more time-consuming as additional items were recorded on different lines on the questionnaire expenditure tables of each HBC program. Organizations or countries using the questionnaire in the future may need to tailor it their needs by adding still other items, so that all costs can be captured and, where multiple programs are being costed, the costs are recorded consistently from one HBC site to another.

In each program visited, a mix of respondents was necessary to data collection completion. The program coordinator, logistical officer, and accountant are key informants. Where necessary, community health workers and volunteers can be interviewed to collect additional data.

Administration of the questionnaire would have been easier had the questions been ordered slightly differently, to accommodate the programs that already had the cost data available and therefore did not need to work through the estimation tables. The questionnaire will be amended to make the flow of the questions more logical and consistent with the field-test experiences.

4.2 Findings about HBC Costs

The field-test of the costing guidelines continued with the estimation of HBC program costs based on the data collected according to the guideline methodology. There is great variation in the resources used by the different programs in the study sample, to some extent a result of the programs' different foci but also perhaps due to a program's staff mix or operating efficiency.

The following sections look at different aspects of the HBC programs' costs to try to understand the key cost drivers and the implications for scaling up of this approach to HIV/AIDS patient care. Particular attention is paid to staffing costs, as this is the overall highest cost for the programs. Both total costs (and rankings of 10 categories of total costs) and unit costs are discussed.

4.2.1 HBC Program Staffing Cost

HBC programs draw on the skills of medical professionals, community health workers, and community volunteers to carry out HBC activities. Because staffing costs are such a significant proportion of total program cost (see Section 4.2.2), it is important that the programs have an effective mix of staff. To better understand this cost component, the current study looked at the staff composition of each program in the sample; staffing profiles are shown in Table 4. All numbers represent full-time equivalents (FTEs).[2]

Table 4. HBC Program FTE Staff Numbers, by Staff Category

Staff category	Hoima	Hospice	Kitovu	Meeting Point	Mengo	Mbuya	Nsambya	Rubaga	TASO
Doctors	0.4	1.2	0.4	0.2	1	0.4	0.05	0	5
Clinical officer	0	0.3	0	0	1	0.4	0.4	1	1
Nurse	4	5.2	4	4	1	2	7.1	3	8
Counselor	0	0	12	18	1	1.6	3.2	0	1
Social health worker; pastoral counselors	0.6	0.1	0	9	1	0.4	4	0	11
Community health worker/patient support worker /community nurse	0	0.5	0	0	0	62	50	0	0
Driver	0.6	1.7	6	2	1	0	2	1	3
Occupational therapist	0	0.1	0	0	0	0	0	0	0

[2] The sum of time spent by all the staff members in a particular category (e.g., nurses) in a month divided by the number of hours a full-time staff members would normally work in a month gives the FTE number of staff required for that position.

Staff category	Hoima	Hospice	Kitovu	Meeting Point	Mengo	Mbuya	Nsambya	Rubaga	TASO
TB and other coordinators	0	0.3	1	0	0	0.2	0	0	0
Other non-clinical and office support staff	0.05	0.9	3	0	0	0.2	2.1	1	0
Total FTE non-community volunteer HBC staff	5.65	10.3	26.4	33.2	6	67.2	68.85	6	29
Community volunteers	90	0	70	25	35	53	262	10	66
Total staff	95.65	10.3	96.4	58.2	41	120.2	330.85	16	95

4.2.2 Cost Impact of Range of Services

The range of services offered affects the costs of the program. This can be seen in the impact of food support and care for orphans. These two items are quite significant in the programs that provide these services. In Hoima, food costs account for about 77 percent of total costs and for 52 percent in Meeting Point. Meeting Point has the largest orphan care component of all the programs studied and this accounts for 25 percent of its total costs. The introduction of ARV therapy is one service that may change the cost profiles of programs significantly, given the cost of the drugs as well as the need for more highly trained staff to administer them.

Other differences in the composition of the service package may not impact heavily on total costs. This study did not examine the impact of quality of care on costs. Programs providing the same package of services may incur substantially different costs depending on the quality of care they choose to provide, as determined by the caliber of staff they employ as well as they quality of other inputs e.g., the frequency of home visits.

4.2.3 Program Total Costs

Table 5 shows the total cost profile of the nine HBC programs. Each cost is expressed in absolute amounts and as a percentage of the total program cost. It shows which costs are most significant to each program.

