KINGDOM OF CAMBODIA

Nation - Religion - King

Ministry of Health

HEALTH CENTER OUTREACH GUIDELINE

5th Edition

2020

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LIST OF ABBRVIATION

AOP	Annual Operational Plan
AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BS	Birth Spacing
CBAW	Childbearing Age Women
CCWC	Commune Committee for Women and Children
DTP	Diphtheria, Tetanus, Pertussis
EID	Emerging Infectious Diseases (EID),
GMP	Growth Monitoring and Promotion
HC	Health Center
HEF	Health Equity Funds
HCMC	Health Center Management Committee
IFA	Iron/Folic Acid
IMCI	Integrated Management Childhood Illness
ISC	integrated supervisory checklist (ISC)
ITN	Insecticide Treated Net
MAM	Moderate Acute Malnutrition
MOH	Ministry of Health
MUAC	Mid-upper arm circumference
NCD	Non-Communicable Disease
ND	Newborn Death
NT	Neonatal Tetanus
OD	Operational District
OPD	Outpatient Department
PHD	Provincial Health Department
PMD	Prevention Medicine Department
PNC	Postnatal Care
RMNCHN	Reproductive, Maternal, Newborn and Child Health and Nutrition
SAM	Server Acute Malnutrition
TT	Tetanus Toxoid
VHSG	Village Health Support Group
WIF	Weekly Iron-Folic Acid

FOREWORD

Health Center is a front-line health facility where provides people with essential health care services, especially quality preventive and curative services. These basic essential services are provided through health care and prevention at both health center and outreach activities by utilizing the boosted approach to increase the accessibility of health care and prevention services, and education by people with aims at improving their knowledge about the benefits of health prevention and the appropriate use of quality health services.

Some issues such as poverty, long-distance and transportation difficulties, being occupied with work, migration and limited knowledge are factors that impede the access to health care and prevention services at the health center, therefore, the outreach activity is crucial to ensuring complement of health service delivery of the HCs with comprehensive coverage as needed.

The Ministry of Health has begun to develop and implement the Outreach Guideline since March 2001. This guideline specifies the roles and responsibilities of outreach activity in the health system for standard implementation throughout the country. After three years of implementing experiences, the guideline was revised in 2003 to align with real situation and ensure the implementation of quality and smooth outreach activity. Subsequently, it was further updated in 2008, 2012 and 2020 with modifications to the technical areas, service procedures and the integration of several service activities of national programs.

The MOH would like to extent its sincere thanks to the Preventive Medicine Department (PMD) and the National Programs and its relevant partners for their collaboration in updating this outreach guideline to be more comprehensive. We strongly believe that this guideline will serve as a guiding tool for health staff at all levels and relevant organizations which are implementing and supporting outreach activities to ensure the delivery of quality health services to people everywhere is effective and efficient manner.

CHAPTER 1 – RATIONALES AND OBJECTIVES

1.1. Rationales

The Health Center outreach guideline was printed and disseminated for the first time in March 2001, the second time in May 2004 and the third time in February 2013 respectively. After five years of implementation, the consultation on the outreach guideline revision was conducted by the MOH in order to align with the updated policies and guidelines of relevant national programs to improve effectiveness and efficiency for better health outreach service

Currently, the road infrastructure in rural areas has been dramatically improved as the Royal Government of Cambodia (RGC) has continuously constructed roads connection everywhere in the country. There are the needs for strengthening quality of health care services at health facilities, increasing knowledge and awareness as well as encouraging people to utilize health services at health center are critical and require the reconsideration on improving utilization of health services stimulating at health center. Moreover, in order to ensure that fixed site service delivery and service delivery through outreach are complemented each other, the HC outreach guideline needs to be revised to incorporate the guideline on improving quality of health service delivery at health facilities for nearby villages or communities where villagers can access to health care services at health facilities .

1.2. Objectives of the Guideline

A) To redefine the role of outreach activities in the strategic framework of service delivery at health centre and provide implementation guidance for effective and efficient service delivery, and better outcomes.

B) To re-determine health service packages to be delivered during outreach at community level and provide the overall guiding principles for preparing and conducting outreach services activities and to clarify the implementation support and regular monitoring required to ensure the quality of the services as the complement to the health facilities service delivery.

C) To strengthen quality and efficacy of the provision of health care services by HC including:

- Outpatient consultation and general treatment for adult, the integrated management of childhood illness, counselling and health education and promotion;
- Fixed site immunization services at HC, vaccine waste reduction, as well as safe vaccination management;
- Reproductive, maternal, newborn and child health and nutrition (RMNCHN) services including antenatal care (ANC), delivery care, and postpartum care (PNC) for both mother and newborn, including supplementation of vitamin A, iron/folic acid tablets, and periodic deworming (Mebendazole or albendazole);
- Outpatient consultation and treatment for communicable and non-communicable diseases;
- Provision of health care services at community level through outreach activities including both basic essential and expended packages of health services; and
- Communication between health centre and community: Village Health Support Group (VHSG), local authorities, private provider, and traditional birth attendants and traditional healers.

D) To incorporate essential and updated technical protocols and guidelines of relevant national programmes into the outreach guidelines.

E) To provide consistent guidelines for the implementation of outreach activities and the improvement of fixed site service delivery for both health staff and relevant health development partners. Health officials at all level shall follow the guidelines in strengthening and improving the quality of health care service delivery at health center and during outreach activities and shall make this document available all the time at health center.

1.3. Definitions

1.3.1. Outreach Activities

Outreach activity is a service delivery modality conducted by HC staff at the village or community level for remote areas where people, especially underserved population, have difficulty in accessing to health care services and this service delivery modality is a complement to the provision of routine health care services at health center level in order to improve the accessibility of health services by people, especially the essential health services and to ensure that there should not be any disturbance to the routine and regular health care service provision at health center level.

The methods for service delivery recommended in this guideline have been updated according to the updated policies and guidelines of relevant national programmes and other reference documents such as the guideline on minimum package of activities for health centre development, the guideline for operational district development, and guideline on community participation.

1.3.2. Fixed Site Health Services

Fixed site health services are essential services delivery provided at health facility level (health centre) as stipulated in the “guideline on minimum package of activities for health centre development”, focusing on improving effectiveness, efficiency, and quality of health services through reducing the outreach activities to the villages or communities where villagers can access to health care services at the health centre.

To maintain the high facility utilization, HC needs to be strengthened quality of services delivered at HC level by providing regular routine services such as ANC, PNC, immunization, and nutrition and strengthening the relationship between HC and community and improving linkage between HC and communities to build awareness and knowledge of communities on the importance of ANC, PNC, immunization, nutrition and other health care services.

1.4. Advantages and Disadvantages of Outreach Activities

1.4.1. Advantages

Outreach activity is a critical service delivery modality as:

1) It complements to the provision of health care services in health facility in effectively improving coverage of effectiveness and efficiency for some basis health care services such as vitamin A, Mebendazole, and iron-folate supplementation, immunization, distribution of birth spacing commodity, providing communicable diseases services such as Malaria and communities, insecticide treated net distribution and health education etc.

2) It provides opportunity to receive some basic health care services for people who live in the HC catchment areas but far away from HC where traveling to HC to receive such basic services are difficult.

3) It provides opportunity to HC staff to meet with the people in their catchment areas, and to understand their health status and the issues they encounter as well as their needs and they can also inform citizens about health care services at HC, their rights and benefit in using health care services at the HC, and enhance their understanding on patient referral in emergency from community to health facility.

4) It is a point of contact where other outreach activities of other relevant national programmes may be coordinated so that the use of scarce resources available with good productive outcomes.

1.4.2. Disadvantages

Giving attention on only the outreach activities may disturb and even disrupt routine health service delivery at HC level as:

1) If there are limited staffs at HC and most of them engage in outreach activities at the same time, it may disturb the function of HC.

2) Routine and frequent outreach activities may induce people habit in receiving health care services at home or in their villages and discourage them to seeking and using health care services at HC, which is integral with more optional services.

3) Routine and frequent outreach activities may not be sustainable, especially in the circumstances in which there is limited financial and human resource.

4) It critically requires regular monitoring and supervision to ensure the quality health services delivered through outreach activities.

5) Even though the outreach activities can be conducted regularly and frequently, it cannot respond to the health needs of people.

6) For the poor, health equity funds (HEF) only cover the cost of services provided at facilities, but not those delivered through outreach.

1.5. Advantages and Disadvantages of Fixed Site Services

1.5.1. Advantages

Delivering health care service at facility is more advantageous as:

1) Many health care services can be provided in one visit to a health center including essential preventive and curative care without disturbing the health center function.

2) Visiting HC provides opportunity to citizens to know HC staff and receive information on health care services .

3) Increase health services utilization at fixed site, which in turn leads to increased HC user fee revenue.

4) Health care services delivered at HC is integral with better quality compared to the health services delivered during outreach activities as the HC is better equipped than the outreach session.

5) Fixed sited services make citizens become familiar with HC and health care services that HC can provide on routine basis.

6) Time would be saved for health staff to provide routine curative and preventive care services at facility, including midwifery services.

1.5.2. Disadvantages

There are several inconveniences and disadvantages associated with only fixed site service provision such as:

1) Health care services coverage shall not be reached to rural remote areas and underserved population, which are far away from the HC or have particular difficulty especially in receiving health care services from health facilities, therefore, the service coverage would not achieve the target set.
2) Without visiting the villages or community, health staff may not be fully aware about the living standard, current health status and needs of the people in their catchment areas.
3) HC would be difficult to have closer relationship and trust with communities.
4) It would be more difficult to coordinate other community activities of other national programmes, and therefore lead to inefficient use of scarce resources.

CHAPTER 2 – GUIDING PRINCIPLES FOR IMPLEMENTATION

2.1. Catchment Areas of the Health Center

In addition to the instruction on how to classify villages in the catchment areas of a HC as per guideline on operational district development and based on the rationales in health care service delivery and improvement of quality services at all villages and communities within the catchment areas of a HC can be classified as follows in accordance with their administrative status, geographical location, road infrastructures, distance, means of transportation, and duration of travel.

2.1.1. Classification in Accordance with Administrative Status

A) **Administrative villages:** are villages registered by local administration, and therefore, are officially recognized by commune/Sangkat, district administration, and Ministry of Interior (MOI) before the Cambodia Census in 2008. In general, these villages have physical infrastructure in place and also the VHSG.

