

**KINGDOM OF CAMBODIA**  
**Nation-Religion-King**



**Ministry of Health**

# **STANDARD OPERATING PROCEDURE**

**For the**

## **CONTINUUM OF CARE**

### **For PEOPLE LIVING WITH HIV/AIDS**

#### **In CAMBODIA**

**Revised and up-dated 2008**



**National Centre for HIV/AIDS, Dermatology and STD**

**November 2008**

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## ABBREVIATIONS

AIDS:	Acquired Immunodeficiency Syndrome
AHF:	AIDS Healthcare Foundation
ARV:	Anti-Retroviral
CAA:	Children Affected by HIV/AIDS
CBO:	Community Based Organization
CBC:	Community Based Care
CDC-GAP:	Center for Disease Control-Global AIDS Program
CHAI:	Clinton Foundation HIV/AIDS Initiative
CHBC:	Community and Home Based Care
CMS:	Central Medical Store
CNAT:	National Center for Tuberculosis and Leprosy
CoC:	Continuum of Care
CPN+:	Cambodian Network of PLHA
DU:	Drug Users
GFATM:	The Global Fund to fight AIDS, TB and Malaria
IC:	Institutional Care
IEC:	Information, Education and Communication
IDU:	Injection Drug Users
HBC:	Home Based Care
HCBC:	Home and Community Based Care
HC:	Health Centre
HCW:	Health Care Workers
HFBC:	Health Facility Based Care
HIV:	Human Immunodeficiency Virus
MARPs:	Most At Risk Population
MCH:	Mother and Child Health
MoH:	Ministry of Health
MMM:	Mondul Mith Chouy Mith (Friend help friend centre)
MSM:	Men have Sex with Men
NAA:	National AIDS Authority
NCHADS:	National Centre for HIV/AIDS, Dermatology and STD
NGO:	Non Governmental Organization
NMCHC:	National Mother and Child Health Center
OD:	Operational District
OI:	Opportunistic Infection
PAO:	Provincial AIDS Office
PEP:	Post Exposure Prophylaxis
PHD:	Provincial Health Department
PLHA:	People Living with HIV/AIDS
PLHASG:	People Living with HIV/AIDS Support Group
PMTCT:	Prevention of HIV/AIDS from Mother to Child Transmission
PSF:	Pharmacist Sans Frontier
RH:	Referral Hospital
RHAC:	Reproductive Health Association of Cambodia
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
TOR:	Terms of References
UP:	Universal Precaution
VCCT:	Voluntary Confidential Counseling and Testing
WVC:	World Vision Cambodia

# 1 Background

For a decade Cambodia faced the highest burden of HIV infection in the Asia-Pacific region. The latest data from the Cambodia DHS 2005 and the HIV Sentinel Surveillance 2006 estimate the number of adults aged 15-49 years living with HIV in Cambodia to be 67,500 – 0.9% of that population. Although this represents a significant reduction in prevalence from earlier estimates, the HIV epidemic in Cambodia has now evolved into the phase in which increasing numbers of people infected with HIV could become sick and seek care. Numbers of PLHA in need of ART are projected to grow from some 30,100 in 2006 to over 35,000 in 2010.

For the past few years there has been a rapid increase in providing comprehensive continuum of care and treatment to people living with HIV/AIDS (PLHA) in the country. The Ministry of Health (MoH) Strategic Plan for HIV/AIDS and STI Prevention and Care in Cambodia 2008-2010 has the improvement of quality and accessibility of care and treatment of PLHA through the extension of HIV/AIDS care services nationwide. Moreover, substantial additional funds for HIV/AIDS care and treatment, including antiretroviral treatment have become available, particularly through the Global Fund to fight AIDS, TB and Malaria (GFATM).

Since the implementation of the original continuum of care and treatment Framework in prioritized areas with high HIV burden and was guided by a comprehensive, evidence based operational framework, has resulted in CoC services being available in over 50% of ODs. NCHADS plans to scale up coverage to 43 of 77 ODs, reaching 35,000 adults and children with ART by 2010. The plans emphasizes expanding coverage in underserved areas and for most at risk populations (MARPs); in the Cambodian context MARPs include men who have sex with men (MSM), injecting drug users (IDU)/drug users (DU), and workers in the entertainment services.

As the Continuum of Care has been expanded throughout the country over the last four years, a number of lessons have been learned, and a number of new elements have been added, based upon the real, practical experience of introducing and implementing the Continuum of Care, and upon new techniques, drugs, procedures and knowledge becoming available. In addition, a number of reports, reviews and assessments have been published (see Annex 1); perhaps the most thorough being the *“Cambodia’s Continuum of Care for People Living with HIV Programme: Assessment of quality and cost effectiveness”* conducted in October 2007 by DFID for NCHADS.

The most important lesson that has been learned from the pilot projects, start-ups, early introductions of CoC, assessments, and various partners’ efforts over the last five years, however, has been the critical importance of ensuring that the Continuum of Care is fully integrated into the public health services being provided in referral and provincial hospitals around the country. This principle also guides the introduction of further, new elements into the original CoC: pediatric care, nutrition, care in ‘closed settings’, care for MARPs, and the linked response.

The purpose of this revision and up-dating of the framework is to bring together these lessons and new elements, in an up-dated Continuum of care and treatment Framework and to assist HIV/AIDS care managers and other key players to continue to develop and implement the continuum of care for PLHA at local level to provide high quality, comprehensive care, within the existing health system.

## 2. Comprehensive Continuum of HIV/AIDS Prevention and Care

### 2.1 What is Comprehensive Prevention and Care?

Throughout the course of HIV infection, people living with HIV/AIDS (PLHA) face a number of consequences of HIV infection including physical health (opportunistic infections, possible side-effects from antiretroviral drugs, premature death) and mental health (psychological distress, adjustment to life-time drug taking, adherence to complex regimes, etc); but also economic consequences (inability to work and cost of health care leading to poverty), and often social and legal consequences (stigma, discrimination, human rights violations).

HIV/AIDS care should not only focus on medical care but also include a wide range of services, such as psychological, social, and legal support; hence the need for comprehensive care.

Developing comprehensive care is complex and requires careful planning, coordination, referral and monitoring. Broad based mobilization of the community and organizations working inside and outside the health sector are needed for comprehensive care to develop and be sustained.

In addition, people at risk need prevention support and services aimed at helping them ensure they do not get infected. Prevention efforts need to be closely linked to care and treatment; and range from helping PLHA learn how not to infect their loved ones, to helping people identify their status and avoid infection, to helping people in high risk situations learn how to protect themselves.

The key activities needed to develop comprehensive HIV/AIDS care are:

#### ➤ **Clinical care**

- Diagnosis of HIV infection
- Management of opportunistic infections (OI) including TB
- Prophylaxis of opportunistic infections
- Symptomatic and palliative care
- Antiretroviral (ARV) therapy
- Universal precautions (UP) and post-exposure prophylaxis (PEP)
- Prevention of mother to child transmission (PMTCT)

#### ➤ **Support**

- Counseling
- Psychosocial support
- Support for caregivers and children affected by HIV/AIDS (CAA)
- Reduction of stigma and discrimination

#### ➤ **Health promotion and education**

- Information and education on HIV/AIDS issues for PLHA and their families about HIV and HIV care
- Nutrition
- Prevention of further HIV transmission and family planning

## ➤ Prevention

- Quality counseling for primary prevention at VCCT services
- PMTCT
- Targeted prevention services for MARPs

## 2.2 Where is Comprehensive HIV/AIDS Prevention and Care conducted?

The provision of HIV/AIDS care extends from home to hospital through various levels of care delivery:

- Health Facility Based Care (HFBC) including the private sector.
- Mondul Mith Chouy Mith (MMM)
- Community Home-based care (CHBC) including:
  - Home-based care teams PLHA peer support groups (PLHASG)
  - Other community support organizations
  - By community members themselves
- VCCT at registered public and private sites
- PMTCT at ANC services
- Prevention for MARPs in specific settings where MARPs can be reached.

