



Ministry of Health

Continuum of care for people living with HIV/AIDS in Cambodia



National Center for HIV/AIDS, Dermatology and STDs (NCHADS)

April 2003

**Approval of the Continuum of Care for People Living With HIV/AIDS
Operational Framework in Cambodia,**

The Ministry of Health appreciates the hard work and attention to detail that the staff of the National Centre for HIV/AIDS, Dermatology and STD have put into the preparation of this Framework. It is the result of careful HIV/AIDS Care analysis. Several meetings, a lot of work within the Centre, and sharing and exchange with all the Centre's partners, government and NGOs and donors.

This Framework is welcome and approved, as an effective response to the serious problems that HIV/AIDS Care and support it is causing to Cambodia. It provides an Operational framework for implementation at provincial level, Referral hospital, Health Center. It can be prepared gaps in resources identified, requests for assistance shaped, and resources from all sources coordinated. But like all plans. It should be flexible.

Phnom Penh, May 2003
Senior Minister and Minister of Health

Acknowledgements



The National Centre for HIV/AIDS, Dermatology and STD has invested in the preparation of this Framework many meetings, a lot of work within the Centre, and sharing and exchange with all the Center's partners, including Government, NGOs and donors.

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Phnom Penh, 22 May 2003

Dr. Mean Chhi Vun
Director of NCHADS

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ANNEX

ABBREVIATIONS

AIDS: acquired immunodeficiency syndrome
ARV: antiretroviral
CAA: children affected by HIV/AIDS
CBO: community care organization
CBC: community based care
CoC: continuum of care
CPN+: Cambodian Network of PLHA
Global Fund to fight AIDS, TB and Malaria: GFATM
IC: institutional care
IEC: information, education and communication
HBC: home based care
HCBC: Home and Community based care
HC: health center
HCW: health care workers
HIV: human immunodeficiency virus
Ministry of Health: MoH
MMM: Mondul Mith Chouy Mith (Friendly support center)
NCHADS: National Center for HIV/AIDS, Dermatology and STD
NGO: non governmental organization
OD: operational district
OI: opportunistic infection
PAO: provincial AIDS office
PEP: post exposure prophylaxis
PLHA: people living with HIV/AIDS
PLHASG: people living with HIV/AIDS support group
PMTCT: prevention of mother to child transmission
RH: referral hospital
STI: sexually transmitted infection
TB: tuberculosis
TOR: terms of reference
UP: universal precaution
VCCT: voluntary confidential counseling and testing

1 Background

Cambodia faces the highest burden of HIV infection in the region. New data from the HIV Sentinel Surveillance 2002 estimates the number of adults aged 15-49 years living with HIV in Cambodia to be 157 500 (2.6%). Although this represents a stabilization of prevalence the HIV epidemic in Cambodia is now evolving into a phase in which an increasing number of people infected with HIV will become sick and seek care. New AIDS cases in 2002 are estimated to be about 19 000 and new deaths related to HIV/AIDS about 18 000.

So far, efforts have been concentrated on prevention of HIV transmission. However for the past few years there has been an increasing awareness of the urgent needs to provide comprehensive care 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 2001-2005 has included the improvement of quality and accessibility of care of PLHA through the extension of HIV/AIDS care services nationwide and provision of a continuum of care as main objectives regarding care. Moreover, substantial additional funds for HIV/AIDS care and treatment, including antiretroviral treatment will be available soon, particularly through the Global Fund to fight AIDS, TB and Malaria (GFATM).

A number of pilot projects have been implemented in various components of treatment and care and there is a need to learn the lessons of these projects and to scale up. There is also likely to be substantial benefits from incorporating expanded programs into a framework at the national and local level that coordinates HIV/AIDS care activities. Adequately coordinated and resourced care programs increase the impact of individual care activities and form the basis for the provision of ARV therapy.

The purpose of this framework is to plan the national approach to HIV care needs and to assist HIV/AIDS care managers and other key players to develop a continuum of care for PLHA at local level that should provide comprehensive care within the existing health system.

2 Comprehensive HIV/AIDS care across the continuum

2.1 What is comprehensive care?

Throughout the course of HIV infection, people living with HIV/AIDS (PLHA) will face a number of consequences of HIV infection including physical health (opportunistic infections, premature death) and mental health (psychological distress), 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 requires a wide range of services, such as psychological, social, and legal support, hence the need of comprehensive care.

Developing comprehensive care is complex and requires careful planning, coordination, referral and monitoring. Broad based mobilization of the community and organizations working outside the health sector is needed for comprehensive care to develop and be sustained. The key health sector 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 and financial support
- Support for caregivers and children affected by HIV/AIDS (CAA)
- Reduction of stigma and discrimination

➤ **Health promotion and education**

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

2.2 Where is HIV/AIDS care conducted?

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

- Institutional care (IC) including the private sector.
- Home-based care (HBC)
- Community-based care (CBC) including
 - PLHA peer support groups (PLHASG)
 - Other community support organizations
 - By community members themselves

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

2.3 HIV/AIDS care activities are interdependent

Implementation of the whole is more effective than implementation of any of the parts. The uptake and quality of each activity is dependent on the availability and quality of the other services:

- HBC, IC and Voluntary Counseling and Testing (VCCT) can play a role in reducing stigma and discrimination encouraging uptake of VCCT and producing an enabling environment for PLHASG
- Availability of quality treatment improves the survival of PLHA enhancing the capacity of PLHASG
- PLHASG can only exist if uptake of VCCT is adequate and people are being tested at an early stage of disease progression
- Strong PLHASG can help to improve the quality of IC and HBC and encourage the timely and appropriate use of health services
- HBC can be enhanced by adequate support from IC
- The workload of IC can be reduced by effective HBC
- Home and Community-based care act to encourage uptake of VCCT
- PLHASG can be important contributors to Home and Community-based care

2.4 HIV/AIDS care should be focused on the evolution of needs of PLHA over time

	Diagnosis	Early stage	Advanced stage	Terminal stage
Testing	•	•	•	
Treatment of OI		•	•	
Prevention of OI		•	•	
Palliative care				•
ARV		•	•	
UP and PEP	•	•	•	•
PMTCT	•	•	•	
Counseling	•	•	•	•
Social support	•	•	•	•
Support for caregivers / CAA	•	•	•	•
Reduction of stigma	•	•	•	•
IEC / health promotion	•	•	•	•

2.5 Guiding principles of the continuum of care

- 2.5.1 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**.
- 2.5.2 **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 are developed they should remain flexible to local needs and capacity.
- 2.5.3 **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.
- 2.5.4 **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.
- 2.5.5 **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
- 2.5.6 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.
- 2.5.7 **Greater involvement of PLHA (GIPA)** 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.
- 2.5.8 **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.

- 2.5.9 **Coordination.** The function of the continuum is complex and dependent on effective communication and coordination between different organizations. This can necessitate the development of specific coordination mechanisms and changes to current work practices.
- 2.5.10 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.
- 2.5.11 Working with the **private sector.** Many HIV care activities occur in the private sector. Design of the continuum of care should address the 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 current status of HIV/AIDS care in Cambodia

The need for HIV/AIDS care is increasing as the number of AIDS cases grows. However access to comprehensive care is still limited, particularly in provinces.

