CHAPTER 1 – RATIONALES AND OBJECTIVES

1.1. Background

The outreach guidelines was printed and disseminated for the first time in March 2001. It was re-printed and disseminated for the second time in 2004. After three years of implementation, in 2008, the consultation on outreach guideline revision was conducted by the MoH in order to review and adapt the outreach guideline in accordance to the updated policies and guidelines of relevant national programs to ensure effectiveness and efficiency of the health service delivery through outreach activities.

As currently the road infrastructure at rural areas has been dramatically improved as the Royal Government of Cambodia has continuously constructed roads connection everywhere in the country, there is the need for improving quality of health care services delivered at health facilities, increasing knowledge and awareness as well as encourage people to come and get health care services at health facilities is critical and requires the consideration on encouraging and improving facility utilization. Moreover, in order to ensure that these two service delivery modalities complement each other the outreach guideline need to be revised to incorporate the guideline on improving quality of health care service at health facilities and promoting facility utilization by people who live in closer villages or communities.

1.2. Objectives of the guidelines

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

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

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

- Outpatient consultation and treatment for adult, the integrated management of childhood illness, counselling and health education and promotion;

- Fixed site immunization services, vaccine wasted reduction, safety injection, as well as effective vaccine management;
- Reproductive, maternal, newborn and child health and nutrition services including antenatal care (ANC), delivery care, and post-partum care for both mother and newborn, micronutrient supplementation (vitamin A, iron-folate tablet), and periodic deworming;
- Outpatient consultation and treatment for communicable and non-communicable diseases;
- Provision of health care services at community level through outreach activities for both basic and expended packages of health services; and
- Communication between health centre and community structures and stakeholders including village health support group (VHSG), local authorities (commune council, commune committee for women and children – CCWC), 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 should follow the guidelines in improving and strengthening the quality of health care service delivery at health facility and during outreach activities, and should make this document available all the time at health facility.

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. This service delivery modality is a complement to the provision of health care services at health facility 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 health care service provision at health facility 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 (2007), the guideline for

operational district development (1996), and guideline on community participation (2003).

1.3.2. Fixed site services

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

To maintain and improve the facility utilization, HC need to strengthen quality of services delivered at health facility level by managing to provide regular routine services such as ANC, PNC, immunization, and nutrition and strengthening the relationship between HC and community and improving community awareness and knowledge towards 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 transitional but critical service delivery modality as:

1) It complements to the provision of health care services in health facility in effectively improving coverage of some basis health care services such as immunization, vitamin A and iron-folate supplementation, periodic deworming, distribution of birth spacing commodity, and health education and promotion.
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 is difficult.
3) It provides opportunity to HC staff to meet with the people in their catchments areas, and to understand their health status and the issues they encounter as well as their needs. During outreach, they can also inform them about health care services that are available at HC, their rights and benefit in using health care services at the HC, and enhance their understanding and participation in emergency referral from community to health facility.
4) It is a point of contact where other community activities of other relevant national programmes may be coordinated and integrated so that the use of scarce resources available is rationalized and effective.

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 in providing health care services at facility level.

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 and with better quality.

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 supportive supervision, monitoring, and spot-checking to ensure the quality health services delivered through outreach activities.

5) Even though the outreach activities can be conducted regularly and frequently, it cannot response 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 service

1.5.1. Advantages

Delivering health care service at facility is more convenient and advantageous as:

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

2) Visiting HC provides opportunity to villagers to get to know HC staff and receive information on health care services available at health centre.

3) Quality fixed site services may increase facility utilization, which in turn leads to increased HC revenue and incentive for staff.

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 villagers 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 fixed site service provision such as:

1) Essential health care services coverage do not currently reach rural remote areas and underserved population, which are far away from the HC or have particular difficulty in receiving health care services from health facilities, therefore, the service coverage would not achieve the target set.

2) Without visiting the community and villages, especially the rural remote one, health officials may not be fully aware about the current health status and needs of the people in their catchment areas.

3) HC would have 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 centre

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, all villages and communities within the catchment areas of a HC can be classified as follows in accordance to their administrative status, geographical location, road infrastructures, distance, means of transportation, and duration of travel from HC to those villages:

2.1.1. Classification according to administrative status

A) **Administrative villages** are villages registered by local administration, and therefore, are officially recognized by commune and district administration (council) before the Cambodia Census in 2008. In general, those villages have administrative structure and VHSG in place.

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

C) **Non-administrative villages** are villages 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. Those villages have yet been recognized by the local administration for some reasons. Similar to annex villages, the non-administrative villages do not have administrative structure or VHSG in place.

The OD office should provide supports required to HC and request to local administration for the acknowledgement to the outreach services conducted for those non-administrative villages, and coordinate the establishment of VHSG or other community worker structure for those villages.

2.1.2. Classification according to 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 should 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 in**: is a village locates in zone "A" in accordance to the guideline on operational district development. People from this village should 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 should not take longer than 1 hour. People from these villages should be encouraged to use health care services at HC.

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

- Villages located farther than 5 kilometres from the HC but closer than 10 kilometres **OR**
- Traveling from HC to those villages take longer than 1 hour, but should not exceed 2 hours by using locally available mean of transportation.

These villages are eligible to receive outreach services provided by HC staffs.

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

- Villages located farther than 10 kilometres from the HC OR
- Traveling form HC to those villages is difficult: need to pass by forest or mountainous areas, or travel by waterway, OR
- Traveling from HC to those villages take longer than 2-3 hour by using locally available mean of transportation.

Those villages should receive outreach with expanded packages of services provided by HC staffs.

According to the travel condition (pass by forest or mountainous areas, or travel by waterway) or travel distance (40 kilometres or more) or travel duration (take longer than 2-3 hours by using locally available mean of

transportation), the team conducting outreach to those villages should be eligible to stay over-night at those villages if necessary.

Transport cost to reach those villages should be reimbursed according to the actual cost. To facilitate the organization of the activities and to increase the cost-effectiveness in the context that human and financial resource are limited, outreach for those remote villages should be conducted for a cluster villages rather than for a single village.

The decision to classify villages as above-stated as well as the package of outreach services should be through the comprehensive consideration, consultation and agreement between HC and OD office during annual 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 outreach activities should be developed. This micro-plan should include name and location of the villages to be visited, distance and travel duration using locally available transport mean from HC to a specific village, estimated budget for conducting one outreach session to a specific village or community, equipment and supplies required (vaccines, drugs, injection devices etc.), number of outreach session planned during the year for specific village or community, and schedule, with expected date, of the outreach session.

2.2. Health service packages for outreach

2.2.1. Basic package

The basic package of health care services to be delivery during outreach session includes:

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

2) Vitamin A supplementation for children aged from 6-59 months (twice a year that is in May and November together with periodic deworming by mebendazole);

3) Health education and promotion;

4) ORS and zinc distribution for children with diarrhoea;

5) Iron and folic acid supplement for pregnant women, and encouraging pregnant women to have ANC visit early during the

first of missing menstruation, to continue ANC visit 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;

6) Iron and folic acid supplementation and periodic deworming by mebendazole for post-partum women;

7) Weekly iron and folic acid supplementation for child bearing age women holding ID poor card, and encouraging them to use health care services at health facility;

8) 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;

9) Regular deworming with mebendazole for children age 12-59 months and child bearing age women (twice annually that is in May and November together with vitamin A supplementation) especially for pregnant women (after the first trimester of pregnancy);

10) Regular distribution of multiple micronutrient powder (MNP) to children aged 6-23 months (15 days per months, every month) in the areas with MNP implementation;

11) Screening and referral children for severe acute malnutrition (SAM) by checking for bilateral pitting oedema, and

    a. Using mid-upper arm circumference OR weight for height for children age 6-59 months

    b. Checking for visible wasting for children age less than 6 months.

