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Model for Comprehensive Community and Home-based Health Care

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1. INTRODUCTION

With the double burden of communicable and non communicable diseases, increase in health care costs and increase in the older population (up to 300%, according to WHO's recent estimates), there is a steep increase in the need for long-term and chronic care and care to manage daily living, in addition to strengthening basic health care services. Accessibility to health services has become an important issue, which countries of the South-East Asia Region (SEAR) need to address. This need is further emphasized by the continuing trend towards shortened hospital stays.

Given the escalating costs of health services, the poor, the vulnerable and the disadvantaged groups (who normally have only limited access to health care) will be even more deprived. There is an urgent need, therefore, for countries of the Region to extend health services beyond hospital walls and establish an alternative to hospital care. This strategy will ensure the accessibility of health care as well as strengthen the continuum of care between the hospital and home.

Most countries of the Region have established several community-based health care services, such as community-based rehabilitation, community-based care and support programmes for people living with HIV/AIDS (PLHA), community midwifery, community health nursing, community mental health and other community services for target diseases, e.g. childhood illnesses with the implementation of integrated management of childhood illnesses, and tuberculosis (TB) with the implementation of directly observed treatment short-course (DOTS) strategy. With few exceptions, many of these services, although integrated into the primary health care (PHC) structure, lack horizontal integration or proper coordination with other related key programmes. Therefore, there is a need to provide comprehensive and properly coordinated health services in support of an essential health care package at community level, because these services usually fall under the responsibility of the same core health workers.

In light of the above, the South-East Asia Regional Office (SEARO) of WHO undertook the initiative for the development of a generic model for comprehensive community and home-based health care (CCHBHC) to provide direction to Member Countries on how they can further strengthen community health services in response to the changing health needs and services requirements of people in the Region.

The Regional Office contracted the Joint WHO Collaborating Center for Nursing and Midwifery Development, Mahidol University, Thailand, through an Agreement for Performance of Work to develop such model using the services of a multidisciplinary working group. The model was developed in close collaboration with Member Countries. It was field-tested in 2001-2002 in Bhutan, Myanmar, Nepal and Thailand to assess its relevance and practicality within the regional context.

Following the field test, a consultative meeting was convened in Bangkok, Thailand from 2-4 December 2003 to finalize the model and to advocate its application in countries of the Region. Eighteen participants, one special invitee, ten observers and seven members of the WHO Secretariat participated in the meeting. The List of Participants and Programme of the Meeting are at Annex 1 and 2 respectively.

2. OBJECTIVES

The objectives of the consultation were to:

- (1) To critically review the process, outcomes (with special emphasis on core principles of the model, i.e. equity, quality, partnership, effectiveness and efficiency), and lessons learned of the field test of the SEARO CCHBHC model in Bhutan, Myanmar, Nepal and Thailand;
- (2) To finalize the CCHBHC model taking into account the field-test outcomes and other experiences at country level, and
- (3) To identify ways forward to promote the adaptation and application of the SEARO CCHBHC model in countries of the Region.

3. INAUGURAL SESSION

Professor Dr Srisin Khusmith, Vice President for Research, Mahidol University, welcomed the participants on behalf of the President of Mahidol University. She pointed out that this meeting was the second meeting facilitated by the Joint WHO Collaborating Centre for Nursing Midwifery Development, Mahidol University, with respect to the CCHBHC model. The first consultation meeting held in August 2001, had three distinctive outcomes: it identified good practices in community and home-based health services; it reviewed the proposed CCHBHC model, in terms of its practicality and relevance, and thirdly, it recommended further development and testing of the model.

The address by Dr Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region, was then read-out by Dr Bjorn Melgaard, WHO Representative to Thailand. The Regional Director noted that there was urgent need for countries of the Region to extend their health services beyond hospital walls. With increasing health care costs, the poor, vulnerable and disadvantaged groups of the population were further deprived. Therefore, there was an urgent need to introduce cost-effective care and support in communities and homes. It was further pointed out that this care and support could be carried out by less trained health personnel and/or family members, provided that proper supervision by qualified health personnel was provided. However, the importance of such care and support services to be horizontally integrated or properly coordinated with other related programmes at the PHC level, was further stressed, as they are usually carried out by the same health worker/s.

In response to this challenge, the Regional Office therefore took initiative in 2001, in collaboration with the Joint WHOCC for Nursing and Midwifery Development, Mahidol University, Thailand, to develop a generic model for countries to provide comprehensive community and home-based health services.

It was highlighted that the outcome of the field-testing of the model in Bhutan, Myanmar, Nepal and Thailand in 2001-2002 was encouraging. The participating countries had reported the model to be a useful tool in assisting them in better organizing and managing their community health services. This meeting would be an opportunity to learn more about how this model is seen

by the countries of the Region as a tool to improve accessibility and quality of community health services.

Dr Pakdi Pothisiri, Deputy Permanent Secretary, Ministry of Public Health, Thailand inaugurated the meeting on behalf of the Permanent Secretary. He pointed out that the work on CCHBHC model and related field-testing had been very contributive to improving the accessibility and quality of community health services as well as to enhancing the participation of individuals, families and communities for proper self care and healthy lifestyles. He further referred to the successful launching in Thailand of a universal coverage health care campaign, (including introduction of health promoting hospitals, the 30 Bahts scheme and primary care units) and expressed that the CCHBHC model would be both congruent to, and beneficial for this campaign.

4. NEED FOR COMMUNITY AND HOME-BASED HEALTH CARE SERVICES IN COUNTRIES OF THE REGION

Health is at the centre of development in the Region. As such, there are increasing concerns within the Region, related to the issues of protecting the health of people as a fundamental right, and for increasing the access to health care. Health services need to be available close to the client and community, and to aim at increasing the accessibility of care to the poor, vulnerable and disadvantaged groups. In order to achieve this further, PHC services need to be strengthened in order to develop cost-effective interventions and build the necessary capacity.

In light of the ongoing efforts towards increasing the access to TB/DOTS, scaling up anti-retroviral (ARV) treatment in line with the 3 by 5 strategy, and improving the coverage of treatment for opportunistic infections related to AIDS, it would be essential to further develop structures for CCHBHC services as part of the health systems of countries of the Region, which would specifically focus on human resources for health organization and management.

The demographic transition in countries of the Region means that there is an increase in life expectancy at birth, a decline in the population of 15 years and under, an increase in the ageing population (65 years and over) and that more people will be at higher risk of developing chronic and debilitating diseases associated with old age.

Moreover the epidemiological transition within countries of the Region shows that there are persistent, emerging and reemerging communicable diseases, and that there is an increase in chronic noncommunicable conditions. This is observed in addition to cardiovascular diseases (CVD), cerebrovascular diseases, cancers and diabetes mellitus emerging as major causes of morbidity and mortality in some countries of the Region. Mental health problems and problems related to substance abuse continue to be serious public health concerns that often require long-term chronic care and support. This double burden of diseases requires health systems, more than ever, to deliver affordable, effective and easily accessible health services, and to incorporate disease prevention and health promotion into all programme activities.

The need for community health services is great, because they offer an alternative to hospital care, specifically in the context of shortened hospital admissions unfolding in the Region as a way of reducing health expenditures. The CCHBHC services can provide continuum of care, and many basic care and support interventions can be carried out at home by formal and informal care-givers. Moreover, home is the setting of choice for most ill persons receiving care.

The need for CCHBHC services is further emphasized by the increasing importance of providing care and support to PLHA and being able to implement the 3 by 5 strategy in the Region.

Strategies for further developing the community and home-based health services are in place in several countries of the Region. For example, Sri Lanka has introduced a family health worker (public health midwife) for every 3 000 population (approximately 500 families) recruited by the government and trained in nursing schools for two years. In India the strategy for providing the necessary human resource for health (HRH) in support of community and home-based health services had been to ensure an auxiliary nurse midwife

(ANM) per 5 000 population with two years of training, in recognition that the ANM was the main provider of basic health services.

The main issue highlighted by all participating countries was the need to have solid HRH planning and management. Ensuring the necessary staffing at the peripheral level was seen as essential. To this end, capacity-building and training of front-line health workers was stressed and would include revision and updating of basic curricula for nursing/midwifery personnel and greater involvement and training of community volunteers. Moreover, the capacity within the intermediate health system, e.g. district or township-level health offices, would need to be strengthened in order to improve supervision and technical support to peripheral levels.

5. OVERVIEW OF THE SEARO CCHBHC MODEL AND FIELD-TESTING PROCESS

The Regional Office initiated the development of a model as an interdepartmental collaboration to coordinate efforts in response to the needs for strengthening community- and home-based health care in countries of the Region. By early 2001 the draft CCHBHC model, developed by a multidisciplinary group at the Joint WHO Collaborating Center for Nursing and Midwifery Development, Mahidol University, Thailand, was ready.