B) **Annex villages:** are villages created by settlement of people that have split from any administrative villages or migrated from their homeland for any reason. Those villages were identified during the 2008 Cambodia Census. They are recognized by commune and district administration and Ministry of Interior. However, some of those villages have not yet had physical structures or VHSG in place.

C) **Informal settlements:** are communities created by settlement of people that have split any from administrative villages or migrated from their homeland for any reason after the Cambodia Census in 2008 or communities of workers in concession areas. Those communities have yet been recognized as villages by the commune/sangkat and district administration, and MOI for some reasons. Similar to annex villages, those informal settled communities do not have physical structures or VHSG in place.

The OD office should provide supports to HC and request to local administration for the recognition of the outreach services conducted for those informal settlements, and coordinate for the establishment of VHSG or other community volunteers structure for those communities.

2.1.2. Classification in Accordance with Geographical Status, Distance, Mean of Transportation and Travel Duration

For comprehensive and quality health care services, people are encouraged to use health care services at health facilities. However, due to the need for providing basic health care services through outreach, villages and communities in the catchment areas of a HC shall also be classified according to geographical status, distance form HC to the village, mean of transportation and travel duration as follows:

A) **Village where HC located**: is a village locates in zone “A” in accordance with the guideline on operational district development. People from this village shall be encouraged to use health care services at HC (fixed site village).

B) **Nearby villages**: are villages located closer than 5 kilometres to the HC. Those are some villages locate in zone “B” according to the guideline on operational

district development and the travel from HC to those villages by using locally available mean of transportation shall not be taken longer than 1 hour.

C) **Further villages**: are villages with the following characteristics:

- Villages locate farther than 5 kilometres from the HC but closer than 10 kilometres
- Traveling from HC to those villages are taken longer than 1 hour, but should not exceed 2 hours by using locally available mean of transportation.
- These villages are eligible to receive basic health service package through outreach activities provided by HC staffs.

D) **Remote villages**: are villages with the following characteristics:

- Villages locate farther than 10 kilometres from the HC OR
- Traveling form HC to those villages are required to pass by forest or mountainous areas, or travel by waterway, OR
- Traveling from HC to those villages are taken longer than 2-3 hour by using locally available mean of transportation.

Those villages should receive outreach with extended packages of services provided by HC staffs (Outreach with extended package of services)

According to the travel condition by passing the forest or mountainous areas, or travel by waterway or travel distance from 40 kilometres or more or travel duration taken longer than 2-3 hours, the team conducting outreach to those villages shall be eligible to stay over-night at those villages if necessary.

Transport cost to reach those villages shall be reimbursed according to the actual cost. To facilitate the outreach preparation and to increase efficiency in the context that resources are limited, traveling for outreach for those remote villages should be conducted for cluster villages

The classification of villages as above-stated as well as decision of the package of outreach services should be made through the comprehensive consultation, consideration, and agreement between HC and OD office during annual operational planning process.

Relevant local administration should be communicated in advance on the above-mentioned issues to facilitate the development of action plan and budget and other necessary administrative procedure for conducting outreach activities.

When the category and the number of villages had been decided, micro-plan for conducting an outreach activity should be developed by including name and location of the villages to be visited, distance and travel duration, estimated budget for conducting outreach session for a year and schedule, with expected date, of the outreach session.

2.2. Health Service Packages for Outreach

2.2.1. Basic Health Service Package

1) Immunization services as per national policy and guidelines of national immunization program;

2) Vitamin A supplementation for children aged from 6-59 months and immunization, mebendazole 500gm or albendazole 400mg for children from 12-59 months (twice a year that is in May and November)

3) Provide mebendazole or albendazole regularly for children from 12-59 months and women in reproductive age twice a year is in May and Nov.

4) Outpatient consultation, screening, treatment (non-dehydration diarrhoea with oral rehydration solution (ORS) and zinc to children who have no respiratory infection symptoms: cough or cold) and referral of children who have acute respiratory infection diseases and diarrhea with bleeding stool to health center or referral hospital nearby.

5) Monitoring and support to VHSG's activities, and distribution of ORS and zinc to VHSG to provide to children with non-dehydration diarrhoea in the community;

6) Iron and folic acid supplementation for pregnant women, and encouraging pregnant women to have ANC visit early during the first month of missing menstruation, to continue ANC visits for at least 4 times, to give birth at health facility, and to come with their newborn at least 3 times for PNC in the first 6 weeks after delivery;

7) Iron and folic acid supplementation and mebendazole/albendazole for post-partum women;

8) Weekly iron and folic acid supplementation (monthly basis) with one dose of deworming every 6 months (May and Nov) to child bearing age women (CBAW) and encouraging them to use health care services at HC;

9) Birth spacing services including counselling on informed choice for birth spacing methods, distribution of birth spacing commodities, and referral to health facility based on method chosen or currently used;

10) Screening and referral of children with severe acute malnutrition (SAM) by identifying:

    - Children under 6 months: check for
      - Bilateral pitting oedema, and
      - Difficult or unable to breastfeed or severe weight faltering

    - Children from 6-59 months:
      - Measure MUAC to calculate SD (W/H standard chart)

11) Also, follow-up of defaulters of SAM (*treatment dropout*) and refer them to health facility for appropriate continuing treatment and care;

12) Follow-up of defaulters of TB and Leprosy patients and active referral of TB and Leprosy suspects to health facilities where are implemented community DOTS;

13) Community surveillance of emerging infectious diseases (EID), neonatal deaths (before aged 28 days), maternal deaths, and other outbreak-prone diseases as guided by the national programs

14) Health education and health promotion

15) Dissemination to childbearing age women for breast and cervical cancer screening at HC or the closes RH.

16) Dissemination to people over 40 years of age to come to the HC for hypertension, diabetes and cholesterol screening.

17) Dissemination and screening people aged 60 and over who suffer from chronic illness or disability for referrals to HC and collaborate with home-based care teams to provide health care services based on care need for each disease status (Read Clinical Guideline on MPA, page 358)

18) Dissemination and screening child impairment and disabilities to referral them seeking care and treatment services at health facility nearby (Read Clinical guideline on MPA, page 347)

19) Promote and guide communities to refer women and children who have been victims of sexual violence to the HC immediately (Read national guidelines for the health system on management of violence against women and children) .

2.2.2. Expanded Package

In addition to the basic health care package, the following essential health care services shall be included in the expanded package.

1) **Antenatal Care (ANC)**: including ANC check-up as:
   - Check for pallor (conjunctiva and palm pallor)
   - Ask and check sign of night blindness and goitre
   - Iron-Folate Acid supplementation
   - Provide mebendazole to all pregnant women from 2nd trimester
   - Blood test for Syphilis and HIV
   - Tetanus immunization
   - Checking for danger signs during pregnancy so that pregnant women with danger signs can be referred on time to health facility for further care.
   - Counselling: Food dietary, taking iron tablets, and birth preparation etc.

2) **Postpartum care (PNC)**: including immediate care for postpartum women and newborn to 2 years old:

   a) Checking maternal health:
   - Check for pallor (conjunctiva and palm pallor)
   - Ask and check sign of night blindness and goitre danger signs during post-partum
   - Iron-Folate Acid supplementation 42 tablets (if not having received during delivery)
   - Provide one single dose of mebendazole to all postpartum women
   - Testing for syphilis and HIV if the status is unknown or before delivery has not been tested.
   - Tetanus immunization (is due)
   - Check for danger signs of postpartum
   -

   b) Checking newborn and children under 2:
   - Check newborn from head to toe by following the guideline
   - Observe breastfeeding
   - Complementary feeding for children from 6 months
   - Check for immunization
   - Growth Monitoring and Promotion (GMP) W/A

- Provide Vit A to children from 6 months
- Deworming for children from 1 year

c) Checking children from 2-5 years old:

- Check for immunization
- Growth Monitoring and Promotion (W/A)
- Provide Vit A and deworming
- Check paleness and night blindness

d) Provide counselling

-

3) **Rapid diagnostic test and early treatment for malaria**: this activity should be implemented only in the villages where there is active transmission of malaria, and where there are trained staff. Diagnosis is received from rapid test using dipstick and pre-packed combined therapy is given only for positive dipstick test (please read the national protocol for diagnosis and treatment of malaria, the national centre for malariology, parasitology, and entomology, annex 9).

2.2.3. Activities that should be out of outreach packages

1) Curative services, in general, are not the main component of regular outreach session due to limited public health impacts and difficulties in logistic supplies. People with illness shall be referred to health facility to get appropriate medical treatment and follow up in term of technical standard as required. For remote villages where the accessibility to health care services at health facility is extremely difficult and where special consideration to provide curative services through outreach activities is required, the decision should be made through the consultation with the HC management committee (HCMC), OD office, and PHD office.

2) Insecticide treated net distribution and re-impregnated bed-net in the areas with active transmission of malaria that need to be undertaken every 3 years. Insecticide treated net distribution is a specific activity that requires special supply, and therefore should not be considered as part of the routine outreach activities.

3) Vertical disease surveillance and other infection control.

2.3. Preparation for the Outreach Activities

Outreach activity complements to the fixed site service delivery by HC to people in order to improve accessibility of basic essential health services in the equitable manner and will not replace the service delivery at HC. Conducting outreach activity without careful and comprehensive planning will disturb or disrupt the service delivery function of the HC.

1) In principle, the outreach team shall have two staffs for the distant villages or communities, and three staffs including one midwife if available, for remote villages or communities. All HC staffs should participate in this activity, especially midwife, in a rotation manner to avoid disturbing or disrupting service delivery function of the HC.

2) HC shall organize the outreach activities by linking to existing community structures such as Village Health Support Group (VHSG), commune committee for women and children (CCWC), local authorities and other

community workers, village development committee (VDC), school, pagoda etc. to maximize effectiveness of the activities.

3) HC should also consult with local administrations, CCWC, VHSG, VDC and other relevant institutions with support from operational district (OD) office and provincial health department (PHD) on:

   a. Conducting outreach activity and establishing of VHSG for informal settlements;
   b. Conducting outreach activity for poor communities in urban/town areas;
   c. Conducting outreach activity for remote villages;

   d. Improving knowledge and awareness, mobilizing community, encouraging people to use health care services at HC, and improving fixed site service delivery;
   e. Classifying villages as either outreach or fixed site villages;
   f. Determining health service packages for outreach activity;

   g. Improving quality of outreach service in dealing with seasonal migration;

   h. Improving community participation in outreach activities.

