



Cambodia Cares

Implementing a Continuum of Care for PLHA, including ART in Moug Russey, Cambodia

Documentation of an experience in a resource constrained setting



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Table of Acronyms and Abbreviations

AD	Administrative District
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
CBO	Community-Based Organization
CHBC	Community and Home-Based Care
CoC	Continuum of Care
CoC-CC	Continuum of Care Coordination Committee
CR	Cambodian Riel
DOTS	Directly Observed Therapy, Short-Course
FBC	Facility Based Care
FHI	Family Health International
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HBC	Home-Based Care
HC	Health Center
HIV	Human Immune Deficiency Virus
INGO	International Non-Governmental Organization
IPT	Isoniazid Preventive Therapy
KHANA	Khmer HIV/AIDS NGO Alliance
LNGO	Local Non-Governmental Organization
MoH	Ministry of Health
MMM	Mondul Mith Chouy Mith (Friends Help Friends Center)
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	Non-Governmental Organization
OD	Operational District (one health OD comprises 2-4 administrative districts)
OFD	Operational Framework Document
OI	Opportunistic Infection
OPD	Outpatient Department
PAO	Provincial AIDS Office
PCP	Pneumocystis Carinii Pneumonia
PHD	Provincial Health Department
PLHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RACHA	Reproductive and Child Health Alliance
RH	Referral Hospital
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB/HIV	The relationship between the two diseases and the need to link care and treatment.
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
UP	Universal Precautions
USAID	United States Agency for International Development
USD	United States Dollars
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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Foreword

The Cambodian National Center for HIV/AIDS, Dermatology and STD (NCHADS), the Ministry of Health, and Family Health International are pleased to share with you “Cambodia Cares”, the document describing the efforts to provide care and treatment for people living with HIV/AIDS (PLHA) in Cambodia.

This document is written based on the experience of the Moug Russey Operational District in Battambang Province.

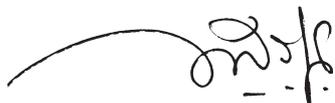
We are very grateful to the various technical trainers and all the staff of Moug Russey Operational District, particularly personnel of the Moug Russey Referral Hospital, staff of the Battambang Provincial Health Department, community based organizations and NGO colleagues, international organizations, local authorities, community members, PLHA and all the patients that make continuum of care for People Living with HIV/AIDS a reality in Cambodia.

Special appreciation goes to the staff of NGOs working in Moug Russey – Family Health International (FHI), the Reproductive and Child Health Association (RACHA), the Khmer Rural Development Association (KRDA) and the Cambodian Red Cross (CRC).

We thank Robert McPherson who spent time in Moug Russey and drafted this vivid report and Pratin Dharmarak who edited the document.

The Moug Russey project greatly benefited from the strong support of USAID, UNICEF, and the ADB.

We hope that this report will be a source of inspiration and will be useful to those interested in ways to develop HIV care and treatment program in a resource constrained setting.



Dr. Mean Chhi Vun

Director, NCHADS
Ministry of Health



Dr. Chawalit Natpratan

Country Director
Family Health International

Background

Before, when I was thin, the children in my village used to call me AIDS-man. But now that I have gained weight and look normal, they don't tease me anymore

Mr. Nun, HIV/AIDS client, Moug Russey District, Battambang Province

Introduction

Mr. Nun (a pseudonym) is one of many Cambodians who suffer from AIDS. What is unique about Mr. Nun is that his physical condition is better now than it was last year and that his improvement happened after receiving HIV care and treatment from a local hospital. Mr. Nun is the beneficiary of a new collaborative initiative in Moug Russey Operational District (OD) between the district health services, the National Center for HIV/AIDS, Dermatology and STD (NCHADS), communities, people living with HIV/AIDS (PLHA), and international and local non-government organizations. These partners have worked together to improve health services for PLHA by instituting a continuum of care (CoC) for HIV/AIDS clients that provides complementary health care services in both the hospital as well as in the clients' homes. In less than six months, with a strategic set of inputs, this partnership has implemented specially designed services in the Moug Russey Referral Hospital (RH) that prevent HIV infection, provide testing and counseling for suspected HIV cases, and make available diagnostic and treatment services for PLHA suffering from HIV-related illnesses such as opportunistic infections (OIs) and TB, including the provision of INH preventive therapy (IPT) for PLHA. These services are integrated within the referral hospital system and fully linked with community and home-based care provided through partnerships between community groups, local NGOs (LNGOs), and health center staff. The best news is that NCHADS has made ARV available for 150 PLHA in Moug Russey OD, beginning in June 2004.

The Moug Russey experience has shown that dedicated partners, working together, can make major strides in a relatively short time in

instituting new services as well as improving existing services as they develop a continuum of care for PLHA in a resource-poor setting. This document chronicles the successes achieved and the lessons learned from the early stages of implementing a CoC for PLHA in Moug Russey. It also provides guidance to individuals and organizations that plan to implement CoC for PLHA elsewhere in Cambodia or the region.

The status of the HIV/AIDS epidemic in Cambodia

The HIV/AIDS epidemic in Cambodia is often described as having reached a mature stage. The rapid infection of the highly susceptible population — and the initial surge in HIV prevalence — has peaked, and the annual number of deaths among PLHA now exceeds the annual number of newly infected individuals. As evidence of this, the prevalence of HIV infection among the general adult population aged 15-49 years has declined from 3.3 percent in 1997 to 2.6 percent in 2002¹. New infections, estimated to number approximately 7,300² annually, are divided among three groups: 1) individuals practicing high-risk behaviors, such as commercial sex workers and their clients; 2) housewives infected by their husbands; and 3) newborns infected through mother-to-child transmission. The relative contribution of these three transmission modes to the total number of infections is estimated to be approximately 20, 50 and 30 percent, respectively³. There are an estimated 157,000 PLHA in Cambodia, and approximately 22,000 individuals are expected to develop serious AIDS related illnesses in 2004. Although continued efforts to prevent the transmission of the virus are crucial to maintaining the current trend in decreasing HIV prevalence, the increasingly large numbers of Cambodians suffering from AIDS-related illnesses calls for a coordinated response to provide them with care, treatment and support.

What is a continuum of care for PLHA?

The term Continuum of Care for PLHA in this document refers to provision of comprehensive, continuing, and multi-level of care. The Guidelines for an Operational Framework for Continuum of Care in Cambodia were developed and approved by the Ministry of Health in early

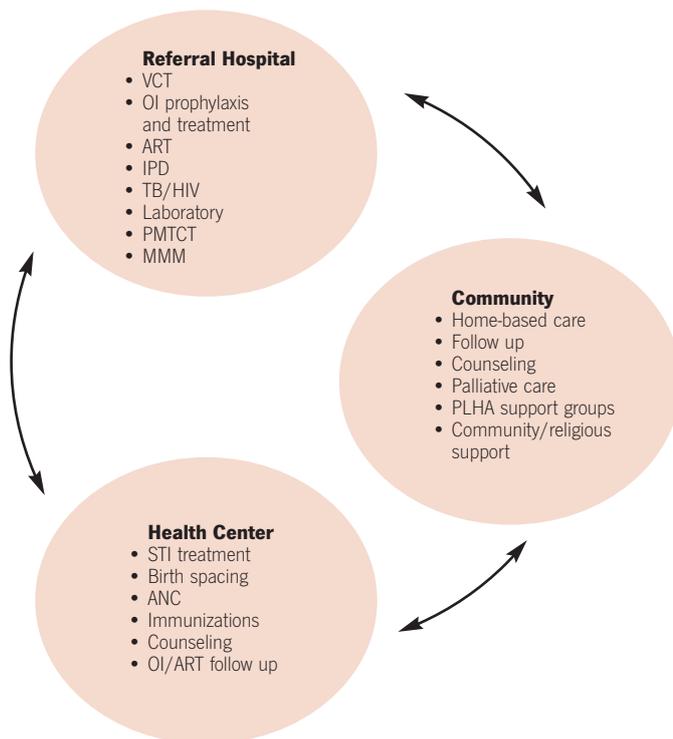
¹ HIV Sentinel Survey Report. NCHADS/MoH. 2002.

² Projections for HIV/AIDS in Cambodia: 2000-2010. The Cambodia Working Group on HIV/AIDS Projection. November 2002.

³ Ibid

2003. The comprehensive package of care includes VCT, clinical care for OIs, ART, TB/HIV care, PMTCT and psychosocial support. The care services take place from the referral hospital (facility based) to health centers and home-based care providers at community level.

Figure 1: Continuum of care for PLHA



Components of care in CoC

The components of a fully-developed CoC for PLHA consist of the range of health care services that are provided in one or more of a continuum of sites. These services generally include Voluntary Counseling and Testing for HIV (VCT), diagnosis and management of opportunistic infections (OIs), provision of anti-retroviral therapy (ART), diagnosis, treatment and prevention of tuberculosis among PLHA (TB/HIV), prevention of mother-to-child transmission (PMTCT), and coordinated home-based services that focus on follow-up care, counseling, and palliative care. Other important components of an operational framework to provide CoC for PLHA include the functional elements of a health system or facility that require special attention in order to support the effective implementation of a CoC for HIV/AIDS in Cambodia. These elements include referral systems, medical recording and

information systems, financing mechanisms, systems to procure and manage drugs and supplies, laboratory services, and physical infrastructure.

Continuum of care for PLHA in Cambodia

The evolution of CoC in Cambodia

The need to provide care and support to PLHA in Cambodia emerged in the mid-1990s, at a time when the Cambodian public health services were being reestablished following decades of civil conflict. In the late 1990s the provision of care to PLHA through government health facilities was generally felt to be requiring a great deal of capacity building in the public health sector. Care and support to PLHA was initially provided by non-governmental organizations (NGOs) through home-based care (HBC) in partnership with NCHADS and health center staff and initially supported by the WHO and DfID. The HBC program later expanded and supported by other donors including the MoH/World Bank, USAID, and the Global Fund (GFATM). Although the MoH had identified the three pillars of care and support for PLHA to be hospice-based care, HBC, and facility based care (FBC), most health care providers in government health facilities were not fully trained to manage the medical conditions suffered by PLHA. Inability of care providers to diagnose and treat the new diseases has also resulted in AIDS patients being turned away and is seen as discrimination in health care settings. A growing realization of the need to strengthen facility based care (FBC) to provide early diagnosis and treatment for PLHA to reduce morbidity and mortality and to improve the quality of life for adults and children living with HIV/AIDS led to a shift in MoH policy at end of 2002. The new policy placed a stronger emphasis on the development of a continuum of care (CoC) for PLHA that includes both FBC as well as HBC. NCHADS developed and launched an operational framework for a CoC for PLHA⁴ in May 2003. This document is hereafter referred to as the *Operational Framework Document* (OFD). Government support for the implementation of CoC is strong — evidence of this support is found in the increase in budget for drugs to treat opportunistic infection from 100,000 USD in the fiscal year 2003 to 600,000 USD in the

⁴ Continuum of Care for People Living With HIV/AIDS: Operational Framework. NCHADS/MoH. First Edition, April 2003.

fiscal year 2004. The potential of the government health system to move forward in the provision of HIV/AIDS care and support services is likewise demonstrated through the expansion of VCT services from 13 to 58 facilities within the last two years.

Through early 2004 two major models of HIV clinical care have been implemented in Cambodia. In the first, international organizations have emphasized providing antiretroviral therapy to PLHA as soon as possible, thus limited efforts have been made to strengthen the public health system.

The second model has emphasized working through the public health system to strengthen FBC and provide a broad set of care and support services through partnerships between the operational district, health facilities, NGOs, communities and international organizations (IOs). Under this model, ART is provided when many care components of CoC have been sufficiently well established and functioning to provide initial care and treatment prior to the provision of ART. **The effort in Moug Russey is a leading example of this model.**

The role of NCHADS in supporting these efforts includes coordinating with all partners, resource mobilization, and developing guidelines, strategies, and frameworks. NCHADS also manages significant amount of donor and national budget funding in support of its Strategic Plan.

Introducing a CoC for PLHA in Moug Russey

For a resource-poor country like Cambodia, implementation of the continuum of care for PLHA seemed at first like a dream

Dr. Mean-Chhi Vun, Director, NCHADS

The decision to introduce and implement a CoC for PLHA in Moug Russey developed initially out of a strong partnership between NCHADS and Family Health International in Cambodia (FHI), an international non-governmental organization (INGO) supported by the United States Agency for International Development (USAID). NCHADS and FHI held discussions in late 2002,

during the development of the operational framework for CoC, regarding how and where the two organizations might collaborate to operationalize the CoC framework at the OD level. FHI was interested in forming a partnership with government health facilities at the OD level and emphasizing the development of facility based care for PLHA. Both NCHADS and FHI were most concerned with determining the extent to which different aspects of care for PLHA could be provided successfully through the referral hospital (RH) — the highest level government health facility in the operational district. Linking different aspects of care across the institution-community-home continuum through collaboration with different types of organizations was also a primary focus of the planning effort. This approach was based on the principle that the delivery of ART — the ultimate objective of the CoC — is most effective when it is delivered as one component of a comprehensive set of prevention, care and support services for PLHA. In following this approach, the Moug Russey CoC is one of relatively few examples in developing countries of programs that have integrated the delivery of ART into a continuum of care services for PLHA.

Government, international organizations and non-government partners, and FHI conducted intensive assessment and planning activities for the Moug Russey (MR) during the first quarter of 2003. Implementation activities, in particular a series of various trainings for hospital staff began almost immediately following the official endorsement of the Operational Framework for the CoC by the Minister of Health in May 2003. Key components of the CoC, such as VCT, OI management, Mondul Mith Chouy Mith (MMM; a monthly meeting of PLHA on the grounds of the referral hospital), TB/HIV, and PMTCT commenced in August, September, and October of 2003, and ART was provided to the first client in June 2004.

The implementation of the CoC in Moug Russey is still in its initial stages and substantial work remains to consolidate achievements. Nonetheless, at this early point in the development of the continuum of care for PLHA in Cambodia, NCHADS and its partners feel that it is important to document the processes that have been followed in MR and to publicize the achievements and lessons learned. What has become clear in

Moug Russey is that the Cambodian government health services, given adequate support, *are* capable of providing quality institutional care and support to PLHA — including the provision of ART — and that PLHA will make use of these services if they are perceived to be of high quality and are provided in an environment free of stigma and discrimination.

Principles of CoC in Moug Russey

The principles that have been followed in the design and implementation of the CoC in Moug Russey have been drawn from the OFD, international standards of care and support, and the context surrounding the implementation of a CoC for PLHA in rural Cambodia. These principles can be summarized as follows:

1. The CoC should be based on a respect for human rights and address issues of stigma and discrimination, including self-stigmatization by PLHA.
2. The CoC should have a client-centered approach that focuses on expressed needs of PLHA and their families and maximizes the role of PLHA in the development and implementation of the CoC.
3. The community should be involved in the planning and development of care and support in order to maximize linkages among public, private, non-profit and traditional partners.
4. The CoC should include activities and services that facilitate early diagnosis and treatment of infection.
5. The CoC should include both preventive as well as care and support services in order to allow for effective synergies to develop between these two sets of activities.
6. Services provided through the CoC should address the needs experienced by HIV suspects, clients, and their family members at different stages of HIV infection.
7. The CoC should include appropriate referral systems between components.
8. Barriers that limit access of PLHA to high-quality services, such as PLHA's lack of funds to pay for services or health care personnel's lack of motivation to provide high-quality care, should be removed or minimized.
9. The CoC should support strategies that maximize treatment adherence for PLHA.

10. Mechanisms should be developed that support effective coordination between CoC partners and services.
11. PLHA should receive health care from integrated services (i.e. services used by non-PLHA as well) to the extent possible, both to maximize the efficiency of health services as well as to reduce stigma.

Purpose of document

What follows is an account of the early stages of a success story. While this document is a case study of a flourishing project, the planning and implementation of a CoC for PLHA in Moug Russey is presented in a manner that is intended to be pragmatic and useful to all levels of stakeholders who will implement CoC in other ODs in Cambodia, as well as in locales outside of Cambodia. This document also aims to motivate stakeholders to implement CoC for PLHA and build confidence among concerned individuals and organizations that it *can* be done.