In August 2001 the first regional consultation was held to critically review the draft model. Then later in October 2001 a meeting of Principal Investigators from each of the four participating countries; Bhutan, Myanmar, Nepal and Thailand, was held at the Regional Office to finalize both the Model document and the Guideline document for field-testing. By November 2001 the introductory training for participating personnel from the four field-test countries had already been conducted in Ayutthaya Province, Thailand to have first-hand comprehensive experience on how integrated and continuous health care could be provided at community and home levels. During the following 10 months, starting from December 2001 – September 2002, each of the countries carried out their field-testing.

The CCHBHC model was meant as a guide to countries to develop their own community and home-based health services and variations in the way countries would adapt and implement the model were expected.

The CCHBHC model is based on the principles of holistic, integrated and continuous care. It acknowledges the contribution that individuals, groups and communities make in achieving and maintaining their health, and in managing illness throughout the lifespan.

The model provides an overall framework for developing community and home-based health care as part of PHC and it includes systems and processes that can be adapted to meet the needs and priorities of local communities. In doing so, it builds on the existing health system structures and seeks to build capacities of the available health personnel for provision of health services. It is underpinned by partnership between health personnel and members of the local community.

The Model emphasizes that care can be provided in various settings and by various people, including health professionals, care assistants and non-formal caregivers such as volunteers and family members. It includes primary, secondary and tertiary prevention. Specific diseases, health conditions or categories of clients will be targeted according to needs of local communities. Increasing the self-care ability of individuals, families and communities is part of the strategic thinking.

The goal of CCHBHC is to increase the access to effective and efficient health services and health care in community and home settings, in order to contribute to morbidity and mortality reduction.

The objectives are broadly divided into four categories:

- (1) Promoting healthy lifestyles and preventing illness;
- (2) Managing the consequences of illness;
- (3) Serving the needs of the vulnerable and underprivileged populations, and
- (4) Supporting informal caregivers.

By expanding the focus of the existing system of PHC and including rehabilitation, curative and emergency care, the Model offers a holistic approach to addressing the health and illness continuum throughout the lifespan.

The access to care will be through multiple entry points, and it is seen as essential that the care provision is cocordinated and integrated. A key success to this is efficient and effective use of information by all those involved in the provision of services to patients whether based in health centres or hospitals, homes or in communities.

The provision of care at a health centre or primary care unit should include:

- Outpatient clinic;
- Home visits;
- 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, and
- Health promotion and disease prevention programmes.

The programme management is dependent upon the relationships and sense of ownership between the community and the relevant health providers such as the health centre. Intersectoral collaboration and support are necessary and can play an important role, e.g. with NGOs, and private sector. A District Leading Team should be established to undertake the management and coordination of the CCHBHC programme.

Human resources for health are basically found among the existing personnel at health centre level who will work together with community volunteers. Health personnel should train and supervise the volunteers and family caregivers according to needs. Financial resources available for CCHBHC will largely depend on existing national policy. Monitoring and evaluation will follow the guidelines and contain both qualitative and quantitative indicators.

6. EXPERIENCES IN FIELD-TESTING OF SEARO CCHBHC MODEL AND LESSONS LEARNED

For the following review of each participating country's experiences of field-testing the CCHBHC model and lessons learned, a simple template format has been used to organize and present the data.

6.1 Bhutan

The main objective of the CCHBHC model in Bhutan was to increase the accessibility to health, and to quality community health care.

The implementation strategy for field-testing the CCHBHC model was in accordance with the guidelines. The field-testing took place in 2002 over a six-month period.

Process

The implementation was carried out as under:

(A) Identification

The main components of the CCHBHC programme were identified through village-level meetings conducted in each village within the catchment area of the two selected Basic Health Units (BHUs). These meetings, lasting up to 4-5 hours each, were conducted by the Principal Investigator (PI), supervisor and the participating health personnel, and they aimed, first of all, to advocate for the CCHBHC model and to negotiate and involve the beneficiaries from the very beginning. The meetings were held at either monasteries, outreach clinics or in the open field and were usually participated by an average of 30 persons in each meeting. During this consultative process, the following five core elements for the CCHBHC model emerged:

- (1) Personal and environmental hygiene and sanitation;
- (2) The under-5 growth monitoring and immunization;
- (3) Reproductive health, including safe motherhood;

- (4) Follow-up of chronic cases, and
- (5) Control of by-pass from BHU to hospital.

The model was field-tested within the existing structures of both health system and community systems, and to this end, the Village Health Workers (volunteers) and community members came to play an important role in the preparatory as well as the implementing phase of the field-testing.

The model appears to be appropriate in the specific country context of Bhutan, because not only is it integrated into the existing PHC structure, it has also helped strengthen it. Concrete suggestions for improving the management and service delivery of PHC were made during the community meetings and were mainly related to the need for strengthening:

- record-keeping in health centres;
- follow-up of chronically-ill community members, and
- referral system.

These issues were to be addressed by the CCHBHC programme.

(B) Preparations

The briefing of Principal Investigator and training of participating health personnel took place according to plans. There was no specific training conducted for village health workers or community volunteers. However, as they were actively involved in preparatory meetings and problem-identification, the following actions were taken:

A CCHBHC Orientation Workshop for the two Health Assistants and the Supervisor was conducted prior to their departure to Thailand to participate in the introductory training at Ayutthaya. Upon their return to Bhutan, an orientation workshop was conducted for the rest of the BHU team (four health personnel). Hands-on training of health personnel was also provided during the supervision visits later on in the process.

(C) Coherence

The relationship between objectives of the model and its actual implementation and results, appears to be consistent. However, there

apparently were some capacity constraints regarding the required preparation, training and supervision of health personnel and community health workers in relation to the CCHBHC concept and the related issues that were not addressed in the guidelines for field-testing.

(D) Implementation system

The implementation of the model builds on existing structures and available resources and does not seek to establish parallel structures. The field-testing period was divided into two phases: preparation and implementation.

During the first phase, two BHUs in Punaka district were selected according to the criteria for the field-testing: Kabesa BHU and Samdingkha BHU. Both these BHUs have a number of out-reach clinics under them. The target group for the CCHBHC programme was the population living within the catchment area of the two selected BHUs.

The health personnel working in these BHUs were the key players for conducting the field-testing; they comprised six careproviders and two supervisors; the caregivers were: two Health Assistants (two-year education after the 9th standard); two Auxiliary Nurse-Midwives (two-year education after the 9th standard), and two Basic Health Workers (one-year education after the 8th standard). The supervisors were: one District Health Supervisory Officer who is usually involved in supervising the BHUs and one selected Principal Investigator.

Technical input to BHU personnel and community health workers was provided by the PI and the Supervisor.

There is no reporting on whether families and clients received training and/or support for self-care at home.

During the second phase, a number of changes were introduced in the working procedures at the BHUs and supervision was undertaken regularly. An interim assessment of the model was made in early July 2002, involving visits and discussions with personnel at two selected outreach clinics under the BHUs.

The final assessment of the model, carried out by the PI who spent three days in each of the two selected sites, covered field observation (BHU and community), review of health information and documentation, interviewing the participating personnel, interviewing the supervisor, and focused group discussions with health workers and community members

(E) Management structure of the model

The guidelines suggest establishing a District Leading Team comprising health officers at the district level, health personnel at health centres and community leaders within the catchment area. This appears to have been achieved to some extent vis-a-vis the formation of the Village Development Committee to oversee sanitation and other health-related activities. However, there was no reporting of a clearly defined structure for the CCHBHC programme.

Results

First-level results (Knowledge gained): Changes in the knowledge and skills of participating health personnel was reported in terms of benefiting from the experience of field-testing the model. No knowledge assessment test was conducted following the introduction and training workshops. However, the orientation workshop and supervision appear to have been effective because they provided a basis for change in performance (see below).

Second-level results (changes in individual performance): Changes were observed in individual performance of health personnel, e.g. they were polite and courteous towards patients and families, seeking detailed history and thus improving diagnosis capacities, collecting drugs for chronic patients and thus contributing to higher quality of care and increased confidence of patients.

Health personnel were observed to organize their work better and to be more dedicated in filling out forms and maintaining schedules and registers. To this end, initiatives were taken by health personnel to improve the daily working procedures.

Third-level results (change in organizational performance): A change occurred in organizational performance, primarily related to achieving an integration of the following services at the outreach clinic of the BHU: health

education, ANC, immunization, treatment of minor illness, follow-up of chronic cases and home visits for sanitation follow-up.

Family folders were introduced in households and improvement effected in case management, primarily in relation to chronically-ill patients, e.g. related to medicine intake/distribution, personal record-keeping, registration and continuum of care. However, there was no reporting on the establishment of care/support groups within the community.