A continuum of care between home, community, and health facilities is a key element for the provision of comprehensive care to PLHA at local level.

At the same time the 'linked response' approach embeds the continuum of care within the wider primary health care at OD level, bringing together all elements of community mobilization, outreach and referral networks, and health facility care in a well-coordinated, synergistic network of public health services responding to women, children, the poor and those most in need.

## 2.3 Guiding Principles of the Continuum of Care

- Human rights shall be respected in any circumstances and discrimination in any form be prohibited. The design of continuum of care should be in line with the **National Law on the prevention and control of HIV/AIDS**.
- **Focus on the needs of PLHA and their families.** Policy development should begin with the needs expressed by PLHA. This should sit within a larger dialogue that builds collaborations between PLHA and service providers. As programs developed should remain flexible to local needs and capacity.
- **Early diagnosis.** The timing of diagnosis is a key determinant of how the rest of the continuum functions. Early diagnosis is dependent on availability of quality treatment, perceived levels of stigma and discrimination and accessible VCCT services.
- **Appropriate referral after diagnosis.** Linkage of people recently diagnosed with HIV into appropriate services is a key determinant of the quality of life for that person.
- **Reducing barriers to uptake of services**

- Reducing financial barriers
  - Minimizing stigma and discrimination in health care environments
  - Improving access to essential equipment and supplies
  - Improving quality of the care through adequate financial reimbursement to staff, training and support and quality improvement systems
- Developing ways to **support treatment adherence** for PLHA. Effective treatment for HIV and prevention and treatment of its complications is dependent on continuity of complex and prolonged drug regimens. For treatment programs to be successful they must address these issues with carefully designed interventions to optimize adherence.
  - **Real involvement of PLHA** respects the right of PLHA to play an active role in the development of programs that concern them. Building collaborations with PLHA is dependent on non-discriminating attitudes and the development of trust. The role of PLHA should be encouraged at all stages of the development and implementation of the continuum of care. Appropriate support should be given to capacity development of PLHA.
  - **Community mobilization.** Sustainability of HIV care programs is dependent on broad community involvement. Activities that seek to encourage the involvement of communities should build on the specific existing strengths and resources of each community. Direct contact with PLHA can be a critical factor in initiating a community response, which in turn can be used to reduce stigma and discrimination enabling greater involvement of PLHA in the community.
  - **Client-friendly approach.** Especially when working with MARPs must recognize that MARPs are often marginalized, sensitive and may be under threat of harassment, stigma and discrimination. Approaches that recognize their rights protect them from harassment, stigma and discrimination, and which adjust to their needs and ways of accessing services are very important.
  - **Coordination.** The continuum of care and treatment is complex and should be effective communication and coordination between different organizations, which necessitate the development of specific coordination mechanisms and changes to current work practices.
  - Finding the **balance between HIV specific services and integrated services.** The development of the continuum of care should be carefully designed to maximize effectiveness whilst strengthening health services generally and promoting sustainability.
  - Working with the **private sector.** As for some countries, many HIV care activities occur in the private sector. Design of the continuum of care should address issues of access to care and quality of care in the private sector. Private public partnership initiatives should be also considered as a way to increase access to ARV.

### 3 The Components of the Continuum of Care in Cambodia

The Continuum of Care in Cambodia currently comprises a number of components:

- Voluntary confidential counseling and testing services (VCCT)
- Health Facility Based Care (HFBC) – including TB/HIV and Pediatric Care
- Nutrition
- Community and Home Based Care (CHBC)
- Mondul Mith Chouy Mith (MMM)
- PLHA Support Groups
- Most at Risk Populations (MARPs)
- Care and Treatment in Closed Settings
- Linked Response.

#### 3.1 Voluntary Confidential Counseling and Testing services (VCCT)

##### *Importance of VCCT*

Counseling and Testing are important parts of the overall HIV/AIDS continuum of prevention and care for several reasons, and in several forms:

- Voluntary counseling and testing services can significantly reduce HIV transmission by reducing sexual risk behavior. People who know their HIV status after good counseling are less likely to indulge in unprotected sex with multiple partners.
- Counseling and testing can help people access appropriate medical and social services. People who understand the nature of HIV infection and its effects on their health and life can make better choices about the services of medical care they choose.
- Counseling is an important part of the psychosocial services offered as part of home and community care programmes, as well as institutional and hospice care.
- Testing and counseling are particularly important in PMTCT programmes. Pregnant women need to know and understand their HIV infected status so that they can take full benefit from the PMTCT services offered.
- Testing is an important diagnostic tool in providing effective institutional and clinical care.
- Testing is an essential part of the sero-surveillance system and [research](#)<sup>1</sup>.

But all these forms of testing and counseling demand special attention to the ethics of HIV/AIDS and quality assurance. Confidentiality in all counseling and testing is very important. Compassion is at the root of all counseling.

##### *MoH Policy*

The original policy and strategy for HIV/AIDS Counseling and Testing was approved by the Ministry of Health in 1995; then reviewed and revised in September 2001. The Ministry of Health policy for HIV testing lays down:

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<sup>1</sup> Note that testing for blood screening is the responsibility of the National Blood Transfusion Centre

- **Mandatory\*** testing for HIV under any circumstances is prohibited in the Kingdom of Cambodia.
- **Compulsory\*** testing for HIV under any circumstances is also prohibited unless required by law.
- All testing for HIV should be full and informed agreement of the person being tested.
- All anonymous, un-linked testing conducted for research or survey purposes must have prior approval of the Ethics Committee and the Ministry of Health and be in conformity with the Ethical Guidelines for HIV/AIDS and STI related Research approved by the Ministry of Health.

All public and private institutions which conduct voluntary HIV tests must strictly follow the policy and guidelines for HIV testing lay down by the Ministry of Health. They must provide adequate pre-test and post-test counseling, and accurate results. All such institutions must be licensed and supervised by the Ministry of Health, and must be run by staff who have been trained under courses approved by the Ministry of Health.

All HIV/AIDS testing and counseling services, public and private, must report regularly to the National Centre for HIV/AIDS, Dermatology and STI/Ministry of Health using standardized reporting formats determined from time to time by NCHADS and NGOs.

#### ***Diagnostic testing in public and private health care facilities***

Testing for diagnostic purposes is conducted at all National and some Referral Hospitals at Provincial level.

- HIV testing for diagnostic purposes should only be carried out where confirmation of the patient's HIV status would clearly benefit the patient in terms of determining of the best course of treatment, and with the full informed consent of the patient.
- Minors should only be tested with the permission of their parents or their legal guardians with appropriate pre- test counseling.
- Pre-test counseling should be provided as part of informed consent; the patient should be informed of the results of testing only with post-test counseling, and only at the request of the patient.
- Test results must be kept strictly confidential and confined to staff directly responsible for the patient's medical care and treatment.
- No relative of the patient should be notified of the test or of the result, unless the patient has given explicit permission.

#### ***Testing within voluntary counseling and testing services***

A network of HIV testing and counseling centers already exist in Cambodia. In 1995 the first testing and counseling centre was established at the Pasteur Institute of Cambodia, which has a specialized HIV laboratory service. Over the next year five further voluntary confidential counseling and testing centers (VCCT) were established: two in Phnom Penh (at the National STI Clinic and Khmer-Soviet Hospital), and three centers in Battambang, Kampong Cham and

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\* Mandatory testing refers to testing that is conducted without any option for refusal. Compulsory testing refers to testing which is required in order to access a particular benefit or service (eg visa, employment, medical care, etc) but where the subject has the option of rejecting the service or benefit and thus avoiding the test.

Siem Reap. In 1999 a seventh was added in Sihanouk Ville. NCHADS expects to establish 250 VCCT centers in each province throughout the country by the year 2010.

