THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Standard Operating Procedures for the Provision of Psychosocial Care and Support Services

December, 2020

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FOREWORD

Tanzania faces numerous socio-economic challenges due to HIV and AIDS pandemic, poverty, disasters like health quake, flood, bomb blast, accidents and unemployment. These challenges have considerably contributed to the increased vulnerability whilst simultaneously affecting the psychological and social wellbeing of individuals, families, households, and communities.

Notable progress has been made in Tanzania through the establishment of various policy and legal frameworks to address these social challenges. These include, but are not limited to, the National Health Policy (2007), the National Aging Policy (2003), the National Disability Policy (2004), the Child Development Policy (2008), the Anti-Trafficking in Persons Act (2008), the Law of the Child Act (2009), and the Persons with Disability Act (2010).

Although efforts have generally been made to improve the social wellbeing of individuals and families, the provision of psychosocial care and support is often not considered as an integral part of the multidisciplinary continuum of social welfare services to the needy. In situations where psychosocial care and support is provided, evidence shows that such services are fragmented and inconsistent from one service provider to the other.

The essence of developing this document is to enable psychosocial care and support service providers to provide services in a standardized and user-friendly way at individual, family and community levels. The Government also recognizes that effective utilization of these guidelines requires comprehensive involvement of various actors to respond to psychosocial care and support needs. I therefore urges all services providers to consistently utilize these tools for better service outcomes.

Dr. John K. Jingu
PERMANENT SECRETARY

ACKNOWLEDGEMENT

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) acknowledges the collaborative efforts from different stakeholders who participated in the development of these Standard Operating Procedures (SOPs). Indeed, their active participation and contributions has made it possible to finally put in place these SOPs. Though the space does not permit to mention everyone, we are thankful to all of them for their contributions.

The Ministry appreciates the technical and financial support from various development partners both local and international. It also extends its gratitude to experts from the Department of Social Welfare (DSW), President's Office-Regional Administration and Local Government (PO-RALG), Regional Secretariats (RS), Local Government Authorities (LGAs), organizations, institutions and individuals who participated throughout the entire process in the development of these SOPs.

The Ministry expects that these SOPs will be used by all stakeholders to provide standardized, quality psychosocial care and support services that adequately respond to the needs the people.

Dr. Naftali B. Ng'ondi
COMMISSIONER FOR SOCIAL WELFARE

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
CSWO	Council Social Welfare Officer
DSWO	District Social Welfare Office
HIV	Human Immunodeficiency Virus
LGAs	Local Government Authorities
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly & Children
PO-RALG	President's Office-Regional Administration and Local Government
PSS	Psychosocial Care and Support Services
SOPs	Standard Operating Procedures
SWO	Social Welfare Officer

DEFINITION OF KEY TERMS

Community: A group of people living in the same area with common background or shared interests within a society. This can include people with shared values, identity or belief system.

Counseling: A process where children or adults are helped in dealing with their personal and interpersonal challenges by a third party.

Psychosocial care and support intervention: Any planned program or activity aimed at supporting families and community interactions to effectively contribute to psychosocial wellbeing.

Psychosocial: Refers to the close relationship between psychological experience (i.e. thoughts, emotions and behavior) and social experience (i.e. relationships, practices, traditions and culture).

Psychosocial care and support: Illustrates a continuum of care and support that addresses social, emotional and psychological problems in order to safeguard the well-being of individuals, their families and communities.

Psychosocial wellbeing: A state in which an individual, family or community has material, cognitive, emotional and spiritual strength combined with positive cultural relationship, economic and political environment in which people live.

Social services: Services offered by various institutions (public or private) for the purpose of addressing the needs and problems of the most vulnerable populations, including those most vulnerable children, families, elderly and people with disabilities, people who abuse drugs and alcohol, people living with chronic illness, and survivors of various life-threating situations.

Vulnerable groups: A group which has diminished capacity to access their rights to survival, development, participation, protection and deprived or likely to be deprived or may be at risk of being exploited and/or denied necessary rights.