4) Special attention shall be made when organizing outreach activities for ethnic minority groups or villages by:

   - Ensuring that at least one outreach team member can communicate with ethnic minority group using their own local dialect. If not, the support from VHSG or village leader must be sought for;

   - Respecting to local tradition or culture practiced by ethnic minority group when providing health care services. Try to integrate as much as possible basic health education and promotion messages as well as essential and key behaviour change messages to increase their accessibility and acceptability of basic and essential health care services.

5) Based on the above-mentioned consultation and in accordance with the agreement with the OD office, HC should develop action plan and micro-plan for conducting outreach activities include name and location of the villages to be visited, distance and travel duration, estimated budget for conducting one outreach session , equipment and supplies required (vaccines, drugs, injection devices etc.), number of outreach session planned during the year, and schedule, with expected date, of the outreach session.

6) HC should discuss with OD office to incorporate their action plan and micro-plan for outreach into annual operational plan (AOP) of the OD during each planning development cycle to ensure that appropriate and adequate fund is allocated for outreach activities.

7) When the OD AOP together with the action plan and micro-plan is approved, the schedule for conducting outreach with expected date of the outreach session should be shared with VHSG, local authorities and relevant institutions at the community level as advanced notice, and the outreach session should be conducted according to the planned schedule and date.

8) Mechanism for communicating in advance with local authority and community on any delay or postponement of outreach session is critically important to maintain trust of community to the outreach service.

9) Before visiting the villages, outreach team should verify and develop a list of target groups such as pregnant women and children, and post-partum women in the village by including new settlers, whom the outreach team need to know their health and immunization status, and to provide them essential interventions as appropriately required.

10) After completing activities planned for each outreach session and before leaving the village, outreach team should register target groups, both women and children, that require follow-up or due to receive specific services in the next outreach session. The list should be shared with the VHSG for their advanced preparation before the coming outreach session.

11) Strengthen the integrated outreach as much as possible by considering quality ANC, counselling on birth preparedness and plan, and checking for danger signs during pregnancy. If there is insufficient midwife in the team, the nurses in team members should at least ensure the supplementation of iron-folate tablets, periodic deworming or mebendazole (*should not give mebendazole to pregnant women in their first trimester*), TT immunization, and checking for danger signs during pregnancy so that the pregnant women with danger signs is timely referred to HC for further care and support.

12) Outreach team shall ensure that postpartum women and newborn received appropriate PNC such as adequate number of iron-folate tablets supplementation, periodic deworming, TT immunization if due, and are checked for danger signs. Explain and encourage women to continue PNC follow-up at HC as least 3 visits, advise on how to keep the baby warm, to take the baby to get immunization including BCG and HepB birth dose if yet received, and to exclusively breastfeed their baby until they are 6 months old.

13) Strengthen the quality of re-hydration for children with diarrhoea, especially those living in remote villages. At the end of each outreach session, outreach team should verify report of VHSG on re-hydrating children with diarrhoea, and replenish ORS and zinc stock for VHSG to ensure that they have sufficient ORS and zinc to managing children with diarrhoea (please read national policy on the control of ARI and diarrhoea disease– annex 7).

14) ANC, PNC, and basic and essential treatment for other diseases should be put in expanded outreach package for remote villages (Reading National guideline ANC, Delivery and PNC package)

15) Even though some specific disease surveillance can be incorporated into outreach activities, the investigation of the onset of a disease outbreak such as rubella; paralysis etc, It is required specific arrangement, planning and budgeting in addition to an ordinary outreach session.

16) Other activities that have not been mentioned in the basic or expanded outreach packages should not be the major components of outreach services.

2.4. Frequency of Outreach Session

In the circumstances where there is limited resources, the main direction of the operation is to assure that farther or remote villages can receive quality health care services as frequent as possible. As recommendation, the frequency of outreach session in different categories of villages should be as follow:

A) **Fixed site villages:** are villages locate **closer than 5 kilometres** from the HC or the travel duration from HC to those villages should not exceed 1 hour and the road infrastructure is favourable. To define whether any village of those where villagers should be encouraged to use health care services at HC. The

decision on classifying villages as fixed sites should be made through thorough discussion process, and to get consensus between HC and OD office. The transition from outreach to fixed site should be phase-based and with caution in order to assure the quality and continuity of service delivery (*please read chapter 3*: the guideline on reducing outreach activities and strengthening quality of fixed site services). During the transition from outreach to fixed site, HC may consider:

1. Continued visiting those villages to raise their awareness on benefits in utilization of health care services at HC. In consultation with OD office and local administration, HC can provide occasionally essential health services if needed. If OD office and HC decide to continue providing outreach services to any village in this category, the outreach session should be conducted 4-6 times per year.
2. Strengthening community mobilization mechanism through regular meeting with HCMC and VHSG.
3. Encouraging people in the village to access to HC services and informing them about this change. HC shall distribute invitation letters to mother-women to visit or take their children to HC.

B) **Distant villages**: are villages locate **farther than 5 kilometres** from a HC but **less than 10 kilometres** OR the travel duration from a HC to those villages taken longer than 1 hour but not exceed 2 hours using locally available mean of transport. Those villages should receive **at least 6 outreach visits per year**. For large and populated villages, the OD office, HC, and outreach team may consider increasing additional outreach session days as required. During each visit, outreach team should consider appropriate operational duration for each village in order to implement and complete essential services and activities recommended in this guideline. As the recommendation, outreach team should spend **4 hours in average** per village for each outreach session.

C) **Remote and hard-to-reach villages**: are villages located very far from a HC (farther than 10 kilometres), OR travel to those villages has to pass-by forest or mountainous areas, OR travel can be made only by waterway, OR the travel duration taken longer than 2-3 hours using locally available mean of transport or villages where are low coverage of immunization. Those villages should receive **at least 4** outreach visits annually (every quarter).

To increase cost effectiveness, and to minimize transport cost as well as duration of travel, the outreach visit to those villages should be conducted for **cluster villages** for nearby villages. During decision making process on frequency of outreach sessions, HC should take into account the size of villages in their catchment areas, their staffing status, as well as availability of mean of transportation, road infrastructure and its seasonal accessibility, and distance from HC to each village. These would facilitate the development of annual operational plan as well action plan for conducting outreach activities of the HC. It is critically important that the HC should justify the outreach action plan for all villages within their catchment areas to ensure that all villages receive outreach services in an equitable manner.

In the occasion on natural disaster or unpredicted event, HC should review and justify their plan and schedule for conducting outreach activities, or they may consider increase the number of outreach sessions for specific geographic areas according to actual requirement and need.

2.5. Outreach to Informal Settlements

Conducting outreach activities to informally settled communities in catchment areas of HC as they have not been registered and recognized by local administration but they

are **eligible to receive health care service through outreach** activities (due to geographic and road infrastructure status, distance, mean of transportation, and travel duration) is critical, and should be highly focused in order to ensure equitable access to health care services and to increase the coverage of essential health care services to reach universal health coverage of basic essential health services.

Special attention should be made to this category, and feasible solution should be pursued through consultation with OD office and local authority to ensure that routine outreach visit to those settlements can be implemented.

OD office should provide all supports required to HC and request to local authority for the official recognition to the outreach activities conducted to those informal settlement as well as to facilitate the establishment of VHSG for those communities.

2.6. Outreach to Poor Communities of Urban Areas

For poor communities in urban areas, outreach activities should be paid particular attention, as the majority of people living in these areas are poor with lack of resources and difficult living conditions, and limited knowledge toward health care, encounter many major health problems, and always hesitate to seek care at health facility. These factors contribute to low coverage of essential health care services in these areas, especially preventive and promotive care.

2.6.1. Determining Package of Outreach

1) Decision on fixed site or outreach villages should be made according to the instruction in section 2.1 in this guideline on “catchment areas of a HC”. All poor communities in urban areas that classified as zone “B” in accordance with the guideline on operational district development should be eligible to receive outreach services.

2) HC should consider on increasing the number of VHSG proportional to the number of households in order to facilitate the community mobilization activities. The recommended ratio of VHSG to households is 1/30 to 1/50.

3) Health service package for outreach to poor community of urban areas should be reviewed at least annually and in consultation with HCMC, local administration, and CCWC to reflect local need in place with agreement from OD and PHD office to incorporate it into AOP with specific emphasis on strengthening community participation.

2.6.2. Frequency of Outreach

Poor communities of urban areas where had been classified as outreach communities should receive outreach services regularly on a quarterly basis.

The specific date for conducting outreach session should be developed in consultation with local authority and representative of those communities.

2.6.3. Service Delivery Methods

Outreach to poor communities of urban areas should focus on the integration of community participation strengthening mechanism and basis health care services:

1) During outreach session, provide basis health service package as described in section 2.2 in this guideline on “Health service packages for outreach” in

integrated manner as possible rather than providing single or easily delivered service.

2) In addition to delivering basis health service package, strengthen community participation components as described in chapter 3 on “Strengthening fixed site services” by focusing on health education and promotion, enhancing and encouraging facility utilization, and strengthening the roles of local authority, CCWC, and VHSG through regular HCMC meeting.

CHAPTER 3 – STRENGTHENING QUALITY OF FIXED SITE SERVICES

Outreach activity is a service delivery modality try to complement to fixed site service of HC. HC shall have clear outreach activities plan of action, and should monitor the increased knowledge and awareness of community towards health care services available at health center as well as the increased trend in facility utilization by the community members.

To reduce the outreach services by HC, HC chief and OD office should take into account all factors affecting accessibility to health care services in the community such as geographical, road infrastructure, collaboration, coordination and participation of local authority. These may help appropriate decision on reducing outreach services to the villages where people can have access to health care service at HC.

To define a village/s by which people should receive health service at HC or village/s should receive outreach services, it should follow the the instruction mentioned in section 2.1 in this guideline on “catchment areas of a HC”.