12) Also, follow-up of defaulters of SAM and refer them to health facility for appropriate continue treatment;

13) Follow-up of defaulters of TB and Leprosy patients and active referral of TB and Leprosy suspects;

14) Counselling on exclusive breastfeeding for 6 months, and start appropriate complementary when the child age 6 month with continue breastfeeding until the child age at least 2 years;

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

2.2.2. Expanded package

In **addition to the basic health care package**, the following essential health care services should be delivery in the outreach session for remote villages and communities.

1) **Antenatal care**: including ANC, iron-folate supplementation and mebendazole to all pregnant women (do not give mebendazole to pregnant women during the first trimester), TT immunization, and checking for danger signs during pregnancy so that pregnant women with danger signs can be referred on time to health facility for further care

2) **Post-partum care**: including immediate care for post-partum women and newborn, immunization, iron-folate supplementation, deworming by mebendazole, TT immunization (if due), and checking for any danger signs during post-partum for both mother and newborn. Outreach team should also advise the women to continue follow-up at health facility, to keep newborn warm, and to exclusively breastfeed their child for at least 6 months

3) **Checking the report and replenish ORS and zinc tablets**: including checking and verifying the report of VHSG in distributing ORS and zinc tablets to children with diarrhoea, and replenishing their stock of ORS and zinc tablets to ensure that they have sufficient ORS and zinc tablets for distributing to children with diarrhoea (please read the national policy on the control of ARI and diarrhoea disease, annex 7)

4) **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 is trained community workers (village malaria worker - VMW). Diagnosis is received from rapid test using dipstick and pre-packed artemicinin 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).

5) **Growth monitoring and promotion** of children age under five years using weight for age.

2.2.3. Activities that should not be in outreach packages

Several health care services are not the main components of outreach activities, therefore, should not be included in routine outreach activities. Those are:

1) Curative services, in general, are not the main component of outreach session due to limited public health impacts and difficulties in logistic supplies. People with illness should be referred to health facility to get appropriate medical attention 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 health centre 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 implemented once annually 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 control should not also be part of the routine outreach activities as well.

2.3. Preparation for the outreach activities

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

1) In principle, the outreach team should 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 should organize the outreach activities in consultation and collaboration with existing community structures such as village health support group (VHSG), commune committee for women and children (CCWC), local authorities including commune council (CC), other community workers, village development committee (VDC), school, pagoda etc. to maximize effectiveness of the activities.

3) With support from operational district (OD) office and provincial health department (PHD), HC should also consult with those community authorities and other relevant institutions on:

   a. Conducting outreach activity and establishing of VHSG for non-administrative villages;

   b. Conducting outreach activity for poor communities in urban areas;

c. Conducting outreach activity for remote villages;

d. Improving knowledge and awareness, mobilizing community, encouraging people to use health care services at health facility, 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. Encouraging and improving community participation in outreach activities.

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

a. 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;

b. 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 to the agreement with the OD office, HC should develop action plan and micro-plan for conducting outreach activities. This micro-plan should include name and location of the villages to be visited, distance and travel duration using locally available transport mean from HC to a specific village, estimated budget for conducting one outreach session to a specific village or community, equipment and supplies required (vaccines, drugs, injection devices etc.), number of outreach session planned during the year for specific village or community, 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 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, children aged under 1 year, 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 no midwife in the team, the other team members should at least ensure the supplementation of iron-folate tablets, periodic deworming (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 health facility for further care and support.

12) Outreach team should ensure that post-partum women and newborn received appropriate post-partum care (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 among children aged under five – annex 7).

14) ANC, PNC, and basic and essential treatment for other diseases should be considered and put in expanded outreach package for remote villages.

15) Even though some specific disease surveillance can be incorporated into outreach activities, the investigation of the onset of a disease outbreak 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 human and financial 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) **Nearby villages:** are villages located **closer than 5 kilometres** from the HC or the travel duration from HC to those villages should not exceed 1 hour. If the road infrastructure is favourable, **those villages should be considered as fixed site villages**, where villagers should be encouraged to use health care services at health facility. The decision on classifying villages as fixed sites should be made through thorough consultation and 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 continued visiting those villages to inform them about this change, to raise their awareness on benefits and advantages in using health care services at health facility, and to encourage them to visit health facility.

If the HC and OD office decide to continue providing outreach services to any villages in this category for any reason, the outreach session should be conducted on a **quarterly basis** (4 times per year).

B) **Distant villages**: are villages located farther than 5 kilometres from a HC but less than 10 kilometres OR the travel duration from a HC to those villages take longer than 1 hour but not exceed 2 hours using locally available mean of transport. Those villages should receive routine bi-monthly outreach visit (every two months). For large and populated villages, the OD office, HC, and outreach team may consider increase additional outreach session 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** for each outreach session.

C) **Remote 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 take longer than 2-3 hours using locally available mean of transport. 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 **a cluster villages** rather than for a single village.

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 non-administrative villages

Conducting outreach activities to villages classified as non-administrative villages (as they have not been registered by local administration, and therefore have not been recognized by local authority) that 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 focussed in order to ensure equitable access to health care services and to increase the coverage of essential health care services to reach universal coverage.

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 villages 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

non-administrative villages as well as to facilitate the establishment of VHSG for those villages.

2.6. Outreach to poor communities of urban areas

People living in the poor communities of urban areas are generally poor, with 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, especially preventive and promotive care. Therefore, special attention in providing outreach services should be made to this specific area.

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 to the guideline on operational district development should be eligible to receive outreach services.

2) HC, with support from OD, should discuss with local authority on increasing the number of VHSG proportional to the number of household in order to facilitate the community mobilization activities. The recommended ratio of VHSG to households is 1:30-50.

3) Health service package for outreach to poor community of urban areas should be reviewed at least annually, in consultation with HCMN, local authority, and CCWC to reflect local need. HC should seek agreement from OD and PHD office on this package and incorporate it into annual operational plan with specific emphasis on strengthening community participation.

2.6.2. Frequency of outreach

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

Schedule and 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 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” but 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, promoting and encouraging facility utilization, and strengthening the roles of local authority, CCWC, and VHSG through regular HCMC meeting.

CHAPTER 3 – STRENGTHENING FIXED SITE SERVICES

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

To reduce the outreach services, HC chief and OD office should take into account all factors affecting accessibility to health care services in the community such as geographic, road infrastructure, and collaboration and participation of local authority as well as current development and improvement in the areas. These will have appropriate decision on reducing outreach services to the villages where people can access and use health care service at health facility.

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".

HC should consider reducing outreach service from the villages with improved road infrastructure together with other following characteristics:

1) Located closer than 3 kilometres from the HC in mountainous areas;

2) Located closer than 4 kilometres from the HC in highland areas; and

3) Located closer than 5 kilometres from the HC in plain areas.

4) Improved quality of health care services at health facility through:

    a. HC open 24 hours every day and 7 days a week;

    b. HC staffs should be competent and skilled;

    c. HC has adequate equipment, drugs, and supplies;

    d. With good management and organization of work at the health facility, and clear schedule for conducting outreach activities;

    e. With active and committed VHSG and functioning HCMC;

    f. HC collaborates well with local authority, and therefore, is supported and participated by local authority and community;

    g. HC staffs receive continued technical support from OD office and PHD through training and supportive supervision.

