Kingdom of Cambodia
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Ministry of Health

Standard Operating Procedures (SoP) For Boosted Continuum of Prevention to Care and Treatment for Most at Risk Populations in Cambodia

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

April 2013

Foreword

More than two decades, Cambodia has made tremendous efforts to response to the spread of HIV and provides the universal access to the continuum of care services with good achievements, particularly access to the Antiretroviral Treatment. In fact, the HIV prevalence among general population aged over 15 years-old was declined from 1.7% in 1998 to 0.7% in 2011. At the meantime, more than 80% of PLHIV adults and children who are eligible for ART are on ART up to Quarter 3, 2012. The achievements are recognized by the United Nations and presented its awarded to the Royal Government of Cambodia for its efforts to dramatically reduction of HIV prevalence and incidence, and provide universal access to care and treatment services for PLHIV in Cambodia.

Despite the success for prevention, care and treatment for PLHIV, the HIV prevalence remains high for MARPs including Entertainment Workers (EW), Men who have Sex with Men (MSM), Transgender (TG), and People who Use Drug (PWUD). Furthermore, the access to continuum of care and treatment services for MARPs is limited.

Cambodia supports the new global initiatives "Three Zero" Strategy of the United Nations, leading to the elimination of new HIV infections, zero death related to HIV, and no-discrimination against PLHIV. To achieve the above ambitious goals, the Ministry through the National Center for HIV/AIDS, Dermatology and STD, together with all development partners conducted reviews of the achievements, and identified gaps of the implementation of SOP for CoPTC, and develop a Boosted CoPTC for MARPs.

This comprehensive standard document will be implemented at hot spots where MARPs are located. All stakeholders include government institutions, development partners, civil society, and community that actively participate in the reviews this document to improve access to CoPTC services for MARPs.

The Ministry of Health strongly hopes that all concerned stakeholders will implement this SOP innovatively by adapting to local context to achieve to the goal of elimination of new HIV infections in Cambodia by 2020.

Phnom Penh, 02./April/.2013
Ministry of Health

Prof. ENG HUOT
SECRETARY OF STATE

Acknowledgements

On behalf of the National Centre for HIV/AIDS, Dermatology and STD (NCHADS), I would like to express my sincere appreciation and great gratitude to all members of the Core-Group Group on the Continuum of Prevention to Care and Treatment (CoPCT), including NCHADS' BCC Unit and development partners namely UNAIDS, WHO, UNICEF, UNODC, US-CDC, USAID, FHI-360, PSI, KHANA, RHAC, FI, CHAI who dedicated their valuable time and efforts to provide reference documents, inputs and share valuable experience from national and international perspectives as well as the initiatives to analyze the results of the implementation the CoPCT's SOP for MARPs, and successfully develop the SOP for Boosted CoPCT.

The National Centre for HIV/AIDS, Dermatology and STD would like to express its thanks to the network of EW, MSM, TG and PWUD who expressed their concerns and make their requests to access to the Continuum of Prevention to Care and Treatment Services with user-friendly and non-discrimination manner.

Phnom Penh, 26 /..03/2013

Dr Mean Chhi Vun,
Director, NCHADS

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
ATS	Amphetamine Type Stimulants
BCC	Behaviour Change Communication
(B)CoPCT	(Boosted) Continuum of Prevention to Care and Treatment
BLR	Boosted Linked Response
C/PITC	Community/Peer Initiated Testing and Counseling
CBO	Community-Based Organisation
CBTx	Community-Based Drug Dependence Treatment
CCC	Country Coordinating Committee
CCWC	Commune Committee for Women and Children
CDHS	Cambodia Demographic and Health Survey
CoC	Continuum of Care
CoPCT-R	Continuum of Prevention to Care, Treatment and Rehabilitation
CQI	Continuous Quality Improvement
CUP	Condom Use Programme
DIC	Drop In Centre
DSC	District Steering Committee
EE	Entertainment Establishment
EW	Entertainment Workers
FBCC	Facility Based Community Coordinator
FHC	Family Health Clinic
FP	Family Planning
GDoP	General Department of Prisons
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
HTC	HIV Testing and Counseling
HC	Health Centre
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug Users
ITB	Implementation team of Boosted CoPCT
LR	Linked Response
M&E	Monitoring and Evaluation
MARPs	Most At-Risk Populations
MMM	Friends Help Friends (in the Cambodian/Khmer language)
MMT	Methadone Maintenance Therapy
MoI	Ministry of the Interior
MoU	Memorandum of Understanding
MoWA	Ministry of Women's Affairs
MSM	Men-who-have-Sex-with-Men
MSMO	Men who have Sex with Men Only
MSMW	Men who have Sex with Men and Women
MT	Mapping Team

NAA	National AIDs Authority
NACD	National Authority for Combating Drugs
NCHADS	National Centre for HIV/AIDS, Dermatology and STI's
NGO	Non-Governmental Organisation
NSP	Needle/Syringe Programme
(N)TWG	(National) Technical Working Group
OD	Operational District
OI	Opportunistic Infection
OST	Opiate Substitution Therapy
OW	Outreach Worker
PASP	Provincial AIDS and STI Programme
PCPI	Police Community Partnership Initiative
PHD	Provincial Health Department
PLHIV	People Living with HIV.
PMTCT	Prevention of Mother To Child Transmission
Pre-ART	Prior to Anti-Retroviral Therapy.
PSC	Provincial Steering Committee
PSI	Population Services International
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RGC	Royal Government of Cambodia
RH	Reproductive Health or Referral Hospital
RRT	Rapid Response Team
SBC	Strategic Behavioural Communication
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SSS	STI Sentinel Surveillance survey
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TB	Tuberculosis
TG	Transgender
ToR	Terms of Reference
UN	United Nations
VCCT	Voluntary and Confidential Counseling and Testing

MARPs Definitions

Target populations of this SOP, are defined as follows:

Most At-Risk Populations (MARPs)

Definition: Population groups that have an increased probability of being infected by a communicable disease, such as HIV, and whose involvement is vital for an effective and sustainable response. Such key populations vary according to the local context and include in Cambodia, people who sell sex, men who have sex with men, transgender women, people who inject drugs, and prisoners. Also to be considered at high risk, are the sexual clients and partners of individual members of MARPs.

Entertainment Workers (EWs)

Definition: EWs are defined as women or girls who exchange sexual services for money or goods, either regularly or occasionally, where the sex worker may not consciously define such activity as income-generating.

Men-who-have-Sex-with-Men (MSM)

Definition: An inclusive public health term used to define the sexual behaviors of males having sex with other males, regardless of sexual identity, motivation for engaging in sex or identification with any or no particular 'community'. The words 'man' and 'sex' are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM spans a large variety of settings and contexts in which male to male sex takes place.

Transgender (TGs)

Definition: An umbrella term for individuals whose gender identity and expression does not conform to norms and expectations traditionally associated with their sex assigned at birth. Transgender people may self-identify as transgender, female, male, trans-woman or trans-man, transsexual, or other culturally specific transgender identities, and may express their gender(s) in a variety of masculine, feminine and/or androgynous ways. This SOP targets TGs who were biologically male at birth because they are the TG population in Cambodia at high risk of contracting HIV.

People Who Inject Drugs (PWID)

Definition: In the Cambodian context, most PWID use a needle and syringe to inject the illicit drug Heroin into a main vein located in the arm, leg, groin or neck. Other forms of illicit drugs may also be used for injection, such as crystalline methamphetamine, or may be mixed with Heroin.

People Who Use Drugs (PWUD)

Definition: PWUD includes all other people who use illicit drugs such as amphetamine, methamphetamine, yama, marijuana, ketamine, LSD, ecstasy, cocaine, or solvents. The means of administration varies depending on each drug, and could include smoking, chasing, ingesting, snorting or sniffing. For the purpose of this SOP, PWUD are targeted as part of another most at-risk population, such as drug-using EWs, MSM or TG.

Prisoners[1]

Definition: For the purposes of this SOP Prisoners refers to individuals who are incarcerated in a prison facility under the management of the General Department of Prisons (GDoP) or have recently been released from such a facility back into the community.

[1] For a more in depth description of provisions for Prisoners, please refer to the Standard Operating Procedures for HIV, STI and TB-HIV prevention, care, treatment and support in prisons (and correctional centers) in Cambodia, January 2012.

1. Introduction

Cambodia has been in the forefront of the fight against HIV and AIDS having successfully reversed its generalized HIV epidemic. Estimates and Projections published by NCHADS in 2012 show a steady decrease in prevalence in the adult population (aged 15-49) from a high of almost 1.75% in the late 1990s to a projected 0.7% in 2012.[1] Moreover, a stronger health system and improved service delivery and linkages have made it possible for approximately 80% of adults and children living with HIV and in need of antiretroviral therapy (ART) to access care and treatment at Continuum of Care (CoC) sites.[2]

Despite these successes, pockets of high prevalence continue to exist, particularly in most at-risk populations (MARPs), entertainment workers (EWs), men who have sex with men (MSM), transgender women (TG), and people who inject drugs (PWID). Notably, with 70 percent of the population in the country under 30 years, and that many members of MARPs are young. Vulnerability among MARPs is further compounded by multiple and overlapping risk behaviors, such as PWID who buy and sell sex, and EWs, TG and MSM who use drugs. For instance, a survey on Most-at-Risk Young People (2010) found that 29.2% and 13.8% of sexually active young men and women respectively reported the use of illicit drugs, compared to 5.3% of young men and 0.4% of young women who never had sex.[3]

1.1 Entertainment Workers

HIV transmission in Cambodia is primarily due to heterosexual sex, which is linked to the country's sex industry. According to NCHADS mapping (December, 2010) there are 37,034 entertainment workers (EWs) in Cambodia. Although not all EWs sell sex, direct and indirect sex workers are currently referred to collectively as "entertainment workers". The majority of EWs live in Phnom Penh (59%), followed by Siem Reap (9%), Battambang (6%), and Banteay Meanchey (4%). EWs are categorized into a number of sub-groups, including karaoke, massage, beer promotion girls, beer garden girls, and freelance; however, currently there is no standardized definition. Estimating the number of EWs in each sub-group is made difficult by EWs' frequent movement between different venues.

HIV prevalence varies among EWs. According to the 2010 HSS study, among those who have more than 7 clients per week, prevalence is estimated at 13.9%,[4] while 2012 C/PITC data show a positivity of 10.5% among massage girls. This situation is compounded by the blurring of distinction between commercial partners and sweetheart relationships, with over 35% of men reporting paying their sweetheart for sex.[5] Anecdotal evidence suggests that many sweethearts of EWs are previous clients. Although condom use with clients is relatively high (81.5% among EWs with less than two partners per day, and 86.2% reported by men in the past three months)[6], studies have found that condom use in sweetheart relationships is much less consistent (39.4% in the past three months according to EWs, and 51.3% according to men)[7]. Of note, condom use with sweethearts is also on the decline.

