

**KINGDOM OF CAMBODIA**  
**Nation Religion King**  
ព្រះព្រះព្រះ



**Ministry of Health**

**Standard Operating Procedures (SOP)  
for Implementing Social Care for  
Orphans and Vulnerable Children (OVC)**



**National Center for HIV/AIDS  
Dermatology and STD**

**March 2007**

## **Foreword**

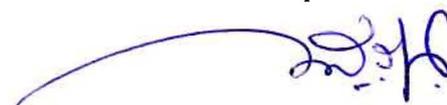
Despite increased coverage of care, treatment and support services, People Living with HIV/AIDS (PLHAs) still experience many challenges in accessing these services, particularly financial, social and psychological support. Even greater is the challenge to adequately provide social care and support services to the multitude of Orphans and Vulnerable Children (OVC), whether they are infected with or affected by HIV/AIDS.

Understanding these problems, the National Center for HIV/AIDS, Dermatology and STD (NCHADS), in collaboration with partners including UNICEF, Save the Children Australia, New Hope for Cambodian Children (NHCC), and the Clinton Foundation HIV/AIDS Initiative (CHAI), developed “Standard Operating Procedures for Implementing Social Care for Orphans and Vulnerable Children (OVC).”

NCHADS acknowledges that all stakeholders in civil society, including religious organizations and local NGOs who already support OVC, have a key role in providing social care and improving the lives of OVC. This document will be a key tool for use by all interested organizations and stakeholders as they address the problems facing OVC across Cambodia.

6 March 2007

On behalf of NCHADS and partners,

A handwritten signature in blue ink, appearing to read 'Dr. Mean-Chhi Vun', with a long, sweeping underline that extends to the left.

Dr. Mean-Chhi Vun  
Director, NCHADS

<p style="text-align: center;"><b>STANDARD OPERATING PROCEDURES (SOP)</b> <b>FOR</b> <b>IMPLEMENTING SOCIAL CARE FOR</b> <b>ORPHANS AND VULNERABLE CHILDREN (OVC) IN CAMBODIA</b></p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## **1. Background and Rationale**

In 2003, it was estimated that 123,100 adults aged 15-49 years of age were living with HIV/AIDS in Cambodia, of which approximately 20,000 were AIDS patients and were in need of care and treatment. UNICEF estimated that there were 670,000 orphans across the country in 2003, with an estimated 100,000 orphans caused by HIV/AIDS in Cambodia by the end of 2005. With so many orphans in the population, along with hundreds of thousands of vulnerable children, strategies must be developed to respond more effectively to their critical needs.

Due to increased demand for care for PLHAs, the Ministry of Health of Cambodia approved the Operational Framework for Continuum of Care (CoC) for People living with HIV/AIDS in April 2003. Holistic and comprehensive care and support for PLHAs was approved for implementation and has been strengthened and gradually expanded. As of October 2006, 18,060 PLHAs, including 1,560 children, were receiving ART services provided by over 40 OI/ART centers, with over 13,000 more people receiving OI treatment. Collaboration between different national programmes (HIV/AIDS, TB and MCH) has been strengthened. Community and home-based care services, support groups for PLHAs, and VCCTs have been strengthened and expanded to provinces and Operational Districts (OD) nationwide.

Despite increased coverage of care, treatment and support services, PLHAs still experience many challenges in accessing these services, particularly financial, social and psychological support. Even greater is the challenge to adequately provide social care and support services to the multitude of OVC, whether they are infected with—or directly and indirectly affected by—HIV/AIDS.

Many government institutions, local and international NGOs, pagodas and orphanages, among others, already provide imperative social care for OVC. However, each organization uses a different approach to implement social care programs. Currently, no coordinating mechanism exists for collaboration and dissemination of strategic, effective social care programs for OVC. This SOP seeks to provide such a mechanism.

## 1.1 Definition of Orphans and Vulnerable Children

Orphans are defined as children below the age of 18 who have lost one or both parents. A child made vulnerable by HIV/AIDS is below the age of 18 and meets one or more of the following criteria:

- \* Has lost one or both parents/caregivers
- \* Has a chronically ill parent/caregiver
- \* Lives in a household where in the past 12 months at least one adult died or was seriously ill for an extended period of time
- \* Lives outside of family care (i.e. lives in an institution or on the streets)

OVC face many problems, which include:

- \* Increase in poverty due to death of parents
- \* Loss of family and identity
- \* Lack of adequate adult support
- \* Increased risk of exploitation, esp. labor and sexual exploitation
- \* Fewer opportunities for education
- \* Loss of access to health care
- \* Poor nutrition and malnutrition
- \* Homelessness and vagrancy