The document is organized according to the classic programming framework. Chapter Two describes the assessment process that was used in Moug Russey, while the subsequent chapter catalogues the planning activities that were undertaken. Chapter Four documents the implementation of the CoC and Chapter Five notes principle achievements and lessons learned. The final chapter looks ahead and discusses plans and directions for the future in Moug Russey.

Assessment

This chapter begins with the presentation of a brief description of Moug Russey Operational District (OD). This portrayal is followed by an outline of the process that was used to select Moug Russey as a site for CoC, establish an initial operational framework, and conduct an assessment of needs at both the referral hospital as well as in the community.

Description of Moug Russey Operational District



An operational district (OD) is a group of two or more administrative districts (ADs) that has been formed by the MoH for the purpose of delivering health services more effectively. Moug Russey, one of five ODs in Battambang Province, is located in northwestern Cambodia. The OD, which is made up of two administrative districts — Moug Russey and Koh Kralor — has an area of 2,879.3 square kilometers. The population of 167,930 inhabitants lives in 17 communes that contain 160 villages. The most highly populated areas of Moug Russey lie close to National Highway 5 which runs through the middle of the OD.

There are a variety of health facilities in Moug Russey OD. The Moug Russey Referral Hospital (RH) is located in the town of Moug Russey. The RH, which currently has 49 staff members, is an inpatient facility that has been classified as *CPA++* (complimentary package of activities — level 2).

There is a health center (HC) that is located on the grounds of the RH; the HC provides basic outpatient services and health promotion and disease prevention activities, including reproductive health services such as birth spacing and antenatal care, and vaccination for children. When necessary the outpatient clinic refers patients to other services or for inpatient admission at the referral hospital. There are 12 other HCs located throughout the OD, nine of which are classified as *MPA facilities* (minimum package of activities) and three of which are *commune clinics*.

Background, site selection and assessment

USAID/Cambodia provided funds to Family Health International under the IMPACT Cooperative Agreement to implement a major portion of HIV/AIDS strategies in 1998. In late 2000, USAID designated Cambodia as the only “rapid scale-up” country in Asia. “Rapid scale-up” countries were designated to receive significant increases in resources to achieve measurable impact within a relatively short timeframe (a few years). Targets to be achieved include the scale-up of coverage for prevention interventions among vulnerable populations and helping local institutions to provide basic care and support services to HIV infected persons and to provide community support services to children affected by AIDS.

In January 2002 USAID/Cambodia released the Interim PHN Strategy 2002-2005 to address this new status. To operationalize the USAID/PHN Strategy, USAID/Cambodia undertook an extensive joint planning exercise with its main health partner agencies in Cambodia. The process identified the key activities to be accomplished and prioritized the geographic focus areas for each agency. As a result, 13 ODs across 7 provinces have been selected by USAID and implementing partners in consultation with the Ministry of Health based on epidemiological data, population density, and past program history.

With prior experience working in Battambang Province supporting projects for children affected by AIDS, FHI understands the extent to which the province has been severely affected by HIV/AIDS

and therefore chose Battambang to be its focal province for the establishment of a comprehensive prevention-to-care and treatment continuum within a 2003-2005 program of HIV/AIDS care and treatment.

FHI's plan, approved by USAID, is to work in partnership with the Ministry of Health to implement HIV care and treatment in all four ODs of Battambang Province – either through direct support or through other partner agencies. FHI decided to provide direct technical and operational support to three ODs: Moung Russey, Battambang, and Thmor Koul, and works in partnership with Catholic Relief Services (CRS) in Sampov Loun OD with similar activities. FHI signed an MoU with NCHADS for the overall three year HIV prevention and care collaboration in October 2002.

The selection of Moung Russey Referral Hospital and OD as the first to implement the CoC was based on the fact that there are a high number of PLHA being served by home-based care teams run by local NGOs. The various services of the medium-sized referral hospital are contained in a small compound with basic functioning physical facilities including a laboratory. The hospital, which is located in an easily accessible area for patients, also has a track record of working in collaboration with international organizations.

It was clear to the Provincial Health Department (PHD), FHI, and NCHADS, that the development of an operational and support management structure was a prerequisite to beginning the assessment process in Moung Russey. This process began in November 2002 with the establishment of a working relationship between the three parties – the Provincial AIDS Office (PAO), the Provincial Tuberculosis Office, and the Operational District. The initial steps included a meeting between these groups to discuss the role of the PHD, FHI aims and objectives, and the establishment of a provincial level technical support team (comprised of the PHD Deputy Director, the Chief of the Technical Bureau, the PAO Manager, the Provincial TB Manager, and FHI personnel). The PHD wanted to use the introduction of the CoC as an opportunity to model a decentralized decision-making process, and therefore limited its role throughout the implementation of the CoC to helping select

members for the CoC Coordination Committee, locating and mobilizing resources, supporting and motivating those responsible for implementing the CoC at the OD level, and monitoring the intervention. The identification of an HIV/AIDS/STI Coordinator at the OD level in January 2003 was a final key step in the initial stage of developing an operational structure.

FHI opened its field office in Battambang town in January 2003 with staff to support and facilitate activities of the PHD and ODs. FHI staff both in Battambang and in Phnom Penh work closely and always consult with NCHADS officials to jointly address operational difficulties or needs that may arise as the program progresses.

Analyzing needs in Moug Russey Referral Hospital

Partnerships and collaboration played a major role in the assessment of the capacity of the RH to support a CoC for PLHA. The needs analysis (NA) was conducted in February 2003 by FHI, NCHADS, PHD and OD/RH partners. The NA encompassed services provided in the RH as well as those provided in the health center⁵ (HC) that is located on the grounds of the RH. The assessment focused on the areas of managerial systems (structure, organization, cooperation), human resources (staff capacity and skill), cross-cutting services (lab, x-ray, drug supply, referral systems) and training. Key recommendations emerging from the assessment are presented in the box below.

Key recommendations presented to Moug Russey OD and RH for implementing CoC

- Strengthen coordination by conducting regular meetings and appointing HIV/AIDS Coordinator.
- Overcome staffing shortages by mobilizing staff members to cover two or more related positions.
- Basic training in HIV/AIDS is needed for all OD and RH staff, from physicians to custodians.
- Selected staff members must be trained in HIV counseling.
- Medical staff require technical training in a variety of areas.
- Laboratory staff need training, laboratory equipment needs to be maintained, and a reliable supply of reagents and other equipment as well as external quality control mechanisms are needed.
- The Central Medical Store must provide a reliable supply of essential drugs needed by PLHA.
- The RH information system should be revised so as to generate CoC-related statistics.

was chaired by the district governor to improve the coordination of NGOs, IOs, and local government with regard to CoC. Community level activities and resources in the OD were mapped during this and subsequent meetings. These initial meetings also provided an ideal forum for coordination and the dissemination of information regarding program aims and objectives to the local authorities (from districts, communes and villages), community members, government health workers, religious leaders, NGOs and IOs — and through them, to PLHA and their families.

Key steps in the assessment phase

A summary of the principal steps in the assessment of Moug Russey OD for development of CoC are listed below:

1. Selection of OD based on criteria such as need, health system capacity, commitment of authorities, and support from LNGOs, will increase the potential for success.
2. Development of an operational and support structure at the provincial and OD level that clarified the role of the PHD as providing technical support and monitoring, and placed operational control at the level of the OD.
3. Conduct of facility assessments of the RH and HCs in functional areas that included management, human resources, cross-cutting services and training.
4. Resource mapping at the community level to coordinate partners and manage resources.

Analyzing needs in the community

Moug Russey was selected for the implementation of CoC based, in part, on the active efforts of communities, LNGOs and international organizations (IOs) to provide HBC to PLHA. The assessment of community level needs therefore addressed issues of coordination and cataloguing of resources in order to avoid overlap of activities. As an initial step, FHI facilitated a district coordination meeting which

⁵ Services provided by the HC include birth spacing, STI management (through a syndromic approach), general medical consultation, antenatal care, and basic child care including immunizations.

Planning and Preparation

The Provincial Health Department plays a supportive role in the implementation of the CoC in Moung Russey. We are using this effort as a tool to implement our policy of decentralization

Kuy Sok, M.D., Deputy Director, PHD, Battambang Province

The following two chapters describe the planning and implementation phases of the project. Planning and implementation are integrally related and often occur simultaneously — any division of the two for reporting purposes is somewhat arbitrary. In the text below *planning* is defined as covering topics such as service location, human resources, training, protocols, physical structure, laboratory requirements, job-related tools, and other forms of support.

This chapter describes the overall planning process supported by FHI and how it was used to engage and educate stakeholders, plan for specific services including antiretroviral therapy at the RH as well as cross-cutting components of hospital management, and strengthen community and home-based care while simultaneously linking it to facility based care.

FHI's mission in Cambodia is to strengthen the capacity of Cambodians both in the public and NGO sectors to prevent and mitigate the impact of HIV/AIDS. FHI sees its role as an enabler and facilitator in working with partner organizations towards achieving clear goals and objectives. The role of FHI in the entire process in Moung Russey has been the provision of technical and operational assistance – be it technical training, facility improvement, coordination, negotiation, and resource mobilization among various donors and stakeholders. Staffed by personnel with expertise in HIV care and treatment in developing countries and capacity building experience in the public health sector in Cambodia, FHI understands difficulties faced by local government workers and works with them to improve the situation.

The planning process: engaging, educating and motivating stakeholders

Planning for the CoC in Moung Russey included important goals outside of developing methods and activities to implement the CoC. The planning process also sought to directly address barriers that can threaten the effective implementation of a CoC for PLHA in Cambodia such as: a tradition of centralized, top-down planning by health system authorities; formal health providers' perception that they have limited responsibility to provide care to PLHA, and; discrimination towards PLHA by both health providers and community members.

The planning process was participatory in nature with broad involvement of stakeholders, including PLHA. The CoC Coordination Committee (described in more detail below), with representation which ranges from community leaders such as the district governor to People Living with HIV/AIDS, is emblematic of this approach. The inclusion of community leaders, technical experts, health providers, and clients in such an important body emphasizes the broad nature of the response that is required while establishing CoC, and has contributed to breaking down stereotypes about the role of the client in health services in Moung Russey. It also has brought PLHA — their problems and their needs — directly in front of decision-makers. PLHA have not taken part in planning the CoC just “for show”; their participation in all facets of planning as well as implementation represents the efforts of the project to both introduce the client perspective as well as to increase understanding and interaction with PLHA thus reducing discrimination towards them.

It is clear that much of the historical reluctance of local authorities, health system officials, and health care providers in Cambodia to become involved with providing care and support for PLHA stems from their lack of knowledge and skills regarding how to do so. For this reason, planning for the CoC in Moung Russey has included a variety of workshops, trainings, meetings, and study trips. Planning for the CoC in Moung Russey has been as much about educating, engaging, and motivating stakeholders as about scheduling activities for the future.

The PHD is a key partner in planning for the establishment of the CoC. The PHD has relatively few financial resources allocated at present for CoC (but does have human resources) and a clearly recognized mandate to provide leadership in the initial stages of a new effort. After an initially central role in developing the framework for planning and implementation, the PHD moved into the background and promoted decentralized decision-making at the periphery of the health system while participating selectively in planning and supervision, generally through the Provincial AIDS Office (PAO). The PHD also focused on building staff commitment throughout the OD health system. While FHI does not provide salary supplement to government workers, a form of motivation or encouragement for the health personnel involved in service provision has occurred through various technical trainings, study trips, and periodic on-the-job training during which a small per diem is given to participants.

The governors of Moug Russey and Koh Kralor districts, as the leading elected officials in the project area, likewise play key leadership roles in planning and implementing the project. Their representation on, and participation in key activities such as the CoC Coordination Committee has proven to be crucial to show communities that the project has the support of all branches of government. Commune leaders play a similarly important role at the community level. The most important leadership from the local health system comes from OD and RH officials who, due to staffing shortages, work together as a seamless team to plan project activities and provide services.

Forming the CoC Coordination Committee

The CoC Coordination Committee (CoC-CC) has emerged as the central body involved in planning and implementing CoC in Moug Russey. Beyond its importance as a representative planning group, the CoC-CC is where stereotypes are shattered and new visions are created. For example, the CoC-CC was the forum where health care providers from the hospital sat down around the same table with representatives from community based organizations that provide care to PLHA in order to discuss the role of the RH in providing care to PLHA — thereby putting this topic on the table for the first time.

The CoC-CC has a diverse membership — groups working with and providing support to the CoC-CC, such as NCHADS, the PHD, and FHI, all note that selecting committee members carefully, working with and engaging them, defining their roles and responsibilities, and assigning them the responsibility for planning, has paid invaluable dividends in terms of enhancing the ownership and the forward progression of the project. Members of the Committee include PLHA, representatives from government, religious leaders, local NGOs, international NGO's, medical and administrative personnel from the OD and RH, and FHI.

The first key step towards the establishment of the CoC-CC was the conduct of a dissemination workshop on the NCHADS CoC Operational Framework Document (OFD) in Moug Russey in June 2003. This workshop, which was facilitated by NCHADS staff and the PHD/PAO, was attended by OD and district health officials and workers, local authorities, representatives from different government sectors, religious leaders, staff from community-based organizations (CBOs)/LNGOs/IOs, and community members.



CoC dissemination workshop in Moug Russey

A follow-on workshop was facilitated by the PHD/PAO in early July 2003 in order to consult with key individuals and groups in the OD, RH, and communities regarding the establishment of the CoC-CC. The PHD notes that the OFD gives broad suggestions about memberships and roles but does not strictly dictate. The PHD, which did not place any staff members on the CoC-CC in order to promote decentralization, developed a document to clarify these issues for the Moug

Russey OD and sent it to NCHADS. Continued consultations among key groups culminated in the establishment of the CoC-CC by the PHD/PAO on July 29. The full membership of the CoC-CC, which is co-chaired by the OD Director and the Moug Russey Administrative District Governor, is listed in Appendix 2.

CoC-CC meetings are extremely participatory. Activities undertaken in the first meeting of the CoC-CC were to set goals and objectives and develop a work plan for 2003. The objectives that were developed include 1) ensure that stakeholders at OD level work together; 2) identify needs, gaps and areas of collaboration and coordination; 3) define referral mechanisms; and 4) provide a regular forum for discussion of issues related to CoC.

Mondul Mith Chouy Mith

At its heart Mondul Mith Chouy Mith is a strategy to reduce discrimination towards PLHA and among PLHA

Dr. Mean-Chhi Vun, Director, NCHADS

Building on a model that has proved successful elsewhere in the region, the **Mondul Mith Chouy Mith** (MMM), which translates as “friends helping friends”, is a monthly meeting of PLHA and the different groups that work together with them to provide care and support. While the MMM may appear at first glance to be primarily a strategy to provide care and support to PLHA, it also has the goal of reducing discrimination against PLHA by both health care providers and community members as well as self-stigmatization among PLHA.

Planning for the MMM in Moug Russey was greatly facilitated by the inclusion of MMM in the NCHADS OFD. By including the MMM in this important policy and planning document, MoH policy makers have classified MMM as a essential component of a comprehensive CoC rather than an optional activity. In the OFD dissemination workshop held in June 2003, NCHADS presented MMM as an integral part of CoC, explaining what it is and why it is so important.

Stakeholders in Moug Russey wanted to plan the MMM in such a way that it achieved the goals of

providing services and reducing discrimination. They felt that the MMM should be held at a regular time and place so that PLHA traveling from long distances away would know where to go and would be assured that the meeting would take place. The idea of holding the MMM on the grounds of the RH was attractive because it would bring PLHA directly to the services and also facilitate the formation of positive relationships between PLHA and RH staff. It was therefore decided to hold the MMM on the fourth Saturday of every month at the Moug Russey RH. A comprehensive set of medical care and social support activities were planned to be offered through activities that include health education (often through peer education), prayer and meditation, support for orphans, self-help group discussions including income generation, psychological support, and medical services. The medical services available throughout the day of the MMM include VCT, a OPD that provides medical care for opportunistic infections (OIs) including TB, and counseling for the prevention of mother-to-child transmission (PMTCT).