Many EWs are at particular risk due to their concomitant use of illicit drugs, high consumption of alcohol, low condom use with sweethearts, and sexual activity with men who have sex with men and women (MSMW). According to the 2005 STI Sentinel Surveillance survey (SSS), 40% of MSM had sex with a female partner in the past year, with female EWs identified as the most common sexual partner. Drug

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[1] NCHADS (2011), Estimates and Projections of HIV/AIDS in Cambodia 2010-2015
[2] NCHADS (2012) ART Report, Quarter 1, 2012
[3] Ministry of Education, Youth and Sports (2010), Most at Risk Young People Survey: Cambodia.
[4] HSS 2010
[5] PSI 2010.TRaC Summary Report: TRaC Study Evaluating Condom Use with Sweethearts among High-Risk Urban Men (HRUM) from Phnom Penh, Siem Reap, Battambang and Sihanoukville2010. Phnom Penh, 2011.
[6] NCHADS 2011.Estimation of the HIV Prevalence among General Population in Cambodia, 2010.
[7] Ibid.

use is also an emerging issue: the 2007 Behavioral Sentinel Surveillance (BSS) found 10% amphetamine (yama) use among brothel-based EWs. In a 2006 study by Population Services International (PSI) up to 6% of female karaoke workers reported ever injecting drugs.

EWs also have distinct sexual and reproductive health needs. A study among 600 EWs in Cambodia found 28% had had an abortion in the past year (compared to an 8% abortion rate in the general population according to the CDHS); this is despite EWs reporting almost 100% condom use with last client.[8] EWs also reported low use of other methods of contraception (3% were using hormonal methods), particularly in comparison to the general population.

1.2 Men who have Sex with Men (MSM)

MSM have been considered most at-risk of HIV infection since they were identified early in the HIV epidemic, yet information on this group remains limited. To date, the population size of MSM has not been officially estimated nationwide. In 2010, according to KHANA and FHI 360, the MSM population was estimated to be 21,327, though no transgender segment was enumerated.

FHI 360 and NCHADs' BROS Khmer study (2010) found an HIV prevalence of 2.1% amongst MSM and 55.3% and 67.5% consistent condom use by MSM only (MSMO) with male paid partners and male non-paid partners respectively. This study also found that 42.9% had a self-reported STI; and only 34% had had an HIV test in the past year and knew the result. Only 63.7% of respondents had received HIV and AIDS education.

Like EWs, MSM appear to have overlapping risks. The BROS Khmer study (2010) found that men who have sex with men and women (MSMW) had more than double the drug use rate as MSMO and men who have sex with women (MSW) – 42.4% compared to 19.6% and 20.9% respectively. According to the BROS Khmer study, among high-risk urban men, 72.3% reported using condoms with a paid partner, while 51.2% reported condom use with a non-paid partner.[9]

1.3 Transgender (TG)

Although little is known about the TG population, including its size, members of this population appear to be at particular risk. In the past TG have been included in prevention programs targeted at MSM and as a result their unique needs have often been neglected. In the 2005 STI prevalence assessment, HIV prevalence was higher among transgender than MSM (9.8% vs. 2.6%). In the Bros Khmer study (2010), the proportion of HIV positive TG was also higher than that of MSM (2.6% vs. 1.9%). Additionally, STI prevalence (including rectal or urethral chlamydia and gonorrhea, or syphilis) was 21% for TG while only 7% for MSM.

The 2007 BSS revealed that more TG reported having 'ever sold sex' than MSM (60% vs. 36%). Among all who sold sex, TG reported 'first selling sex' at an earlier age than MSM. The first sexual partner for TG was more commonly a man (93%) and for MSM it was more commonly a woman (56%). The survey also reported that TG tended to use condoms less consistently with all sexual partners, and reported more condoms breakages and using lubricant less frequently than MSM. For both TG and MSM, condom use was the lowest among non-paying partners.

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[8]Morineau, G., et al. 2011. Falling through the cracks: Contraceptive needs of female sex workers in Cambodia and Laos. *Contraception* 84, pp. 194-198. Delvaux, T. et al., The Need for Family Planning and Safe Abortion Services among Women Sex Workers Seeking STI Care in Cambodia. *Reproductive Health Matters*. Volume 11, Issue 21, Pages 88-95, May 2003.

[9] FHI 360, 2010.Behavioral Risks On-Site Serosurvey among At-Risk Urban Men in Cambodia (BROS Khmer).

An upcoming IBBS study and size estimation among transgender will be conducted by FHI 360 in 2012, which will help to understand transgender risk behavior, sexual health needs, and the size of the population. This in turn will allow for the design of better targeted, culturally relevant, appropriate, and acceptable prevention and care programs.

1.4 People Who Use Drugs (PWID and PWUD)

In Cambodia, the population size of drug users (PWUD) is estimated to be approximately 13,000, with 2,000 PWID,[10] although some NGOs consider the actual number to be far higher. Most drug users are young people, aged 18-25 years[11] and drug use is predominantly concentrated in the urban centers of Phnom Penh, Battambang, and Poipet, though almost all provinces have recorded at least some drug use. Injecting Drug Users are thought to be mostly confined to Phnom Penh.

HIV prevalence among PWID was estimated to be 24.4% in 2007, compared to the much lower 1.1% among PWUD.[12] An assessment of HIV risk behavior found that 47% of PWID had shared injecting equipment at least once, while 32% reported sharing on the day of the assessment.[13] The 2007 Drug User IBBS reported that 35% of PWID had shared at last injection. Although 74% reported always using clean or new equipment within the previous month, no one reported disinfecting equipment with bleach as recommended. Condom use with all partners is lower among PWID than among PWUD.

The NACD five-year National Plan on drug Control (2010-2015) sets forth strategies in five key areas, including Demand Reduction, Supply Reduction, Harm Reduction, Law Enforcement and International Cooperation. The main law enforcement bodies are the National Police of the Ministry of Interior (MOI) and the Military Police of the Royal Cambodian Armed Forces. Drug use is illegal in Cambodia under the Law of Drug Control (January 2012).

Symptomatic treatment programs are offered via NGOs and progressively by the Ministry of Health in selected areas. The law also allows for the distribution of methadone and buprenorphine for Opiate Substitution Therapy (OST) for people dependent on heroin by agencies authorized by the NACD. The Ministry of Health is currently the only provider of Methadone Maintenance Therapy (MMT), with the program located in Khmer-Soviet friendship hospital. In 2010, a Community-based Drug Dependence Treatment Program (CBTx) endorsed by NACD, has been piloted in Banteay Mean Chey Province (with plans to replicate nationwide). This program aims to provide an alternative evidence-based, human-rights focused, community-based system to the Temporary Centers for Drug Education (Treatment) and Rehabilitation (TCDER). The possession of needles/syringes is legal in Cambodia. With MOI authorization, in 2004, a formal pilot needle/syringe program (NSP) commenced. As of mid-2012, there are two NGO's with a NACD license for the delivery of NSP as part of a comprehensive harm reduction package and hepatitis C.

While non-injecting drug use dose not in itself leave the user at a higher risk of HIV infection, it can lead to the user taking part in other high-risk behaviors. As a result of this, non-injecting drug users are targeted by HIV program interventions through their exposure via other risk behaviors.

1.5 Prisoners

The prison system in Cambodia is under the General Department of Prisons (GDoP), which is under the Ministry of Interior. There are a total of 28 prisons in Cambodia, four are National Correctional

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[10] NCHADS, Drug User IBBS 2007
[11] Id. 2007
[12] Id. 2007
[13] Report for 2011, Secretariat General, National Authority for Combating Drugs, 2012

Centers and under the direct management of the GDoP, while 24 are provincial prisons under the joint management of the provincial authorities and the GDoP. In 2012, the number of people in prison was 15,404; an estimated 8% of the population is female.[14]

Assessing the overall prevalence of HIV in prisons is difficult due to the lack of systematic HIV surveillance. During the first six months of 2011, the GDoP reported 310 individuals within the prison population who were known to be living with HIV, which is an overall prevalence of 2%. However HIV prevalence varies from prison to prison. Numerous surveys by NGOs have reported higher incidence amongst female detainees[15], who may have been infected prior to imprisonment or who have higher exposure to HIV and TB while in prison. Furthermore, due to the concentrated epidemic in Cambodia and current policies negatively affecting MARPs, especially women, it is estimated MARPs are overrepresented amongst prisoners. In response, a in January 2012 a Standard Operating Procedure for HIV, STI, and TB-HIV Prevention Care Treatment and Support in prisons (and correctional centers) in Cambodia was developed by NCHADS, in cooperation with UN, NGOs and development partners.[16] As part of this SOP, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) is tasked with providing systematic referrals to prisoners upon release. For newly released prisoners who are identified as members of MARPs, this mechanism requires strengthening to ensure a reliable bridge to HIV-related services in the community.

1.6 Legal Barriers

The implementation of the Human Trafficking and Sexual Exploitation Law (enacted in March 2008) and the Village Community Safety Policy (implemented since January 2011) constitute the barriers affecting HIV-related outreach activities and service provision to MARPs. To address this situation, the Ministry of Interior (MoI) with technical and programmatic support from NAA, the Police-Community-Partnership Initiative (PCPI) will be employed at the municipal and operational district level and below as part of this Boosted SOP. The PCPI aims to strengthen a collaborative partnership among AIDS officials, health care providers, local authorities, police, military police, development partners, non-governmental organizations and MARPs to foster an enabling environment where MARPs may freely and voluntarily access services. The PCPI underpins the Cambodia 3.0 (and its accompanying frameworks and SOPs) and ensures its effective implementation.

[14] 2010 report on Prisons, The General Department of Prisons, Ministry of the Interior

[15] In 2011, Medecins Sans Frontiers (MSF) concluded a HIV screening in three prisons in Phnom Penh [CC1, CC2 and Police Judiciaire (PJ)] indicating that HIV was 4 to 6 times higher than the general population amongst male inmates; and estimated a HIV rate of 12.2% amongst female detainees. MSF Cambodia Annual Report 2011.

[16] http://www.nchads.org/SOPs/SOP%20for%20Prison%20Setting%20Eng.pdf.

2. Rationale

Program data and recent implementation research of the National Center for HIV/AIDS, Dermatology and STD (NCHADS) demonstrates that HIV prevalence in Cambodia remains high among EW, MSM, TG and PWID and that high-risk behaviors, unprotected sex with multiple partners and clients, selling sex and injecting drug use, continue or are on the rise. National program data also indicates that HIV testing among some groups of MARPs is low (e.g. only 34% of MSM were tested in 2009 and knew their result). The combination of high frequencies of risk behavior and low HIV testing coverage threatens the success to date of the prevention and care of PLHIV in Cambodia. It also increases the likelihood that the positive trend will be reversed, leading to a resurgence of HIV in Cambodia. As such, to prevent new infections, efforts are needed to reach MARPs with more effective high quality HIV prevention, care and treatment.