HC could reduce outreach service provided to villages with improved road infrastructure together with other following characteristics:

1) Locate within 3 kilometres from the HC for villages in mountainous areas;
2) Locate within 4 kilometres from the HC for villages in highland areas; and
3) Locate within 5 kilometres from the HC for villages in plain areas.
4) To successfully implement this, HC should:

    a. Open 24 hours every day and 7 days a week;
    b. HC staffs should be competent and skilled;
    c. Have adequate equipment, drugs, and supplies;
    d. Have good management and schedule for conducting outreach activities on monthly and quarterly basis;
    e. Have active and committed VHSG and functioning HCMC;
    f. Have good collaboration with local authority, with support from local authority and the community;
    g. Receive continued technical support from OD office and PHD through training and supportive supervision.

5) Develop mechanism to ensure functioning service delivery at HC by having:

    a. Regular staff meeting at the HC;

    b. Regular bi-monthly meeting with VHSG and HCMC;

    c. Disseminating health care services to the community on monthly basis by HC staffs and in collaboration with the VHSG;

    d. Monitoring the coverage rate after stop conducting outreach service in order to make proper planning.

CHAPTER 4 – FINANCIAL SUPPORT FOR OUTREACH AND STRENGTHENING FIXED SITE SERVICES

4.1. Workplan and Budget Plan

4.1.1. Planning Mechanism

With technical support from OD office and in collaboration with HCMC, VHSG or other community workers and local authority that include Commune Committee for Women and Children (CCWC), community representative from the target areas, HC should develop workplan and micro-budget plan with date of outreach activities, annual schedule, list of target villages by categories, detailed estimated budget for conducting the activities based on number of villages in different categories as agreed upon health service packages to be delivered, frequency of the outreach sessions.

The consultation and preparation for each above-mentioned component should be ready before the beginning of planning cycle. The workplan and micro budget plan for conducting outreach session will be discussed and finalized with OD office during AOP development to ensure fair justification in budget allocation among all priority programmes and adequate fund for outreach activities is allocated in the OD AOP.

4.1.2. Components of Workplan and Micro-Budget Plan

In annual workplan and micro-budget plan, cost of each item should be estimated according to the current official instruction and actual cost. Costs that need to be estimated and incorporated in the workplan and micro-budget plan are:

1) **Budget for conducting outreach activities**:

- Mission support
- Food allowance
- Accommodation support
- Travel cost.

4.2. Funding Sources

1) Fund required for conducting outreach activities and strengthening quality of fixed site services can be supported by government budget, development partners, or other funding sources. The funding support rate, although being supported by any funding source, shall follow Prakas Ministry of Economic and Finance No 5995 SHV/OT.

2) Contracting staff should be eligible to receive similar rate of support.

3) VHSG, HCMC members, and other community representatives who participate in the meeting or training and coaching organized by PHD or OD office, or HC, should be eligible to receive appropriate support to facilitate their active participation.

4) OD office, in consultation with HC and PHD should develop a tariff of travel cost from a HC to specific villages and review it every year.

CHAPTER 5 – COORDINATION, MONITORING AND EVALUATION

5.1. Coordination

Coordinating the consultation with local authority, community representative in HC's catchment areas and OD office in the process of developing workplan for conducting outreach activities and the implementation of plan is critical for ensuring the efficacy as well as cost-effectiveness of fund allocation to the activities. Make sure that the following steps will be taken into account and implemented during the workplan development and implementation of outreach services:

1) Consultation with local authority, CCWC, community representative in catchment areas, and OD office on determining target villages and communities for outreach activities, focusing especially on:

   - Remote and hard-to-reach villages; informal settlements and poor communities of urban area those are eligible to receive outreach services;

   - Target population and their up-to-date status;

   - Community participation in improving quality of health service delivery;

   - Participation of HC in community development, and integration of health sector plan into commune/Sangkat and district/municipality development plan.

2) Advocacy to receive support from local authority, CCWC, community representative in catchment areas, and OD office on:

   - Community mobilization and participation in outreach activities, and seeking health services at health facility;

   - Recognition for outreach activities conducted by HC to specific geographic location, especially remote hard-to-reach villages, informal settlements, and poor communities of urban area;

   - Support and commitment to implementation of agreed plan.

3) Development of workplan and micro-budget plan for conducting outreach activities and improving quality fixed site services, and incorporation of these plans into AOP of the OD.

4) Develop schedule for outreach activities for the whole year with expected date, villages to visit, equipment and supplies required according to the health service package to be delivered.

5) Communication with local authority, VHSG and other relevant stakeholders to inform in advance about schedule for outreach activities, villages to be visited, and expected date for conducting outreach session. Any change in the schedule and date of visited should be informed in advance in order to avoid any possible undesirable effect.

5.2. Monitoring and Evaluation

Supervision, regular monitoring and evaluation are critical mechanism for strengthening quality and efficacy of outreach and fixed site services. OD office and HC shall have such mechanism in place such as:

1) Organize OD supervision and assessment for the implementation of outreach and fixed site service activities (by using integrated supervisory checklist (ISC) module C).

2) Ensure regular monthly monitoring and updating HC outreach plan.

3) Occasionally conduct spot check (spot check) based on the schedule of the outreach activities to ensure that the outreach is conducted as planned and the HC is functioned and effective without any interruption or conduct the rapid assessment of quality and effectiveness of the service delivery.

4) Enhance utilization, record, and maintenance of registration logbooks (including outreach registration) to make easy in verification and monitoring.

5) Organize regular function of community participation activities and to get feedback from local authority on performance and efficacy of the outreach and fixed site services.

6) Organize quarterly and annual review to track progress, and SWOT analysis that will be valuable input for further planning and implementation of the outreach and fixed site services.

7) Prepare for countrywide bi-annual evaluation by national level in order to review and evaluate the cost-effectiveness of the implementation.

8) Integrate workplan of the HC into commune/Sangkat development plan, by focusing initially on health education and promotion activities, community support and participation, and other non-medical activities.

ANNEX 1 – EQUIPMENT AND SUPPLIES FOR OUTREACH

1. Basic Outreach Package

1.1. Immunization Equipment

1) Vaccine carrier, vaccine, and distilled water
2) Auto-disable (AD) syringe
   - Syringe 0.5ml
   - Syringe 0.05ml
   - Syringe for dilute vaccine 2ml and 5ml
3) Polio vaccine dropper
4) Safety box (5 litter)
5) Cotton swap with boiled water,
6) Alcohol hand rub (please read IPC) or gel
7) Immunization registration book for both child and infant this year and previous year
8) TT registration book for pregnant women and childbearing age women (15-44 years)
9) Tally sheet (needles, OPD cases and adverse event following immunization (AEFI) report)
10) TT Cards (pink) and plastic card holders
11) Child health book (yellow card) and plastic card holders
12) Lunar calendar, Immunization calendar, and paper clock (child age calculator)
13) Loudspeaker (Megaphone)
14) Banner for outreach
15) Handbag for keeping material, paper, pen, stapler etc.
16) Black bag for waste disposal
17) Thermometer
18) Paracetamol 100mg
19) Promethazine syrup, etc.

1.2. Equipment for Nutrition Services

1) Tally sheet for vitamin A and Mebendazole
2) Tally sheet for daily weekly iron/acid folic
3) Scissors-needles for cutting and piercing Vitamin A
4) Vitamin A 100,000 IU and 200,000 IU, daily and weekly IFA
5) MUAC measuring tape, child weighing scale, height board and W/A growth chart
6) Record card and referral card for malnourish child
7) BFCI flipchart
8) MamaBreast and baby doll.

1.3. Health Promotion

1) IEC materials for health (immunization, birth spacing services, ANC, PNC, STI, HIV /AIDS, TB, malaria, dengue haemorrhagic

other health issues related to smoking, alcohol, sweet drinks, salty, more cholesterol and public health issues etc.)

2) Flipcharts and posters for breast cancer education, and flip books for cervical cancer education
3) Flip books for medical check-up and screening NCD
4) Flip books for home-based care for elder
5) Flip books for educating women and children suffering violence to receive counselling at health center or referral hospital.
6) Flipchart, poster and flip books for client's rights and services provider's right and obligation
7) Manual on Community Primary Health Care 2019

1.4. Birth spacing services

1) Clinic follow-up cards
2) Client cards
3) Leaflet on birth spacing (BS), and family planning (sterilization)
4) Flipchart for BS education
5) Birth spacing registration book

1.5. Periodic Deworming

Tally sheet for mebendazole (or integrated tally sheet) together with vit A

1.6. Management and Referral of Children with ARI & Diarrhoea

1) Tally sheet for replenishment of ORS and zinc tablets.
2) Tally sheet for promotion of home-based activities for children having acute respiratory infection (ARI), diarrhoea and rehydration.
3) Referral slip for child
4) ORS and zinc tablets
5) Patient registration
6) Tool for measure respiratory rate
7) Thermometer

2. Expanded Outreach Package

2.1. ANC and PNC

In addition to all equipment and material for the basic outreach package, the following should be included for the expanded outreach package:

1) Sphygmomanometer for measuring blood pressure
2) Tape measure

3) Stethoscope/Doppler
4) ANC registration book (included tally sheet for iron-folate tablet supplementation)
5) Postpartum care registration book
6) Newborn registration book
7) Mother health book
8) Leaflet on danger signs during pregnancy
9) Flipchart for health education
10) Blood test for HIV/AIDs and Syphilis for pregnant women
11) Soap and hand brush
12) Screening tool for weakness of infants (0 to 28 days) or children (1 to 5 years)