5) Ensure regular community participation mechanism by having:

   a. Regular staff meeting in the HC;

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

   c. Regular community mobilization activities at community level by HC staffs together with VHSG to raise awareness of community regarding health care service available at health facility;

   d. Good monitoring on the coverage rate of essential services and interventions and facilitation after implementing fixe site service in order to consider on corrective action.

CHAPTER 4 – FINANCIAL SUPPORT FOR OUTREACH AND FIXE SITE SERVICES

4.1. Plan of activities 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 CCWC, community representative from the target areas, HC should develop plan of actions and micro-plan for outreach activities. Micro-plan should consist of list of village 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, schedule and expected date of outreach for specific villages.

The consultation and preparation for each above-mentioned component should be ready before the beginning of planning cycle. The plan of action and micro-plan for conducting outreach session will be discussed and finalized with OD office during AoP development to endure 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 plan of action and micro-plan

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

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

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

2) **Budget for convening routine meeting for community mobilization**:

- Refreshment during the meeting
- Support for VHSG, HCMN members, and other community representatives for participating in the meeting:
  - Food support
  - Accommodation support

– Travel cost.

4.2. Funding sources and rates

1) Fund required for conducting outreach activities and strengthening quality of fixed site services can be support by government budget, the second health sector support programme (HSSP-2) pooled fund, or other funding sources available. To ensure equity and faireness in using scarse resources, the funding support rate, although being supported by any funding source, should follow a single standard rate as in the below table.

	Distance	Rate for each item
1	○ Villages in zone "B" closer than 10 kilometres **OR** ○ Travel duration not exceed 2 hours	○ Mission support ..... 8,000 Riels **AND** ○ Travel cost ..... Actual cost
2	○ Farther from HC, from 10 to less than 40 kilometres (**OR** less than 30 kilometres for remote provinces according to Sub-Decree No. 10 ANK.BK[1]) **OR** ○ Travel duration net exceed 2-3 hours	○ Mission support ..... 8,000 Riels **AND** ○ Food support ..... 15,000 Riles **AND** ○ Travel cost ..... Actual cost
3	○ Very far from HC, from 40 kilometres (**OR** from 30 kilometres for remote provinces according to Sub-Decree No. 10 ANK.BK) or more **OR** ○ Travel to village take longer than 2-3 hours **OR** ○ Require overnight stay	○ Mission support ..... 8,000 Riels **AND** ○ Food support ..... 15,000 Riles **AND** ○ Accommodation ..... 40,000 Riels **AND** ○ Travel cost ..... Actual cost
4	○ Support to VHSG	○ Support ..... 8,000 Riels/VHSG/day

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

3) VHSG, HCMN members, and other community representatives who participate in the meeting or training 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 PHD and HC should prepare and review a tariff of travel cost from a HC to specific villages.

[1] The 5 provinces include: Ratanak Kiri, Mondol Kiri, Stung Treng, Kratie, and Preah Vihear

CHAPTER 5 – COORDINATION, MONITORING AND EVALUATION

5.1. Coordination and facilitation

Coordinating the consultation with local authority, community representative in HC's catchment areas and OD office in the process of developing plan of action for conducting outreach activities and in 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 plan development and implementation of outreach services.

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

   - Remote and hard-to-reach villages;
   - Non-administrative villages 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, and OD office on:

   - Community mobilization and participation in outreach activities, and seeking health services at health facility;
   - Recognition to outreach activities conducted by HC to specific geographic location, especially remote hard-to-reach villages, non-administrative villages, and poor communities of urban area;
   - Support and commitment to implementation of agreed plan.

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

4) Prepare schedule for outreach activities for the whole year with expected date for conducting outreach session, villages to visit, and equipment and supplies required according 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

Regular supervision, monitoring and evaluation are critical mechanism for strengthening quality and efficacy of outreach and fixed site services. OD office and HC should 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 to the outreach activities conducted by HC to ensure that the outreach is conducted as planned and that the HC function effectively without interruption. In addition, conduct the rapid coverage assessment of the service delivery through outreach activities.

4) Encourage and enhance utilization, record, and maintenance of registration log books, including outreach registration, to facilitate record checking and monitoring of the service provision.

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 other to review and evaluate the efficacy and cost-effectiveness of the implementation.

8) Integrate plan of action 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 syringe (0.5ml and 0.1ml)
3) Disposable syringes with needles, Polio vaccine dropper
4) Safety box (5 litter)
5) Cotton swap with boiled water
6) Immunization registration book for both child and infant
7) List of children age 0-23 moths whose immunization status is not up to date
8) TT registration book for pregnant women and child bearing age women (15-49 years)
9) Tally sheet
10) TT Cards and plastic card holders
11) Yellow Cards and plastic card holders
12) Lunar Calendar, Immunization calendar, and paper clock (child age calculator)
13) Loudspeaker
14) Banner
15) Hand bag for keeping material, paper, pen, stapler etc.
16) Black bag for waste disposal
17) Thermometer

1.2. Micronutrition supplementation

1) Tally sheet for vitamin A and mebendazole
2) Tally sheet for MNP daily and weekly IFA
3) Scissor
4) MUAC tapes

1.3. Health education and promotion

1) IEC materials for immunization, birth spacing services, ANC, PNC, HVI/AIDS, TB, malaria, dengue hemorragic fever, nutrition, etc.

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

1) Tally sheet for mebendazole (or integrated tally sheet) together with vitamin A.

1.6. Management of children with diarrhoea

1) Tally sheet for replenishment of ORS and zinc tablets for VHSG in remote villages
2) VHSG reporting form for diarrhoea management by the VHSG.

2. Expanded outreach package

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

2.1. ANC and PNC

1) Sphygmomanometer for measuring blood pressure
2) Tap metre
3) Foetoscope/Doppler
4) ANC registration book (included tally sheet for iron-folate tablet supplementation)
5) Post-partum care registration book
6) Newborn registration book
7) Mother health card
8) Leaflet on danger signs during pregnancy
9) Flipchart health education
10) Soap and hand brush
11) Scale

2.2. Malaria

1) Dipstick, cotton swap, alcohol

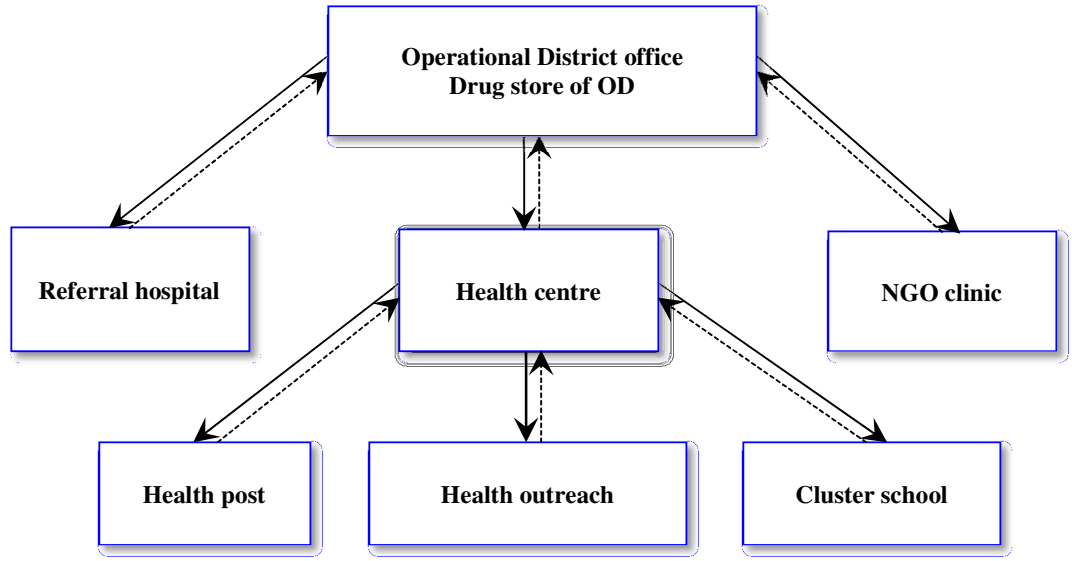
2) Pre-packed malaria drug
3) Tally sheet for malaria management

2.3. Other equipment that should be available during outreach

1) Rain coat, especially in rainy season
2) Life jacket if traveling by waterways
3) Helmet if riding on motorbike etc.