To prevent HIV infection, NCHADS and development partners must improve detection of HIV-positive individuals and provide them the adherence ART treatment. Further, MARPs have distinct health needs that are defined by aspects of individual biology, context and risk behaviors. Individuals engaging in risky sexual practices must be reached with HIV testing along with sexual health services, including STI screening and treatment. Women involved in high risk activities require contraceptive services and access to safe abortion. People who inject drugs require mental health services and may also be in need of opioid substitution therapy, in addition to access to clean injecting equipment through needle and syringe programs. For PLHIV, retention in care and treatment services is critical to ensure optimal patient outcomes, reduce transmission of HIV from the infected person to their partners, and to reduce HIV-related mortality.

Strengthening management and coordination structures are also needed to improve retention and follow up among individual MARPs. Efforts to improve coordination should also address challenges related to the enabling environment, particularly recent policy and law enforcement realities that can impede access to services for MARPs. The coordination and management structure must increase the active engagement of PCPI stakeholders and strengthen the partnerships between health and non-health institutions at national, provincial and district levels.

In June 2011, at the UN General Assembly, Cambodia expressed its support for global goals and targets and committed to reaching Zero New Infections by 2020. In line with the global "Three Zeros" and "Treatment 2.0" initiatives, the National Centre for HIV/AIDS, Dermatology and STI (NCHADS) of the Ministry of Health (MOH) is working to eliminate new HIV infections using a range of strategies. Cambodia 3.0 proposes building on successful responses — HIV prevention targeting MARPs, the linked response for PMTCT, and the continuum of care for ART expansion — to actively detect HIV cases and ensure immediate enrolment in care, and immediate/early initiation of ART and retention in treatment.

To reach most at-risk populations (MARPs) with prevention, care and treatment services, the national Core Group on Elimination of New HIV Infections chaired by NCHADS, developed a boosted strategy, known as the Boosted CoPCT. This boosted strategy builds on successes of the previous CoPCT framework, while aiming to maximize impact by strengthening service delivery, retention and coordination.

Since 2009, EW CoPCT SOP developed by NCHADS and development partners played a major role in guiding and coordinating public, international and local NGO services in priority provinces. In late 2010, a similar SOP was produced for MSM and TG but was never fully implemented. In addition, a number of relevant documents, such as the framework on CoPCT-R for PWUD-PWID, the concept note on community/peer initiated counseling and testing (C/PITC) and the needle and syringe policy, have been

developed. There has also been a newly published SOP for HIV, STI and TB-HIV prevention, care, treatment and support in prisons.[17]

Although much has been achieved through the implementation of existing CoPCT frameworks and related policies, they are limited by addressing risk according to simplistic group classifications, defining risk groups as mutually exclusive and targeting each group separately. This Boosted CoPCT — a single SOP for all MARPs that recognizes individuals' multiple and overlapping risks — is intended to bring together these various policy documents to create a cohesive guide for a coordinated continuum of HIV prevention, care and treatment for all most-at-risk populations in Cambodia.

This Boosted CoPCT has been developed to ensure an integrated, coordinated, comprehensive national response to HIV.

[17] http://www.nchads.org/SOPs/SOP%20for%20Prison%20Setting%20Eng.pdf

3. Goal & Objectives

3.1 GOAL: To eliminate new HIV infections in Cambodia by 2020 (Cambodia 3.0).

3.2 OBJECTIVES:

3.2.1 The overall objective of the Boosted CoPCT is to contribute to improvements in the health status of MARP's (PWID, PWUD, EW, MSM, TG, and prisoners,[18] together with their partners and clients). This objective will be achieved by significantly reducing the transmission of STIs and HIV and increasing the level of testing to facilitate early treatment.

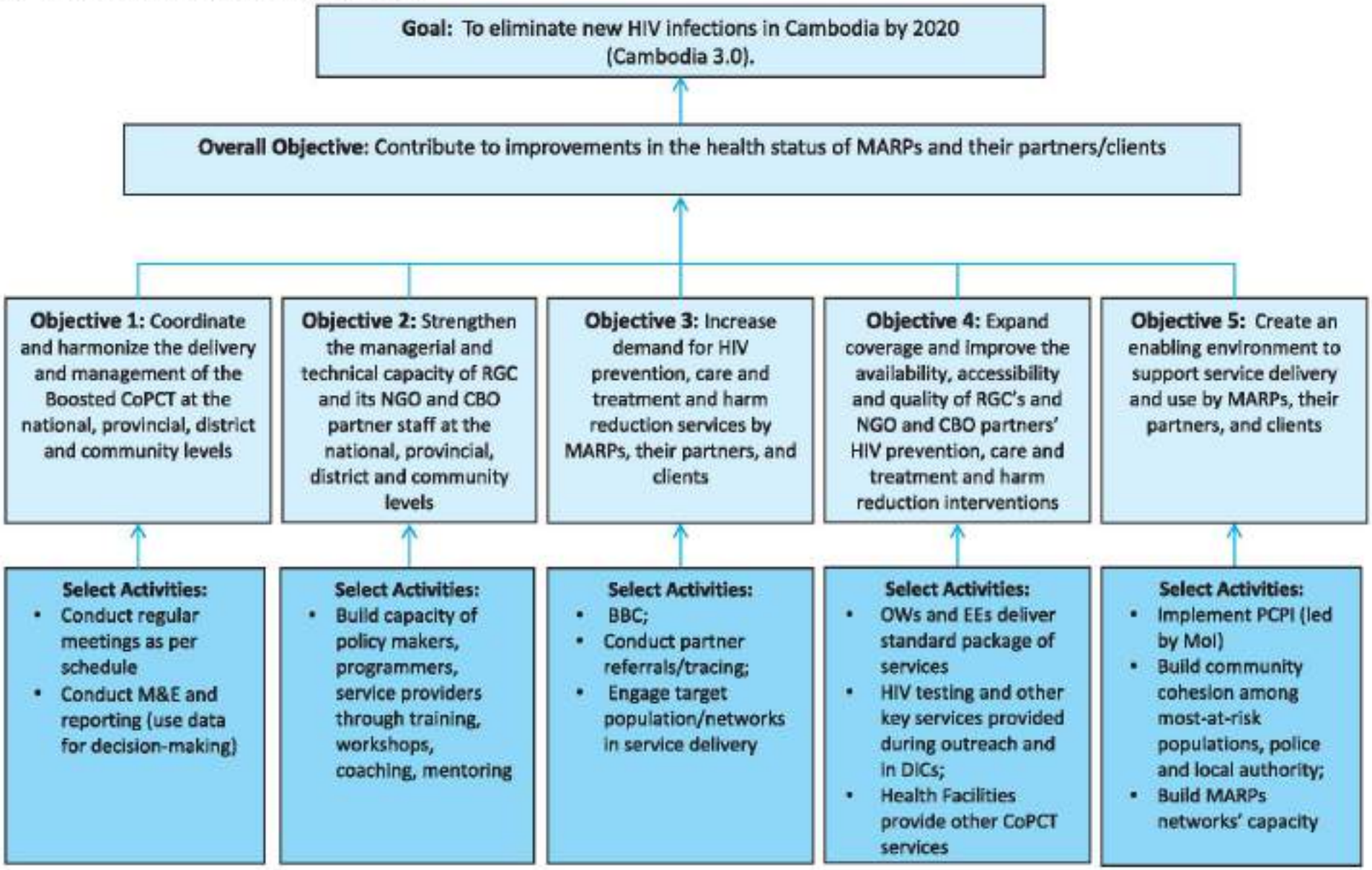
The goal and objectives of the Boosted CoPCT will be achieved through a strong partnership led by the Royal Government of Cambodia (RGC) in close collaboration with NGOs, CBOs and the community with support from relevant UN/Development Partners, at the national, provincial, district and community levels.

3.2.2 Five specific objectives will contribute to achieving the overall objectives:

- Coordinate and harmonize the delivery and management (including monitoring, evaluation, research, use of data) of the Boosted CoPCT at national, provincial, district and community levels;
- Strengthen the managerial and technical capacity of RGC and its NGO and CBO partner staff at the national, provincial, district and community levels to implement the Boosted CoPCT;
- Increase demand for HIV prevention, care and treatment and harm reduction services by MARPs, their partners, and clients;
- Expand coverage and improve the availability, accessibility and quality of RGC's and its NGO and CBO partners' HIV prevention, care and treatment and harm reduction interventions in areas where MARP's are most concentrated;
- Create an enabling environment to support service delivery and use by MARPs, their partners, and clients.

[18] Prisoners are officially part of MARPs in Cambodia; however specific needs of prisoners are addressed in the Standard Operating Procedure for HIV, STI AND TB-HIV Prevention, Care, Treatment and Support in Prisons (and Correctional Centres) in Cambodia published by NCHADS in January, 2012: (http://www.nchads.org/SOPs/SOP%20for%20Prison%20Setting%20Eng.pdf)

4 Strategies & Expected Outcomes



5 Packages of Services

To achieve the objectives of preventing HIV infection and HIV-related mortality among MARPs, NCHADS and implementing partners will deliver a range of service packages developed to address the risk behaviors and exposures relevant for each target population. This section of the SOP describes the services—(a) Core CoPCT and (b) Expanded Core Package—that are available through the Boosted CoPCT. Modes of service delivery at all service delivery points are described in the following pages. Service packages have been tailored to meet the needs of individuals according to risk behaviors documented among MARPs in Cambodia:

- unsafe vaginal and anal sex,
- unsafe drug injection practices,
- selling sex,
- having multiple sexual partners, and
- Being the sexual partner of an EW, MSM, TG, or injecting drug user.

HIV Service Packages for the Standard & Boosted CoPCT for MARPs

Key: Provide = provision of service; Refer = referral only; Both = provision of service and/or referral to other providers for provision of service
Note: Provide indicates that the provider/service modality must provide and hence not need to refer the client

PACKAGE		COMPONENT	Service Modality			EW				MSM				TG				DRUG USER			
			Outreach	Drop-In Centre **	Health Facility*	EW	HIV	IDU	DU	MSM	HIV	IDU	DU	TG	HIV	IDU	DU	Injecting		Injecting & Other Drug Use	
																		Inj.	HIV	Other	HIV
Core CoPCT	1	BCC	Provide	Provide	Provide & Refer																
	2	Condom & Lubricant	Provide	Provide	Provide																
	3	STI screening	Provide & Refer	Provide & Refer	Provide & Refer																
	4	HIV Testing point of care	Provide & Refer	Provide & Refer	Provide																
Expanded Core Package	5	NSP	Provide & Refer	Provide & Refer	Provide																
	6	MMT	Refer	Refer	Provide & Refer																
	7	Pre-ART / ART	Refer	Refer	Provide & Refer																
	8	RH (including FP + LR)	Provide & Refer	Provide & Refer	Provide & Refer																
	9	Psycho-Social Support	Refer	Provide & Refer	Provide & Refer																

BCC	Behavior Change Communication
STI screening	Sexually Transmitted Infection assessment via syndromic approach or confirmed by laboratory test
RH	RH services targeting women, including contraceptives, access to safe abortion and links to sexual and reproductive health (SRH) services through the Linked Response
HIV Testing	Either outreach, including C/PITC, and/or fixed site, including VCCT
NSP	Sterile Needle/Syringe Program and related interventions
Pre-ART	PLHIV with CD4 count >350/mm3 are enrolled in pre-ART and prior to initiation on ART
ART	Anti-Retroviral Therapy
PMTCT	Prevention of Mother-To-Child Transmission
MMT	Methadone Maintenance Therapy
*	Health facilities refer to any health facility (public or private)
**	Drop in Centers may provide additional services, such as vocational training, library, peer support, make up. Where all these services are available, the package is to be called Expanded Core Package

5.1 Core Service Package

All components of the Core Package should be provided to all MARPs through the Boosted CoPCT. Services will be provided during outreach (by outreach workers at each contact), via referral, or through direct service delivery.