2.2. Malaria

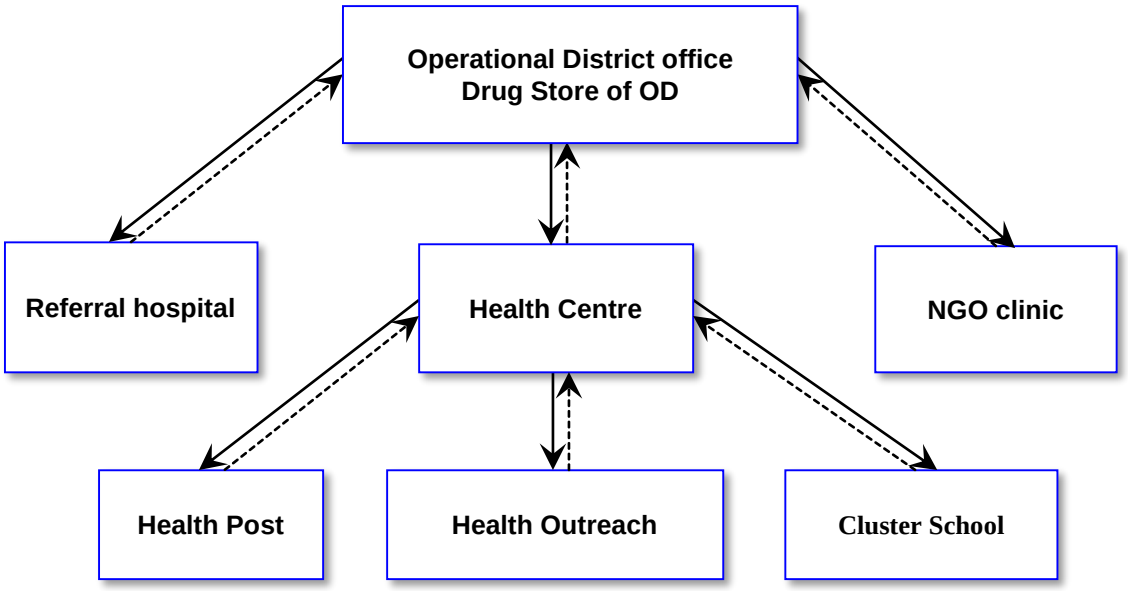
1) Dipstick (cotton swap and alcohol)
2) Pre-packed malaria drug
3) Tally sheet malaria case check and treatment
4) Tally sheet for malaria management (Dipstick and medicine)
5) Report form on the case with side effects of Vivax for malaria treatment

2.3. Other Equipment that should be available during outreach

1) Raincoat, especially in rainy season
2) Life jacket if traveling by waterways and helmet if riding on motorbike.

ANNEX 2 – DRUG AND EQUIPMENT SUPPLY SYSTEM AT OD LEVEL

1. Drug and Equipment Supply System at OD level



Note:

→ Drug and Equipment Supply System

⇢ Reporting System of Used Drugs and Equipment

2. List of Essential Drugs Required for Outreach

Nº	Drugs	Presentation/Route	Dosage	Observation
1	Paracetamol	Oral tablet 100mg	10-15mg/kg/day (Every 6 hours until server fever become better or pain relief	protect children fever from post vaccinated
		Oral tablet 500mg	Every 6 hours until server fever become better or pain relief	Post-Partum
2	Vitamin A (Retinol)	Blue oral capsule 100,000IU	one capsule every 6 months	Children 6-11 month
		Red oral capsule 200,000IU	One capsule every 6 months	Children 12-59 month (1y-5years)
3	All vaccines (13 items) for children (include HPV)	Subcutaneous, intradermal injection, Muscular injection and oral drop.	0,05ml and 0,5ml and 2 drops	Children under 1 year, under 2 year and girl with 9 years for HPV
4	Tetanus toxoid vaccine	Flacon vaccine for Muscular injection	0,5ml	Childbearing age women
5	Condom	size 49 mm	12 condoms per month	Men in reproductive age
6	Combined Oral Contraceptive (COC) (progesterone+ Oestradiol)	One blister pack for 1 month - oral	One pill/day	Childbearing age women
7	POP Progesterone (Overette)	One blister pack for 1 month - oral	One pill/day	Childbearing age women
8	Depo-Provera (Depo-medroxy-Progesterone acetate)	Injectable contraceptive vial of 3ml (150mg/ml)	One vial for every 3 months	Childbearing age women
9	Oral rehydration salt (ORS)	powder pack to dissolve in boiled water 2 packs per case	Dissolve one pack in 1 litre of boiled water to use for 24 hours	Children who have diarrhea
10	Zinc tablet	Tablet 20 mg	10mg/day for 10 days	Infant age under 6 months
		Tablet 20 mg	20mg/day for 10 days	Children age from 6 months or older
11	Mebendazole	Oral tablet 500mg	250mg single dose for every 6 months	Children age 24 months
		Oral tablet 500mg	500mg single dose for every 6 months	Children age form 2 years or older
		Oral tablet 500mg	500mg single dose for every 6 months	Pregnant women after first trimester of pregnancy
		Oral tablet 500mg	500mg single dose for every 6 months	Post-partum women within 6weeks after delivery
		Oral tablet 500mg	500mg single dose per year	Childbearing age women 15-49 for every 6 months
12	Albendazole	Oral tablet 400mg	200mg single dose for every 6 months	Children age 12-23 months
		Oral tablet 400mg	400mg single dose for every 6 months	Children from 2 years
		Oral tablet 400mg	400mg single dose for every 6 months	Pregnant women after first trimester of pregnancy
		Oral tablet 400mg	400mg single dose for every 6 months	Post-Partum within 6 weeks after delivery s
		Oral tablet 400mg	400mg single dose per year	Childbearing age women for every 6 months

13	Iron and folic acid	Oral tablet of ferrous sulfate 200mg + folic acid 0.04mg	One tablet daily	Pregnant women: – First: 60 tablets – Second: 30 tablets – Post-partum: 42 tablets
14	Multiple micronutrient powder (multi-vitamin)	Package	1 pack every 2 days OR1 pack/day for 15 days per month (15 packs per month)	Children age 6-23 months old
15	Weekly Iron-Folic acid tablets (Red rose)	Oral tablet of ferrous sulfate 60mg + folic acid 2.8mg	One tablet for every week	Childbearing age women (1 5-49 years)
16	Promethazine syrup	Flacon 60ml	5ml for single dose (2 times per day)	Use for any incident post vaccinated

ANNEX 3 – LOGISTIC PROCEDURE

Provincial Health Department..... Operational District.....
Health Centre.....

Report on Drugs and Equipment Used for Outreach Activities

From ../../202 - To ../../202 .

No	Items	Dose	Presentation	Advanced Qty	Actual Qty	Balance	Recipient	Other
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								

Date..... Date.....

Seen and approved
Chief of Health Centre

Signature of deliverer

Prepared by

Note: Please fill in 2 forms for advance request: one for HC drug dispenser, one for HC's staff who requests drug and equipment for outreach services and reporting.

Formula for Requesting Drugs and Equipment for Outreach Activities

1. Common formula for requesting drugs and equipment for outreach activities by HC including mebendazole tablet of 500mg and vitamin A capsule of 100,000IU and 200,000IU.

Requested Quantity =	Percentage of target children X Number of population X Number of tablets/capsules required for each child

2. Formula for requesting iron and folic acid tablets (ferrous sulfate 200mg + folic acid 0.04mg).

Requested quantity =	Percentage of Expected Pregnant Women X Number of Population X Number of tablets required for each pregnant women X 60%

Note: 60% is a proportion of expected pregnant women who receive iron and folic acid tablets in the village.

Responsibility of HC Chief and Drug Dispenser

- Approves on the advanced request for drugs and equipment required for outreach activities by HC staff (Advanced manner), and liquidates on accomplishment of the activities (or once per month).

- After every outreach activity, HC staff in the outreach team who actually conducted outreach activity shall fill-in the “Report on Drugs and Equipment used for Outreach activities” using the enclosed form. Outreach team must be required to complete this report.

- Other relevant document and reference provided by relevant national programs are remain unchanged.

  All HCs should fill-in the “Report on Drugs and Equipment used for Outreach activities” and send to OD office regularly on monthly or quarterly basis according to timeframe specified by the OD office (in the next month or next quarter). Therefore, the requested quantity shall be included in quantity used in service (in column “Advanced Quantity Requested”) and quantity used/distributed out of service (in column “Other” of the monthly or quarterly report).

ANNEX 4 – GUIDING PRINCIPLES FOR HEALTH EDUCATION AND HEALTH PROMOTION

Health promotion is focus on key practices in family to improve maternal and child health and nutrition through health education related to health care, communicable diseases, non-communicable diseases, by using behavioural change communication skill and facilitation skills, and counselling skills related to health care, communicable and none communicable diseases

Health education activities package does not mean that health centre staffs have to organize specific health education session every time during the outreach session but importantly, HC staff take opportunity of meeting with specific target groups during outreach session to provide educational message as needed and actual schedule based on medical technical manners to raise awareness to target groups on health benefit, practice participation and behaviours change from harmful practices to the better one in order to improve health condition.

Process for conducting health education (for individual or group):

- Select only one subject for one education session
- Select the existing subject which is the real need of the local community (individual or group)
- The member of the target group is 10 persons in average
- An education session is in average one hour (should half an hour)
- Select an appropriate location (avoid disturbance)
- Select appropriate methodology that fit to the target group
- Select IEC material appropriate to the target group
- Use simple language which is easy to understand and acceptable by the target group
- Use different skill in health education

ANNEX 5 – GUIDANCE FOR MICRO PLANNING FOR IMMUNIZATION FOR HC AND OD OFFICE

1. Steps for outreach immunization

1.1. Preparation before outreach session:

a. Before outreach, HC staff should use tally sheet for immunization to register children and women vaccinated.

b. After registered children and women vaccinated, HC staff should inform VHSGs, local authorities, other relevant stakeholders for 2-3 days in advance on schedule and date of outreach included villages and location at least 1 day in advance (Inform on cancellation or any delay up on schedule in advance to build trust from communities). Request VHSG to inform parents/guardians of children who registered by HC staff.

c. Reminding VHSGs and local authorities 1 day in advance before outreach.

2. Outreach day

2.1. Vaccine and equipment preparation before departure from HC

-Manage dose vaccine and equipment required (Target population expectation or based on previous outreach experiences)

-Before putting vaccines in the cold box, the conditioned ice pack (containing a mixture of ice and water) should be checked to avoid vaccines being frozen. Use ice box for outreach sessions at community level for many day (example 3-5 days) then return to HC.

2.2 Outreach Undertaking:

- Consult with VHSG or village chief to set up a meeting location.
- Should provide health education to caregiver group on advantages of vaccines before vaccination.
- Start to provide vaccination at appropriate location (Should mobilize 1 or 2 location is necessary)
- Conduct home-to home check to seek children who did not yet receive vaccines before closing session
- Asking if any suspected of measles/ rubella, neonatal TT, Diphtheria, Pertussis etc.
- Provide briefing report to VHSGs and local authorities

3. Post Outreach day at community level:

- Asking VHSG/Village chief if any incident from post vaccinated.

