Joint Ministry of Health/NGO Pilot Project on Nome and Community Care for People with HIV/AIDS

Phnom Penh, Cambodia

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Executive Summary

The HIV/AIDS epidemic in Cambodia is growing at an alarming rate, estimated in 1998 to have reached 2.8% of the adult population. The current uncertain political and economic situation suggests that factors fuelling the rapid spread will persist into the foreseeable future. The Ministry of Health initiated a plan to control the epidemic in 1991, with their efforts supported by an increasing number of bi-lateral donors, UN Organisations and NGOs. One recent initiative has been the drafting of the National Strategic Plan 1998-2000, which aims to be a 3 year framework for action and coordination of the response to HIV/AIDS. This document identifies AIDS Care as a priority area, and discussion has begun in an attempt to address this. However, it remains as a significant gap in the resource allocations of the major players, both government and non-government.

Despite some achievements in reforming the health system, government provision of health care remains weak in most areas. Capacity building is currently directed at providing primary health care at the Health Centre level, with access to secondary and tertiary level care as required. The concept of HIV/AIDS care for resource-poor countries pioneered by WHO (known as ‘Comprehensive Care across the Continuum’) fits with this approach. Lessons learned from other countries facing similar epidemics include the importance of initiating community-based care activities before health services become overwhelmed by patient demands.

This project aimed to pilot a model of community-based HIV/AIDS care that effectively utilised the scarce resources available in Cambodia, whilst remaining true to the government's health reforms. Eight Home Care Teams were formed from mixed government and NGO staff, operating from Health Centres across the city of Phnom Penh. After a period of training and consolidation, the teams spent the following 10 months supporting families in the physical and psycho-social management of HIV/AIDS (and other conditions) in the home environment. In addition they initiated contacts with local leaders; pagodas and traditional healers in order to raise awareness of HIV/AIDS in the community at large.

By the end of the pilot period the teams are visiting over 700 families, approximately 60% of whom are known to have HIV or AIDS. Patients, NGO and government partners, health staff and community leaders all report a high level of satisfaction with the teams’ activities, including their effect on community awareness of HIV transmission and prevention. A comprehensive review of the project at the mid-point revealed that the majority of the objectives had been met within the time frame. Several small adjustments to team activities were made for the second half of the project. An evaluation by a WHO consultant in December 1998 recommended strengthening of the programme in Phnom Penh, and expanding it to selected provinces. Suggested areas of development were counselling and clinical skills, and the referral system with the hospitals. An analysis of cost-effectiveness was also recommended.

The next phase of the project will be supported financially and technically by KHANA, the local linking organisation of the International HIV/AIDS Alliance. It is anticipated that this will be a phase of consolidation and continued analysis. Both government and NGOs are interested in adapting the model for the provinces.
Background

HIV/AIDS in Cambodia

Cambodia is experiencing a rapidly increasing HIV epidemic. The first case of HIV infection was notified in 1991. As of June 1998, around 15,000 people in Cambodia have been reported as having antibodies to HIV. The number of reported AIDS cases is also growing rapidly. In 1997, 572 AIDS cases were reported, a more than five-fold increase since 1995. In addition, high rates of STD are reported for the general population, including amongst low-risk groups such as ante-natal patients.

It can be assumed that the speed of the epidemic coupled with the poor capacity of Cambodia's health information systems result in extremely low reportage of HIV/AIDS cases. Estimates based on the government's National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) 1998 surveillance figures points to 150,000 current infections. This makes Cambodia's adult prevalence rate of 2.8% the highest in Asia, overtaking Thailand at 2.24%.

Contributing factors to both the speed and spread of the epidemic include large shifts in population in a region with already high seroprevalence and porous borders. The recent socio-economic disruptions have fed an already well-established and unregulated commercial sex industry, with poverty increasing the widespread trafficking of Cambodian women and children. In addition, inadequacies in the health system result in the use of contaminated blood, a lack of universal precautions against infection, and poor diagnosis and treatment of STDs, all of which further infection spread.

In the face of the regions current unstable political and economic climate it is unlikely that these factors will charge, indeed the situation may well exacerbate the problem further. The Cambodian Ministry of Health has had an AIDS Prevention and Control Programme in place for the past 7 years, but it is significantly underfunded by the government, and has also suffered from the recent tying of donor money to political stability. Despite a large-scale Health System Reform programme, supported primarily by WHO and DFID, state per capita health spending fell last year to less than $1, stalling much of the progress of the past few years in capacity building at central and provincial levels.

Nevertheless 1998 saw the development of the "HIV/AIDS National Strategic Plan 1998-2000", which aims to be a framework for action and coordination for all partners contributing to the response to the HIV/AIDS epidemic in Cambodia. The drafting of the Plan was a joint effort involving ministries, UN organisations, bi-laterals and NGOs, and followed a comprehensive country-wide review of all HIV/AIDS activities in 1997. The Plan outlines 13 targets using criteria of
prioritisation that include geographic and population potential for the greatest impact on the epidemic.

Care and Support for people with HIV/AIDS (PWHA) was included in the target list, with an emphasis on providing appropriate access to care at primary as well as secondary and tertiary levels. This was the first time AIDS Care was included as a serious component of the prevention and control strategy, and has sparked a number of positive interventions. The first was the drafting of National AIDS Care Guidelines by the NAP (National AIDS Programme) and WHO. Treatment protocols for adult and paediatric care were adapted from the WHO standards for the different levels of health service provision available in Cambodia. Separate guidelines for home and community-based care were developed, as well as mother-to-child transmission. Unfortunately these remain in draft form, but plans are underway to field-test and finalise them over the next year.

Another step forward was the establishment of the AIDS Care Unit within the reorganised National AIDS Programme (renamed as NCHADS). Previously subsumed under STD activities, the new Unit has already devised a comprehensive workplan in line with the Strategic Plan. Funding, however, remains a major stumbling block. The main financial resource for the NCHADS is $6 million over 5 years given in 1997 as a World Bank loan to the Ministry of Health. Although as yet this has proved difficult to access, there are signs that this will improve over the coming months. However, under no budget line is there any mention of care, having been drafted at a time when the epidemic was just being recognised and prevention activities were of paramount importance. Other major sources of funding are the EU/ITM STD project, a 3 year $1.2 million project primarily facilitating STD services for high risk groups. UNFPA and WHO have a joint 3 year project training public health workers across the country in management of STD using the Syndromic Approach. This will be extended to military health workers through a WHO/UNAIDS collaboration. Through UNAIDS and individually other UN agencies are involved in strengthening a multi-sectoral approach to AIDS activities, particularly in the provinces, as well as other smallscale activities in the areas of IEC and formal education.

