

Comprehensive Community- and Home-based Health Care Model



World Health Organization

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FOREWORD

With the double burden of communicable and noncommunicable diseases, and demographic changes, particularly an increase in population of the elderly, the need for long-term and chronic care, and care to manage the activities of daily living, in addition to strengthening the basic health care services, has increased significantly. Moreover, given the escalating costs of health services, vulnerable and underprivileged groups will be even more deprived. Therefore, there is an urgent need for Member States to extend health services beyond hospitals. This is particularly crucial for addressing the challenge posed by HIV/AIDS and other priority public health problems.



Most countries of the South-East Asia Region have established various community-based health care services that integrate into the primary health care structure. However, many of these services lack horizontal integration or proper coordination with other related key programmes even though these services normally fall under the responsibility of the same core health workers. Therefore, it is imperative to provide comprehensive and properly coordinated essential health care services at the community level.

The South-East Asia Regional Office has developed a generic model for comprehensive community- and home-based health care to provide information to Member States on how they can strengthen community health services to meet the changing health needs and to provide holistic, integrated and continuous care that is patient/client-centred, with the active involvement of communities. I am pleased to note that during field-testing this model has been found to be a useful tool in assisting countries to better organize and manage their community health services.

WHO is deeply committed to help Member States adapt this model for use, including developing national capacity and to strengthen their health services to the community. I am confident that its application will contribute substantially to increased accessibility to quality health services, particularly for vulnerable and underprivileged groups. I firmly believe that our joint efforts can, and will, make a major difference to the quality, effectiveness and efficiency of health care in the Region.

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

ACKNOWLEDGEMENTS

This Comprehensive Community- and Home-based Health Care Model is a collaborative work of Departments of Family and Community Health, Health Systems Development, Non-communicable Diseases and Mental Health and Communicable Diseases. This has been developed with the assistance of a Multidisciplinary Working Group formed by the Joint WHO Collaborating Centre for Nursing and Midwifery Development, Faculty of Nursing (Siriraj) and Nursing Department, Faculty of Medicine at Ramathibodi Hospital, Mahidol University, Thailand. Acknowledgement is gratefully made to the Joint WHO Collaborating Centre and each member of the Multidisciplinary Working Group who has helped in developing this Model.

This Model was under critical review for its relevance and practicality within the South-East Asia Region context by concerned national authorities from the countries of the Region in a regional consultation held in August 2001. It was then field-tested in Bhutan, Myanmar, Nepal and Thailand in 2002–2003. A regional consultation was later convened in December 2003 to review the lessons learned from the field test and finalize the Model. WHO gratefully acknowledges the valuable contribution of concerned authorities who participated in the consultations for the development of this Model.

Deep appreciation is due to Dr Guru Prasad Dhakal of Bhutan, Dr Pe Win of Myanmar, Ms Vijaya KC of Nepal and Dr Ronnachai Tungmunanantakul of Thailand and their respective teams, who painstakingly field-tested the Model and provided valuable inputs for its development.

WHO gratefully acknowledges the valuable contribution of Dr Yongyuth Pongsupap of the Ayuthaya Urban Health Centre Project, Thailand and his team who provided training to the principal investigators and participating personnel of countries involved in the field test on the concepts and practices of the Model.

Sincere appreciation is also extended to many WHO Staff from the Regional Office as well as from the Country Offices and Headquarters for their valuable contributions throughout the process.



1. INTRODUCTION

The countries of the South-East Asia Region (SEAR) face a major challenge from increasing health care costs. Thus, accessibility to health services becomes an important issue that the SEAR countries need to address. There is a continuing trend to shorten hospital stay. In addition, with the increase in the incidence of noncommunicable diseases and an ageing population, there is a great need for long-term and chronic care. For cost-effective care, several health interventions can be effectively carried out within the community or at home. Furthermore, for most people, home is the setting of choice for receiving care. Therefore, it is imperative to extend the health services beyond the hospital walls, particularly to those in the greatest need.

The model for comprehensive community- and home-based health care (CCHBHC) has been developed to ensure better accessibility to health and quality community health care.

This document contains background information related to the development of the model, clarification of the goal and objectives, and articulation of the principles underpinning the model. A range of strategies to facilitate delivery of the model is highlighted. The document identifies the core elements of the model and provides an overview of the issues that need to be taken into consideration wherever the model is implemented. The model is based on partnership and local context, linking formal and nonformal caregivers, empowering individuals, the family and community for self-care and self-reliance, and providing a bridge between the individual, family and community, and the health care system. The document concludes with guidelines for implementing the model.

2. BACKGROUND

Several decades ago, primary health care was successfully established in many SEAR countries as an essential approach for the delivery of the 'Health for all' policy of the World Health Organization (WHO). The primary health care infrastructure provides a foundation for the provision of health care in most of the countries. This approach has increased the accessibility to health care in most countries in the region. However, there are still a considerable number of people for whom this is not yet a reality.

Early models of primary health care focused on the prevention and control of communicable diseases. However, the health needs of the population are changing because of increased life expectancy, an ageing population and changes in disease patterns. There is an increasing need to provide health care

within peoples' homes and in local community settings. This includes acute, curative and rehabilitative care in addition to the promotion of health and prevention of illness. Existing models and approaches need to be adapted and developed to meet these changing needs and provide more effective support to individuals, families and communities, enabling them to make better use of existing resources. Traditionally, for many people, health care has been mostly provided by nonformal caregivers. These caregivers have had little recognition for their contribution and little support from the health care system.

The Regional Office developed the model for CCHBHC to provide information to countries on how best they can strengthen their community health services to meet the changing health needs and for better utilization of resources. This model places patients/clients at the centre of care and acknowledges the contributions that individuals, groups and communities make in achieving and maintaining their health, and managing illness throughout the lifespan. It provides an overall framework, and includes systems and processes that can be adapted to meet the needs and priorities of local communities. It, however, builds on the existing health system that is available in the community, and aims to make essential care for priority health problems more accessible to the needy, such as Directly Observed Treatment, Short-course (DOTS) for the treatment of tuberculosis (TB) and home-based AIDS care in support of the 3 by 5 Strategy.¹

This model is developed with the active involvement of Member States.² It is based on good practices in countries within and outside SEAR. It was field-tested in Bhutan, Myanmar, Nepal and Thailand in 2002–2003. The field test revealed that this model is a useful managerial tool to assist countries in strengthening their existing community health services and enable them to effectively work with individuals, families and communities for the provision of quality health care.³

This model has been further refined by taking into account the outcomes of the field test exercises. It is intended to be a generic model that can be adapted and implemented by each SEAR country according to the country's needs and context.

1 WHO AIDS Strategy to treat 3 million AIDS patients by 2005.

2 The Model was developed with assistance of the Multidisciplinary Working Group formed by the Joint WHO Collaborating Centre for Nursing and Midwifery Development, Mahidol University, Thailand. It was under critical review before field-testing in a regional consultation in August 2001. It was then field-tested in Bhutan, Myanmar, Nepal and Thailand in 2002–2003. A regional consultation in December 2003 reviewed the field-testing experiences and finalized this model. The list of Working Group members, participants of the two consultations and principal investigators of the field test are given in Annex 1.

3 Detailed information of the outcomes of the field test is provided in WHO (2004) *Model for comprehensive community- and home-based health care: Report of a regional consultation*, 2–4 December 2003. New Delhi: World Health Organization, Regional Office for South-East Asia.

3. DEFINITION

In this model, CCHBHC is defined as an integrated system of care designed to meet the health needs of individuals, families and communities in their local settings. It includes primary prevention, i.e. prevention of health problems and/or diseases before they occur (health promotion and disease prevention); secondary prevention, i.e. early detection of problems or diseases and intervention (curative care and support); and tertiary prevention, i.e. correction and prevention of deterioration, rehabilitation and terminal care (rehabilitative care). It is underpinned by the partnership between health workers, clients/patients and members of the local community.

CCHBHC can be provided in numerous settings in the community, by various people including health professionals, care assistants, and nonformal caregivers such as volunteers and family members. Examples of the types of activities involved are provided in Table 1.

Table 1. Examples of community- and home-based health care activities

Setting	Primary prevention	Secondary prevention	Tertiary prevention
Home	<ul style="list-style-type: none"> • Health education⊕ • Health promotion♦ • Disease prevention • Antenatal care • Immunization • HIV counselling • Condom promotion 	<ul style="list-style-type: none"> • Simple treatments, e.g. wound care • Referral • Drug administration • Safe delivery • Newborn care 	<ul style="list-style-type: none"> • Rehabilitation • Palliative care • Management of chronic diseases, e.g. diabetes, HIV/AIDS*+♣♦
Community, e.g. <ul style="list-style-type: none"> • Health centres • Schools • Village halls • Places of worship • Workplaces 	<ul style="list-style-type: none"> • Exercise programmes*♣ • Elderly/health clubs♣ • Environmental health campaign♣+♣ • Mosquito control campaign*+♣ • School health* • Development of personal skills *+♣ • Parenting classes • Women/community empowerment groups • Safe sex campaign*+♣ • Information, education and communication, e.g. family planning 	<ul style="list-style-type: none"> • Screening* • Referral • Needs assessment • Care • Mass/group treatment (e.g. deworming of schoolchildren) 	<ul style="list-style-type: none"> • Self-help groups such as mental health support groups♣ and HIV/AIDS self-help groups♣ • Emergency care • Community-based rehabilitation • Community-based AIDS care

Activities could be led by:

*Health worker including doctors, nurses and midwives

⊕Traditional healers and traditional birth attendants

+Community member

♣Volunteer

♦Family member

♣Client/patient/consumer

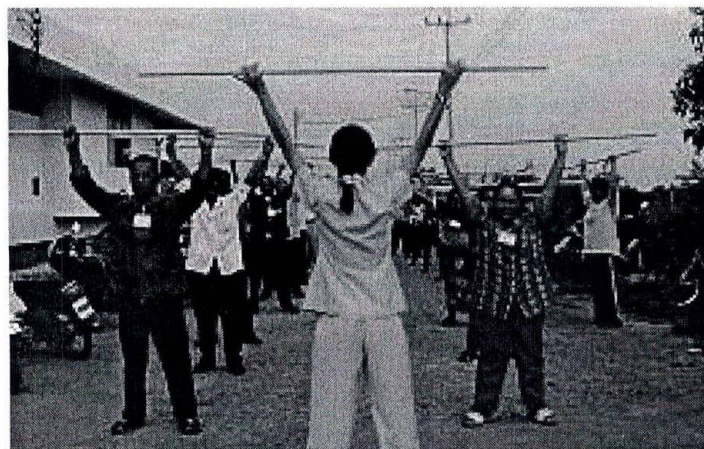
4. GOAL

The goal of CCHBHC is to ensure better accessibility to effective and efficient health care in community and home-settings to improve health and well-being, and contribute to morbidity and mortality reduction.

5. OBJECTIVES

To achieve the goal of providing accessible, effective, efficient and comprehensive health care addressing the country/community's priority health problems, the objectives of CCHBHC are broadly divided into five categories as follows:

5.1 *Promoting a healthy lifestyle and preventing illness* by motivating and supporting members of the community to proactively maintain and resist threats to their health. Self-care reliance of the individual, family and community, and proper health-seeking behaviours are the expected outcomes.



5.2 *Managing the consequences* of illness by meeting the needs of those requiring care as a result of changing physical, psychological, social and/or cognitive functional capacities across the lifespan.

5.3 *Serving the needs of the vulnerable and underprivileged* by reaching out to them and meeting their health needs as identified in the community assessment. This would include people with disability, mothers and children, the elderly, and the poor and minority groups.

5.4 *Supporting informal caregivers* by acknowledging the contribution of family members, neighbours and volunteers and providing them with the

knowledge, skills, resources and emotional support to enable them to continue to provide hands-on care at home.

5.5 *Strengthening the community* by establishing, and/or strengthening partnership and networking between the community, health care providers and other sectors within the government and nongovernmental organizations (NGOs) to facilitate community actions for health and well-being.

