Comprehensive Community- and Home-based Health Care Model
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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 Tungmunantakul 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. 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

<table>
<thead>
<tr>
<th>Setting</th>
<th>Primary prevention</th>
<th>Secondary prevention</th>
<th>Tertiary prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>• Health education@</td>
<td>• Simple treatments, e.g. wound care</td>
<td>• Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>• Health promotion♦</td>
<td>• Referral</td>
<td>• Palliative care</td>
</tr>
<tr>
<td></td>
<td>• Disease prevention</td>
<td>• Drug administration</td>
<td>• Management of chronic diseases, e.g. diabetes, HIV/AIDS*♣♠♦</td>
</tr>
<tr>
<td></td>
<td>• Antenatal care</td>
<td>• Safe delivery</td>
<td>• +♣♠♦</td>
</tr>
<tr>
<td></td>
<td>• Immunization</td>
<td>• Newborn care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Condom promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community, e.g.</td>
<td>• Exercise programmes*♣</td>
<td>• Screening*</td>
<td>• Self-help groups such as mental health support groups♠ and HIV/AIDS self-help groups♠</td>
</tr>
<tr>
<td>• Health centres</td>
<td>• Elderly/health clubs♠</td>
<td>• Referral</td>
<td>• Emergency care</td>
</tr>
<tr>
<td>• Schools</td>
<td>• Environmental health campaign♠♣</td>
<td>• Needs assessment</td>
<td>• Community-based rehabilitation</td>
</tr>
<tr>
<td>• Village halls</td>
<td>• Mosquito control campaign*♣</td>
<td>• Care</td>
<td>• Community-based AIDS care</td>
</tr>
<tr>
<td>• Places of worship</td>
<td>• School health*</td>
<td>• Mass/group treatment (e.g. deworming of schoolchildren)</td>
<td></td>
</tr>
<tr>
<td>• Workplaces</td>
<td>• Development of personal skills *♣</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Parenting classes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Women/community empowerment groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Safe sex campaign*♣</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information, education and communication, e.g. family planning</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, integrated and continuous, 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;
- **Effectiveness** – special efforts are made to ensure that an intervention or service provided for the patient/client yields the intended result(s); and
- **Efficiency** – 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.

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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

<table>
<thead>
<tr>
<th>Empowerment</th>
<th>Input</th>
<th>Process</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major stakeholders such as:</td>
<td>Education and training</td>
<td>Major stakeholders who are:</td>
</tr>
<tr>
<td></td>
<td>• Individuals</td>
<td>• Mechanisms for communication and decision-making</td>
<td>• Committed</td>
</tr>
<tr>
<td></td>
<td>• Families</td>
<td></td>
<td>• Supportive</td>
</tr>
<tr>
<td></td>
<td>• Caregivers</td>
<td></td>
<td>• Involved</td>
</tr>
<tr>
<td></td>
<td>• Volunteers</td>
<td></td>
<td>• Motivated</td>
</tr>
<tr>
<td></td>
<td>• Communities</td>
<td></td>
<td>• Influential</td>
</tr>
<tr>
<td></td>
<td>• Organizations</td>
<td></td>
<td>• Confident</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Self-reliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership and</td>
<td>• Individuals</td>
<td>Partnership building</td>
<td>Involvement of relevant major stakeholders in</td>
</tr>
<tr>
<td>participation</td>
<td>• Families</td>
<td>• Networking</td>
<td>primary, secondary and tertiary prevention</td>
</tr>
<tr>
<td></td>
<td>• Community groups</td>
<td>• Coordinating</td>
<td>(i.e. health promotion, disease prevention,</td>
</tr>
<tr>
<td></td>
<td>• Village committees</td>
<td>• Advocacy</td>
<td>curative care and support, and</td>
</tr>
<tr>
<td></td>
<td>• Existing local structures</td>
<td>• Organizing community meetings</td>
<td>rehabilitation)</td>
</tr>
<tr>
<td></td>
<td>• Self-help groups</td>
<td>• Developing mechanisms for communication</td>
<td>• Ownership</td>
</tr>
<tr>
<td></td>
<td>• Key contacts in other sectors</td>
<td>and decision-making</td>
<td>• Commitment</td>
</tr>
<tr>
<td></td>
<td>• Agencies in other sectors</td>
<td></td>
<td>• Agreed priorities</td>
</tr>
<tr>
<td></td>
<td>• Religious groups</td>
<td></td>
<td>• Joint action</td>
</tr>
<tr>
<td></td>
<td>• Nongovernmental organizations (NGOs)</td>
<td></td>
<td>• Solidarity</td>
</tr>
<tr>
<td></td>
<td>• Referral organizations</td>
<td></td>
<td>• Sustainability</td>
</tr>
<tr>
<td></td>
<td>• Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Academic institutions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3. Strategies for mobilizing and managing resources