All voluntary counseling and testing services, whether in the public or private sector, must conform to the following standards:

- They must be licensed by the Ministry of Health
- They should provide HIV testing services only to people who request these services
- All testing must be accompanied by pre- and post-test counseling as laid down in these guidelines.
- Counseling and laboratory staff must be qualified according to Ministry of Health standards
- Testing procedures must conform to the protocols laid out in the guidelines, or as amended by the Ministry of Health from time to time.
- They must maintain strict confidentiality of all test results.

The Guidelines also set out detailed procedures for ensuring confidentiality, and what should be covered in supportive pre- and post-test counseling.

### ***Quality Assurance***

The VCCT Quality Assurance programme rests on four pillars:

- registration of all sites in the public, NGO and private sectors;
- all VCCT centers complete bi-annual External Quality Assurance (EQA) serum panels prepared by NIPH (National Institute of Public Health) - the national VCCT Reference Laboratory;
- NCHADS staff regularly visit the VCCT sites to provide technical support; and
- Regular networking meetings of counselors at regional level for quality assurance mentoring and training.

## **3.2 Health Facility Based Care (HFBC)**

### ***Establishing Health Facility Based Care at the OD within the Continuum of Care***

A set of systems must be established at the OD to establish the Continuum of Care and manage HFBC.

#### ***OD coordination and referral mechanisms***

To ensure the continuum of care is effective it is essential that strong coordination and referral mechanisms are established. This requires the establishment of a **Coordination Committee at OD level** as a forum to coordinate planning and encourage collaboration. The OD Continuum of Care Coordination Committee could be co-chaired by a representative of Health sector - e.g. the director of OD or the OD HIV/AIDS/STI Coordinator, or for the OD based at Provincial town, the PHD or PAO manager - and a representative of the civil society such as a religious leader or an active representative of PLHA group leader.

The coordination committee will ensure that all stakeholders at OD level work together for the optimum use of resources available. It will identify needs, gaps and areas of collaboration and coordination among the partners involved in HIV/AIDS care and prevention in the OD. It will help define referral mechanisms between institutional care, home and community based care and will provide a regular forum for the discussion of issues relating to the continuum of care.

For provinces with few ODs, coordination of activities could be achieved through a provincial level coordination committee. In larger provinces where coordination committees will be OD based, the need for provincial coordination mechanisms should be discussed. Whenever possible existing structures and coordination groups will be used (e.g. by adding more members to HBC working groups).

### ***Mechanisms for CoC***

To manage the CoC at the OD the following mechanisms are established:

- **HIV care coordinator.** One staff member of OD/RH is designated as the coordinator of HIV care, for example the Director or Deputy-director of the Technical Bureau. The role of this position is to coordinate the HIV activities of the different units of the hospital – inpatient department (including the medical and/or infectious diseases ward, TB service and MCH service), outpatient department, the laboratory and the VCCT service.
- **HIV care technical working group.** Regular meetings of a HIV care technical working group within the referral hospital will improve the coordination of HIV care between the various clinical units. This group should involve key staff involved in HIV care and the referral hospital HIV care coordinator. It should act as a forum for staff to discuss problems and ideas and to provide feedback to the management staff of the hospital, the OD and PAO and to the OD Continuum of Care Coordination Committee.
- **The OI/ART Team.** At each site an OI/ART team for adults consists of 9 individuals (see SOP).
- **Referral mechanisms:** operational procedures regarding discharge and referral mechanisms between HIV/AIDS care services based on national recommendations need to be developed.
- **Financial mechanisms.** Local financing mechanisms should be developed to improve HIV care in health care facilities and improve access for PLHA. These should be based on national recommendations, but be adapted to local circumstances. They should involve the local community and may include the management of an equity fund by a local social NGO.

### ***Capacity building***

The CoC is a new service, and new way of working. Considerable capacity building for staff is therefore required.

- **Basic training.** Provision of basic HIV training to all health staff using national training modules. Combining some components of this training with HBC team training should be encouraged. Active involvement of local PLHA could facilitate the building of partnerships with health care services.
- **Advanced training.** Medical staff working at referral hospitals should be encouraged to apply for advanced training in HIV management. Selection of trainees should take into account recommendations from hospital management, the PAO and local PLHA and NGOs. Selected medical staff could then be offered a range of training modules based in the major HIV clinical services.
- **Support and supervision.** Support should be provided for health care staff addressing the specific needs of health center staff, referral hospital nursing staff, referral hospital medical staff and medical staff that have completed advanced training in HIV

management. This could include identification and encouragement of local informal mentoring.

### ***Logistics: drugs, laboratory, radiology and medical supplies***

- **Drug procurement and distribution.** Local mechanisms to support drug procurement and distribution may need to be investigated.
- **Laboratory and radiology.** An assessment of the capacity of the referral hospital laboratory and radiology department should be performed. Any necessary improvements should be implemented based on national recommendations.
- **Medical supplies.** Supplies necessary for the practice of universal precautions should be provided.

### ***Quality Assurance:***

The OI/ART services Quality Assurance programme contains a number of elements:

- **mentoring** from a national core mentors;
- regional **network meetings** every 6 months for clinicians for OIs & ART for adults, and for Counselors for OI/ART for Adults, and national meetings every 6 months for staff managing pediatric care;
- development of standardized **Early Warning Indicators** and **HIV drug resistance** thresholds;
- a **Continuous Quality Improvement (CQI)** strategy, under which ODs are supported to collect indicators measuring the quality of patient management across the CoC, measure their own performance against these, and monitor and improve on these as an integral part of their work;
- the **HIV/AIDS Care and Treatment Symposium**, conducted with contributions from partners every two years.

### ***Other***

- **ART Adherence support.** Similarly, mechanisms to support PLHA to continue chronic treatment must be developed locally with the active involvement of both PLHA and clinicians. The ultimate success of any treatment program is dependent on the quality of these mechanisms to support ART adherence.
- **Basic needs of abandoned PLHA.** Local approaches to the issue of providing care for abandoned PLHA in hospital should be developed. This could involve the development of a team of community volunteers, the involvement of PLHA attending MMM, but other approaches may also be feasible. Linkage to an equity fund should also be investigated. Health facilities based care should also link with hospices run by NGOs or pagoda for abandoned or homeless patients at an advanced stage of the disease and requiring palliative care.

Details of managing Health Facility Based Care satellite sites are in the SOPs for “Quality of OI and ART services in Referral Hospitals”.

### ***Pediatric AIDS Care***

Since 2006, the HIV/AIDS care and treatment of children & adolescents has been integrated into the Continuum of Care. Management of HIV clinical treatment for pediatric patients is administered by the Pediatric OI/ART team within the pediatric care and treatment services of the Referral Hospital.

The March 2006 “*Standard Operating Procedures (SOP) for Integration of Pediatric AIDS Care into the Comprehensive Continuum of Care*” provides details of how this is done. It covers such things as:

- ***Human Resources:*** OI/ART services for children & adolescents are headed by the head pediatrician of the Referral Hospital. The pediatric OI/ART teams work closely with the adult OI/ART team in order to refer adolescents. The Pediatric OI/ART team varies depending on the number of patients being cared for.
- ***Training:*** Training is conducted according to the National Training Curriculum for Pediatric HIV care and treatment management developed by NCHADS.
- ***Referral of children & adolescents living with HIV/AIDS:*** There are a number of possible entry points involving care and treatment for children & adolescents into the Continuum of Care. These entry point services include PMTCT service, Well Child Follow-up and immunization services, pediatric wards, home based care teams, MMM and the VCCT network. All these entry point services should be targeted in order to increase awareness of the availability of HIV care and treatment services for this age group.
- ***Psychosocial Care and Support and ‘mmm’ for Children:*** Pediatric wards providing HIV pediatric care and treatment shall ensure that a room is set for providing counseling for children and adolescents. The room should be child-friendly and equipped with age-appropriate IEC materials, toys, drawing materials and a play area. ‘mmm’ for children takes care of the children whose parents seek services at the adult MMM. In addition to traditional MMM activities, mmm offers toys and educational games to create an environment of comfort that children will want to return to.
- ***Nutritional Support:*** Nutrition activities shall be integrated in the care of all in-patient and out-patient children regardless of their HIV status. Given the link between nutritional status and HIV infection however, particular attention shall be given to nutritional assessment of infants and children who have been exposed to HIV. Growth is a indicator of HIV disease and disease progression in children.
- ***Laboratory Support for Pediatric OI/ART services:*** Laboratory and X-ray support for pediatric OI/ART services is provided by adult OI/ART services. All HIV-exposed infants requiring a diagnostic DNA-PCR test, the blood samples are referred to testing at laboratory in Phnom Penh.
- ***Logistics Support for Pediatric OI/ART services:*** The Pediatric OI/ART services are supported by the Logistics Officer of the Adult OI/ART team. Storage and Distribution of medicines and the submission of reports/requests to CMS and NCHADS is the responsibility of the Logistics Officer.
- ***Dosing Guidelines for Pediatric ARVs:*** NCHADS has prepared material for each pediatric HIV care and treatment services with guidelines for the correct dosing of ARV medicines.
- ***Orphans and Vulnerable Children:*** Orphans and Vulnerable Children (OVC) are integrated into the Comprehensive Continuum of Care in coordination with social welfare and education programs according to the OVC – specific Standard Operating Procedures.

- **Family-based Care:** Family based care plays a strong underlying role in providing care and treatment to children & adolescents. The full range of CoC elements can help to support this.

### ***TB/HIV***

Similarly, responding to the need to address TB/HIV co-infection, the National Centre for HIV/AIDS, Dermatology and STI (NCHADS) and the National Centre for Tuberculosis and Leprosy Control (CENAT) have created frameworks for implementing TB/HIV care and treatment activities and the Continuum of Care (COC) for people living with HIV/AIDS and TB. With the Ministry of Health endorsement, these policies were implemented nationally in 2002.

In order to effectively implement these programs and preventing them from overlapping one another, NCHADS and CENAT have agreed to release a joint statement which includes the following:

- **Provision of care and treatment for TB-HIV/AIDS co-infection:** Care and treatment of TB-HIV/AIDS co-infection shall include DOTS and Continuum of care services to be delivered within the existing public health system at the operational district level.
- **Supply of drugs-equipment and test kits:** Regular supply of materials and reagents is under the responsibility of the two National Centers (NCHADS and CENAT) and provisions should be included in their respective quarterly/yearly plans of action.
- **Training of health personnel:** The two national centers will collaborate to develop and implement training activities for health service providers to enhance their knowledge and capacity to provide treatment services for TB-HIV/AIDS co-infection.
- **Awareness on TB-HIV/AIDS treatment and care promotion:** The two national centers through their networks and agents will promote TB-HIV/AIDS care and treatment services and educate TB-HIV/AIDS patients to use such services.
- **Monitoring and evaluation:** Follow-up, monitoring and evaluation of care and treatment for TB-HIV/AIDS co-infection will be included in the plan of action of the two national centers and will remain under their individual responsibilities. Activity reports will be included within the reports made by the two national centers.

Full details are in the Joint Statement which can be found on the NCHADS web-site at [www.nchads.org](http://www.nchads.org)

### ***CoC Satellite Sites***

In order to strengthen the care and treatment of people living with HIV/AIDS in Cambodia, NCHADS foresees the establishment of secondary CoC sites, or *CoC Satellites* at Referral Hospitals in Operational Districts that are deemed too small to require a comprehensive CoC site. The objectives of the *Satellite services for Continuum of Care and Treatment* will be to:

- Reduce the workload of the OI/ART team at the comprehensive CoC sites
- Minimize the travel burden for patients living with HIV/AIDS
- Build the capacity of clinicians and nurse counsellors at Referral Hospitals in small Operational Districts

- Broaden the scope of assistance to PLHA by introducing MMM and other support activities to secondary sites.

Details of establishing satellite sites are in the SOPs for “Expanding the continuum of care – satellite sites”.

### **3.3 Community Home Based Care (CHBC)**

Since 1997, extensive home care services have been conducted by NGOs in collaboration with health center staff, particularly in urban areas. There are currently some 255 HBC teams covering some 26,000 PLHA in provinces and municipalities.

Community home-based care is an essential element of the Continuum of Care (CoC) for people living with HIV/AIDS (PLHA). It enables PLHA to access health care services such as voluntary and confidential counseling and testing for HIV (VCCT), treatment for opportunistic infection and anti-retroviral therapy (OI/ART), prevention of HIV transmission from mother to child (PMTCT), and diagnosis and treatment for Tuberculosis (TB). In addition, community home-based care also helps other people in the community access correct information on health and social services. Community home based care therefore plays an important role in encouraging people in the community to use existing health and social services in the community.

The Ministry of Health, through the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) has collaborated with civil society to implement community home-based care in Cambodia. To ensure harmonization and support the implementation of community home-based care, the Ministry of Health has developed SOPs for implementing this activity, providing guidance on coordinating mechanism, home-based care team structure, package of home care activities, and estimated budget for operating community home-based care activities.

#### ***Implementation at National Level***

Implementation of community home based care is overseen by the Sub-committee on CHBC, with membership drawn from representatives from various departments of the health sector, partner agencies, and local and international non-governmental organizations working on care of PLHAs and CPN+. The Subcommittee is chaired by NCHADS, who will serve as the Secretariat of the Sub-committee to be responsible for:

- Programme planning, coordination and resource mobilization
- Monitoring of the implementation of the programme
- Provision of Advices and Technical Assistant
- Sharing experience in community and home-based care

#### ***Implementation at Provincial Level***

In each province where CHBC activities are being implemented, a Provincial Network for CHBC is established with membership drawn from representatives from partners involved in care and support activities, such as NGOs, CBOs, referral hospitals, health centers, Provincial and district PLHA Network (DPN+ and PPN+), and PHD. The Network is chaired by the Provincial AIDS Programme Manager (PAO manager) and one officer in charge of CoC serves as the coordinator of the Network. Details of the responsibilities of the Network are in the HBC SOP.

### ***Implementation at OD Level***

Coordination of the CHBC activities at OD level is assured by the OD HIV/AIDS/STI Coordinator.

### ***Implementation at Health Center and Community Levels***

Implementation at this level is by community home-based care teams. The total number of team members may vary from 3 to 5 depending on the real situation and needs within the catchments area of a health center. However, in the case of insufficient number of PLHAs (less than 100 PLHAs), the team may perform their activities in the catchments area of more than one health center. Three options are proposed in the HBC SOP, depending on involvement of health centre staff and NGOs. The adoption of the appropriate option for CHBC team shall be the responsibility of the HIV/AIDS/STI OD Coordinators in consultation with the PAOs and their partners. Community members can participate in the home-based care activities as volunteers. Volunteers can be PLHAs, their family member(s), community leaders or other community members (including monks) interested in home and community care. Generally, there are 5 volunteers for each CHBC team.

### ***Home-based care teams***

Based on the discussion among team members, the CHBC team submits to the HIV/AIDS/STI OD coordinator a monthly work plan that specifies the number and location of visits to be made.

### ***Recruitment of NGOs to implement CHBC activities***

In light of annual assessment of the CHBC needs, gaps are identified and annual national and provincial targets will be set. The Sub-committee recommends additional numbers of CHBC teams needed for each province. Local NGOs can be selected to implement the CHBC activities at specific location(s). The recruitment process is done by individual funding partners in a transparent and fair manner.

### ***Programme monitoring and reporting***

Indicators specified in the HBC SOP are used for monitoring and reporting the progress of the CHBC programmes. Field supervision is carried out by OD Coordinators and PAO's Officer using the checklist in the SOP.