3.1 Voluntary confidential counseling and testing services

- The first VCCT center was opened in 1995 by Pasteur Institute of Cambodia in Phnom Penh; 6 other public VCCT centers were established in 5 provinces between 1996-1999. Early 2003, there were 17 public VCCT sites and 13 private non for profit VCCT centers run by NGOs. There are plans to extend VCCT services to all provinces.
- The current model is standalone VCCT service.
- Linkages to care services are a major issue.
- There is widespread access to unregulated private VCCT services in Phnom Penh and some major towns.
- Guidelines for HIV counseling have been developed in the setting of HIV diagnosis but not with regard to supportive or follow up counseling.

3.2 Institutional care

- Hospital and health center services for the care of PLHA are underdeveloped in most Operational Districts.
- Coordination of services, supply of drugs and medical supplies, training and support of health care staff and cost of services are all major issues that limit access to care.
- Six specific HIV care programs currently exist at Preah Bat Norodom Sihanouk Hospital (with support from MSF-France), Calmette Hospital (one program supported by MDM and one by the ESTHER program of the government of France), Sihanouk Hospital Center of Hope (with support from HOPE Worldwide), National Pediatric Hospital (with support from UNICEF) and Siem Reap provincial hospital (with support from MSF-Belgium and the ESTHER program).
- All of these programs include the provision of ARV resulting in a total of approximately 900 PLHA receiving ARV through not-for-profit programs at present.
- Two further HIV care programs including ARV provision will commence shortly at Kompong Cham provincial hospital (with support from MSF-France) and Takeo provincial hospital (with support from MSF-Belgium).
- HIV care within health care institutions is being developed in the provinces of Banteay Mean Chey (with support from USCDC-GAP), Battambang (with support from FHI and ADB) and Koh Kong, Prey Veng and Svay Rieng (all with support from ADB).

3.3 Home and Community Based Care

Since 1997, extensive home-visit services have been conducted by NGOs in collaboration with health center staff, particularly in urban areas. There are 52 HBC teams in 10 provinces and municipalities. However, it has been difficult to expand in rural areas where residence of PLHA is scattered and coverage of NGOs is very limited.

A few numbers of hospices and pagoda provide care for terminally ill and abandoned patients.

3.4 PLHA groups

- Cambodian Network of PLHA (CPN+) has been established
- PLHA groups are being developed by home-based care services. NGOs or hospital arrange activities. PLHA are recipients.
- Peer support activities are mobilized in the major referral hospitals providing ARV
- Access to socio-economic services is scarce. Occupational promotion oriented peer support among marginalized women including PLHA is facilitated by a NGO (NYEMO)

4 Lessons learned from other countries

Many of the experiences and lessons learned regarding HIV/AIDS care are bound to the local context and cannot be directly copied to other countries or situations. However, many countries have learnt from the difficulties and approaches of others, minimizing the repetition of less effective approaches.

Below is the summary of constraints frequently observed and successful approaches to overcome them, mainly in Asian countries. It is important to note that training of personnel, drug supply and provision of basic equipments are essential, but never be enough for effective and sustainable implementation of comprehensive HIV/AIDS care including ARV.

4.1 Leadership, management and coordination

4.1.1 Frequently observed constraints

- Passive attitude of authorities in health, other sectors and local governments
- Fragmented and inconsistent care activities and training among institutional care (IC), home-based care (HBC) and community-based care (CBC)

4.1.2 Successful approaches

- Multi-sectoral political commitment at the national level influenced attitudes of authorities at the local level
- PLHA care site with comprehensive peer support activities or day care center attached to district hospital provided opportunities for local authorities to directly interact with PLHA and to learn their needs
- Partnership of medical services, public health services and PLHA care sites such as a day care center at district level served as a “hub” or “main focus” for provision of IC, capacity building of PLHA and families for HBC and involvement of civil society for CBC.

4.2 Institutional care (IC)

4.2.1 Frequently observed constraints

- Trained health workers do not work for VCCT or AIDS care in their daily work
- Limited psychosocial and educational support in outpatient department of hospital
- High user charge of basic curative services even for the poor
- Limited utilization by marginalized PLHA such as sex workers and homeless
- Discriminatory attitudes of health workers and lack of confidentiality
- Diagnosis often too late for effective treatment (TB, ARV, etc.)
- High drop-out rate for OI prophylaxis, TB treatment and ARV

4.2.2 Successful approaches

- Appointment and intensive training of HIV/AIDS care coordinator and/or care team with political support were effective in overcoming many barriers.
- PLHA care site/day care center as well as public health services including TB program provided psychosocial and educational support, increased access/utilization of marginalized PLHA, promoted early diagnosis of TB and enhanced adherence to OI prophylaxis and ARV.
- Identification and provision of affordable care packages for every level mobilized PLHA group and community organizations and prevented unnecessary diagnosis and treatment

4.3 Home-based care (HBC)

4.3.1 Frequently observed constraints

- Limited capacity of health services to conduct home visit services
- Overburden of health workers for home visits for externally funded programs affecting other health programs
- Low cost effectiveness particularly in rural areas

- Limited link with health facility resulting in delay of TB diagnosis and inappropriate side-effect management of OI and ARV treatment
- Limited link with community making PLHA and families passive, depriving them of opportunity to meet with other PLHA and no involvement of community

4.3.2 Successful approaches

- Capacity building of family and community volunteers worked and minimized home-visits which is expensive in rural areas.
- Well-managed HBC can improve clinical management including TB diagnosis and adherence to treatment.
- Careful and active involvement of community in HBC reduced discrimination.
- PLHA groups were formed through home-visits services particularly by PLHA

4.4 Community-based care (CBC)

4.4.1 Frequently observed constraints

- Strong stigma and discrimination
- Health volunteer scheme not functioning well for HIV/AIDS care
- General information campaign does not necessarily change attitudes
- Passive responses particularly when external funding driven activities

4.4.2 Successful approaches

- Local context bound IEC as well as village forums to discuss HIV/AIDS issues were effective in modifying attitudes of community people towards PLHA
- Committed health workers and PLHA made a difference in reducing stigma and discrimination through talking to community people including influential persons.
- Day care center and home-based care provided the opportunity for community to interact with PLHA and to participate in HIV/AIDS care and support
- Proposal-based funding mechanism for community organizations including PLHA groups led to creative local solutions and partnership building in the community.
- PLHA support group established a partnership with community organizations through joint efforts to address issues related to HIV/AIDS and other social problems in the community.

5 The development of Continuum of care for PLHA in Cambodia

5.1 Key Strategies for establishing a Continuum of Care for PLHA

The expansion of the Continuum of Care for PLHA in Cambodia will be based on the following strategies:

5.1.1 Partnerships between medical services, PLHA groups, the public health system and NGOs at operational district level

Facilities and services should be close to PLHAs. The operational district is the proposed level for planning, implementing and managing the continuum of care. A HIV/AIDS/STI coordinator will be employed at the OD office. One of their duties will be to support a coordination committee at OD level to coordinate planning and encourage collaboration between all the key players in HIV/AIDS care, including NGOs and community -based organizations.