Continuum of care was strengthened and planned discharge from the hospital was tried out. The following are some examples of improved organizational performance:

- New village health workers were selected in those places where there was a need for more support.
- A village Development Committee was formed to oversee sanitation and other health-related activities.
- A weekly schedule for BHU activities to be carried out was introduced including outreach activities for integrated services.
- Expanding the follow-up and long-term care at home to chronically-ill individuals.
- Regular update was done of family folders and registers of chronic patients, pregnant women and under-5 children. Follow-up was introduced for missed appointments.
- Intensified use of VHWs for follow-up and contacts with families.
- Drugs for chronic patients were collected and disbursed.
- Improved referral and communication between hospital and BHUs and vice versa.

It appears that the field-testing process has been relatively effective in achieving progress and results in areas needing strengthening, that were identified during the first phase: record-keeping in health centres; follow-up of chronically-ill patients, and the referral system.

Fourth-level results (Improvement in public health situation): It is beyond the scope of this field-testing to be looking for improvements in public health situation measured by prevalence/incidence rates.

Relevance of the model as a capacity-building strategy for strengthening community-and home-based care and support

The CCHBHC model seems to have been relevant in improving the health workers, and community health workers, understanding of PHC. Likewise, their performance in the delivery of basic health services also seems to have improved. Various initiatives have been taken to change and improve the daily working routines and practices. However, the specific delivery of care and support at homes, including supervision of family caregivers at home could probably be more emphasized and developed. Collaboration with the community as well as with the hospital has improved and certain coordination mechanisms established.

Main Findings

The main achievements and challenges related to the process of implementing the CCHBHC model are listed below.

(A) Achievements

- The Community participated well in the provision of care, and the relationship between the community and health personnel was strengthened.
- Health personnel in BHUs changed their attitudes and improved the quality of work.
- Health personnel and the Supervisor found the model easy to follow and easy to adapt to the local context.
- The best help to health personnel was frequent supervision visits, and orientation and trainings on the model concept.
- Need-based health care to the community.
- Continuity of care improved.
- Better communication with community.

- Improved referral system.
- Timely follow-up of patients.
- Efficiency in care delivery was achieved due to systematic and rational working procedures.

(B) Challenges

- The knowledge of health personnel and the Supervisor regarding community and home-based care is limited; they could be better prepared for the model implementation.
- It takes time to change behaviour, belief and attitudes of people.
- The Supervisor and PI did not have frequent interaction with the community.
- Shortage of supervision and excess workload of Supervisor.
- Delayed release of funds for the field test.
- Insufficient time to prepare for field-testing.
- Shortage of staff at the BHU to cover large areas.
- The field-test period was too short and health personnel had to be absent for other training and duties during the field-testing period.

Lessons learned

Even though the concept and practice of community and home-based care already existed in the health system, the model has made these activities more integrated, comprehensive and better organized.

The model contributes to increased accessibility to care, due to improved outreach, follow-up and referral. It also contributes to better quality of care, with existing resources, due to the integration of services and higher level of performance of the individual health personnel.

However, it was reported that it was difficult to judge the applicability and usability of the model in other parts of the country, because the field-testing period was too short and only one district was selected.

Continuous and supportive supervision was very much needed during field-testing, and is seen as the key to success in implementing the model .

Recommendations for further improvement of the Model, and for its expansion in the country

The following are the recommendations for further improving the model:

- (1) The field-testing should be carried out at additional sites within the country to provide more informed opinion concerning the applicability and usability of the model;
- (2) Health personnel and the Supervisor should have adequate and clear knowledge of community and home-based care, and of the CCHBHC model before the implementation, and
- (3) The Supervisor and PI should have more frequent interaction with the community.

6.2 Myanmar

Community Health Care is one of the 12 broad health programmes included in the National Health Plan. Community and home-based care falls under the responsibility of the Department of Public Health, Department of Health, Ministry of Health (MoH), and the main objective of Community Health Care programme is to improve and expand the accessibility to primary health at the most peripheral level. The Self Care at Home programme was one of the important initiatives taken in this area in the past.

The key health personnel involved in PHC are: Township Health Nurse; Lady Health Visitor; Midwife; Auxiliary Midwife, and Health Assistant. The Midwife is a multipurpose worker in Myanmar with a range of tasks and duties to perform including home visits.

The implementation strategy for field-testing the CCHBHC model was in accordance with the guidelines. The field-testing took place from May to October 2002.

Process

The implementation was carried out as under:

(A) Identification

The core services to be provided under the CCHBHC programme were identified by the investigation team in collaboration with health personnel selected for the field-testing during the orientation workshop. The core services were further discussed with families during the systematic and initial household visits to each family residing in the catchment area.

Advocacy meetings were held at the central level to obtain support and commitment for the field-testing and at the local level to obtain commitment, motivation and participation of key stakeholders, e.g. local authorities, divisional and district health personnel, NGOs, schoolteachers and community members.

The model appears to be responding to the basic priority health needs of the population, excepting the needs of PLHA. The CCHBHC programme has introduced activities in the ongoing working programme of the urban health centres, provided additional resources and technical input, and has been entirely built upon the existing health centre structure. However, the model assumes that there is capacity to also undertake the new functions and roles in relation to community and home-based care in addition to the existing tasks related to ANC, deliveries and postpartum care, vaccinations, growth monitoring, water and sanitation, etc.

(B) Preparations

The Principal Investigator attended the introductory training at Ayutthaya, Thailand arranged by the Regional Office. Upon his return to Myanmar, he conducted a three-day orientation workshop for selected health personnel and supervisors. The objectives of the workshop were achieved.

The model documentation, including the tools for evaluation, were translated into the Myanmar language and distributed to participating health personnel and the district leading team. There is no reporting on training of community volunteers or others at this stage.

(C) Coherence

There seems to have been good consistency in implementing the model. The relationship between programme goal/objectives and actual programme implementation and service delivery was satisfactory. Accessibility to basic health services was increased. However, affordability remained a challenge although initiatives were taken to raise additional funds and expand the community cost-sharing mechanisms.

(D) Implementation system

The model was implemented as part of the existing urban health centre structure. However, some roles and responsibilities were added to the jobs of midwives and Lady Health Visitors, and new activities were introduced in addition to the ongoing activities of the centres. The CCHBHC model does not target specific groups of the population, health conditions or diseases, e.g. long-term and chronically-ill individuals and their families. In fact, it provides services to anyone in need of basic health care services. The field-testing period was divided into two phases: preparation and implementation.

During the first phase the investigation team selected two urban health centres: Bago and Pyay, for field-testing the model. Both centres are located in Bago Division close to the capital Yangon. Both health centres fulfilled the selection criteria concerning adequate infrastructure, operational budget, staffing, material supply, and referral options.

A total of 16 health personnel were selected for the field-testing of the model. The selected health personnel comprised: six lady health visitors and ten midwives. A total of eight supervisors were assigned to the two urban health centres (five medical officers, two township health assistant and one health assistant). As per their job descriptions the supervisors were usually involved in supervision of Basic Health Staff in the Division.

The catchment areas were well defined and comprised two urban wards (areas), each estimated to have 5 000 population. An initial household visit was conducted by the midwives to each family residing in the two wards to obtain specific data and establish the family files. This approach appears to be very time and resource consuming and might not be realistic on a larger scale.

Community volunteers and members of the community were involved in the CCHBHC programme primarily from the perspective of identifying families and locating houses as well as drawing up the family files during the household survey. Some became involved in chronic care at home later on.

In terms of the technical input provided, the PI facilitated the formulation of an action plan for the implementation of the model with clearly-assigned responsibilities.

The main services provided for the CCHBHC programme were:

- Curative services at urban health centres
- Home care for curative services:
 - Patients suffering from a broad range of illnesses and symptoms were sent to the health centre for treatment.
 - Follow-up was conducted during home visits to ascertain the status of patients. Dialogue with the patient and family.
- Hospital services:
 - Laboratory investigation.
 - Referrals for patients needing admission.
 - Health centre personnel visited patients at hospital.

Supervision of involved health personnel was carried out as prescribed in guidelines for field-testing. Families and clients were supervised to some degree and encouraged to undertake self-care. Health education was also provided.

Additional financial resources were mobilized for the existing revolving drug fund to cover expenditures for the poorest in the CCHBHC programme. The community cost-sharing scheme is well implemented in the country with funding from/through NGOs, community resource persons, donors and agencies.

The investigation team headed by the PI conducted the final assessment and collected data from field observation, review of health information and documentation, interviewing the participating personnel, interviewing the supervisor, and through focus group discussions with (i) health workers and

supervisors; (ii) clients, their families and non-formal caregivers, and (iii) community members, local authority and community volunteers.