Amongst the bi-lateral donors USAID has just begun a 5 year special objective on HIV/AIDS, with $2.2 million available for the first 2 years, but again this bypasses care issues. The French Cooperation, on the other hand, has supported small-scale interventions in medical care for some time, in part through MSF-France. Their 3 year plan currently awaiting ministerial approval includes expansion of testing facilities, continued support to 2 Phnom Penh hospital services for AIDS patients and support to prevent maternal transmission of HIV (total $235,000). Prior to the Home Care Project, of the many NGOs involved in HIV/AIDS activities only MSF-France and the catholic charity Maryknoll were active in AIDS care, with World Vision and Quaker Services Australia working in the related area of counselling. Of the estimated $5.5 million available to spend on HIV/AIDS activities in Cambodia in 1998, less than 3% is allocated for care.

2 UNAIDS/NCHADS, September 1998
Concepts of Care for PWHA

To date, the care needs of PWHA generally remain unaddressed until a country is well into its HIV/AIDS epidemic. Apart from the fact that PWHA remain publicly ‘invisible’ for several years, one of the main reasons for ignoring care as an issue is the mystique surrounding how to treat AIDS patients. There is now widespread awareness of current drug therapies available in the West, but at over $10,000 per patient per year these are unfeasible in most developing countries. Nevertheless, knowledge of the success of such drugs often encourages the idea that people with HIV/AIDS will treatment; and this belief, only benefit from highly specialised added to people's fear of contagion, frequently leads to calls to isolate AIDS patients in special institutions. Such an approach however is now widely denounced, being costly to set-up and maintain; diverting scarce resources and encouraging the attitude that PWHA should be segregated from the community.

In an effort to counter this trend and offer viable alternatives for developing countries, WHO has been advocating since 1994 early adoption of the concept of "Comprehensive Care across the Continuum". This approach promotes the interrelation of different elements of care, from institutional clinical management to social support for the affected family. The concept hinges on good co-ordination between hospitals, district level health facilities and community support structures. Clear referral systems between these three enable PWHA to access the appropriate level of care according to the stage of their illness, avoiding both overburdening hospitals with minor ailments, and ensuring more serious conditions are treated promptly. Countries where this approach has an impact on managing the care needs of PWHA fit the following picture:

1. unable to afford current prophylactic drug therapies on a significant scale
2. shortage of hospital beds to cope with the numbers of AIDS patients predicted
3. advanced opportunistic infections largely untreatable due to low capacity of health services i.e.inadequate laboratory facilities, drugs, skills and experience
4. existing familiarity with the majority of symptoms associated with HIV/AIDS

This picture fits Cambodia exactly. In 1999 Cambodia has a rapidly increasing number of HIV/AIDS patients presenting with a range of common symptoms such as diarrhoea, fever, skin infections and weight loss. The typical pattern of illness for these people is a series of minor infections which will respond to treatment, followed by one or more serious conditions which will lead to rapid decline and death. Given that they are likely to have several periods of both minor and more serious illness over a number of years, the most logical approach is to provide an appropriate level of health care for the management of symptoms as they present. For minor illnesses, there is rarely anything a hospital can offer that cannot be

3 The average length of time from the first infection to death in developing countries is 5-7 years
managed at home, where their care will be cheaper and more convenient, and they will be less exposed to other infections. Similarly, at the end of life, many people express a preference for palliative care at home amongst their family members, rather than the anonymity (and often expense) of death in hospital\(^4\).

Most of the literature about Home-Based Care projects for PWHA comes from developed countries, but the WHO approach has been widely adopted in Sub-Saharan Africa, and more recently in India and Thailand. Implementation, however, varies considerably. In general, in situations where there is a strong tradition of Community-Based Organisations (CBOs) initiating grassroots projects, successful Home-Based Care programmes have been started from the bottom-up. In other situations where there are already established outreach programmes from district hospitals, Home Care for PWHA has been added to these. Many such programmes in Africa began from the Christian Mission Hospitals, but this model has also been adopted in Thailand, where government hospitals often have existing programmes in the community. A problem with this approach is that grassroots projects do not make successful links with hospitals, and hospital schemes fail to mobilise community resources. Ideally, projects need to combine all available resources into one coordinated programme, for which all parties feel equal ownership.

As yet very few home care programmes have been properly evaluated, but those that have reveal a variety of useful lessons learned. It is clearly essential to create a strong link with hospital services from the start, and to ensure any new initiative is consistent with current or planned government health systems. A further lesson is the importance of home care staff having a mix of skills, both clinical and psychosocial. In particular, Home Care that takes a heavily medical approach has led to neglect of the emotional and social aspects of HIV/AIDS, and in taking expensive staff away from the hospital for long periods is rarely cost-effective.\(^5\) A third lesson learned particularly in Thailand, is that labeling the Home Care service as exclusive to PWHA causes negative feeling from other patients and furthers anti-HIV discrimination. At least in the initial stages of a project, treating other chronic conditions serves to normalise community care of PWHA, and can help raise the general level of awareness of HIV/AIDS. In countries where testing is limited and many people are unaware of their HIV status, staff performing home visits can both provide early detection of HIV (this was found in many people presenting with TB) and education for prevention.

In recognition of the growing demand for effective AIDS Care with limited resources one major bi-lateral (the UK's DFID) have recently published a broad review of AIDS Care strategies to be used as a guide for donors. It concludes that the care and support agenda is an often neglected but vital part of a country's response to HIV/AIDS, and strongly recommends that comprehensive care across the continuum is promoted as an effective framework for action\(^6\).

\(^4\) AIDS Action, May 1996. "Home and Hospital"

\(^5\) MSF "Home Care Activity Review" Surin, Thailand, April 1997

\(^6\) Gilks et al. "Care and Support for People with HIWAIDS in Resource-Poor Settings", 1998
The Project

Origins

An awareness of the theory and practise of the AIDS Care Continuum' and its potential application to the Cambodian situation was the driving force behind the beginnings of a discussion on home and community care early in 1997. Channelled through the HACC Sub-Group on Counselling and Care, those organisations interested in becoming involved in care issues met together and began a debate on the best way forward. As is often the case when many players are responding to a crisis situation, AIDS organisations in Cambodia have not always co-ordinated successfully in their programmes, either with each other or with the government, and it was a concerted effort to avoid this that gave birth to the current project. In aiming to pilot a joint approach to HIV/AIDS care, it was hoped that scarce resources would be shared and the comparative advantage of different players would be utilised effectively.

In the absence of either existing hospital outreach services or strong CBO activity the most appropriate place to base Home Care services seemed to be at the 'community' level of the health system - in Cambodia the Health Centre. This was timely in that it coincided with the transition from Phase 2 to 3 of the Ministry's programme of health reform, where the focus shifted further from Central to District level services, paying particular attention to the Health Centres. Although many Health Centres have begun to be strengthened their general capacity is still weak, no less in Phnom Penh than in the provinces. This has led to a thriving private sector of practitioners and pharmacies, as well as various supplementary health care services from the NGO community. Poor coordination has led to gaps and overlap across the city, with some Health Centres falling into disuse in the face of fierce competition, whilst others struggle to cope with the demands of the community they serve.