The most significant cost overall is staff – for five programs, it is the highest costs category, representing 40–80 percent of total costs. The next five costliest items in order are transport, training, medical supplies, food, and capital costs.

As Table 5 shows, the level of staff costs has no correlation to the number of staff employed (Table 4). This demonstrates a great diversity in remuneration packages for staff; HBC programs pay different salaries for similar staff positions, related to the availability of funding for salaries. It also is influenced by the staff mix (doctors, nurses, community health workers).

Table 5. HBC Program Total Costs

	Hoima		Hospice		Kitovu		Meeting Pt		Mengo		Mbuya		Nsambya		Rubaga		TASO Mlgo	
Cost item	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**	**UShs M**	**%**
Staff costs	15.7	4%	12.3	12%	5.9	3%	75.7	11%	171.8	80%	53.6	45%	16.4	7%	19.4	40%	30.3	43%
Volunteer incentives	4.5	1%	0.3	0%	8.1	4%	0.2	0%	5.2	2%	0	0%	3.3	1%	0.6	1%	3.1	4%
Medical supplies	13.6	3%	14	13%	10.5	5%	6.4	1%	3.1	1%	40.2	34%	22.1	9%	3.8	8%	10.3	15%
Food	265.8	82%	0.7	1%	5.7	3%	346.4	52%	0.5	0%	17	14%	37	15%	0	0%	14.5	20%
Training	40.1	9%	24.2	23%	23.8	11%	19.3	3%	5.4	3%	0	0%	17.8	7%	12	25%	1.1	0%
Orphan support	0	0%	0	0%	59.2	26%	171.2	26%	5.3	2%	0	0%	0	0%	2.7	6%	0	0%
Other family support	0	0%	2.4	0%	18.5	8%	20	3%	9.6	4%	1.2	1%	0	0%	0.1	0%	3.8	5%
Transport	1.7	0%	32.5	31%	35.6	16%	17.7	3%	4.2	2%	3.1	3%	61.9	26%	6.1	13%	0	0%
Capital costs	1.2	0%	9.1	9%	56.2	25%	5.2	1%	9.1	4%	0.9	1%	35.7	15%	3	6%	8.4	12%
Other costs	1.8	0%	10.8	10%	2.8	1%	3.3	0%	0.2	0%	1.9	2%	47.4	20%	0.3	1%	0.2	0%
	344.4	100%	106.3	100%	226.3	100%	665.4	100%	214.4	100%	117.9	100%	241.6	100%	48	100%	71.8	100%

Table 6 displays the cost categories ranked in order of their significance among the HBC programs. The top row of the table ranks the 10 cost items studied from 1 to 10. The numbers in the columns show how many times the cost item appears at that rank. For example, staff costs are ranked number 1 in five programs, and number 3 in two programs. The column headed score takes each ranking and weights it, from 10 for rank 1 to 1 for rank 10 – for example, staff costs scores: (4x10) + (0x9)+(2x8)+(0x7)+(0x6)+(0x5)+(1x4)+(1x3)(+0x2)+(0x1). This approach allows us to visualize the order of significance of cost categories of HBC programs.

Table 6. Cost Rankings

Ranking	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Score**	**Rank**
Rank weight	***10***	***9***	***8***	***7***	***6***	***5***	***4***	***3***	***2***	***1***		
Staff costs	4	0	2	1	0	0	1	1	0	0	70	1
Transport	2	0	2	1	0	1	2	0	1	0	58	2
Training	0	3	0	2	1	1	1	1	0	0	57	3
Medical supplies	0	1	2	2	1	1	1	1	0	0	55	4
Food	2	1	2	0	0	0	0	1	2	1	52	5
Capital costs	0	1	1	2	1	1	1	2	0	0	46	6
Volunteer incentives	0	0	0	0	1	2	2	2	1	1	43	7
Other family support	0	1	0	1	2	1	1	0	3	0	43	8
Orphan support	1	1	0	0	1	1	0	1	3	1	38	9
Other non-capital costs	0	1	0	0	2	1	0	2	1	2	30	10

It is clear that volunteer incentives and compensation (lunch and traveling allowances, gum boots, raincoats, umbrellas, bicycles) are not a major cost for the programs. However, given the importance of this cadre of health worker, it is important to examine the sustainability of the volunteer approach to providing care to home-bound AIDS patients.