The MMM in Moug Russey represents an open meeting of PLHA in Cambodia that gathers on a regular basis. Although there was initially some doubt whether PLHA would congregate openly, 37 PLHA attended the first MMM in Moug Russey on August 23, 2003. Attendance has gradually increased over time and over 100 PLHA have attended recent MMMs.

Addressing stigma and discrimination

At the first Mondul Mith Chouy Mith (Friends Helping Friends meeting of PLHA at the referral hospital) in August 2003 the health workers all wore masks. They stopped shortly after that

Pratin Dharmarak, Deputy Country Director, FHI-Cambodia

The need to reduce discrimination against PLHA in Cambodia exists both within the health system as well as in communities. How can planners best target this problem? Planning in Moug Russey has focused on reducing stigma and discrimination through education, engagement, capacity building, interaction and involvement of PLHA and health care financing mechanisms.

Education of health providers and community members through workshops, trainings, and community meetings has removed many misconceptions regarding HIV/AIDS and motivated them to help PLHA. RH staff members' participation in trainings and their growing experience working with PLHA has increased their knowledge and skills while at the same time virtually eliminated discrimination at the RH. The lesson learned here is that health workers who feel capable of providing care for PLHA are less likely to discriminate against them. Stigmatization of PLHA at the community-level is more widespread and harder to reduce. The project has addressed this problem by sensitizing political leaders (e.g., the governor) and supporting them and LNGOs in their efforts to promote acceptance towards PLHA through community meetings.

Training

Training has been an integral part of planning and preparing for the CoC in Moung Russey. The initial facility assessment at the RH revealed that a comprehensive and wide range of training was required to prepare staff members there to provide effective care and support to PLHA. Planners of the CoC initiative also realized that there was a broader need to provide general information on prevention and control of HIV/AIDS and the care and support needs of PLHA to a range of stakeholders.

Both health providers as well as non-medical staff in the RH and health centers of Moung Russey — literally every staff member in the Moung Russey OD health system — attended an initial orientation of one-to-three days duration (depending on staff position). The orientation provided basic information on HIV/AIDS, TB, STIs, and universal precautions. The cascade model was used to conduct this training. An initial training-of-trainers (ToT) was conducted by experts from the national and provincial level for participants who were drawn from OD staff. OD staff members then “rolled-out” the training by training lower levels of participants.

A second basic training was designed to provide information on self-care and support to PLHA and their families. This training, which is repeated periodically according to need, follows the outline presented in the series of four *Self-Care Books* that

have been developed and published by FHI. These books cover the following topics:

1. Book One: What should I do if I think I have HIV/AIDS?
2. Book Two: Living with hope and staying healthy for people living with HIV
3. Book Three: Living peacefully with AIDS
4. Book Four: Staying healthy for mothers living with HIV



The duration of training for each volume is one day. PLHA and their family members have been trained to conduct these trainings. The content of the training is then reinforced in health education sessions conducted in the MMM.

Details of the technical trainings that were attended by various staff members from the RH and other collaborating organizations are provided below in the pertinent sections. These trainings were supported by different organizations including ADB, FHI, the MoH, and UNICEF.

VCT

CoC planners realized that the Voluntary Counseling and Testing (VCT) Clinic needed to be located on the grounds of the hospital in order to facilitate coordination and referral with other aspects of facility based care (FBC). It was felt that the clinic needed to be located near the entrance gate of the hospital so that clients seeking testing — some of whom may feel uneasy about entering a clinic associated with HIV — would be able to enter and exit the clinic with ease. The VCT clinic was designed to have a large, comfortable waiting room, complete with educational literature, a television with DVD (for health education), and

two counseling rooms. Rooms were not available in the RH to house the clinic. The ADB, UNICEF, RACHA, and FHI therefore collaborated to construct and equip a new building that currently houses the VCT clinic and other office and meeting rooms. While the new building was being constructed, the VCT clinic functioned on a temporary basis in rooms in the RH for four months. Plans called for the VCT clinic to be open five days per week both morning and afternoon. Given that two counselors must be on duty in the clinic at all times, it was decided that three counselors would be trained to staff the clinic in order to avoid overwork and staff burnout. Two nurses and one medical assistant were selected from RH personnel to staff the clinic. The three VCT counselors participated in trainings on basic HIV/AIDS (one day), universal precautions (three days), tuberculosis (two days), sexually transmitted infections (one day), self-care for PLHA (four days), infection control (five days), theoretical counseling (five days), and practice counseling (two days). Laboratory staff received additional training organized by NCHADS.

The VCT services in Cambodia started as stand alone services, but they are being changed through the development and introduction of CoC. To help health personnel and counselors at the national and local level see how VCT can be linked to care and treatment services, FHI facilitated a study trip to VCT clinics in Thailand in June 2003.

The counselors, OD staff, and FHI worked together to develop protocols and checklists to guide VCT counseling. Counseling tools consisting of leaflets, posters and a flip chart (the latter based on the self-care books) were produced. The hospital laboratory provides HIV testing capability and the necessary reagents and equipment are supplied by the ADB, UNICEF, and FHI.

To motivate staff to keep the VCT clinic open all day, NCHADS provides performance based salary incentives of 60 USD per month for each counselor and lab technician.

Management of opportunistic infections

The Outpatient Department (OPD) at the RH is the center of out-patient services for PLHA in Moug Russey. Project planners felt that the

availability of high-quality care for opportunistic infections (OIs) was key to the project; if good OI management services are not accessible there is little incentive for members of the general population to discover their HIV status. Although the OPD is informally known as the “OI Clinic” and only serves PLHA at this time, the intention of the RH and the CoC-CC is for the OPD to eventually offer integrated services for PLHA and non-PLHA alike in order to avoid labeling the clinic as “for PLHA only”.

If the VCT Clinic is where most clients enter the medical care system, then the OPD is where clients establish relationships with medical personnel and receive ongoing care. The primary components of this care include: physical examination, prophylaxis and treatment of OIs; screening and treatment of TB, including isoniazid preventive therapy (IPT); education and information on HIV/AIDS including self-care; drug education and treatment counseling, including the assessment of any drug side effects; antiretroviral therapy (ART); and referral links to a variety of other services, including inpatient services at the RH, other outpatient services at HCs, home-based care (HBC), and community-based PLHA Support Groups. MoH clinical protocols guide care for OIs and the classification of disease staging. Health center staff are being trained to maintain good compliance among the patients receiving treatment for OI and ART, to address side-effects, and to provide continuing follow up supportive counseling for PLHA. HC staff will play a key role in connecting FBC to community and home-based care in remote areas.

Planning for personnel and training

Planning for the establishment of the OPD has required that the Moug Russey RH — a facility that normally offers only inpatient services — be flexible enough to provide care to outpatient PLHA clients. The OPD is located in a room in the Admissions Building of the RH, less than twenty meters from the VCT Clinic. Human resource needs for the OPD that were identified in the planning stage included physicians (or medical assistants), nurses, and pharmacists (the latter with capability to provide drug education). Serving in the OPD represents an addition to a physician’s and nurse’s normal responsibilities and the client load can be high on certain days. For these

reasons, two physicians, a medical assistant, and three nurses have been trained to provide services. A team comprised of the RH Pharmacist and a PLHA volunteer has been formed to provide drug education. Major elements of the training programs for these personnel are noted in the table below.

Table 1: Training program for personnel in the OPD at Moug Russey (MR)

Physician / Medical Assistant / Nurse	Pharmacist / PLHA Volunteer
<ul style="list-style-type: none"> • Five-day on-site training in diagnosis and management of OIs in Calmette Hospital in Phnom Penh. • On-site training at MR RH by physician from Calmette Hospital, twice a month for two days beginning in October 2003 and continuing throughout 2004. • Four-day training in diagnosis and management of OIs at MR RH conducted by a visiting Thai physician. • Five-day study trip to Thailand to visit VCT services that link with care and treatment. 	<ul style="list-style-type: none"> • Pharmacist attended a five-day training in Phnom Penh on drug education and counseling for HIV/AIDS. The training content included drug storage, key messages to give to client, counseling techniques, and specific information on drug side-effects. • PLHA Volunteer has received informal on-the-job training in drug education from the pharmacist.

Planning for training activities in relationship to the management of OIs also must address the training of the PLHA clients in self-care. All clients who register at the OPD are encouraged to take part in a one day training in self-care that is offered at the RH. The training, which is conducted by medical staff and PLHA, is attended by approximately fifteen clients. The content of the training is later reviewed in health education sessions during the MMM.

Planning for support of OPD services

Clients of the OPD require pharmaceuticals to treat and prevent OIs. Planning for a constant supply of drugs has been a major challenge to the OD. The OD has worked closely with the Central Medical Store (CMS) of the MoH to attempt to maintain an uninterrupted supply of key drugs such as Bactrim and Fluconazole.

The Moug Russey RH has the capability to perform basic laboratory tests that are needed to support the care of OIs — these include stool exam (microscope), complete blood count, blood chemistry, and screening for TB (microscope, reagents, and x-ray machine).

The establishment of the OPD has also required planning for patient records, educational materials, and office equipment and supplies. The OD and FHI have collaborated to develop client record forms that have been revised following initial pilot-testing. These forms consist of a *First Visit Form* and a *Follow-Up Form*, both of which remain in the patient record at the RH. Additional information is noted by the medical provider in a *Patient Booklet* that the client takes home. This booklet contains information that is important for home-based care (HBC) such as weight, vital signs, diagnosis, prescriptions, follow-up instructions, and health education. FHI has provided other equipment that improves the functionality of the OPD including filing cabinets, stationery, and seating in the outdoor waiting room. FHI has made available the Self-Care Series of four booklets to guide clients in self-care.

TB / HIV

The term *TB/HIV*, in the context of care and support for PLHA, refers to the co-infection relationship that exists between the two diseases and the resulting need for care and support for both conditions to be closely linked and coordinated. PLHA who have latent TB infection have a 10 times greater chance to develop active TB than non-PLHA. PLHA who have active pulmonary TB can spread TB to their family members and to the general population. The HIV epidemic therefore holds the potential to fuel a general TB epidemic, presenting public health authorities with a unique problem that demands special attention.

Planning for TB services for PLHA

Planning for TB services as part of a CoC for HIV/AIDS must address the need for a variety of services that include screening PLHA for TB; providing outpatient and inpatient treatment for TB to PLHA according to each client’s need; and providing outpatient isoniazid preventive therapy (IPT) to PLHA who do not have active TB and who meet eligibility criteria.

Outpatient diagnosis and treatment of TB in Cambodia is provided through health centers (HCs). As noted previously, the Moug Russey CoC-CC planned to screen PLHA who attend the OPD for TB and refer clients diagnosed as TB-positive to the HC for Directly Observed

Treatment – Short-course (DOTS), or to the inpatient TB Ward at the RH.

The CoC-CC also planned to include the provision of isoniazid preventive therapy (IPT) as part of the CoC. The majority of Cambodians (64%) are infected with TB and the risk of reactivation of latent TB infection among people who are HIV positive has been estimated as between 5 to 10 percent per year whereas among non-HIV positive people, this risk is about 5% over their entire lifetime. In the context of the CoC, IPT consists of treating eligible clients for nine months with isoniazid and Vitamin B-6, thus significantly reducing their risk of developing active TB and subsequently transmitting it to others. The provision of IPT through the CoC in Moug Russey was planned and established through collaboration between the MoH, the National Tuberculosis Program (NTP), FHI, and Gorgas TB Initiative, University of Alabama at Birmingham (UAB), the latter being an academic and research partner that works on issues concerning the relationship between TB and HIV. These partners have worked together to develop and test draft guidelines for the administration of IPT to PLHA. Planning for IPT has also focused on the links between the OPD and HBC teams, given the important role that HBC has in ensuring adherence by the client to the IPT regimen.

HIV positive people are encouraged to attend TB screening. PLHA with no OI symptoms and who do not have active TB will be counseled for IPT. This is to encourage HIV positive people to access the care and treatment system as early as they can because TB can cause disease in PLHA during the early stage of progression while the CD4 count is still high.

Inpatient care for TB patients is provided through the TB ward at Moug Russey RH. In addition to a physician's room and a nurse's room, the ward has three different rooms where inpatients stay – one for confirmed TB cases that are not HIV positive, a second for PLHA with confirmed TB, and a third for PLHA with suspected TB who are waiting for a confirmatory diagnosis. Project planners decided to separate PLHA with confirmed or suspected TB from other TB patients in order to minimize the possibility of PLHA acquiring a secondary TB infection. Treatment protocols for PLHA at Moug Russey RH follow national TB treatment guidelines.

Staffing and training for TB/HIV

The Tuberculosis-Leprosy Supervisor (TLS) from the Moug Russey OD office was appointed to be the focal person for the TB/HIV component of the CoC. Trained as a medical assistant, the TLS at Moug Russey is also one of three individuals who provide care to PLHA through the OPD. These three medical providers participated in the training program described in the previous section for OIs that included elements on TB. They also attended a five-day training course in reading x-rays at the Battambang Referral Hospital that was conducted by Gorgas. Nine staff members from the RH have participated in trainings on IPT (both basic and specialized). Prior to commencement of the IPT provision, FHI arranged for a team of 16 individuals from the Moug Russey and Battambang RHs, LNGOs providing HBC, and PLHA to visit hospitals in Thailand that provide IPT and learn about their results. The visit helped give confidence to the Cambodians about the new initiative. Activities in TB/HIV in Moug Russey have also been supported by the training of 96 staff members of the RH and the HCs in basic HIV/AIDS and TB. The trainings were conducted by staff of the MoH, FHI, and Gorgas/UAB.

The RH has the following laboratory capabilities to support efforts in TB/HIV: an x-ray machine; a microscope and reagents for testing sputum for the presence of acid-fast bacilli; and an ultrasound (to test for abdominal TB). Both the laboratory and the TB ward have been renovated as part of planning for the implementation of the CoC.

Prevention of mother-to-child transmission

The establishment of programs for the prevention of mother-to-child transmission (PMTCT) of the HIV virus has great importance for the people of Cambodia, given the increasingly high contribution (an estimated 30 percent) of this route of transmission to the total new cases of HIV infection. The PMTCT program in Cambodia aims to identify HIV positive pregnant women and, by providing them with ARV therapy during delivery and their newborns with ARVs soon after birth, reduce the HIV infection rate of newborns. The NCHADS Operational Framework for CoC includes PMTCT. However, direct implementation and supervision of PMTCT is under the responsibility of the National Maternal and Child Health Center (NMCHC). The CoC planners agree that PMTCT should be implemented as a component of CoC because PMTCT includes primary prevention among women, improved ante, peri and post natal care, administration of ARVs, correct infant feeding, and mother and infant care after delivery.

The NMCHC has also received support from UNICEF to implement the PMTCT program. Moug Russey CoC planners worked with colleagues from relevant organizations (NMCHC and UNICEF) to plan and develop the service at the hospital.

There are several structural prerequisites in facilities where PMTCT services are to be established. To begin with, VCT services must be present in order to provide HIV testing capacity. Adequate human resources are also a prerequisite — there must be a sufficient number of midwives in the ANC services and maternity ward and nurses in the pediatric unit who can work full-time to provide PMTCT services. The PMTCT program in Moug Russey — one of six sites in Cambodia where PMTCT services have been established — has met additional criteria that maximize the potential effectiveness of the PMTCT program. First, PMTCT has been incorporated within the antenatal care (ANC) program at the health center (HC) that is located on the grounds of the RH. This maximizes both program sustainability and the number of pregnant women who have direct contact with the

PMTCT program. Second, PMTCT is best implemented as a component of a continuum of comprehensive care because the mother receives care from components of the CoC other than PMTCT in addition to the care received by the newborn through PMTCT. This allows the mother to live longer and results in direct benefits for her child and family.

Planning for PMTCT

Planning for PMTCT at Moug Russey has addressed a number of key areas:

Location: The PMTCT program is located in the ANC clinic at the HC (located within the RH compound) and its components have been integrated within standard ANC clinic activities such as mother's classes.

Human resources: Six midwives — three from the ANC clinic, and three from the maternity ward — form the team that implements the PMTCT program. The Director of the Moug Russey OD serves as the PMTCT Program Coordinator. Current plans call for traditional birth attendants (TBAs) to be trained in PMTCT beginning in March 2004. TBAs will refer pregnant women under their care to the PMTCT program and help with home-based post-partum follow-up of HIV positive mothers who have had ARV therapy during delivery.