One of the major activities of Phase 3 is to enable all Health Centres to provide a baseline Minimum Package of Activities (MPA) to their communities. This includes some outreach activities such as vaccination programmes, midwifery and in some areas community-based TB treatment (DOTS). Supplementing the skills of the Health Centre staff in Home-Based health care principally but not exclusively for PWHA at this stage was considered to be in line with the objectives of Phase 3. Tying experienced community NGO health staff in with a recognised Health Centre not only strengthens it but also allows for more coordinated outreach activities to the community. Thus the project model emerged as one of combined care using the related skills of government nurses and NGO community workers, formed into a number of linked outreach teams based in established state Health Centres.

7 HIV/AIDS Coordinating Committee, a specialised group of NGOs formed from the larger health NGO group Medicam
Project outline

The project combines staff from seven NGOs with nurses from eight government Health Centres into eight Home Care Teams across the city (see Figure 1, p.13, and Map, Appendix 1). All the NGOs were already involved to some degree in HIV/AIDS work. Two are international; two are local subsidiaries of internationals and three are entirely local. The Health Centres were selected by the Municipal Health Department based on location, capacity and degree of Health Centre manager support.

Recruitment and Training

Both NGOs and Health Centres were asked to select interested staff members who were then interviewed by a panel including the Project Coordinator and representatives from the different partners. A rating system was used for all the interviewees to assess knowledge, attitude and practical issues such as where they lived, other commitments, family's reaction to their working with PWHA etc. The 40 staff selected discussed and signed an agreement of Roles and Responsibilities for the year's duration of the project. (Appendix 4)

The first 2 weeks of the project were devoted to "getting to know each other" exercises. Whilst the majority of staff from the same NGO were together in a team, some were mixed with others in order to share skills and provide a gender balance. During this time the teams were increasingly asked to work together, for example in mapping the catchment area of their Health Centre base to include all community resources. Formal training began in March, with the staff split into 2 mixed groups of 20. The training was divided into 3 one-week modules (Appendix2), with the second week consisting of a practical placement in the community with an existing community health care programme. With the community placements allowing an overlap of modules, the training for both groups was completed by the end of the month. Trainers came from a wide variety of organisations and institutions, and were encouraged to use participatory techniques as much as possible. The whole course was facilitated by a nurse trainer from the Ministry of Health's Master Trainer Programme, who ensured lesson plans and handouts were available in advance, and that a summary of all the sessions was written daily. The students were given 2 evaluations to complete at the end of the course - one on knowledge and attitudes and one on the course itself. Lesson plans, handouts, summaries of the sessions (with comments) and the results of the evaluations were compiled into a 'Training Pack' which the AIDS Care Unit has available as a resource for others wanting to set up a similar programme.

The main resource for the training and indeed the project is a Khmer version of WHO's "Handbook on AIDS Home Care". This was adapted and translated by a team of individuals led by the NCHADS during 1997. The bulk of the text remains the same as the original developed by NGOs in Africa (including TASO) in 1994, showing primary health care workers how to use stories to teach people in the

8 WHO, 1994, reprinted by SEARO, 1996
community about the realities of HIV/AIDS, in addition to managing symptoms in the home. The main changes made to the Khmer version are the substitution of a village girl's over-use of injectable medicines for the intravenous drug user of the original; and the addition of a section on traditional Khmer medicinal plants commonly used to relieve symptoms associated with AIDS. All the Home Care Team members were given a copy of the Handbook on completion of the training. Forty other copies were distributed and after 6 months field-testing the Handbook is currently being revised for the printing and distribution of 5000 copies of a final draft by mid-1999.

Project Activities

The teams are based in the Health Centres, but spend the majority of their time in the surrounding districts, visiting patients. They have 2 objectives - to care and to educate. In the patient's home they show the family by example how to provide simple relief of symptoms, including those which may not be AIDS-related. Depending on the need, they make several visits a week, during which they will reinforce the facts about HIV/AIDS, from transmission to life-expectancy. Although they carry simple medicines and supplies (see Home Care Kits below) and have some welfare funds, they encourage families to buy essential items where possible. The emphasis is on supporting the family, rather than providing all the answers. With this in mind, the team's activities can include accompanying someone to a support group, negotiating with local monks over funeral arrangements, even mending a leaking roof.

**HOME CARE KITS**

<table>
<thead>
<tr>
<th>Contents:</th>
<th>Hydrogen Peroxide 30mls vials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol 500mg tablets</td>
<td>Bicarbonate of Soda 500mg tablets</td>
</tr>
<tr>
<td>Potassium Permanganate 10mg sachets</td>
<td>Gentian Violet 15mls vials</td>
</tr>
<tr>
<td>10% Iodine solution 30mls vials</td>
<td>Oral Rehydration Salts</td>
</tr>
<tr>
<td>Calamine Lotion 500mls</td>
<td>Nystatin suspension 25mis</td>
</tr>
<tr>
<td><strong>Benzy! Benzoate 30mls</strong></td>
<td>Bandages</td>
</tr>
<tr>
<td>Gloves</td>
<td>Household Bleach</td>
</tr>
<tr>
<td>Soap powder</td>
<td>Condoms</td>
</tr>
<tr>
<td>Cloths</td>
<td>Plastic Bags</td>
</tr>
<tr>
<td>Matches</td>
<td>Scissors</td>
</tr>
<tr>
<td>Tweezers</td>
<td>Cotton Wool</td>
</tr>
<tr>
<td>Plasters</td>
<td>Elastic Bands</td>
</tr>
<tr>
<td>Micropore <strong>Tape</strong></td>
<td>Menthol Balm</td>
</tr>
<tr>
<td>Safety Pins</td>
<td>Coconut Oil</td>
</tr>
<tr>
<td>New Items added at 6 months:</td>
<td></td>
</tr>
<tr>
<td>Promethazine 100mls</td>
<td></td>
</tr>
<tr>
<td>Multivitamins</td>
<td>Loperamide</td>
</tr>
<tr>
<td></td>
<td>Primperan</td>
</tr>
</tbody>
</table>

Box 1; Home Care Kit: Each team has 2 kits so they can divide into 2 groups for visits. The Health Centre nurses are responsible for the upkeep of the kits and...
recording of items used. The co-ordinators report when stocks are low and they are replaced accordingly. All the items in the kits were explained in detail to the teams during the training, with the opportunity to try them out as much as possible. This is emphasised during the monthly supervision sessions of medical staff.

Having a good relationship with the local leaders is considered very important, and all the teams spent the first month after their training meeting community leaders in their area. Many referrals come directly from phum (village) leaders, who often accompany the team to the patient’s house. Formal referrals come by phone or referral form and are passed to the appropriate team at a weekly meeting held at NCHADS.