Training plays a major role in the development of staff capacity for HBC activities. Training is provided for both permanent staff and volunteers. Training approaches differed among the HBC programs: some programs sponsored their staff to attend courses at other organizations while others did most of the training internally. Training costs include course materials, trainers' costs, participant per diems and transport.

Food was a significant cost item in five programs, which ranked it among the top three expenditure items. The food rations distributed tended to be fairly similar among the HBC programs as some of the food is donated from a common source, the World Food Program. Others purchase significant amounts of food from other sources of funds. Meeting Point has the most intensive food distribution component, coupled with the largest orphan and family support program. Food costs also are a significant item in Hoima, due perhaps to its collaboration with Meeting Point Hoima; more investigation would be needed to verify if these costs are truly incurred by the Hoima HBC or if they belong to Meeting Point Hoima (not part of the sampled programs). If the latter is the case, they should be excluded from Hoima HBC costs.

Transport is a key input into the HBC programs' service delivery. Overall it is the second most important cost. Transport costs include costs incurred to run vehicles for home visits and food distributions. The capital costs of vehicles are shown under "capital costs."

Medical supplies are the fourth most important cost item for most HBC programs. This cost category tends to comprise various non-pharmaceutical supplies as well as drugs for treating OIs and sexually transmitted infections. Only four programs (Kitovu, Mbuya, Nsambya, TASO) offer ARV drugs directly. The majority refer their patients to hospitals that are able to provide ARVs; home care then follows up to ensure compliance with the prescription and proper nutrition. Providing ARVs impacts on the cost of medical supplies as well as staff, as a higher caliber of staff is required to treat patients.

4.2.4 Unit Costs

A unit cost (or average cost) captures the relation between total costs and the relevant volume of services (output) and provides more detail to allow the user to see the intensity of resource use.

The outputs of a HBC program are the indicators of performance in terms of quantity of services delivered. Performance may be measured in many ways and each program may have its own specific indicators that management tracks. Indicators that were collected included:

- Number of patients served
- Number of households served

4.2.5 Unit Costs for Core Activities

Annual unit costs were calculated for each of these performance indicators. Unit costs – for example, for patient care – were obtained by dividing the total costs (of patient care) by the volume of

services delivered in the period. The total costs used in the calculation may not necessarily be the total program costs as some costs may not be relevant to patient care.

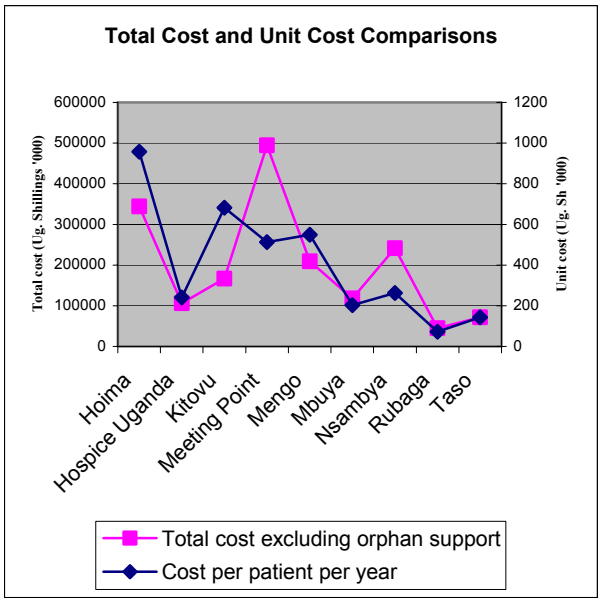
When estimating unit costs (shown in Table 7) of the HBC programs, the current study excluded the cost of orphan support from the total program costs (Table 5). (Unit costs for orphan support are shown below, in Table 8.) This was because orphan support is offered by only four of the programs in the sample and, as noted previously, where it is offered, its costs are appreciable. Including it here would have distorted the value of the unit costs for comparison purposes.