CHAPTER ONE
INTRODUCTION

1.0 Background

Tanzania faces socio-economic challenges due to poverty, social disintegration, natural calamities, unemployment, and pandemic diseases such as HIV and AIDS. These challenges have considerably contributed to the increased vulnerability whilst simultaneously affecting psychological and social wellbeing of individuals, families, households and communities. Such problems have caused psychological effects, including but not limited to anxiety, depression, stress, distress, loss of life and post-traumatic disorders. As a result, psychosocial care and support services have been of great demand among the infected and affected populations, including individuals, families and communities.

A Baseline Assessment of Community-Based HIV and AIDS Services in Tanzania, conducted in 2017, by the MoHCDGEC in collaboration with PO-RALG and the Tanzania Association of Social Workers, revealed that there are greatest needs of psychosocial care and support services (PSS) services among the infected and affected population. The affected population requires comprehensive, effective, and quality PSS. Although Tanzania has made progress by establishing policy and legal frameworks to address social challenges, provision of such services are fragmented and inconsistent from one service provider to the other.

The essence of developing this document is to enable psychosocial care and support service providers to provide services in a standardized and user-friendly way at individual, family, and community levels.

1.1 Rationale

These SOPs have been developed to enable PSS providers to effectively, efficiently, and consistently respond to psychosocial care and support needs. They provide a practical guide for the psychosocial care and support service providers to deliver quality and standardized psychosocial care and support services throughout the country.

1.2 Objectives of the SOPs for the Provision of PSS

The SOPs are aligned with the National Guidelines for Provision of Psychosocial Care and Support Services, 2020. The objectives of this guideline are threefold:

- Improve the quality of PSS provided to all individuals across the country
- Enhance the quality of PSS provided to all families across the country
- Improve the quality of PSS provided to communities across the country

1.3 Intended Users and Targeted Beneficiaries

This document is mainly intended for use by all providers of psychosocial care and support in both public and private sectors. It is a useful document for relevant officials at national, regional and Local Government Authorities (LGAs) in the provision of technical support for delivery of standardized and quality PSS. The SOPs are designed to address the psychosocial care and support needs at individual, family and community levels.

CHAPTER TWO

STANDARD PROCEDURES FOR PROVISION OF PSYCHOSOCIAL CARE AND SUPPORT SERVICES

These SOPs translate what is in the National Guidelines for Provision Psychosocial Care and Support and set the instructions and provide aid to PSS service providers on how to deliver PSS services in an organized manner. These set of instructions are designed to address PSS needs for individuals, families and communities.

2.0 SECTION ONE: INDIVIDUAL LEVEL

2.1Overview

Provision of the PSS services to an individual should be base on the recognition that every individual is unique. Thus, provision of PSS services should consider such uniqueness.

2.2 Indications to recognize an individual in need of PSS

An individual with PSS needs may be recognized by having, but not limited to, the following indications or signs:

♦ Losing self-control and responsibility ♦ Bed wetting for older children and adults ♦ Physical diseases ♦ Restlessness and Revenge ♦ Despair after diagnoses with long illness e.g HIV and cancer ♦ Denial of illness	♦ Feeling of worthlessness ♦ Aggressiveness ♦ Inability to think logically/rationally ♦ Memory decay/loss ♦ Loss of self/illness identification ♦ Sense of abandonment ♦ Sense of isolation ♦ Confusion	♦ Anxiety and depression ♦ Poor concentration ♦ Lack of support from significant others ♦ Social stigma ♦ Self-isolation ♦ Criminal behavior ♦ Separation or divorce ♦ Unrealistic beliefs ♦ Self-blame ♦ Losing hope

2.3 Guiding principles

The PSS provider should consider the following principles when providing PSS services to an individual:

1. Avoid any sort of discrimination, stigma, or instilling fear or pain of any kind.
2. Avoid exposing an individual to a vulnerable situation.
3. Respect the client and use a simple and appropriate language.
4. Do not judge clients or interrupt during conversation to ensure his/her comfort ability.
5. Use an appropriate and favorable location that ensures privacy and confidentiality.