Initially, 2 medical doctors joined the team every month to both supervise the team’s activities and provide some clinical assistance to difficult cases. After the 6 month review this was split into one visit for medical consultation and one to supervise team management. The supervisors are asked to give feedback on both aspects using simple forms, the information from which is fed into the monthly reports given at the Project Committee Meetings (PCM). These reports also include a summary of monthly team activities, which is provided by the Team Coordinator. The coordinator is one of the full-time (i.e. NGO) team members who is responsible for day-to-day supervision of the team, as well as communicating important information between teams and the Project Coordinator. For this they each carry a mobile phone, which is also used for referrals. The coordinators were initially selected by the Project Committee, but for the second half of the project were elected by their own teams.

In addition to establishing regular links with the main hospitals, the teams attempt to raise awareness of the care needs of PWHA within their own Health Centres. Different teams have different characters, and are encouraged to develop their own activities within the overall scope of the project objectives. One team holds informal discussions with monks at the local pagodas, another is working together with a local Kruu Khmer (traditional) healer who is called upon by many of their patients, and a third held an awareness campaign for World AIDS Day. During the second quarter of the project the teams began recruiting volunteers from the community, who have begun to assist with simple activities whilst receiving ongoing training from the team members. Each team has five volunteers.

Management Structure

The pilot period was guided by a WHO Project Coordinator, in close association with the AIDS Care Unit of the NCHADS. As a pilot of a joint response, however, progress has been monitored closely by all the project partners. Representatives from all the NGOs, the Municipal Health Department, NCHADS and WHO met monthly to review the team reports and supervision feedback; discuss ways of solving any problems and exchange ideas for future direction (the Project Committee - see Figure 1). Financially each team is the responsibility of an NGO, and all team expenses, as well as salaries and transport costs of NGO staff, are administered.
directly to the organisation by a grants manager (PACT). One exception is the salaries of the seven international NGO staff, which is a contribution to the project by the INGOs. Salaries and transport costs of government staff are administered quarterly through the Municipal Health Department.

The Project Coordinator has taken responsibility for raising awareness of the project. In addition to local press articles, a bi-lingual presentation to approximately 50 NGOs was given at their monthly meeting in June. An information sheet on the project is also distributed in English and Khmer (see Appendix 1). The AIDS Care Unit recently held 2 workshops for participants from Battambang and Siem Riep provinces, to introduce the concept of home-based care. As part of this workshop, the mixed group of government and NGO staff spent a full day out with the teams observing their daily activity.

The next phase of the project will focus on consolidating current activity, as well as strengthening areas identified during the evaluation. The eight teams have undergone some restructuring, based on patient load in different areas. Financial and technical support for government and local NGOs in the next phase will come from KHANA (Khmer HIV/AIDS NGO Alliance), with coordination becoming the role of the AIDS Care Unit. The 2 INGOs are taking on full support of their 3 teams. The Project Committee is expected to become more autonomous, and individual teams to diversify according to the different needs of their communities. At least three new teams will be created during this phase, to include areas of the city as yet uncovered. The AIDS Care Unit will continue to support provinces in their efforts to start Home Based Care, although funding for care activities will need to be found from other sources.
Figure 1

For further details of Roles and Responsibilities see Appendix 4.
Progress Report

The following information was gathered by the teams over the course of the pilot year. Much of it was collated for the six month review in August, in particular the qualitative data which was obtained by questionnaire (see Appendix 5) and interview. Where possible it has been updated to reflect the entire pilot period.

Patient Profile:

Ten months since the first patient contacts began the total number of patients being visited by the Home Care Teams is 710. Patient load per team is roughly similar (around 80) with the exception of one team covering a densely-populated squatter area, with consequently higher numbers of patients\(^9\). The caseload increased steadily and has met pre-set targets (appendix 7). Visiting patients with general health needs seems to have been successful in preventing the teams being labeled as "AIDS Teams". The current percentage of known HIV patients is approximately 60\% of each caseload. As the project becomes more established and awareness of HIV/AIDS increases, it is expected that the non-HIV caseload will decrease in favour of PWHA. However, as long as awareness and testing facilities remains minimal, the exact HIV positive caseload will continue to be difficult to define. For example, 30\% of the other conditions' seen by the teams were TB and STDs, both of which may indicate the presence of or potential for HIV.

\(^9\) This team has now been split into two, with extra staff recruited
Average Number of Patients per team by month

Non-HIV/AIDS Conditions Seen
(differential diagnosis only)
The male to female ratio is roughly the same, and most patients are in the 20-35 age range. The vast majority are extremely poor, with a growing number of homeless patients presenting. In addition the teams have come across more and more orphans, whom they have endeavoured to place in an appropriate situation.

**Patients Referral Source**

![Referral Source Chart]

Formal referrals are outnumbered by patients 'found' in the community, often self-referring or known through the volunteers. Hospital referrals have been sporadic, despite efforts to identify a regular weekly time to collect and discuss referrals with the 5 main clinical centres catering to AIDS patients. The teams have found it helpful that the village leaders have taken such an active role in assisting them and in making referrals. Three of the four government testing centres have made a significant number of suitable referrals, but the other may need more information about their role in AIDS care. This is also true for some of the hospitals, who have not made full use of the formal referral system and have occasionally been obstructive to the teams (refusing their referrals). The idea that teams would make initial contact with many of their patients in hospital has not materialised, as many are referred post-discharge. This has occasionally led to difficulties in finding the home, or rejection of the service on first contact. Hospitals without a formal referral system have rarely made referrals at all.
The majority of patients first heard of the Home Care Teams in the community, and 90% had their first meeting with the team at home.

Patients First Contact with Home Care Teams

An increasing number of patients are having HIV tests, often as a result of a family member being diagnosed and referred for Home Care. The Teams encourage partner notification but also respect the patient’s desire for confidentiality. In general a team member will accompany someone having a test, and pay for their transport if necessary. Those testing both positive and negative are followed up with appropriate support and prevention messages.

Home Care Patients Tested Month
The objective of linking prevention with care appears to be being met to some extent. In addition to informal education given during home visits all the teams have made formal contacts with pagodas and community groups, some also with local factories, schools and traditional healers. Both formal and informal teaching on transmission and non-transmission has been organised by the teams, and this appears to have had an encouraging effect on the number of HIV tests that have been initiated and supported. All participants also reported that the project had significantly increased understanding of how to prevent HIV infection. It is clearly difficult to know whether such knowledge is translated into behaviour change.

Each team experienced an increasing number of patients requiring palliative care at home, and often liaise with local monks on funeral arrangements. One problem encountered is a misconception about viral transmission from a dead body. A local NGO working specifically with monks to educate about HIV/AIDS (Salvation Centre Cambodia) has been successfully called on for assistance on occasions, and their monks are now working regularly with three of the teams.

Deaths by Month
Team Activity

As expected, the vast majority of the teams' working day is taken up with visiting patients. However, a rough breakdown of other monthly contacts shows around 20% of their time is spent in non-patient activity, such as liaison with community leaders, monks and hospitals. All patients are visited at least once a week, with 65% visited more than twice.