<table>
<thead>
<tr>
<th>Input</th>
<th>Process</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nonformal caregivers</td>
<td>• Identification of key people</td>
<td>• Right people right place, right skills and right attitudes</td>
</tr>
<tr>
<td>• Volunteers</td>
<td>• Identification of skills required*</td>
<td>• Training programmes</td>
</tr>
<tr>
<td>• Family members</td>
<td>• Education, training and development of health workers and nonformal</td>
<td></td>
</tr>
<tr>
<td>• Community members</td>
<td>caregivers</td>
<td></td>
</tr>
<tr>
<td>• Health workers</td>
<td>• Supportive supervision</td>
<td></td>
</tr>
<tr>
<td>- assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- others</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financial resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Resource mobilization</td>
<td>• Identification of key stakeholders and potential backers</td>
<td>• Efficiency</td>
</tr>
<tr>
<td>• Funding mechanisms</td>
<td>• Integration with existing systems</td>
<td>• Accountability</td>
</tr>
<tr>
<td>• System of financial</td>
<td>• Agreement on costing and control mechanisms</td>
<td>• Transparency</td>
</tr>
<tr>
<td>management</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Material resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Equipment</td>
<td>• Establishment of systems and processes to ensure a continuous and</td>
<td>• Right equipment, drug and technical materials in the right place at</td>
</tr>
<tr>
<td>• Drugs</td>
<td>timely supply of essential materials in the right quantity</td>
<td>the right time</td>
</tr>
<tr>
<td>• Technical materials</td>
<td>• Maintenance of equipment</td>
<td></td>
</tr>
</tbody>
</table>

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

### Table 4. Strategies for developing and implementing appropriate information systems

<table>
<thead>
<tr>
<th>Input</th>
<th>Process</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and management information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Systems for collecting, using, storing</td>
<td>• History-taking of individual and family health</td>
<td>• Information to plan, implement, monitor and evaluate needs and care</td>
</tr>
<tr>
<td>and retrieving information</td>
<td>provided when and where needed</td>
<td>provided when and where needed</td>
</tr>
<tr>
<td><strong>Information for Practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information resources including books</td>
<td>• Development and use of knowledge and skills to identify and manage</td>
<td>• Appropriate levels of access and ability to use relevant information</td>
</tr>
<tr>
<td>and journals</td>
<td>appropriate information</td>
<td>including evidence to change and develop practice</td>
</tr>
<tr>
<td>• Teaching aids</td>
<td></td>
<td>• Use of evidence-based guidelines and protocols</td>
</tr>
<tr>
<td>• Quality improvement tools, e.g. care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visit protocols or guidelines</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

**Comprehensive community- and home-based health care**

**Health promotion**
- Distribution of health information
- Health promotion activities for all age groups, e.g. elderly clubs and school health
- HIV counselling
- Management of the environment in the family and community to prevent accident/injuries and promote health

**Disease prevention**
- Immunization
- Health surveillance
- Condom promotion campaigns
- Surveillance of specific health problems, e.g. drug misuse, adolescent health and behavioural problems

**SECONDARY PREVENTION**

**Health screening and treatment of common illnesses and ailments**
- Health assessment
- Treatment of illnesses and ailments such as diarrhoea, fever, sore throat, wounds and abrasions, and acute respiratory infections
- Health care at home
- Referral

**TERTIARY PREVENTION**

**Rehabilitative, palliative and long-term care**
- Self-help groups
- Health care at home/palliative and hospice care
- Community care for AIDS
- Care for people with disabilities and impairments, e.g. following cardiovascular accidents
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.