6. Obtain permission (willingness and readiness) from a client before provision of PSS services.
7. Understand cultures and traditions of the client.
8. Do not engage into any other relationship with the client apart from working relationship.
9. Be alerted to refer cases beyond your limits to appropriate institutions or authorities.

STANDARD OPERATING PROCEDURES FOR PROVISION OF PSS SERVICES TO INDIVIDUALS

SOP 1: CASE IDENTIFICATION

This procedure aims at facilitating the PSS service provider to obtain initial information about the problem and an individual client in need of PSS services. Case identification for an individual client should consider the following steps:

Step1: Contact the respective LGAs, local leaders or influential people **before** gathering clients' identification.

Step 2: Introduce yourself and state reasons for the visit.

Step 3: Request the local authorities, local leaders or influential people to link and introduce you to the client.

Step 4: Introduce yourself to the client and create a rapport.

Step 5: Conduct preliminary interview with client to obtain initial information.

Step 6: Document the issues observed.

Step 7: The nature of the case should determine further proceedings. If the case falls within the capacity of PSS provider, then proceed to SOP 2. If not, refer the client to an appropriate referral service point or provider.

Consideration for emergency situation: In an emergency situation, use an appropriate procedure to save the life of a client.
Considerations at the service point: If client visits a service provision point to obtain PSS services, begin with step 4.

SOP 2: ASSESSMENT OF PSS NEEDS

This procedure is done to collect information from an individual client and from the environment within which the client lives to determine the magnitude of the problem and

potential of the client. Assessment of PSS needs should take into account the following steps:

Step 1: Conduct an in-depth discussion with a client to determine the problem.

Step 2: Conduct interviews with people (relatives, parents, caretakers) close to the client to obtain more information about the problem, if need be.

Step 3: Identify and prioritize PSS needs in agreement with the client.

SOP 3: DEVELOPMENT OF CARE PLAN

A care plan outlines the identified PSS needs, objectives, activities, resources, timeframe, and responsible person. This is developed in consultation between the service provider and an individual client. The following procedures should be followed in developing care plan:

Step 1: Identify individuals or institutions to work with in addressing client's PSS needs.

Step 2: Determine resources required to facilitate provision of PSS services.

Step 3: Engage client to develop clear objectives to address the identified PSS needs or problem.

Step 4: Engage the client to propose PSS activities to be done.

Step 5: Engage client to identify responsible persons or institutions for each of the identified PSS activities.

Step 6: Set realistic timeline for each PSS activity identified.

Step 7: Establish and assign clear roles for service providers and client.

Step 8: Make agreement with client on the implementation of PSS activities and timelines.

Consideration for emergency situation**:** An emergency involves different levels of interventions. These steps can be followed once the emergency has been addressed.

SOP 4: PROVIDE PSS SERVICES

This procedure sets the steps to be followed by the service provider when implementing activities agreed in the care plan. The following steps should be observed:

Step 1: Identify an environment suitable for provision of PSS services.

Step 2: Remind the client on issues agreed upon in the care plan. This may result in changes

to the plan.

Step 3: Recognize and use clients' strengths in the provision of PSS services.

Step 4: Select appropriate techniques and skills to actively engage the client.

Step 5: Support and encourage client to use the identified strengths in meeting the identified PSS needs.

Step 6: Guide the client to have consistency on positive behaviors.

Step 7: Identify other cycles of support available for PSS continuum of care services for the client.

Step 8: Engage and help the client to identify, assess and address his/ her limitations and other barriers during PSS service provision.

Step 9: Engage the client to assess the progress of PSS service provision.

Step 10: With the client, agree on the action needed to address the identified challenges. In case there are no challenges identified then proceed with PSS service provision.

Step 11: Conduct periodic assessment of the problem/signs/conditions to determine the extent of changes as a result of PSS interventions.