A key partnership will be that between medical and public health services and PLHA groups. This may be enhanced by the development of a “care site” or so-called day care center (MMM = Mondul Mith Chouy Mith = Friend Support Friend Centre): a place where peer support and a wide range of care activities are conducted. This could improve the relationship between health care workers and PLHA, facilitate referrals and improve adherence.

5.1.2 Strong referral mechanisms between the home, the community and the institutional care level

To ensure a continuum of care it is crucial to develop strong and effective referral mechanisms at OD level between health facilities, VCCT services, HBC teams, support groups and social support organizations (See Annex 2). Referral mechanisms will be developed for each OD by OD coordination committee using national recommendations.

5.1.3 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.

5.1.4 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 hospital HIV care technical working group
- 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 PHLA in the planning and implementation of HIV care in health care facilities

5.1.5 Development of care packages at each level of the health system

Recommended activities for each level and sector of the health care system will be developed. This process will involve all partners involved in HIV care and will be based on needs, available resources and local capacities (See Annex 3). The recommendations will include the use of ARV treatment and TB/HIV services.

5.2 Development and planning of the Continuum of Care at national Level

A number of activities must be developed at national level for effective planning and implementation of the Continuum of Care at OD level.

- Form coordination mechanisms and coordinate the development of the Continuum of Care
- Conduct situational analysis
- Develop and revise specific strategies for coordination and referral, VCCT, HBC, IC, ARVs and PLHA support groups
- Develop guidelines and training programs
- Develop monitoring and evaluation systems

5.2.1 Formation of coordination mechanisms

Activity	Description
National CoC technical working group	<ul style="list-style-type: none">• Formation and operation of national body to coordinate the expansion of the Continuum of Care.• Regular meeting to coordinate national strategies, guidelines and programs• Selection of Continuum of Care pilot ODs• Secretariat provided by AIDS Care Unit, NCHADS

National CoC sub-groups	<ul style="list-style-type: none"> • Formation and operation of 3 working groups: VCCT, Home and Community Care, Institutional Care and ARV. • Secretariat provided by AIDS Care Unit, NCHADS.
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5.2.2. National HIV/AIDS care situational analysis

Activity	Description
Epidemiological assessment	<ul style="list-style-type: none"> • Estimate current number of people living with HIV at different stages of disease progression by province using data from HSS and census. • Project future number of people living with HIV at different stages of disease progression by region using data from HSS, BSS and census
PLHA needs assessment	<ul style="list-style-type: none"> • Perform a participatory assessment of the needs of PLHA
Assessment of services and resources	<ul style="list-style-type: none"> • Compilation of HIV care services provided throughout the country by OD. • Quantify current resource flows by province and activity. • Document current plans of organizations involved in HIV care. • Identification of gaps in services and resources.
Costings	<ul style="list-style-type: none"> • Cost current and planned HIV care activities including traditional and private sector activities.

5.2.3 Develop and revise specific HIV care strategies

COORDINATION AND REFERRAL	
Activity	Description
Coordination mechanisms	<ul style="list-style-type: none"> • Development of model OD level coordination mechanisms including recommended OD Continuum of Care coordination committee membership and TOR.
“Care site”	<ul style="list-style-type: none"> • Development of the concept of a “care site” (MMM) as a link between health care workers and PLHA. Investigation of how this could be piloted in Cambodia.
Care packages	<ul style="list-style-type: none"> • Recommended activities for each level of the HIV care system
Referral mechanisms	<ul style="list-style-type: none"> • Development of recommended practical mechanisms to improve referral between HIV care services

VCCT	
Activity	Description
Assessment of current VCCT services	<ul style="list-style-type: none"> • Evaluation of current VCCT services • Assessment of current HIV testing usage patterns • Recommendations of the advantages and disadvantages of different VCCT models
Licensing and marketing	<ul style="list-style-type: none"> • Development of a system for licensing of all VCCT services by the Ministry of Health. Only services providing counseling of a defined standard will be licensed. This will be supported by the AIDS Law when it becomes operational. • Marketing of approved VCCT using two approaches: national marketing of HIV testing and local marketing of specific licensed VCCT services.
Development of a standardized national monitoring and evaluation system	<ul style="list-style-type: none"> • Development of monitoring and evaluation tools for VCCT expansion program • Standardized routine data collection and reporting including new and private services. Revision of VCCT dataset and training of staff from new VCCT services in data management • Revision of supervision tools for VCCT services including quality of counseling • Development of a national external quality assessment program for HIV test covering all licensed VCCT services. • Involvement of VCCT staff in developing the standardized national monitoring and evaluation system, for example through a national workshop.

National counseling network	<ul style="list-style-type: none"> As the number of VCCT services grow it will become increasingly difficult for support of counselors to be provided from central level. One way of filling this gap is to use experienced counselors to provide support and monitoring visits to other counselors. The first step could be to involve counselors in the design of the network during a national workshop.
Local counseling network	<ul style="list-style-type: none"> Linkage of counseling services within each OD. This could include not only pre- and post-test counseling services, but also supportive counseling and adherence support services. A local network would help support counselors, share experiences, update information on HIV/AIDS. This could be facilitated by the OD HIV coordinator
National standardized HIV counseling curriculum	<ul style="list-style-type: none"> Revision and standardization of HIV counseling curriculum. A curriculum that is owned and used by all counseling training organizations is an important way to improve the quality of counseling.
Involvement of PLHA in VCCT services	<ul style="list-style-type: none"> Training and employment of PLHA as counselors in VCCT services. This may help to improve post-test counseling and referral.
Strategy to improve post-test referral.	<ul style="list-style-type: none"> This should include practical guidelines on referral to HBC, PLHASG and IC, the use of referral mechanisms such as referral cards and telephone numbers and discussion of confidentiality. Familiarization of staff from care services with each other's service is a useful way to improve referral and coordination at the local level.

Home and Community-based care	
Activity	Description
Continue to support a wide range of HBC models, including mixed clinical and social support roles of HBC teams	<ul style="list-style-type: none"> Description of the advantages and disadvantages of current models of HBC in Cambodia. Revision of national community home based care clinical and organizational guidelines.
Reduce the time HC staff spend on HBC activities	<ul style="list-style-type: none"> Modification of the role of HC staff to focus on technical assistance, support and monitoring. At the same time strengthen the support HCs provide to HBC teams by training all HC staff in basic HIV care and improve HC drug supply. The aim is to increase the resources available to HCs and to strengthen the support HBC receives from institutional care.
Improve drug supply	<ul style="list-style-type: none"> Inclusion of all home care kit drugs on the Essential Drug List, clarification of the role of HBC teams in the provision of OI prophylaxis, revision of the drugs included in home care kits, further training of HBC teams in the appropriate use of home care kit drugs and by finding ways to improve drug procurement and distribution.
Improve linkage between HBC and institutional care	<ul style="list-style-type: none"> This is dependent on improvements in the care available in health care institutions, but can also be enhanced by specific activities such as OD coordination committee meetings, clarification of the complementary roles of HBC and IC, practical guidelines on referrals, familiarization of IC staff with HBC and by improving discharge planning, for example by designating one staff member of the referral hospital as responsible for coordination of PLHA discharges.
Build the capacity of PLHA and their families to provide self-care	<ul style="list-style-type: none"> Promotion of home care, not only home visits: providing self-care skills to PLHA can be a powerful way of improving their quality of life. PLHA can also be trained to work as village caregivers or as HBC team members.
Facilitate community care initiatives for PLHA and their families	<ul style="list-style-type: none"> Learning from pilot projects on community care for PLHA and their families. Facilitation community mobilization and initiatives through AIDS committee or NGOs; project implementers being people from the community.
Facilitation of social support	<ul style="list-style-type: none"> Encourage social support organizations to expand their geographical coverage to areas currently not served. Link PLHA with social needs to social support organizations.