Type of Team Activity

![Pie chart showing distribution of team activity]

Activities Carried out on Home Visits

- make the patient feel better
- take to hospital
- give some money or food
- show compassion to sick people
- give information about HIV/AIDS
- help you to understand about the illness
- give medicine
- show you how to manage symptoms (e.g. cough, pain, month infection)
The range of activities reported to be carried out meets the objectives, although supervisors report marked individual variations between teams. A checklist of tasks for different types of visits was given to the teams as an attempt to counter this (appendix 6).

Project Impact

Families and patients were asked to what degree the Home Care Teams had had an effect on areas relating to quality of life, including financial burden and community responses to HIV/AIDS:

What effect have the Home Care Teams had on the following?
Community Leaders, Health Centre Managers and others indirectly involved in the project were asked similar questions about quality of life as families and patients, but in slightly more detail.

What effect do you think the Home Care Teams have had on the following?

- Amount of money spent by families on care
- Amount of time spent in hospital
- Quality of life of terminal patients
- Understanding of how to prevent HIV infection
- Discrimination against people with HIV/AIDS
- Coordination of care across Phnom Penh
- Ability of patients to be cared for at home
- Community awareness of HIV/AIDS
All of those questioned at six months stated that they were 'very happy' with the Home Care Teams, giving their reasons as a non-discriminatory approach; encouragement given to patients and families, and a free service. All would recommend the teams to another family. Many asked the teams to increase their social work role, by helping the poorest families to buy food and medicines. Everyone felt that the project had a positive effect on reducing discrimination, as well as increasing families' ability to care at home. Less significant, but still positive, was the project's role in reducing the amount of money spent on health care, as well as the time spent in hospital. This was reported more by the patients themselves than perceived by others involved in the project - principally hospitals for whom the teams have increased the patient load in many cases.

**Monitoring and Evaluation**

As a result of the six month review the following improvements were made:

- a review of the contents of the Home Care Kits, with the addition of Loperamide for acute diarrhoea; an anti-emetic (Primperan); Promethazine cough linctus and multivitamins
- a request to the World Food Programme resulting in the provision of nutrition bars for the poorest families
- 2 hospital placements for all the nursing staff on the teams, in rotation, to improve clinical knowledge and skills
- additional monthly Medical Consultation visits by hospital doctors, supplementary to the supervision visits for team management
- improved links with the TB programme, including joint training with TB DOTS workers

In December a two week evaluation was carried out by a WHO consultant. This concluded that home and community care for PWHA was "very much needed" in Cambodia, and that the project should be both strengthened and expanded. The model demonstrates that it is possible to mobilise both government and nongovernment agencies to work together in providing care. However it was also recommended that a cost-benefit analysis should be undertaken, as well as further analysis of the mechanisms of the model. It is yet to be identified who will undertake these tasks.

As part of the process for transferring financial support from WHO to KHANA, each team has undergone their own internal review of the year. All eight teams requested a larger proportion of team funds for patient welfare i.e. food, water, transport to hospital etc. Although referred patients come from a range of backgrounds, it is generally only the very poor who require the services of the home care teams. As such the teams are increasingly concerned about how to manage homeless patients and orphaned children. In general, discrimination against PWHA has been manageable, with only a few cases reported. The teams have often been able to persuade people to help out their relatives or neighbours, with the promise of regular support from themselves or the volunteers. Nevertheless, as numbers of AIDS patients increase the pressures on the resources of an already over-stretched community may become unbearable,
leading to increased isolation of PWHA. This is already happening in the squatter area of Tonle Bassac, which led to the decision to create an extra team to cover this area.

The teams also discussed ways to improve links with some of the hospitals. Many patients are refusing to allow the team to take them to hospital because of both long waiting periods and the perceived unwelcome reception from hospital staff if they are both very sick and very poor, which is usually the case. On a more positive note several Health Centre Managers stated

that the project had improved the functioning of the Health Centre in the community, and was relieving the hospitals. Many of those involved mentioned the need to get high-level recognition of the real problems of PWHA at community level, before it began to overwhelm the health system and the communities themselves.

A final area identified as one to develop during the next phase of the is project the role of PWHA themselves. During the past year 3 separate support groups have started up, each with approximately 20 members. Many of these members are also involved with Home Care, some as volunteers attached to the teams. The Teams are already acting as advocates for PWHA in the community, and are ideally placed to encourage and support further self-help activities as they develop.
The Future

The project has been relatively successful to date. An examination of the indicators for fulfillment of objectives (Appendix 7) shows that the majority have been met. Government and NGO staff have worked well together and succeeded in sharing their different skills in a cooperative and equitable manner. Community Leaders have generally been more supportive than expected, showing their concern for the increased health burden they are beginning to witness in their communities. Through the Health Centre Managers and Senior Municipal Health Staff growing interest in the teams they have shown an increased awareness of the care needs of PWHA. The rapid increase in patient numbers clearly demonstrates a desire to use such a service.

However, ten months of visiting is too short a period to truly test the model, and further and more detailed evaluation should be done. It would be useful to carry out a comprehensive cost-benefit analysis. Quality indicators could also be usefully developed.

With new support from KHANA during 1999 the Phnom Penh teams will hopefully be able to both consolidate their skills in Home Care and provide support to others wishing to start Home Care. By incorporating the lessons learned from the pilot year the eight (now nine) teams will continue to strengthen and build their capacity. The Ministry of Health's AIDS Care Unit will take on a greater role of supervision and monitoring, and will also provide support to provincial care activities. A Technical Advisor at KHANA is available to be called upon as necessary, but the Project Committee is now sufficiently experienced to be largely autonomous. Through KHANA's links to the Alliance, there is also potential for specialist support to the teams, and opportunities for operational research.

In the past year there has been a growing awareness of the link between prevention and care and an appreciation of the importance of initiating appropriate care activities in Cambodia earlier rather than later. This is shown by various activities begun and planned this year, including the establishment of the AIDS Care Unit of the NCHADS, and a Round Table discussion on Care and Support planned for the First National AIDS Conference in Phnom Penh in March 1999. WHO is also supporting the development of a National AIDS Care Strategy, into which the experiences of the Home Care Project will hopefully feed. Nevertheless, there remain significant gaps in resources for AIDS Care, both institutional and community based. The National AIDS Care Strategy will be a useful framework for the both government and non-government organisations to lobby funders to address this. However, the essence if not the details of the gaps are already quite clear. It is important that, if Cambodia is to benefit from any of the lessons learned from other resource-poor countries, the care needs of PWHA are more significantly addressed than at present. This project shows the potential of one approach that makes use of the limited range of skills and resources available in Cambodia at the micro-level, whilst remaining true to the macro-level reforms being instigated by the Ministry of Health. It is hoped that it will usefully contribute to a serious dialogue on approaches to AIDS care.
Appendices

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HENRIETTA WELLS, PROJECT CO-ORDINATOR TEL. 012 804 855
Joint Ministry of 14cithINC0 Pilot Project in Home and Community Care of
People with HIV/AIDS, 1998-99
APPENDIX 1:

Joint MoH/NGO Pilot Project in Home and Community Care for people with HIV/AIDS

The National AIDS Programme (NAP) estimates that there will be 30,000 people with AIDS in Cambodia by the year 2000. There will not be the resources to treat these people with the drugs currently used in richer countries, costing between S 10 - 15,000 a year for each patient. Evidence from other countries suggests the most cost-effective way to manage a large-scale AIDS epidemic with limited resources is to establish a continuum of care between hospital and home. This allows patients' symptoms to be managed at the appropriate level as their illness progresses. It also encourages acceptance of people with HIV/AIDS by the community, and promotes better understanding of how the virus is and is not transmitted.