Recently, the Ministry of Health has strengthened the CoC to make it more comprehensive by establishing the Happy Youth Center in referral hospitals (RH) where the CoC is implemented in order to respond to the needs of PLHA and their families. Furthermore, health services for youth are also being integrated into the existing health care system in the referral hospitals.

### ***Additions to the package of Community Home-Based Care Activities***

To be more comprehensive, community home-based care should expand its scope to include additional activities to support orphans and vulnerable children (OVC), adolescents, and maternal and new-born health (MNH), so that these groups of people can gain access to appropriate HIV/AIDS prevention and care services. A number of new elements have therefore been added to this component of the CoC Framework.

- **Activities to Support OVC:** Needs assessment for HIV testing for all children; referral for all children needing HIV testing to VCCT; referral and follow-up for all HIV positive children to pediatric OI/ART services; to pediatric mmm; assessment of living status of children and seeking social support for them; promotion of children's rights in

the community; collaboration with NGOs/CBOs to provide social support to children and their families.

- **Activities to Support Adolescents:** provision of education on HIV/AIDS prevention and genital and reproductive health care; encouragement for youth to use public health care service when they have health problems; collaboration with volunteers in the Happy Youth Centre to provide information on the centre's activities; encouragement and referral of young people to attend the activities in the Happy Youth Centre; referral of youth who need HIV testing to VCCT; referral and follow-up of HIV positive adolescents to OI/ART services.
- **Activities to Support Maternal and New-born Health (MNH):** provision of education on MNH and HIV/AIDS; encouragement and referral of pregnant women to antenatal care (ANC) services; provision of information on PMTCT services; support and referral of pregnant women to PMTCT services; follow-up of positive mother and children; referral of pregnant women to health centres, VCCT, and birth spacing services.
- **Happy Youth Centres:** Happy Youth Centres should be established in referral hospitals to encourage the involvement of young people in understanding genital and reproductive health and accessing care and treatment for STIs, so that they are able to protect themselves from becoming infected with HIV and can avoid any problems related to genital and reproductive health. Activities in Happy Youth Centres include: provision of counselling on genital and reproductive health, particularly HIV/AIDS and STIs; provision of education on genital and reproductive health, and HIV/AIDS prevention; encouragement of HIV/AIDS/STI risky behavioural change; referral of youth who need HIV testing to VCCT; referral of young people with health problems to appropriate health care services; collaboration with community home-based care teams to provide education and follow-up youths in the community; contact with NGOs and other involved institutions to seek support for youth.

### 3.4 Mondul Mith chouy Mith (MMM)

This programme is implemented by CPN+ (Cambodian Network of People living with HIV); it involves half-day monthly meetings that provide a crucial link between PLHA and health staff at the hospital. The purpose of these meetings is to ensure a two-way flow of information between PLHA and facility-based treatment providers. Through MMM meetings, healthcare providers gain an understanding of the PLHA's non-clinical troubles, their daily struggles and their gaps in medical understanding. PLHA learns more about their illness and their treatment program, and how to access all the resources available to them. They also learn from each other, sharing their successes and challenges, gradually becoming more confident and competent in self-care and appropriate health-seeking. The MMM program also aims to reduce stigma in the referral hospitals as well as self-stigma experienced by PLWHA themselves. CPN+ is working closely with other CoC partners to ensure that MMM programs are attached to every OI/ART site. This part also covers 'mmm', activities for pediatric care and children on OI/ART.

The standard package of activities at MMM includes:

- Peer support activities;
- Health education for PLHAs and family on self-care, home care, health promotion, nutrition and prevention of HIV transmission;
- Adherence support and counselling for PLHAs receiving ART - the counselling should be performed individually or in group;
- Spiritual support including prayer and meditation with monks;
- Exercise program;
- Referral to OI/ART service in the referral hospital for screening for OIs including TB, Health checks including treatment of simple OIs, ART;
- Referral of women for PMTCT and other MCH services such as family planning;
- Facilitation in referral to social and financial support, available income generation and occupation promotion services, available services for support for orphans.

As in many countries, marginalized populations such as MSM and IDU may prefer not to access services at public sector health facilities. Linking prevention interventions for MARPs with the CoC services could substantially improve access and utilization for MARPs. Experience has shown that more effort is needed to develop MARP-friendly services, and ensure coverage of MARPs with peer support groups and outreach. Based on experience from Botswana, Ethiopia, India, South Africa, and Zambia, it is clear that either the MMM space can be used as a drop-in space for peer/support group meetings for pregnant women PLHA, MSM, and DU/DU. This will also help to facilitate improved access to CoC services for these groups. Organizing specific meetings at the MMM for pregnant women PLHA to discuss about PMTCT and birth control is relatively easy. But attracting other MARPs such as sex workers, MSM and DUs may be more difficult; but will be strongly encouraged them.

Details for establishing and managing the MMM are in the “Standard Operating Procedures (SOP) For Implementing MMM activities in Cambodia”.

### **3.5 PLHA Support Groups**

PLHA play a major role in the Continuum of Care. However, the involvement of PLHA should be developed carefully. PLHA are often best placed to understand and respond to the needs of other PLHA, but their capacity may be limited by poverty, illness, lack of training and discrimination. Their roles should always be seen as optional and not imposed on PLHA.

The CoC framework specifically calls for the establishment of PLHA support groups as an explicit component. This may be initially facilitated through MMM, NGOs and CBOs. Or existing groups may need strengthening. Strengthening PLHASG enables PLHA to initiate activities, to have active participation in service delivery, to be engaged in community response. Capacity building in management and coordination of group leaders could be one strategy to strengthen PLHASG. Other strategies need to be developed.

Since the Cambodian Network of PLHA (CPN+) has been established much of this strengthening is being done by the PLHA themselves.

The involvement of PLHAs in VCCT services may help to improve post-test counseling and referral. PLHAs could be selected on a voluntary basis to receive training and be employed as counselors in VCCT services.

**Socio-economic support:** systematic identification of support organizations at OD level or provincial level will improve social support for PLHA. These organizations should be encouraged to increase their coverage and link with health care services and PLHASG. Structures like MMM and community initiatives may help to identify socio-economic needs of PLHAs and their families and find ways to address them.

### 3.6 Nutrition

Two aspects of nutrition are critical in the CoC Framework: nutrition advice and care for children and food support for PLHA in various specific situations.

#### *Infant feeding*

The National Policy on Prevention of Mother-to-child Transmission of HIV (2005) reiterates the importance of optimal infant feeding. It recommends that HIV-positive women should be given the full facts about breastfeeding and the choice of infant-feeding options in order to make an informed decision. The policy recommends providing support to mothers who choose to breast-feed or that formula-feeding should only be used in instances where it demonstrates adherence to evidence-informed international standards (ie *accessible, feasible, affordable, sustainable and safe*).

#### *Food support for PLHA in-patients*

Food support may be provided to PLHA who are admitted in hospitals as in-patients. Many PLHA first come to the CoC when they arrive at hospitals when they are already very sick.

#### *Food support for TB/HIV patients*

Under the Ministry of Health policy, TB patients are eligible for food support when they are in-patients. TB patients with HIV also qualify for such support.

#### *Food support for PLHA on ART during the first six months*

Good nutrition is essential for effective ART. Patients starting ART may need food support for up to 6 months while their health status stabilizes.

### 3.7 Most at risk populations (MARPS)

As in many countries, marginalized populations such as MSM, transgender, IDU etc. prefer not to access services at public sector health facilities. Linking prevention interventions for MARPs with the CoC services could substantially improve access and utilization for MARPs. Experience has shown that more effort is needed to develop MARP-friendly services, and ensure coverage of MARPs with peer support groups and outreach. Based on experience from Botswana, Ethiopia, India, South Africa, and Zambia, it is clear that either the MMM space, or the STI clinic, or both, can be used as a drop-in space for peer/support group meetings for the following: (1) pregnant women, (2) MSM, (3) IDU/DU and (4) transgender. This will also help to facilitate improved access to CoC services for these groups.