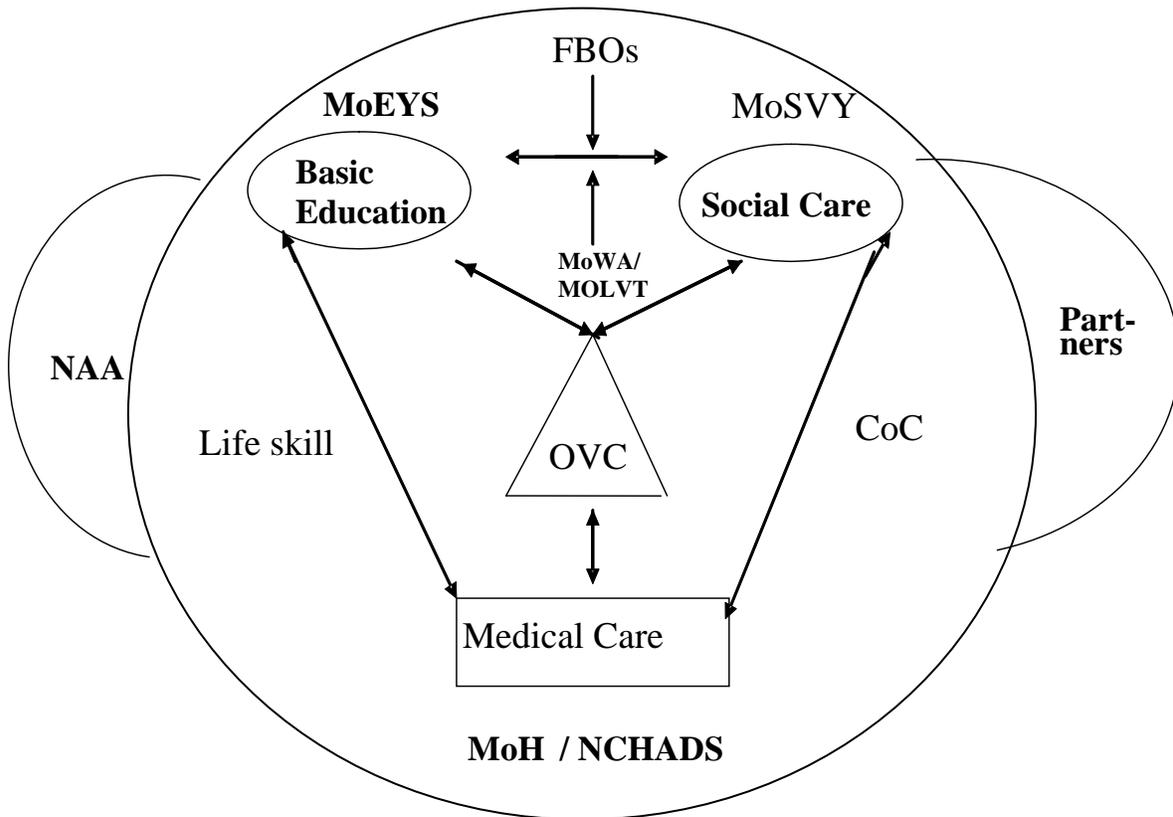
## 1.2 Model for Comprehensive Care and Protection of OVC

Social care for OVC falls directly under the *National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS in Cambodia 2001-2005*, whose central goal is:

“Empowering the individual, family, and community in preventing HIV and dealing with the consequences of HIV/AIDS through the promotion of a social, cultural, and economic environment conducive to the prevention, care, and mitigation of HIV/AIDS.”

Furthermore, social care is a key component in the model for comprehensive care and protection of OVC as outlined by NCHADS. The model for comprehensive care and protection for OVC promotes a multi-sectoral approach that combines medical care, social care, protection and education.

*Diagram 1: Model for Comprehensive Care and Protection of OVC*



### 1.3 Overview of Continuum of Care

The Continuum of Care (CoC) links the following key elements of comprehensive HIV/AIDS care:

- \* **Clinical Care:** *Diagnosis of HIV infection, Management of Opportunistic infections (OI) including TB, Prophylaxis of opportunistic infections, symptomatic and palliative care, antiretroviral (ARV) therapy, universal precautions (UP) and post-exposure prophylaxis (PEP), and prevention of mother to child transmission (PMTCT).*
- \* **Support:** *Counseling, psychosocial and financial support, support for caregivers and children affected by HIV/AIDS (CAA), and reduction of stigma and discrimination.*
- \* **Health Promotion and Education:** *Information and education for people living with HIV/AIDS (PLHA) and their families about HIV and HIV care, nutrition, and prevention of further HIV transmission and family planning.*

As seen in the diagram in section 3, Social Care for OVC is directly linked to the “Support” element as well as the “Health Promotion and Education” element of CoC.

## 2. Objectives

The purpose of this SOP on Social Care for OVC is to provide a structural mechanism and clear strategic direction for the implementation of social care programs by all stakeholders working with and for OVC. It aims to build upon policies set out by NAA and MoSVY pertaining to OVC and the alternative care for children. It seeks to harmonize the multisectoral implementation of social care at the provincial and operational district levels in a well-coordinated manner. In so doing, the SOP defines the components of social care as they relate to OVC.

Social care must be provided to OVC who have already been identified. However, large numbers of OVC have yet to be officially identified, and are systematically excluded from social care programs until they have been identified. This SOP elaborates a strategy for improving the identification of OVC.

This SOP proposes linkages between social care and medical care for OVC, especially the linkage between the identification of OVC and the provision of needed medical care, including HIV testing. The SOP creates a linkage mechanism to improve the access of HIV+ OVC to medical care and ART. The SOP seeks to promote linkages between adult and child social care support systems in order to close the gap that currently exists between these realms.

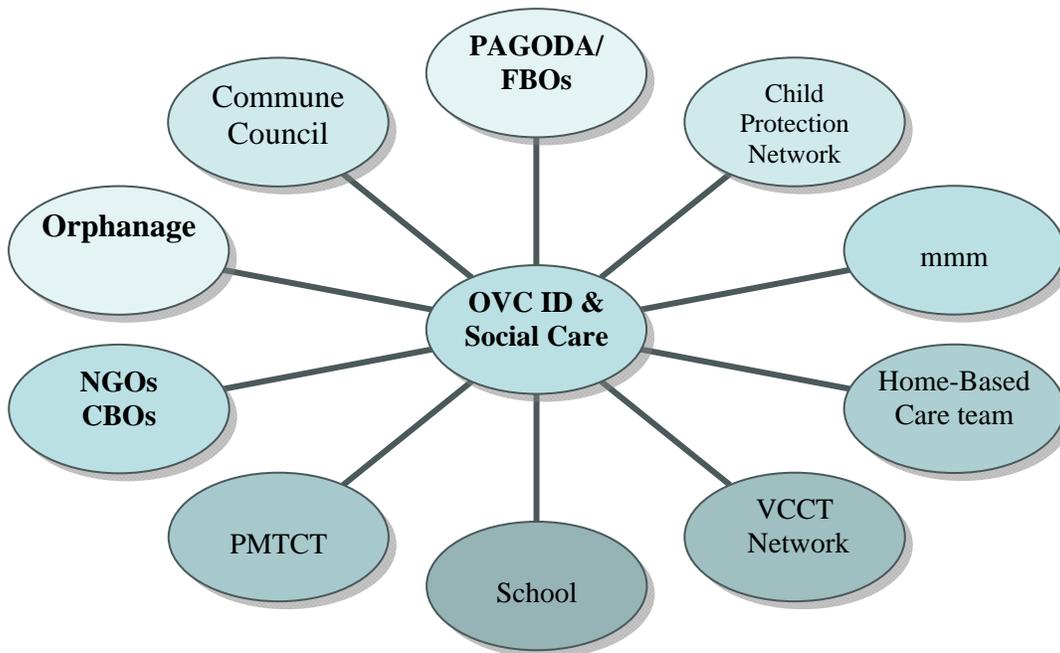
By outlining a coordinating mechanism for social care for OVC, this SOP carries the following broad goals:

- To strengthen the capacity of families to protect and care for OVC
- To mobilize community-based responses to support affected families
- To ensure equal access to essential services for OVC
- To provide government protection for the most vulnerable children, as per the MoSVY plan of action
- As per MoSVY's *Policy on Alternative Care for Children*, to ensure access to health services, free education, nutrition, and free psychosocial support for OVC survival and development
- To raise awareness and create a supportive environment for OVC and all children.

### 3. Standard Minimum Package of Social Care

#### 3.1 OVC Identification

*Diagram 2: Sources for identifying, testing, and providing social care to OVC*



As demonstrated by this diagram, a multifaceted approach is needed for the identification of OVC. Identification must be expanded so that OVC receive the medical and social care they need. Unofficial community centers, such as pagodas, as well as those institutions with direct contact with children—such as schools, mmms, CBOs, and orphanages—shall serve as important identification points.

The Commune Council shall serve as the local database for the number of OVC identified, the number who have received testing, and the number receiving social care in each operational district (OD). Confidentiality must be respected, and therefore, individual names, addresses, and health status will not be kept here.

The system of identification must also promote advocacy, broad-based community awareness campaigns and capacity-building programs to ensure that the identification system operates effectively.

### 3.2 Referral Mechanisms for Testing OVC

The linkages and referral mechanisms between OVC identification and HIV testing must be strengthened as an integral part of the continuum of care, which links medical care with social care (see Diagram 1 above). Therefore, referral for HIV testing shall be included in the standard package of care for OVC. For a clear description of the referral mechanisms for each institution involved in identifying, testing and providing social care for OVC, see Section 4.4.

### 3.3 Nutritional Support

OVC are at increased risk of malnutrition and illness, and they are less likely to get the medical care they need. Often this increased risk is a result of economic hardship following the loss of a parent and/or increased exploitation, vulnerability, and/or stress.

Nutritional support activities shall be integrated into the social care package of all OVC. Given the link between nutritional status and HIV infection, particular attention shall be given to nutritional assessment of infants and children who have been exposed to HIV. Furthermore, good nutrition is essential for children who are HIV+ and on ART. Good nutrition while on ART has been shown to lead to better health and less resistance to ARVs. Growth is a very sensitive indicator of HIV and disease progression in children.

The growth and development of all OVC shall be carefully assessed and monitored by a variety of bodies, including caregivers, such as families, monks, and orphanages, as well as NGOs, HBCs, mmm, and schools. These groups shall be trained in the national nutritional guidelines (when available) to support nutritional care for all children.

Nutritional support shall be sought from a variety of organizations and/or private donations. World Food Program (WFP) nutritional packages have greatly improved the nutrition of OVC, but the basic supplement provided lacks key ingredients such as proteins. Where possible, protein supplements should be acquired to accompany WFP packages. NGOs and CBOs shall oversee the distribution of nutritional supplements. The distribution itself shall be carried out on-the-ground by the same OVC support groups that support identification (pagodas, CBOs, NGOs, orphanages, and other community centers). When the families of OVC come to pick up their nutritional support, OVC support group members raise awareness in OVC and their caregivers regarding nutritional requirements, hygiene, and advocacy.

For OVC living with HIV/AIDS, a strong linkage must be established between the provision of nutritional support and pediatric AIDS care. This linkage can be established through incentives and frequent monitoring, primarily through two mechanisms:

- Distribution of nutritional support at pediatric OI/ART and mmm sites, ensuring that HIV+ OVC come in for medical care appointments and psychosocial support. Nutritional and hygiene education will be provided at mmm meetings and upon food distribution.
- For all OVC, (not just those infected with HIV/AIDS), regular monitoring through a coordinated effort between OVC support groups and HBC teams must be established to ensure that the nutritional requirements of OVC are being met. Regular monitoring (more than once a week) shall prevent cases in which most nutritional support goes to the strongest member/breadwinner of the family.

#### **Standard Minimum Nutritional Basket**

<b>Item of expenditure</b>	<b>Rate</b>	<b>Remarks</b>
Standard Minimum Food Bundle (30 kg rice, 1 L vegetable oil, ½ kg iodized salt)	US\$15 per family per month	Quantities based on family of 5, with at least 1 OVC and max. 2 caregivers. Adjustments must be made as needed to meet familial needs. Support must be linked to nutritional requirements of OVC
Protein Supplement—dried fish	US\$ 4.50 per family per month	Quantities based on family of 5, with at least 1 OVC and max. 2 caregivers. Adjustments must be made to meet familial needs.

### **3.4 Education and Life Skills**

Education for OVC shall be overseen by the Ministry of Education and Youth Services (MoEYS) in coordination with the Ministry of Labor and Vocational Training and the Ministry of Women’s Affairs.