In 1997, the NAP, WHO and local and international NGOs working in HIV/AIDS decided to co-ordinate on provision of home and community-based care for people with HIV/AIDS, and a 1 year pilot project was designed for Phnom Penh. Eight Health Centres were selected by the Municipal Health Department, and linked with staff from different NGOs to form 8 Home Care Teams covering the central part of the city (see map). Each team has 3 full-time and 2 part-time staff, who are either nurses, counsellors or HIV/AIDS educators. They have all received basic training in management of symptoms; palliative care; psychological support; working with families and raising awareness of HIV/AIDS in the community. They carry a Home Care Kit of simple medicines such as paracetamol and ORS, and practical materials such as soap and condoms. They aim to support family carers in providing basic care at home, including how to practise good hygiene, nutrition and patient comfort. For reference they use the "Handbook on AIDS Home Care", translated and adapted from the WHO Handbook in 1997 specifically for the project. In addition to information on symptom management it includes picture-based Khmer stories about people affected by HIV/AIDS, and a section on commonly-used traditional plants.

The project began in February 1998, and the teams began taking referrals at the beginning of May. Referrals come from hospitals, testing centres, clinics and the community itself. The project is monitored by a committee representing the 7 NGOs, WHO, NAP, Municipal Health Department and the Health Centre Managers, to whom the teams submit monthly reports. In addition each team receives a supervision visit each month from 2 medical doctors and a member of the Project Committee. The project will be evaluated at 6 months and at the end of 1 year, when it is hoped that it will be expanded to at least 2 other provinces.

To make a referral please contact the appropriate team by mobile phone (see map) or at the Health Centre. Yellow Referral Forms are available from WHO, the NAP and the Health Centres. Although the project focuses on people with HIV/AIDS, as 'Home Care Teams' the staff will visit patients with other chronic illnesses whom they feel they can help. In all cases they will try not to visit anyone without prior agreement. For further information on the project, please contact Henrietta Wells, WHO Project Co-ordinator, on 012 804855; or Dr. Nong Kanara, NAP AIDS Care Department, on 023 722515.
## Training Course, Home Care Teams

### GROUP 1, MODULE A

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<td>Working with the Community</td>
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<td>$90 per month</td>
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<td>Government Supplements</td>
<td>2 half-time government nurse members of each of 8 HCTs 16)</td>
<td>$45 per month</td>
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<td>moto-taxi</td>
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<td>refreshments, transport, photocopying for meetings; referral, record keeping, collection of data, quarterly reports</td>
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<td>transport, refreshments, training materials</td>
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<td>5 community volunteers per team</td>
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<td>Mobile Phones and charges</td>
<td>1 per team (8) @ $200. 860 monthly charge**</td>
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APPENDIX 4

Roles and Responsibilities of Project Partners:

**HCTs**
- Carry out activities of home care (see below)
- **Health Centres**
  - Provide 2 half-time staff for HCT
  - Keep up to date with HCT activities and promote appropriate use of the service
  - Represent Health Centre Managers at monthly Project Committee Meetings (in rotation)
  - Assist Project Coordinator in managing issues relating to Health Centre.
  - Participate in team/clinical supervision
- **NGOs**
  - Provide between 2-6 full-time staff for HCT
  - Keep up to date with HCT activities and promote appropriate use of the service
  - Represent NGO at monthly PCM
  - Assist Project Coordinator in managing issues relating to their organisation and personnel
  - Assist Team Coordinator in producing monthly report and quarterly financial statements.
  - Participate in team/clinical supervision

**Team Coordinators**
- Produce monthly reports on HCT activity
- Represent Team at monthly meetings
- Produce quarterly financial reports
- Provide day-to-day supervision of team activities
- Delegate responsibilities appropriately
- Ensure Home Care Kits are maintained and proper use is made of the mobile telephone
- Ensure information is passed between team and Project Coordinator

**WHO Project Coordinator**
- Provide overall management of project
- Ensure project partners are kept up to date with project progress
- Liaise between Project Committee and HCTs
- Ensure quality standards are maintained in project activities
- Carry out 6-month review
- Promote a continuum of care and seek funding for extension/expansion of project

**PACT**
- Allocate budget to NGOs
- Regulate budget spending
- Assist NGOs in financial management as required

**Municipal Health Department**
- Keep up to date with HCT activities and promote appropriate use of the service
- Represent Municipal Health Department at monthly PCM
- Assist Project Coordinator in managing issues relating to government participation
NCHADS
- Keep up to date with HCT activities and promote appropriate use of the service
- Represent NCHADS at monthly PCM
- Participate in team/clinical supervision
- Provide technical input into training and ongoing activities
- Assist Project Coordinator in promoting a care continuum and seeking funding for project continuation and expansion

Hospitals and Testing Centres
- Refer patients as appropriate
- Receive referrals from HCTs
- Participate in clinical supervision
APPENDIX 5

Questionnaires (given at 6 month review)

QUESTIONS FOR FAMILIES AND PATIENTS
(to be asked by neutral interviewer)

Name of team that visits this family:

1. How did you first hear about the Home Care Teams?
   - in hospital
   - at the clinic
   - at home
   - from the neighbour
   - other:

2. Where did you first meet the Home Care Team?
   - in hospital
   - at home
   - at a phum meeting
   - other

3. How often do they visit you each week?
   - less than once
   - once
   - twice
   - more than twice

4. What of the following do they do?
   - show you how to manage symptoms (e.g. cough, pain; mouth infection)
   - give medicine
   - help you to understand about the illness
   - give information about HIV/AIDS
   - show compassion to sick people
   - give some money or food
   - take to hospital
   - make the patient feel better
   - other (please specify)

5. How happy are you with the Home Care Teams?
   - very happy
   - quite happy
   - not happy
   Why?
6. What effect have the Home Care Teams had on the following:
   - your ability to care for the patient at home
     less/more/same
   - amount of money you spend on care
     less/more/same
   - how encouraged you or the patient feel
     less/more/same
   - your understanding of how to prevent HIV infection
     less/more/same
   - other people's discrimination against people with HIV/AIDS
     less/more/same
   - other (please specify)