Training: The six midwives who conduct the program participated in a five day training at NMCHC in Phnom Penh. The training, which covered the topics of PMTCT and counseling techniques, was supported by FHI.

Protocols: PMTCT services at Moug Russey are provided according to protocols that have been developed by the NMCHC in coordination with the MoH, WHO and UNICEF.

Physical structure: The PMTCT program requires physical space for 1) Mother's Classes and 2) counseling of pregnant women as well as their husbands. UNICEF funded the physical expansion of the HC at Moug Russey RH that added two new rooms (one large room for mother's classes and one counseling room) and supplied furniture and a television with a DVD player.

Laboratory requirements: The establishment of a PMTCT program requires the procurement of reagents to test pregnant women and their husbands for HIV. UNICEF supplies the reagents to NCHADS for a number of VCT and PMTCT sites in the country.

Educational tools and stationery: UNICEF and FHI have provided funding for the tools needed to conduct the PMTCT program at Moug Russey, including educational materials (e.g., leaflets, health education videos), condoms, and stationery.

Staff incentives: A PMTCT program requires that staff members spend the full day in the clinic, foregoing opportunities to supplement their low salaries with work outside the health facility during the afternoons. For this reason, UNICEF provides incentives for the midwives who work in the PMTCT staff. The midwives at the ANC clinic receive an incentive of \$25 per month while midwives from the maternity department receive an incentive of \$15 per month.

Antiretroviral drugs: HIV positive women who elect to use ARV therapy during their delivery and for their newborns require appropriate drugs. UNICEF provides Nevirapine to NCHADS that is required for this service.

Antiretroviral therapy

Every element of the CoC is an integral part of the care and support framework for PLHA. However, no component of the CoC is more important than the provision of antiretroviral therapy (ART) — a treatment that slows or arrests the progression of HIV/AIDS. Planners of the CoC in Moug Russey have emphasized the need for project efforts to be sustainable by employing a strategy of establishing other components of the CoC and strengthening the health system prior to the introduction of ART. Special importance has been placed on developing a clinical care site (i.e., the OPD) that provides comprehensive, high-quality management of OIs. In June 2004, less than one year after the establishment of the CoC, the first client initiated ART in Moug Russey.

ART consists of the provision of antiretroviral drugs (ARVs) according to a regimen that is tailored individually to the needs and medical

conditions of the client, along with the medical and social support that helps the client manage and adhere to the therapy. Clients in Moug Russey are recruited and receive ART through the OPD as part of the continuous process of prophylaxis and management of opportunistic infections (OIs) that takes place in the clinic. In a broader sense, the provision of ART through the Moug Russey CoC represents an initial step in what will become a phased approach to scaling up ART through the public sector health services in Cambodia. The MoH, NCHADS, and its partners view the process of scaling up ART as a lever that can be used to strengthen the overall Cambodian health system as investments are made in human resources, infrastructure and logistics.

From a public health perspective, the goal of providing ART within a CoC is to provide ARVs to as many eligible clients as possible while ensuring that clients adhere to the therapy and are able to access medical services to manage opportunistic infections. From the client's perspective ART is the fundamental key to long-term survival, although receiving it is rarely a short-term emergency.

Side-effects from the ARVs can be severe, pre-ART education and counseling are needed and the support from various components of the CoC, including home-based counseling and follow-up treatment at local health facilities, can be crucial for maintaining patient adherence to the therapy.

This section of the document describes how the CoC Coordination Committee (CoC-CC) planned for the establishment of ART services in Moug Russey. The implementation of ART is detailed in the following chapter.

The ART Committee: membership and roles

An ART Committee has been formed at the Moug Russey RH to provide leadership and make key decisions regarding treatment with antiretroviral drugs. The members of the committee depicted in the following table represent major local stakeholder groups in the CoC.

Table 2: Members of the ART Committee

Physician / Medical Assistant / Nurse

- ART Coordinator: Director of the Moug Russey RH
- Representative of CoC-CC: Director, Moug Russey OD/OD chief of technical bureau
- Representative of OPD physicians
- Representative of ART Counselors
- Representative of PLHA Support Group Leaders
- Representatives of HBC team (two members)
- Representative of local government
- Representative of FHI

The ART Committee, which meets on a weekly basis, plays an important role in the determination of each patient's eligibility for ART. The committee reviews the applications of clients who have met the initial set of medical and biological screening criteria that are assessed in the OPD. The committee then uses additional selection criteria⁶ to identify clients who will receive ART.

Planning for the provision of ART

The CoC-CC's plans to make ART available in Moug Russey required decisions to be made regarding the location of the service, human resources and training needs, protocols for the provision of ART, laboratory requirements, and the supply of ARVs.

Location: ART is provided through the OPD located in the Moug Russey Referral Hospital (RH).

Human resources and training: Personnel from a broad range of groups that provide care and services to PLHA across the continuum of care in Moug Russey have participated in training activities on ART management. The table below outlines the participants and content of the training activities that they have attended through April 2004. FHI has facilitated training by a regional expert from Bamradnardura Institute in Bangkok who came to Moug Russey in January 2004 and provided training in OI and ART management. Where applicable, training activities are based on the national training curricula for ART management that was developed by NCHADS with support from collaborating partners.

Table 3: Training program for personnel who support ART in Moug Russey

Participants

Medical staff at Moug Russey Referral Hospital (physicians and medical assistants) including the Director of Moug Russey Referral Hospital (total of 8 participants).

Physicians and medical assistant who provide medical care in the OPD at Moug Russey and Director of Moug Russey Referral Hospital (total of 5 participants)

Community volunteers, staff members of local NGOs that provide HBC, PLHA Self Help Group Leaders, health center staff members who provide HBC, and RH staff nurses and midwives (total of 76 participants divided into 3 groups, three-day training per group)

ART Training Content

Two-week training on management of OIs and ART management conducted by physician specializing in ART from Bamradnardura Institute, Bangkok, Thailand.

In-service training on management of patients undergoing ART conducted throughout March and April 2004 by physician specializing in ART from Phnom Penh, Cambodia.

Training on management of patients undergoing ART, drug counseling and monitoring adherence to ART.

Protocols: ART is provided at Moug Russey RH in accordance with guidelines on ART management that have been developed collaboratively by NCHADS and its partners, including FHI. These guidelines, which are based on WHO Clinical Guidelines for scaling up ART in resource-poor settings, are reflected in structured patient encounter forms (i.e., patient records) that have been developed by local partners in Moug Russey.

Laboratory requirements: Extensive laboratory services are required to support the selection of clients for ART and the ongoing management of their therapy. The central requirement for the laboratory is the machine that performs a CD4 count. A field type CD4 count machine was purchased by FHI for placement in the Moug Russey RH and was installed in June 2004. Prior to the installation of the cytometer FHI arranged for blood samples drawn from PLHA in Moug Russey to be assessed by the Pasteur Institute laboratory in Phnom Penh for CD4 lymphocyte counts to help assess immune level of the patients.

The list of clients who are prioritized to receive ART include clients who have suffered from pulmonary or extra-pulmonary TB in the previous year, chronic pneumocystis carinii pneumonia (PCP), cryptococcal meningitis, oro-oesophagus candidiasis, or CMV retinitis. All of these conditions can be diagnosed by clinical examination or by the laboratory services at

⁶ Note: Both screening and selection criteria are described in the following chapter

Moug Russey RH. Laboratory tests to assess hematology (including complete blood count, platelet count, hemoglobin, and hematocrit) and biochemistry (including ALAT, ASAT, creatininemia, triglyceridemia, and amylasemia) also form an essential aspect of ART support services. All of these tests are available at the Moug Russey RH.

Educational tools: A booklet and leaflet describing different aspects of ART are being developed for PLHA clients. These materials will be distributed to all clients who receive ART.

ARV supply management: PLHA have a life-long need for ARVs and the cost of ARVs is high. Identifying sustainable sources of ARVs for clients who can not afford to pay for them is one of the most challenging aspects of supporting a CoC for PLHA.

NCHADS with support from UNICEF has provided ARVs for 150 clients in Moug Russey. The ARVs are provided through the government system in response to a request form that is submitted by the OD to the PHD, from where it is then forwarded to NCHADS. It is crucial that the supply chain be secure to avoid leakage of drugs and supply interruptions. This has been accomplished in Moug Russey through rigorous inventory checks and a secure drug storage facility. The triple therapy drug regimens that are supplied to clients in Moug Russey follow NCHADS ART protocols and include d4T (AZT can be substituted if client cannot tolerate d4T), 3TC, and Nevirapine (Efavirenz can be substituted if client cannot tolerate Nevirapine).

Additional ARVs will be required as more clients are identified and found to be in need for ART. NCHADS has submitted a proposal to the Fourth Round of the Global Fund (GFATM) to purchase ARVs. The outcome of this proposal will be known some time in 2004.

Health centers

The focus on improving facility based care in the early stages of the establishment of the CoC in Moug Russey has been on the services at the referral hospital. The PHD, OD, and FHI plan to increase the capacity of 10 health centers (HCs) in Moug Russey OD to provide HIV care during 2004. With regards to the CoC, the role of HC staff will be to provide primary care and treatment of OIs; education and counseling on HIV/AIDS, medication, and self-care; follow-up care for severely ill PLHA; counseling and care for clients who are taking ART; and technical support to the HBC teams. All HC medical staff will be trained in basic OI management and HIV counseling during 2004.

Facility management

Preceding sections of this chapter have described planning activities for the major service components of facility based care. These services are supported by cross-cutting components of health facility management that include financing mechanisms, laboratory services, physical facilities, drugs and medical supplies, medical information systems, and revision of staff roles. Details of how managers of the CoC in Moug Russey planned for these cross-cutting components can be found below.

Financing mechanisms

An important step that was taken recently towards improving the quality of services in Cambodian government health facilities was the introduction of the Health Financing Plan. Under this plan health facilities are allowed to charge fees for the services they provide and to distribute approximately 50 percent of the fees that are collected to staff members as salary supplements. The Moug Russey RH is more highly utilized than many referral hospitals in Cambodia and currently collects from six to eight million Cambodian Riels per month in patient fees (1,500 to 2,000 USD). RH administrators perceive the high utilization levels as a marker of high quality of service and staff commitment.

The Moug Russey RH, which is classified as an inpatient facility, charges 30,000 riels

(approximately \$7.50) per inpatient admission as a one-time, all-inclusive fee. Most laboratory services and drugs in stock are free of charge once this fee has been paid. Outpatient clients of the OPD pay a fee of 2,000 riels (0.50 USD) as an initial payment and are charged additional fees as necessary for laboratory tests. These clients also receive drugs at no cost. Indigent clients may apply for the fee to be waived.

The RH has applied to be covered by the MoH Equity Fund Plan that would reimburse the hospital for fees that are waived for indigent clients (including PLHA). This fund became operational in Moug Russey in July 2004.

Laboratory services

Laboratory services compose one of the most important of the cross-cutting services that support the CoC. Planning for the strengthening of laboratory services focused on training of personnel, renovation of the physical laboratory, and ensuring a reliable supply of laboratory reagents.

Two laboratory technicians at the RH participated in training conducted at the Pasteur Institute in Phnom Penh on the topics of HIV testing (five days) and hematology / parasitology (five and one-half days). Current plans call for these technicians to participate in a training on bacteriology at the Pasteur Institute in the 3rd quarter of 2004 in order to provide more effective support to the OPD.

The building that houses the laboratory was renovated with support from FHI. FHI also arranged for a microscope to be purchased. The reagents required for HIV testing are supplied by NCHADS through support from two sources – UNICEF and ADB.

Laboratory tests that are conducted in support of the CoC include stool test, TB sputum test (acid fast bacilli), complete blood count, urine analysis (for HIV inpatients), spinal fluid (for Cryptococcal meningitis), and testing for HIV.

The protocol that is used at Moug Russey to conduct HIV testing follows the NCHADS official guidelines which call for all samples to be initially tested using the Serodia method. If the test result

is negative, the client is diagnosed as HIV negative. If the Serodia test result is positive, the Determine test is used to confirm the diagnosis. If the Determine test result is also positive, the patient is diagnosed as HIV positive. If the Determine test is negative, a discordant diagnosis is noted and the client is asked to return within two weeks to be retested. If the result remains discordant at that time, the client is requested to return in three months for a second follow-up test.

The laboratory also performs other tests required for the provision of antiretroviral drugs (ARVs) to PLHA who are clients of the Moug Russey health system. Details regarding the laboratory services that are provided in this regard have been described above.

Physical facilities

Despite the relatively good condition of the physical facilities at the RH, collaborating partners felt it was necessary to improve the buildings as well as the physical infrastructure through a combination of new construction and renovation. Physical facilities that were renovated include the TB, pediatric, minor injury, and general (adult) wards, the laboratory, and the water system of the RH. New construction included the addition of rooms to the HC for the PMTCT program and the construction of an entirely separate building to house the VCT Clinic, meeting rooms, and offices for different partners supporting the CoC. Support for improvement, renovation and construction was provided by different partners including ADB, UNICEF, RACHA and FHI.

Drugs

The cost of drugs (subsidized) is included in the consultation fee charged to clients of government health facilities in Cambodia. In order to be able to provide clients with effective drugs, facility managers must address issues that include drug supply, storage, and management. As part of the overall effort to strengthen the systems that support the CoC in the RH, RACHA supported strengthening drug storage and management through the development of a drug database and inventory system. The drug storage room was also renovated. The PHD provides supervisory oversight for the management of drugs at the RH.

Medical records and information systems

The establishment of the VCT and OPD and the PMTCT program has required that new or revised medical records be developed to support the new services. Each of these three services has developed a separate set of patient records that are being pilot tested in the respective services. Some formats have already passed through several iterations. Filing cabinets to store and protect the confidentiality of patient records have been procured. Project partners are assessing the need for and feasibility of installing a computerized record system for the entire RH in the coming year.



Medical staff discuss patient record forms

Orienting staff and reorganization of staffing roles

The establishment of the CoC and strengthening of facility based care has required the identification of staff members who can assume the positions and responsibilities created in the new and strengthened services. Several staff members have to work in both the RH and OD due to under-staffing at the hospital. Preceding sections of this document noted the personnel who are providing services to PLHA. Details regarding how the principal new positions have been filled are summarized in the table below.

Table 4: New positions necessitated by the establishment of the CoC in Moug Russey

New position / role	#	Ongoing position
ART Coordinator, RH	1	RH Director, Moug Russey
OPD Care Provider, RH	3	<ul style="list-style-type: none"> Physician in medical ward Supervisor of Medical Ward, RH TB-Leprosy Supervisor, OD
Drug Education Counselor, RH	2	<ul style="list-style-type: none"> Pharmacist, RH PLHA Volunteer
MMM Facilitators	4	<ul style="list-style-type: none"> MCH coordinator and 1 Health center staff 2 PLHA self help group leaders
PLHA Caregiver, RH	1	<ul style="list-style-type: none"> PLHA support group
PMTCT Coordinator, OD	1	Director, Moug Russey OD
PMTCT Counselor, Health Center	6	Maternity ward midwife, RH (3) ANC Clinic midwife, Health Center (3)
STI/HIV/AIDS Coordinator, OD	1	Physician in medical ward
TB/HIV Coordinator, OD	1	TB-Leprosy Supervisor and chief of TB ward
VCT Counselors, RH	3	<ul style="list-style-type: none"> Nurse, RH (2) Medical Assistant, RH (1)

Planning to strengthen community and home-based care in a CoC framework

A simplified description of the CoC project in Moug Russey might note that strengthening and then linking two basic groups of services — facility based care (FBC) and community and home-based care (CHBC) — represents the heart of the effort. With regard to care for PLHA, CHBC in Cambodia has been in existence for much longer than FBC. For this reason efforts to establish the CoC in Moug Russey have focused on establishing new FBC services and establishing links between FBC and CHBC, along with moderate efforts to strengthen CHBC as well.

