

KINGDOM OF CAMBODIA  
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Ministry of Health

**Consolidated Operational Framework on  
Community Action Approach to implement B-IACM  
Towards achieving 90-90-90 in Cambodia**

August 2017



National Center for HIV/AIDS, Dermatology and STD (NCHADS)

## Preface

The National Centre for HIV/AIDS, Dermatology and STD (NCHADS), together with implementing partners developed the consolidated operational framework on Community Action Approach to support of the implementation of the Boosted Integrated Active Case Management (B-IACM) strategy towards achieving the UNAIDS 90-90-90 targets in Cambodia by 2020 and virtual elimination of new HIV infections by 2025.


The Community Action Approach was designed as a consolidation and harmonization of Boosted-Continuum of Prevention to Care and Treatment (B-CoPCT), Community Based Prevention Care and Support (CBPCS) and the Identify Reach, Intensify and Retain (IRIR) operational strategy to strengthen HIV case detection among key populations, targeted general populations and provide comprehensive support to PLHIV in greatest needs in the community.

Based on recent evidences and in line with recent WHO recommendations, it aims to introduce innovative strategies to detect the remaining PLHIV who still don't know their HIV status in Cambodia, and to ensure they are initiated ART "Treat All", to retained them in care and virologically suppressed to improve the outcomes of the whole HIV cascades. It emphasizes the importance and defines the roles of community support organizations and ART sites in introducing differentiated of care for stable patients.

The Ministry of Health officially approved of the use of the Community Action Approach and expects that all development partners will support and collaborate with NCHADS/health facilities at all level to ensure the successful implementation of this Approach.

Phnom Penh, 28 August, 2017

For Minister for Health *[Signature]*



**Prof. ENG HUOT**  
**SECRETARY OF STATE**

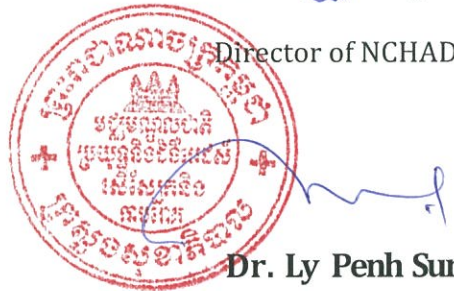
## ACKNOWLEDGEMENTS

National Center for HIV/AIDS, Dermatology and STD (NCHADS) together with partners initiated to develop the Community Action Approach, which is the consolidated and harmonized strategies of Boosted-Continuum of Prevention to Care and Treatment (B-CPoCT), Community Based Prevention Care and Support (CBPCS), and the Identify Reach Intensify and Retain (IRIR) operational strategy, to support the national strategies towards achieving the UNAIDS 90-90-90 targets in Cambodia by 2020 and virtual elimination of new HIV infections by 2025.

We wish to thank all partners who contributed to the development and finalization of this document in particular, the Staff of the AIDS Care Unit, Logistic Management Unit, Data Management Unit and the technical bureau of NCHADS, all the Members of the AIDS Care Technical Working Group and University of Health Science. Moreover, with special thanks to WHO, US-CDC, PEPFAR, UNAIDS, USAID, KHANA, CPN+, AUA, CRS, FHI-360, CHAI, AHF, PC and WOMEN for their active contribution.

Phnom Penh, 21 August 2017

Director of NCHADS



**Dr. Ly Penh Sun**

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## ABBREVIATIONS

ART:	Anti-retroviral therapy
ARV:	Anti-retroviral
B-CoPCT:	Boosted-Continuum of Prevention, Care and Treatment for KPs
B-IACM:	Boosted-Integrated Active Case Management
B-LR:	Boosted-Linked Response
CA:	Community Action
CAC:	Community Action Counselor
CAD:	Community ART delivery
CAW:	Community Action Worker
CBPCS:	Community-Based Prevention Care and Support
CMA:	Case Management Assistant
CMC:	Case Management Coordinator
CMP:	Case Management Provider
CSO:	Community Support Organization
CV:	Community Volunteer
DPHI:	Department of Planning and Health Information
FBW:	Facility-Based Worker
FEW:	Female Entertainment Worker
GOC:	Group of Champion
HC:	Health Center
HCP:	Health Care Provider
HIV:	Human Immunodeficiency Virus
HTC:	HIV Testing and Counselling
HTS:	HIV Testing Services
IRIR:	Identify-Reach-Intensify-Retain
KP:	Key Population
LTFU:	Lost to Follow-Up
MSM:	Men who have Sex with Men
NGO:	Non-Governmental Organization
NGO-FS:	NGO-Field Supervisor
OD:	Operational District
OW:	Outreach Worker
PASP:	Provincial AIDS and STI Program
PHD:	Provincial Health Department
PLHIV:	People Living with HIV
PNTT:	Partner Notification, Tracing and Testing
TB:	Tuberculosis
TG:	Transgender
VCCT:	Voluntary Confidential Counseling and Testing
VL:	Viral Load
VHSG:	Village Health Support Group
WHO:	World Health Organization

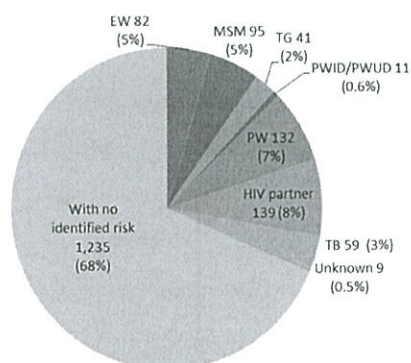
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## 1. INTRODUCTION

### Current HIV epidemic and HIV response achievements in Cambodia

- The National HIV program in Cambodia has been successful in reducing the HIV prevalence among adult general population from 1.7% in 1998 to 0.6% in 2016 with strong prevention programs, extension of HIV testing and the development of the continuum of care with an ART coverage rapidly reaching more than 80% PLHIV in need<sup>1</sup>. For those achievements, the country received a United Nations millennium development goal award in 2010.
- Cambodia's HIV program is now focusing on the UNAIDS 90/90/90 targets by 2020<sup>2</sup> and on achieving virtual elimination of HIV transmission by 2025 (defined by less than 3 new infections/100,000 populations and Mother-to-Child Transmission below 5%).
- As of end 2016, 70,498 people were estimated to be infected by HIV in Cambodia. Among them, 58,338 (83%) knew their HIV status and 56,754 of them (97%) were on ART<sup>3</sup>. According to these estimations, almost 12,000 PLHIV still don't know their HIV status in Cambodia, and program data suggests that almost 70% of the undiagnosed might be found among target populations within the general population (hidden KP, non-current KP with past cumulative risk of HIV infection, partners of KP, migrants...)<sup>4</sup>. (Figure 1).



**Figure 1:** Client type of newly identified PLHIV identified through B-IACM Jan-Dec 2016 for 27 operational districts (N = 1,803)

- Regarding Key Populations (KP) based on KHANA programme reports from implementing partners during the period of January 2014 to June 2015, only 55% of 37,185 identified FEWs, 40% of 13,431 identified MSM, 27% of 1,829 identified TG women, 53% of 5,566 identified PWUD and 43% of 376

<sup>1</sup> <http://www.unaids.org/en/resources/presscentre/featurestories/2010/september/20100920fsmgdcamboda-award/>

<sup>2</sup> National Health Sector Strategic plan for HIV and STI control (2016-2020), draft

<sup>3</sup> Spectrum/AEM modelling 2016

<sup>4</sup> Report on an assignment for Operationalization of the Active Case Management and Partner Notification, Tracing and HIV Testing before nationwide scale-up under the Global Fund new grant M.C. Vun & P. Godwin, June-December 2015



identified PWID actually received community-based finger prick HTC. Among them, HIV positivity was low (0.7%, 0.6%, 1.6%, 0.6%, and 6.1% among FEWs, MSM, TG women, PWUD and PWID respectively). This suggests that HTC coverage of KP could be improved and that hard-to-reach KPs potentially at high risk of HIV infections are not currently reached.

- This epidemic picture emphasizes the critical need to strengthen strategies aimed to identify still unknown PLHIV among KPs and general targeted populations in the communities, and to tackle the burden of health providers working with PLHIV on ART.

### **Current HIV response interventions within the communities in Cambodia**

- In support to the Cambodian 3.0 initiative, streamlined Continuum of Prevention, Care, and Treatment (CoPCT) approach was developed including sharpened responses to higher risk KPs and maximizing access to community- and facility-based HIV testing and retention in prevention and care <sup>5</sup>.
- Following the implementation of Integrated Active Case Management (IACM) under operational district (OD) leadership to maximize patient retention across HIV cascades, a streamlined Boosted-IACM (B-IACM) approach was designed in 2015 with the Identify-Reach-Intensify-Retain (IRIR) operational strategy for hard-to-reach KPs through Boosted-CoPCT (B-CoPCT) and targeted general populations through community-based prevention, care and support (CBPCS)<sup>6,7</sup>.
- The objectives of IRIR operational strategy are to strengthen case detection among KPs and targeted general populations and improve HIV cascade outcomes by focusing on PLHIV in need through the revised CBPCS model <sup>8</sup>.
- The B-IACM/PNTT including IRIR strategy was initially piloted and evaluated in 2 ODs in Siem Reap and Battambang in 2015, and the B-IACM/PNTT SOP was recently finalized.