ANNEX 2 – DRUG AND EQUIPMENT SUPPLY SYSTEM AT OD LEVEL

1. Drug and equipment supply system at OD level



Notice:

Drug and equipment supply system

Reporting system

2. List of drugs required for outreach

Nº	Drugs	Presentation/Route	Dosage	Remarks
1	Paracetamol	Oral tablet 100mg	30-40mg/kg/day	children
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)
		Red oral capsule 200,000IU	One capsule up to 8 week after delivery	Women after delivery
3	All vaccines for children (7 traditional)			Children
4	Tetanus toxoid vaccine	Muscular injection		Child bearing age women
5	Condom	size 49 mm		Men
6	Combined oral contraceptive (COC) (progesterone+ estradiol)	One blister pack for 1 month - oral	One pill/day	Child bearing age women
7	POP Progesterone (Overette)	One blister pack for 1 month - oral	One pill/day	Child bearing age women
8	Depo-Provera (depo-medroxy-progesterone acetate)	Injectable contraceptive vial of 3ml (150mg/ml)	One vial for every 3 months	Child bearing age women
9	Oral rehydration salt (ORS)	pack for one litre	Dissolve one pack in 1 litre of boiled water	Children
10	Zinc tablet	Tablet 20 mg	10mg/day for 10 days	Infant age under 6 months
			20mg/day for 10 days	Children age form 6 months or older
11	Mebendazole	Oral tablet 100mg and 500mg	250mg single dose for every 6 months	Children age 12-23 months
			500mg single dose for every 6 months	Children age form 2 years or older
			500mg single dose for every 6 months	Pregnant women after first trimestre of pregnancy
			500mg single dose for every 6 months	Post-partum women within 8 weeks after delivery
12	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
13	Multiple micronutrient powder	Package	1 pack every 2 days OR 1 pack/day for 15 days a months to make it 15 packages per month	Children age under 6-23 months old
14	Weekly Iron-Folic acid tablets	Oral tablet of ferrous sulfate 60mg + folic acid 2.8mg	One tablet for every week	Child bearing age women (14-49 years)

ANNEX 3 – LOGISTIC PROCEDURE

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

Report on Drugs and Equipment used for Outreach activities

From..... **- To**.....

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.....

Seen and approved
Chief of Health Centre

Signature of deliverer

Date.....

Prepared by

Notice: Please fill in 2 forms: one for HC drug dispenser, one for HC's staff who requests drug and equipment for outreach services for 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 tablet/capsule 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%

Notice: 60 per cent is a proportion of pregnant women expected to receive iron and folic acid tablets during outreach activities at the community level.

Responsibility of HC chief and drug dispenser

- Approves on the advanced request for drugs and equipment required for outreach activities by HC staff, and liquidates on accomplishment of the activities or on monthly basis.

- After every outreach activity, HC staff in the outreach team who actually conducted outreach activity should fill-in the "Report on Drugs and Equipment used for Outreach activities" using the enclosed form.

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

- All HC should fill-in the "Report on Drugs and Equipment used for Outreach activities" and send to OD office regularly on monthly or quarterly basis and according to timeframe specified by the OD office (in the next month or next quarter). Therefore, the requested among should include among advanced (in column "Advanced Quantity Requested") and among used/distributed (in column "Other" of the report).

ANNEX 4 – GUIDING PRINCIPLE FOR HEALTH EDUCATION AND PROMOTION

Health promotion focus on key family practices to improve health and wellbeing of mother and children through health education related to communicable diseases, non-communicable diseases, by using behavioural change communication skill and facilitation skills, information, education, and communication (IEC) materials and the seven steps of health education (please read the minimum package of activities (MPA) training module 7).

Conducting health education activities does not mean that health centre staffs have to organize specific health education session every time during the outreach session but to use opportunity of meeting with specific target groups during outreach session. During outreach session, health staff should use provide information and educational message as needed based on the priory assessment and consultation to raise awareness and understanding of those target groups on health benefit of specific behaviours and participate in the change from harmful practices to the better one in order to improve health of their family.

Procedure in conducting health education and health promotion during outreach session (for individual or group)

- Select only one subject for one session of education
- Select existing subject which is the real need of the local community
- The member of the target group is 10 person in average
- The session of education is in average one 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 the language easy to understand and acceptable by the target group
- Use different skill in health education

ANNEX 5 – GUIDELINE FOR MICROPLANNING

Steps in micro planning

1) Mapping population in catchment area
2) Analysing data on current performance
3) Planning for health centre immunization session
4) Identifying barriers to access and utilization, and solution to the issues identified
5) Planning for implementation with problem solving activities
6) Developing monitoring system
7) Tracking for defaulters and unreached
8) Managing stocks and supplies
9) Managing the implementation of micro-plan and
10) Managing VHSG.

Step 1 – Mapping population in catchment area

1) **OD map**

Map should display location of OD office, HC within the OD and their catchment areas, location of RH, key administrative location, road infrastructure, distance, waterways, and mountains. Information on actual population and target population of the OD and HC is important.

2) **HC map**

Map should display location of HC and its catchment areas, key administrative location (commune hall, pagoda, school, market, krong), road infrastructure, waterways and mountains, and location of population in its catchment area (administrative villages, annex villages, non-administrative village, and poor community of urban areas or other vulnerable groups). Information on actual population and target population of the HC, distance from HC to villages and travel duration, name and mobile phone number of VHSG, village head and CC chief is important

Table 1 – List of villages in the catchment areas of the health centre

No	Name of Village	Total Population	Under 1year	Expected Pregnant Women	Child Bearing Age Women	Distance to HC	Name of VHSG	Mobile number of VHSG
1								
2								

Step 2 – Analysing data on current performance

- **a.** Ordering number of HC
- **b.** Name of the HC
- **c.** Number of pregnant women in the HC catchment area
- **d.** Number of children age under 1 year in the catchment area
- **e.** Doses of penta-3 (DTP-Hep B-Hib3) given
- **f.** Doses of measles vaccine first dose (M9) given
- **g.** Doses of TT2+ given
- **h.** Number of children not received penta-3 = Target children – Doses of penta-3
- **i.** Number of children not received measles vaccine =Target children – Doses of M9
- **j.** Number of pregnant women not received TT = Target women – Doses of TT2+
- **k.** Review all rows and mark priority order for HC where there is the highest number of unimmunized among target population (mark number 1 for the highest number of unimmunized among target group using finding from measles campaign 2011 or other data sources).