The Core Service Package will be delivered during outreach in hotspots/entertainment establishments and in Drop in Centers (DICs) (Please refer to section **6.2** for details on DICs). It will also be provided in Family Health and NGO clinics.

The Core Service Package is:

5.1.1 Behavior change communication (BCC):

5.1.1.1 BCC aims to increase awareness of the risks associated with key behaviors as well as the strategies and means available to reduce the risk of HIV transmission. BCC services are delivered by Outreach Workers (OWs) during HIV-related education sessions.

- OWs provide BCC to all clients at least once per month either in one-on-one or small group sessions.
- Clients identified by OWs or district-level Boosted CoPCT Implementation Teams as needing additional outreach and/or at higher risk will receive 2-4 BCC sessions per month. PWID and freelance sex workers are examples of those who may be considered at higher risk.
- OWs are actively encouraged to provide BCC services to those whom have not previously received them.

5.1.1.2 BCC tools will be used during sessions; written information, such as service directories, will also be distributed. Ideally, a BCC tool will be developed for each specific behavior/risk-related topic, with tools and topics used with clients changing on a quarterly basis.

- BCC messages delivered by different NGO/CBO partners will be coordinated by the Implementation Team at the district level to ensure consistency of approach.

5.1.2 Condoms:

- At every contact, OWs, NGO service providers and health workers are to provide at least one sample pack of condoms and lubricant for free to MSM and TG clients and at least one condom for free to EW, PWID and PWUD clients.
- Condoms and lubricants will be available for purchase throughout the country at diverse points of sale, including pharmacies, small markets, and petrol stations.

5.1.3 STI screening/testing:

- STI screening is an important entry point into care for MARPs and their partners. Each MARP is to receive STI screening/testing on a quarterly basis (once each quarter).
- Symptomatic STI screening will be provided during outreach in hotspots/entertainment establishments and in DICs. During screening, clients

diagnosed with symptoms will be given appropriate medicine, as well as doses for their primary partner.

- Outreach workers will also provide referrals for STI lab testing in health facilities. Referral cards will provided to MARPs with positive symptom screening to direct them to a health facility for lab testing.
- STI testing will be conducted in health facilities. STI services targeting MSM and transgender will also include anal health consultations.

5.1.4 HIV testing:

- Each MARP is to receive an HIV test every six months.
- HIV Testing and Counseling (HTC) is provided in approved government and NGO health facilities (such as VCCT), and through Community/Peer Initiated Testing and Counseling (C/PITC) during outreach and in Drop In Centers.
- HIV testing is also provided in the private sector which licensed by the Ministry of Health. All private HIV testing facilities refer HIV positives clients for second or third HIV confirmation test at VCCT having the pre-ART/ART services and refer syphilis positive clients for RPR confirmation test at the family health clinics.
- All individuals receiving an HIV test will be encouraged to bring their partners for testing, or to provide a referral card to their partner.
- Rapid HIV testing must follow the SoP on Counselling and Testing approved by the Ministry of health in 2012. Syphilis test is also screening by taking blood from the finger.

5.2 Expanded Core Service Package

The Expanded Core Package is the Core Service Package plus additional services, which should be provided based on an individual's risk behaviors identified during consultation and core package service delivery:

5.2.1 Needle and Syringe Program (NSP):

- NSP is to be implemented in accordance with the (1) Policy (2) Operational Guidelines, and (3) sub decree on drug treatment and rehabilitation of the Ministry of Health and National Authority for Combating Drugs (NACD).
- NSP is available at the Khmer Soviet Friendship Hospital and NGO clinics in Phnom Penh. Additional hotspots for NSP provision may be identified over the course of Boosted CoPCT implementation.
- Outreach workers will identify clients who need clean needles and syringes and provide these commodities during outreach sessions. Clients will also be referred to NSP distribution points, as needed.

5.2.2 Methadone Maintenance Therapy (MMT):

- MMT is provided in accordance with the protocols established by the Ministry of Health.

- MMT is provided at the Khmer Soviet Friendship Hospital, in conjunction with NSP services.
- Regular referral or direct transportation support to MMT services may be provided to clients by NGOs. These NGOs also regularly follow-up with MMT clients to minimize loss, non-adherence, and to support their access to other services, as needed.

5.2.3 Pre-ART and ART Services:

- ART is only provided in government and NGO health facilities that are integrated into the national program's Continuum of Care. Referral to ART services is required following an HIV positive diagnosis and post-test counseling.
- Individuals receiving a positive HIV test will be immediately enrolled in care and treatment in the comprehensive Continuum of Care provided at pre-ART/ART services.
- Patients with a CD4 count of ≤350/mm3 will be enrolled on Antiretroviral Therapy (ART).
- The concept note on the provision of Treatment as Prevention is also being approved by the Ministry of Health in late 2012 and will be implemented in the second quarter of 2013 and will be rolled out as part of the Cambodia 3.0 strategy. Initially, to minimize transmission to the non-infected partner, ART will be provided to HIV+ partners in sero-discordant couples with a CD4 count is between 350<CD4<500.
- PLHIV will receive necessary laboratory support based on their specific needs. Additional services, such as CD4 and viral load testing, toxicity screening, and other monitoring necessary to detect Opportunistic Infection, will also be available at ART sites.
- Individuals enrolled in pre-ART/ART care will be encouraged to bring their partners for HIV counseling and testing.

5.2.4 Reproductive Health Services:

- During outreach and in DICs, clients with an unmet need for contraception will be referred to health facilities for contraceptive commodities. Clients will also be referred for basic sexual and reproductive health care, including safe abortion and STI screening and treatment.
- EWs who become pregnant and wish to sustain their pregnancy will be referred by OWs for antenatal care and follow-up as described in the Boosted Linked Response for elimination of mother to child transmission of HIV and syphilis.

5.2.5 Psychosocial support:

- Pre and post-test counseling will be provided at health facilities where HIV testing is provided.
- Support groups organized in NGO DICs will entail sessions on issues of particular importance to clients, including drug use and abuse.
- Counseling will be provided, at the ART site and through support groups, to HIV positive MARPS to ensure ART adherence.

- Psychosocial support services are made available to PWUD/PWID based on assessment and follow-up by NGO partners and by Mental Health Unit of the MoH, including through CBTx. Refer to the existing CoPCT-PR for PWUD/PWID for details.

6. Service Delivery and Referral Mechanisms

The services described above in the core package and expanded package are provided in a range of facilities by government, NGO and peer service providers. Services will be delivered through outreach in the community, at NGO health facilities, and at government health facilities

When clients access a single service included in the CoPCT, the health worker, NGO staff or Outreach Worker may determine that they are eligible for additional services. Based on this individual consultation and assessment, clients may be referred for all services in the CoPCT service packages. Referral cards will be issued and the client may be requested to attend services at a different location or simply at a different service point in the same health facility.

Some services, such as HIV Testing and ART, will be provided free of charge, while other services may entail a fee. Recognizing that many members of MARPs are also often poor, clients will be supported to benefit from social protection mechanisms, such as Health Equity Funds that provide free medical care and enrolment in the ID Poor program. These mechanisms enable its members to access a variety of other social protection schemes, depending on one's residence. When able, it is expected that MARPs will pay for the services they access, but when they are unable, necessary services will be provided free of charge.

6.1 Service delivery through Outreach:

Outreach workers will conduct visits to venues where MARPs can be reached, including places of work and drop in centers. Outreach workers will be equipped to provide the core package of services: BCC, condom, referral for STI screening and treatment, and HIV testing or referral for HIV testing, to individuals during each outreach visit. Outreach workers will also provide referrals for additional services that are deemed to be necessary.

6.1.1 Outreach Services and Referrals

Direct service provision at Outreach	Referral at Outreach:
1. BCC 2. Condoms distribution 3. STI screening 4. HIV testing 5. TB Screening 6. NSP	1. HIV testing 2. Reproductive Health 3. STI testing 4. TB Diagnostic workup 5. Antiretroviral therapy 6. Needle and syringe programs (Referral to licensed hospitals) 7. Methadone Maintenance Therapy (Referral to licensed hospitals) 8. Psychosocial services

6.1.2 Travel Subsidies

Travel subsidies will be provided by the NGO service providers through their OWs to those MARPs who are identified as unable to pay for their services. The amount of subsidy will vary depending on the

distance to be travelled and the level of poverty of the individual. It is estimated that the individual rate will be between USD$1 - 3. Travel will be coordinated where necessary by the Implementation Team on a district level to ensure improvement in both access to services and in cost efficiency.

6.2 Service delivery at Drop in Centers:

6.2.1 Drop in centers (DICs) are vital for reaching key affected populations in hot spot areas with services. They can reach individuals that outreach work cannot, while also providing a safe space for people to socialize without fear of stigma or discrimination. DICs also provide a space where people can network with others with a similar lifestyle and who face similar issues. Drop in centers are established by NGOs and they are located in close proximity to the populations they are serving and maintain opening hours to ensure maximum accessibility. The Core Service Package will be provided at all drop-in centers. Additional services can also be provided, depending on the needs of the target population and the mandate of the service provider, including:

6.2.2 Drop in Centers Services and Referrals

Direct service provision at DIC	Referral from DIC to Health Facility:
.1 BCC	.8 HIV testing
.2 Condoms	.9 Reproductive Health
.3 STI screening	.10 STI testing
.4 HIV testing	.11 TB diagnostic workup
.5 TB screening	.12 Antiretroviral therapy
.6 NSP	.13 Needle and syringe programs (Referral to licensed hospitals)
.7 Psychosocial support	.14 Methadone Maintenance Therapy (Referral to licensed hospitals)
	.15 Psychosocial services

6.3 Service delivery at Health Facilities:

Health workers at Health facilities will provide the expanded package of services either directly or through referral:

6.3.1 Family Health Clinics Services

Direct service provision at Family Health Clinics
1. BCC
2. Condoms
3. HIV testing
4. STI screening
5. TB screening
6. RH/FP for EWs

6.3.2 Referral Hospital Services

Direct service provision at Referral Hospitals:
1. HIV testing (at Referral Hospital) 2. Reproductive Health/ Family Planning 3. STI screening 4. TB services (screening, diagnosis, treatment) 5. Antiretroviral therapy 6. Needle and syringe programs (Referral to licensed hospitals) 7. Methadone Maintenance Therapy (Referral to licensed hospitals) 8. Psychosocial services

Note: In areas with no family health or NGO clinic, MARPs will be referred to the nearest Health Center for services and further referrals.