Education provides children a safe, structured environment—with supervision and support by adults, something which they may not have at home—and a forum to develop social networks. Additionally, education can reduce risk of HIV infection by increasing knowledge, awareness, skills and opportunities.

Teachers shall be trained to identify OVC in their classrooms. They shall also be trained in advocacy and awareness-raising regarding the need for HIV prevention and testing.

School fees for OVC shall be waived or minimized, according to Cambodian law. Financial assistance for private lessons shall be an option if available, at the discretion of the institution providing assistance. Financial assistance for uniforms, shoes, and start-up kits—which include books, book bags, writing materials and writing implements—shall be encouraged, to be implemented by NGOs and CBOs.

In addition, practices shall be implemented that favor school attendance for OVC. In a pagoda-based system, monks speak with each family with an OVC, and together they make a contract in which families agree to send their children to school. Monks shall speak with the school director every month to ensure that OVC are on the attendance rolls. Local authorities or the Commune Council can also carry out the function of negotiating and making sure that OVC attend school. If OVC are not enrolled, assistance will be revoked until the children return to school.

For OVC, especially for those who have experienced the premature death of parents, skills are no longer passed down from one generation to another. In the absence of parental guidance and support, adolescents and young children are forced to take on responsibilities for which they may not be prepared. Training children to cope with such demands is an essential element of the educational response. HIV prevention education shall be an integral component of life skills training.

Caregivers—whether monks, orphanages, families, or communities—must be trained to provide life-skills education to OVC. NGOs will be instrumental in organizing these trainings at the community level.

**Standard Minimum School Package**

<b>Item of expenditure</b>	<b>Rate</b>	<b>Remarks</b>
Bookbag	US\$2 per child	As needed based on annual assessment
Notebook and Pencil	US\$ 1 per child	Provide notebooks and pencils to each child annually
Uniforms	US\$ 3 per child for 2 uniforms	As needed based on annual assessment, most likely need to provide every year
Shoes	US\$ 1 per child	As needed based on annual assessment, most likely need to provide every year
Assistance for private lessons	US\$ 5 per child per month	This expense based on community realities, and represents optional educational support.

### 3.5 Medical Transportation

OVC often cannot receive necessary medical care because they are structurally prevented from accessing health clinics or hospitals. Depending on their location, families may lack the road access and funds to arrive at a medical care facility. Furthermore, the roads that exist often lack infrastructure and are plagued by flooding. Finally, many OVC and their families do not understand the need to take transport—they have not been educated on the services available to them at medical care facilities.

Social care for OVC must therefore address transportation costs for medical visits, both in terms of direct payment and in terms of access in an area (improved roads and the provision of vehicles). Social care programs must include an educational component to teach families what services are available to them at medical care facilities, and how to arrive at these facilities for low or no cost.

#### **Standard Minimum Monthly Transportation Fee**

<b>Item of expenditure</b>	<b>Rate</b>	<b>Remarks</b>
Moto ride to/from health clinic	Allocate lump sum of US\$2 per child (plus caregiver) per round-trip ride.	Based on actual costs of transport. Allocate funds to allow for max. 2 rides per child per month.

### 3.6 Child Village Social Fund

Each village shall have a social fund for children. The funds shall be used only for emergency cases, not for one-time or ongoing support. In this way, OVC can access emergency support if needed. NGOs/CBOs can help the village set up the Child Village Social Fund. The managing committee of the social fund shall include the following people:

- Two child village representatives
- Village chief
- Community social helper
- Achar (monk's assistant)
- Two Planning and Budget Committee members

Fundraising is conducted on a regular basis by members of the committee, such as at religious ceremonies at the local pagoda, national holidays or when wealthy patrons visit the village. No funding shall be provided by NCHADS, and little, if any, funding shall be provided by NGOs after the establishment of the social fund.

### 3.7 Follow-Up

Follow-up by OVC support groups must be included in the overall project of social care. Once OVC have been identified and services provisioned to them, support groups must ensure that the children are getting what they need to survive. Furthermore, precisely

because of their vulnerability, support groups must assess how OVC are protected. Follow-up must prevent the forced labor, exploitation, and trafficking of OVC.

## **4. Coordination and Implementation of Identification, Testing, and Social Care**

### **4.1 Needs assessment and initial planning process**

An initial rapid assessment shall be carried out as part of CoC assessment by the OD Coordinator with assistance from the PAO and NCHADS, and focused on:

- Scope of the HIV/AIDS and OVC problem in the OD: estimated number of PLHAs and AIDS Cases, orphans and vulnerable children;
- Identification of an appropriate locations for centers of identification and support of OVCs
- Identification of members of social support group (monks, members of community governance structure, institutions, NGOs, community-based organizations (CBOs))
- Identification of needs of OVCs;
- Resources needed/cost estimates
- Identification of stakeholders and supportive partners

The report of the assessment (with findings and recommendations) will be presented, discussed and endorsed by the OD Continuum of Care Coordination Committee (CoCCC), where all stakeholders, including representatives of OVCs (caregivers), CBOs and local and international NGOs who work in that OD, are included.