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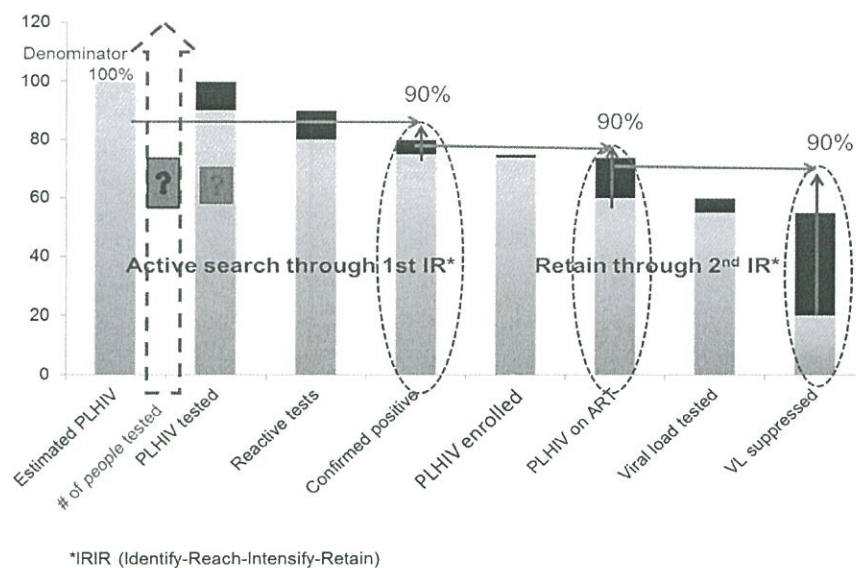
<sup>5</sup> Concept note on sharpening the B-COPCT for key populations at highest risk including IRIR approach, MOH approved 30/04/2014

<sup>6</sup> SOP on B-IACM/IRIR, 2017

<sup>7</sup> Rapid advice on operationalizing Identify, Reach, Intensify, Retain (IRIR) for Hard-to-Reach key Populations, NCHADS, Oct 2015 (signed by implementers)

<sup>8</sup> Concept Paper Streamlining the Community-based Prevention, Care and Support (CBPCS) Model for People Living with HIV in Cambodia, draft Nov 2015

**Figure 2: Strategic approach to B-IACM/PNTT at PHD level toward achieving 90-90-90 targets by 2020**



**Community workers involved in B-CoPCT among KPs and in CBPCS for PLHIV and targeted general populations**

Currently in Cambodia, peer and lay counsellors are actively involved under the B-IACM/IRIR strategy to identify and reach still unknown PLHIV and provide support to KP (including prevention package as described in SOPs of B-CoPCT) and PLHIV in the community. More specifically under the IRIR strategy (described in B-IACM's SOP), they are involved to provide the following services in the community:

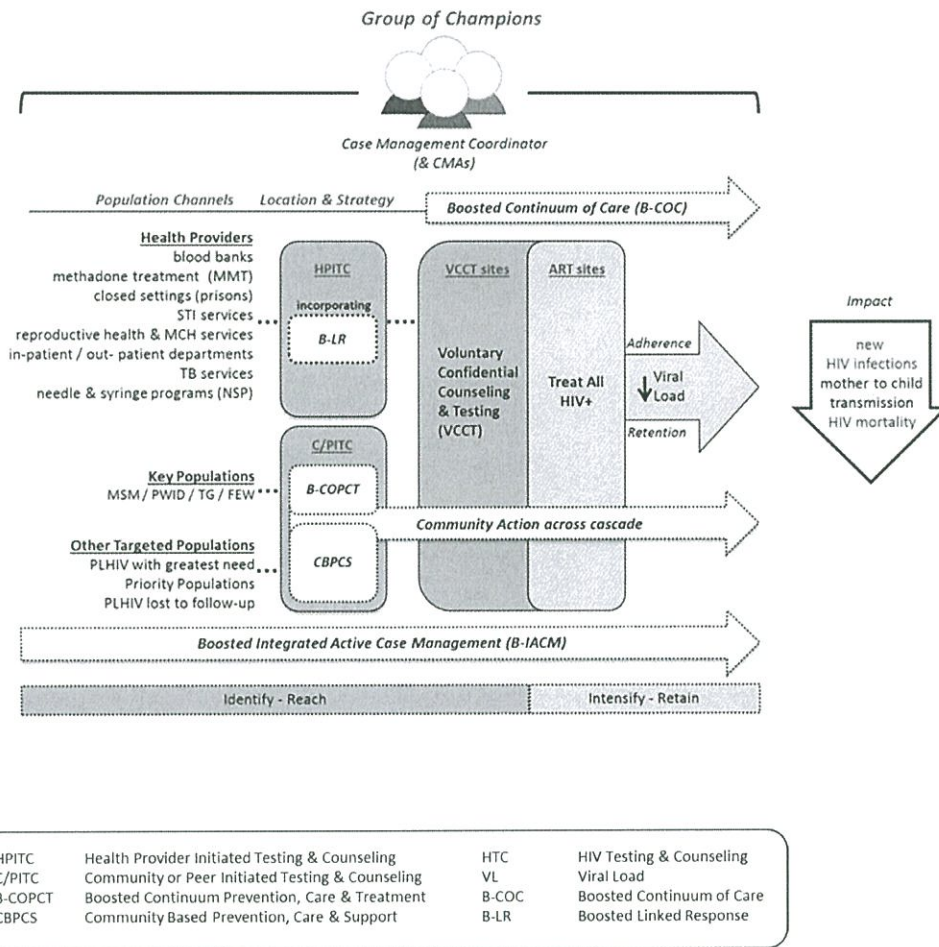
- ✓ While implementing B-CoPCT among KPs, peer and lay counsellors <sup>9,10</sup>:
  - Provide finger prick HIV testing at hotspots and in communities (outreach HTC, PDI+, Snowballing), refer reactive cases to VCCT for confirmation and inform CMC/CMA of reactive cases;
  - Refer and follow up HIV+ KPs in greatest need (support for transportation cost) for ART enrolment and follow-up visits to retain them in care with VL suppression;

<sup>9</sup> Concept note on sharpening the B-COPCT for key population at highest risk in Cambodia, NCHADS/MOH, April 2014

<sup>10</sup> Rapid advice on operationalizing Identify, Reach, Intensify, Retain (IRIR) for Hard-to-Reach key Populations, NCHADS, Oct 2015 (signed by implementers)

- ✓ Under CBPCS among targeted general populations, lay counsellors <sup>11,12,13,14</sup>:
  - Provide finger prick HIV testing among targeted general populations within the community, refer reactive cases to VCCT for confirmation and inform CMC/CMA of reactive cases;
  - Refer and follow up PLHIV in greatest need (transportation cost) for accessing ART services and retain them in care with VL suppression .

**Figure 3: B-IACM showing B-CoPCT and CBPCS as key components of Community Action across the HIV cascade**



<sup>11</sup> SOP on B-IACM/IRIR, draft 2017

<sup>12</sup> addendum letter of MOH on community finger prick HIV testing among general population

<sup>13</sup> Rapid advice on operationalizing community based prevention, care and support (CBPCS) to support the boosted integrated active case management-partner notification, tracing and testing (IACM-PNTT) approach at the OD level in Cambodia, draft

<sup>14</sup> Concept Paper Streamlining the Community-based Prevention, Care and Support (CBPCS) Model for People Living with HIV in Cambodia, draft Nov 2015

## 2. RATIONALE ON CONSOLIDATING COMMUNITY ACTION IN CAMBODIA

- With the ambitious objective of eliminating new HIV infections by 2025 in a context of more constraint financial resources while implementing “Treat All Strategy”, the national program in Cambodia is focusing on the most efficient interventions to detect remaining HIV positives and reduce burden at ART facilities.
- Based on recent evidence from many HIV programs, WHO now recommends the introduction of innovative cost-effective and efficient strategies with active community involvement like decentralisation, task shifting and differentiated care with community-based ART delivery to maintain or improve outcomes at lower cost while reducing the burden at the facility level <sup>15</sup>.
- For Cambodia, consolidating community action will contribute to addressing specific needs to control the epidemic and provide lifelong ART to all PLHIV:
  - To further improve targeting of KPs as well as targeted general populations (hidden KPs, partners or ex-partners of PLHIV or KPs, migrant workers ...) and priority populations, including pregnant women, TB patients... by streamlining and sharpening the community intervention according to the IRIR operational strategy;
  - To reinforce reaching and testing those who still do not know their HIV status within the KPs but also within the general population and link them to HIV care;
  - To improve retention and adherence along the HIV cascade by promoting adherence and reducing loss to follow-up after ART initiation through close follow-up of ART patients within the community in link with B-IACM;
  - To improve access to Health Equity Fund (HEF) for PLHIV;
  - To improve community support to those with greatest needs who are still non-stable on ART, by providing them with specific HIV packages;
  - To reduce HCP workload at ART facilities, improve the quality of life for PLHIV and reduce PLHIV transport costs by reducing the frequency of visits to the ART facility for stable PLHIV and introducing community ARV delivery.