6. PRINCIPLES

The model is designed to reflect the following principles that are used to guide decision-making and strategy development:

- Quality – structures and processes of care are organized to ensure that the care delivered is holistic,⁴ integrated⁵ and continuous,⁶ and in accordance with the agreed standards;
- Partnership – appropriate opportunities and methods are made available to enable and empower all stakeholders, including intersectoral partners to participate in decision-making and work in an honest and open partnership;
- Equity – equitable access is ensured to all services and resources with a focus on the vulnerable and underprivileged groups;
- Effectiveness⁷ – special efforts are made to ensure that an intervention or service provided for the patient/client yields the intended result(s); and
- Efficiency⁸ – optimal use is made of the range and mix of available resources (e.g. financial, human, physical and technical resources) in support of the delivery of evidence-based practice.

4 *Holistic care* focuses on the interaction among physical, psychological, social and spiritual well-being. Interconnectedness between the individual, family and community is recognized.

5 *Integrated care* is characterized by integrating different care dimensions to derive the best benefit including primary, secondary and tertiary prevention (i.e. health promotion and disease prevention, curative care and support, and rehabilitation).

6 *Continuous care* refers to the smooth continuation of care between home/community and health facilities, including the referral system.

7 *Effectiveness* is a measure of the extent to which a specific intervention, procedure, regime or service when deployed in the field in routine circumstances achieves what it is intended to do for a specified population (WHO Health Systems Performance: <http://www.who.int/health-systems-performance/doc/glossary.htm#effectiveness> accessed 3/30/04).

8 *Efficiency* is the capacity to produce the maximum output for a given input (WHO Health Systems Performance: <http://www.who.int/health-systems-performance/doc/glossary.htm#effectiveness> accessed 3/30/04)

7. STRATEGIES

To attain the objectives and ultimately achieve the goals, a variety of strategies need to be employed. It needs to be ensured that all parts of the health care system function in a coherent and integrated way. The strategies reflect the principles underpinning the model and include the following:

- Strategies for involving all stakeholders ensuring political commitment and support;
- Strategies for mobilizing and managing resources building on the existing system; and
- Strategies for developing and implementing appropriate health information systems.

Some of the components of these strategies are given in Tables 2–4.

Table 2. Strategies for involving all stakeholders

	Input	Process	Output
Empowerment	Major stakeholders such as: <ul style="list-style-type: none"> • Individuals • Families • Caregivers • Volunteers • Communities • Organizations 	<ul style="list-style-type: none"> • Education and training • Mechanisms for communication and decision-making 	Major stakeholders who are: <ul style="list-style-type: none"> • Committed • Supportive • Involved • Motivated • Influential • Confident • Self-reliant
Partnership and participation	<ul style="list-style-type: none"> • Individuals • Families • Community groups • Village committees • Existing local structures • Self-help groups • Key contacts in other sectors • Agencies in other sectors • Religious groups • Nongovernmental organizations (NGOs) • Referral organizations • Hospitals • Academic institutions 	<ul style="list-style-type: none"> • Partnership building • Networking • Coordinating • Advocacy • Organizing community meetings • Developing mechanisms for communication and decision-making 	<ul style="list-style-type: none"> • Involvement of relevant major stakeholders in primary, secondary and tertiary prevention (i.e. health promotion, disease prevention, curative care and support, and rehabilitation) • Ownership • Commitment • Agreed priorities • Joint action • Solidarity • Sustainability

Table 3. Strategies for mobilizing and managing resources

	Input	Process	Output
Human resources	<ul style="list-style-type: none"> • Nonformal caregivers • Volunteers • Family members • Community members • Health workers <ul style="list-style-type: none"> – assistants – nurses – midwives – doctors – others 	<ul style="list-style-type: none"> • Identification of key people • Identification of skills required* • Education, training and development of health workers and nonformal caregivers • Supportive supervision 	<ul style="list-style-type: none"> • Right people right place, right skills and right attitudes • Training programmes
Financial resources	<ul style="list-style-type: none"> • Resource mobilization • Funding mechanisms • System of financial management 	<ul style="list-style-type: none"> • Identification of key stakeholders and potential backers • Integration with existing systems • Agreement on costing and control mechanisms • Self-financing • Third-party payers 	<ul style="list-style-type: none"> • Efficiency • Accountability • Transparency
Material resources	<ul style="list-style-type: none"> • Equipment • Drugs • Technical materials 	<ul style="list-style-type: none"> • Establishment of systems and processes to ensure a continuous and timely supply of essential materials in the right quantity • Maintenance of equipment 	<ul style="list-style-type: none"> • Right equipment, drug and technical materials in the right place at the right time

*An example of the required skills is provided in Annex 2

Table 4. Strategies for developing and implementing appropriate information systems

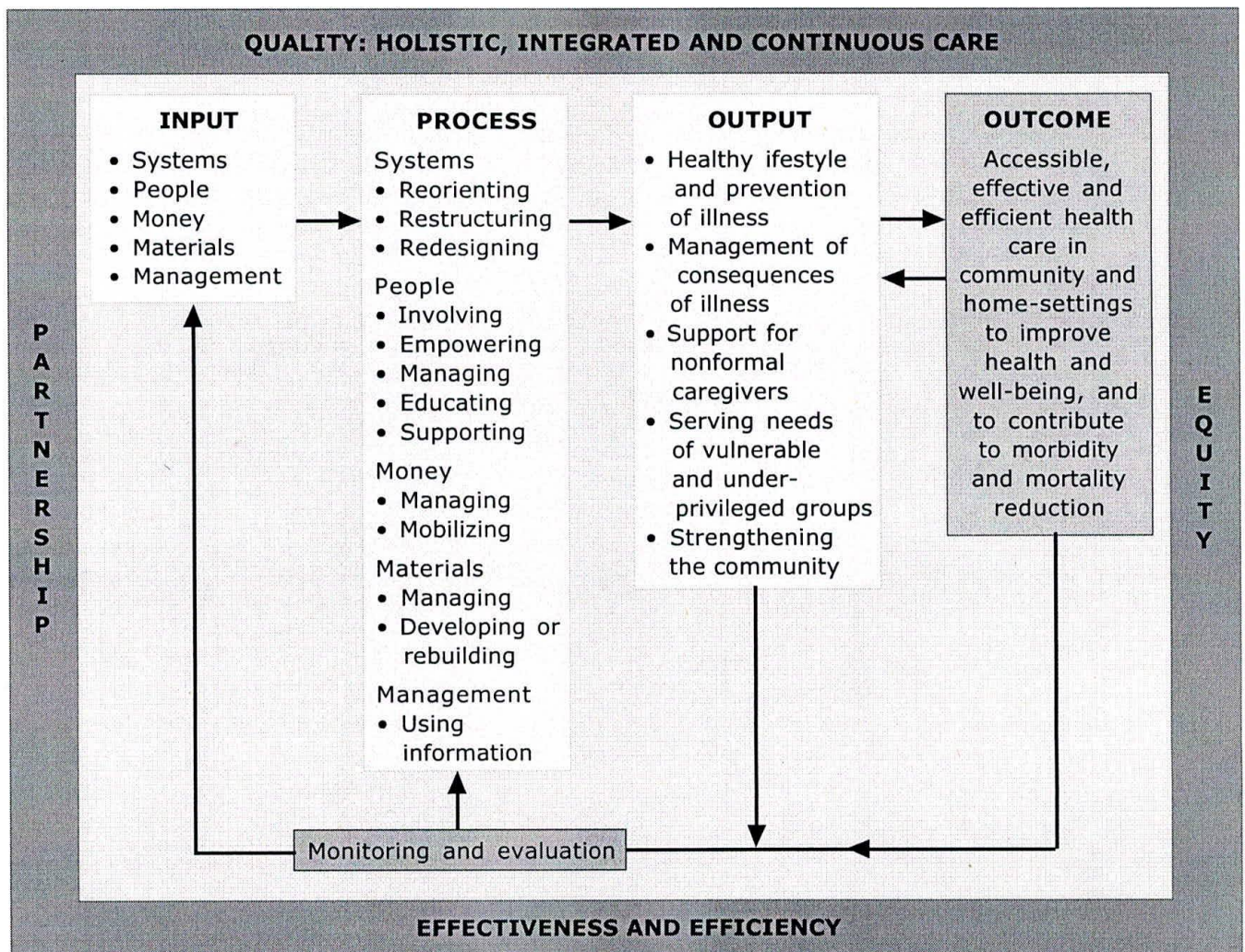
	Input	Process	Output
Health and management information	<ul style="list-style-type: none"> • Systems for collecting, using, storing and retrieving information 	<ul style="list-style-type: none"> • History-taking of individual and family health • Assessing community needs • Ongoing dialogue 	<ul style="list-style-type: none"> • Information to plan, implement, monitor and evaluate needs and care provided when and where needed • Information to improve and monitor the system of care
Information for Practice	<ul style="list-style-type: none"> • Information resources including books and journals • Teaching aids • Quality improvement tools, e.g. care standards, home visit protocols or guidelines 	<ul style="list-style-type: none"> • Development and use of knowledge and skills to identify and manage appropriate information 	<ul style="list-style-type: none"> • Appropriate levels of access and ability to use relevant information including evidence to change and develop practice • Use of evidence-based guidelines and protocols

8. CONCEPTUAL FRAMEWORK

A conceptual framework of the model is provided in Figure 1. It highlights the dynamic nature of the model, which includes multiple feedback loops, and ongoing monitoring and evaluation indicating that changes and deviations can be addressed at any point in the ongoing implementation of the model. The principles are shown to underpin every aspect of the model.

This model is based on the assumption that, at present, comprehensive health care provided at home and in community settings is not well established or in place in the existing health system.

Figure 1. A conceptual framework of the model



To implement this model, the existing health care system has to be reoriented towards the provision of holistic, integrated and continuous health care that needs to be extended beyond health care facilities. In addition, there needs to be a restructuring of health services to shift the emphasis on curative care (or to restore health) towards increased attention to health promotion and protection (or to build good health). Health care services must be redesigned to meet local health needs as agreed with the community.

The community must be actively involved in planning, implementing, monitoring and evaluating care. The active participation of individuals, families and communities in protecting and promoting their own health has been shown to improve effectiveness. In addition, empowering individuals, families and communities will increase the awareness and demand for quality health services.



There should be sufficient health care providers to give care at home and in communities. In addition, these health personnel must be educated systematically and continuously to improve their understanding of the concepts and practices in CCHBHC, and build their skills for providing quality care. In addition, community and nonformal caregivers must be supported and empowered. Moreover, partnership will also need to be established or strengthened with other key actors in the community (e.g. NGOs, social welfare workers, etc.) to provide quality health care.

For the sustainability of CCHBHC, special efforts have to be made for effective financial management and resource mobilization. Costing, when

appropriate, and financial control mechanisms will need to be decided with the involvement of community to ensure equity, effectiveness and efficiency of care.

Moreover, tools to provide holistic, integrated and continuous care will need to be developed or redesigned for use in target populations, such as home visit standards, family folder or personnel book for home visit. The use of information in the management of CCHBHC needs to be strengthened to provide as well as monitor and evaluate the quality of CCHBHC. These will facilitate the attainment of the objectives of CCHBHC, which will ultimately lead to achieving the goal of better accessibility to effective and efficient health care in community and home settings. This will improve the health and well-being of the community, and contribute to morbidity and mortality reduction.