CHBC in Moug Russey includes two principal sets of activities that complement each other – 1) home-based care (HBC) and 2) activities conducted by PLHA support groups. CHBC services have been the only services available to many PLHA in the past few years. Transport constraints, financial difficulties, and limited ability to provide care have made FBC virtually inaccessible to many PLHA. Other individuals have been reluctant to determine their HIV status and seek FBC. Much of the effort to provide CHBC has therefore involved providing palliative care to PLHA at the final stages of their illness.

The text below describes planning efforts that were made in the context of the CoC to support HBC and PLHA support groups. The implementation of referral links between FBC and CHBC are described in Chapter 4.

Home-based care

Local non-government organizations (LNGOs) play a crucial role in organizing and supporting HBC services in Cambodia. The Provincial AIDS Offices (PAOs) are responsible for training and forming HBC teams but receive considerable support from LNGOs.

One of the tasks to be done for planners of the community-based component of CoC in Moug Russey is to find partners to provide HBC to all of the communes in the OD. The Khmer Rural Development Association (KRDA)⁷, a local non-government organization (LNGO) provides support for HBC activities in seven of the eleven communes in Moug Russey Administrative District (AD). Each of these seven communes is served by a HBC team composed of a KRDA field worker, a PLHA, a community volunteer (from the Village Health Support Group – a part of the government structure), and a trained health worker from the local health center. The Cambodian Red Cross (CRC) supports HBC in an additional four communes in Moug Russey. There are currently no LNGO-supported HBC services in the six communes of Koh Kralor Administrative District (part of Moug Russey OD). FHI is conducting a needs assessment in the district and may fund an NGO to begin providing HBC there in the near future.

KRDA staff working in HBC have participated in a variety of training activities that include a four day training course in counseling, a two day training course in tuberculosis, and a four day training in using the Self-Care books in community-based work. CRC staff have participated in a five day training course on supporting HIV/AIDS activities in the community, a three day refresher training course in communication and counseling skills, a two day training in how to establish support groups for PLHA, a three day training in HIV-related vulnerability, discrimination, and stigma, and the four day training on using the Self-Care books. Details regarding the activities conducted during HBC are provided in Chapter 4.

PLHA Support Groups

PLHA Support Groups (PLHA-SGs) are groups, primarily composed of PLHA, that serve as sources of information and care in communities. KRDA has supported the formation of PLHA-SGs in the seven communes in Moug Russey where it works. Each of the PLHA-SGs has been established by a PLHA who serves as a Support Group Leader. The Support Group Leaders participated in a five day training course on how to establish support groups conducted by the local NGO Cambodian People Living with HIV/AIDS Network (CPN+). KRDA supports the PLHA-SGs by providing transportation for PLHA to attend monthly meetings of the Support Group and helping the Support Group Leaders to plan and facilitate the meeting. Details regarding the activities that take place through PLHA-SGs are provided in Chapter 4.

⁷ KRDA receives funding support from USAID through KHANA/International HIV/AIDS Alliance

Implementation

Before it was like being strange, different from others, and I just wanted to die. Now I feel better, like everyone else, because I have access to good treatment

PLHA Support Group Leader, Moung Russey District, Battambang Province

What is remarkable in the CoC project in Moung Russey is the ownership of the project by government and community officials and the quick pace at which activities have been implemented. In the nine months since the NCHADS operational framework for CoC was officially approved, Moung Russey has gone from a district where PLHA had essentially no access to government health services to the most comprehensive, advanced model of CoC for PLHA in Cambodia.

This chapter describes how the various components of the CoC are being carried out and moved forward. For the purposes of this document, *implementation* covers issues that may include date of service initiation, working hours, activities, how the patient moves through the system, how personnel work together, referral networks, supervision and monitoring, regular meetings, and preliminary data that describe effectiveness.

Stakeholders and partners moving forward together

The collaboration that is so much a part of planning for the CoC in Moung Russey persists during the implementation of the project. From running the monthly MMM to providing home-based care to PLHA in the community, health workers, PLHA, elected officials and personnel from various organizations have all found different roles to play in carrying out project.

Stakeholder roles during implementation

During the implementation phase partners have gradually assumed roles that allow them to contribute most effectively to the implementation of the project. The following table outlines these functions:

Table 5: Stakeholder roles in the implementation of the CoC

Partner	Roles
PHD technical support team	<ul style="list-style-type: none"> Support capacity building of personnel who implement CoC Monitoring and supervision of OD
OD technical staff	<ul style="list-style-type: none"> Service provision at RH Monitoring and supervision of RH and HCs
Referral hospital	<ul style="list-style-type: none"> Service provision
Health centers	<ul style="list-style-type: none"> Service provision in HC and HBC Monitoring and supervision of HBC
District-level authorities	<ul style="list-style-type: none"> Motivate commune leaders to coordinate and work with LNGOs and support local CoC efforts Information dissemination to local government (through District Committee) and communities Coordinate NGO efforts to avoid overlapping efforts
Commune-level authorities	<ul style="list-style-type: none"> Attend and support community-level activities and functions for PLHA Advocate for tolerance of and care for PLHA among community members Information dissemination
Monks and lay preachers	<ul style="list-style-type: none"> Lead spiritual component of CoC Advocate for tolerance of and care for PLHA among community members Information dissemination
LNGOs	<ul style="list-style-type: none"> Provide and/or support the provision of community-based services Advocate for tolerance of and care for PLHA among community members Information dissemination
PLHA	<ul style="list-style-type: none"> Participate in service provision Utilize services and attend functions
INGOs / IOs	<ul style="list-style-type: none"> Provide technical and financial support Advocate for CoC Network to identify opportunities to improve and expand CoC
FHI	<ul style="list-style-type: none"> Provide on-the-ground, day-to-day technical and operational support Advocate for CoC Network to identify opportunities to improve and expand CoC Assist in resource mobilization among various donors and collaborators Liaise with relevant partners/stakeholders at OD, provincial and national levels Assist in monitoring and supervision

Mondul Mith Chouy Mith

The meetings in the community are where we (PLHA) exchange information. The Mondul Mith Chouy Mith is where we feel like we re part of a big family and where we come to get support and care

PLHA Support Group Leader, Moug Russey District

The Mondul Mith Chouy Mith (MMM) has quickly evolved into the central component of the CoC. The MMM – which is attended not only by PLHA from Moug Russey but also by PLHA from other districts in Battambang where CoC has not started, and a few from other neighboring provinces – is where PLHA can openly meet and laugh, learn, play, pray, and cry with others who share their condition. It is also the day when they can easily receive medical services that they find to be effective and of high quality.

The activities for the MMM generally consist of registration, a welcome speech by a local official, a blessing or meditation time led by a Buddhist monk or lay preacher, games, educational activities including lectures, discussions and small group work based on the Self-Care books, group discussions and presentations, and a closing speech. Lunch and snacks are provided. Small group work is led by RH staff members and PLHA Support Group Leaders. The educational activities generally build on and reinforce the lessons that PLHA are taught in the trainings that they attend based on the Self-Care books.

PLHA find the MMM to be very useful. It gives PLHA the opportunity to share experiences as they both teach and learn. Some bring additional food from home to share with others. They like the games and being among friends. They all remark on how helpful they find the education on topics such as nutrition, use of pharmaceuticals, and condom use.

The only problems that are being faced by the MMM are due to its popularity. There were 122 PLHA attended the MMM in May 2004. Three physicians provided consultations to fifty-four PLHA on that day. The main hall in the RH is too small for more than one hundred people to meet and the demand for services places a significant burden on the staff of the OPD. But this is a

problem that PLHA and the staff at the RH are happy to see – a problem born of success. It is expected that the situation will ease once the CoC is fully functioning in other ODs of Battambang.



Games and peer education on self-care during MMM day

Addressing stigma and discrimination

Perhaps the greatest success has been in eliminating the perceived discrimination among personnel at the RH and other health facilities. PLHA openly attend the hospital. They find the care they receive there to be effective and of high quality and do not feel any discrimination from the personnel there. PLHA use common services to the extent possible and PLHA inpatients are integrated into the general inpatient ward. PLHA are only kept separate from other patients in the TB ward for their own protection.

Major strides have also been made in reducing the self-stigma that PLHA feel as their disease advances and the world closes to them. PLHA clearly feel that the services they now have access to have improved their health and allow them to

be “just like everyone else”. Feeling and looking healthier and having access to services that offer help is clearly important to how PLHA in Moung Russey view themselves and how they are viewed by the community. As one PLHA puts it, “I don’t worry about my disease. I am just trying to live my life. I don’t want to dwell on my misfortune.”

It is in the community where PLHA still perceive some discrimination. Although they feel that the situation has improved over the past year, PLHA note that some people refuse to buy the food that they prepare or that they are teased by the village youth. “But it’s not a problem since I started going to the hospital and got my weight back,” noted a client of the OPD.

VCT

The Voluntary Counseling and Testing (VCT) Clinic at Moung Russey Referral Hospital was formally opened on August 11, 2003. It is open five days a week from 7:30 to 11:00 am and from 2:00 to 5:00 pm. Services are free of charge.

How do clients enter the VCT Clinic?

For most clients who suspect that they may have HIV the VCT clinic is their entry point to facility based care (FBC). They may be referred by health workers, friends, or may be self-referred. Some clients are referred to the VCT clinic by other departments in the RH that suspect the client may have HIV; for example, tuberculosis inpatients (after discussion with the patient) may be referred by staff of the TB ward if they suspect the client may be HIV positive. There is also a referral link between the VCT and the surrounding health centers. For example, outpatient health services to diagnose and manage sexually transmitted infections (STIs) are offered through ten of the thirteen HCs in Moung Russey OD. Staff at the HCs have been instructed to refer high-risk STI patients to the VCT Clinic for counseling and HIV testing.

What happens to clients who come to the VCT Clinic for counseling?

Clients entering the VCT Clinic are assessed for understanding of HIV transmission, risk of infection, counseled on how to prevent HIV, and evaluated regarding the strength of their personal support network and personal coping ability. Clients are informed about confidentiality and

allowed to make their decision whether to take the test. Clients who accept testing give a blood sample and are then given an appointment (usually the same day) to return for post-test counseling. The test result is usually ready within 2-3 hours. Clients who test negative are counseled in how to “stay negative”. Clients whose test results are inconclusive are asked to return in 3 months for a follow-up test. Clients who test positive are informed of their results and then receive counseling regarding how to manage their disease, build a support network, and prevent their infection from spreading to others. They are then referred to the OPD. There are also many low risk young adults planning to get married who come in to be tested together prior to their marriage.

Achievements in VCT:

Data describing utilization of the VCT clinic demonstrate the success that has been achieved. 2,164 clients were tested during the period from October 2003 through March 31, 2004. Some of these clients came from other districts. 1,955 clients have returned to learn their test results (90%). Among those clients who have been tested, 370 have been diagnosed as HIV positive.

How do referral networks link the VCT Clinic to other components of the CoC?

The client who is diagnosed as HIV positive is given a referral slip to the OPD and sent there to make an appointment. Regardless of the test result any client of the VCT Clinic who is pregnant



VCT counseling

is referred to the ANC Clinic at the health center. The referral links between the VCT clinic and other services for PLHA are illustrated on page 33 of this report.

Managing and improving VCT services

In the context of the Cambodian health system, supervision of the VCT clinic is most appropriately conducted by provincial level staff. FHI is currently working with the PAO to develop a supervision checklist and clarify supervisory roles.

FHI supports the improvement of VCT services and professional growth of VCT counselors through two types of regular meetings. A weekly meeting to discuss current issues in the VCT clinic takes place at the Moung Russey RH. This meeting is attended by RH laboratory technicians, VCT counselors, the HIV/AIDS/STD Chief, and FHI personnel. A monthly meeting of the Battambang VCT Counselors Network is held in Battambang town at the PHD. This meeting, which is facilitated by the PAO manager and is attended by VCT and PMTCT counselors from the Moung Russey, Battambang and Sampov Loun Referral Hospitals, includes in-service trainings by NCHADS and FHI as well as opportunities for counselors to share experiences.

Management of opportunistic infections

The Moung Russey Referral Hospital began to offer services to manage and prevent OIs through its OPD on August 23, 2003 in conjunction with the first Mondul Mith Chouy Mith (MMM). The working hours of the OPD are 7:30 to 11:00 am and 2:00 to 5:00 pm Monday, Wednesday, and Friday. OPD services are also offered throughout the day of the MMM, which takes place on the fourth Saturday of every month. The MMM is by far the busiest day for the OPD – for example, 54 clients were seen at the OPD during the MMM that was held on May 29, 2004.

How do clients access services at the OPD?

The most common way for a new client to access services at the OPD is through a referral from the VCT Clinic following a HIV positive diagnosis. Returning clients come on an appointment basis and regular clients generally attend the clinic once a month, although they may come more frequently if necessary. New MMM attendees have access to the OPD as well.



A child receiving an examination



Registration at OPD

How are services at the OPD structured?

The new or returning client registers as a patient and is then triaged by the nurse. The client is then examined by the physician, who takes the client's history, conducts screening tests and a physical examination, and makes diagnoses as necessary. The most common conditions that clients suffer from include diarrhea, chronic headache, *Pneumocystis carinii* pneumonia, and fungal infections. The physician may prescribe treatment and/or prophylaxis for OIs, provide education and information on HIV/AIDS and self-care, and assess whether the client suffers from any drug side-effects. The physician then refers the client as necessary to other complementary services in the CoC.

If any pharmaceuticals have been prescribed including ARVs, the client takes the prescription to the pharmacy, collects the prescribed drugs, and then proceeds to the drug counseling clinic (DCC). The DCC, which is open at the same time

as the OPD, is staffed by the OD pharmacist and a PLHA volunteer. The two staff members work together using a checklist to provide patient education and drug counseling to both inpatients in the medical wards as well as outpatients. Part of the checklist is completed by the pharmacist and the other part is completed by the PLHA volunteer. The pharmacist focuses on technical aspects of the drug counseling including drug side effects while the PLHA volunteer provides general health education. The PLHA volunteer is a key member of the team; clients appreciate working with someone who shares their status while members of the CoC-CC feel that it is important to show that PLHA can play a role in providing medical services for PLHA.

After exiting the DCC the client makes an appointment for his next visit and leaves the OPD.

How do referral networks link the OPD to other components of the CoC?

Clients of the OPD may be referred to services within the RH – to the medical or TB wards if the client is severely ill. Clients of the OPD who meet initial screening criteria may be referred to the ART Committee to apply for ART. The referral networks that support the OPD also link FBC to community-level HBC components of the CoC. For example, OPD clients are often referred to HCs and/or groups that provide HBC for follow-up management of OIs.

The referral links between the OPD and other components of the CoC are illustrated on page 33 of this report.

Managing and improving services in the OPD

The OPD is the service at the RH that touches the largest number of PLHA. As such, the CoC-CC has made it a focal point of managing and improving services that are included in the CoC. A nurse and a PLHA have been assigned to administer the OPD in order to streamline the management and increase the involvement of PLHA in service provision. Recognizing that the RH medical staff members lack experience and skills in the management of OIs, on-site training activities are implemented in an ongoing manner to improve their ability to provide high quality service. A weekly case conference has also been instituted with support from FHI in order to introduce quality assurance activities to the RH.

Achievements in management of OIs:

The availability of effective medical services provided by trained professionals in an environment free of discrimination has resulted in higher than expected utilization of the OPD. To date, 635 PLHA clients had registered and received services through March 31, 2004, and almost all of them had made multiple visits to the clinic. In addition, over 200 clients have participated in additional training in self-care that complements the care and services provided in the OPD.

TB / HIV

Integrated TB/HIV services were established in Moug Russey RH on September 1, 2003. These services encompass the inpatient care that is offered 24 hours a day through the TB ward as well as outpatient care that is offered three days a week from 7:30 to 11:00 am and 2:00 to 5:00 pm through the OPD.

How do PLHA clients access TB/HIV services?

HIV suspects generally enter the medical care system at the RH through the VCT. The client, if found to be HIV-positive, is referred to the OI clinic where he is screened for various OIs including TB. The client, if s/he is a suspect for TB, may have their sputum tested and/or a chest x-ray may be taken. If the client is diagnosed as having active TB, then s/he is treated either as an inpatient or outpatient, depending on their health status and proximity to a health center (HC). The active TB patient may be treated through DOTS therapy on an outpatient basis at any HC in the OD. In general, active TB patients who live far away from the HC and/or are severely ill stay in the TB ward at the RH and are treated as inpatients. Active TB patients who live close to a HC and are in relatively good health are treated as outpatients through HCs.