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<sup>15</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, WHO, 2nd ed. 2016

### **3. OBJECTIVES OF THE CONSOLIDATED FRAMEWORK FOR COMMUNITY ACTION**

#### 3.1. General objective

- The overall goal is to provide consolidated community support to PLHIV in Cambodia to detect all undiagnosed PLHIV (first 90) by promoting HIV counseling and testing at the community for people who still do not know their HIV status and and to improve HIV cascade outcomes through retaining PLHIV along the HIV care cascade, improving ART adherence and achieving continuous VL suppression among PLHIV by focusing on PLHIV in greatest need and implementing differentiated HIV care for stable PLHIV (second and third 90).

#### 3.2. Specific objectives

- To increase awareness within the communities of HIV testing and counseling as well as value of early detection and immediate ART;
- To increase accessibility to HIV testing and counseling services with high confidentiality at community levels for reaching all PLHIV who still don't know their HIV status (Identify-reach) among KP under the B-CoPCT and among targeted general populations under CBPCS;
- To adapt existing support for PLHIV in greatest need in order to decrease loss to follow up and improve adherence to achieved VL suppression to all PLHIV (Intensify-Retain);
- To introduce differentiated care including community ARV delivery for stable PLHIV on ART.

### **4. COMMUNITY ACTION FRAMEWORK TO OPERATIONALIZE THE IRIR STRATEGY**

Community actions have already been part of the HIV response in Cambodia, but needs to be consolidated to optimise impact of the IRIR operational strategy among KPs and targeted general populations:

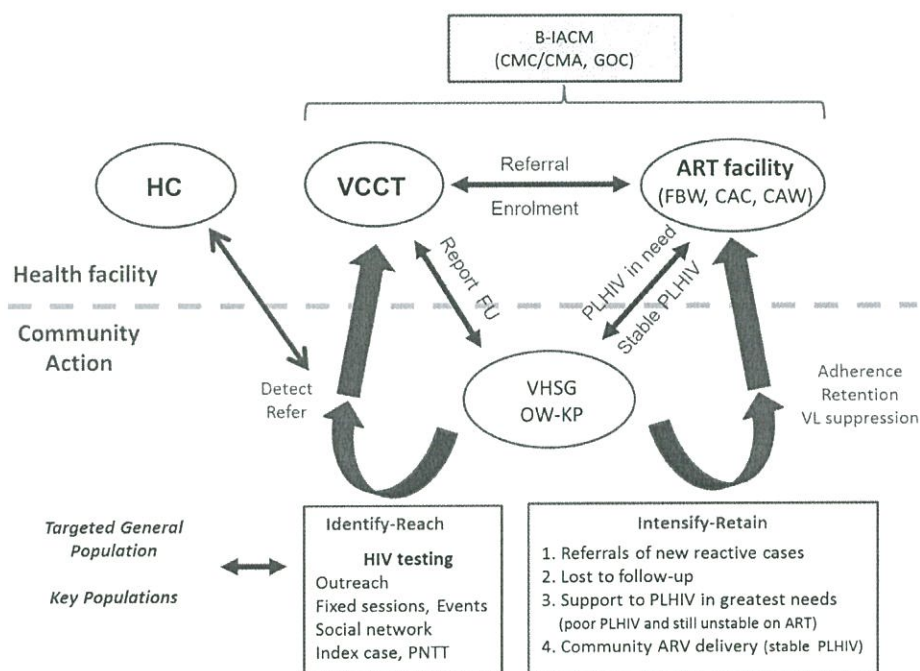
- For KPs, Community Action will be provided by NGO peer workers, including Outreach Workers (OW) and NGO-Field Supervisors (NGO-FS), in charge of implementing Boosted-Continuum of Prevention, Care, and Treatment (B-CoPCT) and operationalizing the IRIR strategy (Figure 4).

- For PLHIV in greatest need and other targeted general populations, Community Action will be conducted by PLHIV community peer workers from Community Support Organisations (CSO), like AUA, CRS and CPN+, based at ART sites, while implementing CBPCS and operationalizing the IRIR strategy (Figure 4). They will be **based at ART facilities** to contribute to the every-day functioning of ART centres and the coordination between patients and health care providers. They will comprise Facility-Based Workers (FBW), Community Action Counsellors (CAC) and Community Action Workers (CAW), whose respective roles are the following:
  - FBW contribute to the everyday functioning of ART site as part of the ART team in charge of triage activities (including vital sign taking), patient files management, appointment organization, miss-appointment identification, referrals and lab results management.
  - CAC are providing support to patients with individual or group educational counselling sessions on HIV, ART adherence and Viral load testing, promotion of immediate ART initiation (Treat All), partner testing and are following-up up those who miss an appointment or are LTFU.
  - CAW will be in charge of case management and support for PLHIV in greatest need (GN) according to the WHO definition of non-stable patient (see below). CAW will actively follow up non-stable PLHIV at ART sites to identify those in real need, refer poor PLHIV to HEF post identification to access ID poor, conduct eventual outreach activities if needed to provide effective support, follow-up those with poor ART drug adherence, miss-appointment issues or treatment failure together with CAC. In some sites, some CAW might be dedicated to support adolescent PLHIV. CAW will also link with communities and facilities to improve case detection in the community and link reactive cases to VCCT for confirmation and ART sites if confirmed HIV positive. They will be in contact with VHSG (key informants) and HC as well as other medical departments to encourage HTS, trace new cases (through linkage with hospital e.g. out-patients, in-patients, lab, maternity ward, etc.); support index testing/PNTT, and follow-up reactive cases in link with CMC/CMA under B-IACM.
- Finger prick testing will be provided at the communities (through KP community programs, Index case finding/PNTT and specific events for targeted general populations) to improve the detection of undiagnosed HIV positives (with the

collaboration of local key informants) and enrol them in HIV care (Identify-Reach) contributing to the first 90 of UNAIDS targets for 2020.

- In addition, Community Action will provide active support to PLHIV in greatest need and implement differentiated HIV care including visit spacing and introducing ARV delivery in the community for stable PLHIV to improve retention and adherence along the HIV cascade (Intensify-Retain) contributing to the second 90.
- Community Action will work closely with HC and VCCT for referrals and follow-up of new reactive cases and partner testing, and with ART facilities for identification and close follow-up of PLHIV in greatest need and for introduction of differentiated care for those stable on ART.
- Community Action will be implemented under the B-IACM/PNTT approach in close collaboration with CMC/CMA and the GOC at the OD level. As CMP, FBW/CAC/CAW working at ART facilities will contribute to the identification and follow-up of poorly adherent and treatment failure patients in coordination with CMA/CMC under B-IACM.

**Figure 4: Community Action Framework for operationalizing the IRIR strategy**



#### 4.1. Identify and Reach PLHIV who still do not know their HIV status (first 90):

The Identify-Reach component of the IRIR operational strategy aims to improve coverage of HTC within the community to better identify and reach PLHIV who still do not know their HIV status and link them to HIV care for immediate ART initiation (Treat All strategy).

##### 4.1.1. Identify-Reach strategy for hard-to-reach KPs <sup>16,17</sup>:

- Important challenges for reaching high risk KPs mainly relate to confidentiality and privacy issues, as well as lack of confidence and trust in OW.
- Some measures to implement Identify-Reach have been described previously<sup>16</sup> (see below implementation arrangements).
- This framework aims to facilitate the implementation of the Identify-Reach strategy at scale in each OD (optimizing geographical coverage) and to propose some additional innovative measures.
- Some new interventions should be implemented or reinforced to further improve HIV case finding among high-risk KPs and link them to care:

##### Proposed measures to operationalize the Identify-Reach strategy for KPs:

- Extend **social network approaches** (snowball and peer-driven) to KPs (MSM, TG women, PWID) in each OD according to the proposed concept note
- Effective use of social media to reach hidden KPs and encourage HIV testing
- Conduct index case finding and Partner Notification Tracing and Testing (PNTT)
- Introduce HIV **self-testing** for specific KPs at higher risk when national guidance is available

##### 4.1.2. Identify-Reach strategy for targeted general populations:

- In close link and collaboration with local authorities (village chief, Mekrom) and village health support group (VHSG) as key informants, CAW will work to raise awareness for HTC among targeted general populations and increase accessibility to HTS services (including NGO and public health facilities like HC and VCCT) either through proper referral or by organizing HTC during special community events. Indeed, HTC could be offered during specific co-organized

<sup>16</sup> Concept note on sharpening the B-COPCT for key population at highest risk including IRIR approach, MOH approved 30/04/2014

<sup>17</sup> Rapid advice on operationalizing Identify, Reach, Intensify, Retain (IRIR) for Hard-to-Reach key Populations, NCHADS, Oct 2015 (signed by implementers)



events or at specific locations with agreement and support of local authorities and VHSG and in collaboration with implementing partners in the area.