(E) Management structure of the model

A District Leading Team was established, according to the guidelines for field-testing, as the managerial entity for the CCHBHC programme. The Team comprised two district health officers, two health centre personnel, two representatives from local administration and three major stakeholders (PI and two additional model staff). Their main responsibilities were: coordination; management, and ensuring completion of field-testing activities. This management structure does not appear to be part of the existing PHC structure at the township level.

Results

First level results: The participating health personnel expressed that they had learnt a lot from the orientation workshop, supervision and model practice. Knowledge test was not part of the guideline instructions.

Second level results: Changes in individual performance of health personnel was reported in terms of being more confident and being able to establish open relationships with patients and their families during home visits and at community meetings. A majority of health personnel reported that they had started doing home visits more frequently, including visits to patients recently discharged from hospital. Some health personnel had experienced the results of their improved care and support to patients and families, e.g. self-care had improved and family caregivers were able to provide the necessary care for their ill family members at home.

Third level results: Change in organizational practice was reported both in relation to facility-based services and community home-based care.

A new system of patient registration, including card and files, was introduced both at health centre level and at home with the individual person e.g.:

- Personal book to be kept at home by the long-term or chronically-ill person;

- Tickets to be kept by the acute or short-term ill person, and
- Family files to be kept at the health centre.

This recording and updating of health events led to increased continuum of care and better quality of care.

Approximately five-seven home visits were undertaken every week day during afternoon hours to a broad range of patient categories, including acutely-ill, recently-discharged-from-hospital, chronically-ill, and the elderly. The visits were made in addition to the regular home visits conducted by midwives and lady health visitors to attend to high-risk pregnancies, deliveries and postpartum care.

Better coverage was established and people in need of care, especially rehabilitation at home, were identified. Family members and community volunteers were trained in care and support with focus on the chronically-ill; and those suffering from paralysis and/or diabetes.

Community meetings were organized monthly to address the needs for long-term care and follow-up to high-risk groups.

The effectiveness of the model in achieving the objectives was stated as relatively good. However, it would take more time and input from other sectors in order to achieve the objectives fully.

Fourth level results: A decrease in morbidity and mortality due to dengue haemorrhagic fever and diarrhoea was recorded as compared to data recorded during the same time last year. However, it is difficult to determine whether this decrease is caused by the services provided vis-a-vis the CCHBHC model or other factors external to the model field-testing activities.

Relevance of the model as a capacity-building strategy for strengthening community-and home-based care and support

Both health personnel and community members expressed that their general knowledge and awareness of health promotion, health prevention and community home-based care had increased. The model had helped establish a better dialogue between the health facility and the community, and had contributed to better health seeking behaviours.

During the community meetings, priority areas and issues that needed improvement had been identified and proper actions and solutions were discussed. Cooperation had also been established with other sectors like the municipal committee and education department.

The model has helped bring focus on ways of more rational utilization of basic health staff at the health centre level to deliver primary health care and home-based care in particular. To this end, the involvement of community volunteers and non-formal caregivers could be explored to much higher potential.

Main findings

(A) Achievements

- The model documentation is easy to understand and follow.
- Participating health personnel expressed that they had learnt a lot from the model field-testing.
- Some cost-sharing mechanisms were tried out in the community, both with respect to medicines and transportation, as well as at the hospital for medicines.
- Gatherings at the meeting hall were organized for children under five who had missed immunization days, growth monitoring of children and health education to mothers, including birth spacing and antenatal care.
- An increase in health clinic attendants was reported during the months of the field-testing, a higher number of timely referrals to hospital took place and a better follow-up to ill patients at home was performed.

(B) Challenges

- Health expenditures are high, and a majority of clients have difficulties finding sufficient funds to cover medicines, doctors' fees, transportation etc. In some cases hospitals and communities can support the poorest to meet health expenditures.

- The workload of health centre personnel is high and should be more equally distributed among different categories of public health staff. Further to this the demand for reporting and filling out forms needs to be reduced and better coordinated.
- The coverage of CCHBHC services was pointed out as a main challenge. Additional health personnel are needed in order to utilize this model approach in the future. A suggestion was made for a more realistic coverage and workload; 200 households per one health personnel.
- The CCHBHC model needs to target priority groups, diseases and/or conditions in order to avoid overload, e.g. request for including home visits during minor illnesses. An optimum utilization of scarce resources is necessary.
- Limited understanding and knowledge among communities, families and health personnel of the community home-based care concept, and of health promotion and disease prevention.
- Training modules and other resource materials are needed for upgrading of skills and for capacity-building.

Lessons learned

The CCHBHC model field-testing meant that there was more efficient use of drugs at the health centre, which led to an increase in the utilization rate, and in the confidence and credibility in the relationship between health personnel and patients.

Although cost-sharing schemes exist at health centres, and revolving drug funds are used for replenishment of drugs, it was found that more funds were needed to keep up with the demand for cover medicines for the less privileged.

The community meetings gave an opportunity to discuss the prevailing issues like control of dengue haemorrhagic fever; diarrhoea control measures; sanitary latrines; transportation for emergencies, and fund-raising for replenishment of medicines. They also brought about a sense of ownership and shared responsibility within the community.

The systematic household survey conducted in phase 1 in the catchment area is not reported to be necessary and in some cases redundant. Some families are wealthy and have no health problems or are not interested in home visits, while others expressed that systematic visits were too time consuming and required different staffing.

Advocacy for the model is essential for successful implementation. Local administration, NGOs and hospital staff are interested in collaboration, if benefits and gains are clearly recognized.

The use of a home-based care kit containing medicines and items for basic care would make the work of health personnel more effective. Patients would also perceive health personnel differently, while families and communities, and health personnel would gain more credibility.

Home visits are not an effective way to do under-5-years-children check-ups, because children of working parents are often not at home, and thus not available for under-5-year check-ups, because they are following parent to work place.

Recommendations for country adaptation of the model and for its further implementation

- (1) Health personnel should be assigned to cover only a defined catchment area (e.g. 200 households/health personnel) and use community volunteers to higher potential;
- (2) Model should be as simple as possible, and reconsider the purpose of systematic household visits for initial data collection;
- (3) Criteria for home visits should be more selective and focused on target groups, and
- (4) Study tours should be arranged for health personnel to get more knowledge from other experiences.

6.3 Nepal

Ecologically the country is divided into three regions from east to west; the mountain region constitutes 35%, the hill region 42% and the terai (lower plains) 23%. An estimated 90% of the population lives in rural areas.

The National Health Policy of 1991 has brought structural changes to the community level to increase the access to basic health services by ensuring at least one health unit in each VDC covering 4 000-5 000 population, and within one hour walking distance. The health worker ratio per population is minimum 1/1000-2000 and one primary health care centre (PHCC) should be opened in each of the 205 constituencies of the country.

Nepal has adopted an integrated health service delivery system at the district level down to the sub-health posts and identified the main components of this health service delivery package. The country had no tradition for home visits and home-based care prior to the CCHBHC model field-testing.

The main objective of the CCHBHC programme in Nepal was to increase the accessibility to health services, and to quality community health care.

The implementation strategy for field-testing the CCHBHC model was in accordance with the guidelines. The field-testing took place in 2002 during a four-month period.

Process

The implementation was carried out as under:

(A) Identification

The main components of the CCHBHC programme were identified during four CCHBHC orientation workshops conducted for all stakeholders of the CCHBHC programme at different levels. These orientation workshops also clarified the goal and objectives and principles and strategies of the CCHBHC Programme. (Refer to 7.3.2. Preparations). The core elements of the CCHBHC programme correspond with Nepal's main components of the integrated health services delivery package:

- treatment of common diseases and injuries
- reproductive health
- expanded programme on immunization

- leprosy control and TB
- integrated management of childhood illnesses
- nutrition and health education and control of diarrhoeal diseases and ARI
- STD/HIV/AIDS
- Vector-borne diseases

The model appears to be appropriate in the specific country context of Nepal, because it is integrated into the existing PHC structure and has helped strengthen the utilization of PHCC and the demand for home-based care services.

(B) Preparations

The Bishnu Devi Primary Health Care Centre (PHCC) at Kirtipur, Kathmandu District, was selected according to the criteria for the model field-testing. The urban PHCC has 19 wards and a catchment area with a population of 47 515. Four wards with 240 households were selected within the catchment area of the PHCC.

The Director-General, Health Services, conducted a meeting for participants who attended the initial CCHBHC training workshop in Ayutthaya, Thailand, August 2001, and for health personnel at the selected PHCC, local community leaders, the school principal and NGOs, in order to gain consensus for launching the CCHBHC field-testing.

Two medical doctors, who were familiar with supervision, were selected as supervisors. They participated in the CCHBHC training workshop.