- Asking if any suspected of measles/ rubella, neonatal TT, Diphtheria, Pertussis etc.
- Asking VHSGs and Village chief any information on other rumours.
- Reporting preparation

ANNEX 6 – SUMMARY GUIDELINE ON PROVIDING ANC, PNC, AND BIRTH SPACING SERVICE DURING OUTREACH SESSION

1. General Guidance

- Check all supplies and drug to be taken for the outreach activities (see annex 1 and 2)
- Find an appropriate location for providing antenatal care (ANC), post-natal care (PNC), and birth spacing (BS) services during outreach session
- Provide ANC service during outreach sessions with assistance from VHSG.

2. Birth Spacing

2.1. New Acceptant (New Client)

A. Counselling

1) All women can use appropriate contraceptive methods after she receives comprehensive information (basic service provided, pills, and injection and male condoms).
2) Provide counselling and discuss the advantages, disadvantages and possible side effects.
3) Clarify some rumours or myths regarding contraceptive methods if the woman is concerned.
4) Assist clients to select appropriate contraceptive methods.

B. Asking Client's History

Ask about client's history following the clinical card

C. Examination

1) Take blood pressure and weight
2) Check for anaemia (pallor)
3) Check for abnormal mass in breasts or ovarian cysts
4) Calculate BMI

D. Filling in documents and Providing Methods

1) Fill in all questions in clinical card and client card
2) Inform about date for follow-up
3) Record client detail information in birth spacing registration book.
4) Provided the selected contraceptive method and give leaflet of contraception.

2.2. Continued Users (Old Clients)

A. Asking

Problems encountered in using contraceptive method.

B. Examination

1) Take blood pressure and weight
2) Check for anaemia (pallor)
3) Check for abnormal mass in breasts, ovarian cysts if women complain about or in the case of suspicion

C. Filling in documents and Providing Methods

1) Inform about date for follow-up
2) Record client's detail information in birth spacing registration book.
3) Provide contraceptive method

2.3. Birth Spacing Defaulter

1) Follow up and ask the reason they stop using contraceptive method for any month
2) If women are worried that using contraceptive may make them permanently sterilized, counsel accordingly.

3. Antenatal Care

3.1. First ANC visit

A. Asking (Following service package of ANC, delivery and post-partum guideline, June 2019)

1) Asking mother book and check previous month recorded
2) Name, age, address, number of pregnancies, and number of deliveries
3) Delivery complication with previous delivery
4) History of the current pregnancy:
   a. Last period
   b. Important medical histories
   c. TT immunization status
5) Expected date of delivery

B. Examination

1) Take blood pressure, and measuring weight & height
2) Check for pallor (conjunctiva pallor)
3) Examine both breasts to find out scars or short (inverted) nipples
4) Measure uterus (for evolution of pregnancy)
5) Listen to foetal heartbeat (if pregnancy is over 24 weeks)
6) Ask about foetal movement
7) Check for oedema on both feet and ask for other danger signs
8) Ask about signs of sexually transmitted diseases, and whether a pregnant woman has received testing and counselling for syphilis and HIV if the status is not known or pregnant woman has not been tested.
9) Record all information in mother book.

C. Counselling and Advices to Women

1) Avoid smoking or alcohol drinking
2) Avoid taking any medicine without consulting with physician
3) Practices hygiene
4) Take nutritious food daily
5) Take iron-folate tablet daily to complete 90 tablets during pregnancy (do not take with tea or coffee)
6) Have at least 4 ANC visits
7) Get two doses of TT (if not complete yet)
8) Provide education to woman on delivery preparation and danger signs during pregnancy
9) In the areas with active transmission of malaria, encourage women to stay in insecticide treated net.

D. Iron-Folate Supplementation and Mebendazole

Give iron-folate 60 tablets to pregnant women for their first visit, and advise them to take one tablet during night-time, avoid taking with tea or coffee and inform them also about possible side effects. Provide mebendazole/albendazole during their first visit for ANC (pregnancy from 2nd trimester).

E. TT Immunization

Check TT immunization status of pregnant women. If they have not received complete TT immunization, give an appropriate dose of TT to them.

3.2. Continued ANC for 2nd, 3rd and 4th Visits

A. Asking

1) Any complication with previous ANC visit and any complication after ANC visit and progress of these complications
2) Number of TT immunization receiving before the current pregnancy and number of TT immunization receiving during this pregnancy.

B. Examination

1) Take blood pressure
2) Check for pallor (conjunctiva and nail pallor)
3) Measure uterus (for evolution of pregnancy)
4) Fell for foetal presentation
5) Listen for foetal heartbeat
6) Ask about foetal movement
7) Check for oedema on both feet and ask for other danger signs
8) Ask about signs of sexually transmissible diseases, and whether a pregnant woman has received testing and counselling for syphilis and HIV. if the status is not known or pregnant woman has not been tested.

9) If the status is known, check their adherence with instructions and advices given.
10) Record all information in mother health book.

C. Counselling and Advices to Pregnant Women

In addition to the counselling and advices given during the first ANC visit, advise them on.

1) Signs of sexually transmitted diseases and importance of being tested for syphilis and HIV, if the status is not known. If the status known, check their adherence with instructions and advices given.
2) Importance of delivery by trained health staff
3) Importance of birth preparedness and plan:
   - Advise on expected date of delivery
   - Advise on HC or hospital where they should give birth
   - Advise on the critical arrangement required: mean of transport, contingency fund that may need, other supplies and equipment that they should have, and when they should go to the facility they prefer to deliver.
4) Importance of early initiation of breastfeeding within 1 hour after delivery
5) Importance of exclusively breastfeeding for 6 months and give appropriate complementary feeding when the child age 6 months
6) Postpartum birth spacing (after 6 weeks)
7) Importance of bringing children to get immunization starting from HepB birth dose, and BCG.
8) Importance of putting the naked baby directly on mother's chest and making skin-to-skin contact after he/she was born and putting him/her for at least 1 hour.

D. Iron-folate supplementation and mebendazole/albendazole

1) Give iron-folate supplementation 30 tablets to pregnant women to complete 90 tablets during pregnancy, and remind them that they should not take the tablet with tea or coffee.
2) Give mebendazole 500mg or albendazole 400mg one tablet to pregnant woman and suggest her to take the tablet in front of you (Do not give mebendazole to pregnant women during the first trimester.)

E. TT immunization

Check TT immunization status of pregnant women. If they have not received complete TT immunization, give an appropriate dose of TT to them.

4. Postnatal Care:

4.1. For Mother

A. Examination

Assess and check for:

1) Pallor
2) Pain
3) Fever
4) Any breast problem: engorgement, nipple soreness or fissure, reddened
5) Vulva and perineum tears, swelling
6) Vagina discharge: bad smell, any bleeding
7) Uterus involution
8) Measure vital signs: blood pressure, temperature, and pulse

B. Provide preventive care and advice:

1) Advise on postpartum care and hygiene and counsel on nutrition
2) Counsel on birth spacing and family planning
3) Help with breastfeeding positioning and attachment and counsel on exclusive breast feeding. After baby was born, mother shall put the naked baby directly on mother's breast and make skin-to-skin contact and putting him/her for at least 1 hour. If mother had BK+, she would adhere medicine following the DOTS and prevention actions by wearing mask or using mouth wrapping scarf.
4) Dispense 42-day supply of iron/folic acid (or provide anaemia treatment if needed) and counsel on compliance.
5) Advise on danger signs and when to return for routine and follow-up visits
6) Give TT immunization if due
7) Give mebendazole 1 tablet of 500mg or Albendazole 400mg 1 tablet
8) Promote use of impregnated bed-net use for mother and baby to prevent malaria transmission.

4.2. For Baby:

1) Essential newborn care interventions at outreach:

    a. Provide counselling on exclusive breastfeeding
    b. Give Hep B birth dose & BCG (if not received)
    c. Hygiene and cord care,
    d. Keeping baby warm,
    e. Weight and monitoring of baby gained weight

2) Advise about danger signs in a baby and when to seek emergency care:

    a. Not able to breastfeed or stopped feeding well
    b. Convulsions

c. Fast breathing OR difficult breathing
d. Fever (body temperature is 37.5 °C) or baby temperature is cool when touch (abdomen) body temperature is lower than 35.5 °C
e. Non-movement or movement only when stimulated
f. Any bleeding signs (including blood in stool)

3) Advise on routine visits.

ANNEX 7 – PROTOCOL FOR MANAGING CHILDREN WITH DIARRHOEA USING ORS AND ZINC DURING OUTREACH SESSION

1. Preparation for Outreach Activities

When preparing for outreach activities, outreach team can take with them 20 packages of ORS and 5-10 blisters of 10 zinc tables for each village for managing 10 children with diarrhoea at community by filling advanced request form from HC drugs dispenser using a form advised by OD office and PHD (see annex 3).

2. Assessing and Managing Children with Diarrhoea during Outreach Session

2.1. Assess and Classification

HC staff in the outreach team should quickly assess all children age under 5 years with diarrhoea seen in community during conducting outreach session for dehydration and classify them according to the below table:

Signs and Symptoms	Classified as
Having at least 2 of the following signs: – Lethargic or unconscious – Sunken eyes – Not able to drink or breastfeed or with difficulty – Skin pinched go back very slowly (longer than 2 seconds)	**Severe dehydration**
Having at least 2 of the following signs: – Restless or irritable – Sunken eyes – Thirsty, drink eagerly – Skin pinched go back slowly	**Some dehydration**
Having no sufficient signs to classify for severe or some dehydration	**No dehydration**

2.2. Rehydration using ORS and Zinc

a) **Children with diarrhoea and classified as severe dehydration**:

- Refer to the nearest health facility for treatment
- Before referral, mix one pack of ORS in 1 litre of boiled water and give it to mother for giving frequent sip to her child on the way to HC and referral hospital.

b) **Children with diarrhoea and classified as some dehydration**:

- Advise mother to take her child the nearest health facility

c) **If mother agrees**: Mix one pack of ORS in 1 litre of boiled water and give it to mother for giving frequent sip to her child on the way to HC or referral hospital

d) **If mother does not agree to take her child to health facility**:
Re-hydrate the child according to plan B (IMCI guidebook), by asking mother and child to rest in a house of villager nearby the outreach session spot. By the end of the session or after 24 hours of giving sip, re-assess the child.