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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 Project 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 centre 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 policymakers, 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

| National policy and support for provision of CCHBHC as integral part of the district health system (DHS) |
| District Health Manager understands the concepts and practices of the CCHBHC 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 the demonstration site |
| 5. Define the catchment area |
| 6. Forge stronger partnerships and linkages |
| 7. Interact and negotiate with the defined population |
| 8. Define health care activities at the health centre, community and home |
| • Health promotion and disease prevention programmes |
| • 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 |
| • Community meetings |
| • Home visits |
| 9. Strengthen the support system at the health centre |
| • Health information system |
| • Referral system |
| • System for interaction with the community |
| • Intersectoral collaboration |
| • Staff training and supervision |
| • Monitoring and evaluation |
| • Other support systems |
| 10. Orient health personnel |
| 11. Formulate a plan of action |

Monitoring and evaluation
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 1: List of members of the Multidisciplinary Working Group, participants of the Regional Consultations and Principal Investigator for the field test

**Multidisciplinary Working Group Members (Thailand)**

Dr KOBKUL PHANCHAROENWORAKUL
Ms SUPANEE SENADISAI
Dr RUTJA PHUPHAIBUL
Dr FONGCUM TILOKSKULCHAI
Ms VAJIRA KASIKOSOL
Dr KANAUNGNI PONGTHAVORNKAMOL
Dr YAJAI SITTHIMONGKOL
Ms SUBWADEE LIMANATHORN
Dr WANTANA MANESRIWONGKUL

**From other organizations**

Dr YONGYUTH PONGSUPAP
General Practitioner
Urban Health Center and Research of Health Care Reformed Project
Ministry of Public Health
Nontaburi

Mr KATHA BUNDITANUKUL
Pharmacist
President of the Community Pharmacy Association
Bangkok

Mrs NUANKANT LIKHITLUECHA
Nursing Bureau
Ministry of Public Health
Nontaburi

Ms RUIJNART AUTTHASIT
Public Health Expert, Primary Care Center
Ministry of Public Health
Nontaburi

Mr CHARAT JUNPRASERT
Public Health Expert
Pathumthanee Provincial Health Office
Pathumthai

Ms JINTANA JANTHARAM
Social Worker
Public Health Care Center No. 31
Bangkok

**Principal Investigators for the field test**

Dr GURU PRASAD DHAKAL
District Medical Officer
Punaka, Bhutan

Dr Pe WIN
Deputy Director (Public Health)
Department of Health
Ministry of Health, Myanmar

Ms VIJAYA KC
Special Secretary
Ministry of Health, Nepal

Dr RONNACHAI TUNG MUANANTAKUL
Director, Wang Noi Hospital
Ayutthaya, Thailand

**First Regional Consultation (August 2001)**

Mr SHEIKH SHAFI AHMAD
Joint Secretary (Hospital and Gender Issues)
Ministry of Health, Bangladesh
Dr Guru Prasad Dhakal  
Principal Investigator, Punaka, Bhutan

Ms Mridula Das  
Assistant Director-General (Nursing)  
Ministry of Health and Family Welfare, India

Dr Rachmi Untoro  
Director  
Directorate of Selected Community Health  
Ministry of Health, Jakarta, Indonesia

Ms Husna Ibrahim  
Nursing Supervisor  
Indira Gandhi Memorial Hospital, Male’, Maldives

Dr Pe Win  
Principal Investigator  
Yangon, Myanmar

Ms Vijaya KC  
Principal Investigator  
Kathmandu, Nepal

Ms Daya Kumarage  
Director of Nursing (Public Health Services)  
Ministry of Health  
Colombo, Sri Lanka

Dr Ronnachai Tungmunananantakul  
Principal Investigator  
Ayutthaya, Thailand

Dr Kanitta Nuntaboot  
Faculty of Nursing, Khon Kaen University  
Khon Kaen, Thailand

Ms Wilawan Senaratana  
Faculty of Nursing, Chiang Mai University  
Chiang Mai, Thailand

Working Group Members

Dr Kobkul Phancharoenworakul  
Associate Professor Supanee Senadisai  
Dr Yongyuth Pongsupap  
Mr Katha Bunditanukul  
Dr Rutja Phuphaibul

Observers (Thailand)

Dr Tassana Boontong  
President, Thailand Nursing Council

Dr Surakit Achananuparp  
Faculty of Medicine  
Ramathibodi Hospital  
Mahidol University

Ms Piyada Prasertsom  
Dental Health, Department of Health  
Ministry of Public Health