6.4 Responsibilities for services delivery by NGO outreach workers and health facility service providers are described in the following table:

Component	Outreach Worker[19]				Health Worker			
	Where	How	Frequency	Transport[20]	Where	How	Frequency	Transport
BCC	Hotspots/ venues	Provide in one-on-one/small group	At least once a month and 2-4 times for high risk MARPs	N/A	N/A (note: health worker provides health education and counseling, but not BCC) refer to OW, DIC.			
Condom & Lubricant	Hotspots/ venues	Provide in one-on-one/small group	At least once a month and 2-4 times for high risk MARPs	N/A	Health facility	Provide during medical check	Every contact	N/A
STI/SH point of care	Refer to health facility	Provide referral card to client	Every 3 months	As needed	Health facility (STI, HC, RH)	Client referred by OW/self-referred	Every 3 months	N/A
HIV Testing point of care	C/PITC: hotspots/ venues; VCCT: Refer to facility	C/PITC: Arrange testing time; VCCT: Provide referral cards	Every 6 months	As needed	C/PITC: hotspots/venues; VCCT: VCCT facility	Client referred by OW/self-referred	Every 6 months	N/A
NSP	Assigned RH, HC, DIC	Provide the service, or if unavailable, provide referral card to client	Every contact	As needed	Assigned RH, HC, DIC	Provide the service, or if unavailable, provide referral card to client	Every contact	As needed
Pre-ART / ART	Refer to ART site	Provide referral card to client	As needed	As needed	ART site	Client referred by OW/self-referred	As needed	Not needed
FP	Refer to health facility (RH, HC, NGO, FHC)	Provide referral card to client	As needed	As needed	Health facility (RH, HC, NGO, FHC)	Client referred by OW/self-referred	As needed	N/A
RH + LR	Refer to health facility (RH, NGO, FHC)	Provide referral card to client	As needed	As needed	Health facility (RH, NGO, FHC)	Client referred by OW/self-referred	As needed	N/A
MMT	Refer to MMT clinic	Provide referral card to client	Every contact	Yes (clinic subsidy)	MMT clinic	Client referred by OW/RH Staff/HC staff or self-referred	Daily	N/A
Psycho-Social Support,	Provide in DICs; Refer to HUB and some satellite health facilities	Provide the service, or if unavailable, provide referral card to client	As needed	As needed	HUB and some satellite health facilities	Client referred by OW/self-referred	As needed	N/A

[19] The Outreach Worker (OW) provides services both during outreach and in the DIC

[20] Transport provision means it is an assisted referral.

6.5 Partner Tracing and Referral for HIV and STI Testing

Partner tracing and referral aims to accelerate HIV case detection and to prevent HIV and STI transmission among couples. It does so in part by facilitating HIV treatment as prevention (TasP).

Partner tracing and referral involves identification of a sexual or drug injecting partner of an individual who is HIV positive, who has an STI, or who is suspected to have an HIV infection due to high risk behaviors. Once identified, the individual is then offered HIV and/or STI testing.

According to UNAIDS and WHO, partner tracing and referral must observe the principles of confidentiality and non-compulsion.

6.5.1 Strategies:

There are three starting points for partner tracing and referral (Figure 1):

6.5.1.1 An HIV positive person is the index case: Providers can offer an HIV positive individual a choice of four partner tracing methods for referring his/her partner(s) to HIV testing:

- Method (A): *Provider referral*: Provider contacts client's partner(s) while maintaining confidentiality of the client (does not disclose client's name or status)
- Method (B): *Client referral with disclosure*: Client contacts partner(s) and discloses status
- Method (C): *Conditional referral*: Client agrees to contact partner(s) within a set period of time, but if unable to do so, provider contacts client's partner(s) while maintaining confidentiality of the client (the provider does not disclose the client's name or status)
- Method (D): *Client referral without disclosure*: Client promotes HIV testing to their partners without disclosing their own status by using a partner referral card

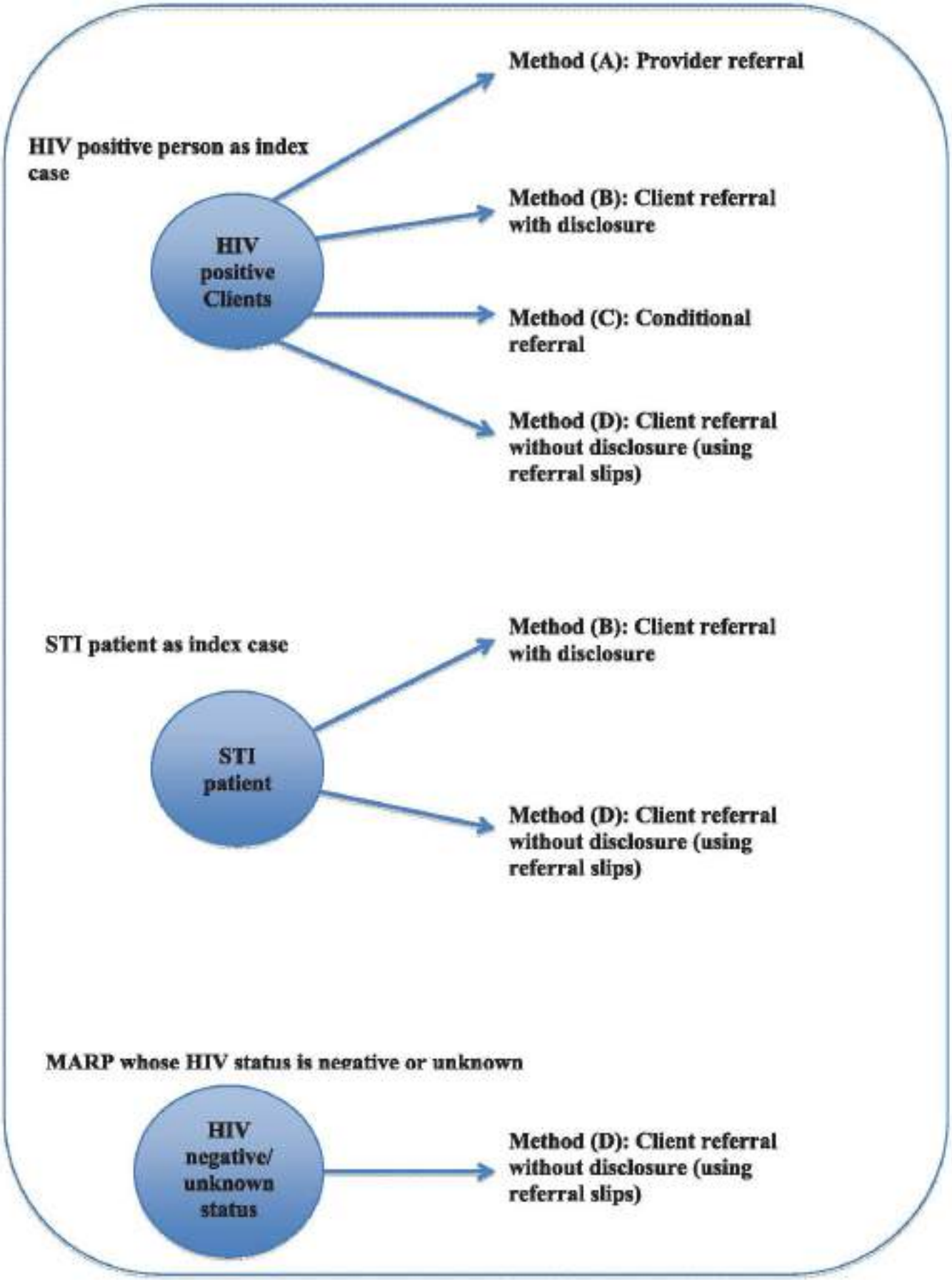
6.5.1.2 An STI patient is the index case: Providers can offer an STI patient a choice of two partner tracing methods for referring his/her partner(s) to STI testing:

- Method (B): *Client referral with disclosure* (as detailed above)
- Method (D): *Client referral without disclosure* (as detailed above)

6.5.1.3 An individual member of a MARP in the community whose HIV status is unknown is the index case: OWs encourage each client to contact her/his partner(s) to encourage uptake of HIV testing via:

- Method (D): *Client referral without disclosure* (as detailed above)

Figure x: Partner Tracing and Referral Strategies



6.5.2 Implementation of the Methods of Referrals:

For HIV positive index cases, Method (A) is to be offered first. If the index case does not want Method (A), Methods (B), (C) and (D) should be offered successively. Similarly, for STI patient index cases, Method (B) should be offered first, followed by Method (D).

Guidance for implementing each Method is as follows:

Method (A) Provider referral and Method (C) Conditional referral (In case provider needs to contact the partners)

The index case provides the health professional the contact details (telephone numbers, email addresses, addresses) of his/her sexual and/or injecting partner(s). Once the contact details are obtained there are different approaches the provider can use to contact the partners. There are advantages and disadvantages to each one.

	By phone	By letter/email	In person
Advantages	• Quick, and appointments can be taken • Low-priced • Confidential	• Anxiety can be reduced by providing written information about testing and confidentiality • Allows the person to choose to phone when their confidentiality is assured	• The health care provider can give full details immediately, deal with the response and link the individual to appropriate support • Immediate STI or HIV testing can be offered, depending on circumstances and staff training
Disadvantages	• Provides only verbal information • Can be uncomfortable disclosing full details • Can be overheard by somebody else • Challenging for people with hearing impairment	• May create anxiety, especially if the letter is read when services are closed • Inappropriate for disclosing details • Difficult for people with low literacy or for the visually impaired	• Physically seeing the provider might affect perceptions of confidentiality, particularly in small rural communities • Can give impression of controlling • Expensive and time consuming

Method (B): Client Referral with Disclosure

The provider encourages the index case to contact his/her partner(s) to encourage uptake of testing. The client discloses his/her status to his/her partner.

Method (D): Client Referral without Disclosure (Use of referral card distributed by client)

The client can promote testing among his/her partner(s) without disclosing his/her own status by providing a partner referral card. These cards are provided by the Outreach Worker during one-on-one and/or small group outreach sessions. These partner referral cards will differ from the primary client's

card in that partner referral cards are only for referrals to HIV and STI testing.

6.5.3 Challenges and Potential Solutions for uptake of Partner Tracing and Referral:

- *Fear of loss of confidentiality*: Offer provider referral for greater anonymity
- *Client unwilling to confront sexual partners*: Practice role play
- *Client does not accept the diagnosis*: Allow more time for counseling and support
- *Client unaware of STI and/or HIV consequences*: Provide appropriate educational materials and discussion
- *Disregard for consequences to contacts*: Explain that contacts tend to find out eventually; emphasize the risk of re-infection
- *Fear of revenge from partner(s)*: Explain the infection process. Encourage and offer support; Discuss various scenarios and how they can be dealt with and also offer to inform the partner on behalf of the client
- *Shame of having a disease*: Explain the infection process

6.6 Service Directories

To ensure target populations know where to access needed services in Boosted CoPCT target areas, directories of available services will be developed. NCHADS will coordinate the development of these directories in collaboration with development partners. There will be two directories produced:

6.6.1 National directory. This directory will provide information on all HIV-related services and service providers operating in Cambodia; it will be reviewed annually and updated, as needed.