Organizing specific meetings at the MMM for pregnant women PLHA to discuss about PMTCT and birth control is relatively easy. But attracting other MARPs such as sex workers, MSM and

DUs may be more difficult. Using the STI clinic as a meeting place for sex workers, MSM and transgender should be considered as an alternative. Expanding the role of STI clinics in this way may attract greater numbers of entertainment workers to the clinic.

NCHADS is already planning to have MMM meetings for HIV-positive children. The MMM can thus be used more optimally for prevention for PLHA including providing PLHA with information on sexual and reproductive health, family planning, dual protection, condoms and PMTCT.

For this to be effective, MMM staff will need training on:

- working with MSM, DU/IDU and transgender groups
- prevention of HIV/STI/TB transmission for PLHA.

### **3.8 In Closed Settings**

The NCHADS has recognized the needs of prevention, and care and treatment of any infectious diseases including HIV/STI for those in closed settings (prisons, etc). Prevention services such as IEC/BCC, outreach and condom distribution are being introduced. Under the CoC in closed settings, VCCT can also be introduced. Provision of full OI/ART services within closed settings is more difficult. Where closed settings can negotiate with a nearby CoC site to provide some services, this is the best option.

### **3.9 The Linked Response – including PMTCT**

The current health system in Cambodia provides access to HIV/AIDS, OI/ART, STI, ANC, family planning and maternal and newborn health services. However, these closely related services are not always available at the primary health care services, and some operational districts do not offer the full package of services; though PMTCT services are being expanded. Because health staff is often specialized such as FP, STI management, ANC, they may miss opportunities to provide comprehensive information and to refer patients to relevant health services for appropriate treatment. As a result, the linkages between related health services need to be strengthened, as well as those between health services and the community at large. This is a challenge for ODs, who must develop capabilities to envision, plan and manage these kinds of linkages. NCHADS has been working with the NMCHC to pilot an approach to the Linked Response which aims to focus effectively at OD level, building capabilities.

The objectives of the implementation of the Linked Response which aims to:

- Contribute to the strengthening of Cambodia's overall health care system;
- Strengthen existing reproductive health services;
- Increase access to comprehensive HIV prevention education, testing, care and treatment.
- Strengthen ownership of public health management teams at operational district

Patient referral has become an increasingly important part of the community-based provider role, with emphasis on referral to VCCT, OI/ART, ANC/PMTCT services, TB screening and cross-referral between CHBC and MMM groups. With an increasing focus on wellness and appropriate referral, and working with CHBC and MMM coordinators. The Linked Response aims to ensure comprehensive services at a low cost per client, facilitate integrated and sustainable services by linking community structures to health centers and referral hospital, and enable, over time, PLHA and their families to take greater responsibility for managing their own health and social

situations. Besides strengthening HBC services, the Linked Response supports the functioning of the overall CoC by bringing together OD HIV/AIDS Coordinators, CoC teams and health centre staff in the planning and implementation of coordinated services; reinforcing community-level referrals so that clients, family members and suspect cases increase their use of OI, ART, PMTCT, STI, VCCT and TB screening/treatment services (as appropriate); and linking teams to service delivery points so that active follow-up of clients who miss appointments can occur.

As part of the increased focus on outreach and referral, pregnant women are routinely referred for ANC, HIV testing and PMTCT services. This effort is supported by community-based workers through information sessions, counseling of known PLHA and increased outreach to women at risk. HBC workers provide active follow up of HIV+ mothers and their infants, making sure that infants are tested on time, referred to pediatric services, provide advice and monitor infant feeding; train and support HBC Teams on infant feeding education promoting exclusive breastfeeding, appropriate weaning and introduction of complementary foods using WFP flip charts, cooking sessions nutritious "bobor" preparations in community education sessions.

Elements of the Linked Response are:

- **Furthering Education:** Health care providers (doctors, nurses, midwives etc.) will be informed on how best to use the Linked Response to provide comprehensive care for patients. This will be accomplished by updating current literature, as well as through orientation and training workshops. Health care providers and home-based care teams at OD level, who have implemented the linked response approach sites, will receive formal training on VCCT testing and counseling, PMTCT (prophylaxis, infant feeding, etc) and DBS collection.
- **Integration of IEC materials:** IEC materials should be consistent with one another.
- **Strengthening patient record keeping and data management** throughout the Linked Response network, especially with regards to HIV-positive pregnant women and HIV-exposed infants.
- **Strengthening referrals** between CHBC care service of HIV/AIDS, OI/ARV, STI, ANC, family planning, safe abortion, adolescent health, and maternal & newborn health services, as well as strengthening logistics and data management. Starting with core packages, experience can be gained about how they can be expanded to include other services. Details of these core packages and how they can be used for the Linked Response are in the Joint Statements and SOP for Implementation of Linked Response being developed by the two Centers and approved by Ministry of Health.
- **HBC teams (Home Based Care)** will work closely with Referral Hospitals and Health Centers to scale up referrals and initiate follow-ups.
- **HPITC (Health Provider Initiated Testing and Counseling)** is vital to providing complete care to clients who visit health facilities. All health professionals (doctors, nurses, midwives and dentists) should encourage clients to seek HIV testing and counseling at the nearest VCCT site. ANC and TB patients should be especially encouraged to be tested for HIV, as should those patients who show symptoms associated with HIV/AIDS. If the patient is being seen at a health care facility that does not house VCCT, blood should be taken from the patient and then tested at the nearest VCCT laboratory site. As always, post-test counseling is of the utmost importance and should be performed in a counseling room by a trained professional.
- **Outreach** to village health volunteers, traditional birth attendants (TBA) and unofficial medical practitioners plays an important role in bringing patients into health care facilities

for testing, counseling, care and treatment. By working closely with these individuals, facility-based providers will be able to identify more patients in need, and increase their patients' incentives to seeking care in the Linked Response network.

## 4. Managing the Continuum of Care for PLHA in Cambodia

As Cambodia moves towards achieving universal access to HIV prevention, treatment, care and support by 2010, coverage, quality, and efficiency of services are becoming critical issues. Coverage is directly linked to quality and impact. Health systems delivering quality care, treatment and support strive to achieve gains accessing in safety services, effectiveness, patient centeredness, timeliness, efficiency and equity. Based on internationally accepted standards, the quality and efficiency of the CoC programme must take into account the following factors as indicators of success:

- **Accessibility:** providing services that are affordable, available and accessible for clients
- **Effectiveness:** providing services that adhere to standards of good practice and are known to produce positive public health impact
- **Client centered:** providing timely services that are respectful of and responsive to client needs

The results, focus and achievements of the CoC programme have engendered community and PLHA confidence in public sector HIV and health services. In line with Cambodia's *Law on the Prevention and Control of HIV/AIDS* and good practice, the CoC provides free treatment and care; this has contributed directly to **expanding access**.<sup>2 3</sup> It is important to note that the cost of travel and food, some of which are covered by NGO partners, are still considered to be barriers to accessing treatment and care.

The expansion of the Continuum of Care for PLHA in Cambodia is therefore based on the following management strategies:

### 4.1 Partnerships between health facility, PLHA network, the public health system and NGOs at Operational District level

The CoC institutionalizes key partnerships with NGOs, community based organizations (CBOs) and PLHA groups. The recent health sector review concluded that in Cambodia, the NGOs are critical for improving equity and access to health services. The CoC meaningfully involves PLHA in multiple structures and services and this has been critical to its success. For example, along with participating in the management and coordination of the CoC, PLHA participate in and contribute to the CoC as MMM Coordinators, peer counselors in VCCT and MMM, and through the PLHA support groups. Furthermore, PLHA are also consulted on research issues through monthly meetings of a forum to discuss research issues and priorities.