Table 2A – Analysing 12-month immunization coverage of OD by HC

		Analysis								**Priority mark**
				Immunized			Unimmunized			Order from the highest number of unimmunized
No.	**Name of Health Centre**	Pregnant women	Child under 1 year	Penta-3	Measles M9	TT2+	Penta-3	Measles M9	TT2+	
	text		number	number	number	number	number	number	number	1, 2, 3, ...
a	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**	**k**
1										
2										

Table 2B – Analysing immunization coverage of OD by high risk characteristic

Measles M9				**Types of community in priority high risk HC areas (indicate as approximate % of each type)**				
Priority order in table 2A	Name of Health Centre	Child under 1 year	Number of unimmunized	1. Urban poor	2. Rural remote	3. Ethnic community	4. Migrant community	5. Other groups
1								
2								

Guide for table 2C - Analysis of priority high risk HC data to understand community access and demand for services in high-risk communities. Use full 12-month data of high risk HC to review the status of the communities.

a. Name of village or community

b. Number of children age under 1 year (figure used by HC)

c. Number of children received HepB-0 in community (HC report)

d. Doses of penta-3 by villages (HC report)

e. Number of children not received penta-3 = Target children – Doses of penta-3

f. Distance from HC to village and travel duration

g. Number of outreach session planned in villages (based on annual plan)

h. Number of outreach session actually conducted annually

i. Suspected case of measles and confirmed cases

j. Newborn deaths before 28 days

k. Other priority action for villages: 1, 2, 3, …

l. Name and mobile number of VHSG or other contact person in village.

Table 2C - Analysis of high risk HC data for access and demand in high-risk communities

Name of village	Children under 1 year	HepB-0	Penta-3	Un-immunized Penta-3	Distance from HC	Number of outreach visit planned for this village	Number of outreach visit conducted for this village	Suspected cases of measles /Confirmed cases	Infant deaths before 28 days	Priority	Name and mobile number of VHSG
	(Year)	(Year)	(Year)	(Year)	(Km)	(Year)	(Year)	(Year)	(Year)	1,2,3..	
a	**b**	**c**	**d**	**e**	**f**	**g**	**H**	**i**	**j**	**k**	**l**

Guide for Table 2D – Detailed analysis on barriers to access and demand

Table 2D is a form for collecting data from interviews with mothers of children aged 12-23 months as at this age children should have completed their immunization. Mothers are also checked for TT immunization status. For children and mothers who are not fully immunized, reasons why they are partially or not immunized will be asked and recorded on the form. Collect information from 20 mothers and 20 children. Also record the mobile phone number of VHSG, village leader, or other focal person in the village for further support.

Table 2D - Questions on immunization of children 0 – 23 months, and TT of mothers

Name of village: Distance from HC

Name of HC: OD: PHD

Response (children 0-23 months)		**Tally Number here**		**1. Total**
A. Number of household visited				
B. Immunization status by yellow card		**Number of Children**		
Partially immunized				
Fully immunized for their age				
No card available Why?	Card lost			
	Never vaccinated			
C. Child name		**Reason for partially or un-immunized**		
1.				
2.				
Response (mothers)				2. Total
D. TT status by card or history		**Number of mothers**		
Never vaccinated				
Partially immunized				
Fully TT immunized				
E. Mother name		**Reason for partially or un-immunized**		
1.				
2.				

Name of community leader and/or VHSG .....

Mobile phone number of community leader and/or VHSG .....

Step 3 - Planning for health centre immunization session

Note for table 3A:

- Proportion of target children is 3% of total population.
- Proportion of child bearing aged women (CBAW) is 22% of total population.
- **Outreach activities**: There is no absolute distance to determine a nearby or distant village. Follow the guideline in conducting outreach activities in the decision process.
- Provide regular immunization services:
  - At village level, there should be annual outreach action plan and the frequency of outreach session should respond to the number of target population in the village. In general, each village should receive at least quarterly outreach visit in order to provide opportunity for all children to be immunized.
  - At HC, immunization services should be regular and frequent enough for the nearby villages that have been decided to access and receive services at HC.

Table 3B – Health Centre immunization plan

Village name	Total Population	Distance from HC (Km)	Annual target children	Monthly target children	Annual pregnant women	Monthly target women	Annual CBAW (22%)	Type of session	Num of session	Mean of transportation
A	10,000	1	300	25	300	25	2,200	Fixed site	3 days /week	
B	4,000	10	120	10	120	10	880	Outreach	6	Motorbike

Table 3C – Outreach session of the HC

Village name	Num of session per quarter	Name and Mobile number of VHSG	January	February	March
A	2		Scheduled date:	Scheduled date:	Scheduled date:
			Visited date:	Visited date:	Visited date:
			Transport mean:	Transport mean:	Transport mean:
			Responsible by:	Responsible by:	Responsible by:
B	1		Scheduled date:	Scheduled date:	Scheduled date:
			Visited date:	Visited date:	Visited date:
			Transport mean:	Transport mean:	Transport mean:
			Responsible by:	Responsible by:	Responsible by:
Monitoring the implementation			Actual session :	Actual session :	Actual session :
			Planned session:	Planned session:	Planned session:

Step 4 - Identifying barriers to utilization and solution to the issues identified

- Identify main problems and possible solution through meeting of HC and OD office.
- Decide on priority solutions to the problems that are practical and feasible.
- Determine problem-solving activities that are feasible and practical within their own capacity and resources.
- OD should provide technical and financial support as possible to the HC.
- Potential solutions identified should be incorporated in the HC work plan (Step 5).

Table 4 – Problem solving table to identify barrier to utilization

Red components (high priority)	**Main problems** Describe main problem encountered by community	**Action for HC** Activities in workplan to be carried out by HC	**Action for OD** Activities in workplan to be carried out by OD
Re-establish outreach and improving quality of fixed sites services			
Link services with the community			
Conduct supportive services			
Strengthen monitoring and data use for action			
Develop plan of action and manage resources			
Other components			

Step 5 - Planning for implementation with problem solving activities

Table 5 – Activities in workplan to be carried out by HC and OD	Monthly schedule			Management Activities
Detailed activities from Table 4	**Jan**	**Feb**	**Mar**	**Designated person**
Re-establish outreach and improving quality of fixed sites services				
1.				
2.				
Link services with the community				
1.				
2.				
Conduct supportive supervision				
1.				
2.				
Strengthen monitoring and data use for action				
1.				
2.				
Develop plan of action and manage resources				
1.				
2.				
Other components				
1.				

Step 6 – Strengthening monitoring system

1) Immunization registration book for outreach activities
2) Trend of immunization coverage charts
3) Monitoring immunization status of children mothers in communities using opportunity of measles second dose (M18) introduction
4) Supervision check list for micro-planning progress monitoring at HC
5) Regular meeting and problem solving.