6.6.2 Small pocket sized directories for each target group. These directories will be distributed to MARPs during outreach. The content and design of these directories will be determined in consultation with clients to ensure suitability and utility. Recognizing the mobility of many MARPs, directories will contain countrywide service information. Print ready files of the directories will be sent to all relevant service providers to print and then distribute.

6.7 Outreach Workers (OWs)

OWs are responsible for delivering the Boosted CoPCT service package during outreach in the community (venues and hotspots) and in DICs, as well as for providing referral to other services.

6.7.1 Conditions of Service:

- OWs will be selected from the community they are to serve
- Transparent selection criteria and methods should be employed, such as social network analysis and nomination techniques
- OWs will receive regular training including comprehensive training at the beginning of service and monthly refresher courses thereafter
- OWs will be provided with the necessary equipment (e.g., uniform/t-shirt, badge, bag, BCC materials) to carry out their role
- OWs will be provided with an allowance of $60 per month for their work
- Each OW will have a minimum number of clients to make contact with each month (80-100 for EW, MSM and TG; and 30-50 for PWID and PWUD)

6.7.2 Responsibilities:

The OW is responsible for meeting on a regular basis (at least once per month) with clients to provide BCC, commodities and referrals to clients and to the client's primary partner, as appropriate. The specific roles of the OW entail:

6.7.2.1 Planning: Drafts a weekly activity plan for his/her defined outreach area (based the mapping)

6.7.2.2 Service delivery (Outreach):

Conducts outreach in venues and hotspots (e.g., karaoke/KTV, saunas, parks) and assigned DICs. Outreach will be conducted with individuals and/or small groups (3-8 people).

- Conduct counseling and HIV, syphilis test by finger prick, family planning (condoms, pills and depo provera)for MARPs; refer those who are HIV positive to do HIV test confirm at VCCT of the referral hospital having OI/ART sites. OWs refer MARPs having syphilis test positive to do RPR at the family health clinics or NGOs STD clinic nearby. OWs that responsible for the above activities must receive training and licensed from NCHADS and NGOs supervisors.
- Build and maintain good relationships with stakeholders, including establishment owners, health care providers, police and clients

6.7.2.3 Service Coordination/Referrals:

- Encourages clients to have two HIV tests and four STI screenings per year
- On every contact, provides clients with a referral card for STI and HIV testing, as well as other services, as appropriate (e.g., reproductive health, daily referral for MMT)
- Provides clients with a referral card for STI and HIV testing for the client's primary partner (using the partner referral card)
- Visits the health facilities (on a monthly basis) to collect referral cards and bring them to the implementing organization's office
- Promotes and provides clients with dates and times of mobile services, such as C/PITC

6.7.2.4 Coordination, M&E, Reporting:

- Completes primary data collection tools (OW log book) to record the delivery of Boosted CoPCT services, such as number of clients reached, and number of condoms and lubricants distributed
- Attends meetings, including those with other OWs and implementing organization staff to discuss issues, plan for upcoming activities, and to share progress and experience
- Compile the report every month and send them to NGOs

6.7.2.5 Outreach and other Service in the DICs:

- Liaises with health care facilities to schedule mobile service delivery
- Ensures all visitors are registered in the register log book and encourages new visitors to sign up for membership

- Ensures condoms are prominently displayed for distribution or social marketing
- Facilitates educational sessions, support groups, etc., as scheduled
- Organizes and participates in special events
- Provide other services same as point 6.6.2.2 for OWs receiving training and licensed from NCHADS and involved NGOs.

6.8 NGOs Support to OWs

6.8.1 Local NGOs who is responsible to monitor the outreach activities should supervise 15 Outreach Workers.

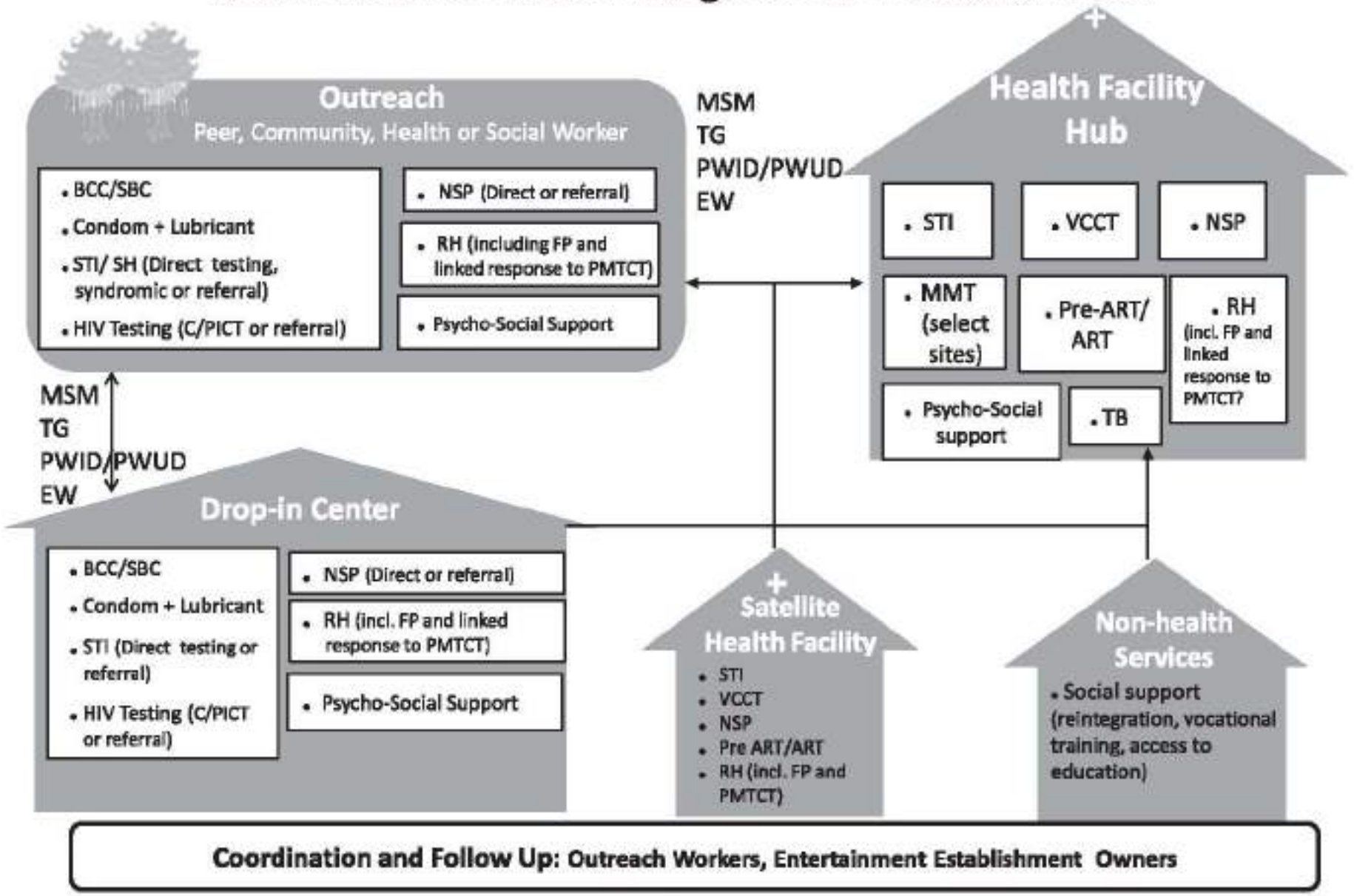
6.8.2 Roles and Responsibilities of NGOs supervisor

- Recruit OWs (Outreach Workers)
- Provide training and refresher session to the OWs;
- Develop monthly workplan and detail schedule for outreach activities;
- Supervise and monitor the implementation of outreach activities conducted by OWs;
- Organize monthly meeting for field staff and the OWs to discuss the progress of the activities, solve problems, address gap etc.;
- Attend DSC meeting every two months and ITB meeting every month;
- Participate in the training /workshop on HIV, syphilis counseling testing;
- Refer MARPs groups who are HIV positive for rapid HIV confirmation test to VCCT at Pre-ART/ART services;
- Ensure that MARPS who are HIV positive will receive immediately ART adherence.
- Collect monthly report from OWs and provide feedback;
- Submit quarterly report to OD HIV/AIDS coordinator and data management unit of NCHADS;

6.8.3 One local NGO staff should supervise:

- 4 OWs for EW or
- 4 OWs for MSM or
- 4 OWs for TG or
- 4 OWs for PWID or
- 4 OWs for PWUD.

Referral and Services Linkage for the Boosted CoPCT



7. Coordination and Management Structure

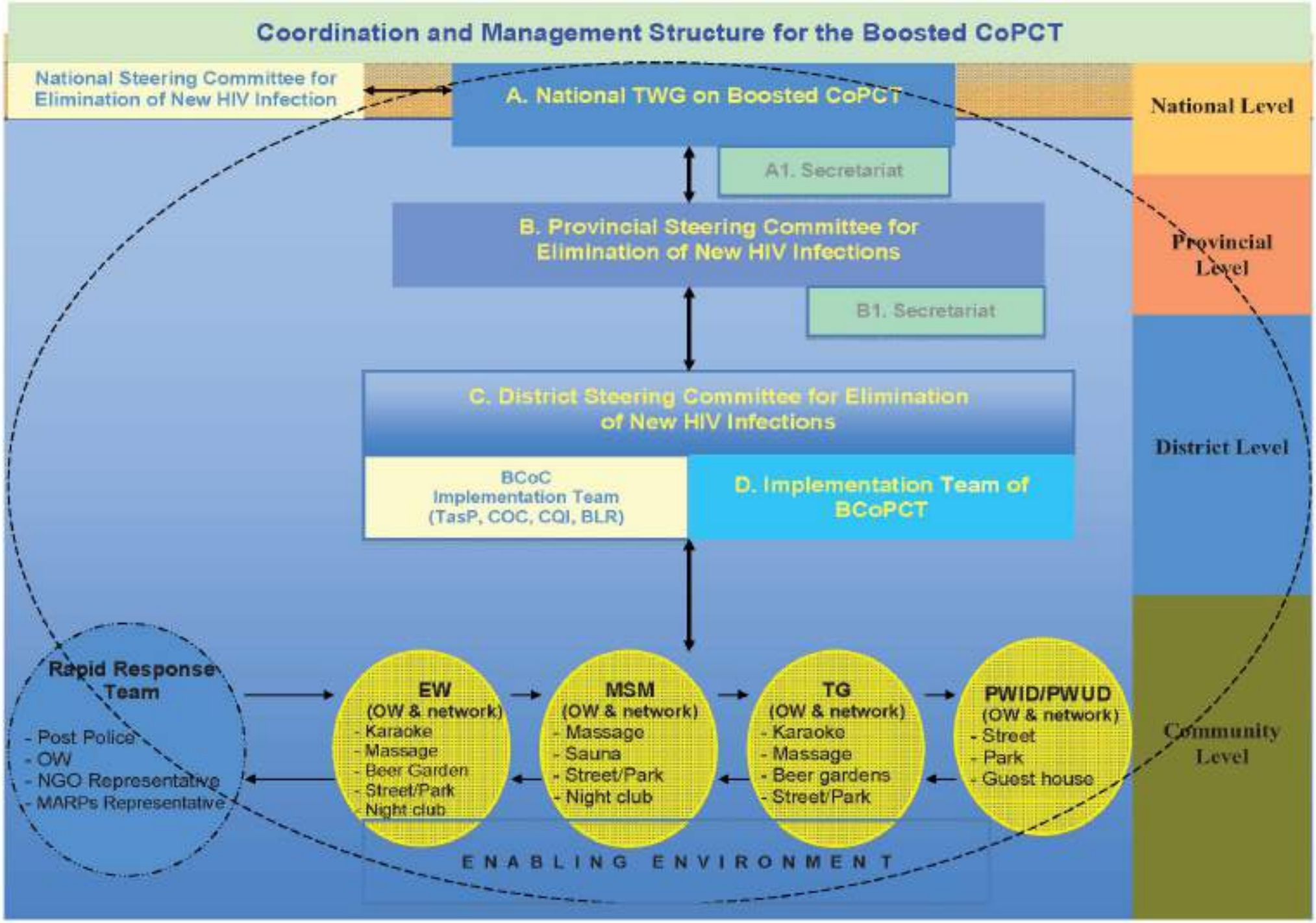
At the national level, the National TWG for the Boosted CoPCT (NTWG), which is chaired by the Director of NCHADS, will play a leading role in coordination, providing guidance, reviewing progress, and endorsing plans and budgets relating to the SOP. Of particular importance, the NTWG will also ensure harmony and synergy with the Boosted Linked Response and the Boosted CoC. Further, it will also be responsible for compiling reports and submitting them to the National Steering Committee. The NTWG will meet on a quarterly basis.