Four CCHBHC orientation workshops were conducted by the Investigation Team during January and February 2002, respectively for health personnel of the PHCC, community members, ward members and the health committee (total participation:19); the second workshop was conducted for health personnel at the Central and District Region Health Office in Kathmandu district (total participation: 34); the third workshop was conducted for health personnel at sub-health posts, MCH workers and village health workers (VHWs) (total participation: 13); the fourth workshop was

conducted for ward chairperson, PHCC development committee members, projects staff, volunteers and health workers (total participation: 19).

A number of plans and forms were developed during the orientation workshops, e.g. plan for home visit service, plan for school health programme, working schedule for home visits, family folder and other forms and booklets to be used in the CCHBHC programme.

An evaluation questionnaire distributed to the participants of the above orientation workshops found that participants were satisfied with the content, had received sufficient briefing and gained understanding of the concepts as well as of their tasks and roles.

A specific five-day training workshop on CCHBHC model and related concepts was held for health personnel of the selected PHCC and the two supervisors.

The materials made available by the Regional Office for the field-testing were translated into the Nepalese language.

(C) *Coherence*

The relationship between model objectives and actual model implementation and results appears to be somewhat consistent. However, there seem to have been some capacity constraints, such as availability of equipment and supplies, and reluctance of health personnel to engage in home visits.

(D) *Implementation system*

The implementation of the model builds on the existing structures and available resources and does not seek to establish parallel structures. The OPD at the selected PHCC was the basis for the CCHBHC programme activities. Services were given at the OPD during morning hours and community and home-based health care was provided during the afternoon hours from 13:00 to 17:00 every week day.

Home visit bags, blood pressure measurement and first-aid equipment were purchased for the field workers.

The health personnel working at Bishnu Devi PHCC at Kirtipur were the key players for conducting the field-testing; they comprised seven health personnel; one Health Assistant, one staff nurse, three auxiliary nurse midwives, one village health worker (VHW) and one CMA. A doctor is also available at the PHCC, who is not a regular staff.

Families and clients received training and/or support for self-care at home, e.g. care of bedsores and rehabilitation exercises for paralysed persons.

Supervision was given by health personnel to five non-formal health care providers, who expressed satisfaction with the training.

During the second phase, some changes were introduced in the working procedures at the PHCC; home visits were conducted during afternoon hours, patient records (family folders) were introduced, and nutritional advice and counselling was introduced.

The final assessment of the model was carried out by the investigation team, who spent seven days interacting with the selected health personnel, supervisors and visiting clients and their families. The assessment covered field observation (PHCC and home visits), review of health information and documentation, interviewing the seven participating health personnel, interviewing the two supervisors, and focus group discussions with health personnel, supervisors, community members, groups of clients/families and informal caregivers.

(E) Management structure of the model

A Leading Team was formed consisting of DPHO, RHD, the Ward Chairperson, School Principal, Officer in charge of the PHCC, and the local community leader, in order to coordinate, manage and complete the field-testing.

Results

First-level results: Changes in knowledge and skills of participating health personnel were reported in terms of feeling more motivated and committed to their work. They had developed positive attitudes towards the care, and were much more aware about the clients' needs. A questionnaire was given

after the conduct of the four orientation workshops to assess participants' satisfaction and the views concerning the workshop. The effectiveness of the orientation workshops appears to have been good, because it provided a clear plan and structure for the model's field-testing and also identified the core elements of the CCHBHC.

Second level results: Positive changes were observed and expressed in individual performance of health personnel, e.g. they enjoyed the variation of the work programme; morning hours at the PHCC/afternoon hours in the community doing home visits. They worked with higher motivation and dedication, and their time was spent more efficiently and effectively. This was clearly a better organization of their work.

Third level results: A change occurred in organizational performance primarily related to achieving an increase in the utilization of the PHCC, which also caused an increase in the expenditure on medicines. More referrals from home/community settings to hospital were done compared to the months before the model field-testing. The follow-up of patients discharged from hospital was improved.

Relevance of the Model as a capacity-building strategy for strengthening community-and home-based care and support

The CCHBHC model seems to have been relevant in improving both the health workers and community members' understanding of primary health care in general and of home-based care in particular. The performance of health personnel improved and they were exposed to new working routines. More focus on health promotion and disease prevention was brought into the usual health service delivery, and some initiatives were taken to change and improve the daily working routines and practices.

Main Findings

(A) Achievements

- Communities and families were very satisfied with the home-based care and demanded a continuation of the service.
- Families were taught how to take care of their ill family members, including basic nursing care, such as cleaning of ulcers/wounds, etc.

- The household survey gave more knowledge about the community. People were interested to learn about their health.
- The seven health personnel at the PHCC were trained and their quality of work enhanced.
- Model documentation was found easy to follow and useful when the necessary training and supervision was given.
- Improved referral system and referral slips were taken into use.
- Nutritional counselling was introduced.

(B) Challenges:

- There was no system of numbering households in the wards or recording of number of families per ward. This was systematically established in the four selected wards.
- Health personnel were hesitant to leave PHCC and go on home visits because they were unfamiliar with this type of health care service.
- The PHCC lacked equipment and supplies; these had to be purchased.
- Introducing and maintaining health records at the PHCC was seen as additional work and personnel were reluctant to fill out records and forms on a continuous basis.
- Health workers demanded remuneration for home visits, although it was within their regular working hours. This payment was not made, with the agreement that home visits were only performed during the field-testing period. However, incentives were provided to the staff in terms of umbrellas, shoes, tea money and kit box.
- Some of the trained PHCC health personnel were to be transferred during the field-testing period. However, these transfers were delayed.
- The community was reluctant to participate in activities, and the assumption that community can organize health-related activities apparently has its limitations: e.g. serious efforts and time were dedicated to initiate community activities like exercises, games and

formation of youth groups. However, the community never accepted them.

- Additional training of health personnel was needed during the implementation phase on issues like holistic, integrated and comprehensive care, in addition to the reinforcement of home-based care.

Lessons learned

The knowledge of health personnel and supervisor regarding community and home-based care is limited and it takes a substantial training effort to build the required skills and knowledge in order to start performing home visits and initiate community activities. The preparation phase of model implementation is a crucial part of the process.

The concept and practice of community and home-based care did not exist prior to the field-testing of the CCHBHC model. However, now appears to be a fast growing demand for home-based services.

The model contributes to increased accessibility to care, due to the improved outreach, follow-up and referral. However, it was reported that it is difficult to judge the applicability and usability of the model in other parts of the country, because the field-testing period was too short and only one district was selected.

Initial training on CCHBHC and continuous supervision were very much needed during the field-testing process, and were seen as a precondition for being able to implement the model as well as for its success.

Recommendations for further improvement of the model, and for its expansion in the country

- (1) Country adaptation of the model is needed before its further implementation.
- (2) Resources and supplies need to be ensured and planned for prior to model's implementation, in order to meet the increasing demand for medicines and basic supplies.
- (3) There is an imbalance in gender representation and participation in the model's implementation; there needs to be an equal

female/male representation in order to counter statements like: "women are not welcome in meetings, there is higher participation and dominance of males".

- (4) The community should manage the home based care programme.
- (5) The Ministry of Health should support the CCHBHC programme implementation; a comprehensive organizational structure should be established as part of the existing health system.
- (6) All health personnel should be trained in CCHBHC, not only health personnel at selected centres. This will increase the model's general understanding and compliance.
- (7) A short curriculum for non-formal caregivers should be developed in support of CCHBHC service delivery.
- (8) The concepts and principles of CCHBHC model should be incorporated into the basic educational curriculum of health personnel.
- (9) Wide advocacy about CCHBHC programme is required to build awareness in communities and among policy-makers, politicians and donor agencies.

6.4 Thailand

The CCHBHC programme was initiated at Wang Noi Hospital, Ayutthaya Province in November 2001 in a Primary Care Unit (PCU) attached to the hospital and in other two PCUs in Lomsai and Payom sub-districts. The programme has developed further since, and expanded to include some of the surrounding eight Primary Health Units (PHUs) under the hospital.

The CCHBHC programme builds on the national "Health Promoting Hospital" initiative for which Wang Noi Hospital is the national model for and the "30 Bahts Scheme". These initiatives were implemented in Thailand in 2001 and 2002 respectively, as part of the recent national health policy on universal coverage and health promotion. The political support and leadership of the CCHBHC programme at Wang Noi Hospital is therefore strong and the environment very enabling for both PHC and CCHBHC model development (also see Section 8: Reflections on Field Visits). As part of this universal

coverage policy an important incentive was given to the participating health personnel of the CCHBHC programme conducting home visits vis-a-vis a payment of 100 Bahts (US\$ 2.5) per home visit.

The CCHBHC model, located in the PCU attached to the hospital, has established a good referral system within the catchment area involving PCUs, communities and civil society resource persons. Communication and collaboration with the PCUs is a strength of the programme. Follow-up to patients for continuum of care is also functioning well.