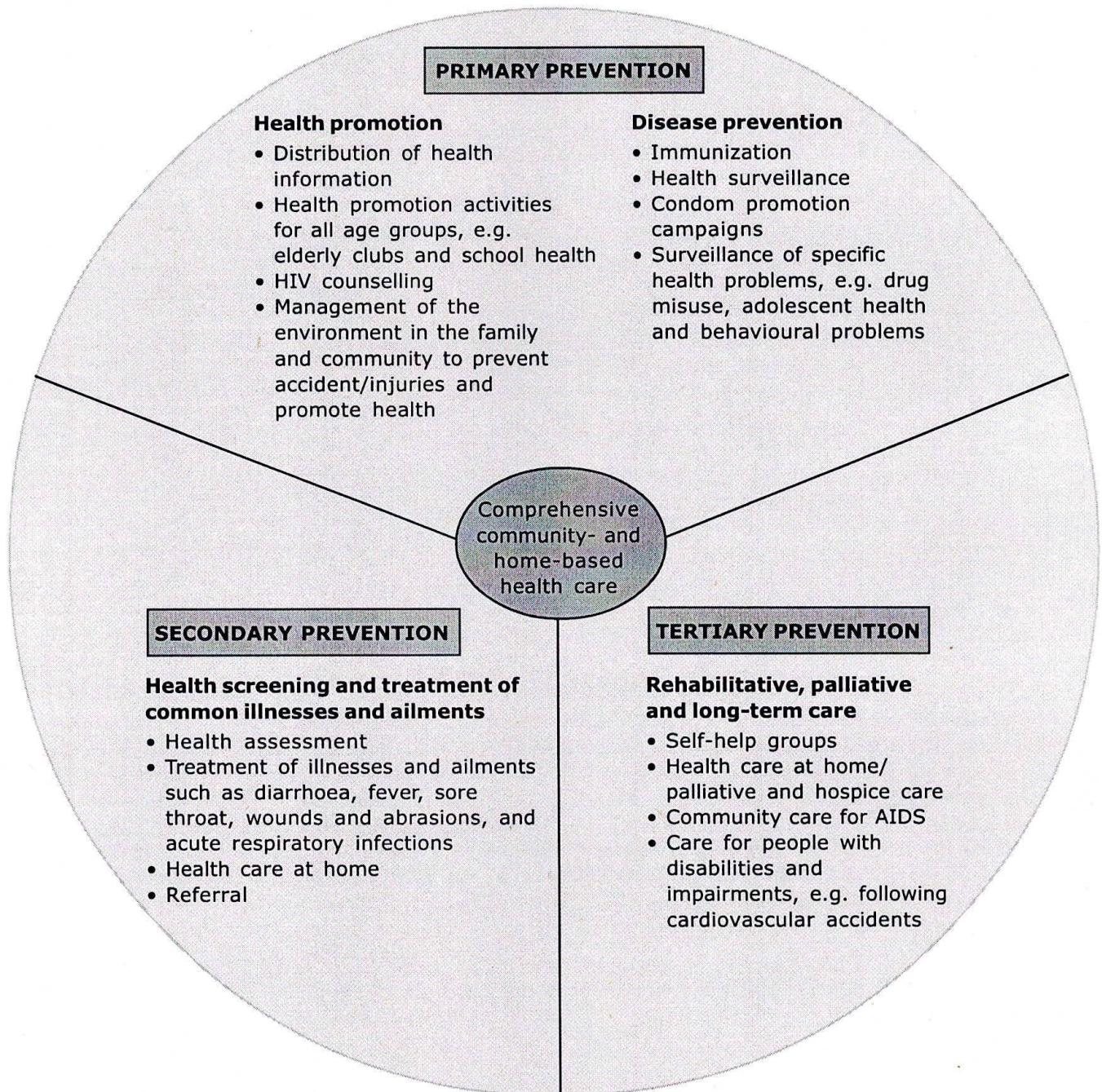
9. CORE ELEMENTS

CCHBHC builds on the three levels of prevention common to primary health care. It places an increased emphasis on health promotion, long-term and palliative care, and rehabilitation in addition to curative care.

- (i) *Primary prevention* consists of activities for health promotion and prevention of illness at the individual, family and community level.
- (ii) *Secondary prevention* focuses on screening, early detection, provision of treatment and care for common illnesses and ailments, and appropriate referral.
- (iii) *Tertiary prevention* comprises the provision of rehabilitative and palliative care for patients with chronic illness and disability.

The minimum service package for CCHBHC needs to be determined in each country based on health needs at the community and home level, and available resources. Examples of care delivery of each core element are provided in Figure 2.

Figure 2. Examples of care delivery of the core elements of comprehensive community- and home-based health care



10. OPERATIONAL OVERVIEW

To develop and implement the CCHBHC model, the following issues need to be taken into consideration.

10.1 Nature of the Programme

The CCHBHC model aims to increase the accessibility to quality health care in the community and home, as well as in facilities (first-level of contact, e.g. health centre). It also aims to increase the self-care abilities of



individuals, the family and community. It places patients/clients at the centre of care. By expanding the focus of existing systems of primary health care with the inclusion of rehabilitative as well as palliative and long-term care, curative and emergency care, the model offers a holistic approach to address the health and illness continuum throughout the lifespan. The care providers could be health personnel, family members, groups, the community, etc. Health personnel will be responsible for providing training and support to nonformal

caregivers and the community. Services can be delivered at home through home visits (*see* Annex 3), at the health centre or in any appropriate place in community settings, e.g. clinic, school, village meeting hall and places of worship, according to the community needs.

10.2 Coverage and Eligibility Criteria

The CCHBHC model aims to cover all age groups in various health states in a geographical area. The priority health states will be based on community diagnosis and priorities agreed upon with the local community. It is not realistic to expect to meet all possible health needs and demands, therefore, services will need to be rationalized accordingly. Thus, criteria for identifying health priorities (e.g. whether to give priority to chronic conditions, or acute illnesses, or health promotion, etc.) as well as the target population and those requiring home visits will have to be clearly defined and agreed to by the community so as to effectively utilize resources.

10.3 Provision of Care

This model builds on the existing health system but because access to care

is through multiple entry points it is essential that supportive mechanisms are in place to ensure that care provision is coordinated and integrated. This requires clear systems and processes designed to facilitate the smooth movement of the patient through the health care system, including the health centre and hospital, and back to the home and community. A key to success is efficient and effective use of information by all those involved in the provision of services to the patient.

The care provided will depend on local priorities. Activities and tasks should ideally be the responsibility of the person or institution best suited to perform them. Health personnel will refer patients for more specialized care and treatment when necessary. All services should place patients/clients at the centre of care and contribute to the development of a good relationship between the service providers and clients, based on mutual trust.

The services at a health centre or primary care unit should include, but not be limited to, the following:

- Health promotion and disease prevention programmes;
- Outpatient clinic;
- Care and active follow-up in emergency situations;
- Care and active follow-up of acute and chronic patients;
- Care and active follow-up of high-risk groups;
- Home visits; and
- Community meetings.

Community meetings provide a forum for health personnel to have systematic interaction with the community. This is imperative as partnership with the community is essential for the successful operation of CCHBHC. Community meetings should be scheduled with a set agenda, which will facilitate active involvement of the community in the management of CCHBHC as well as strengthen the community as a whole.

Annex 4 contains an example of a weekly schedule of services coordinated through a health centre at the subdistrict level. Some examples of the activities carried out in the Ayutthaya Research Project,⁹ Thailand are provided in Annex 5.

9 The Ayutthaya Research Project (1989–96) was a health system research project resulting from a collaboration between the Ministry of Public Health, Thailand and the Institute of Tropical Medicine, Antwerp, Belgium, with EU funding. The general objective of the project was to establish health system research for continuous improvement of the health services to attain an integrated health care system. Principles of the project had been adopted and developed further from the Kasongo Project, Zaire.

10.4 Programme Management

The CCHBHC model will have to be managed as part of the existing health system for the sustainability of services. Successful management of the model is dependent on its integration with health system priorities, the relationships and sense of ownership between the community and relevant agencies such as health centres, and on intersectoral collaboration. However, NGOs, religious organizations and the private sector could be involved in the development, implementation and management of the programme at a certain level. Therefore, special efforts will need to be given to ensure complementarity of services provided by these organizations and those provided under the CCHBHC model, and to minimize duplication of work.

10.5 Human Resources

It is suggested that the health centre or primary care unit should have at least two health personnel who may be nurses, nurse midwives, or other primary health care workers with the necessary knowledge and skills. Health volunteers are also essential and they need to be appropriately trained and supervised by the health workers.



The staff and skills mix ratio will be dependent on the local health needs and priorities, and the level of human resources available in the communities, including the services of volunteers and national human resource for health policies. The roles and functions of each health worker in the provision of CCHBHC will need to be clearly defined and suitable training provided to them.

Where possible, it is also recommended that an appropriate person be identified to manage the clerical and administrative functions, thus enabling health personnel to focus on clinical activities. Leadership in this health centre or primary care unit will also need to be strengthened.

10.6 Finance and Costing

Mobilization of financial resources for the programme will be largely determined by the existing national policy with particular emphasis on

affordability and sustainability. Costing and financial control mechanisms will be agreed within the context of the overall financial strategy in each country.

10.7 Monitoring and Evaluation

Monitoring mechanisms need to be in place to ensure that activities are carried out according to the plan, and in case deviations occur, corrective actions are taken immediately. Feedback loops need to be established so that lessons can be learned and acted upon without delay and waiting for the final evaluation.

The overall evaluation will include a number of facets including the extent to which the objectives have been achieved and their contribution to public health; and the process and outcomes of implementation. As the model seeks to offer people a better quality service based on agreed principles, the indicators used will be both qualitative as well as quantitative. Indicators for monitoring the attainment of health-related Millennium Development Goals at the community and national level may also be used. Some examples for process and outcome indicators are suggested below. Detailed information about the approach used in the Ayutthaya Research Project is included in Annex 6.

- Levels of appropriate health-seeking behaviours
- Utilization rates and trends
- Coverage of the CCHBHC
- Referral patterns
- Immunization coverage, e.g. proportion of 1-year-old children immunized against measles
- General awareness among the population
- Community involvement and sense of autonomy.

10.8 Prerequisites for Successful Implementation of the CCHBHC

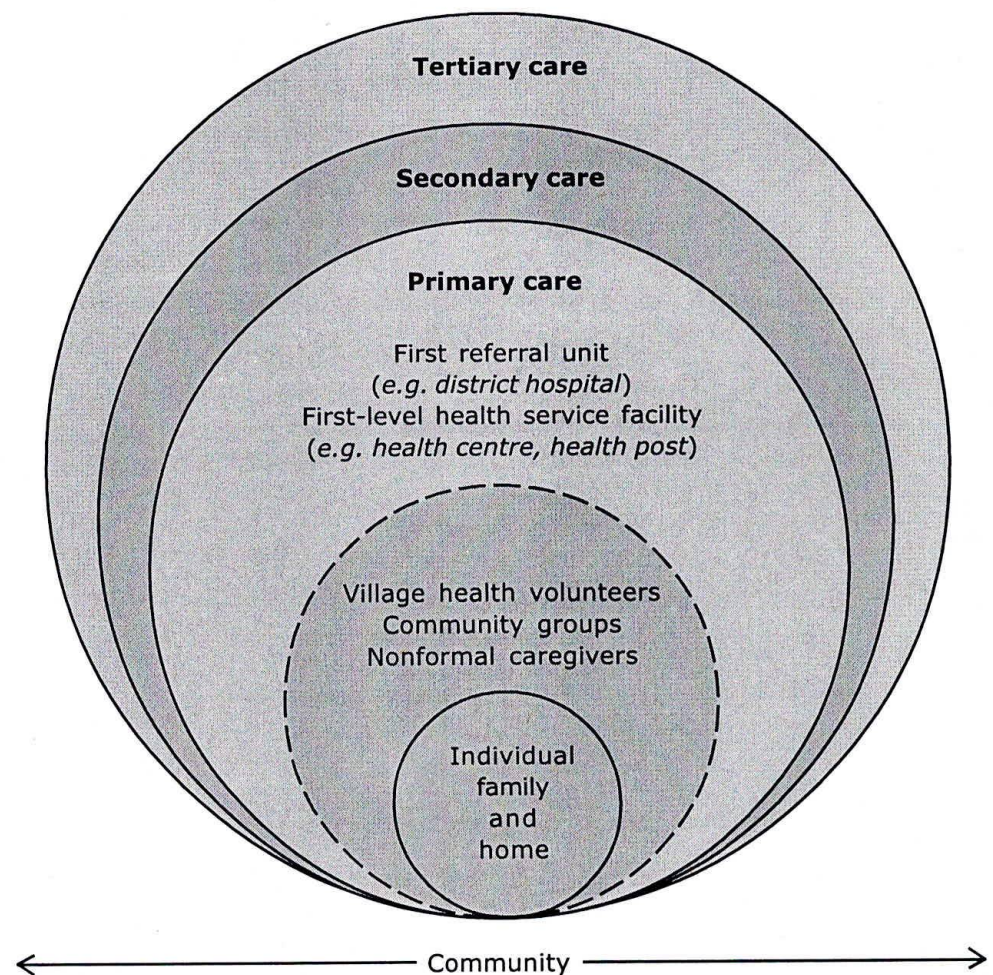
Successful implementation of the model will largely depend on:

- Political support at every level;
- Effective financial management;
- Leadership skills and motivation of health workers and the community;
- Clear understanding of the concepts and practices of CCHBHC at all levels; and
- Level of autonomy of the family and community, and their ability to be involved in and influence the decision-making process.