### **4.2 Coordinating Mechanisms**

#### ***4.2.1 CoCCC Coordinating Committee***

Social care for OVC is an integral component in the successful provision of Comprehensive CoC. As a forum for the coordination and implementation of programs to identify OVC and provide social care to these children, the Continuum of Care Coordinating Committee (CoCCC) in each Operational District (OD) shall assume overarching responsibility. It will improve informational flow and encourage collaboration among all relevant stakeholders in OVC social care and HIV/AIDS care, including NGOs and CBOs. Potential members of the CoCCC include:

- Director of OD
- District Governor
- **OD HIV/AIDS/STI Coordinator**
- Director of RH

- Director or deputy director of the technical bureau of RH (Coordinator of HIV activities at RH)
- Head of infectious diseases or medical ward of RH
- OD TB Supervisor
- Provincial Director of MoSVY where possible, because MoSVY has a mandate for the provision of Alternative Care to OVC
- Provincial director of the Ministry of Education (MoE) where possible, in order to improve OVC access to education
- Representative of NGOs, especially those working on social care for OVC
- Representative of HBC teams
- Director of VCCT service
- Representative of DPN+, or other MMM and mmm coordinators
- Representatives of CBOs
- Religious and Community Leaders

Ideally, the CoCCC will include 12-15 members and will meet once per month. The OD HIV/AIDS/STI Coordinator shall chair the CoCCC. The CoCCC will ensure that all relevant stakeholders at the OD level work together for the optimum use of resources available. It will identify needs, gaps, and areas of collaboration and coordination among partners involved in HIV/AIDS care and social care in the OD. It will help define referral mechanisms between institutional care, HBC, and community-based care and will provide regular forums for the discussion of issues relating to the CoC.

#### ***4.2.2 Sub-Working Group on OVC Identification and Social Care***

A sub-working group on the identification of OVC and the provision of social care to OVC shall be organized at the Operational District (OD) level. Their monthly meetings shall follow directly after the CoCCC meetings, to reduce transportation costs and to discuss relevant issues that arose in the CoCCC meeting. The sub-working group meetings shall explicitly address:

- How many OVC exist in the OD
- How many new OVC have been identified during the month
- How these OVC are being identified
- How organizations are coordinating OVC social care support groups
- How these OVC support groups are implementing social care
- What components of social care are being provided successfully, and
- How social care can be improved

The sub-working group's participants shall include:

- OD Coordinator for HIV/AIDS/STI
- Provincial Director of MoSVY where possible
- Provincial director of the Ministry of Education (MoE) where possible
- Representatives from 2 (or so) organizations (local or international NGOs, CBOs, etc) working directly with OVC in the area

- 1-2 representatives from on-the ground OVC support groups (optional, and only possible after training of initial OVC groups has occurred)

**The OD HIV/AIDS/STI Coordinator shall be responsible for overall coordination of the OVC social care program in his/her own OD, in consultation with the CoCCC and the sub-working group as listed above.** The duties of the OD Coordinator shall include:

- Organizing ad-hoc meetings to plan sites of operation, programs, services, strategies, etc
- Coordinating services among NGOs and OVC teams, HBC teams, mmm, VCCT, and other services involved in the CoC for OVC.
- Coordinating referral mechanisms for identification of OVC among relevant stakeholders
- Coordinating referral mechanisms linking OVC identification and VCCT
- Gathering data from Commune Councils, pagodas, and other institutions to create and maintain an OVC database for the OD
- Assisting the work of OVC support groups, including the coordination and facilitation of trainings.

The small size of the sub-working group shall allow its participants to efficiently and effectively coordinate OVC identification and social care activities within the OD.

The sub-working group shall develop an information booklet on the organization of OVC identification and social care in the OD. The booklet shall include a directory of key partners and providers, and shall be disseminated among health care workers, NGOs, CBOs, OVC support groups, and the community.

#### ***4.2.3 Financial Role of NCHADS***

For on-the-ground OVC identification and social care, the OD HIV/AIDS/STI Coordinator shall assume a role of coordination and support. NCHADS shall contribute few funds directly to OVC identification and social care. Rather, it shall contract out such programs to effective NGOs and CBOs working with OVC at the local level. The OD Coordinator shall oversee implementation of OVC identification and social care, but NGOs, CBOs and other institutions manage the funding, quality, and on-the-ground implementation of the social care package. These organizations are responsible for OVC identification, referrals for HIV testing and other medical care, and the provision of social care, and they shall conduct their work in the manner detailed in sect. 4.3 and 4.4 below.

While NCHADS may cover some costs involved in meetings and trainings, these are thought to be minimal. Linked support from NCHADS-funded programs such as mmm and HBC shall provide important resources to augment the quality and breadth of OVC identification and social care.

### 4.3 Structure for Identification of OVC and Provision of Social Care

As demonstrated in Diagram 2 above, a multisectoral approach is needed for the successful identification of OVC and the provision of Social Care. Unofficial community centers, especially established institutions—such as pagodas—and those with direct contact with children—such as schools, mmm, some CBOs, and orphanages—shall serve as important groups, each playing an important role.

One model uses a pagoda/faith-based organization (FBO) approach. Buddhism is one of the strongest institutions in Cambodia, one that is deeply ingrained in the structures of most communities. By strengthening the capacity of individual pagodas to respond, and through the advocacy of senior Buddhist leaders at local and national levels, one of the country's most significant institutions can be utilized to work in HIV/AIDS and OVC prevention, identification and care.