Table 7. Unit Costs Excluding Orphan Support

	Hoima	Hospice	Kitovu	Mtg Point	Mengo	Mbuya	Nsambya	Rubaga	Taso
Costs									
Total cost (Ushs M) *exclusive of orphan support*	344.4	106.3	167.2	494.3	209.1	117.9	241.6	45.2	71.8
Orphan support	0.0	0.0	59.2	171.2	5.3	0.0	0.0	2.7	0.0
Total costs of HBC (from Table 5)	344.4	106.3	226.4	665.4	214.4	117.9	241.6	47.9	71.8
Outputs									
No. of households	360	440	245	700	381	580	1,000	627	502
No. of patients	360	440	245	962	381	580	920	627	502
Cost per unit (Ushs '000)									
Cost per household per year	957	242	682	706	549	203	242	72	143
Cost per patient per year	957	242	682	514	549	203	263	72	143
Cost per unit (US$) *$=1700 U.SH*	US$	US$	US$	US$	US$	US$	US$	US$	US$
Cost per household US$	563	142	401	415	323	120	142	42	84
Cost per patient per year US$	563	142	401	302	323	120	154	42	84

The HBC programs with the highest total costs also appear to have higher unit costs (see Figure 1). Unit costs depend on both the numerator (costs) and denominator (volume of services). In both Table 7 and Figure 1, it is clear that higher program costs are not necessarily accompanied by higher volume of services. This could mean that the high costs are due to the range and quality of services provided but it could also signify a need for cost containment. This is an important issue for HBC programs to deal with if the HBC strategy is going to be viable and continue to attract support from donor and other collaborating partners. Best technical efficiency in a HBC program would imply that the highest volume of services is delivered for the minimum outlay of resources. (Efficiency must, of course, be evaluated in tandem with the quality of services provided.)

Figure 1. Total Costs and Unit Costs Comparisons



Unit costs are, of course, dependent on the accuracy of cost and volume data. For the current study, cost data were not easily separable between HBC and other activities, and estimates had to be made on many occasions. The range of unit costs, from US$ 42 (Nsambya) to $562 (Hoima) per patient per year, suggests there may be a problem with the quality of data. The highest cost item in Hoima is food support to households. This accounts for 77 percent of the program's total costs and deserves further investigation to determine whether the data provided was accurate. The program works in collaboration with Meeting Point Hoima in the provision of food. Estimates of the cost of food were based on the number of households receiving this support and the quantity given to each household per month. The denominators used also need to be examined further for accuracy, as not all HBC programs had good records of service volume. For example, it was not possible to obtain the number of home visits conducted in a year; instead, this had to be estimated based on the typical number of homes visited in a week by a home visit team. Keeping accurate service delivery records is an important management tool that will lend credibility to the reports that the HBC programs produce for both internal and external consumption. Review of the above results by program managers will help to validate the data and to refine the results.

4.2.6 Unit Costs for Orphan Support

Orphan support is provided by four of the HBC programs, viz. Meeting Point, Kitovu, Mengo, and Rubaga. The size of the orphan support component varies greatly between programs. Numbers of orphans and costs incurred are shown in Table 8. Orphan support includes some or all of the following: school fees and supplies, uniforms, and transport to schools.

Table 8. Unit Costs for Orphan Support (in Ushs.)

	Kitovu	Meeting Point	Mengo	Rubaga
Orphan support costs (total cost)	Ushs. 59,200,000	Ushs. 171,180,000	Ushs. 5,304,000	Ushs. 2,700,000
Number of orphans supported	130	. 680	. 80	. 15
Cost per orphan supported (unit cost)	Ushs. 455,384 (US$ 268)	Ushs. 251,735 (US$ 148)	Ushs. 66,300 (US$ 39)	Ushs. 180,000 (US$ 106)

5. Conclusion

The PHR*plus* HBC costing guidelines, a systematic framework for costing HBC services, were successfully field-tested in nine home-based care programs in Uganda. The field-test found the guidelines and study instrument to be flexible enough to accommodate the various HBC models included in the sample, and it stimulated discussion with HBC staff on the need to establish comparable estimations of the costs of the diverse HBC programs in use.

The guidelines proved easy to implement. The step that calls for drafting an organizational chart that shows the full range of departments in the organization providing the HBC was key in setting the stage for the costing exercise and reaching agreement with program managers on what should be costed.

Program manager sensitized to the HBC costing approach and working definitions understood the study instruments and appropriately responded to the questionnaires during data collection.

The data collection questionnaire was comprehensive enough to collect all data needed for the costing of a HBC organization. However, it needs to be modified to make the flow of questions more logical and to increase the categories of expenditure and staff specified in the data collection tables to make them more comprehensive.

The guidelines' costing boundaries effectively limit what is to be counted in the HBC costing exercise. Moreover, HBC is defined as offers health care services to support the care process **in the home of the sick person**.