If the client is found to be TB negative then s/he is assessed for eligibility to receive INH Preventive therapy (IPT). Those clients for whom IPT is indicated and who have no active TB, are asymptomatic for OIs, and have decided to participate are offered this treatment which is only available through the RH. IPT clients are generally treated as outpatients and are given one month of medicine at a time until the nine month treatment

regimen is complete. The protocol for IPT follows the IPT manual jointly developed by the PHD, OD, FHI, and Gorgas.

The referral and treatment protocols for TB/HIV described in the paragraphs above are illustrated on page 33 of this report.

Managing and improving TB/HIV services

Supervision and monitoring of the TB/HIV services in the CoC at Moug Russey is carried out by partners including the Provincial TB Manager from the PHD of Battambang Province and FHI field personnel. The PHD has developed a checklist with the support of FHI to guide and standardize the supervision of IPT. In addition, issues relating to TB/HIV are routinely discussed in case conferences and regular meetings at the RH, including the CoC-CC.

Achievements in TB/HIV:

This young effort is already showing results. Service utilization data for the period between September 2003 and May 2004 show that 158 PLHA clients had been screened for TB and that 27 of them had been diagnosed with active TB, including 18 pulmonary TB. They have been referred for TB treatment. Eleven TB negative clients who met the criteria for IPT are currently taking the INH preventive therapy.

Prevention of mother-to-child transmission (PMTCT)

The PMTCT program at Moug Russey opened on October 20, 2003, with a ceremony that was attended by the Directors of the NMCHC and PHD, a UNICEF representative, the district governor, commune leaders, government officers, health workers, NGO representatives, religious leaders, and FHI representatives. The ANC Clinic in the Moug Russey Health Center, where the PMTCT program is implemented, is open from 7:30 to 11:00 am and 2:00 to 5:00 pm Monday through Friday. PMTCT services are free of charge, although the HC charges a fee for use of ANC services – clients of the ANC clinic pay 1500 riels on their first visit for an “ANC Booklet” (patient record) and 1000 riels (0.25 USD) for each subsequent ANC visit.

What are the primary components of the PMTCT program in Moug Russey?

A pregnant woman may voluntarily participate in the PMTCT program at Moug Russey if she enrolls in the ANC clinic. The client’s partner is encouraged to participate in all steps of the program. The main components of the PMTCT program are the following:

- Education about HIV/AIDS and risk of infection to the fetus from an HIV positive mother (Mother’s Classes)
- Pre-test counseling about PMTCT
- HIV testing
- Post-test counseling based on test result
- ARV treatment of HIV-positive mother during delivery
- Post-delivery ARV treatment of newborn delivered by HIV-positive mother

What happens to clients who come to the ANC Clinic at Moug Russey?

The client who attends the ANC clinic at the HC in the Moug Russey RH for the first time registers, is issued an “ANC Booklet”, and receives routine ANC services such as a physical examination, immunization against tetanus, and iron supplements. She then is asked to participate in a Mother’s Class (MC) with other clients who have attended the clinic. The MC includes both interactive health education taught by midwives as well as an educational video. The content of the MC includes information about the advantages of ANC, danger signs and risks during pregnancy and delivery, immunizations, preparing for delivery, pregnancy hygiene, nutrition, breastfeeding, birth spacing, HIV and PMTCT. The HIV/AIDS Self-Care booklets are used as part of the MC. Clients are then invited to join the PMTCT program.

Clients who elect to join the PMTCT program meet individually with a PMTCT Counselor and discuss issues related to PMTCT. The client is given a 30-minute “pre-test” counseling during which the counselor takes her history related to childbirth as well as HIV risk factors, provides her with information regarding HIV prevention, explains the benefit of the PMTCT program, and allows the client to decide if she wants to be tested for HIV. The client who accepts gives a blood sample and then returns several hours later for “post-test” counseling and to learn the results of her test. If she is HIV negative she is counseled

regarding how to “stay negative”. If she is HIV positive she is counseled regarding how to manage her situation, build a support network, prevent her infection from spreading to others, and is given information regarding breastfeeding and other maternal HIV issues using the *Self-Care Book 4: Staying healthy for mothers living with HIV* (this booklet is being used nationally). According to protocols that have been developed by the NMCHC, clients who join the PMTCT program and are diagnosed as HIV positive are offered the option of delivering at the RH with Nevirapine therapy. The mother receives one dose of Nevirapine during labor and the newborn receives one dose within 72 hours after delivery. Women who are diagnosed as HIV positive through the PMTCT program are accorded high priority to receive ART if they meet other eligibility criteria.

Clients are encouraged to bring their husbands to the mother’s classes and have them join the PMTCT program. Husbands are counseled with the wives and also offered HIV testing.

What are the referral links between the PMTCT program and other components of the CoC?

As noted earlier in this document, pregnant women who attend the VCT Clinic are referred to the ANC (PMTCT) clinic. PMTCT counselors refer HIV positive clients of the PMTCT program to the OPD. Pregnant women who attend ANC Clinics in HCs elsewhere in the OD are referred to the Moug Russey HC PMTCT services.

Managing and improving the quality of PMTCT services in Moug Russey

Efforts to improve the quality of PMTCT services at Moug Russey HC include a weekly meeting attended by all midwives who work in the program as well as periodic supervision from both NMCHC as well as from the PHD. As with other components of facility based care in the CoC, FHI provides ongoing monitoring support.

Achievements in PMTCT:

404 of 727 pregnant women who attended the ANC Clinic at the Moug Russey HC during October 2003 and May 2004 joined the PMTCT program, as did 122 husbands. The 526 people were counseled and tested for HIV. Six of the 404 women tested positive for HIV and two have subsequently delivered in the maternity ward at the RH. Mothers and their newborns were given Nevirapine.

Antiretroviral therapy

I am very glad to be receiving ART. ART gives me the chance to be alive again

PLHA on ART at Moug Russey Referral Hospital

It can be seen that large number of PLHA will benefit from care and treatment program through effective prophylaxis and management of opportunistic infections (OI). However, smaller number of PLHA will meet the conditions and criteria for antiretroviral treatment (ART).

After the period of nearly 10 months during which the service for OI management has been established and well functioning, Moug Russey referral hospital started ART for eligible patients.

The first client to receive ART at Moug Russey began treatment on June 4th, 2004. Within the month, 20 patients started ART. ART is provided through the OPD, which is open from 7:30 to 11:00 am and 2:00 to 5:00 pm Monday, Wednesday, and Friday. ART is provided free of charge.

The process through which the client’s eligibility to receive ART is determined is outlined below. The procedures for providing eligible clients with ART and follow-up care are also described, as is the way in which RH personnel work together to manage ART. The referral networks that link ART with other components of the CoC are explained along with supervision and monitoring processes that have been instituted to ensure the quality of ART management.

The process of providing ART to clients

The process that is used to identify clients who will receive ART through the Moug Russey CoC is composed of five steps: 1) initial screening, 2) education and counseling, 3) eligibility assessment, 4) initiation of ART, and 5) follow-up care. The client begins the process by being under the care of the OPD for at least three months where his medical conditions and his adherence will be observed. Subsequently, s/he will be screened for eligibility to receive ART. The client who meets the criteria receives education and counseling regarding ART and establishes baseline laboratory test results; the client then elects whether or not to apply to the ART Committee to receive ART.

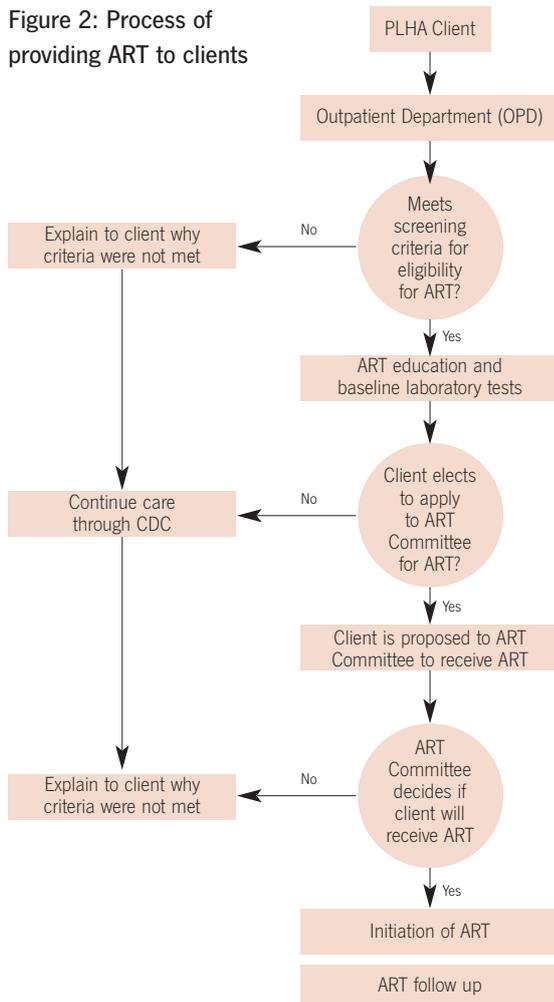
The ART Committee judges the application against established criteria and identifies clients who meet the criteria. The successful client then initiates ART and receives follow-up care throughout the duration of his treatment.



PLHA group leader and first batch of ART recipients at Moug Russey

The figure below outlines the process through which individual clients receive ART.

Figure 2: Process of providing ART to clients



Text below provides additional details regarding the five steps.

Step 1: Initial screening for eligibility

The OPD is the entry point to ART. It is where the client begins to establish eligibility to receive ART. It is also where the health system controls access to ART. The client of the OPD who demonstrates excellent compliance with treatment regimens for OIs or preventive treatment is medically assessed for initiation of ART. Screening criteria include the following:

- The client has been under the care of the OPD team at least 3 months.
- The client has demonstrated adherence to treatment for OIs or preventive therapy.
- The client is classified as HIV Clinical Stage 3 or 4.
- The client is not critically ill.
- The client’s CD4 count is less than 200/mm³ (priority for patients with a CD4 count of less than 50 cells/mm³).
- The client is “ART naïve”⁸ (priority).

The ART Committee discusses the eligibility of non-naïve patients and PLHA who are referred from outside of the Moug Russey OD on a case-by-case basis.

Step 2: Client education and counseling

The client who is found to meet screening eligibility criteria subsequently participates in ART education and counseling activities. The client’s active participation in these activities allows him to understand the benefits, potential risks, and side effects of taking ARV. The client then must decide whether or not he wants to apply to receive ART. If the client decides to apply for ART, his application is transferred to the ART Committee.

The subject matter addressed during ART educational and counseling activities at Moug Russey include the topics listed overleaf:

⁸ A naïve client is a client who has not been treated previously with ARV

Table 6: Topics addressed during ART educational and counseling activities at Moug Russey

- What is ART?
- ART is a life-long treatment.
- Treatment with ARVs can stop the HIV virus from multiplying but it is not a cure.
- The client on ART is still infected with HIV and can transmit HIV to others.
- The schedule for taking ART and for receiving follow-up visits.
- Possible side-effects and drug interactions of ART.
- The need for the client to take all of the prescribed ARVs, and not to share them with family members, friends, or partners.
- The important of adherence to the treatment regimen.

Step 3: Assessment for eligibility by ART Committee

The ART Committee in Moug Russey accepts and reviews applications from clients who have met initial screening criteria, participated in ART education and counseling, and elected to apply to receive ART. The ART Committee determines the individual client’s eligibility to initiate ART based on the extent to which the client meets established selection criteria. The Committee is needed in order to promote transparency and fairness to PLHA. It also helps prevent nepotism or other irregularities. The selection criteria include the following:

- Lives in the Moug Russey OD catchment area (*priority*). (As the capacity to administer ART will not be developed in all RHs, in the future a system to refer patients from other ODs to Moug Russey RH for ART may be set up to meet the needs of PLHA.)
- History of good adherence to treatment regimens.
- Social criteria including mothers who take care of several children, heads of families, couples, and mothers referred from the PMTCT.
- Good understanding of benefits, potential risks and side-effects of taking ART.
- Committed to adhering to ART.
- Actively involved in self-care.
- Able to attend follow-up visits regularly.
- Family support is available.
- Treatment supporter is available (e.g., peer support group, local volunteer, or “buddy”).
- Allows home visit.
- HIV status disclosed to family and friends.

The committee prepares a list of clients who have met the selection criteria and sends this list to the ART Coordinator with instructions to provide ART to the selected clients.

Step 4: Initiation of ART

The eligible client begins the process of initiating ART by receiving pre-treatment counseling that reinforces information given in previous education and counseling sessions. Additional issues that are also discussed include details of the first-line ART regimen (names of drugs, dosage, frequency, etc.); common side-effects and how to manage them; when to attend the OPD and collect ARVs; when to seek care; and the benefit of receiving social and/or spiritual support to help maintain adherence. The client is then issued a one week supply of ARVs and given an appointment time for his follow-up visit.

Step 5: Follow-up care

Follow-up visits for the client receiving ART must be performed frequently in order to monitor side-effects and adherence to therapy. The new client visits the OPD for follow-up each week for the first two weeks following initiation of ART. If the therapy is progressing satisfactorily, the client attends the OPD every two weeks for the next two months. Following this initial intensive follow-up period, the client whose therapy is proceeding smoothly attends the OPD once a month for a medical assessment and to receive ARVs.

The different RH staff members who support the provision of ART have responsibilities that are outlined in the table below:

Table 7: OPD staff responsibilities in the provision of follow-up care for ART

Staff position	Responsibilities
Physician / Medical Assistant	Perform medical assessment (see list of elements of medical assessment below)
Nurse	Perform triage, patient registration, and record keeping
Nurse and Outpatient Department PLHA Volunteer	Assist client to determine his needs and how they can best be met including referral to the following components of the CoC: community / home-based care, PLHA Support Groups, spiritual support, MMM, psychological support, and other hospital services
Pharmacist and PLHA Volunteer in pharmacy	Counsel client regarding use of ARVs and provide information regarding ARVs

The medical assessment that is performed by the OPD physician or medical assistant during the follow-up visit includes the following elements:

- Clinical review of signs and symptoms.
- Review history and check for OIs and other health problems.
- Review the use of medication with the client and his treatment supporter.
- Assess occurrence of side-effects and complications.
- Determine whether there is an adherence problem.
- Identify barriers to adherence (if there is a problem with adherence).
- Reinforce messages given during education and counseling activities.

How is adherence to ART supported through the CoC?

The need for the client to continue ART throughout their life can have a negative impact on their adherence to the therapy. The client’s understanding of the importance of compliance and their motivation and commitment to adhere to the therapy are the keys to achieving a successful outcome from ART. Adherence is supported by OPD staff members who check the client’s understanding of all information regarding ART and monitor his compliance with the treatment regimen on a monthly basis. The continuum of care from hospital to health center to community and home provides invaluable support to the client’s compliance with the therapy. In addition, community-based partners educate community members about ART and its benefits and limitations in order to improve community support for clients on ART and

thereby improve their adherence to ART.

How do referral networks link ART to other components of the CoC?