WHO Secretariat

Dr Kumara Rai  
Regional Adviser, Health Systems Development  
WHO/SEARO

Dr Duangvadee Sungkhobol  
Regional Adviser, Nursing and Midwifery  
WHO/SEARO

Dr Madan Upadhay  
Regional Adviser, Disability and Injury Prevention  
WHO/SEARO

Dr Miriam Hirschfeld  
Director, Home-based Long-term Care  
WHO Head-Quarters
Second Regional Consultation
(December 2003)

Ms Joyessri Datta
District Public Health Nurse
Chittagong, Bangladesh

Dr Lalrinsiki
Deputy Commissioner
(Research, Studies and Standards)
Department of Family Welfare
Ministry of Health and Family Welfare
New Delhi, India

Ms Rusmiyati
Directorate of Community Health
Ministry of Health
Jakarta, Indonesia

Ms Suhartati
Directorate of Nursing and Medical Technician
Ministry of Health
Jakarta, Indonesia

Ms Indira Thapa
Central Regional Health Directorate
Ministry of Health
Nepal

Ms Husna Ibrahim
Nursing Supervisor
Indira Gandhi Memorial Hospital
Male’, Maldives

Dr Myint Myint Than
Medical Officer, Bago Divisional Health Office
Bago Division, Myanmar

Dr Tin Tin Win
Medical Officer, Bago Divisional Health Office
Bago Division, Myanmar

Daw Mu Mu Win
Township Nurse Officer
Shwekyin Township
Kachin State, Myanmar

Ms Kalyani Shrestha
Staff Nurse, District Health Office
Saptari, Nepal

Ms Vijaya KC
Principal Investigator
Kathmandu, Nepal

Dr Pad Tissera
Director (Primary Health Care)
Ministry of Health
Colombo, Sri Lanka

Mrs NN Marikkar
Public Health Nursing Officer
Deputy Provincial Director of
Health Services Office
Kegalle, Sri Lanka

Dr Phattarapol Jungsomjatepaisal
Bureau of Health System Development
Ministry of Public Health
Nontaburi, Thailand

Dr Ronachai Tungmunananakul
Principal Investigator
Ayutthaya, Thailand

Mrs Sommai Hirunuj
Director of Bureau of Nursing
Ministry of Public Health
Nontaburi, Thailand

Mr Agapito da Silva Soares
Head, District Health Services
Dili, Timor Leste
Special Invitee

Ms Lene Svendsen
UNAIDS Nursing Consultants
Strengthening Nursing and Midwifery Personnel for HIV/AIDS in Myanmar
Yangon, Myanmar

Observers (from Thailand)

Mrs Nuankanit Likhitkluecha
Bureau of Nursing, Ministry of Public Health
Nontaburi

Mrs Nuttaya Pattanavanichnun
Wangnoi Hospital
Ayutthaya

Mrs Siripun Bootsri
Wangnoi Hospital
Ayutthaya

Dr Yongyuth Pongsupap
Urban Health Center and Research of Health Care Reformed Project, Ministry of Public Health
Nontaburi

Assistant Professor Supawadee Limpanathorn
Faculty of Nursing, Mahidol University
Bangkok

Pattriya Jarutut
Director
Sirindhorn National Medical Rehabilitation Centre
Nontaburi

Srilluck Hangsasuta
Chief, Community-based Rehabilitation Unit
Sirindhorn National Medical Rehabilitation Centre
Nontaburi

Assistant Professor Varunee Kansook
Faculty of Nursing, Chiang Mai University
Chiang Mai

Mr Sutat Kongkhuntod
Bureau of Health System Development
Ministry of Public Health
Nontaburi

Mrs Wilawan Nangern
Bureau of Health System Development
Ministry of Public Health
Nontaburi

WHO Secretariat

Dr Duangvadee Sungkhopobol
Regional Adviser, Nursing and Midwifery
WHO/SEARO

Dr T Walla
Regional Adviser, Health Systems Development
WHO/SEARO

Ms Rose Johnsen
Nurse Administrator
WHO, Dhaka, Bangladesh

Dr Deborah Hennessy
Short-term professional (Nursing)
WHO, Jakarta, Indonesia

Ms Sarah Sullivan
Short-term professional (Nursing)
WHO, Dili, Timor Leste

Dr Kobkul Phancharoenworakul
Joint WHOCC for Nursing and Midwifery Development
Mahidol University
Bangkok, Thailand (local organizer)

Associate Professor Supanee Senadisai
Joint WHOCC for Nursing and Midwifery Development
Mahidol University
Bangkok, Thailand (local organizer)
**ANNEX 2: Examples of health worker skills**

Examples of tasks and skills\(^\text{12}\) required to deliver comprehensive community- and home-based health care (CCHBHC) and for working with the community are provided below.