- Currently **targeted general populations** within the community which should be proposed HTC are:
  - Patients (any age) with chronic symptoms suggesting HIV infection and their partners (or former partners);
  - TB, STI, viral hepatitis patients who have never been tested for HIV before
  - Index cases, partner(s) or former-partner(s) of PLHIV or KPs;
  - Pregnant women who never came to ANC or were never tested for HIV;
  - Vulnerable populations:
    - Migrants within Cambodia (in-country migrants) and migrants to other neighboring countries (out-country migrants);
    - Other potential vulnerable populations based on evidences from on-going program data and research projects (dashboard, new HIV case profiling, case-control study...) aiming to better understand who are the PLHIV who still do not know their HIV status in Cambodia.
- When HIV positive cases are confirmed and enrolled in ART care, CAW will work with VHSG to conduct index case finding and PNTT in the community.

#### 4.2. **Intensify and Retain strategy to improve retention, adherence and viral load suppression of PLHIV on ART along the HIV cascade (Second and third 90)**

The Intensify-Retain of the IRIR operational strategy aims to strengthen access to HIV services for newly identified PLHIV and ensure high rate of retention and viral suppression for all PLHIV (either KPs or general population) in the community through:

1. Strengthening **referrals of all new reactive** cases (found during outreach activities, HTC events in communities, at HC or other medical departments) to VCCT for confirmatory test in collaboration with CMC/CMA under B-IACM
2. **Reducing the rate of lost PLHIV** by reaching those who miss appointments or are lost-to-follow-up at ART facilities in collaboration with CMC/CMA under B-IACM;
3. **Ensuring that poor PLHIV** have access to HEF post-identification to obtain ID poor for transportation support;
4. Providing adapted **package to PLHIV in greatest need**;
5. Introduce differentiated care for stable PLHIV on ART including **visit spacing and Community ARV Delivery (CAD)**.

- **The PLHIV in greatest need** include those who are **not yet stable on ART** (according of WHO criteria of stability on ART<sup>18</sup>, see below), **HIV-positive children (0-5 years-old) and adolescents**

**PLHIV in greatest need** are defined as those who:

- Are not stable according to WHO criteria<sup>19</sup> for stability (see below)
- Rapidly growing children (0-5 year-old)
- Adolescents

- **PLHIV stable on ART** are defined in the recent WHO HIV guideline<sup>19</sup>:

**Stable PLHIV on ART** are defined as those who:

- have received ART for at least one year and
- have no adverse drug reactions that require regular monitoring and
- have no current illnesses and
- are not pregnant or currently breastfeeding and
- have good understanding of lifelong adherence and
- have evidence of treatment success i.e. :
  - Two consecutive viral load measurements undetectable (<1,000 copies/ml)

- All PLHIV in greatest need will be followed and monitored by either CAW or CAC at ART sites to identify those who have problems and need specific support, counselling and/or intervention (eventually through outreach).
- **Introduction of differentiated care** for stable PLHIV on ART in Cambodia including:
  - Yearly VL monitoring with cessation of CD4 count monitoring according to recently revised Cambodian ART guidelines<sup>19</sup>;
  - Reduced clinical visit frequency at ART facility to every 3 - 6 months as per National ART guidelines;
  - Reduced ARV pickup visits to every 3 - 6 months;
  - Voluntary access to community-based ARV delivery where implemented.
- **Community ARV delivery (CAD) for stable PLHIV on ART:**
  - CAD is a new service delivery intervention recently recommended by WHO<sup>20</sup> to alleviate the obstacles patients encountered in accessing ART facilities to get their treatment and reduce transportation costs, improve the retention in care, and reduce burden for ART facilities. Different models have been

<sup>18</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, WHO, 2nd ed. 2016

<sup>19</sup> National HIV clinical management guidelines for Adults and Adolescents, MoH, Aug. 2016

<sup>20</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, WHO, 2nd ed. 2016

described including appointment spacing for clinical and drug refill visits, peer educator-led ART refill groups, community ART distribution points, and patient-led community ART groups <sup>21</sup>.

- In Cambodia, CAD could be interesting for patients living far from ART delivery centers. The CAD model(s) for stable PLHIV in Cambodia is/are not yet fully defined. Community Volunteers (CAW, CAC) and NGO Field Supervisor (NGO-FS) could play a role in providing ARV for stable PLHIV within the general population or among KPs, respectively. Models suitable for PLHIV situation in Cambodia will be described through specific SOP to facilitate its implementation.
- Below are some principles for CAD implementation:
  - CAD should be available on a voluntary basis to stable PLHIV on ART depending on their needs (living far from ART sites).
  - At any time, patients in CAD care could opt and return to standard care and follow-up.
  - CAD will have to be implemented in collaboration with CMC/CMA and GOC under B-IACM/PNTT.
  - Stable patients on ART should be identified by the ART management team using recent WHO criteria <sup>20</sup>

## **5. IMPLEMENTATION ARRANGEMENTS FOR COMMUNITY ACTION**

### **5.1. Implementation of Identify-Reach Strategy among KP (1<sup>st</sup> 90)**

#### **5.1.1. The Modified Outreach Model to Identify-Reach among KPs**

- Implementing partners working with KPs under the B-CoPCT's SOP will implement Community Action for KPs at the OD level;
- OW working with KPs will be trained to provide quality finger prick HTC;
- Finger-prick HTC by OWs will be done at places where KPs gather or arrange such as entertainment venues, street-based hotspots, community locations where KPs have prevention sessions, private residences;
- OW will work full-time under the supervision of NGO-FS;
- OW KPs case-load will be defined according to the local situation;
- NGO-FS will work in collaboration with CMC/CMA and the GOC at the OD level.

### 5.1.2. The Social Networking Approaches

- Implementing partners will implement social networking approaches to identify hidden and hard-to-reach KPs who have not been tested within the last year.
- Social Networking Approaches include the peer driven intervention (PDI+) and snowballing. The concept is to provide KPs or PLHIV with coupons to recruit other KPs who have not been tested within the last 12 months. KPs with coupons will go to a nearby community-based testing site for HTC and in turn will be offered coupons to recruit other KPs. Recruiters will receive a small incentive for successful recruitment.
- Details of how to implement social networking approaches will be provided following current pilot implementation and guidance.

### 5.1.3. Virtual Outreach through the use of social media and high technology

This is a new promising approach which allows virtual outreach through:

- Outreach through hook-up websites (such as Grindr or boyahoy for MSM): Implementing partners put messages onto such sites or have outreach workers reach out to nearby KPs they “see” on hooking-up websites and provide information regarding testing.
- *Mobile-Link* (SMS/VM) or on-line counseling whereby outreach workers do not go out but answer phone calls or chat on-line with KP and encourage/refer for testing.

### 5.1.4. The following Identify-Reach activities will have to be reinforced and implemented at scale in each OD:

#### Reinforcing at scale the following measures<sup>16, 17, 22</sup>:

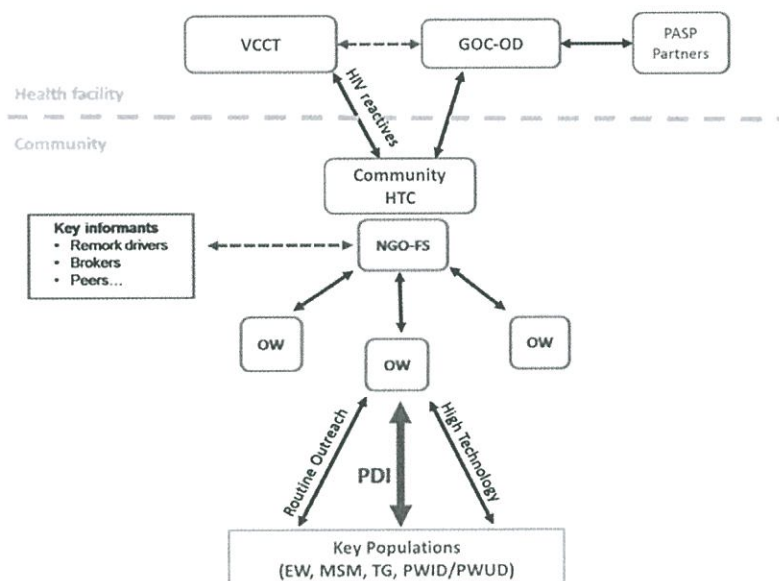
- Identify the appropriate and preferred **locations including physical and virtual hotspots and venues** to reach each KPs.
- **Raise awareness** of HIV testing and the value of early detection and treatment at KPs locations.
- Adapt the **timing** of outreach and service provision activities to each KP venue and hotspot setting up appointments when possible.
- Use innovative approaches for Index case finding and **partner** notification, tracing and testing (PNTT) for KPs.
- Build **linkages** with relevant KP networks and other key informants for setting-up appointments with KPs and improve HTC coverage.