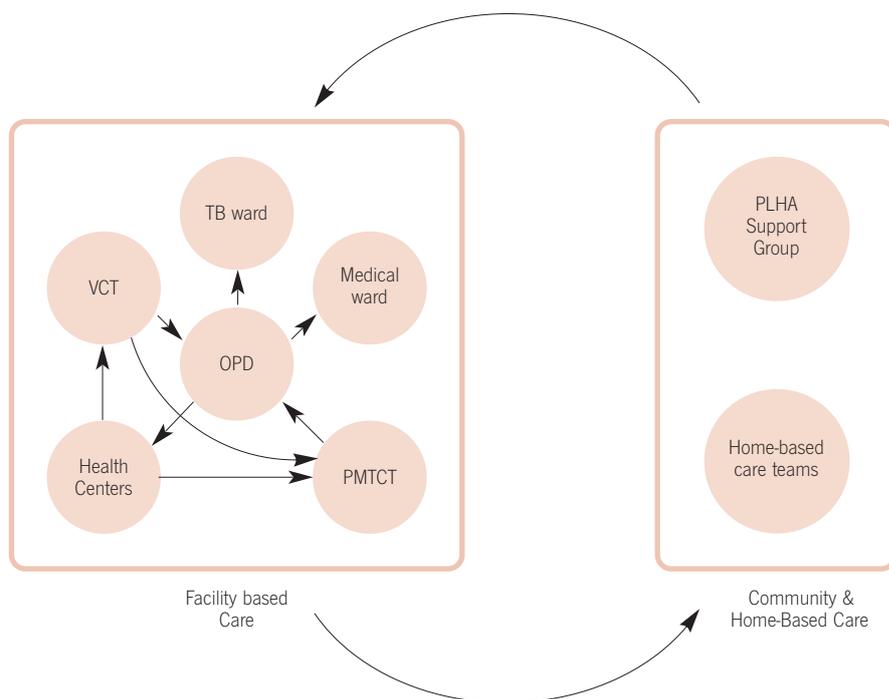
ART is connected to other components of the CoC through a variety of links. OPD staff members assess each client’s eligibility to receive ART and refer clients who meet the criteria to the ART Committee for consideration. Clients who have initiated ART are referred to several community-based components of the CoC for support. Clients on ART are referred to the HBC team serving their village for follow-up care and counseling. They are also referred to health centers where they can receive counseling and care for minor side-effects of ART. Clients on ART are also referred to PLHA Support Groups for community-level support that includes peer education, counseling, and drug monitoring.

Referral mechanisms

Referral systems generally are not well established in the Cambodian health services. The need to establish referral links between the various components in the CoC was not well understood initially by medical personnel at the RH. However, staff members at both the institutional and community-level have been quick to realize the importance of referral processes. The PHD considers the establishment of referral mechanisms to have been a key step in the implementation of the CoC.

A figure and table are presented together on the following pages that outline the primary referral links that have been developed between the major components of the CoC. The figure pictorially describes the CoC components that are connected by referral links as well as the direction of the referral.

Figure 3: Referral network in Moug Russey Continuum of Care



The table below provides additional information that, for each of the referral links in the figure above, describes the client that is referred and the purpose of the referral.

Table 8: Principal referral links in Moug Russey Continuum of Care

CoC component	Refers to	Who is referred, for what
VCT Clinic	OPD ANC Clinic	HIV-positive clients, for examination Any client who is pregnant, for ANC
OPD	TB Ward Medical /Pediatric Ward Health Center Health Center, Home-based care (HBC) ART Committee HBC Health Center PLHA Support Groups	PLHA with severe TB, for admission as inpatients PLHA with severe illness, for admission as inpatients PLHA with active TB, for DOTS therapy PLHA, for follow-up management of OIs PLHA who meet initial screening criteria for ART, for consideration to receive ART. PLHA on ART, for follow-up care and counseling. PLHA on ART, for counseling and care for minor side effects of ART. PLHA on ART, for community-level support that includes peer education, counseling, monitoring of the drugs, and social support.
TB ward in RH	VCT HBC	TB inpatients who are suspected of being HIV-positive, for HIV test PLHA who are taking IPT and TB treatment, for follow-up to ensure adherence
TB services at HC	VCT	Patients on DOTS who are suspected of being HIV-positive, for HIV test
PMTCT service in ANC Clinic	OPD CHBC	Pregnant women diagnosed as HIV-positive, for examination and treatment Post-partum HIV-positive women, for follow-up management of mother and newborn.
Health Centers	VCT PMTCT CHBC	Chronic or high-risk HC clients with STIs, for HIV test Any client who is pregnant, for PMTCT counseling and HIV test PLHA on DOTS therapy, for home-based follow-up
CHBC	VCT	Community members suspected of being HIV-positive, for HIV test

Health centers

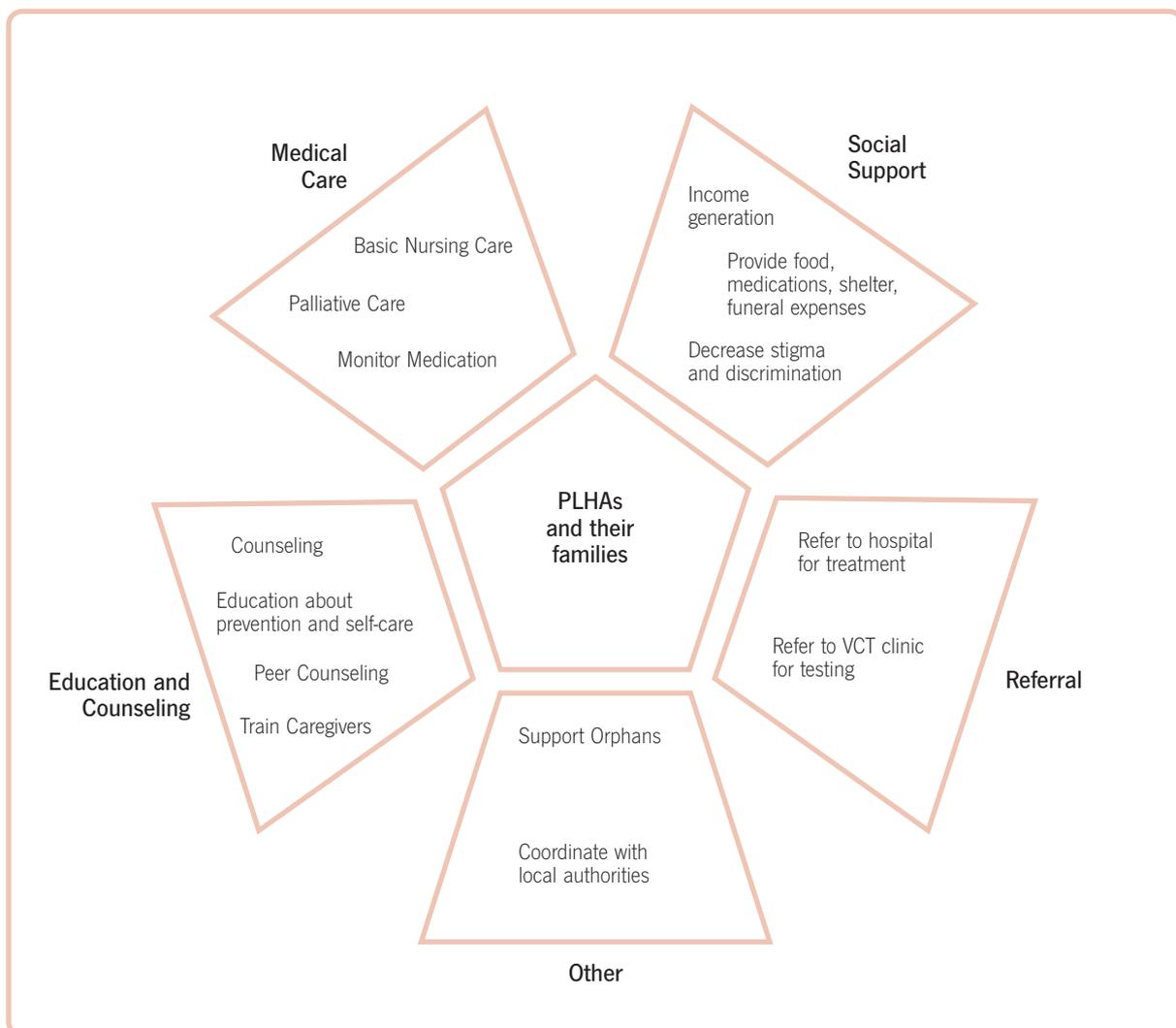
The primary role that some HC staff have played in HIV/AIDS care in Cambodia has been to contribute a member to each of the home-based care teams organized by NGOs to conduct home visits for PLHA. This is also the case in Moung Russey. HC staff are unique among government health personnel in that they have medical training and are also based in the community. HC staff members currently accompany the HBC teams in Moung Russey on home visits almost every day. CoC planners intend to reduce the number of days that HC personnel participate in HBC to one or two days per week, while at the same time improving their capacity to provide high-quality facility-based care in the HC.

In addition to their Minimum Package of Activities (MPA) services, HC staff can provide supportive counseling and pre pre-test counseling to clients. They promote adherence to OI therapy and ART, explain the benefits, and address side-effects of treatment.

Implementing community and home-based care within a CoC framework

The continuum of care model not only enables the strengthening of community and home-based care (CHBC) as an independent group of services, but also allows facility based care (FBC) and CHBC services to reinforce and strengthen each other through linkages. The text and figure below describe how CHBC services are implemented in Moung Russey and how CHBC and FBC services have been linked.

Table 4: Components of home-based care



Providing home-based care in Moung Russey

The teams that provide home-based care (HBC) in Moung Russey represent a diverse set of partners – the government, local NGOs, the community, and the PLHA. These partners each bring their own backgrounds and skills to the task of providing care to PLHA in their homes and communities. The figure above illustrates the different activities that together make up HBC services in Moung Russey.

Community-level care and support through PLHA

Support Groups

Four independent PLHA Support Groups (PLHA-SGs) have been formed in communes supported by KRDA. Each group has a Support Group Leader (SGL), a deputy SGL, and from 15 to 30 members. The SGL, who is generally a PLHA, plays a key role in community-based component of the CoC that includes the following:

- Plan and conduct the monthly PLHA-SG meeting
- Perform health education
- Provide information to members of the HBC team
- Identify sick and/or poor members of the PLHA-SG
- Link PLHA with services (e.g., the SGL will link a client who doesn't want to continue his treatment regimen with a physician) and encourage PLHA to attend the OPD
- Assist in the management of the saving and credit scheme (a fund managed by the PLHA-SG that saves money and lends it at favorable interest rates to members in need)
- Advocate for social support for PLHA

The PLHA-SGs meet regularly every month in the communes. Meetings are attended by PLHA, LINGO staff, community volunteers, and community leaders. The meetings take place at the health center or in a private home and generally run from 1:00 to 5:00 pm.

The Support Groups have given themselves names that include *Red Rose*, *New Life*, and *Hopeful*. Activities that take place during the meetings include discussion and sharing information regarding health and livelihood, identification of members who need extra support, and activities relating to savings and credit schemes that are run by the PLHA-SGs. Three of

the four groups have started savings and credit schemes. The assets of the three groups as of late February 2004 totaled \$220, \$50, and \$8.

Integrating community and home-based care into the CoC

FHI is the catalyst that took a paper project and made it real

Ms. Oeung Sakhory, Home-based Care Team Leader, KRDA

The introduction of FBC for PLHA in Moung Russey – and linking that care with community-based care – has resulted in successes and further challenges. One key finding has been that the purpose of and benefits from PLHA-SGs are not immediately apparent to leaders and members of the community. These stakeholders need to be engaged and educated regarding the objectives and advantages of the CoC before starting the process of establishing PLHA-SGs.

Leaders of community-based care for PLHA note the importance of including PLHA in planning and providing care and support as well as engaging and educating the community. From the inclusion of PLHA who understand CoC on the CoC Coordination Committee to disseminating information to the community through PLHA, the client perspective remains the most important. KRDA staff note that there is no more effective way to garner community support than for a PLHA, with the support of his relatives, to stand up in a community forum and say “I am HIV-positive. I am alive, and I want to stay alive.”

A KRDA representative also noted the importance of the involvement of an organization such as FHI to facilitate and “push” the project in its early stages. The energy, commitment, and resources that FHI provides have been crucial to the rapid progress of the project.

Many PLHA sell their homes and spend their life savings in efforts to treat their illness, rapidly becoming destitute in the process. Future challenges for organizations conducting community-based care and support activities in Moung Russey include the identification of additional resources to build shelters for and support income-generation activities among PLHA.

Referral links between facility and community-based care

Using a CoC model to support the establishment of FBC for PLHA and the strengthening of CHBC as has been done in Moung Russey creates possibilities for the two groups of services to be linked and to create synergies that improve the effectiveness of both components. Referral links that have been established include the HBC teams providing follow-up to care that clients receive through the OPD at the RH including ART. The OPD with support from FHI has developed a small patient personal booklet for recording treatment records and give information about how to stay healthy “Staying Healthy Handbook” that clients take with them back to their homes after they have been treated at the OPD. This sheet is shown to the HBC team and guides the follow-up care that they provide. The referral links go both directions – HBC teams have been trained to recognize severely ill clients and refer them immediately to the RH to receive care. In addition, HBC teams look for individuals in the community who may be HIV positive, and after discussing the benefits of HIV testing may refer them to the VCT Clinic for testing if they agree.



Staying Healthy Handbook

Desired outcomes, achievements, and lessons learned

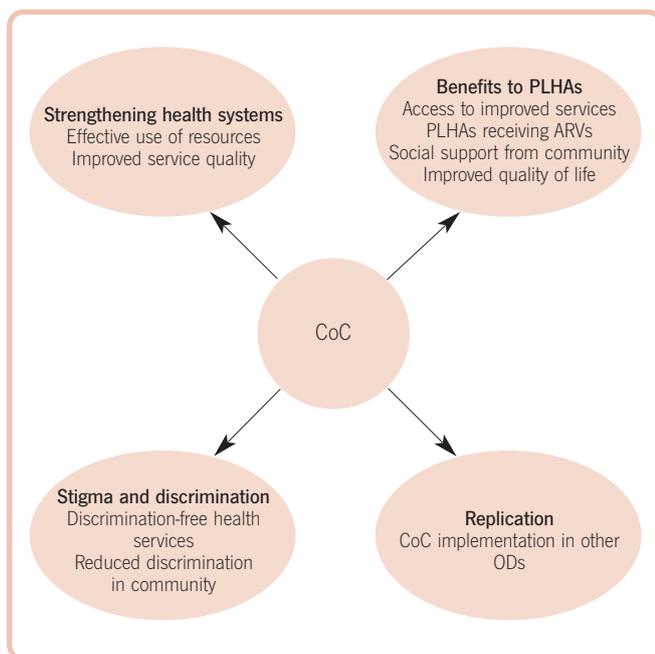
Now it is like a normal disease, because we have access to treatment

PLHA Support Group Leader, Moug Russey District, Battambang Province

What do stakeholders want for the CoC in Moug Russey to produce?

One might expect that the broad range of stakeholders in the Moug Russey CoC would result in an equally wide-ranging set of desired outcomes. Interviews conducted with stakeholders revealed that while there are a number of preferred results, many of them are shared among stakeholder groups. The four major desired outcomes that emerged from the interviews are shown in the figure below.

Figure 5: Desired outcomes from CoC among stakeholders in Moug Russey



The outcome that was most widely mentioned was for PLHA to receive a broad range of benefits that include access to antiretroviral drugs (ARVs), health services, and social support. The Moug Russey project has followed a strategy of incremental strengthening of the capacity of the health system to the point where it now supports all aspects of the CoC, including the provision and management of antiretroviral therapy (ART). The desire of some stakeholders to have the CoC result in a better health system reflects the MoH strategy of using programs that support care for PLHA as a lever to strengthen overall government health services.

Progress and achievements

The desired outcomes as expressed by stakeholders form a useful framework that can be used to frame an early assessment of the progress and achievements that have been attained in less than a year of project implementation.

Strengthening the health system: The broad, collaborative nature of the project has resulted in an equally wide range of signs that the health system in Moug Russey has been strengthened. There has been notable improvement in the cross-cutting components of the health system that reinforces all health services. For example, medical information systems have been improved and in some cases created, referral systems within the hospital and between community and institutional services have been formed, and the capacity of the laboratory services has been improved. A broader perspective also reveals signs of a strengthened health system – the public trusts the health system more than it used to, the health system and the community are working together, and there are active partnerships between communities, the health system, and civil society.