<table>
<thead>
<tr>
<th>Individual and family level</th>
<th>Task</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Health screening and simple treatment</strong></td>
<td>1.1 Health assessment</td>
<td>1.1 Interview skills</td>
</tr>
<tr>
<td>1.2 Prescribe medication from the Essential Drugs List</td>
<td>1.2 Observational skills</td>
<td></td>
</tr>
<tr>
<td>1.3 Refer patients as needed</td>
<td>1.3 Physical and basic mental health assessment</td>
<td></td>
</tr>
<tr>
<td>1.4 Simple tests and interpretation of the results</td>
<td>1.4 Simple treatment as given in the Essential Drugs List</td>
<td></td>
</tr>
<tr>
<td>1.5 Simple treatment as given in the Essential Drugs List</td>
<td>1.5 Decision-making for referral as needed</td>
<td></td>
</tr>
<tr>
<td>1.6 Decision-making for referral as needed</td>
<td>1.7 Emergency management</td>
<td></td>
</tr>
<tr>
<td>1.7 Emergency management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **2. Health promotion for individual and family** | 2.1 Child health services | 2.1 Physical assessment skills for the growth and development of children, and health assessment for the elderly |
| | – Assess and record child’s growth and development | |
| | – Child health counselling | |
| | 2.2 Elderly health services | 2.2 Counselling skills for parenting and elderly |
| | – Health assessment | |
| | – Promotion of health counselling and self-care | |
| | – Empowering the community for the elderly | |
| | 2.3 Health campaigning | |
| | – Distribute health information | |
| | – Conduct and promote healthy lifestyles | |
| | – Collaborate with family and community for environmental and health issues | |
| | 2.4 Advocate for health | |

| **3. Disease prevention** | 3.1 Immunization | 3.1 Skills in maintaining the cold chain |
| 3.2 Case-finding | 3.2 Skills for giving injection |
| 3.3 Health problem alert, e.g. prevalence of drug use and violence in the family and community | 3.3 Assessment skills for health problems, e.g. drugs used, family violence and mental health |
| 3.4 Environmental and sanitation management | |

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<table>
<thead>
<tr>
<th>Duty</th>
<th>Task</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Health care at home</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>6. Referral for appropriate care</td>
<td>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)</td>
<td>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</td>
</tr>
<tr>
<td>7. Counselling and guidance</td>
<td>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</td>
<td>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</td>
</tr>
</tbody>
</table>
### Individual and family level

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

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

### Community level

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

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• 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

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00–12:00</td>
<td>• ANC, counselling and FP</td>
<td>• ANC, counselling and FP</td>
<td>• ANC, counselling and FP</td>
<td>• ANC, counselling and FP</td>
<td>• Well child counselling (immunization)</td>
</tr>
<tr>
<td>(at the outpatient</td>
<td>• Outpatient clinic</td>
<td>• Outpatient clinic</td>
<td>• Outpatient clinic</td>
<td>• Outpatient clinic</td>
<td>• ANC, counselling and FP</td>
</tr>
<tr>
<td>clinic)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient clinic</td>
</tr>
<tr>
<td>13:00–16:00</td>
<td>• Home visit</td>
<td>• Home visit</td>
<td>• School health</td>
<td>• Home visit</td>
<td>• Home visit</td>
</tr>
<tr>
<td>(at home and in the</td>
<td>• Community health surveillance</td>
<td>• Community health surveillance</td>
<td>• Community health surveillance</td>
<td>• Community health surveillance</td>
<td>• Supervision for village health</td>
</tr>
<tr>
<td>community)*</td>
<td>• Campaign for a healthy lifestyle</td>
<td>• Campaign for a healthy lifestyle</td>
<td>• Campaign for a healthy lifestyle</td>
<td>• Campaign for a healthy lifestyle</td>
<td>volunteers†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Environmental health</td>
<td>• Environmental health</td>
<td>• Health report</td>
</tr>
</tbody>
</table>