Step 12: Conduct follow up to ensure continuity of the PSS services. This can be done by conducting home visits, making regular phone calls, and/or engaging client in various activities that may be beneficial to him or her.

Step 13: Once the problem has been resolved, prepare the client for termination of PSS service provision.

SOP 5: REFERRAL AND LINKAGE

This procedure guides the PSS service provider to refer the client to proceed with services at other service points. This procedure should follow these steps:

Step 1: Identify appropriate PSS service provider available within the area.

Step 2: Discuss and agree with the client about the referral plan and the limitations associated with issues related to confidentiality.

Step 3: Contact the identified PSS service provider.

Step 4: Inform the client about the available PSS service point(s).

Step 5: Use appropriate government tools to refer a client to the identified service provider.

Step 6: Document the referral process and keep records.

Step 7: Conduct a follow up to both client and service provider to establish whether the client received the appropriate PSS services.

Step 8: Collect and file the referral feedback form(s) from the referred service provider.

SOP 6: TERMINATION OF PSS SERVICES

This procedure provides important steps towards the ending of PSS service provision to an individual client. The following steps should be observed:

Step 1: Remind the client about the termination of PSS services.

Step 2: Involve the client to evaluate progress of his/her condition or psychosocial well-being.

Step 3: Discuss and agree with client about the termination of PSS process.

Step 4: Remind the client about other **service providers** who can provide similar PSS services.

Step 5: Thank the client for allowing you to serve and assure him/her about the continuity of services when needed.

General considerations :

- Provision of PSS services should take into account the severity of the problem.
- Refrain from blaming client about the factors that caused the problem.
- A PSS counseling session should not exceed 45 minutes, should one occur.
- Apart from referring the client outside the service point, referrals can be made within the service points.
- Where necessary, consult colleagues, supervisors, and seniors for assistance during the provision of PSS services.

Specific consideration:

Provision of PSS services for children should take into account the following: create a favorable environment for children; consider their levels of maturity and physical challenges; often remind them that they are safe; speak in a calm and soft voice; refrain from blaming them for what happened; give them extra time and attention; ensure there is eye contact at the time of service provision; and avoid mixing children and adults while providing PSS services.

3.0 SECTION TWO: FAMILY LEVEL

3.1 Overview

A family is a social group of people who are closely related by birth, marriage, inclusion, fostering or adoption. They live together, care for each other, and have significant connections that bind them and bring them together. The family is an immediate support system for any client who needs PSS services. The problem of one or more family members may affect the whole family, hence PSS services may be needed. Therefore, capacity building on PSS to family members is very important.

3.2 Indications to recognize family in need of PSS

There are signs that may alert that a certain family is in need of PSS services. These signs include, but are not limited to:

♦ Child/youth headed households ♦ Families with children who live with one biological parent or supported by other people or institutions ♦ Families with terminally ill people e.g. HIV and AIDS, cancer etc. ♦ Families grieving due to the death of their loved ones	♦ Families in matrimonial conflicts e.g. divorce or separations ♦ Families where one or both parents are in prison ♦ Families with people affected by substance abuse, such as excessive alcohol and/or drug abuse ♦ Families with children/people living with disabilities

3.3 Guiding principles

The PSS service provider should be guided by the following principles at the time of service provision to the family:

1. Use of the appropriate language.
2. Dressing style should take into account the values and ethics of the resp ective society.
3. Respect of cultural and religious values of the respective community.
4. Be honest and respectful to your clients.
5. Involve the family in planning and decision making.
6. Do not expose or share the family's information without their permission.
7. Observe and appreciate available capabilities and promising practices in the family.

8. Consent sought from caregivers and beneficiaries/families should be documented.
9. Consider age and maturity of family members.
10. Be empathetic and non-judgmental.
11. Be aware of service limitations and boundaries.