Table 6 – Monitoring immunization coverage of high risk villages and communities							Immunization status of child (18-23 mo) TT status of mothers ✧ Fully= M9, Penta-1, Penta-2, Penta-3 are recorded in yellow card ✧ Partially=Missed any dose: M9, Penta-1, Penta-2, or Penta-3 (not recorded in yellow card)					
M18 given to child (18-23m)			**Recorded on card**				**Child (card only)**			**Mother (card or recall)**		
Date	**Child name**	**Mother name**	**M9 ✓**	**Penta1 ✓**	**Penta2 ✓**	**Penta3 ✓**	**Fully ✓**	**Partially ✓**	**None or no card ✓**	**TT3+ ✓**	**TT1 or 2 ✓**	**None TT ✓**
							Total	**Total**	**Total**	**Total**	**Total**	**Total**

Table 6B-1: Quarterly monitoring children 18-23mo in high risk villages

Village Name	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Fully	Partial	None	Fully	Partial	None	Fully	Partial	None	Fully	Partial	None
A												
B												
G												
Total												

Table 6B-2: Quarterly monitoring women TT status in high risk villages

Village Name	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	TT3+	TT1 or 2	None	TT3+	TT1 or 2	None	TT3+	TT1 or 2	None	TT3+	TT1 or 2	None
A												
B												
G												
Total												

Roles of HC staffs

1. For Children aged 18-23 months

- Give second dose of measles (M18) to all children aged 18-23 months during routine immunization. Translate M18 as part of the routine measles immunization.
- If a child age 18-23 months has not received any measles dose, give one dose of M18.
- For children age 18-23 months who received M18, record the dose in yellow card.
- Give all immunizations the child age 18-23 months needs, except BCG and M9.
- Complete filling all information required in the form for children age 18-23 months before give other immunization to the child:
    - Check child card for M9, Penta-1, Penta-2, Penta-3, and tick in the corresponding box
    - Record number of children who are fully, partially, or un-immunized in the form
- If a child age 18-23 months has no card (loss of damaged), give new card and record all immunization provided with date on the yellow card.
- Crosscheck with immunization registration book to verify immunization that the child received or has not received.
- If immunization has not been record in the immunization log book, rely on mother recall
- Fill all parts of the form during outreach activities and send filled form to OD on quarterly basis.

2. TT status of mother

- Check TT card during outreach session for TT3+. Check also for TT1 and 2

- If mother does not have card (loss or damaged), give mother a new card an record doses given and date on it. If mother is not sure about doses, check in TT registration book.
- If mother received TT less than 3 doses, give another dose of TT and record it in TT card and TT registration book.

Roles of VHSG

- Inform family/parents of children age 0-23 months, whose name an age are recorded in their list and ask them to come together on the day of outreach session conducted.
- Ensure that all children have their yellow cards and received immunization needed during the day the outreach session conducted.
- Check the card to make sure whether there is any children age 13-23 missed any vaccine they need.
- Inform to mothers that they should bring their TT card with them when bringing the child to the session so that their TT status can be checked.

Roles of OD office and PHD

- OD office collates and analyzes HC data and send to PHD on quarterly basis.
- PHD collates and analyzes OD data and send further to national program for immunization (NIP) on quarterly basis and feedback to OD office.
- At the end of the year, OD office and HC identify high risk villages based on information and performance of that year:
  - Table 6A – Monitoring system for immunization coverage
  - Table 6B-1 – Quarterly monitoring immunization status of children age 18-23 months in high risk villages
  - Table 6B-2 – Quarterly monitoring TT status of mother and CBAW in high risk villages.

Step 7 – Tracking for defaulter and unreached

Table 7A – List of child defaulters

Village Name:					
No.	**Mother name**	**Child name**	**Age (month)**	**Immunization due**	**Other information**
1					
2					
3					

Table 7B – List of pregnant women and CBAW defaulters for TT doses

Village Name:				
No.	**Name of Pregnant women/CBAW**	**Age (year)**	**TT status**	**Other information**
1				
2				
3				

Step 8 – Managing stock and supplies

Table 9 – Stock card

KINGDOM OF CAMBODIA

Ministry of Health
National Maternal and Child Health Centre
National Immunization Programme

Nation – Religion – King

STOCK CARD (code of vaccines, equipment): .....

Location: Khsach Andet **Vaccine/Equipment**: Pentavalence **Unit**: Vial **Dose**: 10 doses/vial **Sheet 1**
District: ..... **Province**: ..... **Buffer stock**: 30 doses **Max stock**: 80 doses

No	Date	Invoice number	Description	Lot number	Expiry date	VVM Status	In-Coming	Out-Going	Balance (in doses)
				From previous sheet:					10
1	27/01/06	1432A	Received form OD	143B2A	05/07	1	70	0	80
2	27/01/06	-	Conduct session	-	-	1	0	10	70
3	27/01/06	-	Conduct session	-	-	1	0	10	60

Step 9 – Managing the implementation of micro-plan

OD office and PHD are responsible for ensuring that HC has an appropriate micro-plan that includes problem-solving activities for identified problems:

- OD should work closely with HC to ensure that each HC has new micro-plan
- HC should analyze coverage rate by villages to track progress
- OD should, during supervisory visit, ask for updated data and review activities listed in micro-plan
- HC micro-plan is subjected to revision during supervisory visit
- Supervisor checklist can be used when reviewing HC micro-plan
- For each supervisory visit, supervisor should take note all issues observed and corrective actions to be taken.

Table 10 – Managing micro-plan

Observation of Supervisor		Finding and action required
1. Micro-plan and action	– Does HC have a new micro plan for this year? – What action has been taken to solve problems since last visit?	
2. Map and population	– Does map show all villages and all communities? – Is there a list of population by village with target <1 year	
3. Session plan	– Does HC monitor date and place of outreach sessions? – Check if remote villages been visited for sessions	
4. Monitoring	– M9/M18 monitoring chart up to date – What is dropout rate M9 to M18? – Is performance data by village recorded up to date? – What results of card checks during M18?	
5. Monitoring link	– List of VHV names and phone numbers for each village – Date of last meeting of VHVs in HC – Have villages been informed to bring all children 18 to 23 months to sessions?	
6. Supportive supervision	– What training subject is given during this supervisory visit? – What training is need for next supervisory visit?	
7. Defaulter tracking	– Look at the village registers to look for defaulters – Is there a list of defaulters prepared for each session for each village?	
8. Stock management	– Is there any stock out of vaccine? – Check fridge working and VVM status of vials	
9. Surveillance	– Are there any measles cases reported? – Are there any neonatal deaths? – Have reported cases been investigated	
10. Resource management	– Are all staff posts filled? – Have funds been paid to HC as required by budget? – What MCH package is offered with outreach sessions?	
11. Other observation	–	

Step 10 – Managing VHSG by HC

1) VHSG management by HC

- ✧ HC should have a list of VHSG with their mobile phone number and display it in HC
- ✧ HC should have a focal person to coordinate and communicate with VHSG on weekly basis on:
  - o Schedule and date for outreach visit to villages
  - o List of target mothers and children, and their registration during outreach session
  - o List of defaulters or those whose immunization status is not up-to-date
  - o List of pregnant women and child bearing age women (CBAW)
  - o List of newborn for giving HepB birth dose
  - o Report on measles cases, acute flaccid paralysis (AFP), and neonatal deaths (before age 28 days)

2) Monitoring at village level

- ✧ VHSG prepare outreach session in the villages by sharing information as follow:
  - o Prepare list of children age 0-23 months, including newborn
  - o Prepare list of in-coming and out-going family
  - o Prepare list of pregnant women and CBAW
  - o Check yellow card and TT card to identify mother or child whose immunization status is not up-to-date
  - o Mobilize and gather all children and mother, who are partially immunized to the outreach session
- ✧ Prepare the outreach session at village level.

3) Surveillance

- ✧ Newborn
- ✧ Newborn death (before 28 days)
- ✧ Suspected case of measles, AFP, and other diseases
- ✧ Adverse effect after immunization (AEFI)

4) Meeting with VHSG at HC

- ✧ Feedback on the outreach result
- ✧ Sharing information on suspected cases of diseases, suspected outbreak
- ✧ Capacity building for VHSG
- ✧ Exempt health care fees for VHSG and their family.

List of villages in catchment areas of HC

No	Village name	Total population	Child under 1 year	Pregnant women	Women 15-49 years	Distance from HC (Km)	VHSG name	VHSG mobile phone
1								
2								

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

1. General guidance

- Check all supplies, equipment 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, PNC, and birth spacing services during outreach sessions with assistance and support from TBA if available.