The CCHBHC Model Coordinator, supported by the Director of the hospital, has provided strong leadership and inspiration to health personnel, communities, patients and families throughout the development process. Additionally, input and supervision have been provided by the WHO Collaborating Centre for Nursing and Midwifery Development, Mahidol University.

The CCHBHC Model includes community activities for health promotion and environmental improvements in addition to establishing the home visiting programme. It has good support of the civil society and community at large.

Process

The implementation was carried out as under:

(A) Identification

The CCHBHC project team arranged community meetings in three selected villages to provide health examination, curative treatment, and health education, besides and give an opportunity for recreation and interaction.

The CCHBHC team and health personnel from the two selected PCUs then conducted a situation analysis. The situation analysis included home visits to each family residing in two selected villages; one village from each catchment area of the two PCUs, and an analysis of the data gathered. This analysis identified the need to reassess the staffing situation at each PCU and the health personnel's knowledge of the CCHBHC concept. As a result of the analysis an increase in health personnel was arranged for in both PCUs, and a series of workshops followed to upgrade their knowledge and skills.

It was decided that home visits should cover a broad range of patient groups and provide comprehensive and holistic care.

The model appears to be responding to the basic health needs of the population, without setting any specific priorities.

(B) Preparations

A framework for the health services system of the Wangnoi hospital was developed, of which the CCHBHC programme became a part. The framework emphasized four components; (i) health services system; (ii) building good health; (iii) disease prevention, and (iv) quality management. The three main enabling factors in achieving objectives within the four components would be related to performances within (i) information management system; (ii) manpower development, and (iii) financial management system.

A standard guideline for home visits was prepared by the team and introduced to the health personnel. It contained the case criteria, referral and communication procedures and financial management issues.

An assessment of materials and equipment used in the designated settings revealed that it was necessary to develop family folders, prescribing forms, and a range of cards, such as; acute cases cards, ANC cards, well-baby cards, menopausal, chronic-and synthesis cards, as well as daily and monthly boxes for patient registration.

All preparations followed the Regional Office's Model Guidelines document and materials were translated into Thai.

(C) Coherence

The relationship between programme goal/objectives and the actual programme implementation and service delivery was satisfactory. Probably the strongest aspects of the programme so far have been: (i) the range of community activities that have been initiated, e.g. youth clubs, community gatherings and discussions, fund- raising, environmental sanitation, exercise programmes, drug use prevention and reaching out to children, and elderly activities, and (ii) the strengthening of the referral system and improvement of communication and collaboration between different health facilities and the

community. The accessibility to basic health services seems to have increased with more people utilizing the PCUs.

(D) Implementation system

The model was implemented as part of the "Health Promoting Hospital" initiative within the context of the existing district hospital and primary health unit structure.

The Ninety-three participating health personnel, some from Wangnoi Hospital, Wangnoi district and participating PHUs attended a CCHBHC Orientation Workshop in January 2002 to build an initial understanding of the CCHBHC model. Health personnel have been encouraged and empowered to take initiatives and expand their existing job descriptions accordingly.

Each PCU had an estimated 10 000 population catchment area.

Community volunteers were involved in the CCHBHC programme in identifying families in need of care and treatment, notifying health personnel and escorting the ill community members to the PCU, as well as in the actual care and support functions.

Supervision and monitoring visits took place regularly during the two phases of the model implementation; monthly meetings were arranged among health personnel at the PCUs to share their experiences, weekly visits every Friday were conducted by the project team to settings within the PCUs to give supervision in different settings and situations and to solve problems. Additionally, the project team conducted four individual assessments of clients' satisfaction. The results of these assessments were used to further supervise the health personnel and improve the service delivery.

The project team conducted the final assessment of the CCHBHC model and it included qualitative as well as quantitative data. The sources of data included knowledge assessments of participating health personnel as outcome measures of workshops and training programmes; field observation of performance of health personnel, curative care, home visits, record-keeping, outreach activities; review of health information and documentation; interviewing the participating personnel; interviewing the supervisor, and focus group discussions with: health workers, supervisors, clients, their

families, and community members, local authorities and community volunteers.

(E) Management structure of the model

A project team was established, including the Director of Wangnoi Hospital.

Results

First-level results: The participating health personnel expressed that they had learned a lot from the work with the model. They found that the work had made them know and understand the issues in their community better. It had made them change their views on what health services were and should offer to people, e.g. to include comprehensive and holistic aspects in addition to curative services. Their knowledge and experiences concerning community and home-based care had increased.

Second-level results: Changes in individual performance of health personnel were reported in terms of being more confident in initiating community activities and interacting with individuals and their families.

Third-level results: Change in organizational practice was reported both in relation to an improved organization of work, and taking on new roles and responsibilities in relation to comprehensive and holistic care.

New facilities were established both at the district hospital and in one PCU to better accommodate clients for primary medical care, counselling, family planning, and breastfeeding.

The improved registration of patients and detailed family files have led to increased continuum of care, better quality of care and effective follow-up.

Each PCU conducted approximately three-six home visits every weekday during afternoon hours to a broad range of patient categories, including the acutely-ill, recently-discharged-from-hospital, the chronically-ill, the elderly, and pregnant women and children. The PCU would have one-two health personnel available for these visits per day. From January – December 2002, the two participating PCUs recorded home visits, and cases/each visit as: 87 and 164/224, respectively, in addition to a range of other health centre/hospital-based services. The effectiveness of the model in

achieving the objectives related to coverage and improved access to health services could be assessed further.

Relevance of the model as a capacity-building strategy for strengthening community-and home-based care and support

Both health personnel and community members expressed that their general knowledge and awareness of health promotion, health prevention and community home-based care had increased. The model had helped establish a better communication and collaboration between health facilities and the community, and had resulted in a number of community-based initiatives for health promotion and disease prevention.

The model had also facilitated collaboration between the health sector and other sectors: defense, public health, education, and social welfare, in addition to establishing an active community participation.

"Build good health" has been the main focus of the CCHBHC model in Thailand; the model has provided an alternative to the curative-oriented philosophy. However, the provision of actual care and support at home seems to need more time to develop fully.

Main findings

(A) Achievements

- Client satisfaction was high, and the relationship between the community and health personnel had improved.
- Practice of new patient documentation had been put into use.
- The environment around and inside the selected health facilities had improved in terms of cleanliness and beauty; the atmosphere had become patient- friendly.
- Participating health personnel expressed that they had learned a lot from the model field-testing.
- A range of community activities had been initiated for health promotion and disease prevention focusing at different age groups.

- Supplementary funding to CCHBHC had been generated from the community.
- A paradigm shift had taken place towards including health promotion and disease prevention as part of health services.

(B) Challenges

- The initial training of health personnel was not found to be sufficient. Therefore, additional training throughout the implementation phase was provided by the project team. (A detailed training programme syllabus was developed).
- Forms used during the initial household survey were found to be difficult and time-consuming to use.
- The conceptual framework as presented in the WHO CCHBHC guidelines is too broad and needs clarification, especially regarding the health-oriented concept as opposed to the disease-oriented.
- The project team members giving supervision and conducting monitoring meetings with health personnel were short of time due to other duties and obligations besides the CCHBHC project, which resulted in some inconsistency.
- Expenditures on health centre visits can be difficult to meet for underprivileged population groups.

Lessons learned

The strength of the CCHBHC model is its comprehensiveness and its holistic principles of care. However, this could become a weakness in other settings where the understanding and familiarity with concepts of community and home-based care and related issues are not really present among health personnel. Due to the complexity of the CCHBHC model concept, those with less experience and guidance might find the model too broad and difficult to implement. The interpretation of the concepts might also differ from setting to setting.

Community volunteers could be involved fully in caregiving.

Recommendations for country adaptation of the model and for its further implementation

The Project Team suggested the following changes to the CCHBHC model before its broader implementation in Thailand:

- A comprehensive organization and management structure of CCHBHC programme should be established at different levels of the health system; including the central (level) government, ministries, provincial officers, health care administrators, representatives of health personnel and communities.
- Rethink: Everyone involved in the CCHBHC programme would need to reach at a common understanding of the concepts, principles, goals and objectives of the CCHBHC model.
- Restructure: A system reform especially related to the way work is structured should take place in order to make the CCHBHC programme more effective through proper financial support and improved information management systems and communication procedures.
- Reorganize: In some cases there might be a need to change, restructure, or even establish work sectors to expand and enhance appropriate health services in support of CCHBHC.
- Rebuild tools: Appropriate tools for use in PCUs should be developed to facilitate the organization and management of CCHBHC service delivery
- Retrain: Ongoing and continuing training should be provided to health personnel to build understanding and skills related to CCHBHC.
- Curricula for basic educational programmes of different categories of health personnel should be revised and modified to include: (i) Principles of Holistic and Comprehensive Care; Integration of Health Services, and the CCHBHC Concept.
- The CCHBHC Guideline documents should be revised to include clear definitions of all concepts and terminologies used to modify the conceptual framework as per suggestions made in the summary report of experiences on field-testing the model, prepared in November 2003.