STANDARD OPERATING PROCEDURES FOR PROVISION OF PSS SERVICES TO THE FAMILY

The following procedures should be followed in the provision of effective and quality PSS services to the family:

SOP 1: CASE IDENTIFICATION

This is the first procedure in the provision of PSS services to the family. It helps to capture preliminary information about the problem and family background. The following steps should be observed:

Step 1: Prepare and plan to conduct family visit(prepare all necessary tools, attire should be decent and appropriate, seek relevant information about the family/community to be visited).

Step 2: Introduce yourself to the relevant leadership of local government authorities and state the purpose of your visit. Step 3: Request the LGAs or community leaders to introduce you to the family.

Step 4: Create a good working relationship with the family, including the use of greetings and polite, friendly, warm language.

Step 5: Clearly explain your purpose for visiting the family.

Step 6: Conduct preliminary interview with family to obtain initial information.

Step 7: Document all necessary information gathered during interview.

Step 8: Prepare initial report.

SOP 2: ASSESSMENT OF PSS NEEDS

This procedure aims at gathering information about the family and their environment to determine the magnitude of the problem and strengths of the family. It is important to note

that responding to any problem or issues without conducting an assessment may cause more harm than good. Assessment of PSS needs should take into account the following steps:

Step 1: Conduct an in-depth discussion with the family to establish the problem.

Step 2: Where necessary, obtain additional information from other sources about the problem.

Step 3: Involve and guide the family to identify and prioritize their PSS needs.

Step 4: Assist the family to identify their strengths, available resources, services and opportunities to address their needs.

Step 5: Use the information gathered to determine the intervention to assist the family.

Step 6: Share the information gathered and agree with family on the way forward.

Step 7: Prepare the report.

Consideration for emergency situation**:** During an emergency, assessment should only focus on key information that will help service provider offer the family immediate help.

Considerations at the service point: The service provider should be able to understand his/her shortcomings/weaknesses

SOP 3: DEVELOPMENT OF CARE PLAN

A care plan is a framework that guides provision of PSS services. It is developed jointly between the family and service provider. It outlines identified PSS needs, objectives, activities, resources, timeframe and responsible person. The following procedures should be followed in developing care plan:

Step 1: Remind the family about the identified PSS needs.

Step 2: Engage family members to set objectives and identify activities to be carried out.

Step 3: Set clear roles for the service provider, family members and other responsible persons.

Step 4: Set realistic time frame in agreement with the family.

Step 5: Involve the family in identifying available resources for the implementation of the care plan.

Step 6: Agree upon implementation of the care plan.

SOP 4: PROVIDE PSS SERVICES

This procedure requires the service provider and the family to implement activities agreed in the care plan. The following steps should be observed:

Step 1: Involve the family to identify a suitable environment for provision of PSS services.

Step 2: Remind the family on objectives and activities agreed upon in the care plan. This may result in changes to the plan.

Step 3: Recognize and support the family to use identified strengths in the provision of PSS services.

Step4: Use appropriate techniques and skills to actively engage the family.

Step 5: Encourage family members to continuously support each other by focusing on positive behavior taking place.

Step 6: Engage other cycles of support available for sustainability of PSS services to the family.

Step 7: Involve family members to identify, assess, and address their limitations and other barriers during PSS service provision.

Step 8: Involve family members to assess the progress of PSS service provision.

Step 9: Agree with family members on the action needed to address the identified challenges. If no challenges are identified, then proceed with PSS service provision.

Step 10: Conduct periodic assessments of the problem/signs/conditions and determine the extent of changes resulting from PSS care plan implementation.

Step 11: Conduct follow up to ensure continuity of the PSS services.

Step 12: Prepare for termination of PSS service provision after the problem has been resolved OR refer the case to other service point.

Step 13: Prepare report.

Specific Considerations: Termination of PSS services within a family should consider that not all family members may recover over the same period. Therefore, the service provider should only terminate service to the family members whose psychosocial well-being has improved.

SOP 5: REFERRAL AND LINKAGE

This procedure is important to enable the family to proceed with services with other service points. The following steps should be observed when making referrals and linkages:

Step 1: Identify other service options for referral.