11. ACCESS TO CARE AT THE COMMUNITY LEVEL

The CCHBHC model is based on strong linkages between the home, community and health facility. Collaboration between all partners is necessary for the delivery of holistic, integrated and continuous care. Thus, the role of village health volunteers and health personnel at different levels of the district health system needs to be maintained and expanded. Figure 3 shows the relationship between individuals and primary, secondary and tertiary levels of care with the health volunteers at the interface.

Figure 3. Linkages at different levels of care in comprehensive community- and home-based health care services



Definitions of terms used in Figure 3 are as follows:

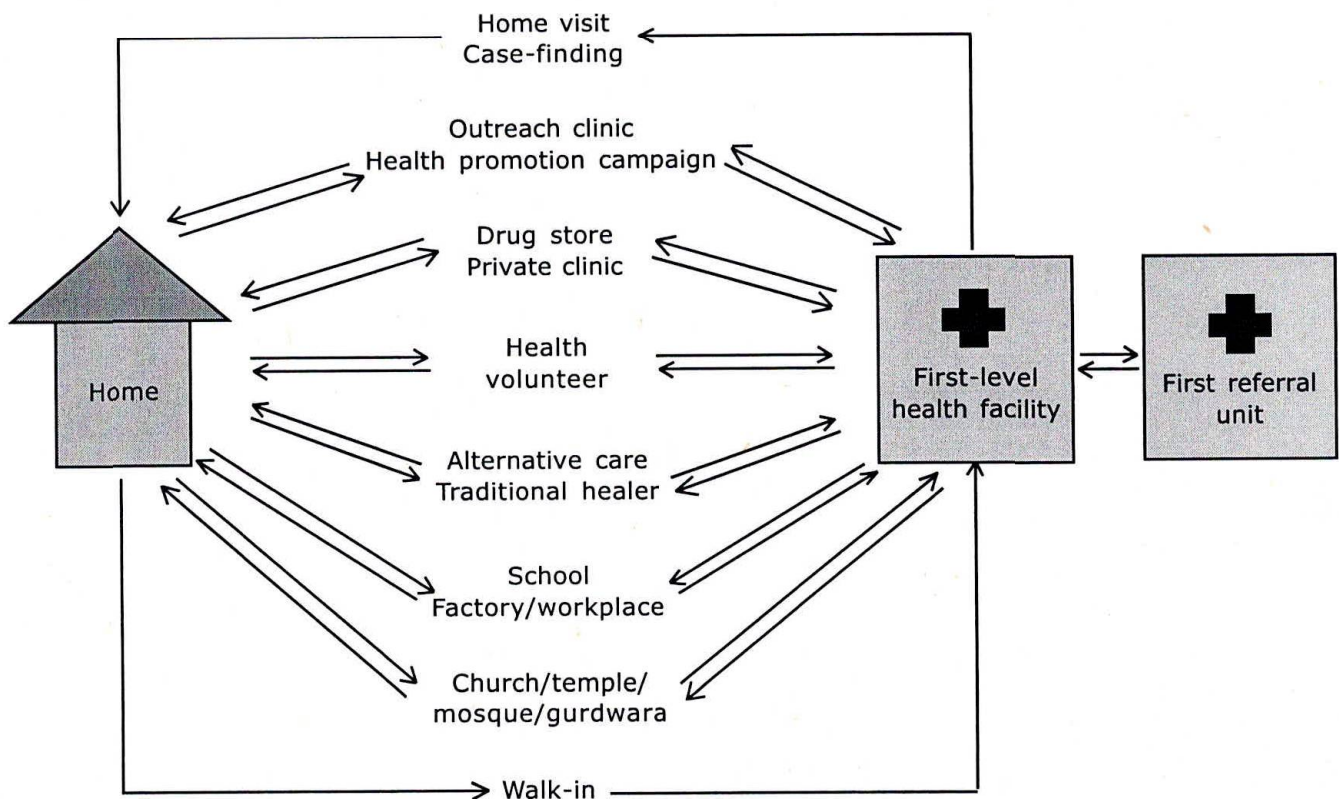
- *Home or family* is the essential unit that influences individual health behaviours and health status. The family provides care for patients with both acute and chronic conditions.
- *Community health volunteers* are selected by their own community and trained by the health sector to carry out particular activities. They

provide an interface between individuals and health facilities wherever necessary. For example, they can work collaboratively with the health personnel to promote health, distribute health information, conduct group meetings, provide care at home, and identify and refer cases to the health facilities.

- *Health centre* is a first-level health care facility which might have different names in different countries. Care is provided in the health centre as well as in the community and home. When necessary, cases are referred to the first referral unit such as a district hospital. For more severe cases requiring complex interventions, referral may take place to a secondary care facility such as a provincial hospital. The most severe cases are referred, as required, to tertiary care facilities such as a regional hospital or medical centre.
- *Primary-level care* refers to care provided at home, in the community, first-level health facilities and first referral unit.
- *Secondary-level care* refers to a higher level of more specialized care requiring sophisticated technology.
- *Tertiary-level care* refers to superspecialized, high-technology care.

Comprehensive community- and home-based health care can be accessed through multiple entry points as illustrated in Figure 4.

Figure 4. Multiple entry points to comprehensive community- and home-based health care



Example: The mother of a 2-year-old boy who has had diarrhoea since the previous evening might use a home-made rehydration remedy or buy an oral rehydration treatment from the local drug store. Alternatively, she may ask for help from the village health volunteer. If the diarrhoea persists, the mother may take the child to the health centre. Following assessment by a health worker at the first-level health facility, enteric fever could be diagnosed. If treatment is not possible at this level, the child is referred for admission to a district or provincial hospital. In recognition of the possibility that this has been caused by the use of contaminated water within the community, the health campaign for preventing communicable diarrhoea is put into operation by the health personnel. Following the child's discharge from hospital, a home visit is made to ensure full recovery and prevent contamination within the family.

12. IMPLEMENTATION GUIDELINES

The guidelines for the implementation of the CCHBHC model are based on strategies that were used effectively in countries within and beyond SEAR. Particular attention was focused on the lessons learned from the Thailand experience of the Ayutthaya Research Project and Health Care Reform Project¹⁰ as well as from the field test of the model in Bhutan, Myanmar, Nepal and Thailand.

12.1 Implementation Principles

A framework for implementing the model is built on the following principles:

- The health centre¹¹ is the main structural focus involved in providing and facilitating community- and home-based health care. Therefore, the infrastructure of the health centre should be strengthened to create maximum opportunities for access in every aspect, i.e. geographical, cultural and psychological, as well as financial aspects.
- Careful planning must precede the implementation of the model.
- Each country must decide its own implementation plan as well as the best strategies and actions.

10 Health Care Reform Project (1996–2000) originated from a series of reform initiatives that started in the late eighties and early nineties, and owed a lot to the Ayutthaya Research Project, which developed a new model of primary health care delivery, and led to the 'Decade of Health Centre Development.'

11 The health centre is defined as an element of the district health system whose specific function in primary health care is to be a point of interaction between the service and a defined community to which it supplies comprehensive health services.

12.2 Implementation Approaches

A policy decision needs to be taken at the national level to implement the model for strengthening community health services and to accept responsibility for the overall management of the model.

Responsibility for planning, strengthening and implementing CCHBHC lies at the district level. Local demonstration sites will be used to develop and strengthen the concept; to learn lessons about the adaptations required to fit the country and local community situations; to ensure effective implementation; and to plan scaling up of CCHBHC within the country.

Close cooperation is necessary at the national, district and local levels at all stages, right from the initial decision-making and planning stages to the implementation and evaluation stages.

Implementation of the model in a country requires

- National policy and support
- Local action
- Involvement of all stakeholders throughout the process
- Initiation of small trials in selected areas to learn lessons
- Evaluation of experiences and lessons learned for sustainable strategies
- Coverage of and expansion to other areas

12.3 Actions

The model should be implemented as part of the existing community health services in countries of the Region. However, some changes will be necessary to enhance the quality and accessibility of the existing community- and home-based health care.

Whenever new changes or innovations are introduced, they are likely to be taken up by only a few leaders. When they are demonstrated to be successful, others begin to adopt the changes. Eventually, these become routine practices. To be successful, the implementation of the model needs to be undertaken in a careful and phased manner. It should be carried out over the following two well-defined phases:

- Phase 1: Preparing for the implementation
- Phase 2: Implementing community- and home-based health care.

However, it is not necessary to carry the following activities in a linear and sequential manner. A number of activities take place at the same time,

depending on the local situation. The activities require different time-scales. Some are one-off activities, such as identifying the demonstration site, while others are continuing activities such as involving communities and engaging in dialogue with families, skills development, providing care and supervision. Throughout Phases 1 and 2, monitoring and evaluation will be ongoing so that changes and deviations can be addressed at any point during the activities.

Phase 1: Preparing for the implementation

First and foremost, it must be ensured that the government supports implementation of the model as an integral part of the district health system. Once the decision has been taken to implement the model, a number of preparatory activities need to be carried out to ensure smooth and efficient implementation.

Activities to prepare for implementation of the model

1. Advocate widely for the need to implement the model.
2. Mobilize support from the local administration.
3. Form a leading team at the district level.
4. Select a health centre as demonstration site.
5. Define/redefine the catchment area for the provision of CCHBHC.
6. Forge strong partnerships and linkages.
7. Interact and negotiate with the defined population to be served.
8. Identify health care activities to be provided at the health centre, community and home.
9. Strengthen support systems at the health centre.
10. Orient health personnel.
11. Formulate a plan of action.

It is important for countries to:

1. Advocate widely for the need to implement the model.

Commitment and motivation from organizations and individuals, who will be involved in implementing the model, at both national and local levels, are critical for successful implementation. Champions need to be identified to share the vision and drive forward the initiative. Advocacy is also needed to motivate the community to be actively involved throughout the implementation process.

Special attention will need to be given to motivate health personnel to accept the model, as they will be required to change their practices. As appropriate, the CCHBHC documents should be translated into the local language to facilitate better understanding of the model.

2. Mobilize support from the local administration for innovative approaches in the implementation.

Support from the district authority is needed to facilitate effective implementation of the model and ensure sustainable development. This is particularly important because of the need to challenge existing practices and routines, and work in a more flexible manner.

3. Form a leading team at the district level, which will be responsible for the coordination, management and completion of all activities.

The District Leading Team should comprise health officers at the district level and health personnel at the health centre, as well as major stakeholders including community leaders. It should be integrated within the existing system to the extent possible. For example, these responsibilities may be incorporated into the remit of an existing group or committee. Optimally, there should be no less than 5 persons or no more than 10 persons in the team. The suggested terms of reference for the District Leading Team are provided in Annex 7.

4. Select a health centre as demonstration site to try out the model.

It is desirable to start on a small scale with a limited number of demonstration sites before the model is implemented in the whole country. The lessons learned from the demonstration sites can be utilized to improve the model during its subsequent implementation in other areas. It is best for each country to decide on the number and locality of health centres to be used as demonstration sites.

Suggested criteria for selecting a health centre as a demonstration site

- The health centre is well established with adequate infrastructure, operational budget, and supplies and equipment.
- There are stable full-time staff.
- Staff are motivated and committed to quality improvement.
- The designated referral hospital of that particular health centre and higher-level administrative support system are likely to support the transformation.