#### The Pagoda-Based System:

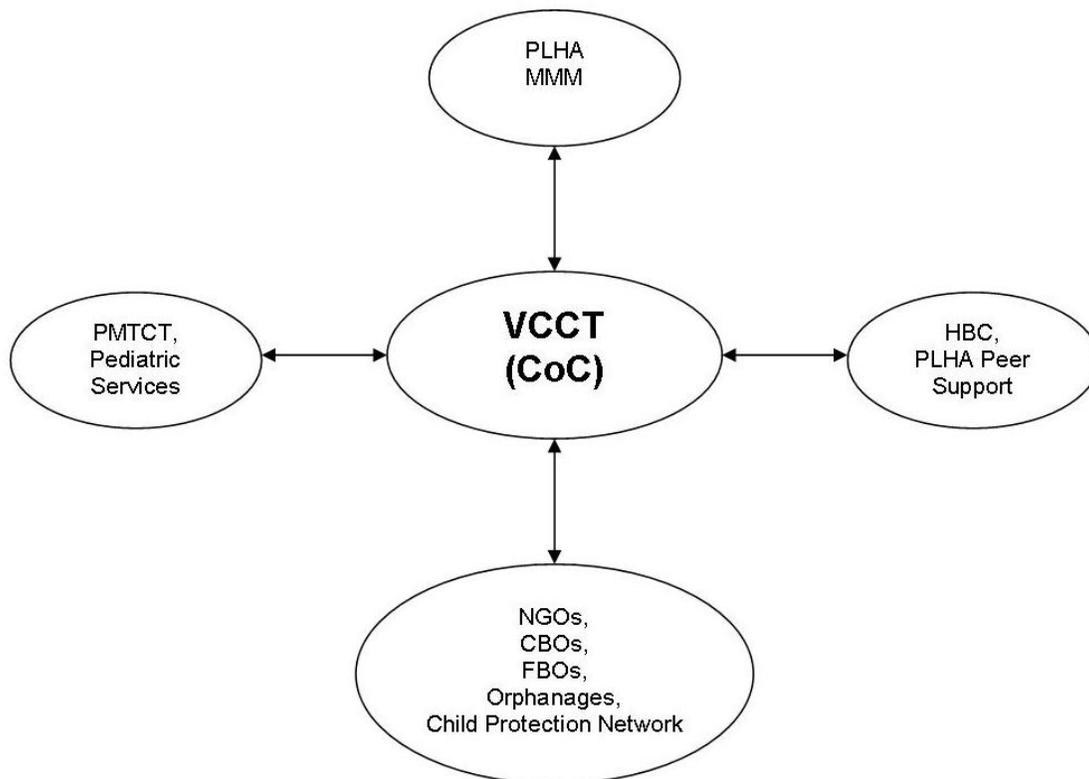
- Monks, once trained as advocates, spend time visiting communities, identifying OVC—most of whom are in non-residential care settings such as family care, child-headed households, kinship care, community foster care, etc—and talking about HIV/AIDS treatment and prevention.
- Each monk working on the OVC support group shall oversee one neighboring village, depending on its size and on a case management basis.
- NGOs, CBOs and other donors shall facilitate training, and throughout the identification process, monks shall work with NGOs and donors to map each village under their jurisdiction.
- After establishing presence in the community, village chiefs often assist the reporting of additional OVC.
- Each pagoda calls for practical and supportive responses to care for the children affected, as well as for the communities from which they come. The pagoda assesses separately the needs of individual children and their families.
- The pagoda works with NGOs and donors to provide material and emotional support to these children.
- Monks shall be trained in the referral of all children, and especially OVC, to voluntary HIV testing. With this training, monks shall actively promote HIV testing for OVC (see section 4.4).

Other important providers of social care for OVC include orphanages, HBC teams, and mmms—specially-designed programs or facilities for the physical and emotional support of children. In each district and provincial hospital, a few nurses shall be assigned to identify OVC and refer them to an organization providing social care in the child's OD. When NCHADS contracts out to orphanages, NGOs, CBOs, and other institutions, the OD coordinator shall work with these institutions to ensure active identification, referral to HIV testing, and adequate provision of the standard minimum package of social care for OVC.

To reach non-Buddhist populations and/or to amplify both the identification of OVC and the provision of social care, representatives from within the community/village governance structure can be trained in a similar manner as the monks, through the support of NGOs and CBOs. In MoSVY's *Policy on Alternative Care for Children*, Commune Councils are given a mandate for social work and capacity-building opportunities at the local level. Certainly, identification and social care for OVC fall under this mandate. Commune Councils shall collaborate with pagodas and other institutions, where possible, in order to distribute tasks, improve identification and medical referrals, establish databases for OVC (as an addition to existing NCHADS databases), and provide broader and more holistic social care for OVC.

#### 4.4 Referral Mechanisms for Testing OVC

*Diagram 3: Referral Mechanisms for identifying and testing HIV status of OVC*



Links must be strengthened between social care and HIV testing, which represent two integral components of the Continuum of Care (CoC). Early detection of HIV and early treatment will lead to longer lives for OVC and to fewer OVC overall. The following list, a detailed elaboration of Diagram 3 above, clearly defines the referral mechanisms for each institution involved in identifying, testing, and providing social care for OVC. Each institution must build capacity in families regarding testing and the possibility and

availability of treatment. Furthermore, these institutions shall facilitate and support medical transportation subsidies and trusted accompaniment to HIV testing sites.

### **Pagoda/FBO**

- Identification of OVC. Referral to commune council and NGO/CBO. Provision of social care to OVC
- Referral for testing directly to testing center (VCCT).
- Accompany to testing center
- Follow-up. If results HIV+, refer to CoC, with direct link to pediatric AIDS care services

### **NGO/CBO**

- Identification, referral to commune council of OVC status, provision of social care
- Referral to VCCT
- Ensure accompaniment to testing center
- Follow-up. If results HIV+, refer to CoC, with direct link to pediatric AIDS care services

### **Orphanage**

- Identification, referral of all children to commune council
- Referral of all children for testing (VCCT)
- Accompany to testing center
- Follow-up. If results HIV+, refer to CoC, with direct link to pediatric AIDS care services

### **School**

- Sensitize teachers for identification and disease progression, weight loss, etc
- Identification, referral to commune council, pagoda, and NGO/CBO. These bodies perform referral and follow up with VCCT

### **PMTCT**

- Direct referral of infant to VCCT, to ensure testing of infant for DNA PCR
- 2 PCRs (6 mo and 12 mo), confirmation testing at 18 mo
- Regular follow-up for mother and child
- Referral to pediatric AIDS care services, CoC
- Identification and referral to commune council and/or NGO/CBO/HBC team for provision of social care

### **VCCT Network**

- When parents come in for testing, inquire about children
- Actively encourage testing for children and spouse for those parents who are HIV+
- Referral to CoC
- Follow-up through VCCT network