Step 2: Clearly explain to the family the reasons for referral and seek their consent.

Step 3: Contact the identified service option(s) prior to issuing referral.

Step 4: Refer the family to relevant service option(s).

Step 5: Provide appropriate contact information (name of the service provider, telephone numbers, physical address and other contact details in case of emergency).

Step 6: Make follow up on the outcomes of the referral made.

Step 7: Document the referral process.

SOP 6: TERMINATION

Termination is the systematic procedure of ending the relationship between a service provider and the family..The following steps should be taken into consideration:

Step 1: Remind the family about termination of PSS service.

Step 2: Involve the family in evaluating the progress of PSS services delivered.

Step 3: Discuss and agree with the family about ending the PSS services.

Step 4: Agree with the family on the way forward.

Step 5: Thank the family for allowing you to serve and assure the family about the continuity of services when needed.

General considerations: Termination of services may happen at any stage of service provision. Reasons for termination may differ from one client to another based on the period and circumstances. This includes service provider's personal limitations that may affect the delivery of PSS services, conflicts between service provider and the family, client is no longer interested in continuing with services, conflict of interest, death of either party, and transfer or shifting of the service provider.

4.0 SECTION THREE: COMMUNITY LEVEL

4.1 Overview

A community is a group of people living in the same area with a common background or shared interests within a society. This can include people with shared values, identity or belief system. Such communities are likely to face common challenges or problems that require PSS interventions.

4.2 Indications to recognize community in need of PSS

There are various signs in the community which indicate the need of PSS for intervention. Indicators may include conflict among community members, frequent complaints reported by community members, frequent reported violence within community, unresolved disputes in the community or undesirable situation in the community that has attracted attention of the media.

4.3 Guiding principles

Provision of PSS services to the community should be guided by the following principles:

1. Use community cultural entry procedures and requirements.
2. Avoid any form of stigma, discrimination or instilling fear.
3. Do not share community's information without obtaining their consent.
4. Engage community members and leaders in effective restoration of community psychosocial well-being.
5. Ensure sustainability of any effort is geared towards addressing PSS problem.
6. Allow community members to own any effort initiated to change their situation.

STANDARD OPERATING PROCEDURES FOR PROVISION OF PSS SERVICES TO THE COMMUNITY

SOP 1: CASE IDENTIFICATION

Case identification is crucial to determine specific community PSS needs for an appropriate and effective intervention plan. The following steps should be observed:

Step 1: Prepare and plan to conduct a visit to the community (consider preparation of necessary tools, dress code should be decent and appropriate; seek relevant information about the community to be visited).

Step 2: Introduce yourself to relevant LGA leaders and state the reason for your visit.

Step 3: Request the LGA leaders or community leaders introduce you to the respective community.

Step 4: Engage community leaders to gather initial information about the problem.

Step 5: Request community leaders introduce you to the respective community committee(s) for further discussion and planning.

Step 6: Document all necessary information gathered during discussions.

Step 7: Prepare initial report.

Consideration for emergency situation**:** In an emergency situation consider the government directives and or multi-sectoral response team coordinator. Also, take all the necessary precautions or safety measures when providing PSS in an emergency.

SOP 2: ASSESSMENTOF PSS NEEDS

The assessment is a critical step in the PSS provision. It helps PSS service providers better understand the situation of their clients and explore all areas that affect the well-being of a community. The following are steps of assessing the community's situation:

Step 1: Engage community leaders to introduce you to the community.

Step 2: Get introduced and become familiar with the respective committees.

Step 3: If there are not applicable committees, or the committee is inactive, engage community leaders to identify a group of active community members to work with in the identification of PSS needs.

Step 4: Engage community leaders and active community members to identify community members that share common PSS needs.

Step 5: Gather information about the existence of other stakeholders also performing PSS services in the community.

Step 6: Conduct participatory interviews and discussions with community members and affected people to identify PSS needs.

Step 7: Engage and assist the community to identify and prioritize their PSS needs.