At the provincial level, the Provincial Steering Committee for Elimination of New HIV Infection (PSC), which is chaired by the Provincial Governor or Governor, will provide political support and overall management for the implementation of the SOP at the provincial and district levels. The PSC will also promote understanding of the Boosted CoPCT and coordinate initiatives under other 3.0 strategies (at the provincial level) to eliminate new HIV infection. This committee will meet two times per year. A secretariat will be established to provide support. This secretary will meet every month.

At the district level, the District Steering Committee for Elimination of New HIV Infection (DSC), which is chaired by the District Governor, will provide political support and overall management, coordination and guidance on the implementation of the SOP at the district and commune levels. In addition the DSC will be involved in the annual mapping of MARPs, hotspots and service delivery points. The DSC will meet every two months.

At the commune level, the Implementation Team of the Boosted CoPCT (ITB) will orient and update the local authority, the entertainment establishments' representatives and MARPs on the availability and location of services. The ITB will also ensure availability of condoms and lubricants in the entertainment establishments, and support the referral of MARPs to appropriate services. Further, the ITB will conduct a review of SOP progress and submit reports to the DSC every six months. The ITB will also compile quarterly reports and submit them to the Provincial Steering Committee as well as the District Steering Committee. The ITB will meet once a month.

Also at this commune level, the Rapid Response Team (RRT, composing of post police, OW, NGO, MARPs and Meka) will be responsible at the ground level for facilitating all activities relating to service provisions for MARPs (e.g. supply of condoms, educational activities, referral, mapping, training etc.). The RRT will interact and immediately deal with any incident which might happen and keep the ITB informed. This team will meet every month and will report to the ITB.


Coordination and Management Structure for the Boosted CoPCT
National Steering Committee for Elimination of New HIV Infection
A. National TWG on Boosted CoPCT
A1. Secretariat
B. Provincial Steering Committee for Elimination of New HIV Infections
B1. Secretariat
C. District Steering Committee for Elimination of New HIV Infections
BCoC Implementation Team (TasP, COC, CQI, BLR)
D. Implementation Team of BCoPCT
National Level
Provincial Level
District Level
Community Level
Rapid Response Team
- Post Police
- OW
- NGO Representative
- MARPs Representative
EW
(OW & network)
- Karaoke
- Massage
- Beer Garden
- Street/Park
- Night club
MSM
(OW & network)
- Massage
- Sauna
- Street/Park
- Night club
TG
(OW & network)
- Karaoke
- Massage
- Beer gardens
- Street/Park
PWID/PWUD
(OW & network)
- Street
- Park
- Guest house
ENABLING ENVIRONMENT

7.1 National TWG for Boosted CoPCT (NTWG B CoPCT)

7.1.1 Membership

• Director of NCHADS	Chair
• NAA Representative	Vice Chair
• MoI Representatives (head of HIV secretariat)	Member
• General Director of Health (MoWA)	Member
• NACD Representative	Member
• MoSVY Representative	Member
• USAID	Member
• USCDC	Member
• AusAID	Member
• KHANA	Member
• FHI360	Member
• PSI	Member
• RHAC	Member
• CWPD	Member
• HACC	Member
• CHAI	Member
• EW Representative	Member
• MSM Representative	Member
• TG Representative	Member
• PWUD/PWID Representative	Member
• PLHIV Representative	Member
• UNAIDS	Member
• WHO	Member
• Chief of BCC Unit	Secretary

7.1.2 Roles and Responsibilities

- Coordinate among the Boosted CoPCT, the Boosted CoC and Boosted LR
  Provide overall management and guidance on the implementation of the Boosted CoPCT
- Review progress of the Boosted CoPCT across targeted ODs for adjustment and improvement
- Prepare and endorse work plans and budgets for the Boosted CoPCT
- Ensure alignment of resources with the objectives and outcomes of the Boosted CoPCT and lead resource mobilization
- Ensure integration of enabling environment work within the Boosted CoPCT
- Review and incorporate emerging evidence in HIV into the Boosted CoPCT
- Compile reports and submit them to the National Steering Committee
- BCC & STI Units of NCHADS will conduct regular monitoring and supervision of the CoPCT activities at the Provincial and OD levels.

7.1.3 Secretariat: Chief of the BCC Unit of NCHADS will be the secretariat of the NTWG with the *additional assistance provided by relevant NGOs or UN agency.*

The responsibilities of the Secretariat are as follow:

- Organize meetings and set the agendas

- Take minutes
- Provide administrative, coordination and technical assistance to the NTWG

7.2 Provincial Steering Committee for Elimination of New HIV Infection (PSC)

7.2.1 Membership

• Provincial Governor or Vice Governor	Chair
• Director of PHD	Vice Chair
• Provincial Police Commissioner	Member
• PASP manager	Member
• Director of each Referral Hospital	Member
• Director of each OD	Member
• NGO Representative (Health/Non Health)	Member
• EW Representative	Member
• MSM Representative	Member
• TG Representative	Member
• PWUD/PWID Representative	Member
• PASP (BCC Officer)	Secretary

7.2.2 Roles and Responsibilities

- Provide political support and secure a safe environment for the effective implementation of initiatives to eliminate new HIV infection, including the Boosted CoPCT
- Provide overall management and guidance on the implementation of the Boosted CoPCT
- Promote understanding of the Boosted CoPCT within the provincial committee and with key stakeholders
- Coordinate initiatives to eliminate new HIV infection, including the Boosted CoPCT
- Ensure alignment of resources with the objectives and outcomes of the Boosted CoPCT and lead resource mobilization
- Ensure integration of enabling environment work within the Boosted CoPCT
- Monitor the results of the Boosted CoPCT
- Compile reports and submit them to the NTWG
- Meet two times per year.

7.2.3 Secretariat: PASP (BCC Officer) will be secretariat of the PSC, with the additional assistance provided by relevant NGOs.

The Responsibilities of the Secretariat are as follows:

- Organize meetings and set the agendas for meetings
- Take minutes
- Provide administrative, coordination and technical assistance to the PSC
- Provide necessary backup to the PSC, such as compiling data, drafting reports, organizing meetings, organizing trainings, etc.
- Conduct monthly field visits to all ODs to monitor and supervise Boosted CoPCT activities.
- Monitor activities of health providers and NGOs at the OD level

- Assist the PSC to develop letters of agreement with implementing agencies.

7.3 District Steering Committee for Elimination of New HIV Infection (DSC)

7.3.1 Membership

• District Governor or Vice Governor	Chair
• District Police Inspector	Vice Chair
• OD Director	Permanent Vice Chair
• RH Director	Member
• NGO Representatives (and OW Representative)	Member
• EW Representative	Member
• MSM Representative	Member
• TG Representative	Member
• PWUD/PWID Representative	Member
• Establishment Owners Representatives	Member
• HIV/AIDS OD Coordinator	Secretary

7.3.2 Roles and Responsibilities

- Provide political support and secure a safe environment for the effective implementation of initiatives to eliminate new HIV infection, including the Boosted CoPCT
- Provide overall management, coordination and guidance on the implementation of the Boosted CoPCT
- Carry out annual mapping of MARPs, hotspots and service delivery points and compile updated maps every quarter
- Ensure integration of enabling environment work within the Boosted CoPCT
- Monitor the results of the Boosted CoPCT
- Monitor and oversee the work of the Rapid Response Team to ensure it functions effectively
- Meet every two months

(The District Police Inspector will provide facilitation to HIV/AIDS activities and resolve any problem locally).

7.4 Implementation Team of BCoPCT (ITB)

7.4.1 Membership

- Outreach Worker
- NGO Representative
- Health staff (VCCT, STI, ART, MMT and SRH)

7.4.2 Roles and Responsibilities

- Orient and update local authority, entertainment establishments' representatives and MARPs on the availability and location of health and non-health services
- Ensure condom, lubricant, and other relevant HIV prevention commodities are available in and around hotspots and entertainment establishments
- Coordinate and develop MoUs with the establishment owners to facilitate the implementation of the Boosted CoPCT

- Perform outreach activities to target populations at the designated areas
- Refer MARPs to appropriate services (with possible transport support)
- Compile quarterly reports and submit to the PSC and the DSC
- Monitor referrals and provide feedback to service providers
- Allocate agenda time for community networks to raise pertinent issues
- Coordinate/ensure consistency of educational/BCC messages to be delivered by all implementing partners
- Meet on a monthly basis

7.4.3 Secretariat: NGO Staff member nominated by the DSCwill be the secretariat of ITB which will rotate on an annual basis.

The responsibilities of the Secretariat are as follows:

- Organize meetings and set the agendas
- Take minutes
- Provide administrative, coordination and technical assistance to the Implementation Team
- Compile the Quarterly report for submission to the PSC and DSC.