5. Define/redefine the catchment area for the provision of CCHBHC.

The target population to be served should be area- and need-based. The number of target population and geographical areas should be manageable to ensure adequate coverage.

6. Forge strong partnerships and linkages to ensure coordination and collaboration among various partners for successful implementation.

Strong partnerships and linkages should be developed between the whole range of stakeholders within and outside the health sector who will be directly involved in the implementation of the model.

7. Interact and negotiate with the defined population to be served to reach a consensus on the health services to be provided based on the priority and requisite community support.



An early outline of the likely operational plan should be shared with the population. Systematic home visits and negotiations should be carried out in the defined catchment area to obtain information about families, and their health needs and demands. Family files/folders should be prepared at this stage (an example of a family file is provided in Annex 8). It is also essential to involve health volunteers and community members in the assessment process from the beginning to build local ownership. This assessment provides health personnel with an opportunity to familiarize themselves with

the community they serve and establish relationships. Based on the outcomes of the community assessment, health personnel will need to negotiate with the community to agree upon the health services that will be provided at the community and home level, and criteria for home visits and support required from the community. This may be done through community meetings.

As resources for health in most countries are limited, it is essential to rationalize the health services to ensure optimal utilization of resources, including the use of volunteers, to address identified priority community health problems. In addition, ongoing interaction between health personnel and communities needs to be maintained to ensure active involvement of communities in the provision of care.

8. Identify health care activities to be provided at the health centre, community and home levels.

Services should be provided to meet identified needs as negotiated with the community. They should include health promotion and disease prevention programmes; an outpatient clinic for curative services; home visits; care, active follow-up and referral in emergency situations for patients with acute and chronic conditions, those needing long-term care as well as those in high-risk groups; and community meetings.

Criteria for home visits and home care will need to be defined for optimal utilization of available resources.

9. Strengthen support systems at the health centre to ensure provision of holistic, integrated and continuous care, and improve the overall service.

Existing support systems (e.g. health information system; supervision, monitoring, recording and reporting system; staff continuing/in-service education system; referral system; system for interacting with the community) need to be assessed in terms of their contribution to the quality of care (holistic, integrated and continuous care) at community and home levels. Where necessary, the systems should be strengthened, adapted or redesigned.

Appropriate records should be modified or developed to facilitate and foster continuity of care between home and health facilities.

10. Orient health personnel to foster positive attitudes about the model.

All personnel need to be enabled to understand and internalize the philosophy of the model: to acknowledge the changing relationships with all stakeholders including patients and to develop a proactive and creative approach to the provision of service.

11. Formulate a plan of action for effective implementation of the model.

The foregoing activities should lead to the formulation of a clear, simple and practical plan of action that can be linked with plans and activities already in existence for the district health system.

It is necessary to ensure that there is ownership of the plan by policy-makers, planners, managers, health personnel and other stakeholders, particularly the community. Everyone involved in the implementation of the model should be aware of the total picture, and what action will be taken by whom and when. Where practical, they should be involved in the formulation of the plan, otherwise they should be given an opportunity to comment on the plan.

Phase 2: Implementing community- and home-based health care

The second phase in the implementation of the model is the provision of community- and home-based health care by the health personnel of the health centre selected as the demonstration site. Actions should also be taken to carry out the plan of action for effective implementation of the model formulated during Phase 1.

Activities to implement community- and home-based health care

1. Determine and mobilize human resources to ensure an adequate number of care providers for the services.
2. Skills development of health personnel and volunteers.
3. Identify and mobilize financial and material resources.
4. Provide holistic, integrated and continuous care.
5. Supervise the provision of care to ensure continuing quality improvement of service provision.
6. Monitor the implementation of the model.
7. Evaluate the implementation of the model.
8. Review lessons learned from demonstration sites.
9. Consider further expansion of the use of the model.
10. Disseminate the results of the evaluation and future action plans to advocate for the wider implementation of the model.

It is important for countries to:

1. **Determine and mobilize human resources to ensure an adequate number of care providers for the services.**

Based on the agreed services, an analysis of human resource requirements needs to be made. This should take into account the available human resources for care within the community such as health volunteers, community groups and NGOs.

The team at the health centre may need to be strengthened to cover a large population or provide supplementary activity if they are to be introduced at the health centre. Health volunteers should be identified early in close collaboration with the community. In addition, roles of health volunteers and other nonformal caregivers for providing CCHBHC, particularly in home care and health promotion, will need to be clearly defined and supported.

2. Skills development of health personnel and volunteers to effectively provide quality community- and home-based health care.

Following a training needs assessment, appropriate skills should be developed in health personnel as well as health volunteers and nonformal caregivers.

The staff need to be equipped with the requisite knowledge, skills and attitudes to work with the community and other sectors as well as to train and support volunteers and other nonformal caregivers in addition to their clinical skills. As a considerable part of care will be home-based special efforts should be made to develop home visit skills in the staff. Hands-on experience and training is required for skills development. Training should be provided systematically and continuously according to needs, to ensure competency.

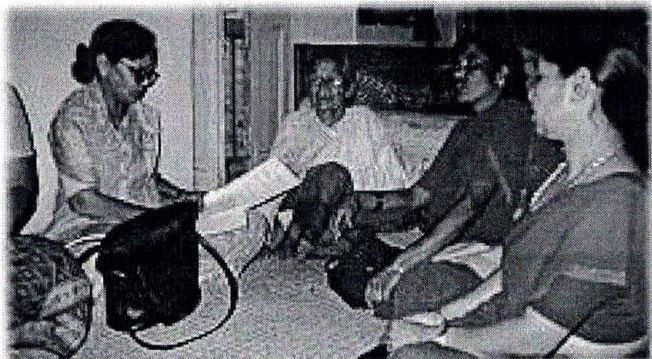
3. Identify and mobilize financial and material resources to ensure the provision of quality care.

The level and type of financial and material resources required depends on the services to be provided. The costing methods used and funding would be based on the existing financial systems in the country. Every effort should be made to maximize the use of available resources. Special efforts should also be made to mobilize additional resources from other sources such as community groups, NGOs or donor agencies.

4. Provide holistic, integrated and continuous care to improve the health of the population.

Health personnel provide care in the community and home in accordance with the criteria agreed upon with the community. They must ensure the use of a systematic approach to maintain close and continuous interaction with the community, and continuing support to nonformal caregivers.

5. Supervise the provision of care to ensure continuing quality improvement of service provision.



Supervision should be carried out in a systematic way to support and develop health centre personnel in providing care, and identify and meet training needs. The supervision process also provides a formal opportunity to acknowledge achievements and developments as well as to identify and address obstacles encountered in the delivery of community- and home-based health care (for further information, *see* Annex 9).

6. Monitor the implementation of the model to ensure continuous feedback on progress.

A monitoring system needs to be established to provide feedback on progress in line with the implementation plan developed in Phase 1. This will enable prompt action to be taken in response to deviations from the plan and further refine the plan to reflect changes in the situation.

7. Evaluate the implementation of the model to learn lessons from the demonstration sites.

The evaluation strategy should address issues related to the acceptability, applicability and usefulness of the model. It will identify achievements, problems and solutions, use of resources and other lessons learned in each demonstration site, and lead to more effective implementation at this and other sites.

8. Review lessons learned from demonstration sites to further improve the effectiveness of the model and services provided.

Evaluation reports from each demonstration site should be critically reviewed and key issues identified. The model should be amended and refined as necessary to improve the quality, effectiveness and efficiency of the services provided.

9. Consider further expansion of the use of the model to improve accessibility, effectiveness and efficiency of care in community and home settings.

A plan of action should be developed to guide the implementation of the model in other sites and support the continuing development of the model in the original sites. Special attention should be given to collaborate with other home-based care initiatives in the area to optimally utilize the available resources.

10. Disseminate the results of the evaluation and future action plans to advocate for the wider implementation of the model.

Information should be shared using a variety of channels including a programme of visits to the demonstration sites. All those participating in the implementation of CCHBHC model in the demonstration sites may be used as resource persons to assist in the implementation in other sites.

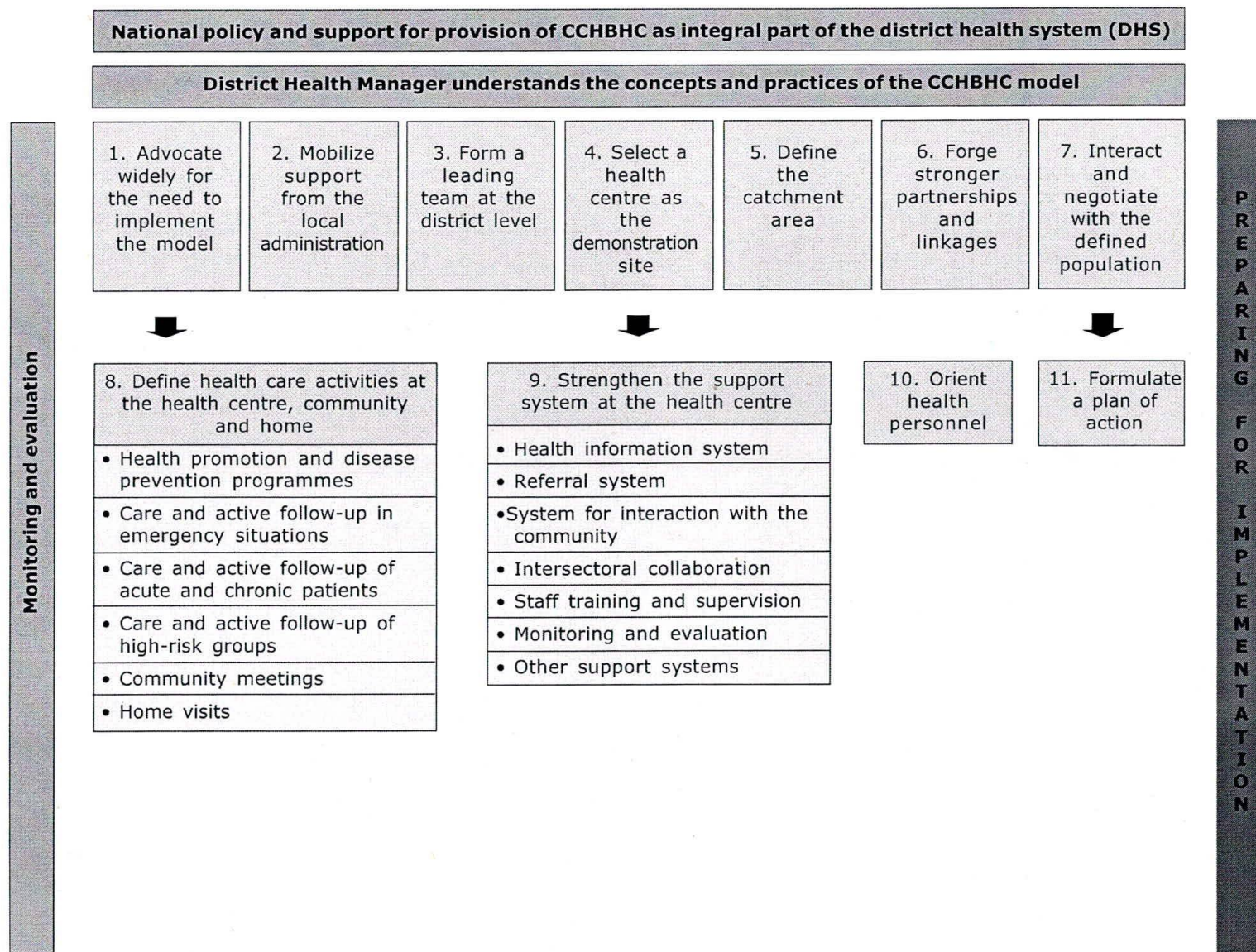
Overall activities for the implementation of the CCHBHC model for both the phases are summarized in Figure 5.