6.5 Indonesia

Though Indonesia was not one of the four countries of the Region selected for the CCHBHC model field-testing, it used the CCHBHC guidelines as a method of improving its community health nursing and home-based care provision. Indonesia has a district-based health service. Each district has a number of health centres, which oversee all community health activities. There is a well-established system of working with the local community and most health centres organize regular meetings with local community leaders to identify needs and establish good relationships. The local community leaders help organize much of the outreach work. Indonesia also has a model of Community Health Nursing (CHN), which has been integrated into the Health Centre Service for two decades. It was further emphasized and included in the 1992 Health Centre Act.

At a national workshop, in 2002, the CHN model and its development was reviewed and compared with the model of CCHBHC. The national meeting concluded that the CHN model was identical to the CCHBHC model and that the CHN role in Indonesia had been further facilitated, since 2001, in those districts that had introduced the Clinical Performance Development and Management System (CPDMS). This system ensures that the community health nurses know and understand the National CHN model and the care standards that are applicable to community health nursing. Each CHN also has a clear job description, which outlines its role and function in relation to local health needs and priorities for care. There are specific clinical performance indicators with regular monitoring schemes and managerial skills training, so that the most senior nurse and midwife in the community can monitor other nurses and midwives constructively. In addition, regular reflective case discussions have been introduced (similar to the clinical supervision group discussions described in the CCHBHC guidelines). The national workshop agreed to use the CCHBHC guidelines to: monitor the evolving CHN role in regard to passive care (where the patient initiates contact with the health professional and nurses) and active care (where the CHN seeks out the patient(s) through health education and by screening the work in different settings as well as during home visits).

The CCHBHC investigation took place in two community health centres in one CPDMS district. The findings following the investigation led to important developments in the District Health Office and their responsibility for developing the role of the community health nurse.

Preparation

A team of principal investigators was selected from both the Central Department of Health level and also the District Health level. The Central-level investigators had seven full workshop days to study the CCHBHC guidelines and to plan each step of their investigation process. The investigators did not provide any additional training for the CHNs, as they had already received training in CPDMS. Day workshops were organized with the District Health Office to advocate the CHN model, and to encourage the District Health Office to take on the responsibility for developing the role, and monitoring the quality of performance. However, families were not trained in self-care in this project.

Results

First level results: During the investigation, an increase in the knowledge and skills was observed among the participating health personnel. The clients claimed to have improved their health education.

Second level results: The personnel were observed to be more confident and to being more proactive in initiating patient contacts and home visits. Hard data about increasing referrals was not monitored but was inferred from interviews and focus group discussions. There is no doubt that the introduction of CCHBHC is enhancing the role of the CHN, but more development is needed still. The development will be long term and will require regular monitoring and clinical supervision.

Third level results: Changes in organizational performance have been highlighted in the two health centres covered by the investigation. The nurses are now using standard procedures and guidelines. They are beginning to provide an integrated, holistic community health nursing service across the six main programmes of community health care provision. The CHNs are making more follow-up home visits, but they can do much more in the future with improved direction from the management.

More patients are seeking health care at health centres. Evidence shows that some hierarchical programmes such as the TB/DOTS programmes, are better implemented.

Relevance of the model as a capacity-building strategy for strengthening community-and home-based health care

The model has been very useful in monitoring the already developing role of CHN in CPDMS districts. It has also been extremely useful in raising the awareness of the District Health Office to the need to create supportive strategies to develop the role of the CHN, so as to achieve the objectives of the decentralized district health service.

The capacity constraints to model's implementation were: limited knowledge and skill preparation for most of the community health nurses, inadequate finances especially to cover travel costs for home visits, and large case-loads. More support was needed from the District Health Office to work holistically and across programmes. (These requirements have all been addressed under 6.5.6 "Lessons Learnt").

The CCHBHC is the same model as the CHN model in Indonesia. The CCHBHC guidelines assist the facilitation and development of CHN's role.

All aspects of capacity-building were addressed at the District Health Office. It was here that the CHN concept emerged through discussions, the agreement on the objectives and holistic role of CHN was outlined, and agreement on performance indicators and on the focus of CHN was reached, in order to give a holistic and active role to health personnel in reaching the poor. Furthermore, it was decided that there would be a budget to cover CHN travel costs, as well as the costs of regular supervision and monitoring activities.

The CHN/CCHBHC model can be used to achieve the objectives of decentralizing health services. It is likely that other district health offices in the country may also identify the importance of CHN/CCHBHC in achieving the objectives.

Main findings

The Indonesian CHN/CCHBHC model develops automatically in districts, which have introduced CPDMS. However, the role of model needs assistance from the District Health Office to be developed further. This can be enhanced by specific changes in the District Health Office, which help focus the role,

develop appropriate strategies including access to regular funding, and ensure quality control. These changes are also essential to ensure the sustainability of the model.

Lessons learnt

The CCHBHC implementation model was very useful to identify further CHN service development needs. The findings of the investigation were the basis for advocating appropriate policies and strategies at the district level towards strengthening the CHN role.

Recommendations for country adaptation of the model, and for its further implementation.

- (1) This model should be expanded to other districts within the country. However, in order to facilitate successful expansion, the changes made during the CHN/CPDMS/CCHHC investigation should be incorporated fully and additional technical tools should be developed in support of the process. The tools should focus on further strengthening the strategy development of district health offices for a comprehensive CHN role. The experiences from the key CHN model district should be shared and replicated by other districts.
- (2) The community health competencies as per the pre-registration curriculum, should be improved.
- (3) Specific and targeted in-service training should be planned to improve the knowledge and skills of CHNs, particularly with regard to community health promotion and home care activities, including teaching of caring skills to family careproviders.

7. FIELD VISITS

Field visits were arranged to study the implementation of the CCHBHC model at Wang Noi Hospital, Ayutthaya. The programme for field visits included visits to:

- **Wang Noi Hospital and PCU attached to the Hospital, Ayutthaya Province**, where the CCHBHC model is presently being practised after being implemented in November 2001. The Hospital Director and the CCHBHC Coordinator started with an introduction and welcome session, which was followed by a guided tour of the hospital. Opportunities for questions and answers were given at all stages of the tour.
- **A Primary Care Unit at Lomsai sub-district**, to learn about the home-based care management and services delivery, including home visits to patients registered with the CCHBHC programme.
- **A community setting** within the catchment area of Wang Noi Hospital, to look at initiatives for community health promotion and healthy lifestyles promotion. The participants were shown an exercise programme for the elderly, and for women and children. They also met with community leaders and representatives of civil society involved in health promotion activities. The recreational area used for the exercise programme had been renovated and had undergone environmental improvement as part of the health promotion initiative.

Reflections on Lessons Learned from Field Visit

Active discussions took place during the field visit as well as at the workshop session dedicated for reflections and lessons learned from the field visit. The following are the main views expressed by the participants:

The CCHBHC programme implemented at the Wang Noi Hospital and in surrounding Primary Health Units (PHUs) under the hospital, builds on the national "Health Promoting Hospital" initiative and the "30 Baht Scheme", implemented in Thailand in 2001 and 2002 respectively, as part of the new national health policy on health promotion and health sector reform. As such, the political support and leadership of the CCHBHC programme is strong and the environment very enabling for PHC development. The participating health personnel have been encouraged and empowered to take initiatives and expand their existing job descriptions accordingly.

The concept of Health Promoting Hospital contains elements of healthy lifestyles promotion, nutritional and behavior counselling, healthy

environment, planned discharge and home-based care, in addition to a broad range of hospital and OPD services. The Health Promoting Hospital is based on the "hospital without walls" concept, where services are provided beyond the hospital and cover all aspects of care.

All participants agreed that the field visit had been an interesting and unique experience to learn how the CCHBHC programme in Thailand as a strategy can be used for:

- Contributing to achieving the new health paradigm for health prevention and promotion;
- Strengthening the existing PHC and outreach functions of a hospital, and
- Encouraging participation of various age groups, e.g. children, adults and the elderly, and the community at large.

However, in spite of Thailand having considerably better staffing, more resources and better infrastructure at the peripheral level of the health system, compared to most other countries in the Region, it appears to have a shortage of health personnel to conduct home visits. It was felt that trained community volunteers could be used to much better effect. This would improve the shortage of caregivers and increase the coverage and quality of services delivery at homes. A further elaboration was done on how the field visit had shown an almost perfect health system and the success of implementing the model in Thailand. These favourable conditions, however, might not exist in other countries of the Region with more limited resources and weaker health systems. Moreover, the model did not need to be health facility-based; it could use settings in the communities such as schools, local administration offices and other public buildings, for registration of patients and for other programme management and administrative functions.