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<sup>2</sup> Implementing Guidelines of the Law on the Prevention and Control of HIV/AIDS. Ministry of Health. Royal Government of Cambodia. 2005.

<sup>3</sup> WHO. Discussion Paper. The Practice of Charging User Fees at the Point of Service Delivery in HIV/AIDS Treatment and Care. December 2005.

The CoC also benefits from the establishment of key capacity building partnerships. For example, NCHADS has been working with Douleurs Sans Frontières to train CoC staff in palliative care, including effective pain management. Another important partnership NCHADS has evolved is with the Clinton Foundation HIV/AIDS Initiative (CHAI), whereby CHAI is providing technical assistance to strengthen services for procurement, laboratory strengthening, and pediatric care; WHO and CDC are also key capacity building partners. Where development partners and NGOs (e.g. Family Health International, AIDS Healthcare Foundation) are involved in supporting ODs, the NGOs especially have provided capacity building support and resources. Important management tools for the NCHADS-NGO partnership as well as management decentralization to OD level have been developed under the EuropeAid project (2004-2007).

## **4.2 Referral mechanisms for PLHAs between the home and community based care and the institutional care level**

OI/ART sites are only established after the minimum CoC package has been put in place. This enables the OI/ART services to establish links with other HIV services in health facilities and communities (e.g. VCCT, MMM, HBC and PLHA support groups). This supports a multi-disciplinary adherence support model, which in line with experience from a range of countries, is key to supporting good adherence.

A well functioning PLHA referral system is thus central to the coverage and quality of CoC services. The performance of the referral system is a good 'marker' of an increase of truly client-centered model of care delivery. To date the CoC coverage and enrolment statistics (i.e. VCCT and ARV uptake) and the overall reduction of HIV prevalence in Cambodia show that the referral system is working well. Cambodia is well on track to meet its universal access targets; without a functioning referral mechanism for expanding uptake of services, these results would not be possible.

There are areas where improvement is needed, however; mainly in relation to essential health service linkages, such as TB/HIV and PMTCT. Assessments have suggested that there are considerable missed opportunities for reaching people in need with comprehensive care. Coverage could be substantively increased by strengthening linkages with ANC/PMTCT, TB and reproductive health services. The development of implementation of the new 'Linked Response' approach (cf section 3.9, above) is a direct response to this.

Referrals between STI services and CoC are also being strengthened. At present an informal system of referrals is in place at some sites (e.g. staffs give verbal referrals to patients, so it is difficult for a recipient service to identify the source of the referral; thus the individual presents as a 'self referral'. This is being phased out as more formal referral mechanisms are put in place.

## **4.3 Effective involvement of PLHA in all aspects of the Continuum of Care**

PLHA themselves can play a very important role in HIV/AIDS care. They can and should be involved in all aspects of continuum of care including home and community based care and institutional care. They can take part, on a voluntary basis, in a wide range of activities such as peer counseling, facilitation of referral, basic HIV/AIDS care and adherence support. Existing

PLHA support groups will be reinforced and the formation of new peer support groups will be facilitated with the close collaboration of PLHA themselves.

The MMM activity is an innovation in client centered service delivery and the main focus of PLHA involvement. The MMM is where PLHA are employed to accompany and support clients. The MMM creates a space for HCWs and PLHA to interact and learn from each other. The MMM is a part of the CoC as it contributes to strengthening the link between health facility based care and community based care and support of PLHA network.

Managed by CPN+ and PLHA Support Groups, monthly MMM meetings bring together HCWs and PLHA to share and discuss different issues of HIV treatment, care and support. Invitations to these meetings are rotated to provide access to a larger number of PLHA with an average of 100 PLHAs. With additional resources, the frequency of meetings and coverage to other groups could be expanded.

The added benefits of the MMM are: (1) increasing client confidence in HCWs, (2) improving treatment literacy on ART, (3) HCWs having an opportunity to better understand PLHA concerns, (4) strengthening HCW/client relationship, (5) sharing experiences with peers and (6) reducing self-stigmatization amongst PLHA. In addition to the meetings, PLHA working at the MMM provide essential patient support (e.g. collecting medicines, ARV adherence support, counseling including for prevention, referral, scheduling appointments).

#### **4.4 Technical Guidance and Training of health care providers**

CoC Guidelines and SOPs are a critical part of the training and capacity building process. The CoC has a comprehensive and systematic training and capacity building component. This includes national level training, refresher training, on-site mentoring, long-distance support through a telephone “warm line” and regional professional networks. The important objective of mentoring support is to ensure that guidelines and SOPs are being implemented consistently at OD/facility level.

#### **4.5 Reinforcement of health care facilities to provide quality care services to PLHA**

Institutional care must be strengthened in order to provide effective HIV/AIDS care across the continuum. Key interventions will include:

- Coordination of HIV/AIDS care activities within health care facilities through an HIV coordinator and the formation of a HIV care technical working group at a referral hospital.
- Development of financial mechanisms such as equity funds to ensure that health care facilities receive adequate funding to provide quality care to PLHA
- Capacity building of health care workers through training, support and supervision
- Improving logistical support including drug supply and laboratory and radiology services
- Involvement of the community including PLHA in the planning and implementation of HIV care in health care facilities.

## 4.6 The Private Sector

The role of private health services in the CoC (e.g. VCCT) is very important. In Asia-Pacific region, studies show that private clinics have been procured and supplied ARV drugs for the past 10 years but rarely collaborate with the national programme. However, health care utilisation behaviour in Cambodia, the private sector is a minor player participating in implementation of continuum of care and treatment. According to the CDHS in 2005, private health facilities were twice as likely to be visited, for all treatments, than public facilities. Given the possibility that clients may seek private facilities for reasons of increased anonymity, the role and interaction of the private sector with public services is very important. The lack of regulation and need for more structured partnership with the booming private health services in Cambodia has also been earmarked for attention in the recent Health Sector Review.

## 4.7 Gender sensitivity

The number of males and females (11,743 and 11,844 respectively at the end of June 2007) are receiving ART. In Cambodia may not be initially obvious in the numbers of HIV/AIDS males and females accessing ART with an evidence of violence, including sexual violence, against women and sexual minorities and current epidemiological trends suggest that improving access to CoC services for women and MARPs such as MSM and transgender populations should be considered a priority. CoC staffs in health facilities require specific training in working with transgender, MSM, and victims of sexual violence.

The following activities are planned under this new CoC Framework, which will go some considerable way towards improving the gender sensitivity of the CoC:

- scaling up comprehensive PMTCT services, especially primary HIV prevention for women, and improving partner testing and counseling,
- expanding community outreach ,especially pregnant women to include, adolescent girls, women visiting family planning and reproductive health services, and entertainment industry workers,
- increasing male involvement in community based care and support to address fear of disclosing to partners (which often deters women from accessing or adhering to treatment), and
- training for CoC staff in working with MSM and transgender populations.

## 4.8 Universal precautions and post exposure prophylaxis

OI/ART clinicians are trained in universal precautions (UP) and post-exposure prophylaxis (PEP) by the national training.. PEP is provided for occupational exposure only at OI/ART sites. For health care workers at the facilities without OI/ART services have to travel to OI/ART sites to access PEP. While currently PEP is not provided for victims of rape plans are being made to address this; OI/ART counselors will be trained on these topics. The national training curriculum for OI/ART nurses is being amended to include UP and PEP content.

## **4.9 Laboratory support**

Although VCCT, STI and TB services had independent laboratories in the past in some health facilities, those laboratories are gradually being integrated into the general laboratory, which potentially promotes efficient use of both human and material resources. NCHADS has also integrated HIV testing and STI laboratory training programmes so that those trained will be able to perform laboratory tests required by VCCT and STI care and treatment services.

However, the process of scaling up integrated testing at labs is still in its early stages. Collaboration, tasks and equipment are not yet shared among laboratory staff, and thus certain tests are not conducted when the responsible staff member is away. Internal QC procedures are being developed. SOPs and a daily quality control chart are being introduced in laboratories.