### **HBC Team**

- Assess need for testing for all children and refer all those in need
- Accompaniment to testing center
- Follow up and referral to CoC if needed
- Proactive identification of OVC status and referral to pagoda and NGO/CBO
- Coordination with pagoda, NGO/CBO on parental status to ensure continuous care

## **MMM**

- Identification of OVC, referral to commune council and NGO/CBO
- Referral to VCCT and ensure accompaniment to testing center
- Follow up, referral to CoC if needed

## **Child Protection Network**

- Identification of OVC, referral to pagoda, NGO/CBO and commune council for social care
- Referral to VCCT
- Ensure accompaniment to testing center
- Follow-up, Referral to CoC

## **4.5 Monitoring and Evaluation**

The OD HIV/AIDS/STI Coordinator shall conduct quarterly site visits with many OVC identification and support groups in the OD. The coordinator shall call additional meetings with the relevant stakeholders listed above (5.2), as needed, to discuss changes in program implementation.

During his/her quarterly site visits, the OD Coordinator shall distribute a report form including a list of indicators of OVC social care to be filled out by the OVC teams. This form will include numbers of OVC children identified in the previous quarter, number that have received services or been referred to services, and social care activities at village and commune level. The OD Coordinator shall be responsible for gathering responses and aggregating the data. Reports shall be forwarded to the national level every quarter. Additionally, a quarterly meeting between relevant stakeholders shall be called to discuss the results of this monitoring effort, evaluate programs, and propose changes in order to better meet the needs of OVC.

At the provincial level, the Provincial AIDS Officer (PAO) shall conduct quarterly visits to each OD in the province. The PAO shall visit a few sites in each OD. Quarterly meetings shall be arranged with relevant stakeholders to discuss recommendations for the future. In Phnom Penh, these activities shall be performed by the Municipal AIDS officers (MAOs).

## **5. Linkages**

As shown in Diagram 1 above, social care for OVC must be linked to medical care as part of the Comprehensive Continuum of Care (CoC). Without linkages and integrated work strategies, the overall well-being of the child will be lost in the interstices.

### **5.1 Link with Home-Based Care (HBC)**

HBC units represent a valuable resource for the identification of OVC. They are responsible for providing care to HIV+/AIDS adults, and it is highly likely that OVC

reside in the same household. Apart from OVC identification by HBC units themselves, coordination between HBC and OVC support groups is imperative in order to provide adequate social care to the family. Currently, many families receive assistance through HBC, but after a parent dies, assistance is revoked from the OVC in that household. To prevent this detrimental disconnect, HBC units and OVC support groups must carefully and cooperatively coordinate their activities. They must establish a notification system between them to improve support of PLHAs and OVCs. They must meet with each other once a month to discuss responsibilities, areas of overlap, and areas in which detailed communication between them is requisite.

## **5.2 Link with mmm—Psychosocial Support for OVC**

Mondol Mith Chuoy Mith (MMM, or peer support groups) is one of the essential elements of the Operational Framework of Continuum of Care for PLHA. It is a primary focus for HIV care activities in the OD. In addition to health care, it can catalyze the development of other services such as social support and community education, and act as an incubator for local innovation, leadership and partnerships.

“mmms” must be established, representing peer support groups among children. Establishing mmms for all OVC is an important component in the provision of psychosocial support to these children. OVC support groups shall be trained in mmm techniques and psychosocial support more broadly. In this way, those people who care for OVC shall become aware and capable of providing safe and kindly environments.

mmms shall be conducted monthly at health centers at the OD level, thereby reducing the size of the meetings, increasing the personal attention for each OVC, and reducing both the distance traveled and the transport subsidies required.

Structure of mmms:

- mmms shall be broken up into two groups based on age, so that support activities meet the developmental stages and needs of OVC
  - The younger group (up to 10 years old) shall play games that have a message of drug adherence, hygiene, etc, as listed below. This younger group shall require that caregivers be present in order to facilitate the program. This structure promotes health education for both OVC and caregivers.
  - The older group (over 10 years old) shall engage in discussions and receive health education.
- If possible, MMM and mmm shall be organized on the same day in order to minimize transport costs.
- Each mmm shall have 2-6 coordinators, depending on the size of the group. The coordinators shall be composed of doctors, nurses, trained mmm specialists, and NGO/CBO support.

The OVC support group shall work with specialized mmm coordinators where possible, but where not possible, the OVC support group can implement many mmm functions on their own. These functions include:

- Peer support activities; effective tools shall be used such as memory books and memory boxes to promote discussion between parent and child about what is happening and who can provide care for the child and the future.
- Health education for OVC and family on self-care, hygiene, home care, health promotion, nutrition and prevention of HIV transmission;
- Nutritional education for OVC and caregivers
- Adherence support and counseling for OVC receiving ART. The counseling should be performed individually or in group;
- Spiritual support including prayer and meditation with monks;
- Exercise program;
- Specialized training for caregivers in HIV/AIDS to reduce stigma of OVC
- Referral to OI service in the referral hospital for
  - Screening for OIs including TB
  - Health checks including treatment of simple OIs
- Depending on their age, referral of female OVC for PMTCT and other MCH services such as family planning.
- Facilitation in referral to:
  - Social and financial supports;
  - Available income generation and occupation promotion services

**This SOP may be revised as needed, as new investigations and situational analyses are performed and as new information arises regarding the situation of OVC across Cambodia. Only with flexibility can we adapt to the changing needs and conditions facing OVC.**

## Appendix 1—Budget

The following budget has been created to illuminate the funds needed for organizations working on-the-ground to carry out OVC identification and social care. All amounts shown are on a per-child basis:

<b>Item of expenditure</b>	<b>Rate</b>	<b>Remarks</b>
Nutritional Support	US\$19.50 per month	Quantities based on family of 5, with at least 1 OVC and max. 2 caregivers. Adjustments must be made as needed to meet familial needs. Support must be linked to nutritional requirements of OVC
Standard Educational Support	US\$ 7 per year	Quantities are as needed PER OVC based on annual assessment
Medical Transport Support	US \$5 per month (max.)	Based on actual costs of transport. Allocate lump sum of US\$2 per child (plus caregiver) per round-trip ride. Allocate funds to allow for max. 2 rides per child per month.
Transport Support for OVC Support Groups	US \$10 per person per month	As needed to cover the costs of transport between villages in order to monitor, ID, and provide social care.
Additional Transportation Support	US\$ 25 per Bicycle	As needed based on annual assessment, in order to facilitate school attendance for OVC.