In setting activity boundaries, particular attention should be given to identify which activities are provided in-home, and estimate the number of individuals eligible for those activities For example, when community-based organizations assist orphans, only direct services provided to sick children at their homes should be included. Similarly, if food supplementation is given, the data collection team must ensure it is included in HBC costs only if it is part of the package of services delivered during home visits.

In order to protect the integrity of the HBC costing exercise while simultaneously accommodating the needs of organization managers who must also cost activities not delivered at home (and which therefore do not qualify for inclusion in the costing of **home-based care**), the guidelines allow for these outside-the-home activities to be included as "addenda." This allows for comparability of the cost estimates of diverse HBC programs and approaches across regions and countries.

Regarding cost estimations themselves, staff costs were found to be the most significant cost item, followed by transport, medical supplies, food, training, and, in sixth place, volunteer incentives.

Orphan care is a significant cost but only for the four programs that provide it. It is important to include only those costs that are part of the HBC service as defined in the guidelines. Other aspects of

orphan support can be shown under non-HBC (addendum) services in order not to distort the costs of the HBC program.

Volunteer incentives rank seventh among the 10 cost categories studied. Their highest ranking in the individual HBC program cost profiles is fifth place in one program. This should not be taken to mean that volunteer workers are not important – on the contrary, it appears that they play a very important role in the delivery of care to patients at home. Therefore, this area requires attention for its long-term viability as a part of the HBC strategy.

Disaggregating the costs of the HBC programs from those of other activities carried out by the same community organization was complicated due to the fact that most organizations do not separately monitor HBC costs. For best monitoring of resource use and efficiency, it is important that major costs are tracked. This will help to inform arguments for scaling up HBC as a viable, long-term strategy for HIV/AIDS patient care.

Annex A. HBC Costing: Data Collection Questionnaire

Data Collection Form

Date of data collection: _____(day/month/year)		
Name of home-based care program	_____	
Name of data collection sites	☐	☐
	☐	☐
Location of home-based care program	City/Town _____	District _____
Name(s) of the respondents	_____ _____ _____	

Notes to Data Collectors:

Please review all questions to ensure that all have been answered. Sign off below to signify completion of data collection for this organization.

Data collector's name _____

Signed _____

Date _____

INTRODUCTION

Hello. My name is (name of person conducting survey). I am working with the Ministry of Health and the Partners for Health Reformplus Project to collect information about your home-based care program. The information collected will be used to develop guidelines for costing home-based care programs. All information will be kept confidential. It will not be given to anyone else and will only be used by the Ministry of Health and the PHRplus Project to understand the scope of home-based care services, how they are delivered and how much they cost.

I would like you to ask you a few questions about the administration services of your home based-care program, as well as some programmatic questions. Please note that the information required will be applicable to the year 2004 (January 1-December 31). All information collected will be kept confidential and will only be used for the intended purpose.

Organization of HBC program

Please describe in this section the type of HBC care services delivered by the program, the way the HBC program is set up and how it fits into any other services that are provided by the organization that is owns the program. Home-based care is defined as a program that offers health care services to support the care process in the home of the HIV-infected person (WHO/GPA 1989).

1. HBC services

Please describe in this section the nature of essential HBC services provided. Such services may include physical, psychosocial, palliative and spiritual activities.

2. Management structure

Obtain or draw an organogram to show the management structure of the HBC program.

3. Administrative support

Please describe how administrative support is given to the HBC program.

HBC statistics – 2004

4. General coverage data–2004

Please collect the following data related to HBC activities in year 2004.Pay attention to obtain data that are limited to the HBC program by reflecting health care services to support the care process in the home of the ill person.

	Category	Data
a.	Total number of HBC patients in 2004	
b.	Number adults HBC patients	
c.	Number of children HBC patients	
d.	Number of male HBC patients	
e.	Number of female HBC patients	
f.	Number of new HBC patients in 2004	
g.	Number HBC patients who died in 2004	
h.	Number of HBC patients treated for tuberculosis	
i.	Number of patients diagnosed as living with HIV/AIDS	
j.	Total number of households covered by HBC	
k.	Total number of orphans supported by HBC	

Personnel

5. Program personnel numbers and costs

Please list all the personnel who had any involvement in HBC activities, i.e., who offered health care services to support the care process in the home of the HIV-infected person in 2004. If the person was a volunteer and not paid a salary, please record them here and enter any cash allowance they are paid in the last column. Volunteers do not include family members for this purpose except those that are contracted by the HBC program officially.