CD4 count facilities are available in four “hub” laboratories which cover demands from facilities nationwide. In total 14,200 CD4 tests were conducted in the first quarter of 2007. External quality assessment (EQA) for CD4 count is implemented by the NIPH once every 6 months – to date the EQA results from the four laboratories have generally been good.

VL and DNA PCR testing are available at Pasteur Institute, NIPH, and laboratory at the Faculty of Pharmacology. From all parts of the country, it is physically possible to send plasma specimens within 30 hours.

## **4.10 Supply management**

Having a supply management system that works is fundamental to the success of a service delivery programme of CoC. The CoC has thus far enjoyed a supply management system that has ensured timely procurement and distribution of supplies and consumables: there have been very few reported cases of ARV stock outs.

Forecasting and procurement of ARVs is done by NCHADS, and the Central Medical Stores (CMS) distribute on a quarterly basis. With the support received through the GFATM Round V health systems strengthening component, CMS’s capacity will be improved over a period of time. Furthermore, experience from countries such as Namibia shows that developing and supporting unified procurement and supply management (PSM) plans is a way that HIV programmes can contribute to health systems strengthening. Supply management capacity at OD level is also being strengthened, especially in the areas of forecasting, dispensing and storage. In order to deal with unforeseen interruptions in the distribution and supply of ARVs, NCHADS keeps a buffer stock.

## **4.11 Monitoring & Evaluation**

NCHADS has established a Data Management Unit at national level and selected province-city levels. Routine reports are submitted from respective services to NCHADS through PAOs every quarter. All the service delivery points, regardless of supporting donors, report to NCHADS using standard reporting forms. NCHADS compiles and monitors national figures on a quarterly basis and produces comprehensive reports every quarter and these are made available on the NCHADS website.

For ART, cross sectional variables include number of new patients, number of lost, number of death during the quarter, number of active at the end of the quarter, disaggregated by sex and age

group. The data that indicates the success of the ART programme (i.e. % first line retention and % survival at 6, 12, 24 months) have been implemented through monitoring system of Early Warning Indicator in 16 provinces in 2008. .

NCHADS and other key national programmes (i.e. NMCHC and CENAT) have made joint efforts to: (1) set PMTCT and TB/HIV monitoring indicators, and (2) exchange relevant data; however, joint reviews of the data are not regularly conducted.

NCHADS is developing a quality improvement component for the CoC.

- **Reporting** A national system for recording and reporting of VCCT, HBC and HIV care activities in health care facilities should be implemented.
- **Monitoring and evaluation.** A national system for monitoring and evaluating OD coordination and referral mechanisms, VCCT services, HBC activities, HIV care in health care facilities should be implemented.

#### 4.12 Planning the introduction of the Continuum of Care at OD Level

Where the CoC is to be introduced in a new OD, careful planning has been shown to be essential.

- **Sensitization:** Initial consultations are required with the key groups in the OD e.g. PLHASG, HBC team, RH, OD office. These groups need to be sensitized to the concept and strategies of the continuum of care.
- **Situational analysis:** A situational analysis needs to be conducted including data from the national situational analysis, mapping of current activities and workloads, needs of PLHA and capacity of local non-governmental organizations.
- **Planning:** Participatory planning process should involve individual and group consultations, identifying goals and priorities and resulting in the development of a Continuum of Care action plan.
- **Referral mechanisms:** Operational procedures to improve referral mechanisms between VCCT CHBC, PLHASG, and HFBC (post-test referral) will be adapted from national recommendations to local situation. They may use referral cards, telephone numbers. Confidentiality must be ensured at any time. Knowledge of VCCT staff with other care services will help improving referral and coordination.

## **ANNEX 1: Current Guidelines and SOPs for the Continuum of Care**

### **Guidelines:**

Clinical guidelines on OIs for adults - 2000  
Clinical guidelines on OIs for children - 2000  
Guidelines for selection of PLHAs for ART – 2003  
OI Prophylaxis Guidelines for PLHAs – 2003  
Use of ARV therapy for Adults and Adolescents – 2003  
Use of ARV therapy for Adults and Adolescents – 2004  
Guidance for Establishing Voluntary Confidential Counselling and HIV testing (VCCT) Centres – 2004  
Guideline on Post Exposure Prophylaxis (PEP) - 2005

### **Training curricula and materials:**

Adult OI and ART management for Clinicians – 2004  
VCCT Training Manual - 2004  
OIs and ARV counseling for Nurses - 2005  
OIs and ARV logistics management for pharmacists – 2005  
OIs and ART Medical Record and reporting Form - 2005  
Pediatric OI and ART management for Clinicians – 2006  
CHBC Training curriculum – 2006

### **Standard Operating Procedures (SOP):**

Logistics Management – 2005  
For implementing CHBC – 2006  
OIs and ART Team – 2006  
For implementing MMM activities – 2006  
Amendment to CHBC: Happy Youth Centers - 2006  
CoC satellites – 2006  
Prompt testing of TB/HIV and rapid access to treatment and care services – 2006  
Integration of Pediatric AIDS Care into the Comprehensive Continuum of Care - 2006  
Implementing Social Care for Orphans and Vulnerable Children (OVC) – 2007  
Linked Response approach between HIV/STI/TB services– 2007

### **Joint Statements:**

TB/HIV activities - 2005  
NCHADS and NCMCH for PMTCT – 2005

## ANNEX 2: List of key documents

1. Health Sector Strategic Plan 2003 – 2007. Ministry of Health. August 2002.
2. Implementing Guidelines of the Law on the Prevention and Control of HIV/AIDS. Ministry of Health. 2005.  
(Accessed at <http://www.un.org.kh/un aids/docs/HIV%20Law%20implementing%20guidelines.pdf>)
3. Strategic Plan for HIV/AIDS and STI Prevention and Care, Ministry of Health, Cambodia. 2004 – 2007
4. Annual Operational Comprehensive Plan 2007 for NCHADS and Provinces. Ministry of Health, NCHADS. 2007
5. Maung Reusey CoC (accessed at <http://www.nchads.org/reports.php>)
6. CoC Operational Framework (accessed at <http://www.nchads.org/aids care.php>)
7. Statement NCHADS-CENAT (accessed at <http://www.nchads.org/aids care.php>)
8. Statement on PMTCT & Revisions on PMTCT (accessed at <http://www.nchads.org/aids care.php>)
9. AIDS Care Guidelines & SOPs (incl. OI prophylaxis, ART selection, ARV treatment) (<http://www.nchads.org/aids care.php>)
10. Pediatric Care and Treatment (accessed at <http://www.nchads.org/aids care.php>)
11. The Continuum of Care for People Living With HIV/AIDS in Cambodia: Linkages and Strengthening in the Public Health System. Case Study. Ministry of Health, NCHADS and WHO, Western Pacific Region. 2006.
12. Care Cambodia: Health Program Achievements and Lessons Learned. April 2006 (accessed at <http://www.un.org.kh/un aids/docs/CARE%20Cambodia%20Health%20Program%20Achievement.pdf>)
13. MoH/NGO Evaluation of Home Based Care Program for People Living With HIV/AIDS in Cambodia. Wilkinson, D. for International HIV/AIDS Alliance. June 2000. (accessed at [http://www.aidsalliance.org/custom\\_ asp/publications/view.asp?publication\\_ id=75&language=en](http://www.aidsalliance.org/custom_ asp/publications/view.asp?publication_ id=75&language=en))
14. Improving Access to ART in Cambodia. Dhaliwal, M. & Ellman, T. for KHANA and International HIV/AIDS Alliance. 2003. (accessed at [http://www.aidsalliance.org/custom\\_ asp/publications/view.asp?publication\\_ id=67&language=en](http://www.aidsalliance.org/custom_ asp/publications/view.asp?publication_ id=67&language=en))