13. CONCLUSION

This model provides one response to improve the equity of, and accessibility to, quality health services within a local community. It includes a particular emphasis on involving all members of the community in identifying their needs and agreeing on priorities. It acknowledges the contribution made by those outside the formal health system to health and health care, and provides additional support.

The model is likely to be subjected to ongoing change and development as a result of lessons learned during the implementation or due to changes within the community, or improved knowledge and skills of health personnel. The lessons learned should contribute to the development of national guidelines. Experiences in the implementation of the model continue to be shared widely with the ultimate aim of contributing to a reduction in morbidity and mortality across communities.

Figure 5. Overall activities for implementation of the model for community- and home-based health care



Implement a plan of action formulated during the preparation phase for effective implementation of the model

1. Determine and mobilize human resources to ensure an adequate number of care providers for services

- Health care providers
- Supportive/clerical staff
- Health volunteers
- Community groups
- Care providers from nongovernment organizations (NGO)
- Other nonformal caregivers



2. Skills development of health personnel and volunteers

- Skills for interacting with the community
- Team work and interpersonal skills
- Empowerment skills
- Financial management skills
- Resource mobilization skills
- Supportive supervision skills
- Technical skills
- Home visit skills
- Other skills



3. Identify and mobilize financial and material resources

- Community resources
- Government resources
- Resources from NGO
- Resources from donors
- Other resource



4. Provide holistic, integrated and continuous care

5. Supervise the provision of care to ensure continuing quality improvement of service provision

6. Monitor implementation of the model

7. Evaluate the implementation of the model

8. Review the lessons learned from the demonstration sites

9. Consider further expansion of the use of the model

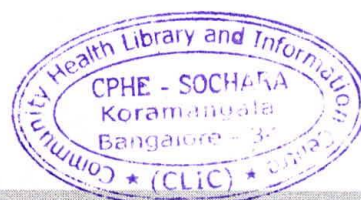
10. Disseminate the results of the evaluation and future action plans to advocate the wider implementation of the model in community and home settings

Note: These activities are not necessarily carried out in a linear sequential manner. A number of activities will be taking place at the same time depending on the local situation. The activities require different time-scales. Some are one-off activities while others are continuing activities.

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ANNEX 2: Examples of health worker skills

Examples of tasks and skills¹² required to deliver comprehensive community- and home-based health care (CCHBHC) and for working with the community are provided below.

Individual and family level		
Duty	Task	Skills
1. Health screening and simple treatment	1.1 Health assessment 1.2 Prescribe medication from the Essential Drugs List 1.3 Refer patients as needed	1.1 Interview skills 1.2 Observational skills 1.3 Physical and basic mental health assessment 1.4 Simple tests and interpretation of the results 1.5 Simple treatment as given in the Essential Drugs List 1.6 Decision-making for referral as needed 1.7 Emergency management
2. Health promotion for individual and family	2.1 Child health services <ul style="list-style-type: none"> – Assess and record child's growth and development – Child health counselling 2.2 Elderly health services <ul style="list-style-type: none"> – Health assessment – Promotion of health counselling and self-care – Empowering the community for the elderly 2.3 Health campaigning <ul style="list-style-type: none"> – Distribute health information – Conduct and promote healthy lifestyles – Collaborate with family and community for environmental and specific health issues 2.4 Advocate for health	2.1 Physical assessment skills for the growth and development of children, and health assessment for the elderly 2.2 Counselling skills for parenting and elderly
3. Disease prevention	3.1 Immunization 3.2 Case-finding 3.3 Health problem alert, e.g. prevalence of drug use and violence in the family and community 3.4 Environmental and sanitation management	3.1 Skills in maintaining the cold chain 3.2 Skills for giving injection 3.3 Assessment skills for health problems, e.g. drugs used, family violence and mental health

12 Adapted from Rujkornkan D. Community health nursing model in Sri Lanka: an assignment report. New Delhi: World Health Organization, Regional Office for South-East Asia, 2001 (unpublished).

Individual and family level		
Duty	Task	Skills
4. Long-term care	4.1 Make home-visit and provide rehabilitative care for clients with: <ul style="list-style-type: none"> - diabetes - hypertension - cardiovascular accidents - heart disease - HIV/AIDS - tuberculosis - mental health problems - impairment and disability 	4.1 Home visit skills 4.2 Skills in providing direct care to patients with diabetes, hypertension, cardiovascular accidents, heart disease, HIV/AIDS, tuberculosis, mental health problems and specific disabilities 4.3 Interpersonal skills 4.4 Counselling skills 4.5 Training skills for caregivers within the family 4.6 Skills in mobilizing community resources
5. Health care at home	5. Home visit <ul style="list-style-type: none"> 5.1 Provide health education to the client and his/her family 5.2 Provide counselling and support to the client and family 5.3 Liaise with medical personnel and clients 5.4 Collaborate with the appropriate sectors for assistance if required 5.5 Provide physical care according to the individual's self-care deficits 	5.1 Build relationships and trust 5.2 Assess self-care ability 5.3 Skills for wound dressing, insulin injection and positioning 5.4 Teaching and guiding skills 5.5 Counselling and emotional support skills 5.6 Communication skills 5.7 Skills for promoting self-care
6. Referral for appropriate care	6.1 Coordinate with the individual and agencies 6.2 Collect data for referral 6.3 Give information to the patient and family 6.4 Conduct first-aid or appropriate care before referring (if needed)	6.1 Communication skills 6.2 Interpersonal skills 6.3 Decision-making skills 6.4 Skills in cardiopulmonary resuscitation 6.5 Skills in caring for burns, surgical wounds, injuries, etc. 6.6 First-aid techniques
7. Counselling and guidance	7.1 Establish appropriate counselling facilities 7.2 Provide marriage counselling 7.3 Provide counselling on substance abuse, STDs, voluntary counselling and testing for HIV/AIDS 7.4 Promote family functions and relationships 7.5 Assist the family in problem-solving 7.6 Refer to a specialist if required	7.1 Family assessment skills 7.2 Family intervention skills 7.3 Trust-building skills 7.4 Being reliable and trustworthy 7.5 Being flexible 7.6 Counselling skills 7.7 Maintaining emotional stability

Individual and family level		
Duty	Task	Skills
8. Building strengths and coping skills of the family	8.1 Provide information regarding social support systems, employment or occupation 8.2 Liaise with GOs and NGOs for health and social support 8.3 Find information about health and social services needed for the family 8.4 Mobilize community resources 8.5 Provide psychosocial support	8.1 Collaborating skills 8.2 Interpersonal skills 8.3 Management skills 8.4 Psychosocial support skills

GO: governmental organization; NGO: nongovernmental organization; STDs: sexually transmitted diseases

Community level		
Duty	Task	Skills
1. Community assessment and diagnosis	1.1 Collect data about health and related factors 1.2 Identify needs and problems 1.3 Identify resources and constraints	1.1 In-depth interviewing skills 1.2 Skills to conduct focus group discussions 1.3 Community survey skills 1.4 Observation skills 1.5 Constructing interview guidelines
2. Working with the community to implement activities	2.1 Set priorities for problems and needs 2.2 Set objectives 2.3 Write a project proposal 2.4 Mobilize funds as needed 2.5 Implement projects 2.6 Manage projects 2.7 Evaluate projects	2.1 Decision-making skills 2.2 Interpersonal skills 2.3 Leadership skills 2.4 Management skills 2.5 Group process skills 2.6 Planning skills 2.7 Project planning and writing skills
3. Mobilizing community participation and resources	3.1 Promote self-reliance 3.2 Promote interdependence in the community 3.3 Organize regular meetings with community representatives 3.4 Establish self-help groups and awareness programmes 3.5 Design appropriate activities for aggregates and high-risk groups	3.1 Management skills 3.2 Group process skills 3.3 Stress management skills 3.4 Counselling skills 3.5 Teaching skills 3.6 Training skills

ANNEX 3: Home visits

Home visits provide an opportunity for health personnel to see a complete picture of clients' living experiences, in which illness is only one aspect of their lives. This will enable them to better provide holistic care that meets the physical, psychological, social and spiritual needs of their clients. In the home, health personnel see environmental factors that affect health, and social and psychological influences; relationships between and among family members; and interaction of clients with families and social networks. In addition, health workers can see first-hand how well the clients can perform self-care at home and make a more accurate evaluation of the health care interventions required.

A home visit is effective when clients are able to exercise more control over their care and are part of the health care team, rather than dependent, passive recipients of care. Health personnel should promote a sense of empowerment in the clients and families for self-care and healthy living as well as proper health-seeking behaviours.

PURPOSES

Home visits are carried out for several purposes such as:

- case-finding for public health and protection in cases such as abuse, neglect communicable diseases and school-related health conditions;
- promoting health and preventing illnesses by providing services such as antenatal, newborn and well-baby care; child development and care of the elderly; and
- providing care for the sick and terminally ill such as home health, and palliative and hospice care.

CRITERIA FOR HOME VISITS

It is not cost-effective to provide care at home for every client. For optimal utilization of resources for the health of the community, eligibility criteria for home visits and home care will need to be decided and agreed upon with the community. This will vary from place to place, depending on the health needs identified during community assessment.

In general, priority should be given to make health care more accessible to vulnerable, disadvantaged and high-risk groups. These include the following:

- Handicapped people;
- Elderly people;
- Those who are confined to their homes and are unable to seek care at health facilities, such as mothers who have delivered recently and newborns, and post cardiovascular accident cases;
- Pregnant women and children under 5 years of age who miss appointments;
- Chronic patients whose condition is not under control and those who miss their appointments;
- Clients requiring long-term, home-based care such as those with HIV/AIDS; and
- Clients requiring follow-up care at home post-hospital/operation.

CONDUCTING A SUCCESSFUL HOME VISIT

Actions that health personnel should carry out for a successful home visit from the beginning to the end are provided below.¹³

Pre-visit/planning stage

- Determine which clients need to be seen according to the agreed criteria.
- Prioritize the scheduled visits based on clients' health needs and in coordination with other health team members.
- Review family folders, clients' records, goals of care and reasons for the home visit.
- Validate the scheduled visit with clients and/or family members, and assess the specific needs of clients and nonformal caregivers (such as supplies).
- Conduct inventories of the home visit bag, equipment needed, and supplies and educational materials for clients.
- Review safety considerations, such as the timing of the visit and assessment of the environment.

Implementing the visit

- Initiate the visit by the introduction and identification of health personnel to the client, and a brief social dialogue to establish rapport.

13 Lundy, KC. The home visit. In: Lundy KC, Janes S (eds). *Essentials of community-based nursing*. Ontario: Jones and Bartlett Publishers, 2003:301.

- Practice appropriate hygienic practices before assessing the client such as hand-washing.
- Review plans for the visit with the client.
- Determine the expectation of the client regarding home visits.
- Conduct an assessment of the environment, client, medication, nutrition, functional abilities and limitations, psychosocial-spiritual issues, and evaluate the effectiveness of previous visit interventions.
- Modify the plan of care based on clients' needs and situation.
- Carry out health interventions.
- Deal with distractions—environmental and behavioural.

Evaluating the visit

- Evaluate the effectiveness of the interventions based on established short-term (response during the visit) as well as long-term outcome criteria (effects of the intervention at subsequent visits).
- Evaluate the conduct of the visit: availability of appropriate supplies and preparation of health personnel for a visit.

Documentation

- Document in the family folder and other record(s) according to standard procedures.
- Validate diagnoses and additional health needs based on visit.
- Record actions taken, response of client and outcomes of intervention (short-term and long-term).
- Record both objective data (health worker-based) as well as subjective data (client-based).

Termination

- Termination begins with the first visit as the health worker prepares the client for the time-limited nature of home visits.
- Review goal attainment with the client/family, and make recommendations and referrals as appropriate for continued health care issues.
- Develop strategies for appropriate closure with clients who die, refuse visits, or are terminated as care is no longer required due to various reasons such as complete recovery or moving out from the area.