	Staff Category	Number of full-time equivalents	Average % of time on HBC activities per month	Total monthly salary before deductions	Cash stipends and allowances (volunteers)
a.	Doctor				
b.	Clinical officer				
c.	Nurse				
d.	Counselor				
e.	Social health worker				
f.	Community health worker				
g.	Driver				
h.	Other (please, specify) _____				
i.	Other (please, specify) _____				
j.	Other (please, specify) _____				
k.	Other (please, specify) _____				
l.	Other (please, specify) _____				
m.	Other (please, specify) _____				

6. Staff attrition levels

	Staff cadre	Number available	Number of staff lost in 2004				
			Retired	Resigned	Transfer	Death	Other? Specify _____
			Record the number of staff who left and dates when they left organization				
a.	Doctor						
b.	Nurse						
c.	Clinical officer						
d.	Counselor						
e.	Social health worker						
f.	Community health worker						
g.	Driver						
h.	Other (please, specify) _____						
i.	Other (please, specify) _____						
j.	Other (please, specify) _____						

7. Volunteer workers' compensation

Please list all the volunteer workers' compensation for their work in HBC activities in 2004.

	Type of compensation	Value in 2004
	Monetary	
	Lunches	
	In-kind (please specify) _____	
	In-kind (please specify) _____	
	In-kind (please specify) _____	
	Other (please specify) _____	
	Other (please specify) _____	
	Other (please specify) _____	

Drugs and medical supplies used

8. What was the total value of drugs and medical supplies used in HBC activities in 2004?

Drugs _____
Medical supplies _____
Commodities (soap, towels, clothes, bags, etc.) _____
Traditional remedies _____

Home-based care kits

*In case the price of home-based care is **NOT** included in the total value of drugs and medical supplies reported in question 9, fill out questions 10, 11, and 12. If applicable, complete question 13 and 14.*

9. Do you have more than one HBC kit? Please circle the appropriate answer YES NO
10. What is the content of HBC kit #1?

	HBC Kit Components	Quantity	Cost
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			

- What was the total # of HBC kits #1 used in 2004? _____

- What is the content of HBC kit #2?

	HBC Kit Components	Quantity	Cost
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			

- How many HBC kits #2 were used in 2004? _____

- Disease-specific drugs: Tuberculosis

Please specify the drugs used to treat tuberculosis cases. Enter the names of the drugs and medical supplies used in the column "Drug/Supply Name". Enter the quantity that would normally be used to treat an episode of this disease – remember that an episode may require more than one home visit. Under the Column "Unit of Measurement", enter the unit of counting the quantity of the item used e.g. tablets; needles; pairs of gloves etc. If any traditional remedies are used, please include these only if the program purchased them.

	Drugs and medical supply	Qty per episode	Unit of measure *(Tab; cap; inj; etc)*	Total quantity	Total cost
a.					
b.					
c.					
d.					
e.					
f.					
g.					

15. Condoms

	Condoms *(Please specify brand of condoms)*	Source	Total number	Unit cost	Total cost
a.					
b.					
c.					

16. Other family planning supplies

	Items	Total number	Unit cost	Total cost
a.	Please specify _____			
b.	Please specify _____			
c.	Please specify _____			

Home visits

17. Home visits data

The purpose of this table is to estimate the average time spent by the HBC staff to do a home visit. The total time spent each day for all home visits that day includes the traveling time i.e. from the time the team left the office to the time they returned

	Category	Number
a.	Number of days per week spent on home visits activities	
b.	What is the total number of hours spent on the home visits day (*From the time team leaves program base to the time they return?)*	
c.	Number of homes visited in a day	
d.	Average time per home visit (b / c)	

18. Average staff time spend on home visits

The purpose of this table is to estimate the proportion of staff time devoted to home visits. This should only include those who go on home visits.

	Staff category	Average no. of days on HBC activities per week
a.	Doctor	
b.	Nurse	
c.	Clinical officer	
d.	Counselor	
e.	Social health worker	
f.	Community health worker	
g.	Driver	
h.	Other (please specify) _____	
i.	Other (please specify) _____	

Program expenditures

19. Program expenditures

Please obtain expenditure reports or if none are available ask the program accounting office. Fill in the table below with all the expenditures by budget "line item" or account code.