<p>Institutional Care and ARVs</p> <p>There are five main areas of activity needed to develop HIV care in health care facilities and to expand the use of ARVs:</p> <ul style="list-style-type: none"> • Finance and management • Capacity building • Logistics: drugs, laboratory, radiology and medical supplies • Community involvement • Reporting, monitoring and evaluation 	
<p>• Finance and management</p>	
Activity	Description
Coordination	<ul style="list-style-type: none"> • A recommended model for coordination of HIV care activities within health care facilities is being developed. This will include appointment of a HIV coordinator and regular meetings of staff involved in HIV care in a referral hospital HIV care technical working group • Mechanisms for national coordination of ARV programs should be developed. This could be performed by the Institutional Care/ARV working group.
Financial mechanisms	<ul style="list-style-type: none"> • National recommendations should be made on possible financial mechanisms to bridge the gap between the money needed by health staff to perform their public sector roles and the money available by PLHA to pay for health care. This could include supplemented equity funds for health care institutions that have relatively high utilization and sound management. These mechanisms should involve the local community and could be administered by a local NGO. There has recently been a decision that all care in government health care facilities should be free for PLHA. The impact of this decision on access needs to be carefully monitored. • Current and planned funds available for ARV supply should be documented. Additional financial mechanisms for funding ARV supply should be investigated and pursued.
Design of HIV care and ARV services	<ul style="list-style-type: none"> • Effective approaches to the delivery of HIV care in health care facilities need to be determined. This needs to include investigation of a “care site” concept, but should also examine to what degree HIV care should be integrated into existing services, the roles of different health care services and the relationship with TB services. • The most effective way to deliver ARVs also needs to be determined. Key questions include the site of ARV delivery, the degree of integration with other health care services, the roles of different levels of the health care system, and the appropriate roles of the governmental, non-governmental and private sectors.
<p>• Capacity building</p> <p>A key requirement for improved HIV care is greatly expanded training and support of health care staff. Training should include all health care staff as many will be providing HIV care in the private sector. Training programs should address four main training needs.</p>	
Activity	Description
Initial training	<ul style="list-style-type: none"> • Expansion of training in HIV for medical and nursing students. This should include the development of training modules and field placement programs. Exposure to PLHA in settings such as support organizations can help to develop positive attitudes and minimize stigma and discrimination.
Basic training	<ul style="list-style-type: none"> • Provision of a basic package including basic HIV facts, key HIV care guidelines, universal precautions, post-exposure prophylaxis, basic counseling, stigma and discrimination. Some of the initial training of HC staff could be combined with HBC team training. The AIDS Care Unit of NCHADS has developed a basic HIV training package. This should be reviewed and if necessary updated.
Advanced training	<ul style="list-style-type: none"> • More advanced training should be offered to medical staff that have already shown interest in HIV care. This should involve periods of field placements with HIV clinical services in Phnom Penh. These modules should be based around gaining proficiency in OI prophylaxis, diagnosis and treatment and the use of ARV. Field

	placements should include hospital based clinical experience, attachment to a HBC team and formal tuition. Total field placement experience should not be less than six months for doctors who will be prescribing ARV with minimal supervision.
Support and supervision	<ul style="list-style-type: none"> Ongoing support after training is essential. This could be provided by an informal mentorship system where experienced HIV clinicians provide advice by phone for a defined period. Regular refresher training should be provided. Mechanisms for certification and marketing of certified practitioners should be explored.
<ul style="list-style-type: none"> Logistics: drugs, laboratory, radiology and medical supplies <p>Intermittent drug supply and limited diagnostic capacity are major constraints on institutional care and the success of ARV programs. Mechanisms for improving logistical support in health care institutions include the following:</p>	
Activity	Description
Essential Drug List	<ul style="list-style-type: none"> A separate ‘Specialized items for AIDS Care program’ has been created in the Essential Drug List. This now includes drugs necessary for the treatment of PLHA including intravenous cotrimoxazole, amphotericin and fluconazole. Improved methods of estimating national requirements should be developed. Inclusion of ARV in the Essential Drug List should be investigated.
Drug donation programs	<ul style="list-style-type: none"> Application to international drug donation programs could help to improve the supply of a small number of key medicines such as fluconazole and some ARVs.
Drug procurement and distribution	<ul style="list-style-type: none"> These remain major constraints on drug availability at present. Mechanisms need to be identified that will produce sustainable improvements in drug supply in a relatively short period of time. Issues such as relationships with the private sector, collaboration with HBC team kit procurement programs and local procurement mechanisms should be examined.
Rational drug use	<ul style="list-style-type: none"> Development of guidelines for prophylaxis of opportunistic infections and revision of the national clinical care and ARV guidelines together with associated training modules should help to improve rational drug use
Laboratory	<ul style="list-style-type: none"> Adequate laboratory support is essential for the diagnosis and management of OIs and the safe and effective use of ARVs. National recommendations should be developed for the minimum capacity required of laboratories in referral hospitals implementing the Continuum of Care. Recommendations should also be developed for the expansion of access to CD4 testing.
Radiology	<ul style="list-style-type: none"> Radiology services provide essential support for the management of more complicated OIs especially respiratory tract infections such as smear negative pulmonary tuberculosis.
Medical supplies	<ul style="list-style-type: none"> Although there are many competing needs for improved supply of medical equipment in health care facilities priority should be given to supplies necessary for the practice of universal precautions. This is essential for reduction of discrimination and improvement in the care of PLHA.
<ul style="list-style-type: none"> Community involvement 	
Activity	Description
Basic needs of abandoned PLHA	<ul style="list-style-type: none"> Improved mechanisms for support of abandoned patients need to be found. Many abandoned PLHA are either refused admission or receive little bathing or food whilst in hospital. They are then often faced with homelessness at the time of discharge. One approach to this issue is the development of a team of community volunteers who are paid a small allowance to address the basic needs of PLHA in hospitals. These initiatives could be linked to the management of an equity fund. Recommended approaches should be developed and disseminated.
Linkage with PLHA support groups	<ul style="list-style-type: none"> As institutional care services expand a key linkage will be with PLHA support groups, particularly if more PLHA are diagnosed in asymptomatic stages and if ARV are available. In Thailand this link is the day care center, a place within the hospital where PLHA are able to gather, conduct support activities, receive medical care and meet with the community. The appropriateness of a “care site” such as this to Cambodia needs to be explored.