2. Birth spacing

2.1. New acceptant (new client)

A. Explanation

1) That all contraceptive methods are applicable, and inform them about advantages, disadvantages, and possible side effects
2) Counsel them to clarify some rumours or myths regarding contraceptive methods.

B. Asking

1) Name, age, address in order to fill in clinical card and birth spacing registration book
2) Medical history.

C. Examination

1) Take blood pressure
2) Check for anaemia (pallor)
3) Check for abnormal mass in breasts or ovarian cysts
4) Fill in all parts of clinical card and client card
5) Support client to select appropriate contraceptive method
6) Inform about date for follow-up
7) Record client detail information on birth spacing registration book.

2.2. Continued users (old clients)

A. Asking

Problems encountered in using contraceptive method.

C. Examination

1) Take blood pressure
2) Check for anaemia (pallor)
3) Check for abnormal mass in breasts, ovarian cysts if women complain about or in the case of suspision
4) Inform about date for follow-up
5) Record client's detail information on birth spacing registration book.

2.2. Birth spacing defaulter

1) Ask the reason they stop using contraceptive method for any month
2) Follow-up BS defaulters to find out the reason for stop using contraceptive method
3) If women are worried that using contraceptive may make them permanently sterilized, counsel accordingly.

3. Antenatal Care

3.1. First ANC visit

A. Asking

1) General information: name, age, address
2) Number of pregnancy and number of delivery
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
2) Check for pallor (conjunctiva and nail pallor)
3) Examine both breasts to find out scars or short (inverted) nipple
4) Measure uterus (for evolution of pregnancy)
5) Listen for foetal heart beat (if pregnancy is older than 24 weeks)
6) Ask for foetal movement
7) Check for oedema on both feet and ask for other danger signs
8) Ask for signs of sexually transmitted diseases, and whether a pregnant woman has been tested for syphilis and HIV. Counsel on testing 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

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) Danger signs during pregnancy

D. Iron-folate supplementation

Give iron-folate 60 tablets to pregnant women, and advise them to take one tablet during nighttime, and avoid taking with tea or coffee. Inform them also about possible side effects.

E. TT immunization

Check TT immunization status of pregnant women. If they have not received complete TT immunization, give an appropriate dose of TT and record it in TT card and mother book.

3.2. Continued ANC visits

A. Asking

1) General information: name, age, address
2) Number of pregnancy and number of delivery
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
2) Check for pallor (conjunctiva and nail pallor)
3) Measure uterus (for evolution of pregnancy)
4) Fell for foetal presentation
5) Listen for foetal heart beat
6) Ask for foetal movement
7) Check for oedema on both feet and ask for other danger signs
8) Ask for signs of sexually transmissible diseases, and whether a pregnant woman has been tested for syphilis and HIV. Counsel on testing 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 book.

C. Counselling and advices

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:
   a. Advise on expected date of delivery
   b. Advise on where they should give birth
   c. Advise on the critical arrangement required: mean of transport, contingency fund that may need, other arrangement 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) Post-partum birth spacing (after 6 weeks)
7) Importance of bringing children to get immunization starting from HepB birth dose, and BCG.

D. Iron-folate supplementation

1) Give iron-folate 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 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 and record it in TT card and mother book.

4. Post-partum 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
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
8) Promote use of impregnated bed-net use for mother and baby

4.2. For Baby:

1) Essential newborn interventions at outreach:

   a. Exclusive breastfeeding until 6 months
   b. Hep B & BCG (if not received or born at home)
   c. Hygiene and cord care,
   d. Keeping baby warm,
   e. Weight and weight gain

2) Danger signs in a baby and when to seek care:

   a. Not able to breastfeed or stopped feeding well
   b. Convulsions
   c. Fast breathing OR difficult breathing
   d. High or low temperature
   e. Movement only when stimulated

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 10 blisters of 10 zinc tables each with them (sufficient 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 not sufficient signs to classify for severe or some dehydration	**No dehydration**

2.2. Rehydration using ORS and zinc

1) **Children with diarrhoea and classified as Severe dehydration**:

   a. Refer to the nearest health facility

   b. 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 health facility.

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

   a. Advise mother to take her child the nearest health facility

b. 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 health facility

c. If mother does not agree to take her child to health facility:

- Re-hydrate the child according to plan B, by asking mother and child to rest in a house of villager nearby the outreach session spot.
- By the end of the session, re-assess the child.
- If the child still dehydrated, encourage mother to take her to health facility and keep giving frequent sip on the way.
- If the child get better:
  - Give ORS 3 packs and 1 blister of 10 zinc tablets to mother and explain on how to give
  - Advise mother to continue feeding to her child
  - Advise that she need to take her to a nearby HC, if she find out any of the following signs:
    - Not able to drink or breastfeed
    - Develop fever
    - Abnormally sleepy or lethargic.

3) Children with diarrhoea and classified as no dehydration:

a. Give ORS 2 packs and 1 blister of 10 zinc tablets to mother and explain on how to give

b. Advise mother to continue feeding to her child

c. Advise that she need to take her to a nearby HC, if she find out any of the following signs:

- Not able to drink or breastfeed
- Develop fever
- Abnormally sleepy or lethargic.

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 diarrhoea 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 dehydrating 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 10 children with diarrhoea. If the outreach activities are less frequent, the increased number of ORS packages and zinc tablets for VHSG is recommended, based on the previous experiences.

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**

Provincial Health Department.....

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

Registration of health education activities on improving home care for sick children with ARI and diarrhoea, and rehydration

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 or breast feed	Vomit everything	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	IEC-Diarrhoea treatment using ORS and zinc	IEC-ARI	IEC-Hygiene	IEC-Immunization	IEC-Referral slip
1	12.02.2012	Huot Sary	Hak	15	F	✓													✓	✓	✓	
2	14.02.2012	Hak Sokhom	Heng	20	M	✓					✓											✓
3	11.03.2012	Bun Thoeun	Leng	11	F		✓									2	10	✓		✓	✓	
4	18.03.2012	Chan Sophal	Sok	5	M		✓			✓						2	5	✓				✓

ANNEX 8 – GUIDELINE ON NUTRITION IN OUTREACH

1. Vitamin A Capsule Supplementation

Health Centre staff

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.
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) Emphasize the use of Yellow Card for documenting the date and dose of vitamin A.
5) 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.
6) 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.
7) Record on Yellow Card the dose and the date VAC was given.
8) 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.

Community (Village Health Support Group)

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); these are considered "mop-up" activities.
3) Assist HC and district staff in identifying where hard to reach and vulnerable children live so they can be accessed by health centre staff with transportation.

2. Iron Folic Acid

Health Centre staff

1) Provide health education and counseling about anemia prevention and control, including IFA supplementation for pregnant and postpartum women, through antenatal and postnatal visits at health facilities and during monthly health centre outreach sessions.

2) Record the number of women who receive IFA on Tally Sheets during outreach sessions and on log books at the health centre. 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.

Community (Village Health Support Group)

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) as part of routine "mop-up" activities. Mop- up activities are defined as those that take place outside routine supplementation provided during antenatal or postpartum care.

2) For pregnant and postpartum women not reached through routine distribution channels, special outreach activities should be conducted to ensure coverage of these groups. In urban areas, this includes the very poor, those living in informal settlements, and transient/migrant populations. In rural areas, the hard to reach comprise those living in very remote areas, areas with no health center or limited health center staff, minority tribes, and floating communities.