The CCHBHC programme had resulted in the establishment of a good collaboration between primary health units, the district hospital and the academic entity at the Mahidol University, which meant a clear understanding of the health promotion/disease prevention concepts by the staff, hospital managers and community leaders. The programme had also contributed to the further strengthening of PHC care in the province.

Active participation of the community was demonstrated during the field visit in relation to environmental clean-up, fund-raising activities, and healthy lifestyles promotion among the elderly, women and children, through physical exercises and health talks. Community leaders and civil society representatives who were part of these initiatives, referred to them as a process of empowering the community to create a sense of ownership of the health promotion initiatives, and of building a closer relationship with neighbours and the community at large.

Some of the challenges for health personnel were to better use their human knowledge and skills to communicate with, motivate ill individuals and their families regarding problem-solving in relation to daily living activities, increasing their self care skills and providing them psychosocial support. The other challenges for health personnel were to better understand their exact roles and responsibilities during home visits and the scope of their work in home and community settings. This would include working according to the nursing process with defined objectives for care and support and being able to provide more actual treatment care and support at homes rather than bringing the patients to the health centre/hospital. It would also include providing support to the community to establish self-help groups and community cost-sharing mechanisms.

The issue of how to access people who need help the most would have to be prioritized and addressed further. The assumption that poor and marginalized groups can be referred to a health centre for treatment and care might need reconsideration, because these groups have difficulties in meeting the costs related to such a visit, e.g. transportation, medicines and other health expenditures. The issue would be to optimize the contact between the ill individual and the home-based care team, and to provide care and support at home, of the highest potential. In order to do this, the care-givers, either formal or non-formal, should be equipped with remedies, essential medicines and basic care equipment to be prepared to address priority diseases and conditions according to a defined essential care package. The care-givers need to be clear on what health-related problems they are addressing and what objectives they wish to achieve and how. To this end, standards of home-based care should be established and followed.

The importance of setting priorities for CCHBHC services was further stressed. An elaboration was provided on how these selected care and support services should respond to the top public health priorities of the community, in order to utilize the limited resources optimally.

A monitoring and evaluation mechanism should be developed, including indicators to clearly distinguish the activities of the CCHBHC programme, as an integral part of the services of the health centre/hospital, and to assess the impact of the CCHBHC programme.

8. SUGGESTIONS FOR FURTHER REFINING AND FINALIZING THE MODEL, TAKING INTO ACCOUNT THE OUTCOMES OF THE FIELD TEST AND OTHER EXPERIENCES AT THE COUNTRY LEVEL

Participants were divided into three groups, and asked to comment and make suggested changes to each section of the CCHBHC model document. They made extensive suggestions for further improving the model to make it easy to follow at the country level.

9. WAYS FORWARD TOWARDS PROMOTING THE ADAPTATION AND APPLICATION OF THE MODEL IN ORDER TO STRENGTHEN COMMUNITY HEALTH SERVICES IN COUNTRIES OF THE REGION

The best way to promote the adaptation and application of the model at the country level, would be to highlight the gains and benefits of implementing the CCHBHC programme. The next step would be to link up and collaborate with related initiatives, that need functioning PHC structures, including community and home-based care as a platform for outreach and service delivery.

As a way to build support and ownership of CCHBHC at country level it would be important as a starting point to demonstrate and show evidence of why the country needs community and home-based health care. As part of this advocacy, it would be useful to point out the impact of not implementing the CCHBHC programme. It was suggested to identify the gaps between the

existing situation in a given country and what the country would achieve by implementing the CCHBHC programme.

Basically, the CCHBHC programme functions as an enabling factor for the delivery of a wide range of WHO's own strategies, because these strategies cannot be delivered without appropriate PHC capacity at the local level, e.g. in order to increase access to TB/DOTS there is a need for outreach and collaboration with communities, families and patients. Home-based care programmes are very often seen as the way to ensure this collaboration and continuum of care between home and health facility and vice versa, and to increase compliance and ensure early detection of new TB cases.

Likewise, the newly-launched WHO "3 by 5" strategy related to having three million People Living with AIDS on ART by the year 2005, would need a dramatically increased response in countries towards monitoring and providing care and support to PLHA in their homes or as close to their home environment as possible. Community and home-based care is also, in this respect, a prerequisite for the delivery of services and achievement of the goal.

In relation to CCHBHC programme's linking up and collaboration with related initiatives at the country level, the recommendations of both the Commission on Macroeconomics and Health and the Millennium Development Goals, set out a future agenda, which would see major new investments in health systems. It will be vitally important for countries to identify effective health solutions, including strengthening of PHC and "close-to-the-client" services like the CCHBHC. In the absence of organized community and home-based health services as part of PHC, it will be unrealistic to expect to achieve health and the Millennium Development Goals. A Commission on Macroeconomics and Health will be established in each country to address the needs of the poorest, and this would be an opportunity for the CCHBHC programme to find partners and political support.

The CCHBHC implementation at the country level should seek to link with broader training initiatives, such as the basic educational programmes, as well as in-service training programmes. It should seek to engage and collaborate with other community and home-based care initiatives to pool the lessons learned and provide input to the development of a national approach

and policy on community and home-based care. The programme should try to establish collaboration with other ministries and departments such as education and social welfare, so as to ensure a multidisciplinary approach and broad participation at the local level.

Appropriate tools and guidelines should be provided for use at the country level in support of the CCHBHC programme implementation

10. RECOMMENDATIONS

The meeting made the following recommendations for strengthening community health services in countries of the Region:

For Member countries

- (1) It should be ensured that health promotion and community and home-based health care and support are integral parts of the national health policy of the country, and are reflected in the organizational structure of health ministries;
- (2) It should be ensured that appropriate human resources are made available for health planning and management in support of the provision of community and home-based health care services, including collaboration and coordination with private health care providers;
- (3) Resources should be mobilized to strengthen community and home-based health care and support services in the country;
- (4) The existing health system should be strengthened by focusing on district-level leadership and management, in order to ensure the provision of essential public health services to the population, particularly to the poor, vulnerable and disadvantaged groups;
- (5) Capacity of health workers should be developed for provision of comprehensive community and home-based care;
- (6) Special attention should be given to enhance community participation and actions for health, and to strengthen the role of community health volunteers in community and home-based care and support activities, and

- (7) Countries should consider adapting and applying the Model for Comprehensive Community and Home-based Health Care within the existing Primary Health Care structure, in order to improve the accessibility, equity and quality of community and home-based care..

For WHO

- (1) WHO should advocate for the strengthening of community and home-based care in all programmes based on primary health care principles;
- (2) Support should be provided to Member Countries for adaptation and application of the Model for Comprehensive Community-and Home-based Health Care towards facilitating the improvement of community home-based care in countries;
- (3) WHO should facilitate the networking and sharing of expertise, resources and experiences among countries of the Region for strengthening of community and home-based care in the Region, and
- (4) WHO should develop additional technical tools required for improving the quality of community health care, such as standards of home visit, and ways to facilitate community actions for health

Annex 1

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Annex 2

PROGRAMME

Tuesday, 02 December 2003

0830-0900 hrs	Registration
0900-0930 hrs	Inaugural session
0930-1000 hrs	Introduction to the Consultation
1000-1100 hrs	Plenary Discussion: Need for community- and home-based health services in countries of the Region
1100-1200 hrs	Overview of SEARO Model for Comprehensive Community- and Home-based Health Care and Field Testing Process
1300-1650 hrs	Experiences in field-testing of SEARO Model for Comprehensive Community- and Home-based Health Care: <ul style="list-style-type: none">• Bhutan• Myanmar• Nepal• Thailand
1650-1700 hrs	Briefing on field visits

Wednesday, 3 December 2003

0700-1800 hrs	Field visits at Ayutthaya Province to study the implementation of the Model at Wang Noi Hospital and its field test sites
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Thursday, 4 December 2003

0830-0930 hrs	Reflection on field visits and other successful experiences in improving accessibility and quality of community health services in SEAR countries
0930-1200 hrs	Group work: Suggestions for further refining and finalizing the Model taking into account the outcomes of the field test and other experiences at country level
1300-1400 hrs	Presentation of group work outcomes: Suggestions for further refining and finalizing the Model taking into account the outcomes of the field test and other experiences at country level
1300-1400 hrs	Plenary discussion: Ways forward to promote the adaptation and application of the Model to strengthen community health services in the countries of the Region
1400-1500 hrs	Recommendations for further strengthening community health services in countries of the Region