Adherence support	<ul style="list-style-type: none"> The community, including PLHA, plays a critical role in the support of PLHA to continue difficult life-long medical treatments. The ultimate success of any treatment program is dependent on the development of these mechanisms. National recommendations on the design of HIV care services should emphasize the development of mechanisms to support treatment adherence.
<ul style="list-style-type: none"> Reporting, monitoring and evaluation 	
Activity	Description
Reporting	<ul style="list-style-type: none"> A standardized national HIV care recording and reporting system that is integrated into the Health Information System would contribute substantially to the information that is available for monitoring and planning of HIV care services. This should include approval and dissemination of a national AIDS case definition.
Monitoring and evaluation	<ul style="list-style-type: none"> A system should be developed for monitoring and evaluating HIV care within health care facilities. This could include the collection of a minimum data set from all approved ARV programs. The development of a national HIV resistance surveillance mechanism should also be explored.

PLHA Support Groups	
Activity	Description
Increasing the role of PLHA in HIV/AIDS care	<ul style="list-style-type: none"> PLHA can play a role in the care of PLHA such as counseling, transport, facilitation of referral, adherence support and personal care. Recommendations should be developed in collaboration with PLHA groups for appropriate ways to facilitate the voluntary participation of PLHA.
Facilitation of the establishment of PLHA support group	<ul style="list-style-type: none"> Support establishment of new PLHA group through MMM, NGOs, CBO Provision of care package including self care, counseling, home visit, income generating activities Increase access to comprehensive care
Empowerment of PLHA and enhancement of capacity building process among PLHA	<ul style="list-style-type: none"> Gradual shift from a dependent phase of PLHASG (NGOs or hospital staff arrange activities; PLHA are recipients) to a partnership phase (PLHA wants active participation in service delivery) PLHASG support their own activities including advocacy PLHASG working in collaboration with the resources organizations at different levels and being engaged in community response

5.2.5. Development of guidelines and training programs

Activity	Description
Development of guidelines	<p>The following are areas where development or revision of guidelines are a priority:</p> <ul style="list-style-type: none"> Prophylaxis of opportunistic infections Selection of PLHA for ARV therapy Rational use of ARV Management of HIV/TB co infection Clinical management of HIV (revision) Palliative care
Development of training programs	<ul style="list-style-type: none"> Training programs to encourage the use of the above guidelines should be developed. They should complement the existing training of staff involved in HIV/AIDS care and should include plans for ongoing support of staff in these activities.

5.2.6. Development of monitoring and evaluation systems

See specific plans related to VCCT, HBC, IC and OD

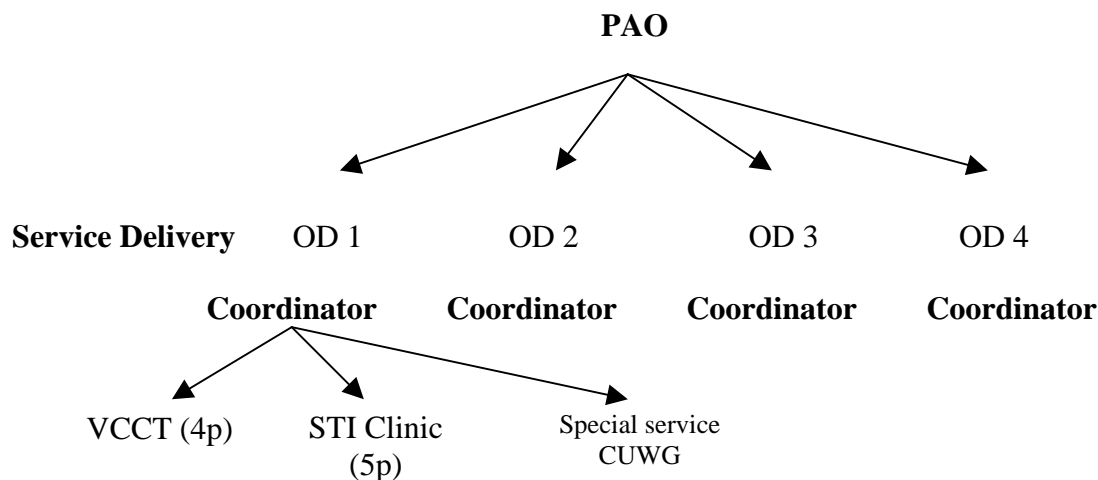
6. Key activities for planning and implementing the Continuum of Care at OD level

This section outlines the key activities that will be carried out to plan and implement the Continuum of Care at OD level.

Practical guidelines will be developed to provide practical steps for planning and implementing CoC and details on how activities could be conducted.

6.1 Restructuring of PAO and OD

In the new structure of the Provincial AIDS office and Operational District office staff responsibilities are divided into management (PAO) and implementation (OD).



The PAO team includes 4 members: the PAO manager, the assistant to PAO manager who is responsible for Continuum of Care, the IEC/BCC/100% condom use/Outreach Officer and the STI Officer.

The assistant to the PAO manager is responsible for Continuum of Care coordination, supervision of Home and Community Based Care activities, training and monitoring. An OD HIV/AIDS/STI coordinator will liaise with the assistant to PAO manager regarding continuum of care related activities. The number of implementation staff in each province depends on the number of services that exist e.g. targeted STI clinics, VCCT, Home based Care.

6.2 Planning the activities of the Continuum of Care at OD Level

6.2.1 Sensitization

- Perform initial consultations with the key groups in the OD e.g. PLHASG, HBC team, RH, OD office. Sensitize these groups to the concept and strategies of the continuum of care.

6.2.2 Situational analysis

- Conduct a situational analysis including data from the national situational analysis, mapping of current activities and workloads, needs of PLHA and capacity of local organizations.

6.2.3 Planning

- Participatory planning process involving individual and group consultations, identifying goals and priorities and resulting in the development of a Continuum of Care action plan.

6.2.4 Care packages

- Adaptation of national recommended care packages – i.e. the recommended key HIV/AIDS activities according to key players - to the OD based on situation analysis and planning process. (see annex 3)

6.2.5 Consolidated work plan

- Development of an OD Continuum of Care consolidated work plan involving the PAO, OD, RH and NGOs.

6.3 Implementing the Continuum of Care at OD Level

6.3.1 Establish OD coordination and referral mechanisms

To ensure the continuum of care is effective it is essential that strong coordination and referral mechanisms are established.

6.3.1.1 OD Continuum of Care Coordination Committee

- Establishment of a Coordination Committee at OD level as a forum to coordinate planning and encourage collaboration.
- Potential members of the group could include:
 - Director of OD
 - Director of RH
 - Director or deputy director of the Technical bureau of RH (Coordinator of HIV activities in the Referral Hospital)
 - OD HIV/AIDS/STI coordinator
 - Head of infectious diseases or medical ward of RH
 - Health care worker facilitating MMM (day care centre)
 - Head of TB ward
 - Representative of NGOs
 - Representative of HBC teams
 - Director of VCCT service
 - Representative of PLHASG
 - Representatives of CBO
 - Religious and community leaders

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 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).