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.
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 patients\(^{14}\) 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

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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.
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.
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

<table>
<thead>
<tr>
<th>ADDRESS</th>
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<tbody>
<tr>
<td>House no.:</td>
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<tr>
<td>Village no.:</td>
</tr>
<tr>
<td>Subdistrict:</td>
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<tr>
<td>Household head:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>No</th>
<th>Registration date</th>
<th>Sex</th>
<th>Name</th>
<th>Date of birth</th>
<th>Occupation</th>
<th>Education</th>
<th>Marital status</th>
<th>Family relationship</th>
<th>Health insurance coverage</th>
<th>Note (SC–OC)</th>
<th>Discharge from FF</th>
<th>Others/WBC/ANC/FP/disabled</th>
<th>Code</th>
</tr>
</thead>
<tbody>
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</table>

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:** ...............
## Personal Ticket for acute episodes

No. .........................
No. of family File .........................

Name ................................. Date of Birth ......................... Occupation .................................
Address  ..........................................................................................................................
Health Insurance Coverage  .................................................................................................
History of drug adverse effects  ............................................................................................
History of chronic conditions/diseases  ....................................................................................

### Records of treatment

<table>
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<tr>
<th>Date of visit</th>
<th>Chief complaint</th>
<th>Physical examination</th>
<th>Diagnosis</th>
<th>Treatment and advice</th>
<th>Follow-up appointment</th>
<th>Examining health personnel</th>
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### Personal Ticket for acute episodes

#### Records of treatment

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</tbody>
</table>
# Operational Card (OC) for chronic episodes

**Name** ...........................................  **Sex** .......................  **Date of birth** ..........................

**Marital status** .................................  **Occupation** ..........................

## Diagnosis

<table>
<thead>
<tr>
<th>Disease 1</th>
<th>Disease 2</th>
<th>Disease 3</th>
</tr>
</thead>
</table>

## Chief complaint

<table>
<thead>
<tr>
<th>Disease 1</th>
<th>Disease 2</th>
<th>Disease 3</th>
</tr>
</thead>
</table>

## Place provided diagnosis and treatment

- *UC* *General Hospital/regional hospital*
- *Private* *Hospital Centre/District Hospital*

Records of important finding and plan of treatment (record only when findings or treatment were changed)

<table>
<thead>
<tr>
<th>Date</th>
<th>Investigation results</th>
<th>Findings from investigation</th>
<th>Treatment</th>
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</thead>
<tbody>
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</table>

Remarks:

1. For hypertension (HT) ..................................................................................
2. For diabetic mellitus (DM) ........................................................................... 
3. Others (identify) ..........................................................................................
**Operational Card for chronic episodes**

**Records of appointment and treatment (record every visit)**

<table>
<thead>
<tr>
<th>Appointment date</th>
<th>Date of visit</th>
<th>Cause of delay in visit/action</th>
<th>Physical examination and investigation</th>
<th>Treatment and action (including care and home visit)</th>
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<tbody>
<tr>
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<td></td>
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<td>BW</td>
<td>BP</td>
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BW: body weight; BP: blood pressure; FBS: fasting blood sugar
### Child Health Operational Card

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<th>2</th>
<th>3</th>
<th>B1</th>
<th>B2</th>
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<tbody>
<tr>
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<td>Inject</td>
<td>Appoint</td>
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<td>Measles</td>
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<td>Remarks</td>
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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)

<table>
<thead>
<tr>
<th>Appointment date</th>
<th>Date of visit</th>
<th>Causes of delay in visit and operation</th>
<th>Diagnosis and finding</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
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</table>

Summary of significant illness or risk (Synthesis Card)

<table>
<thead>
<tr>
<th>Starting date</th>
<th>Ending date</th>
<th>Hospital no.</th>
<th>Problem/diagnosis/treatment</th>
<th>Result of treatment</th>
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<tbody>
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</table>
Operational Card for children under 5 years of age

Back page

Tick / for things done or X for nothing done

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Date of Birth</td>
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<td>3</td>
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<tr>
<td>Nutritional status and child health</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

Important history of child health

Labour  □ term  □ preterm
Weight
Abnormality/deformation
Allergic to medicine
Blood group
Others
## Operational Card (OC) for pregnant woman

<table>
<thead>
<tr>
<th>Type</th>
<th>No. of OC</th>
<th>Date</th>
<th>FF No.</th>
<th>Household head</th>
</tr>
</thead>
</table>