- Build **confidence and trust** with each KP by:
  - Recruiting fewer but more qualified peers with health/promotion counselling skills who know the local context and provide full time employment;
  - improving the quality of HTC through continuous strengthening capacities and counselling skills of OW, and quality assurance processes;

**Extending and introducing innovative measures:**

- **Extend social network approaches** like snowball and peer-driven Intervention (PDI+) to all high-risk KPs (MSM, TG women, PWID) **at scale** according to the proposed concept note.
- Effective use of social media to reach hidden KP and encourage HIV testing.
- Conduct Index case finding and Partner Notification Tracing and Testing (PNTT).
- Introduce **Self-testing for specific groups** when national guidance is available.

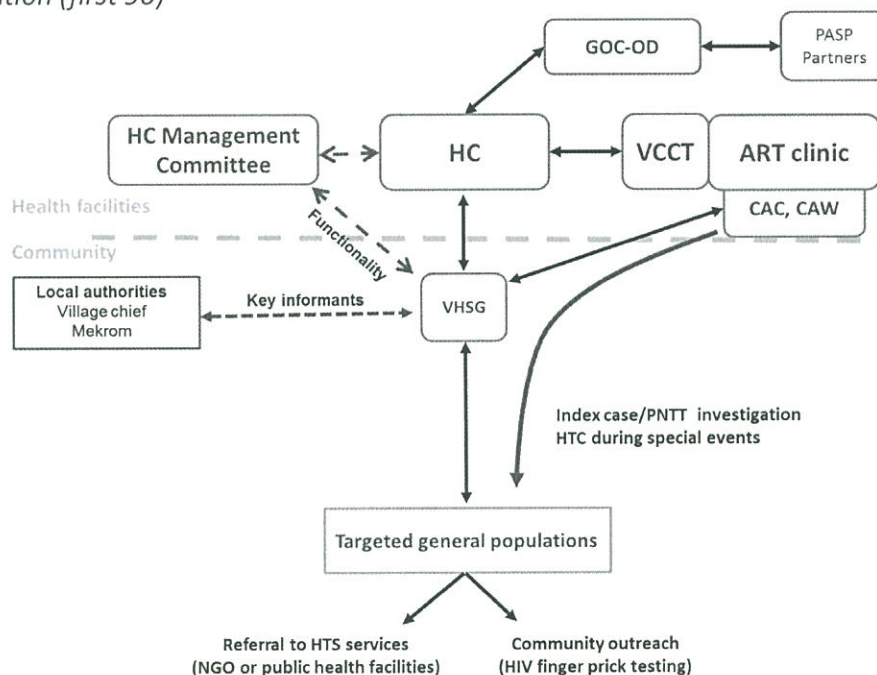
**Figure 5: Implementation of Identify-Reach strategy among KPs (first 90)**



## 5.2. Implementation of Identify-Reach strategy for Targeted General Population (1<sup>st</sup> 90)

- CAC and CAW based at ART facilities will work closely with VHSG as key informants to identify targeted general population which should be proposed referrals to HTS and to conduct index case finding and PNTT when HIV positive cases are identified (with respect of confidentiality).
- VHSG will work in collaboration with HC management committee and local authorities as key informants to identify targeted general populations in their areas and propose them to access HTC at health facilities (HC, VCCT) or NGO.
- CAW with VHSG could also organize relevant events and/or locations for offering confidential finger-prick HTC through community outreach to targeted general populations in collaboration with NGO-FS from local NGO working in the area (Figure 6).
- To build strong relationship and respecting patients confidentiality, local authorities will be informed about targeted general populations through:
  - Regular HC management committee meetings;
  - Informal meetings and discussions between VHSG and village chiefs or mekroms;

**Figure 6:** Implementation of Identify-Reach strategy among targeted general population (first 90)



- Thus, CAW will have to implement the following Identify-Reach activities according to the IRIR strategy:

- Work closely with VHSG and the local authorities (village chief/Me-Krom) to identify and map the **targeted general populations**, and refer them for HTS at NGO or public health facilities (HC, VCCT);
- With VHSG and local authorities, CAW will organize specific events/locations to propose HTC to targeted general populations in collaboration with NGO-FS;
- Develop a quarterly plan for organizing **special events** (New Year/Pchum Ben/specific session) to propose **HTC outreach** sessions at pagoda or other appropriate locations to targeted general populations;
- Organize regularly HTC outreach events based on work plan in collaboration with NGO working in the area ensuring **high confidentiality** at commune level
- In collaboration with VHSG perform index case finding and PNTT when HIV positive cases are identified;
- **When organizing HTC outreach event, will refer** clients with reactive test result for confirmation at a nearby VCCT and inform CMC/CMA and use the 115 hotline to signal HIV reactive cases (when available).

### 5.3. Implementation of Intensify-Retain strategies for PLHIV (2<sup>nd</sup> & 3<sup>rd</sup> 90)

#### 5.3.1 Strengthen referral of all new reactive cases to VCCT for confirmatory test

- NGO OW for KPs in collaboration with NGOs field will ensure that all newly identified HIV reactive people access VCCT for confirmatory test and enroll immediately at ART services once confirmed HIV positive.
- CAW for targeted general populations in collaboration with health facility staff at HC or other medical departments as well as with NGO staff providing HTC to targeted population in the community will ensure that all newly identified HIV reactive people access VCCT for confirmatory test and enroll immediately at ART services once confirmed HIV positive (Figure 7).
- Both NGO OW for KPs and CAW for targeted general populations need to signal any HIV reactive case (using 115 hotline) and collaborate actively with CMC and CMA under B-IACM/PNTT approach at the OD level to follow up each HIV reactive cases.

#### Follow-up all new HIV reactive cases:

- Build effective **linkage system** to support all newly HIV reactive cases to access VCCT for confirmation and enroll in ART service including by accompanying clients, using referral slip/UIC cards and providing support for transportation if necessary.
- Use the 115 hotline to signal HIV reactive cases (when available).
- Work closely with CMC/CMA and CMB/CMS as well as CoC members to provide

### 5.3.2 Reduce the rate of lost PLHIV by reaching those with missed appointments or lost-to-follow-up

- CAC/CAW, for general population and OW-KP for KPs will play a key role in tracing patients who had missed-appointments or were lost-to-follow-up to facilitate their reintegration in care.
- They will contribute to prevent miss-appointments by systematically reminding appointments for clinic visits and ARV delivery to PLHIV at risk of being lost.
- The identification of these PLHIV will be done in collaboration with CMC/CMA and ART facility team on a regular basis.

#### **Activities to prevent and reduce loss to follow-up:**

- Work with CMC/CMA/CMP at ART facility to get the list of PLHIV with miss appointments or who are lost to follow up (LTFU) on a monthly basis;
- Work with village chief and VHSG considering confidentiality issues about miss-appointment or LTFU cases to reach them in the community for re-enrollment and retention in ART care;
- Provide regular appointment reminders to clients who have been lost to follow-up before or are at risk of being lost.