6.3.1.2 Referral mechanisms

- Develop operational procedures regarding discharge and referral mechanisms between HIV/AIDS care services based on national recommendations

6.3.1.3 IEC material

- Develop an information booklet on organization of Continuum of Care in the OD including directory of key partners and providers to be disseminated among health care workers, PLHA and the community.

6.3.2 VCCT

6.3.2.1 Models of VCCT

- VCCT services should be made available at OD level. The choice of model and site for VCCT services will be based on the results of the situation analysis. It will depend on existing VCCT resources and logistical considerations.
- Diversity of VCCT services within the province or OD is likely to increase the access and the utilization of VCCT, however in the context of national expansion of VCCT it may be difficult to implement various VCCT sites within OD. Options include stand alone VCCT site located outside or inside referral hospital compound, VCCT integrated services in MMM, in clinical care settings, STI clinics, ANC, TB services.

6.3.2.2 Referral mechanisms

- Operational procedures to improve referral mechanisms to HBC, PLHASG, and IC (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.

6.3.2.3 Involvement of PLHAs

- 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.

6.3.2.4 Licensing

- All VCCT sites (public, private non for profit, private for profit) should be licensed according to MoH regulations.

6.3.2.5 Counseling

- Pre and post-test counseling is provided to each client of VCCT services. Supportive counseling for PLHAs and their family should be developed at all level of care, particularly at institutional care level. Health care workers should be provided with basic counseling skills and selected staff should receive more advanced training.
- At OD level a counseling network, facilitated by the OD HIV coordinator, could help improve counseling services through provision of "peer-support" to counselors, opportunities to share experiences and to receive updates on HIV/AIDS care, and through supportive supervision and monitoring counseling quality.
- Community counselors provide general counseling at community level. They should be aware of VCCT and understand pre/post test counseling. They could act to help link HIV care services with the community including dissemination of information and referral of PLHA.

6.3.3 Institutional Care

6.3.3.1 Finance and management

- **HIV care coordinator.** One staff member of the referral hospital should be 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.

- **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.
- **Design of HIV care services.** The location, activities, staffing and linkages of HIV care services should be defined based on national recommendations, but with input from local stakeholders, for example through the OD planning process described above. This should emphasize the importance of outpatient services in the care of PLHA and could develop the idea of a ‘care site’ or so-called Day Care Centre (or MMM) as a way of linking health care staff with community activities. Particular attention should also be paid to the way HIV care services interact with other health care programs especially TB services.

6.3.3.2 Capacity building

- **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 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 in Phnom Penh.
- **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.

6.3.3.3 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.

6.3.3.4 Other

- **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.
- **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.

6.3.4 Mondul Mith Chouy Mith (MMM)

- **Care Site.** An approach to reinforce the continuum of care and to develop a partnership between medical services, PLHA groups, the public health system and the NGOs, will be the establishment of day care centre, or MMM, attached to referral hospital. MMM located in health centers and community (pagoda) could also be an option.
- **Functions of MMM.** MMM is a place where PLHA meet together and conduct a wide range of activities, facilitated and supported by Health Care Worker. Potential activities carried out within MMM are:
 - Peer support
 - Health education for PLHA and family on self-care, home care, health promotion, nutrition and prevention of HIV transmission.
 - Individual and group counseling
 - Spiritual support including prayer and meditation with monks
 - Exercise program
 - Screening for OIs including TB
 - Health checks including treatment of simple OIs
 - ARV clinic
 - Adherence support and counseling
 - Socio-economic support
 - Income generation and occupational promotion
 - Support for orphans
 - Production and supply of traditional medicine
 - Training of peer educators
 - Training of PLHA to provide community education
 - Base for home visiting by PLHA and HCW
 - VCCT for general public

- **MMM** can act as a focus for HIV care activities in the OD.
- **Establishment of MMM.** The establishment of a successful MMM requires the following components: commitment of OD and RH directors and other key decision makers, commitment of one or two key long-term health care workers, additional benefits for PLHA of attending the MMM over the OPD, ongoing development of the partnership between PLHA and HCW in which NGOs may play a role of catalyzer. Moreover, attention should be paid to the adequate preparation of both community and HCW prior to commencement of activities. This includes community consultation and education, social marketing, training and developing coordination/networking mechanisms. For a MMM to function, HCW must have appropriate attitudes, skills and ethics. The best way for HCW to learn these is through observation of role models. The development of genuine groups that will grow and thrive should be promoted.

6.3.5 Home and Community Based Care (HCBC)

6.3.5.1 Community care initiatives for PLHA and their families

- It is possible to mobilize the community so that they can care for those affected by AIDS. Community care projects should belong to the community, not to any other organizations. AIDS committee or NGOs can initiate community response and facilitate the process, but the real implementers should be people from the community.
- Needs of PLHA in a selected village and way to address them can be identified through meetings involving village leaders, monks, nuns, pagoda committee, traditional healers, schoolteachers, health workers, PLHA and their family. These meetings could be facilitated by the Provincial AIDS secretariat.
- Examples of activities related to community care initiatives. Villagers are encouraged to visit patients and help them in their daily work. Monks provide moral support to PLHAs and their families, and pagoda committee some material support. Traditional healers participate in providing herbal treatment; free treatment are given by the health centers; teachers are advised to avoid discrimination towards children affected by HIV/AIDS whom are also encouraged not to leave schools.

6.3.5.2 Capacity building of PLHA and family for home based care

- Home care by family members could be facilitated by the provision of training in basic nursing skills including universal precautions and nutrition and with information and education on HIV/AIDS.
- PLHA can also be trained to work as village caregivers or as HBC team members.

6.3.5.3 Home visits

- The role of the HBC team should be defined according to the local situation and care packages developed at OD level. This should include the role that village caregivers can play in home care.

6.3.5.4 Health Center staff

- The role of HC staff in HBC program should be revised and focus on technical assistance, support and monitoring. The time spent in home visits by HC staff would then be reduced. Health centers should be able to provide more effective clinical management of HIV/AIDS patients that could be referred by HBC teams.

6.3.5.5 Linkages between Home and Community-based care and Institutional Care

- This is dependent on improvements in the care available in health care institutions, but can also be enhanced by specific activities such as OD coordination committee, MMM, clarification of the complementary roles of HBC and IC, practical guidelines on referrals, familiarization of IC staff with HBC and by improving discharge planning, for example by designating one staff member of the referral hospital as responsible for coordination of PLHA discharges.

6.3.6 PLHA support groups

- **Establishment of PLHA support groups.** It may be initially facilitated through MMM, NGOs and CBOs. PLHA are then most often recipients of activities arranged by NGOs or hospital staff, and care for themselves. For example, care package may include self care, counseling, home visit, income generating activities.
- **Strengthening PLHA support groups.** Strengthening PLHASG is needed to enable 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.
- PLHA may play a major role in HIV/AIDS care. However, the role of PLHA in the care of other PLHA in health care facilities 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. These roles should always be seen as optional and not imposed on PLHA.