High utilization of new services: The utilization data presented below should be placed in perspective. Prior to August 2003, PLHA almost never entered the grounds of the Moug Russey Referral Hospital fearful of the discrimination that they might face and knowing that, in any case, the care they needed was probably not available. Today, PLHA receive medical care at the hospital every month and state that they feel completely welcome there. Data showing the utilization of services offered under the CoC include the following:

- Of the 2,164 clients who have been tested for HIV in the VCT Clinic from October 2003 through March 31, 2004, 1,955 have returned for their test results (90%). 370 have been diagnosed as HIV positive.
- The OPD has registered and provided services to 635 PLHA clients through March 31, 2004.
- 27 of 158 PLHA clients who were screened for TB between September 1, 2003 and March 31, 2004 were diagnosed with active TB. Eleven TB negative clients are currently taking Isoniazid Preventive Therapy.
- 404 of 727 pregnant women who attended the ANC Clinic at the Moug Russey HC during October 2003 and May 2004 joined the PMTCT program, as did 122 husbands.
- Over 122 PLHA attended the MMM in February 2004 and 54 clients were seen at the OPD on that day.

Reduced stigma and discrimination: PLHA report a complete absence of discrimination at the health facilities in Moug Russey. PLHA feel that discrimination in the community has been reduced due to 1) education of community leaders and members and 2) health services that provide effective care, thus enabling PLHA to feel and look healthier.

Replication of the Moug Russey model: Representatives of the Moug Russey CoC Coordination Committee presented details regarding the establishment of the CoC in Moug Russey at a CoC dissemination workshop hosted by NCHADS in March 2004. The workshop was conducted in support of NCHADS plans to introduce a CoC model in seven new ODs in 2004. The Moug Russey project is widely considered to be the leading example in Cambodia of a CoC for PLHA implemented through the government health services.

Lessons learned from Moug Russey for expanding CoC in Cambodia

After seeing the continuum of care implemented in Moug Russey, I can say that the dream has come true

Dr. Mean-Chhi Vun, Director, NCHADS

Through the leadership of NCHADS' Director, Dr. Mean Chhi Vun, a great deal of effort has been expended in the initial stages of the establishment of the CoC in Moug Russey. Despite the short duration of project implementation, enough forward progress has been made for several key lessons learned to emerge. These conclusions are listed below.

Gaining health staff commitment to providing services to PLHA is attainable: The turnaround in health staff members' attitudes toward PLHA and their commitment to providing them with services in Moug Russey is striking. How was this commitment achieved? Interviews with a variety of stakeholders suggest that the following factors have contributed:

- Cambodian health professionals respond positively to opportunities for professional growth.
- Lack of basic knowledge among health personnel regarding HIV leads to unwillingness to provide services to PLHA. Possessing the knowledge and skills to provide services and understanding one's roles and responsibilities fosters willingness to help PLHA. Staff will help others if they feel capable of doing so.
- Health care providers in Moug Russey have received modest incentives to provide services to PLHA through sharing revenues generated through fee-for-service and participation in trainings. Given the low level of government salaries, such incentives are important and appreciated.

Making progress through engagement: Discussions with authorities and stakeholders in areas where authorities have been engaged regarding HIV issues (e.g., Moug Russey OD) and in areas where they have not quickly reveal gaps between the two groups regarding knowledge of HIV and the level of stigma towards PLHA. There is a great

deal to be gained in Cambodia simply by working with colleagues in the public health system and transferring knowledge and skills while modeling attitudes. It is often stated that stigma arises from negative attitudes. Experience to date engaging health personnel in Moug Russey suggests that lack of knowledge and skills also leads to stigma, and that engaging health personnel and strengthening their knowledge and skills can reduce stigma and discrimination.

The power of partnerships: The rapid, comprehensive establishment of services in Moug Russey has only been possible through partners working together in a complementary manner. Although any list of partners will invariably be incomplete, the success in Moug Russey owes much to each of the following organizations: the ADB, Battambang PHD, CRC, CWPD, district and local authorities in Moug Russey and Koh Kralor administrative districts, FHI, KRDA, KHANA, MoH, Moug Russey OD, Moug Russey RH, NCHADS, NMCHC, Pasteur Institute, PLHA Support Groups, RACHA, UNICEF, URC and USAID. Many individuals, including community volunteers and PLHA, have also contributed to the success of the project.

Expand coverage of PLHA: It has been a tremendous success for all involved that PLHA now openly utilize the government health services in Moug Russey. The number of clients that utilize services at the RH is beyond what stakeholders had expected. However, it is clear that many PLHA in Moug Russey OD do not know that they are HIV positive and that only a proportion of PLHA are taking advantage of the services available through the CoC. Most Cambodians will only seek HIV testing when they develop symptomatic AIDS disease. A challenge for the project in the future will be to encourage more PLHA – both those who know their status as well as those who don't – to use CoC services in the community and in the health facilities.

Future directions for CoC in Moug Russey

Collaboration among all partners and staff commitment have brought about this success. It is essential that this quality of collaboration continues for the promotion of long-term success. There is a need to further build capacities to improve our services and follow-up systems

Dr. So Sok, Hospital Director, Moug Russey RH

A “can do” attitude on the part of project partners has catalyzed a group of health officials and providers to achieve more progress in one year in Moug Russey than many projects attain in five. In addition to consolidating achievements to date, much remains to be done as stakeholders continue to develop the CoC. The major new initiatives that are planned for implementation during 2004 are noted below.

Consolidate the provision of antiretroviral therapy (ART): NCHADS has initially provided sufficient antiretroviral drugs (ARVs) for 150 PLHA. This provision will be increased considerably in the next year. Some stakeholders consider this aspect of the CoC to be the real challenge for the project. The project faces a number of questions now that it has begun to provide ARVs: What does it take to deliver quality antiretroviral therapy (ART) to all the PLHA who need it in Moug Russey? How can the community and home-based care component best support ART? Given the results that have been demonstrated in Moug Russey to date, it seems reasonable to expect that satisfactory answers to these and other questions will be found.

Establish the Equity Fund: Providing PLHA with support for transportation and subsidizing patient fees at the Moug Russey Referral Hospital is crucial for project success. The Moug Russey OD has been negotiating with the MoH and URC for some time to establish the Equity Fund in Moug Russey. This fund would subsidize the cost of transportation and pay medical fees for indigent clients of the government health services, both PLHA and non-PLHA alike. It is expected that this fund will become operational in Moug Russey in July 2004.

Strengthen care in health centers: Initial project efforts to improve facility based care (FBC) have focused on building up services in the Moug Russey Referral Hospital (RH). Now that the major service components included in the CoC have been established in the RH, new efforts to strengthen FBC will target the health centers (HC). Planned areas of activity will center on enabling HC personnel to carry out the following functions:

- Provide information and education regarding HIV/AIDS.
- Provide basic care and treatment of opportunistic infections and simple side effects from ART.
- Train PLHA in self-care techniques.
- Counsel clients regarding treatment options, ART and other issues.
- Provide follow-up home-based care to severely ill PLHA clients.
- Both refer clients as well as provide services to clients referred from other components of the CoC according to the protocols of the CoC referral system.

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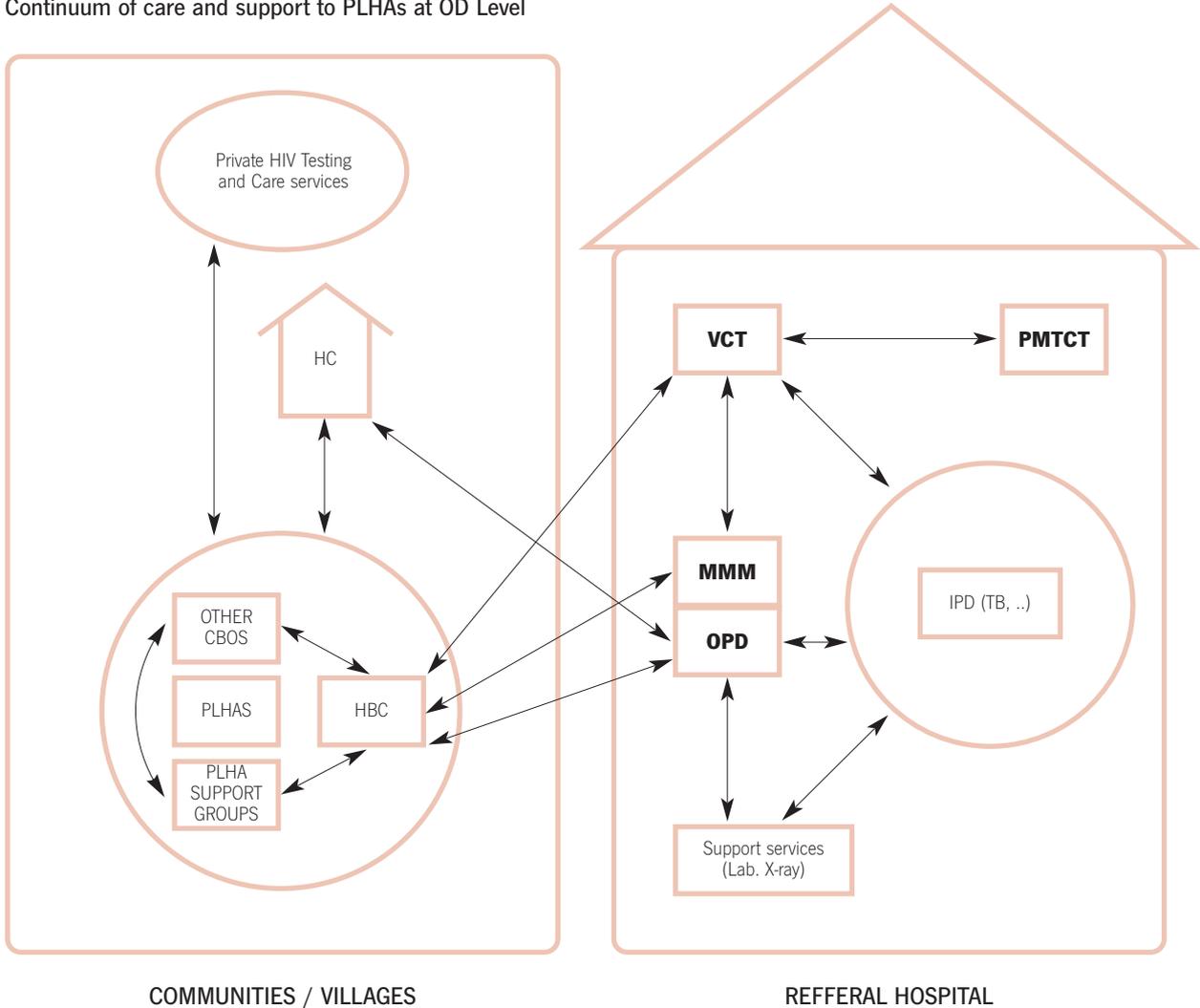
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Appendix 1: NCHADS CoC Chart

Continuum of care and support to PLHAs at OD Level



- In communities:
- CBO
 - Community leaders
 - Religious leaders
 - VHVs, VHSGs
 - Local NGOs
 - Hospices

Appendix 2: Members of the CoC Coordination Committee

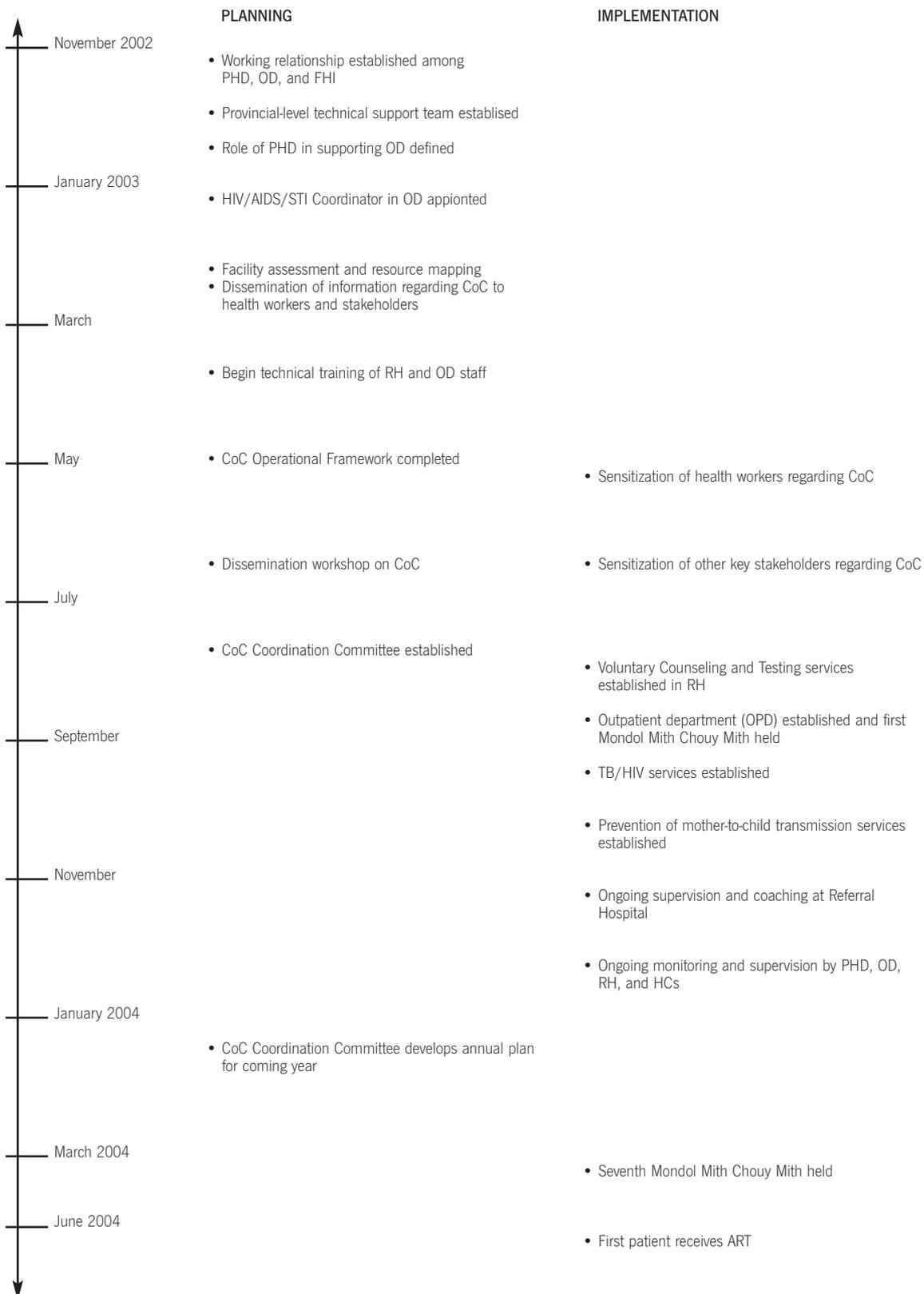
Name	Title	Position
Mr. Lom Som	Governor of Moung Russey District	Co-chair
Dr. Oum Vanna	Director of Moung Russey OD	Co-chair
Dr. So Sok	Director of Moung Russey RH	Vice-chair
MA. Thoung Puthy	Deputy Director of Moung Russey OD	Member
Dr. Pou Savannarin	HIV/AIDS/STI Coordinator of Moung Russey OD	Member
Dr. Eang Kor Vey	Technical Group Coordinator of Moung Russey RH	Member
Dr. Ho Sidara	Maternal and Child Health Coordinator of Moung Russey OD	Member
Dr. Khai Rattana	Director of Technical Bureau of Moung Russey OD	Member
MA. Kem Arunrith	TB Coordinator of Moung Russey OD	Member
MA. Neang Yeurn	VCT Coordinator of Moung Russey OD	Member
Mr. Kha Meng	PLHA-SG Leader from Moung commune	Member
Mrs. Eim Ladh	Chief of PLHA-SG Leader from Talos commune	Member
Acha. Yin Chat	Religious representative from Wat Por	Member
Acha. Leng Thoeun	Religious representative from Wat Por	Member
Ms. Louk Chantha	FHI representative	Member
Ms. Men Kosal	KRDA representative	Member
Ms. Ear Mony	RACHA representative	Member
Mr. Ty Trek	CRC representative	Member
Ms. Chhom Chhoep	CWPD representative	Member

Notes:

1. Source of list is Decision on Establishment of Continuum of Care Coordination Committee for People Living With HIV/AIDS at Maung Russey Operational District. Battambang Provincial Health Department.
2. MA = Medical Assistant

Appendix 3: Timeline of Planning and Implementation

Figure 6: Timeline of planning and implementation of CoC in Moug Russey OD





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