- Updated definition of Lost-to-follow-up patients on ART <sup>21</sup>:

#### **Lost to follow-up (LTFU):**

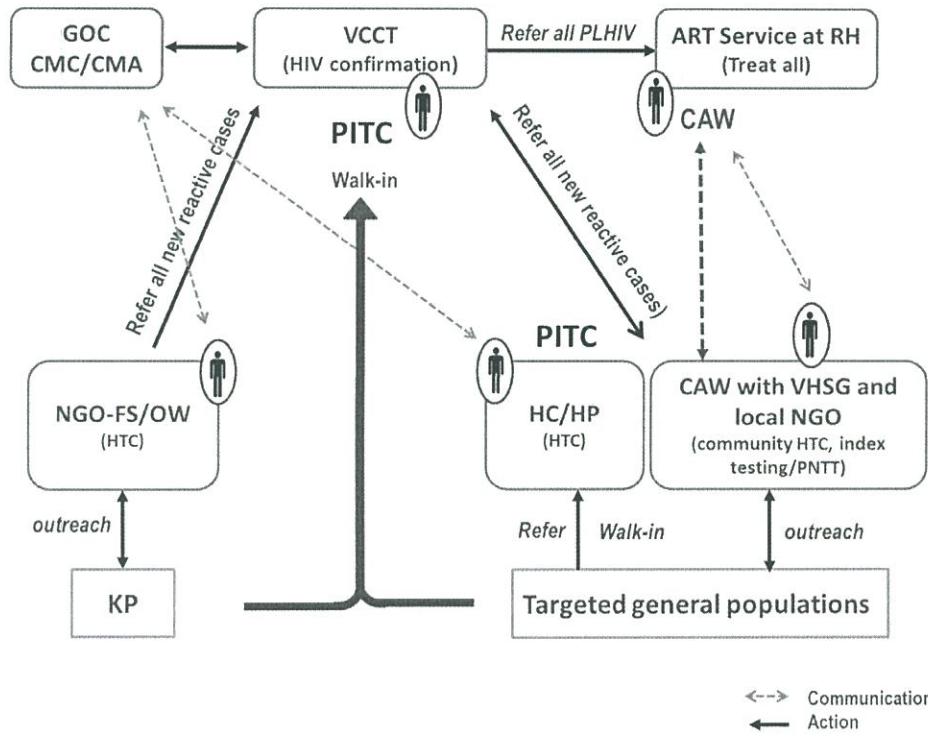
Patients are considered LTFU if they did not come to the clinic **more than 90 days after next appointment**

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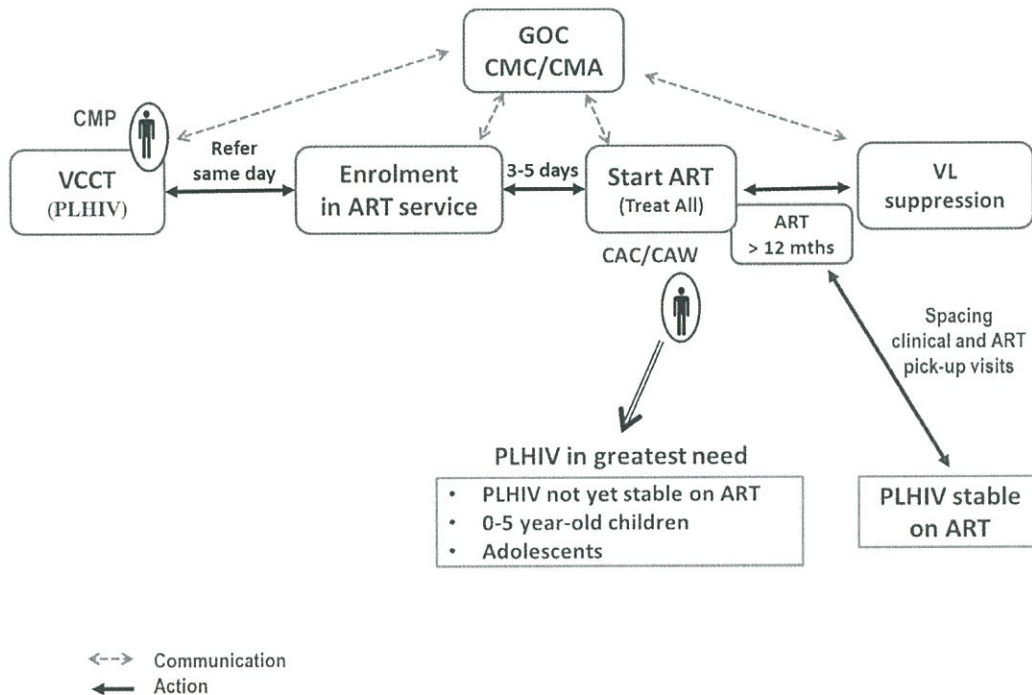
<sup>21</sup> NCHADS letter number 0146 to all physicians to provide ART services to adults, adolescents and children informing about ART, appointment and definition of lost to follow-up, 10 February 2017



**Figure 7:** Strengthen referral of all new reactive cases to VCCT and all confirmed HIV positive to immediate enrollment on ART



**Figure 8:** Linkages and interventions to reduce the rate of the lost PLHIV along the HIV cascade:



### 5.3.3 Provide adapted package for PLHIV in greatest need:

- PLHIV in greatest need include unstable PLHIV on ART, 0-5 year-old children and adolescents.
- Identification of PLHIV in greatest need will be done by the ART management team and communicated to community workers on a regular basis.
- The overall goal is to ensure good adherence to ARV drugs and long term retention along HIV care cascade with viral load suppression.
- All PLHIV in greatest need will be followed and monitored by CAW/CAC to identify those who have problems and need specific support, counselling and/or intervention (eventually through outreach).
- For PLHIV not stable on ART, CAC/CAW will implement the following activities in their areas:

**CAW/CAC will contribute to ensure retention in care and lab test uptake of PLHIV in greatest need by:**

- Working with CMC/CMA and CMP at health facilities to list PLHIV in greatest need in their catchment area.
- Identifying those who have real problems and need specific support, counselling and/or intervention (eventually through outreach).
- Educating PLHIV in greatest need on the importance of regular CD4 and/or viral load.
- Few days before, remind PLHIV with previous miss appointments or loss to follow-up.

### 5.3.4 Implement Differentiated care for stable PLHIV on ART including Community ARV Delivery (CAD)

- CAC/CAW will work with ART facility to identify stable PLHIV and implement the spacing of clinical and ARV pick-up visits to avoid miss appointments.
- CAD could be introduced under community action for stable PLHIV who might benefit from it.
- Community Volunteers (CV), CAC/CAW for targeted general populations and NGO-FS for KP could play a role in providing ARV for stable PLHIV (see Appendix 4).
- However, the CAD model(s) for stable PLHIV in Cambodia is/are not yet defined. CAD models suitable for PLHIV situation in Cambodia will be described through specific SOP to facilitate implementation.

#### **5.4. Steps for implementing Community Action**

The following steps will be needed for Community Action implementation by CSOs, NGO-KP and Health facility teams under PASP coordination:

1. Identify community peer volunteers at ART sites (FBW, CAC, CAW) and OW for KPs;
2. Formation of Community Action team by CMC/CMA and NGO partners with HC Management Community and VHSG under B-IACM;
3. Training of community team;
4. Identification of key informants and supporters of confidentiality at commune and village levels;
5. Site identification for special events proposing finger prick HTC and community ARV delivery where implemented in the community;
6. Development of TOR for NGO-FS and VHSG as well as for FBW, CAC and CAW;
7. Development of letter of agreement between health facilitator and Community Action team (NGO-FS/VHSG) as part of the B-IACM process;
8. Development (for CAD) or provision of existing (for HTC) tools, monitoring forms/register, manuals and job aid;
9. Implementation of M&E tools and reporting for Community Action;
10. CA team to attend regular GOC meetings (PASP/GOC, NCHADS) and monitoring/mentoring activities under B-IACM;
11. Development of implementation plan and national road map for piloting and scaling-up Community Action in Cambodia in concordance with B-IACM scale-up roadmap.

#### **6. LOGISTIC SUPPLY MANAGEMENT FOR COMMUNITY ACTION**

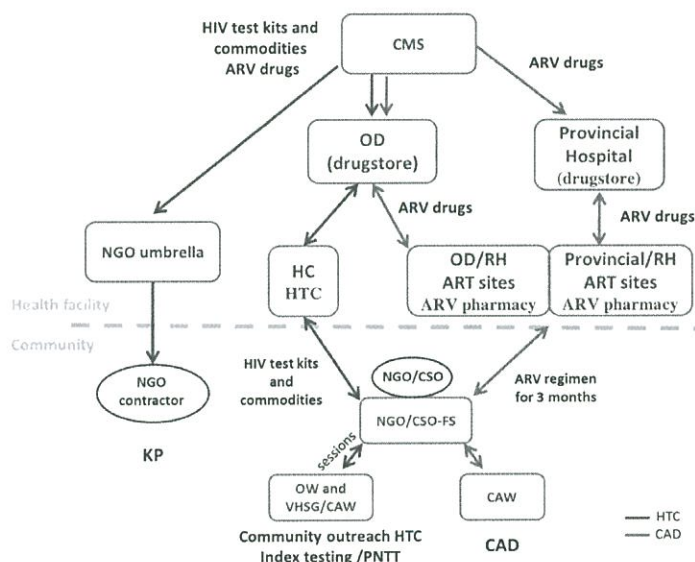
*HIV test kits and commodities (figure 9, red arrows):*

- HIV test kits and commodities are provided quarterly to OD drugstore by CMS to be distributed to HC for HTC;
- HC will also provide HIV test kits and commodities to NGO/CSO-FS of NGO/CSO to propose Index case finding/PNTT and/or outreach HTC during specific sessions in the community for targeted general populations as organized by CAW and VHSG;
- NGO-FS working on outreach HTS among KPs will get HIV test kits and commodities directly from CMS;

ARV drugs (figure 9 green arrows):

- ARV drugs are provided quarterly by CMS to PHD drugstore for PHD RH and to OD drugstore directly for OD ART sites at RH;
- For CAD model involving CSO-FS and CAW, CSO-FS could collect pre-packaged ART at the nearby ART facility for all the stable PLHIV enrolled on CAD under their responsibility and provide pre-packaged ART regimen to CAW for CAD.