6.3.7 Support organizations

- **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. Structure like MMM and community initiatives may help to identify socio-economic needs of PLHAs and their families and find ways to address them.

6.3.8 Linkages with prevention activities

- Prevention and care reinforce themselves. Whenever it is possible, bridges should be established between HIV/AIDS prevention and care programs or projects. The role of

VCCT services in both prevention and care is well acknowledged. Prevention of mother to child transmission of HIV programs should be linked with care programs.

6.4 Monitoring and evaluation of the Continuum of Care at OD Level

- **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.

ANNEX 1

Current strategies and guidelines relevant to the continuum of care

1 Voluntary confidential counseling and testing services

1.1 Strategy

The MoH Strategic Plan 2001-05 contains 8 strategic goals:

- Develop a policy, strategy and guidelines
- Develop and disseminate a curriculum and training materials for counseling
- Provide sufficient resources for operation of VTC services
- Expand primary VTC services
- Establish secondary VTC services linked with primary VTC services
- Build the capacity of personnel working in VTC services
- Enforce the guidelines and protocols for VTC in public health services
- Support the establishment of monitoring and supervision of VTC services

Similar aims are included in the Multi-sectoral Strategic Plan 2001-05.

1.2 Guidelines

Written in 2001. These specify procedures for pre- and post- test counseling including ensuring confidentiality, a testing protocol and the recognition of rapid tests as acceptable.

2 PLHA support groups

2.1 Strategy

The MoH Strategic Plan 2001-05 includes support to networks and associations of PLHA as a mechanism to improve utilization of AIDS care services. The Multi-sectoral Strategic Plan 2001-05 lists the establishment of networks of PLHA self-support groups as an objective.

2.2 Guidelines

There are no guidelines for PLHA support groups.

3 Health care institutions

3.1 Strategy

The MoH Strategic Plan 2001-05 contains 6 strategic goals:

- Ensure drugs for OIs are included in the essential drug list and are available
- Disseminate national case management guidelines and protocols

- Ensure training of public (and where possible private) health care workers in the use of the national guidelines
- Establish at all levels a National AIDS Care policy, strategy and guidelines
- Support networks and associations of PLHA to improve utilization of AIDS care services
- Develop guidelines for avoiding discrimination, stigmatization and isolation of PLHA in the health sector

The Multi-sectoral Strategic Plan 2001-05 includes the following objectives: support for strengthening of health services, expanded training, support and supervision of HCWs, ensuring OI drug supply, and introduction of quality improvement programs.

3.2 Guidelines

There are currently no guidelines for the coordination of institutional care.

4 Home based care teams

4.1 Strategy

The MoH Strategic Plan 2001-05 contains 7 strategic goals

- Support the expansion of the HBC program nationwide
- Ensure that HBC guidelines are disseminated to all HBC team members
- Develop a training curriculum and materials for HBC team members
- Ensure HBC members are properly trained
- Ensure the supply of drug kits and other supplies for HBC program
- Establish coordination mechanisms for implementation of the HBC program
- Support establishment of monitoring and supervision for HBC program at municipal and provincial levels

The Multi-sectoral Strategic Plan 2001-05 includes the following objectives: involvement of the community in HBC, strengthen and expand HBC, support human resource development and the introduction of quality improvement programs.

4.2 Guidelines

- Clinical guidelines were written in 1999. These include guiding principles, management of asymptomatic HIV infection and management of common symptoms.
- Guidelines for the implementation of HBC programs were written in 2001. These define the strategy of the program, management structure and roles and responsibilities.

5 Support organizations

5.1 Strategy

The MoH Strategic Plan 2001-05 does not include any specific goals related to support organisations. The Multi-Sectoral Strategic Plan 2001-05 includes as objectives the strengthening and expansion of support programs and the provision of social welfare support for children affected by HIV/AIDS.

5.2 Guidelines

There are no national guidelines for support organizations.

6 HIV diagnosis

See 1 Voluntary confidential counseling and testing services

7 Counseling

7.1 Strategy

The MoH Strategic Plan 2001-05 and the Multi-sectoral Strategic Plan 2001-05 do not include strategies for HIV counseling apart from those relevant to VCCT as detailed above.

7.2 Guidelines

National guidelines exist for counseling in the setting of HIV diagnosis, but not at other parts of the continuum of care.

8 Support

See 5 Support Organizations, 2 PLHA Support Groups and 4 HBC

9 Opportunistic infection prophylaxis

9.1 Strategy

The MoH Strategic Plan 2001-05 contains a strategic goal that drugs for opportunistic infections are included in the essential drugs list and are available for HIV/AIDS care services. The Multi-sectoral Strategic Plan 2001-05 does not contain any objectives related to opportunistic infection prophylaxis.

9.2 Guidelines

There are no national guidelines for opportunistic infection prophylaxis. Drugs used for opportunistic infection prophylaxis have not been approved for this use.

10 Opportunistic infection treatment

10.1 Strategy

The MoH Strategic Plan 2001-05 contains 3 relevant strategic goals:

- Ensure drugs for OIs are included in the essential drug list and are available
- Disseminate national case management guidelines and protocols

- Ensure training of public (and where possible private) health care workers in the use of the national guidelines

10.2 Guidelines

- Guidelines on the clinical management of HIV infection in adults and children were written in 1999. These provide protocols for the management of specific symptoms as well as advice on recognition of HIV infection, laboratory diagnosis of HIV and management of asymptomatic HIV infected people.
- A Cambodian AIDS case definition has been written, but has not yet been approved by the MoH

11 Antiretroviral therapy

11.1 Strategy

The MoH Strategic Plan 2001-05 does not include any specific goals related to antiretroviral medications outside of PMTCT programs. The Multi-Sectoral Strategic Plan 2001-05 includes as objectives the distribution of ARV guidelines, piloting of ARV treatment, monitoring the results of ARV pilot programs and consideration of expansion of ARV programs.

11.2 Guidelines

Guidelines for the use of ARVs in Cambodia were written in 2001. They are based on a WHO document and have not been adapted to local circumstances.

12 TB/HIV

12.1 Strategy

The MoH Strategic Plan 2001-05 and the Multi-sectoral Strategic Plan 2001-05 do not include strategies for TB/HIV apart from those relevant to IC and HBC as detailed above.

12.2 Guidelines

A TB/HIV Framework was written in August 2002. This provides the outline for the coordination of HIV and TB services.

13 PMTCT

13.1 Strategy

The MoH Strategic Plan 2001-05 contains 6 strategic goals:

- Train health staff to include counseling on HIV/AIDS in mothers and children
- Build VCCT into antenatal services where other care and support services are available
- Introduce family counseling and shared confidentiality
- Advise mothers about the benefits of breastfeeding

- Provide on-going counseling and care for children born to HIV infected mothers, where other care and support services are available
- Introduce prophylactic means for the prevention of vertical transmission in referral services where other care and support services are available

The Multi-sectoral Strategic Plan 2001-05 contains 7 actions:

- Share national PMTCT policy with all relevant parties
- Develop mechanisms to ensure that national guidelines on PMTCT are followed
- Review PMTCT guidelines periodically to ensure that adequate standards are being maintained (in relation to new information available)
- Integrate counseling and testing facilities to ANC clinics and place emphasis on strengthening the counseling skills of staff
- Ensure adequate equipment and materials are in place
- Ensure security of anti-retroviral therapy supply
- Expand clinical ante-natal care in all provinces and cities

13.2 Guidelines

National PMTCT guidelines have been written.