7. How could the Home Care Teams be improved?

8. Would you recommend the Home Care Team to another family?

9. Please add any other comments that may be useful:

Thank you for your cooperation.
QUESTIONS FOR HOSPITALS, TESTING CENTRES, PHUM LEADERS

Name:

1. What effect do you think the pilot project has on the following:
   - community awareness of HIV/AIDS
   - ability of patients to be cared for at home
   - coordination of care across Phnom Penh
   - discrimination against people with HIV/AIDS
   - understanding of how to prevent HIV infection

   less/more/same

2. What would you like to see happening in the next 6 months?

3. What do you think should happen at the end of the pilot year (February 1999)?

4. Please make any other comments that may be useful for the mid-term review:

Thank you for your cooperation.
APPENDIX 6

Checklists for Home Visits

1: First Visit: Needs Assessment

Introduce yourselves and the Home Care Project. There is no need to mention HIV/AIDS at this stage. Tell them you work in the area with sick people and you can visit them often to help them to manage the illness and help them to solve any worries they may have. Tell them you will not be giving out lots of expensive medicines but that you, are trained to teach the family how to relieve symptoms and will try to help with any other problems (eg sending the patient to hospital).

Ask if you can do an assessment of the patient’s and family’s needs. Explain you will need to show at least one family member how to do home care.

NB. Following each question is an example answer you might make from a young male patient “Sophon”. This is to give you an idea of what you could look for.

General needs:

1. do they have good hygiene?
   Sophon: not really, patient scratching self with dirty hands
2. does the patient have good nutrition?
   not eating or drinking because of diarrhoea
3. do they need any special help?
   roof leaking when it rains; not enough food

Emotional needs:

1. how is the mood of the patient? Does he talk of suicide?
   doesn’t want to talk; very sad
2. what do they feel is wrong with them?
   knows he has HIV does not want to talk about it
3. how are the family reacting?
   wife wants to hell) but scared of infection
4. what are the main worries of the patient and family?
   how to manage without the patient's income from work

Physical needs:

1. how does the patient look and feel?
   Sophon: looks thin, flushed, scratching at legs. Doesn't want to eat, body feels hot and itchy
2. if they feel unwell, what are the symptoms?

nauseous at sight/smell of food; diarrhoea; sweating a lot; itchy dry skin on legs and arms

3. how long have they had these symptoms?

sweating, nausea and diarrhoea for 4 days; dy skin for 2 weeks

4. does anything relieve the symptoms?

taking herbal medicine for diarrhoea

5. what do they see as their needs?

want serum and medicine

Educational needs:

The family needs to know all the points below. However, they can be discussed over many visits. Choose only what is most important for the first visit.

1. what is HIV and AIDS
2. how HIV is transmitted and not transmitted
3. what to do to prevent transmission of HIV
4. how to protect carers from infection
5. how to find out if a person has HIV
6. what problems are commonly found with AIDS
7. how to recognise and take care of problems caused by HIV/AIDS
8 when to seek help and where to go
9. where to go for emotional support or counselling
10. how to lead as normal a life as possible
11. how to cope with the stigma of HIV/AIDS
12. how to cope with caring for a person with AIDS
13. what are the common myths of HIV/AIDS
14. what are their rights

Using the example of Sophon, what can we do with this information:

=> ask them what they know about HIV/AIDS. Correct any wrong information. Explain about transmission and how to care safely at home.

=> take each symptom in turn. First wash your hands and show the family how to cover any broken skin.

=> Nausea/diarrhoea - explain how important it is to eat and especially drink. Ask what foods the patient likes. Suggest simple good food with not much taste, in regular small quantities. Show the family how to make up ORS and give to the patient. Explain why they must use clean water. Leave some sachets of ORS with family and write down how and when to use them. If they don't read well, explain very clearly.

=> Check the herbal medicine - if it seems to help then they can keep using it, but try to stop them from spending a lot of money. Ask about where it came from and show them you don't mind about them seeing Kruu Khmer, as long as it is not harmful. Gently explain to them that there is no cure for HIV/AIDS.

=> explain that serum is not necessary if the patient is drinking enough. It is expensive and it could cause infection.

☞ Check if the patient has a fever. If yes, encourage him to take a cold bath often, to bring down the temperature. Give 2 paracetamol and ask the family to continue to give 2 every 6/8 hours until the fever is gone. Ask them to give it with food. If he has no fever but is just sweating, he can still take regular baths.
Physical Needs:

1. do they follow good hygiene?
2. does the patient have good nutrition?
3. do they need any special help? (e.g. extra food; help with transport costs to hospital)

Emotional needs:

1. how is the mood of the patient?
   - depressed, crying, talking about dying
2. how are the family managing?
   - managing well but don't know how to talk to the patient when he cries
3. what are the main worries of the patient and family?
   - money, neighbours talking about AIDS

Physical Needs:

1. how has the patient changed since the last visit?
   - fever and nausea gone; skin looks better; diarrhoea the same, but has a new cough.
   - Patient looks clean and is drinking ORS.
2. check the condition of the mouth, eyes and skin
   - OK - mouth clean and moist, eyes clear, skin unbroken with no red patches.
3. if new symptoms, for how long and how are they treating them?
   - cough for 3 days. No treatment
4. are there any problems with the medication and do they have enough?
   - don't like the ORS, asking for more paracetamol (but fever is gone)
5. what do they see as their needs?
   - paracetamol. Worried cough may be TB

Educational needs:

=> Skin: show the family how to apply lotion to the dry areas, but make sure the patient's body is clean.
   - Try a little coconut oil first. Ask the patient to clean his hands and nails and to try not to scratch the spots. Explain to the family about infection from broken skin.

=> General: encourage them to change and wash the clothes often - give them a small bag of soap if necessary and show how to use it. Explain about hygiene especially when preparing food and drinks.

=> Ask one member of the family to go over what they need to do, so you can be sure they understand.
   - As it is the first visit and you have given a lot of information, tell them you will come back to make sure there are no problems tomorrow. Tell them roughly what time you will come.

=> Mention the leaking roof - do they plan to fix it? You can give them a little money to help if you think they don't have enough.

=> Ask if there are any questions about what you have said or done. Take time to answer them.

=> Be friendly and supportive. Remember they may be anxious.

=> Summarise the visit in your notes.

2. Maintenance Visit

This is a checklist for a regular visit made to a family you already know. The main point will be to follow-up whatever you did/agreed on the last visit, and to give support.