The costs listed above will not be covered by NCHADS, but rather by the NGOs/CBOs who are contracted by NCHADS to implement OVC identification and social care programs at the village level. NCHADS will cover the following costs:

CoCCC Meetings	US\$40-50 per meeting	For transport costs, supplies, stationary, coffee break
Sub-working group meetings	US\$ 20 per meeting	For transport costs, supplies, stationary, coffee break

The following describes the budget for one mmm meeting:

<b>Item of expenditure</b>	<b>Rate</b>	<b>Remarks</b>
Food for mmm meeting	US\$1.50 per person per meeting	List of attendance to be provided as an evidence of the participation. Maximum of 100 OVC, plus caregivers, is allowed for each meeting if funded by NCHADS
Transport for OVCs from the community to attend mmm meeting	Based on actual cost. As lump sum 2\$ per OVC (plus one caregiver) per meeting	List of attendance to be supplied as an evidence for participation. Maximum of 100 PLHA for each meeting is allowed if funded by NCHADS
Monthly allowance for mmm coordinator and assistants	US\$ 30 per person per month	To be covered by NGOs/CBOs.
Stationary for mmm	US\$ 5 per meeting	NCHADS will not covered this cost if supplied by NGOs/CBOs
Other expenses	Based on actual cost. As lump sum US\$ 5 per meeting	For example, offering for monks invited to provide spiritual support during PLHAs meeting

Total Costs: \$250-600 per meeting, depending on the number of OVC and caregivers in attendance.

## Appendix 2—Format for List of OVC Attending mmm Meeting

Date: .....

Name of Province: .....

Name of OD: .....

No	Name	Gender	Referred by (CHBC team, SHG, NGOs....)	No of accompanied caregivers	Signature or Finger Print
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					

**Note:** This list shall be seen and signed by mmm coordinator.

### Appendix 3—Format for List of Supported OVC in the OD

N <sup>o</sup>	Name of Supported OVC	Gender	Address	Support Provided		Type of Caregiver	Supported By
				Items	Quantity		

**Note:** This list should be updated every month and should be signed by the local project coordinator for social care for OVC (the OD HIV/AIDS coordinator). However, because the list includes confidential information about individuals, it shall not be passed upwards to the provincial and national levels.

Total Number of OVC in OD						
HIV positive	HIV negative	Not known HIV status	Referred to			
			VCCT	Mmm	OI/ART	other places (specified)

Social Care Support Provided		
Item	Quantity	Comments

**Note:** These two lists should be updated every month and should be signed by the local project coordinator for social care for OVC (the OD HIV/AIDS coordinator). Only these lists of aggregate data may be passed along to the provincial and national levels.

## Appendix 4—Monitoring Report Form on Quality of Social Care (For NGOs and CBOs providing Social Care)

1. Is there a list of supported OVC (see format): Yes      No
  - If yes, is it up to date? Yes      No
  
2. How are the OVC identified? By whom?
  - To which institutions are OVC referred?
  
3. Are there criteria for OVC to receive support? Yes      No
  - If yes, what are the criteria? Who set the criteria? Are the criteria used?
  
4. Is there any proof that the OVC received support according to the list? Yes      No
  - If yes, what is the proof? Is it reliable?
  
5. Do the OVC support groups visit the OVC at home? Yes      No
  - If yes, how often?
  
  - Do they follow up to make sure that the OVC really get benefits from social care support?
  
6. Access to education:
  - Do the OVC who reach school age attend school? Yes      No
    - If yes, what is the proportion of OVC attending school? What is their performance at school? Is there a school record book for attendance and performance?

- What are the main problems/obstacles for the OVC who do not attend school?

7. Access to health service:

- Do caregivers know where relevant local health services for OVC are? Do they know who should be contacted for these services (the proper referral mechanisms)?

- Are all OVC being referred to HIV testing? If yes, what referral mechanisms and chains-of-communication are being used? If not, how can HIV testing referral be improved?

- Do caregivers and OVC use these services?                      Yes                      No
  - If yes, what services do they access most?

- If not, what are the reasons?

- What are the main health problems that the OVC face? How can these problems be solved?

8. Discrimination issues:

○ Are the HIV+ children accepted in the community? Yes No

- Do other kids play with them?
  
- Are HIV+ OVC are treated in the same way as other kids? (At home: by relatives and neighbors; at school: by teachers and friends...)

9. Conclusions and recommendations of supervisor:

.....  
.....  
.....  
.....  
.....  
.....

## Appendix 5—Supervision Checklist for Coordination Mechanisms

**Date:**

**Name of OD:**

**Name of referral health center(s):**

**Name of supervisor:**

<b>Issues to be checked</b>	<b>Comments</b>
Organization of daily team activities	
Assessment of patient needs	
Contact with community	
Relationship with patients and families	
Management of volunteers	
Educational activities	
Support group activities	
Relationship within the team	
Regular meeting within the team	
Contact with partners in the referral system	
Record keeping and reporting	

**Conclusions and recommendations of supervisor:**

.....  
.....  
.....  
.....  
.....  
.....