Step 8: Assist the community to address the immediate PPS needs.

Step 9: Assist the community to identify their strengths, available resources, services and opportunities to respond to the identified PSS needs.

Step 10: Use the information gathered to determine appropriate interventions to address PSS needs.

Step 11: Share information gathered and plan with community on the way forward.

Step 12: Prepare assessment report.

Key issues to c onsider: PSS service providers should understand community values that may hinder and/or support the provision of PSS services. The service provider should tap into the positive practices that can enhance or facilitate quick recovery from emergency situations. For those that hinder, the service provider should share information that can help community members understand the negative effects of practices while remaining nonjudgmental.

SOP 3: DEVELOP CARE PLAN

A care plan outlines and guides the provision of PSS needs, the type of services to be offered, responsible persons or institutions and time frame. The care plan is developed in collaboration with the service provider, community committees, community leaders and other stakeholders. The following procedures should be followed in developing the care plan:

Step1: Review the identified PSS needs with the committee sand/or identified active community group members

Step 2: Engage PSS beneficiaries, community leaders, and identified community committees to develop objectives and activities for the care plan.

Step3: Set clear roles of the service provider, community leaders, identified community committees, and other responsible persons.

Step 4: Set a realistic timeframe in agreement with the community leaders, identified community committees and PSS beneficiaries.

Step 5: Engage PSS beneficiaries, community leaders, and identified community committees to identify the available resources for the implementation of the care plan.

Step 6: Secure commitment for the implementation of care plan.

SOP4: PROVISION OF PSS IN THE COMMUNITY

This procedure involves clustering community members with common needs to provide PSS services. Follow the following steps to provide PSS services to the identified community:

Step 1: Remind community leaders, identified community committees, and community members about planned PSS activities.

Step 2: Make use of community leaders, influential people, and identified community committees to bring together the community with common PSS needs.

Step 3: Mobilize and make use of available community resources and capacities including the local support groups and self-help groups to facilitate provision of PSS services.

Step 4: Screen and cluster community members into groups according to their PSS needs.

Step 5: Guide the identified groups with mutual PSS needs to utilize their strengths and share their experiences.

Step 6: Assess effectiveness of support groups in addressing PSS needs.

Step 8: Allow relevant potential institutions to provide and support PSS service provision.

Step 9: Conduct a follow up of the progress and to ensure continuity of the PSS services.

Step 10: Prepare report.

Specific Considerations: Use procedures for service provision at individual and family levels if there are PSS needs that were not met at the community level.

SOP 5: REFERRAL

Use referral procedures identified at the individual and family levels to refer clients, individuals and families who may need referral while providing PSS services at the community level. Note that, the referral process should be well documented.

SOP 6: FOLLOW UP

This procedure is fundamental in monitoring and evaluating the condition of the affected community and the continuity of PSS service delivery. The following steps should be followed:

Step 1: Prepare and plan for a follow-up (assessment check list and care plan).

Step 2: Introduce yourself to relevant community leadership and state the objectives for your visit.

Step 3: Request the community leadership to introduce you to the respective community members, including the committees.

Step 4: Accompanied by the community leadership, visit the supported community groups, individuals and families to assess their progress.

Step 5: Engage community leadership and beneficiaries to identify challenges and suggest appropriate strategies to address them.

Step 6: Conduct debrief meeting with community leaders to share preliminary observations, agree on the way forward.

Step 7: Thank all parties for their trust and working with each other.

Step 8: Complete follow-up reports and submit to the relevant authority.

General considerations: In the event that some individuals, families, or/and communities do not see improvement, the service provider, in collaboration with the beneficiaries and community leadership, should revisit the care plan.

SOP 7: TERMINATION

Termination of PSS services at the community level may vary from one situation to another; and from one scenario to another. The service provider should be able to determine an appropriate exit strategy depending on the situation. The exit strategy can be through the community leadership, community meeting and/or stakeholders meeting.