**Figure 9:** Supply chain management for Community Action (CAD shown as an example)



## 7. COORDINATION AND SUPERVISION

CA activity at ART sites will be coordinated and under the supervision of the ART team leader. CA for KP will be coordinated by the GOC under B-IACM.

*Regular meetings:*

- All partners working on CA (NGO-KP and CSOs) will attend regular GoC meetings as described in B-IACM SOP.
- CSOs at ART site will also attend regular meetings held by the ART team.

*CAD supervision and management (principles):*

- A LoA will be needed between ART management team and Community Action team to implement community ARV drug delivery;

- CAD supervision of CAD providers will be conducted by the ART management team in link with Group of Champion (GoC) under B-IACM.
- Regular meetings will be held at ART facilities between CAD providers and ART management team in link with GOC and B-IACM to:
  - Identify stable PLHIV on ART;
  - Report about the monitoring of PLHIV on CAD;
  - Identify any problems and discuss with counsellors and HCP about solution;
  - Report and discuss adverse events such as death or defaulting.
- Quality assurance and monitoring of confidentiality and ARV drug delivery at community levels will be conducted in collaboration with Case Management Coordinators, CSO staff, and ART management teams.

## **8. MONITORING & EVALUATION OF COMMUNITY ACTION**

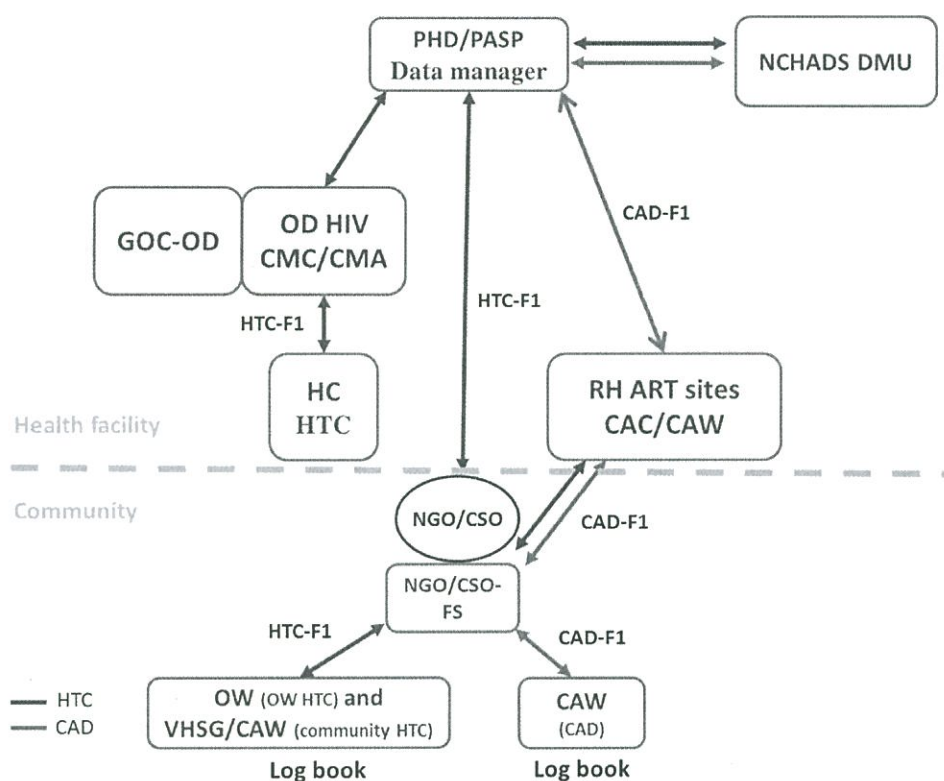
Community Action data to operatize IRIR, including differentiated care, will be collected and reported by each OW and CAW to NGO/CSO-FS and then to PHD/PASP (new reactive cases) and ART site (new enrolments, CAD patients) and shared with GOC under B-IACM.

### **Reporting Flow of HTC activities and Community Action CAD (figure 10)**

*For HTC activities:*

- NGO/CSO-FS will compile HTC-F1 from all OW and CAW under their responsibility and report regularly to PHD/PASP and ART facility;
- Each HC will report HTC activities using the HTC-F1 to OD/CMC/CMA who will report to PHD/PASP;
- PHD/PASP will compile HTC-F1 from NGO/CSO-FS and OD CMC/CMA to report provincial HTC activities to NCHADS DMU;
- The performance against community action indicators will be shared with GOC under B-IACM during GOC meeting by NGO/CSO-FS.

**Figure 10: Reporting system for Community Action (HTC and CAD implementation)**



*For CAD in a model involving CSO-FS and CV:*

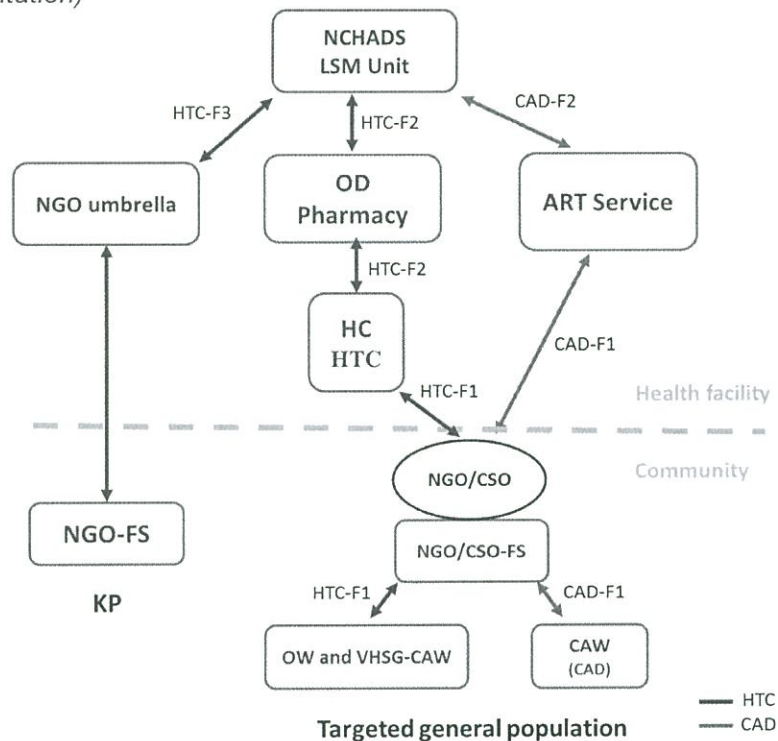
- CAW will submit a report using the CAD-Form 1 (CAD-F1), which includes longitudinal clinical data of each client in particular clients referred to HTC, updated list of ART patients and ARV delivery, on a monthly basis to CSO- field supervisor;
- CSO-FS will then compile data CAD-F1 from each CAW supervised and submit to the ART sites. The data will be reviewed and reported periodically to PHD/PASP to be reported to NCHADS DMU;
- ART team will incorporate clients' information who received ART through CAD into the existing reporting and monitoring tools at facility level.

**Reporting Flow of logistic supply monitoring (figure 11)**

- For HIV test kits (red arrows in Fig.11) and commodities logistic supply, HTC-F1 from VSHG -CAW through NGO/CSO-FS will be compiled by HC for HIV test kits consumption for targeted general populations;
- HC will use the HTC-Form 2 (HTC-F2) to compile HC as well as report targeted general populations HIV test kits consumption to OD pharmacy;

- OD pharmacy will use the HTC-F2 from each HC to report OD HIV test kits and commodities consumption to NCHADS LSM Unit;
- NGO providing outreach HTC to KPs will use the HTC-Form 3 (HTC-F3) to report HIV test kit consumption directly to NCHADS LSM Unit ;
- For ARV drug logistic supply (green arrows in Fig.11), the CAD-F1 from CV through CSO-FS will be used to monitor ARV consumption through CAD and adapt ART site ART forecasting.