	Line item	Total expenditure 2004
a.	Salaries and benefits	
b.	Drugs and medical supplies	
c.	Value of donated drugs and medical supplies	
d.	Food rations purchased	
e.	Value of food rations donated	
f.	Rent	
g.	Vehicle expenses (fuel, insurance, repairs and maintenance)	
h.	Stationery	
i.	Electricity	
j.	Water	
k.	Telephone	
l.		
m.		
n.		
o.		
p.		

20. Cost of stationery 2004:

Please fill out this question only if the cost of stationery was not reported in question 19.

In the table below enter the names of the reports or documents used for HBC activities. For each, enter the number of pages, how many times it is produced per year and the postage cost (calculate this separately and enter the amount in the table). If the report is delivered to the recipient, enter the distance covered in a year (=# of trips x mileage to/from). If the document is printed externally (e.g., forms for reporting), enter the cost of printing one unit, e.g,. a form.)

	Report/document	No. of pages	No. per year	Photocopy cost	Postage cost	Delivery # KM	Print cost per page
a.							
b.							
c.							
d.							
e.							
f.							
g.							
h.							

Training and education costs

21. Training and education session; participant costs:

Please fill out this question only if the cost of training and education was not reported in question 19.

Here we would like to capture the costs of (1) training of health workers and (2) education of community workers, volunteers, and family caregivers. Some of the training includes tuition.

	Date	Type of participant involved	Length of training	Per diem	Transport	Supplies	
a.							
b.							
c.							
d.							
e.							
f.							
g.							

22. External trainers' costs:

Please fill out this question only if the cost of trainers was not reported in question 19.

	Staff	Position	Duration	Per diem	Transport	Other
a.						
b.						
c.						
d.						
e.						
f.						

23. Materials development: staff time:

Please fill out this question only if the cost of materials development was not reported in question 19.

	Staff name	Position	Designation	Document name	Time (hrs)
a.					
b.					
c.					
d.					
e.					
f.					

24. Materials development – printing:

Please fill out this question only if the cost of stationery was not reported in question 19.

	Document name	Cost per unit	# Copies produced
a.			
b.			
c.			
d.			
e.			

Capital costs

25. Cost of buildings

If no information on the cost of the buildings is available, we will need to estimate the cost by using the current construction cost per square foot (or square meter) and multiply by the total area occupied by the HBC program buildings.

a. Cost of buildings _____ (if known),
b. Total area (space) occupied by buildings _____ sq. feet
c. Construction cost per square foot _____

26. Cost of vehicles, motor cycles and bicycles

Only list in the following table the vehicles that are used for HBC. Obtain this data from the Transport Office. Data on use can be obtained from vehicle logbooks or informed estimates by staff.

	Make of vehicle	Model	Year of manufacture	Cost	% use for HBC
a.					
b.					
c.					
d.					
e.					
f.					
g.					

27. Cost of Equipment 2004

	Type of equipment	How many	Model	Cost	% use for HBC
a.	Computer				
b.	Printer				
c.	Photocopier				
d.	Home care kit container				
e.					
f.					
g.					
h.					
i.					
j.					

Financing HBC activities

28. Funding received in 2004

Please enter in the table below all sources of financing for HBC activities.

	Source of funding	Total received in 2004	Purpose
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			

29. Donations received in kind in 2004

Please enter in the table below all in-kind donations received in 2004. In the "Description" column, include as much information as possible to be able to impute a cost if the correct monetary cost is not known.

	Source of donation	Total value	Description	Purpose
a.				
b.				
c.				
d.				
e.				
f.				
g.				
h.				

Family benefits

30. Family benefits for year 2004

Please specify services/goods received by HBC patients and paid for by the HBC program (reimbursement of HBC members visiting health care facilities, cash allowances, bedding, financial support, monetary assistance for access to medical services, and others).

Please ask if any of the items are already included in medical supplies, Question 8.

	Benefits	Number of units	Unit cost	Total cost
a.	Mosquito nets			
b.	Transportation			
c.				
d.				
e.				
f.				

Food supplementation

31. Food rations issued for year 2004

	Food item	Qty per household	No of HH receiving food support	Cost per unit
a.				
b.				
c.				
d.				
e.				
f.				

Annex B. Bibliography

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