ANNEX 4: An example of a weekly schedule of services coordinated by a health centre

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00–12:00 (at the outpatient clinic)	<ul style="list-style-type: none"> ANC, counselling and FP Outpatient clinic 	<ul style="list-style-type: none"> ANC, counselling and FP Outpatient clinic 	<ul style="list-style-type: none"> ANC, counselling and FP Outpatient clinic 	<ul style="list-style-type: none"> ANC, counselling and FP Outpatient clinic 	<ul style="list-style-type: none"> Well child counselling (immunization) ANC, counselling and FP Outpatient clinic
13:00–16:00 (at home and in the community)*	<ul style="list-style-type: none"> Home visit Community health surveillance Campaign for a healthy lifestyle 	<ul style="list-style-type: none"> Home visit Community health surveillance Campaign for a healthy lifestyle 	<ul style="list-style-type: none"> School health Home visit Community health surveillance Campaign for a healthy lifestyle Environmental health 	<ul style="list-style-type: none"> Home visit Community health surveillance Campaign for a healthy lifestyle summary 	<ul style="list-style-type: none"> Home visit Supervision for village health volunteers† Health report

ANC: antenatal care; FP: family planning

Note: A community meeting is organized once a month.

*There should be one health worker on standby at the clinic in the afternoon

†Once a month supervision

A brief description of each of the key activities is provided below.

1. *The outpatient clinic*

The clinic should be organized to provide health screening and simple treatment as active and rational health activities and not as a passive response to an irrational demand while considering the following:

- The use of decision trees (strategies of diagnosis and treatment) drawn up with the objective of detecting and dealing adequately with priority problems.
- The use of essential drugs to reduce costs, improve use and promote the use of effective drugs.
- The systematic referral to hospital and an institution of a higher technical level when needed.

2. *Care and active follow-up in emergency situations*

Health workers should be enabled to develop the necessary knowledge and skills to provide relevant and appropriate advice, care, treatment and referral in emergency situations.

3. *Care and active follow-up of chronic patients*

The follow-up process involves self-evaluation by analysis of data for case-finding as well as monitoring attendance of chronic patients at clinics. A

systematic strategy was developed to retrieve cases, and give a simple and obvious objective to purposeful home visits. It involves identifying, in a small and well-defined group, the cultural and environmental determinants of human behaviours and the means of influencing them positively.

4. Care and active follow-up of high-risk groups

In any community, it is necessary to identify high-risk groups. These may include groups of people exposed to occupational health risks, e.g. industrial workers or agricultural workers exposed to pesticides, or age groups such as the elderly or schoolchildren. The identification of these high-risk groups calls for a certain amount of previous epidemiological knowledge. Epidemiological data would be necessary to formulate appropriate follow-up strategies for these groups.

However, young children and women of reproductive age are considered risk groups found in every community. Family health care services for family planning, and antenatal and postnatal care should be offered. Well-child care with periodic weighing, immunization and education for parents should be included.

5. Health promotion programmes

Promotion of healthy lifestyles in the home and community settings could include a school health programme, an environmental health and occupational health programmes established by health workers. Healthy nutrition, exercising for health, accident prevention, drug abuse prevention, HIV prevention, TB control, anti-smoking campaigns are some examples of healthy lifestyle-promoting activities.

The above services are very basic, and necessary to start and expand primary health care concepts. Other functions such as environmental sanitation, community health education, etc. require a long-term relationship between the health service and community.

6. Community meetings

Community meetings are a part of the formal health centre activities. These should be convened on a regular basis with a set agenda to facilitate and foster active involvement of the community in the provision of health care as well as for addressing priority health issues confronting the community.

Health personnel should facilitate the community meeting. However, it should be chaired or led by a community leader or other prominent figure in the community. Overall development of the community could also be achieved through these meetings.

ANNEX 5: Examples of activities of the Ayutthaya Urban Health Centre, Thailand

Concrete examples of activities carried out by the Ayutthaya Urban Health Centre are provided below.

1. CURATIVE CARE

1.1 Curative care at health centre

Provision of curative services is in great demand. Treatments implemented at the health centre include injections, simple surgery, Thai traditional massage, etc. Time is also invested in explaining how to take the medicine or recommending lifestyle changes based on knowledge about the patient and his/her home circumstances.

The most common diseases seen in the community by personnel at the Health Centre can be summarized as follows:

- Minor conditions, e.g. acute throat infections, vertigo–dizziness, gastroenteritis, etc. are the most common;
- Acute major diseases, e.g. pneumonia, severe depression, acute myocardial infarction, etc.; and
- Chronic diseases, e.g. hypertension, diabetes mellitus, chronic psychiatric problems, heart disease, TB, etc.

The latter two are often detected in the demonstration health centres but are seldom dealt within the existing Thai health centres.

1.2 Home care for curative service

Staff of the Health Centre make home visits to registered patients¹⁴ who need close observation with such conditions as acute febrile illness and vomiting in children or acute asthmatic attacks.

1.3 Organized interaction with the provincial hospital

The Health Centre can use the services of the hospital for laboratory investigations, specialist consultation, drug supply and admission on

¹⁴ Registered patients refer to individuals residing in the catchment areas who are registered at the health centre to be recipients of care.

payment of a fee-for-services basis. In cases of hospital admission, some patients are referred by the Health Centre staff while others go directly to the hospital when the Health Centre is closed. The staff of the Health Centre visits them at the hospital, and uses the opportunity for discussion with the specialist and dialogue with the patient.

2. CARE AND ACTIVE FOLLOW-UP OF PATIENTS WHO NEED LONG-TERM CARE

These services need much more effort to ensure continuity of care compared with purely curative activities. However, because the patients are known to the staff there is more opportunity to address the issues of health promotion and illness prevention.

2.1 Detection: recruitment for chronic disease programmes

The systematic home visits, including the census and negotiation meetings, with the defined population provide opportunities for the staff and family members to get to know each other. Many families ask about chronic diseases, because some members have suffered from them and others are concerned about their future risk. This provides an opportunity to encourage them to go to the Health Centre to confirm their status. Very often the presence of chronic disease is detected at the curative clinic. The overall process of detection is a balance between active (discussion at home) and passive (curative clinical approach) detection.

2.2 Care for the chronically ill: an important part of the workload

As patients make the greatest demands at the start of care, continuity of care requires less treatment. The nature of chronic diseases means that cure is difficult, therefore, a dialogue is needed to enable patients to understand the logic of the treatment. Once chronic diseases or other long-term care problems are detected, it is obvious that the workload of the health centre is increased. Such patients need home visits and home care. However, this aspect of care is included in the minimum package necessary for health centre activities.

2.3 Home visits and home care for chronic and long-term care patients

Home visits are made to patients with chronic conditions who have missed appointments for more than seven days and those with poorly controlled

conditions, such as diabetes mellitus and hypertension. Home-based, long-term care usually involves nonformal caregivers, including family, friends and neighbours. The two main categories of patients who require home care are the elderly suffering from stroke, dementia or degenerative neurological diseases, and people who needing palliative care and wish to die at home. The frequency of visits depends on the patient's condition and the level of nonformal support available to them.

Health Centre personnel carry out a range of activities at home including wound care for patients with bedsores; changing Foley catheters or nasogastric tubes; and teaching and supporting nonformal caregivers in the delivery of care. Home visits also provide an opportunity for health personnel to act as a bridge between the family's traditional belief system and the scientific medicine belief system. This is particularly important in the terminal stages of illness where health personnel need to understand and accommodate the religious and personal belief systems (meeting spiritual and psychological needs) of the patients and their family members.

3. CARE AND ACTIVE FOLLOW-UP FOR HIGH-RISK GROUPS

In the Ayutthaya Urban Health Centre, high-risk groups were identified during the systematic home visits and negotiations with the community. The groups included young children (under 5 years of age), women of reproductive age and pregnant women. The following activities were provided for these groups:

- For young children under 5 years of age, periodic immunization was given at the same time as growth monitoring and education of mothers in nutrition, breastfeeding, etc.
- For pregnant women, antenatal care was organized with periodic surveillance of pregnancies, tetanus immunization, care of associated illness, identification of high-risk deliveries for early referral and training of mothers in breastfeeding. The deliveries took place at the provincial hospital with the Health Centre again taking responsibility for postpartum care.
- For postpartum women, periodic routine home visits for taking care of the mothers and infants at home were carried out.
- Family planning was organized by providing opportunities to discuss health education and select appropriate contraceptive methods.

3.1 Home visits for high-risk groups

To ensure the continuity of care and have better coverage, the Health Centre staff carry out home visits for children less than 5 years of age if they miss an appointment and do not present within 7 days, and for pregnant women who miss antenatal appointments.

4. PRIORITIES FOR HOME VISITS AND HOME CARE

Home visits and home care are integrated into the various activities of the health centre as mentioned above. In practice, they are routinely organized in the afternoon of every weekday with normally not more than 5 cases per day. Priorities are determined as follows:

- Acutely ill patients who require observation or nursing care;
- Patients who are discharged from the hospital and at risk for developing complications;
- Postpartum mothers and their newborn to give health education; family planning for the mother; and immunization for the child;
- Chronic patients whose condition is not under good control;
- Chronic patients who miss an appointment for more than seven days;
- High-risk groups such as pregnant women and children under 5 year of age who miss appointments for more than seven days;
- Handicapped and elderly people for both physical and mental rehabilitation; and
- Collection of samples (e.g. blood, urine, sputum) when necessary.

5. COMMUNITY MEETINGS

There was no formal community organization in this catchments area earlier. Thus, the Health Centre has organized a regular community meeting.

The first community meeting was led by health personnel to discuss the issue of financial management of the centre. The second meeting was also organized by the health personnel by informally inviting people who came to the Health Centre for services to continue the discussion on financial management and care provided by the Centre.

After seeing the usefulness of the community meeting, the members agreed to set a regular meeting once a month to discuss any topic of concern related to the Health Centre and community. Later on, objectives

of the routine monthly community meeting were developed to maintain mutual understanding, evaluate mutual decisions, and find concrete solutions to address new problems.

The number of participants in the community meetings varied from about 10 to over 100 with an average of 20–50 participants at a meeting. With too many people participating in the meeting, community members felt that there was a need to have a community organization to link in a more systematic way with the Health Centre. Consequently, an informal committee was formed to organize the meeting and a chairperson was selected by the community. Health personnel were also members of this informal committee and played a supportive role in these meetings. Community meetings have been organized regularly. The place of the meeting varied among the temples in a village (5 in all) so that people from various areas could participate. The functions of the committee were to maintain and promote mutual understanding and trust between the Health Centre and community, and control and administer the community funds that were set up before this committee was formed.

ANNEX 6: Monitoring and evaluating the Ayutthaya approach

The strategy for monitoring and evaluating the Ayutthaya Project was based on the belief that comprehensive community- and home-based health care (CCHBHC) seeks to offer people a better overall service, and the objective of monitoring and evaluating is not merely to measure the specific impact of health service activities on particular health problems.

Evaluation of the direct impact has often been advanced as a justification for vertical or specific programmes. However, when such programmes are integrated in CCHBHC, the objectives of the programme necessarily change. Therefore, in CCHBHC, the evaluation of direct impact is better replaced by the indirect method of 'process evaluation'. This aims at providing health professionals and the population with methods of self-evaluation so as to produce an internal feedback and improvement in the service. For example:

- A simple measure of the number of contacts per inhabitant per year: In itself this figure is not significant, except in giving information on the acceptability of the Health Centre by means of comparing and observing trends.
- Internal functioning of the district health system: This can be gauged by the rate and impact of referral of patients to the referral unit, and the quality of the transmission of information, e.g. percentage of patients attending the hospital with appropriate, relevant and timely information.
- Continuity of care: This includes the quality of follow-up of chronic patients such as the number of patients with tuberculosis who are regular in their treatment in relation to all patients with tuberculosis who are treated or risk episodes (months of pregnancy at first antenatal visit and number of consultations during antenatal surveillance).
- Coverage for immunization and antenatal care: This can be estimated by a comparison between health centres and evaluation of trends in each centre rather than using targets arbitrarily set by central officials.
- Financial equilibrium of the Health Centre.
- Community involvement: This is evaluated by simple indicators such as regularity and attendance of health committee meetings. More elaborate measurements have been developed such as the type of problems raised, involvement of members in decision-making, identification of problems and putting forward of appropriate solutions.
- General awareness of the population: This can be evaluated by selecting certain major educational objectives and following the gradual development of understanding.