**Figure 11:** Logistic supply monitoring system (in case of VHSG option 2 and CAD implementation)

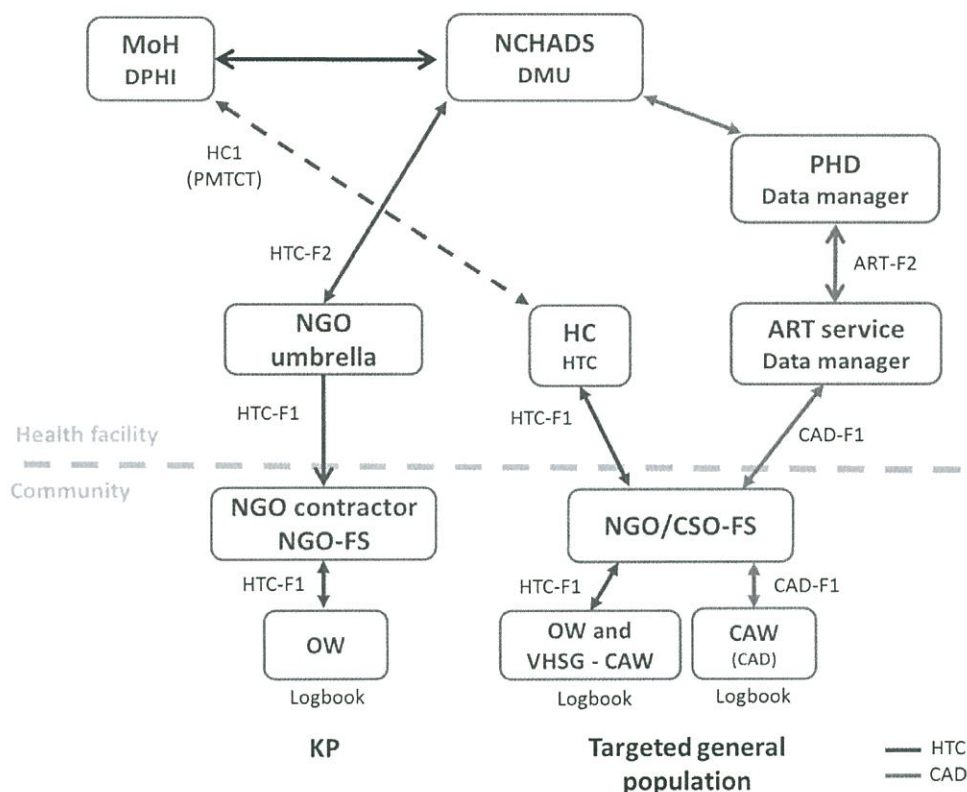


**Standard Recording:**

- CVs and NGO Field supervisors will use standardized facility- and community-based tools for monitoring and record keeping, including:
  - Registration form
  - Activity Logbook
  - Logistic supply management list
  - Monthly Reporting form for CV
  - Service Uptake Form
  - Monthly/Quarterly reporting forms for NGO field supervisor
- For CAD, a database to store client clinical information could be created and utilized by CAW and CSO field supervisors for easy data-entry, monitoring and

follow-up. This database will be linked to the ART clinic database and the client list will be periodically reviewed and an assessment is made on the level of 'stability' and 'need' of each client.

**Figure 12: Program monitoring system (reporting flow)**



### Patient consent and protection for CAD

- A number of basic securities should be put in place to ensure voluntary participation and patient data protection.
- From the beginning, participation in CAD is voluntary. At the start of the program, basic information about the CAD approach, including eligibility criteria and roles and responsibilities of CAD providers will be made available through information sessions in health facility waiting areas and in discussion with stable patients. At any time, patients in CAD care could opt and return to standard care and follow-up.
- No financial or material incentive will be provided for CAD.
- The CAD electronic database should be password-protected and locked and stored in a secure room according to normal standards.



- The program was formally approved by MoH and local health authorities.
- A number of processes are established to ensure the proper functioning of the groups. CAD members are encouraged to report to their clinicians or counsellors any serious problem experienced within a group, such as diversion or non-receipt of ARV drugs.
- Regular meetings are held between community members and health facilities to identify problems and find solutions.
- All adverse events such as death or defaulting will be investigated and documented.

### **M&E indicators for Community Action**

The following indicators will be monitored at the OD level through B-IACM and the GOC during the reporting period:

	<b>Key Indicators (during the period)</b>	<b>Level</b>
<b>1</b>	Number and % of HIV-reactive newly-identified patients among those finger prick tested (breakdown by KPs and targeted general population).	Output
<b>2</b>	Number and % of patients confirmed HIV positive at VCCT among those referred (breakdown by KPs and targeted general populations).	Output
<b>3</b>	Number and % of newly-confirmed PLHIV effectively enrolled at ART sites.	Output
<b>4</b>	Number and % of newly enrolled PLHIV at ART site who received ART.	Outcome
<b>5</b>	Number and % of PLHIV on ART who were in greatest need at the end of the reporting period.	Output
<b>6</b>	Number and % of PLHIV in greatest need who are retained in ART at after 12 months (whole OD).	Outcome
<b>7</b>	Number of stable PLHIV who received ART through CAD.	Output
<b>8</b>	Number and % of stable PLHIV who received ART through CAD who are retained in ART after 12 months.	Outcome
<b>9</b>	Number and % of PLHIV on ART followed by Community Action who are virologically suppressed at 12 months of treatment.	Outcome

## 9. APPENDIX

### Appendix 1: Terms of References (TOR) of NGO contractor (field supervisor) (NGO-FS) coordinating OW for KP

- Refer to B-CoPCT SOP

### Appendix 2: Model of Terms of References (TOR) of Community Action Worker (CAW):

- CAW will be in charge of case management and support for PLHIV in greatest need (GN) according to the WHO definition of non-stable patient (see below). CAW will actively follow up non-stable PLHIV at ART sites to identify those in real need and provide them with appropriate psycho-social and transportation support as needed eventually through outreach activities.
- CAW will follow-up PLHIV with miss-appointment issues which are at risk of being lost-to-follow-up as identified by CAC and FBW.
- CAW will also follow-up those with poor ART drug adherence at risk of treatment failure as identified by CAC and the ART team.
- CAW will follow PLHIV with detectable viral load to make sure they will attend their boosted adherence counselling sessions before being switched to another regimen.
- CAW will also follow closely those with confirmed treatment failure who were switched to second or third line regimen to make sure they fulfil their close follow-up and get a VL test at 6 months after initiation.
- CAW, will make sure poor PLHIV are being referred to HEF post identification to access ID poor
- CAW will also contribute to improve HIV testing at different levels:
  - At the facility level, by establishing close links and collaboration with health facilities, including Health Centres (HC) and other departments at the RH (out-patients, in-patients, lab, maternity ward, medical departments, surgery ward...) to improve case detection among patients reaching health services through H-PITC and contributing to make sure all reactive cases are referred to VCCT for confirmation and to ART sites if confirmed HIV positive.
  - At the community level, by establishing close contacts with VSHG (as key informants) and other community volunteers to encourage HTS among targeted general populations mainly through referral to the HC for finger prick testing. CAW will also work with VSHG to propose and organize HTC

sessions for targeted general populations at the community in collaboration with local NGO.

- Importantly, CAW will work at facility and community level to trace newly identified HIV cases and conduct quality index testing and PNTT according to the revised SOP.
- Both for PLHIV in greatest need and newly identified HIV reactive cases, CAW will work in close collaboration with CMC/CMA under B-IACM to ensure proper follow-up and data report.

### **Appendix 3: Model of Terms of References (TOR) of Community Action Counsellor (CAC):**

- CAC are providing support to patients with individual or group educational counselling sessions on HIV, ART adherence and Viral load testing, promotion of immediate ART initiation (Treat All), and Index testing/PNTT.
- Together with the ART team and/or FBW:
  - CAC will identify those with miss-appointment or poor ART drug adherence at risk of treatment failure and organize their close follow-up with CAW
  - CAC will also identify and organize with CAW the follow-up of PLHIV with detectable viral load to make sure they will be provided with true boosted adherence counselling before being switched to another regimen.
  - CAC will also follow closely those with confirmed treatment failure who were switched by the ART team to second or third line regimen to provide strong treatment counselling adapted to their new regimen.
- Both for PLHIV with poor adherence and those with detectable viral load, CAC will work with ART staff to ensure proper follow-up and data report to GOC.

**Appendix 4: Model of Terms of References (TOR) of Facility-Based Worker (FBW):**

- FBW will contribute to the everyday functioning of ART site as part of the ART team involved in:
  - Triage activities (including vital sign taking and TB symptom screening);
  - Patient files management, including laboratory result management;
  - Appointment organization, especially for stable patient as identified by the ART team to implement clinical and ART pick-up visit spacing according to Community Action SOP;
  - Referrals to other HIV services as needed (STI, FP, TB...).
- Together with the ART team and/or CAC:
  - FBW will identify those with miss-appointment at risk of treatment failure and organize their close follow-up by the CAC and CAW.

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