### Pregnant Woman Operational Card

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
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<tr>
<th>LMP</th>
<th>EDC by</th>
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### History of pregnancy and general health

<table>
<thead>
<tr>
<th>Gravida</th>
<th>Para</th>
<th>Abortion</th>
<th>Last parity</th>
<th>Last abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Abnormal</td>
<td>Stillbirth</td>
<td>Delivery place</td>
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</table>

<table>
<thead>
<tr>
<th>History of latest pregnancy</th>
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<table>
<thead>
<tr>
<th>History of previous pregnancy</th>
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<table>
<thead>
<tr>
<th>History of general health/drug allergy</th>
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<table>
<thead>
<tr>
<th>Plan of present pregnancy</th>
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</table>

### Investigation/vaccination and other important findings

<table>
<thead>
<tr>
<th>Height</th>
<th>centimeter</th>
<th>Blood group</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Laboratory findings</th>
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<table>
<thead>
<tr>
<th>Date</th>
<th>VDRL1</th>
<th>HIV</th>
<th>HBsAg</th>
<th>HCT</th>
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<tbody>
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<tr>
<th>Decision (from laboratory results)</th>
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<table>
<thead>
<tr>
<th>Date of vaccination of tetanus toxoid 1</th>
</tr>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Date of vaccination of tetanus toxoid 2</th>
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</tbody>
</table>

### Decision

- [ ]

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

### Body weight

<table>
<thead>
<tr>
<th>Date</th>
<th>Body weight</th>
<th>Urine albumin</th>
<th>Blood pressure</th>
<th>Oedema</th>
<th>Uterine fundus</th>
<th>Gestational age</th>
<th>Other signs/complaints</th>
<th>Decision</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<thead>
<tr>
<th>Decision Follow-up</th>
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</table>

### Body weight

| Remark: identify foetus position at 34 weeks of gestational age |
## Operational Card for pregnant woman

### Labour history

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Type of delivery</th>
<th>Complication</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Child weight</th>
<th>Sex</th>
<th>Live birth</th>
<th>Stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Complications

### Postpartum mother

<table>
<thead>
<tr>
<th>Date</th>
<th>BT</th>
<th>BP</th>
<th>Lochia</th>
<th>Abdomen perineal wound</th>
<th>Breastfeeding</th>
<th>Other signs, complaints</th>
<th>Decision</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
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</table>

**BT**: body temperature; **BP**: blood pressure

Plan for contraception

Opening date of Operational Card

### Baby

<table>
<thead>
<tr>
<th>Date</th>
<th>BW</th>
<th>Umbilicus</th>
<th>Other signs, complaints</th>
<th>Decision</th>
<th>Follow-up</th>
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<tbody>
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**BW**: birth weight

Opening date of Operational Card (Well-Baby Clinic)
Synthesis Card

Name_________________________ Sex_____________ Date of birth__________________

Address_____________________________________________________________________

History of health

Blood group__________
History of drug allergy, allergic to______________________________________________
Abnormality/deformity_________________________________________________________

Vaccination (identify the date)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>B1</th>
<th>B2</th>
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<tbody>
<tr>
<td>BCG</td>
<td></td>
<td></td>
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<tr>
<td>HBV</td>
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<td>DPT</td>
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<tr>
<td>OPV</td>
<td></td>
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<tr>
<td>Measles</td>
<td></td>
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<tr>
<td>JEV</td>
<td></td>
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<tr>
<td>Tetanus</td>
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</table>

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

#### Synthesis of health problems and risks

<table>
<thead>
<tr>
<th>Problem starting date</th>
<th>Problem ending date</th>
<th>Type/no. of Operational Card or Hospital no.</th>
<th>Problem/diagnosis/services provided</th>
<th>Results of services/treatment</th>
</tr>
</thead>
<tbody>
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</table>
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.)

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.)

Actions agreed upon
(Summary of actions to be taken by individuals, time-scale and review date)
Comprehensive Community- and Home-based Health Care Model

Department of Family and Community Health
World Health Organization
Regional Office for South-East Asia
World Health House, Indraprastha Estate
Mahatma Gandhi Marg, New Delhi 11002, India
Email: fch@whosea.org, hsd@whosea.org
http://worldwideweb.whosea.org