- If the child is still dehydrated, encourage mother to take her child to nearest health facility and keep giving frequent sip on the way.

- If the child gets better:
    - Give ORS 2 packs and zinc tablets in compliance with child age for using within 10 days (5 zin tablets for child under 6 months, 10 zin tablets for child over 6 months) and explain on how to give them.
    - Advise mother to continue breastfeeding and other feedings to her child
    - Explain mother that she needs to take her child to a nearby health facility, if her child is still diarrhoea or more severe or has any of the following signs:
        - Unable to drink
        - Developed fever
        - Abnormally sleepy or lethargic
        - Had blood in stool

e) Children with diarrhoea and classified as non-dehydration:

- Give ORS 2 packs and zinc tablets in compliance with child age for using within 10 days (5 zin tablets for child under 6 months, 10 zin tablets for child over 6 months) and explain on how to give them.
- Advise mother to continue breastfeeding and other feedings to her child
- Explain mother that she needs to take her child to a nearby health facility, if her child is still diarrhoea or more severe or has any of the following signs:
    - Not able to drink or breastfeed
    - Develop fever
    - Abnormally sleepy or lethargic.
    - Have blood in stool

3. Verifying VHSG Report and Replenish ORS and Zinc stock

3.1. General guidance

1) During conducting outreach session, outreach team, in collaboration with VHSG, should provide re-hydration management to all children with diarrhoea seen during the session as stated in part 2.
2) ORS packages and zinc tablets remain after the end of each outreach session should be returned back to HC drug dispensary with report on the use that is the tally sheet for drug distribution during outreach activities (annex 3).

3) For outreach activities to remote or hard-to-reach villages (see chapter 2 of this guideline), ORS packages and zinc tablets remain after the end of the outreach session should be given to VHSG so that they can continue rehydrating children with diarrhoea in the village.

3.2. Check the Report and Replenish the stock of ORS and Zinc

1) Before replenish VHSG stock of ORS and zinc tablets, the outreach team should verify the report of the VHSG regarding their rehydration activities between outreach sessions.
2) Review the “registration of health education activities on improving home care for sick children with ARI and diarrhoea, and rehydration” as enclosed below, to verify that VHSG had actually provide advice and rehydration services appropriately.
3) Verify the number of children reported receiving rehydration with the number of ORS packages and zinc tablets used, and record in the tally sheet for drug distribution during outreach activities as in the model form enclosed.
4) Give the ORS packages and zinc tablets remain from the outreach session to the VHSG, and record the balance of ORS packages and zinc tablets that the VHSG have.
5) Ideally, VHSG should have 10 packages of ORS and 5 blisters of zinc tablets so that they can rehydrate 5 children with diarrhoea.

Note:

Future benefits for zinc supplementation:

- Prevent diarrhoea for a long time
- Regular use for 10 consecutive days can reduce the risk of diarrhoea in the next few months
- Zinc tablets help boost immunity in the body.

Tally Sheet for Drug Distribution
During Outreach Activities

Provincial Health Department..... **Date**
Operational District..... **From**.....
Health centre..... **To**.....

ORS Packages and Zinc Tablets			
Number of under 5 children		**ORS Packages**	**Zinc Tablets**

Tally Sheet for Drug Distribution
during Outreach Activities

Provincial Health Department..... **Name VHSG:**.....
Operational District..... **Date**
Health centre..... **From**.....
Village..... **Commune**..... **To**.....

ORS Packages and Zinc Tablets			
Number of under 5 children		**ORS Packages**	**Zinc Tablets**

Registration of Home Care Promotion Activities for Sick Children with ARI and Diarrhoea, and Rehydration

Provincial Health Department.....
Operational District.....
Health centre.....
Village.....**Commune**..

Date
From.....
To.....

No	Date when meet	Name of mother or caregiver	Name of children	Age (in months)	Child Sex	Health issue		Signs that need referral (8 danger signs)								Diarrhoea management		Home care advice using IEC – according to health issues				
						Acute Respiratory Infection (ARI)	Diarrhoea	Not able to drink	Vomit after breast feed or feeding	Convulsion	Lethargic or unconscious	Cough with chest in-drawing	Diarrhoea-Skin pinched go back very slowly	Diarrhoea-Blood in stool	Sick infant less than 2 months	ORS	zinc tablets	IEC-Diarrhoea treatment using ORS and zinc	IEC-ARI	IEC-Hygiene	IEC-Immunization	IEC-Referral slip
1	12.02.2014	Huot Savy	Hak	15	F	✓													✓	✓		
2	14.02.2014	Hak Sokhom	Heng	20	M	✓					✓											✓
3	11.03.2014	Bun Thoeun	Hay	11	F		✓									2	10	✓		✓	✓	
4	18.03.2014	Chea Chansophal	Hong	5	M		✓			✓						2	5	✓				✓

ANNEX 8 – GUIDELINE ON NUTRITION IN OUTREACH

1. Vitamin A Capsule Supplementation

1.1 Outreach Team:

1) Responsible for conducting vitamin A supplementation in their respective catchment areas, for both universal supplementation and treatment. This includes maintaining adequate supplies and planning semi-annual distribution rounds for children 6-59 months.
2) Prepare distribution schedules and informs VHSGs and local authority of the schedule at least 2-3 days in advance.
3) Provide health education during outreach sessions, record vitamin A distributed on the Tally Sheet and HC1 form and submit to the OD on a monthly basis.
4) Before giving vitamin A, always check if the child already has received a dose in the previous four months. If yes, do not give a second dose.
5) Always explain to the caretaker that the child is receiving vitamin A and that vitamin A strengthens the child's resistance to common childhood illnesses and reduces child mortality.
6) Record the dose and the date was given on child book (Yellow Card).
7) Remind the mother/caretaker to keep (Yellow Card) in a safe place and always to bring it when going to outreach, the health centre or hospital.

1.2 Village Health Support Group in Community

1) Provide support to health centre staff for vitamin A supplementation at the community level. This includes registering and tracking the number of children 6-59 months and mobilizing communities to participate in monthly outreach sessions.
2) Provide Vitamin A to children who are missed during the semi-annual rounds (May and November).
3) Assist HC in identifying areas where are hard-to-reach and vulnerable children live so they can be provided Vitamin A.

2. Iron/Folic Acid Tablets

2.1 Outreach Team

1) Provide health education and counselling about anaemia prevention and control, including IFA supplementation for pregnant and postpartum women, through antenatal and postnatal visits at health facilities and during outreach sessions.
2) Record the number of women who receive IFA on Tally Sheets during outreach sessions and on logbooks at the HC. These data are compiled and reported on the HC1 form which is submitted to the OD on a monthly basis.
3) Emphasized the use of Mother's Book for documenting IFA supplements received.

2.2 Village Health Support Group in the Community

1) Provide support to health centre staff for IFA supplementation at the community level. This includes tracking the number of pregnant and postpartum women in their village,

providing education about the importance of iron supplements and an iron rich diet during pregnancy and the postpartum period, mobilizing the community to participate in outreach activities, and distributing IFA tablets to pregnant and postpartum women (within six weeks of delivery).

2) Mop-up activities are defined as those that take place outside routine supplementation provided by HC staff during antenatal or postpartum care.
3) For pregnant and postpartum women not reached through routine distribution channels, special outreach activities should be conducted to ensure coverage of IFA to these groups.
4) In urban areas, this should be focus on people who are poor and those living in informal settlements.
5) In rural areas, HC should consider areas where are hard-to-reach comprising those living in very remote areas, areas with minority tribes, and floating communities.

3. Weekly Iron Folate

1) Distribution of weekly iron-folic acid (WIF) at health facilities and during routine outreach.
2) Record the number of women who receive WIF on Tally Sheets during outreach sessions and in registration books at the health centre. These data will be combined with information from other distribution channels and be reported to the OD on a monthly basis using the HC1form.
3) Child bearing age women should receive blister packs of a monthly supply, 4 tablets of IFA in the dosage recommended for weekly consumption, on a monthly basis, in combination with anaemia prevention education information.

3.1 Village Health Support Group in Community

1) Provide support to health centre staff for WIF supplementation activities at the community level. This includes tracking the number of Childbearing age women (CBAW) in their village; providing education about anemia prevention and control; mobilizing communities to attend outreach activities; and distributing WIF to CBAW who did not receive supplements through any of the other distribution channels.
2) VHSGs shall receive supplies of WIF by weekly during meetings at HC for monthly distribution to CBAW at regular meetings within their communities.

4. Growth Monitoring and Promotion

4.1 Outreach Team

1- Growth Monitoring and Promotion (GMP) activities have to conduct for children from 0-59 months, especially conduct:
   - W/A for children under 24 months and
   - MUAC for children from 6-59 months during outreach in community level.

2- Weighing the children and plot the weight in the children growth chart/ yellow card and interpret children nutrition status, if only one plotting point interpret it based on the colour:
   - Green color: a child is growing well

- Orange color: underweight for age (stagnant weight and not growing)
- Red color: severe underweight for age (Lost weight)

If there are two plotted points and over, it should interpret based on the growth curve and colour zone:

- **Green zone:** if the growth curve is the (0) SD or align, it means that child is growing well. But if the growth curve flatten or going down from the green zone, it indicatoes a child is healthy, but child did not receive adequate feeding based on needs
- **Orange zone:** If growth curve declined to orange zone, it indicates a child with underweight for age (stagnant weight and not growing)
- **Red zone:** If growth curve declined to red zone, it indicates a child with severe underweight for age. A child required height/length measurement and use W/H standard SD chart for classification:
    - If the SD score is from <-2 SD to -3SD indicates Moderate Acute Malnutrition
    - If the SD score is from <-3SD indicates Severe Acute Malnutrition (SAM),

3- MUAC for children aged 6-59 months:
    - If MUAC ≥ 11.5 cm to 12.5cm: Indicates Moderate Acute Malnutrition (MAM)
    - If MUAC ≤ 11.5cm: Indicates Server Acute Malnutrition
4- Advise mother to bring the child for SAM treatment and refer the child to a HC or hospital.