CHAPTER THREE
MANAGEMENT AND FOLLOW UP OF IMPLEMENTATION OF SOP FOR PSS

3.0: Section One: Management

This SOP is an operational tool designed to ensure that provision of PSS services is of quality and standardized across the country. The Council Social Welfare Officers (CSWO) will use these SOPs to provide technical supportive supervision in collaboration with the Ward Social Welfare Officer and the village/Mtaa Social Welfare Officer. The supervision of PSS services is conceived as an integral part of other supportive supervision within the health system. Therefore, the timing and modalities for implementation of PSS supervision should be harmonized with that of the health system.

Quarterly visits by Social Welfare Officers (SWOs) for observation and provision of mentorship and coaching and supportive supervision will require that services providers document all procedures carried out in the provision PSS services. This includes tracking of the services provided on daily basis and submission of information collected in the form of a report to social welfare services at the respective service point. The report should be compiled and submitted to the relevant CSWOs for compilation and integration into the council social welfare report, which is submitted to the regional level and then to the national level.

The national level team should provide frequent technical backstopping to ensure the SOP is effectively implemented to achieve the intended goal reflected in social welfare policies, guidelines, and national social welfare plans. The national team should also review the submitted supervision reports to identify challenges and gaps for improvement of the PSS SOPs and other related guidelines.

3.1: Follow up: Monitoring and Evaluation of the SOP implementation

The SOPs will be monitored to ensure they are implemented in line with the National PSS Guideline. The purpose is to document the implementation process for analysis to

continuously improve the provision of PSS services throughout the country. The following table presents indicators to be follow up for tracking implementation of SOPs.

Table 1: Indicators for PSS Standard Operating Procedures

Objectives	Target	Indicators	Means of Verification
Improve the quality of PSSservices provided to all individuals across the country	PSS providers trained on standard procedures for provision of quality PSS services	% of PSS services providers trained on SOP for PSS	• Training reports • Certificate for participation
		% of PSS services demonstrating proper provision of PSS services to individual	Assessment/supportive supervision report
		% of PSS services providers appropriately delivering PSS services as stipulated in the SOP for PSS	Assessment/supportive supervision report
	Individual with PSS needs served by trained PSS providers on standard procedures	• % of individual served by trained PSS services providers • Number of clients reached by trained PSS services providers	• Compiled daily health facility reports • Quarterly reports
	PSS clients served by trained PSS providers with improved wellbeing	% of clients with improved wellbeing after receiving PSS services from trained PSS services providers	Evaluation report
	PSS clients satisfied with the quality of PSS services provided	% of clients satisfied with services provided by trained PSS services providers	Evaluation report
Enhance the quality of PSSservices provided to all families across the country	Families with PSS needs served by trained PSS providers on standard procedures	• % of families served by trained PSS services providers	• Compiled daily service point reports • Quarterly reports
		• % of families in needs of PSS services identified	• Quarterly reports
		• % of families in needs of PSS services reached by trained PSS services providers	Quarterly reports
	PSS families served by trained PSS services providers with improved wellbeing	% of families with improved wellbeing after receiving PSS services from trained PSS services providers	Evaluation report

	PSS families satisfied with the quality of PSS services provided	% of families satisfied with services provided by trained PSS services providers	Evaluation report
Improve the quality of PSSservices provided to communities across the country	Communities (ward/village/mtaa) with PSS needs served by trained PSS providers on standard procedures	• % of communities (ward/village/mtaa) served by trained PSS services providers	• Compiled daily service point reports • Quarterly reports
		• % of communities (ward/village/mtaa) in need of PSS services identified	• Quarterly reports
		• % of communities (ward/village/mtaa) in need of PSS services reached by trained PSS services providers	Quarterly reports
	PSS communities(ward/village/mtaa)served by trained PSS services providers with improved wellbeing	% of families with improved wellbeing after receiving PSS services from trained PSS services providers	Evaluation report
	PSS communities (ward/village/mtaa) satisfied with the quality of PSS services provided	% of families satisfied with services provided by trained PSS services providers	Evaluation report