- Intersectoral activities: This could be evaluated in the same way as community involvement.

Comprehensive community- and home-based health care puts stress on community participation and, therefore, on decision-making from bottom-up. One of the challenges is to find an appropriate interface between this form of decision-making and the more traditional top-down system of decision-making. With its role as a point of interaction between the service and community, the Health Centre is evidently in a central position here. Basically, top-down decision-making is necessary, but there is a place for bottom-up decision-making so that people can express their priority demands and use their own resources, including, when applicable, their own financial contribution to the system.

Process evaluation is more complex than traditional forms of evaluation, since it cannot use particular targets (because in the case of a system these are arbitrary) or specific impacts. Instead, it uses local comparisons and trends. In relation to the various aspects of development, this could yield semi-quantitative information. Frequently, the information collected has no single explanation; a number of different hypotheses might be put forward to explain it. It is only by collecting information of different kinds that the uncertainty can be reduced and one of the hypotheses suggested becomes the most probable.



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ANNEX 7: Suggested Terms of Reference of the District Leading Team

1. Plan and prepare for implementation of the comprehensive community- and home-based health care (CCHBHC) model in the demonstration sites.
2. Mobilize support for the implementation of the CCHBHC, as required.
3. Coordinate and manage the overall implementation of CCHBHC in health centres selected as demonstration sites.
4. Monitor and evaluate the implementation of CCHBHC.
5. Disseminate the outcomes of the implementation of CCHBHC.
6. Prepare a progress report of the implementation of the model to be submitted to the health ministry.
7. Plan for further expansion of the model.

ANNEX 8: An example of a family file**ADDRESS**

House no.:

Village no.:

Subdistrict:

Household head:

Ayutthaya Urban Health Centre
in collaboration with
Ayutthaya Municipality and Ministry of Public Health

Family File

Map of house location/house characteristics/neighbourhood
or famous person in the area

Family File (FF)

Inside the cover

Address: House no.: **Village number:** **Subdistrict:**

No	Regis- tration date	Sex	Name	Date of birth	Occu- pation	Educa- tion	Marrital status	Family relation- ship	Health insurance coverage	Note (SC- OC)	Discharge from FF		Others/ WBC/ ANC/ FP/ dis- abled	Code					
											Date	Reason							
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			

SC: synthesis card; OC: operational card; WBC: well-baby clinic; ANC: antenatal clinic; FP: family planning

Net family income: **Bahts/month** **Status/role in the community:** **Household condition:**.....

No.

Name Date of Birth Occupation

Health Insurance Coverage

History of drug adverse effects

History of chronic conditions/diseases

[illegible]

Records of treatment

Page 2 of 2

Records of appointment and treatment (record every visit)

BW: body weight; BP: blood pressure; FBS: fasting blood sugar

Operational Card (OC) for children under 5 years of age**Child Health Operational Card**

Type/no. OC.....

Address no.

Household head.....

Name Sex Date of birth

No.	1		2		3		B1		B2	
Vaccine	Appoint	Inject	Appoint	Inject	Appoint	Inject	Appoint	Inject	Appoint	Inject
BCG										
HBV										
DPT										
OPV										
Measles										
Remarks										

BCG: bacille Calmette–Guérin; HBV: hepatitis B vaccine; DPT: diphtheria, pertussis and tetanus;
 OPV: oral polio vaccine; JEV: Japanese encephalitis vaccine; B: booster dose

Records of examination: treatment–appointment (in case of a child who needs continuous care: OC)

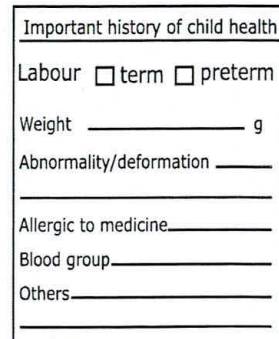
Appointment date	Date of visit	Causes of delay in visit and operation	Diagnosis and finding	Treatment

Summary of significant illness or risk (Synthesis Card)

Starting date	Ending date	Hospital no.	Problem/diagnosis/treatment	Result of treatment

Comprehensive Community- and Home-based Health Care Model

Tick / for things done or X for nothing done

Date of Birth

Operational Card (OC) for pregnant woman

 Type
No. of OC

Date

FF No.

Household head

Pregnant Woman Operational Card

Name Age Occupation

LMP EDC by

History of pregnancy and general health

Gravida____Para____Abortion____Last parity____Last abortion____

Normal Abnormal Stillbirth Delivery place

History of latest pregnancy

History of previous pregnancy

History of general health/drug allergy

Plan of present pregnancy

Investigation/vaccination and other important findings

Height _____ centimeter Blood group _____

Laboratory findings

Date	VDRL1	HIV	HBsAg	HCT

Date of vaccination of tetanus toxoid 1 _____

Date of vaccination of tetanus toxoid 2 _____

Decision (from laboratory results)

HIV: human immunodeficiency virus; HBsAg: hepatitis B surface antigen

	Date	Body weight	Urine albumin	Blood pressure	Oedema	Uterine fundus	Gestational age	Other signs/complaints	Decision	Follow-up
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

Remark: identify foetus position at 34 weeks of gestational age

Operational Card for pregnant woman

Labour history

Date_____ Place_____ Type of delivery_____ Complication_____

Child weight_____ Sex_____ Live birth_____ Stillbirth_____

Complications_____

Postpartum mother

Date	BT	BP	Lochia	Abdomen perineal wound	Breast- feeding	Other signs, complaints	Decision	Follow-up

BT: body temperature; BP: blood pressure

Plan for contraception_____ Opening date of Operational Card_____

Baby

Date	BW	Umbilicus	Other signs, complaints	Decision	Follow-up

BW: birth weight

Opening date of Operational Card (Well-Baby Clinic)

Synthesis Card

Name _____ Sex _____ Date of birth _____

Address _____

History of healthBlood group _____
History of drug allergy, allergic
to _____
_____Abnormality/deformity

_____**Vaccination (identify the date)**

No. Vaccine	1	2	3	B1	B2
BCG					
HBV					
DPT					
OPV					
Measles					
JEV					
Tetanus					

BCG: bacille Calmette-Guérin; HBV: hepatitis B vaccine; DPT: diphtheria, pertussis and tetanus; OPV: oral polio vaccine; JEV: Japanese encephalitis vaccine; B: booster dose

Other important history**1. Physical** _____

2. Psychosocial _____

Synthesis Card

[illegible]

ANNEX 9: Clinical supervision

A key factor in the successful implementation of comprehensive community- and home-based health care is the provision of appropriate clinical supervision for all health personnel. A number of models of clinical supervision exist but, regardless of whether or not a particular model is used, the key to success lies in the relationship established between the supervisor and supervisee. In some situations, the concept of supervision has tended to have negative connotations and is linked in many peoples' minds to criticism and punitive action. However, effective clinical supervision is a supportive developmental process.

PURPOSE

Clinical supervision serves a number of purposes as follows:

- It provides a formal system for health personnel to examine and explore their practices in a safe and supportive environment;
- It enables individuals to develop their knowledge and understanding of ways to enhance delivery of care and improve services; and
- It helps practitioners to accept responsibility and accountability for their own practice.

CRITERIA FOR SELECTION OF SUPERVISORS

Supervisors need to:

- be seen as competent practitioners in the practice setting;
- have personal skills and knowledge to enable personnel to reflect on their work and aim for continuous improvement; and
- create a supportive, positive, nonjudgemental and solution-seeking approach to change.

CHARACTERISTICS OF A GOOD CLINICAL SUPERVISOR

A good clinical supervisor:

- acts as a role model and inspires others by his/her knowledge and attitude or skills;
- has good listening skills, is able to develop supportive relationships and perceptive to supervisees' needs; and
- has a high level of self-awareness and acknowledges his/her own limitations.

SUPERVISION PROCESS

A specific time needs to be identified for the supervisor and supervisee to meet. Supervision is most likely to take place on a one-to-one basis but group supervision may be appropriate in some situations.

As far as possible, the supervision time should be planned so as to meet identified needs. This could include the provision of care to a specific individual or group where the supervisee needs specific support in terms of knowledge or skills to deal with a particular situation. Sometimes, the supervisee may need time for a quiet and confidential discussion with the supervisor away from patients and other personnel.

In implementing a new approach to practice, the supervisee may be unaware of his/her deficits and learning needs. In such circumstances, the supervisor may need to take a more proactive role in determining how to use the time of supervision most effectively. This may include demonstrating new and different ways of providing care and treatment; establishing different systems or processes for managing the provision of services; and using problem-solving skills to address particular difficulties.

It is important that records of the supervision experiences are maintained so that health personnel can reflect on their practice and progress. The supervisor should maintain an overall record of broad issues addressed during the supervision sessions together with a summary of issues related to changes required in the systems and processes of care within the health centre. This is especially important during a period of change when the lessons learned are likely to be generalizable to other people and locations. However, every effort must be made to maintain appropriate confidentiality for individual supervisees. This is essential if an appropriate supportive relationship is to develop. Supervisees should keep their personal supervision records, which should be confidential between them and their supervisor. However, the supervisee should have the option to share them with other colleagues, if so desired. The differences between the notes made and held by the supervisor and those by the supervisee are that the supervisor's notes reflect broad issues related to systems and processes of care delivery, and identification and meeting of training needs. The supervisee's notes reflect his/her personal experiences and progress in developing practice.

The supervision records should include the date, time and location of the supervision session together with a summary of the issues discussed, lessons learned and action agreed. A sample proforma is attached (*see p 69*).

Clinical Supervision Record

Supervisor **Supervisee**

Location

Date **Time**

Supervision activities

(These may include observation; demonstration; care delivery; skills teaching; problem-solving; discussion; constructive feedback; identification of training needs; and action planning.)

[illegible]

Issues addressed

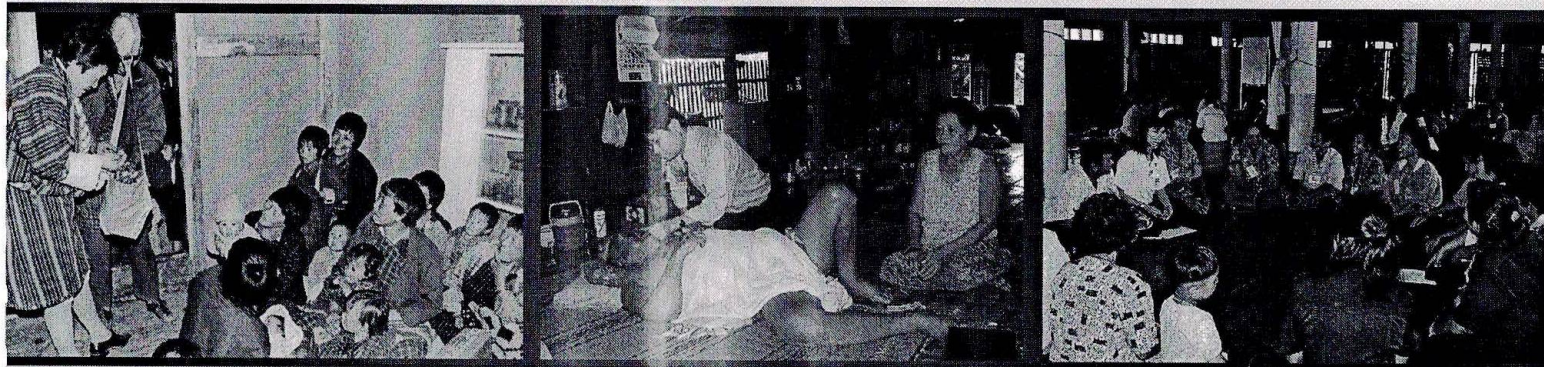
(These could include clinical issues related to specific patients; relationship issues within the health system or with stakeholders; management of workload; health centre processes and procedures.)

[illegible]

Actions agreed upon

(Summary of actions to be taken by individuals, time-scale and review date)

[illegible]



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