4.2 Village Health Support Group in Community

1- Provide support outreach team to continue following up SAM treatment at community
2- Monitoring and screening children aged 6-23 months using MUAC
3- Provide BFCI education which integrated GMP, child feeding and sanitation and hygiene
4- Mobilize community participation in outreach activities
5- Report the progress of child health care activities at every HCMC monthly meeting and share this progress to CCWC.

Tally Sheet for Drug Distribution During the Outreach Activities by HC

Health Center:..... **Operational District:**..... **Date:**.....

Village Name: ..... Total Population:	**Vitamin A capsule**		**Periodic Deworming Tablets**			
	Child 6-11 months (100,000 IU)	Child 12-59 months (200,000 IU)	Child 12-23 months (250 Mg)	Child 24-59 months (500 Mg)	post-partum women (<6 weeks)	Pregnant women (4 months or older)
....						
....						
....						
....						
Total Tablets						

Note: please write down the estimated target population in the small boxes prior to distribution

ANNEX 9 – RECOMMENDATION ON PERIODIC DEWORMING AND MALARIA MANAGEMENT

1. Recommendation for Periodic Deworming

1.1. General guideline

1) All children age 1-5 years olds visiting HC should be given a single dose of 500mg of mebendazole tablet or albendazole 400mg (200mg single dose for children from 12-23 months) and 400mg single dose for all children from 2-5 years old

2) All children age 1-5 years olds in all villages should receive a single dose of 500mg mebendazole or albendazole 400mg (200mg single dose for children from 12-23 months and 400mg single dose for all children from 2-5 years old every 6 months that is in **May** and in **November** through outreach activity at the same time with vitamin A supplementation.

3) All primary school children nationwide should receive a single dose of deworming dose of 500mg of mebendazole or albendazole 400mg for 1 tablet single dose once every six-month that is in **May** and **November** from the school teachers. The HC should provide deworming tablet requested by the school teachers as schedule.

4) All Childbearing age women 15-49 (included all pregnant women from 4 months and over and all lactating women within 6 weeks of delivery or women working in factories/ enterprise) should be deworming (mebendazole 500mg or albendazole 400mg a single dose) once every 6 months in **May** and **November**.

1.2. Deworming tablet administration

1) Children age 12-23 months old should receive half tablet of mebendazole 500mg (break the Mebendazole tablet of 500 mg or Albendazole 400mg into two equal portions so that each a half tablet to chew and swallow it up. If children is difficult to swallow, give a little water to help the children to swallow it.

2) Children age 2 years (24 months) or older should receive one tablet of mebendazole 500mg or albendazole 400mg in single dose. Let the children chew and swallow it. If it is very difficult to swallow, give a little water to help the children to swallow it.

3) Pregnant women (after first trimester) and post-partum women (within 6 weeks after delivery) should receive one tablet of mebendazole 500mg or Albendazole 400mg in single dose.

4) All childbearing age women (15-49 years included women working in factories) should receive a single dose of 500mg mebendazole or albendazole 400mg two times a year that is in **May** and in **November** through outreach activity at the same time with vitamin A supplementation.

Remark:

1) Deworming tablet of mebendazole 500mg or albendazole 400mg has no any documentation of side effect.

2) Before giving the deworming dose to a child, the outreach team member should ask the mother in advance. If the child has already received a dose of deworming within the last 3 months, do not give another deworming dose to him/her.

3) The HC should request mebendazole 500mg or albendazole required for 2 outreach activities per year by taking into account the number of children age 1-5 years including number of kindergarten and primary school children up to high school student (2 times a year) childbearing age women 15-49, pregnant women from four months and over, post-partum women with 6 weeks after delivery included women working in factories/ enterprise and all child bearing age women.

4) Cluster primary schools should request to health centre as earlier for 1 month in advance before the health centre send its request to OD office.

5) Health centre should submit the request for mebendazole or albendazole required for outreach activities one month prior to the implementation of activities.

6) Report form is the drug distribution list during outreach activities.

Report form of Mebendazole or Albendazole Deworming at HC (Required to report into HIS)

Health Center	Children						Pupil and student from 15-20 years old			Women		
	12-59 months			6-14 years old						PW (4-9 months)	CBAW 15-49 years old	Lactating women
	M	F	Total	M	F	Total	M	F	Total			

2. Distribution of Insecticide Treated Net (ITN) and Re-Impregnated Bed Net

ITN use is a recommended strategy for preventing malaria transmission by protecting users from being bitten by anopheles mosquitoes.

3. Malaria Treatment Protocol

3.1. General instruction

The community-based malaria treatment should be provided only for the villages with the following characteristics:

1) Villages locate in or nearby the forest

2) Villages locate farther than 5 kilometres from the health centre or travel to health centre takes longer than 1 hour

3) Villages with malaria cases reported

4) There are supplies and equipment for diagnosis and treatment of malaria in the community

5) Rapid diagnosis test (Dipstick test)

6) Malaria tally sheet/patient record

7) All recommended malaria drugs.

3.2. Diagnosis of Malaria

All villagers with fever should be tested for malaria using dipstick test.

Appropriate diagnosis of malaria based on the result of microscopic examination or rapid diagnosis test for malaria only

3.3. Treatment of Malaria

Provide treatment of malaria according to the result of rapid diagnosis test for malaria.

No	Presentation/Route		Drug Name and Dosage						Observation
1	**Artesunate and mefloquine** (read malaria treatment protocol)								
			Artesunate (50mg)			**Mefloquine (250mg)**			Plasm. falciparum or vivax or mix
	Body weight (kg)	**Age (year)**	Day1	Day2	Day3	Day1	Day2	Day3	
	5 - <10 kg	3mo - <1year	½ tab	½ tab	½ tab	-	½ tab	-	
	10 - <19 kg	1 - < 5years	1 tab	1 tab	1 tab	-	1 tab	-	
	19 - <25 kg	5 - <11years	2 tab	2 tab	2 tab	1 tab	2 tab	-	(A+M2)
	25 - <40 kg	11 - <15years	3 tab	3 tab	3 tab	1 tab	3 tab	-	(A+M3)
	40 kg (A+M5)	15years or older	4 tab	4 tab	4 tab	2 tab	2 tab	1 tab	Don't give artesunate and mefloquine to pregnant women in first trimester. Use quinine tablet for 7 day (30mg/1kg/d) divided into 3 times. Do not exceed 1800mg = 6tab (3 00mg). In 2nd and 3rd trimester, use A+M5

Remark:

1) Use body weight to calculate dose. If body weight is not available, then use age groups

2) Correct dose of treatment should be followed, and full course of treatment should be completed to avoid relapse

3) All falciparum or mix for malaria treatment should complement with primaquine 1 tablet (Read detail malaria treatment protocol)

4)

Explain to patients on:

- Causes of malaria and how to prevent themselves form malaria
- Benefit of taking correct doses and completing the course treatment
- Possible side effects such as anemia, headache, fast heartbeat
- Importance of early diagnosis and treatment before malaria develops to severe form

5) For pregnant women:
   - Quinine is safe for treatment of pregnant women in all trimesters
   - A+M is safe for malaria treatment after first trimester
   - DHA-PIP is also safe for malaria treatment after first trimester
6) For severe malaria, use artesunate suppository at a dose of 50-200mg (5-10mg/kg) by using body weight or age group to calculate dose. Then refer patient immediately to the nearest referral hospital.

ANNEX 10 – KEY TARGET GROUPS TO BE ADVISED AND EDUCATED FOR NON-COMMUNICABLE DISEASES (NCD) PREVENTION AND PROTECTION

The HC staff shall take the opportunity to provide health education in real-situation, on-demand, and specific time and in a medical technical manner with aims at making the target group gain an understanding, benefit and engagement in the implementation and behaviour changes which effect health in particular Non-communicable diseases (NCD), including diabetes, hypertension, and cancer (with a focus on screening for cervical pre-cancerous lesions and breast cancer tumors). NCD cannot be cured but can be prevented by up to 80% (except cancer can prevented by 40%) if we make major changes in habits or behaviours that are at risk, such as: stop smoking, quit or reduce harmful alcohol consumption, healthy diet, and doing exercise regularly and routinely.

1. Target Groups for Screening

1.1 Screening for Cardiovascular Risk

Through community education and outreach, adults with the age of 40 or older shall come to the health center for screening for hypertension and diabetes.

- Pre-intervention to control hypertension and diabetes to prevent stroke, heart attack and other diabetes-related diseases.
- The used materials during community education and outreach include flip books (health check-up for NCD) and risk factors education.

1.2 Screening for Cancer

1.2.1 Screening for Cervical Cancer

Through community education and outreach, women aged 30 to 49 shall come to HC for pre-cancerous lesions screening and education on cervical cancer prevention and risk factors through flip books (Medical check-up is important for your health) to reduce the mortality rate of women cause from cervical cancer.

1.2.2 Screening for Breast Cancer

Childbearing age women should be advised to check their breasts regularly and monthly (flipcharts and posters). When you touch or notice any abnormalities on your breast, immediately go to a hospital or HC for consultation with health staff.

ANNEX 11

TABLE OF BUDGET AND RATE FOR OUTREACH ACTIVITIES

	Distance	Rate for Each Item
1	o Between 5-10 kilometres **OR** o Travel duration not exceed 2 hours	o Mission support ..... 16,000 Riels **AND** o Travel cost ..... Actual cost
2	o From 10 but less than 40 kilometres (**OR** less than 30 kilometres for 6 remote provinces[1] (according to Sub-Decree No. 216 ANK.BK dated 22 July 2014)	o Mission support ..... 16,000 Riels **AND** o Food allowance ..... 16,000 Riles **AND** o Travel cost ..... Actual cost
3	o From 40 kilometres or more (**OR** from 30 kilometres for 6 remote provinces according to Sub-Decree No. 216 ANK.BK dated 22 July 2014) **OR** o Travel duration taken longer than 2-3 hours **OR** o Require overnight stay	o Mission support ..... 16,000 Riels **AND** o Food allowance ..... 40,000 Riles **AND** o Accommodation ..... 80,000 Riels **AND** o Travel cost ..... Actual cost
4	o Support to VHSG	o Support ..... 16,000 Riels

[1] The 6 provinces include: Ratanak Kiri, Stung Treng, Kratie, Mondol Kiri, Preah Vihear and Koh Kong