3. Weekly Iron Folate

Health Centre staff

1) Distribution of weekly iron-folic acid (WIF) at health facilities and during routine monthly outreach.

2) Record the number of women who receive WIFS 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 HC1 HIS form.

3) Women of reproductive age will 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.

Community (Village Health Support Group)

1) Provide support to health centre staff for WIFS supplementation activities at the community level. This includes tracking the number of women of reproductive age (WRA) in their village; providing education about anemia prevention and control; mobilizing communities to attend outreach activities; and distributing WIFS to WRA who did not receive supplements through any of the other distribution channels.

2) VHSGs will receive supplies of WIFS during bimonthly meetings at HC for monthly distribution to WRA at regular meetings within their communities.

4. Multiple Micronutrient Powders

Health Centre staff

1) Responsible for conducting MNP activities in their respective catchment areas. This includes distribution of MNPs at health centres, during health centre staff routine monthly outreach and at the community level.
2) Provide health education during outreach sessions, record MNPs distributed on the Tally Sheet and report on the HC1 form which will be modified to include MNPs and is submitted to the OD on a monthly basis.
3) Provide caregivers with packaged supplies of 15 sachets of MNP per month and careful instructions for each child between 6 and 23 months of age.
4) Instruct caregivers to give the child all 15 sachets over a one month period:
    a. The child can either take 1 sachet every day for 15 day a month; OR
    b. The child can take 1 sachet every 2 days.

Community (Village Health Support Group)

1) Provide support to health centre staff for MNP programme activities at the community level. This will include tracking the number of children 0-59 months of age in their village using registration book developed by NNP;
2) Recruiting and enrolling eligible children;
3) Providing education about infant young child feeding (IYCF) practices, which will include the use of MNPs;
4) Mobilizing communities to attend outreach activities; and distributing MNPs to caretakers of children 6-24 months who did not receive them through health centre distribution channels.
5) VHSGs will be provided with adequate supplies of MNPs at bimonthly health center meetings to support monthly distribution to caregivers as needed.
6) Assist health centre and district staff in identifying where hard to reach and vulnerable children live so they can develop appropriate strategies for providing MNPs in remote rural areas (e.g. possibly providing caregivers of these children with several months supply at one time instead of the usual one month supply).
7) Caregivers who are not readily accessed but do bring their young children in for immunizations could be given MNPs for more than the recommended one month period.

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 health center should be given a single dose of 500mg of mebendazole tablet

2) All children age 1-5 years olds in all villages should receive a single dose of 500mg mebendazole two times a year 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 tablet two time a year that is in **January** and **June** from the school teachers. The health center should provide deworming tablet requested by the school teachers.

4) Deworming (mebendazole 500mg, a single dose) should be provided to all pregnant women after first trimester and to all lactating women (within 6 weeks of delivery).

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 into two equal portions so that each a half tablet is equal to 250mg). Older children may chew and swallow up it. If the child cannot chew the tablet, crash a half tablet in a spoon with some water or breastmilk that make it dissolved, and then give it to the child. If it is very 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. 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.

Remarks:

1) Deworming tablet of mebendazole 500mg is a sweet and chewable, easily to swallow and has no any documentation of side effect.

2) Before giving the deworming dose to a child, the outreach team member should ask the mother whether their child has received any deworming dose in the last 6 months. If the child has already received a dose of mebendazole within the last 3 months, do not give another deworming dose to the child.

3) The health centre should request mebendazole 500mg 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, pregnant women after the first trimester, and post-partum women with 6 weeks after delivery.

4) Cluster primary schools should request to health centre as earlier before the health centre send its request to OD office.

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

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

2. Distribution of ITN and re-impregnated bed net

Insecticide treated net (ITN) use is a recommended strategy for preventing malaria transmission by protecting users from being bitten by anopheles mosquitoes. The ITN has been widely distributed in the area where there is active transmission of malaria.

For the long-lasting insecticide treated net, the insecticide effect can last as long as 3-5 years, where the ordinary ITN need to be re-impregnated annually in targeted villages where the ITN had been distributed in the previous year.

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 located in or nearby the forest

2) Villages located 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 trained malaria workers in the villages with drugs and equipment for diagnosis and treatment of malaria in the community:

   a. Rapid diagnosis test (dipstick test)

   b. Malaria tally sheet/patient record

   c. With 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	Drug name	Age group	Dosage						Observation
1	**Artesunate and mefloquine** (read malaria treatment protocol)								
	Body weight (kg)	**Age (year)**	**Artesunate (50mg)**			**Mefloquine (250mg)**			Plasm. falciparum or vivax or mix
			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 - <30 kg	5 - <11years	2 tab	2 tab	2 tab	1 tab	1 tab	-	(A+M2)
	30 - <40 kg	11 - <15years	3 tab	3 tab	3 tab	1 tab	1 tab	1 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 (300 mg). After first trimester, use A+M5
2	**Di-hydro artemicinine and piperaquine (DHA -PIP) (read malaria treatment protocol)**								
	Body weight (kg)	**Age (year)**	**Di-hydro artemicinine (40mg)-Piperaquine (320mg)**						Plasm. falciparum or vivax or mix
			Day1	Day2	Day3	**Total**			
	5 - <10kg	3mo - <1year	½tab	½tab	½tab	1½tab			
	10 - <19kg	1 - < 5years	1tab	1tab	1tab	3tab			
	19 - <30kg	5 - <11years	1½tab	1½tab	1½tab	4½tab			
	30 - <40kg	11 - <15years	2tab	2tab	2tab	6tab			
	40 - < 80kg	form 15years	3tab	3tab	3tab	9tab			
	form 80kg		4tab	4tab	4tab	12tab			
3	**Quinine and Tetracycline (if artesunate cannot be used) (read malaria treatment protocol)**								
	Body weight (kg)	**Age (year)**	**Quinine (tab 30mg)**			**Tetracycline (250mg)**			Do not give tetracycline to pregnant women and children age under 8 years. Use only quinine for 7 days.
			Dosage in 8 hr	Total dose in 1 day	Total dose in 7 days	Dosage in 8 hr	Total dose in 1 day	Total dose in 7 days	
	<7kg	<6months	¼	¾	5¼	-	-	-	
	7–15kg	6–23months	½	1½	10½	-	-	-	
	16–30kg	2–8years	1	3	21	-	-	-	
	31–45kg	9–15years	1½	4½	31½	1½	4½	31½	
	>45kg	>15years	2	6	42	2	6	42	

Notice

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) Explain to patients on:
    a. Causes of malaria and how to prevent themselves form malaria
    b. Benefit of taking correct doses and completing the course treatment
    c. Possible side effects such as pallor, headache, etc.
    d. Importance of early diagnosis and treatment before malaria develops to severe form

4) For pregnant women:

   a. Quinine is safe for pregnant women

   b. A+M is safe for malaria treatment after first trimester

   c. DHA-PIP is also safe for malaria treatment after first trimester

5) 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.

4	**Treating severe malaria using Artesunate suppository before referral (read malaria treatment protocol)**								
			Artesunate rectocap 50-200mg (5-10mg/kg)						
	Body weight (kg)	**Age (year)**	Dose	Frequency	Total				
	< 5kg	3mo - <1year	50mg	1 time	50mg				
	5 - < 10kg	1- < 5years	50mg	2 times	100mg				
	10 - < 20kg	5 - < 15years	200mg	1 time	200mg				
	40 - < 80kg	15years or older	200mg	2 times	400mg				
	> 80kg or more		200mg	3 times	600mg				