General needs:

1. do they follow good hygiene?
2. does the patient have good nutrition?
3. do they need any special help? (e.g. extra food; help with transport costs to hospital)

Emotional needs:

- how is the mood of the patient?
- depressed, crying, talking about dying
- how are the family managing?
- managing well but don't know how to talk to the patient when he cries
- what are the main worries of the patient and family?
- money, neighbours talking about AIDS

Physical Needs:

- how has the patient changed since the last visit?
- fever and nausea gone; skin looks better; diarrhoea the same, but has a new cough.
- Patient looks clean and is drinking ORS.
- check the condition of the mouth, eyes and skin
- OK - mouth clean and moist, eyes clear, skin unbroken with no red patches.
- if new symptoms, for how long and how are they treating them?
- cough for 3 days. No treatment
- are there any problems with the medication and do they have enough?
- don't like the ORS, asking for more paracetamol (but fever is gone)
- what do they see as their needs?
- paracetamol. Worried cough may be TB
Emotional Needs:

1. have you told them all they need to know from the list?
2. do they have any questions?

Using the example of Sophon, what can we do with this information:

=> praise them for the improvements seen in the patient. Give encouragement for keeping him clean and more healthy.
=> ask them to show you how they make up the ORS and check it is correct. Suggest coconut juice or another soft drink as an alternative.
=> ask if the patient has any pain. If not, explain that they don't need to give paracetamol anymore, as the fever has gone.
=> encourage the patient to cover his mouth when he coughs, and to spit into a covered container, not on the ground. Check for other symptoms of TB and explain that you will come back in a few days to check if the cough gets any worse. However if you suspect TB you should take them to hospital e.g. CENAT.
=> always check that they are following good hygiene and nutrition.
=> talk to the patient about his fears of dying, if possible. Ask if he would like to see a monk or achar, and arrange this. Tell him about the Support Groups and Special Counselling Centres, and offer to take him there if he wants.
=> let the family talk about how they feel. Encourage them that just listening to the patient is helpful. Ask if they would like you to talk to the neighbours, or to give them a leaflet on HIV/AIDS.
=> ask if there are any questions and arrange the next visit. If you, don't know the answers to the questions, write them down and try to find out before the next visit.
=> summarise the visit in your notes.

3: Visit During. Last Stages
This is a checklist for a visit made to a patient close to dying. You will probably already know the family and be visiting regularly.

General Needs:

2. is the patient receiving any food and drink?
   Sophon: cannot eat or drink

3. is the patient being kept clean?
   Sophon: he is a little smelly

Emotional Needs:

1. how is the mood of the patient?
   Sophon: seems peaceful, too weak to talk
2. how are the family members?
   Sophon: wife and brothers seem to accept the situation, young daughter is very quiet and sad
1. what are the main worries of the patient and family?
they worry they will not be allowed to cremate the patient in the usual way. Also worry about the cost
of the funeral, and what will happen to the children.

Physical Needs:

1. how has the patient changed since last visit?
   Sophon: more weak, but otherwise the same
2. is the patient comfortable?
   yes but feels pain in arms and legs
3. are there any signs of skin breakdown?
   small sore on buttock, red area on shoulder blade
4. check the condition of the mouth and eyes
   mouth and eyes sticky
5. what do they see as their needs?
   pain relief

Educational Needs:

1. are there any new people in the house who need to know about HIV/AIDS?
   some relatives have come and are scared to touch the patient
2. do the family know what to do when the patient dies?
   they worry about this

Using the example of Sophon above, what can we do with this information:

=> show the family how to move the patient to prevent pressure on the same spot.
=> help them to wash the patient and change the clothes, being very gentle
=> teach them how to remove the stickiness from the eyes and mouth, using small pieces of cloth and
   clean water.
=> if the patient wants, encourage them to gently massage the arms and legs
=> give increased dose of paracetamol for the pain. Discuss possible ways to relieve pain with
   traditional medicines.
=> show the family how to clean the sore on the buttock with potassium permanganate or hydrogen

=> encourage the patient to take small sips of water or soup. If he cannot drink, moisten his lips and
   give him some ice to suck.
=> ask the family how they feel, and what do they think the daughter is feeling. Talk to the daughter
   in a quiet place about what she thinks will happen to her father.
=> continue to talk to the patient even if lie cannot answer. Touch him so he knows you care and are
   not afraid.
=> discuss in a practical way what will happen when the patient dies. If the monks are not already
   there, ask them to come. Reassure the family that the funeral can be normal (check this with the
   monks). Help them with the funeral expenses if you feel they don't have enough money.

=> talk to the relatives about their fears. Explain about HIV/AIDS and take time to
   answer their questions.
=> Summarise the visit in your notes.
APPENDIX 7
Project Logical Framework

<table>
<thead>
<tr>
<th>Narrative Summary</th>
<th>Measurable Indicators</th>
<th>Means of Verification</th>
<th>Important Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>To reduce the impact of the HIV/AIDS epidemic on a resource-constrained country</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>To provide quality, resource-effective and sustainable primary care to PWHA using resources drawn from government and non-government health systems, family and community.</td>
<td>Access to care, Quality of life, Family health care costs, Community awareness and tolerance towards PWHA, Investment by Project Partners</td>
<td>6 month Project Review, 12 month external evaluation, (Purpose to Goal) Stability and function, Public Health System</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>To identify and measure strengths and constraints of a particular model of care in the Cambodian context.</td>
<td>Monitoring and final evaluation</td>
<td>(Output to Purpose) PiNTHA willing to be visited at home, Demand does not overwhelm the service, Hospitals and testing centres cooperate with referral system, Level of care provision perceived to be adequate by patients/families, Evaluation report considered by policy planners and funders</td>
</tr>
</tbody>
</table>

**Activities**
1. Train and provide support to 8 Home Care Teams to:-
2. Coordinate and facilitate the cooperation of Health Centres, NGOs and community by:-
3. Carry out project evaluation at end of pilot period

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activity to Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Phnom Penh Health Centres - 2 part-time staff from each NGOs - 24 staff Funding and resources for training Funding for operational cost of to recognise and treat teams</td>
<td>(Activity to Output) Political situation allc staff to work contract hours, Home Care Teams ab symptoms correctly, Centre Managers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Important Assumptions</th>
<th>(Output to Purpose)</th>
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<td></td>
</tr>
</tbody>
</table>
Phnom Penh, 07 July 1999

Dear

Subject: Joint MoH/NGO Pilot Project on Home and Community Care for People Living with HIV/AIDS

As you may know, the pilot period for the above project has now come to an end. Following the evaluation by the National Center for HIV/AIDS Dermatology and STD (NCHADS) and World Health Organization (WHO), the project has been considered to be successful, and we recommend that it should be continued, strengthened and expanded.

The next phase of the project will be supported financially and technically by NCHADS and Khmer HIV/AIDS NGO Alliance (KHANA). For more information please contact with Dr. Samreth Sovannarith at the AIDS Care Unit (NCHADS) and Mrs. Henrietta Wells at KHANA.

I have a pleasure to enclose a summary report of the pilot project for your information or supporting activity. Thank to all who have helped to make this project successful. I hope you will continue to cooperate with us in the field of care and support for people living with HIV/AIDS.

Yours Sincerely,

Director
National Center for HIV/AIDS
Dermatology and STD