14 Palliative care

14.1 Strategy

The MoH Strategic Plan 201-05 and the Multi-Sectoral Strategic Plan 2001-05 do not include any specific goals related to palliative care beyond those already stated for HBC and institutional care.

14.2 Guidelines

There are no national guidelines for palliative care apart from the guidelines developed for clinical care and for home based care.

15 Universal precautions and post-exposure prophylaxis

15.1 Strategy

The MoH Strategic Plan 2001-05 contains 4 strategic goals:

- Develop and disseminate national guidelines on UP for all health care settings
- Develop a practical manual for UP
- Ensure health care providers receive appropriate training in UP, especially in HIV/AIDS care settings
- Monitor the application of UP in all health care settings

The Multi-sectoral Strategic Plan 2001-05 does not contain any objective related to UP.

15.2 Guidelines

National guidelines for UP were written in ?? National Guidelines for PEP have not been developed.

16 Planning, coordination and referral

16.1 Strategy

The MoH Strategic Plan 2001-05 contains 4 relevant strategic goals:

- Develop overall strategic goals and plans for NCHADS
- Improve the integration between HIV/AIDS and TB, MCH, NCHP and other MoH programs
- Provision of technical support by NCHADS to PHDs in the development of provincial strategies
- Liaise with other agencies, NGOs, the business sectors, donors, UN etc for the coordination of HIV-related activities

The Multi-sectoral Strategic Plan 2001-05 includes strengthening of coordination mechanisms, decentralisation and strengthening of local structures and improving referral networks as objectives.

16.2 Guidelines

There are no national guidelines for coordination of the continuum of care

17 Monitoring and evaluation

17.1 Strategy

The MoH Strategic Plan 2001-05 contains 1 relevant strategic goal:

- Develop a monitoring system for the work of NCHADS and partners

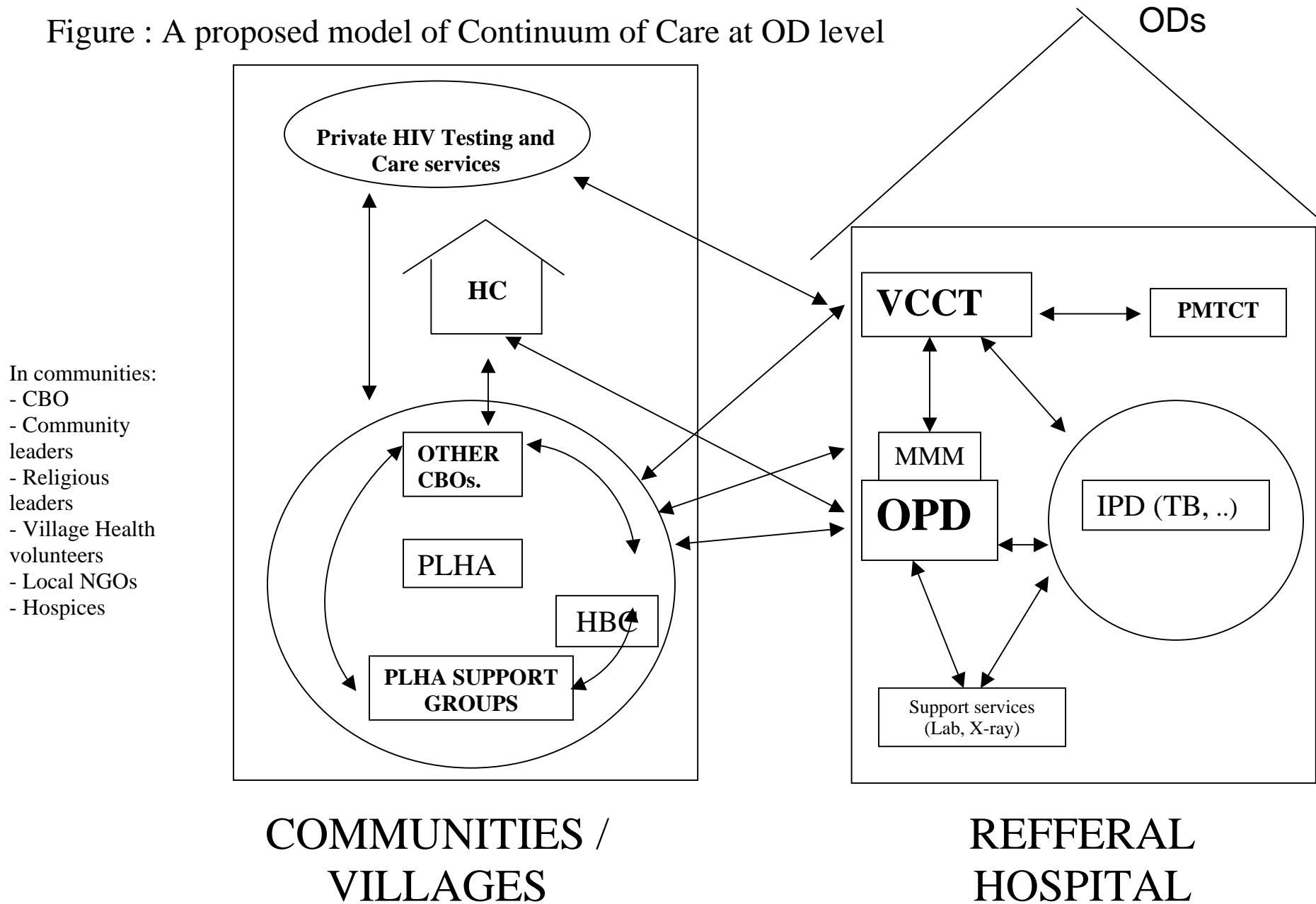
The Multi-sectoral Strategic Plan 2001-05 lists as an objective the development and expansion of national capacity for monitoring and evaluating of programs and their impact. Specific actions to achieve this objective include the conduct of an inventory of existing capacity, training, development of indicators, seeking partners for a network and the provision of adequate resources.

17.2 Guidelines

There are no national guidelines for monitoring and evaluation of the continuum of care.

ANNEX 2

Figure : A proposed model of Continuum of Care at OD level



ANNEX 3

Example of cares packages (activities) and role of key players - summary table

Activity	Role of Key Players							
	Provincial Hosp	Referral Hospital	MMM	Health Centre	HBC team	PLHA group	Community and other sector	Family
VCCT								
Management of OI								
Prevention of OI								
Screening and treatment of TB								
Palliative care								
ARV treatment								
Universal precaution								
PMTCT								
Supportive counseling								
Socio-economic support								
Support for children affected by HIV/AIDS								
Support for care givers								
IEC/health promotion								
Nutrition								