7.5 Rapid Response Team (RRT)

7.5.1 Membership

- Representative of post police at the OD level
- OW at the OD level
- Health Care workers
- MARPs representative (EW, MSM, TG and PWID)
- Meka of the entertainment establishment

7.5.2 Roles and responsibilities

- Facilitate HIV-related program activities, such as training, educational activities, supplies of condoms and other commodities, referrals, mapping, etc.
- Immediately respond to any incident and keep the IT and the DSC informed. The team will keep in contact through phon ecall or sms
- Conduct monthly field visits and meetings. These will rotate montly from one hotspot to another

Note:

- *The Post police will lead this meeting*
- *Each hotspot commune will have one RRT*
- *CCWC (Commune Committee for Women and Children) should be linked to (or be a member of) the RRT, especially when women and children are concerned.*

8. Enabling Environment

8.1 Human Right Protection

Royal Government of Cambodia has recognized and committed to promote and protect human rights of people living with HIV, as well as the rights of women, children, and members of vulnerable and most at risk of HIV populations in the context of HIV (UNGASS 2001). This only not reduce the personal suffering that can be associated with HIV , but also helps to create social and legal environment that encourage people to take up and use HIV services. Such efforts are essential to achieve the High Level Meeting targets in HIV prevention, treatment, care and support. Therefore, advancing human rights and gender equality is one of the three strategic pillars in the response to HIV. In order to protect people living with and affected by HIV and to support the effective response to HIV, national programme needs to include key programme to reduce stigma and discrimination, gender based violence and increase to justice. Their rights to equality- non-discrimination, dignity, respect and participation and voice should be protected. These programme not only help realize basic human rights and access to justice in the context of HIV, they are also critical enablers to the success of basic HIV prevention and treatment programme. Moreover, they should include capacity building and community mobilisation component so that those who are affected can participate in the design and delivery of the programme as well as leadership and advocacy for their HIV related rights.

Special provision and funding are being sought to protect the human rights and provide legal support to the key populations through a targeted legal service provision as a strong referral service. The toolkit developed by International Development and Law Organization (IDLO), in partnership with UNAIDS and UNDP, will be followed while designing the legal services to PLHIV and MARPs.

8.2 Legal Support

The provision of community legal support and services is recognized as being vital for members of MARPs to protect themselves and realize their rights, including accessing and utilizing HIV services. Because MARPs may be marginalized by mainstream society, they may experience stigma and discrimination and face harassment, rape, arrest, as well as loss of housing or other essential services. There is currently no system of documenting legal needs of PLHIV, including MARPS. The document for legal support to MARPs will be formulated in the future.

8.3 Gender Based Equality and Gender Violence

Addressing gender norms and inequities is essential to reducing HIV risk and increasing access to HIV prevention, care and treatment services for women and men. In Cambodia, more than half of those living with HIV are women. Under Boosted CoPCT, reproductive health counseling and services will be provided in outreach services as well as in OI/ART clinics, including providing services for FEW. HIV-infected women who become pregnant will be linked to ANC services and closely monitored in facilities and by MCH/HIV teams at the OD level to minimize loss to follow-up.

Gender-based violence is associated with increased HIV risk for men and women. Curriculum and tools to address GBV will be developed, with particular emphasis on reducing GBV for MARPS and identifying and addressing violence the context of disclosure and partner-testing.

8.4 Police Community Partnership Initiative (PCPI) (Focusing on the Roles of Police)

In the context of the Boosted CoPCT, the *enabling environment* is **defined** as all arrangements and activities at the national, provincial, district and commune levels that create *conditions* that support the smooth implementation of all services for MARPs delivered by government health facilities and NGO partners. Creating an enabling environment is part of the Boosted CoPCT to ensure all conditions required for supporting the country to achieve its 3.0 commitment are in place.

The enabling environment concept has been one of the main components of the MoI's Strategic Plan (for 2008-2013), which clearly states that the police are to serve as enablers at the community level for securing an environment in support of HIV/AIDS intervention among MARPs. As such, police will be active partners, along with OWs, NGO staff and members of MARPs in a new project called the Police Community Partnership Initiative (PCPI). The PCPI will work to prevent any difficulty and seek appropriate solutions to problems/bottlenecks that are occurring due to conflicts among laws or policies and HIV interventions among MARPs. For instance, there is a need to create links across the human trafficking and sexual exploitation law, the recent village safety policy, and the effective implementation of HIV/AIDS interventions, especially among MARPs. PCPI actions will include legal and/or policy adjustment, supporting mechanisms, coordination meetings, and monitoring visits.

The detail information for implementing PCPI is clearly highlighted in the 5 year strategic plan 2008-2013 of the Ministry of Interior.

8 Monitoring, Reporting & Evaluation

9.1 Reporting Process

The official reporting process for this SoP will involve the use of Outreach Worker Log Books by all OWs working with MARPs.

Data collection and reporting entail a number of stages:

1. Outreach workers record all contacts with their target members in their Log Books, including what type of services have been delivered to the client.

2. The NGO field office collects and consolidates the information contained in the OW Log Books on a monthly basis and enters this into their computerized databases.

3. The NGO then completes a quarterly report on the final day of the Quarter and submits this to the Implementation Team. Questions of clarification are asked of the NGO, as needed.

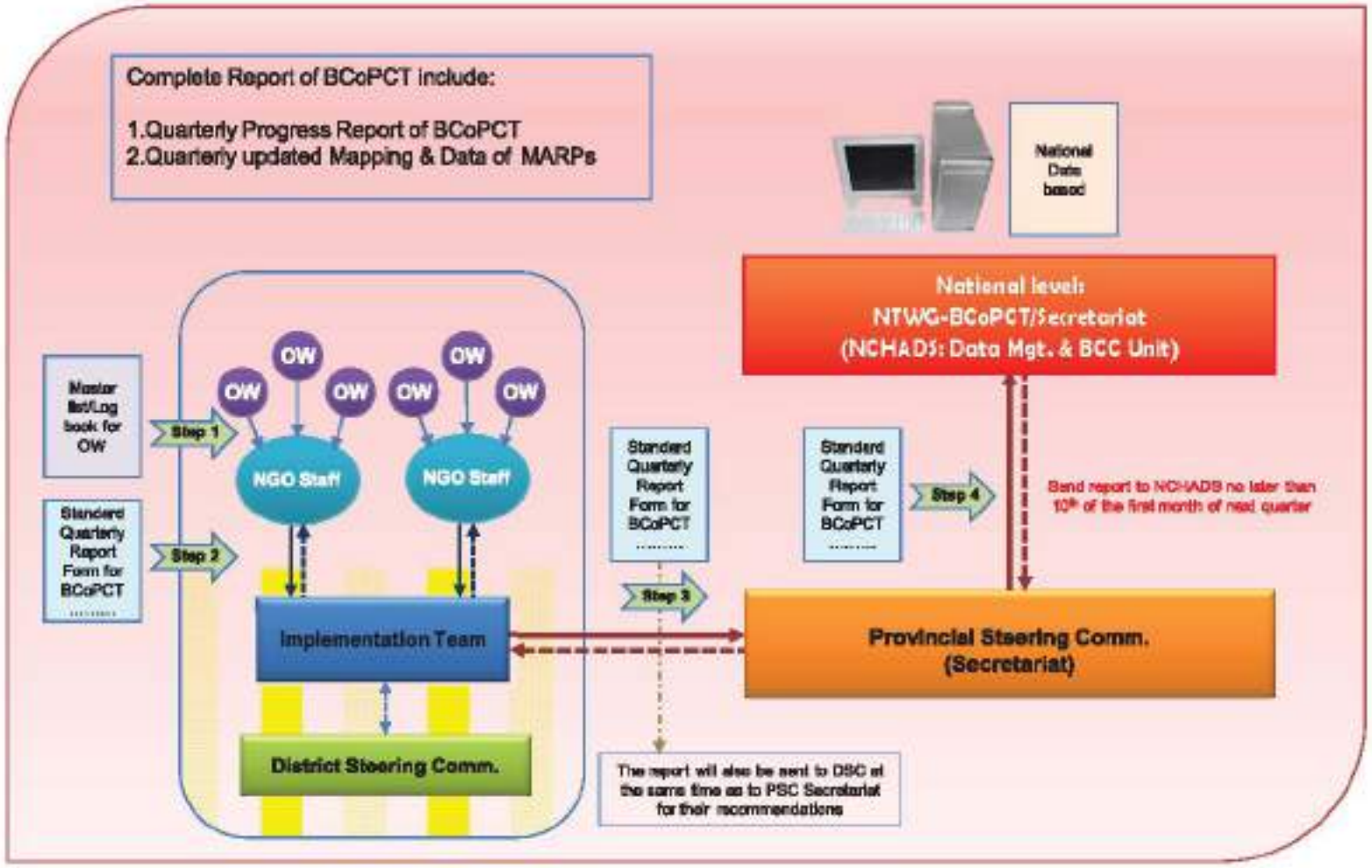
4. The Implementation Team then amalgamates all of the NGO reports into a quarterly reporting form and submits this form to the Secretariat of the Provincial Steering Committee.

5. At the same time the Implementation Team feeds the synthesized information back to the District Steering Committee for use in micro-planning.

6. The Secretariat of the Provincial Steering Committee then amalgamates all of the reports from the Implementation Teams into a final Provincial Quarterly Report on the Boosted CoPCT and submits it to the Secretariat of the National Technical Working Group on the Boosted CoPCT.

9.2 Data reporting flow

Reporting Flow



9.3 Indicators

No.	Indicator	Definition	Disaggregation	Data Source	Reporting Frequency
0	Mapping indicators				
0.1	**# and mapping of entertainment establishments and other open-air venues**	Count the number of entertainment establishments and other open air venues in each targeted OD	By - OD/Commune - Type of establishments/ venues (open-air) - MARPs groups/sub-groups who frequent it	PASP and OD Steering Committees	Annual with quarterly updates
0.2	**# and mapping of individual MARPs in each mapping location**	Estimate the number of individual MARPs present in each hotspot, irrespective of whether or not they are currently being reached by programs	By - OD/Commune/Hotspot - MARPs groups/sub-groups	PASP and OD Steering Committees	Annual with quarterly updates

No.	Indicator		Definition	Disaggregation	Data Source	Reporting Frequency
1	Coverage indicators					
1.1	Core package of prevention services for all MARPs	% of individual MARPs who attended HIV-related education sessions	Numerator: # of individual MARPs who attended at least one HIV-related education session during the reporting period; Denominator: Total estimated # of individual MARPs in OD assessed based on mapping	By - OD/Commune - MARPs group/sub-group - Sex	Consolidated data of health facilities and NGO implementers	Annual with quarterly updates
1.2		% of individual MARPs who received at least one sample condom (and lubricant if MSM/TG) free of charge	Numerator: # of individual MARPs who received at least one sample condom (and lubricant if MSM/TG) free of charge; Denominator: Total estimated # of individual MARPs in OD assessed based on mapping	By - OD/Commune - MARPs group/sub-group - Sex	Consolidated data of health facilities and NGO implementers	Annual with quarterly updates
1.3		% of individual MARPs who received an HIV test and the result through outreach CPITC or VCCT	Numerator: # of individual MARPs who received an HIV test and the result through outreach CPITC or VCCT; Denominator: Total estimated # of individual MARPs in OD assessed based on mapping	By - OD/Commune - MARPs group/sub-group - Sex	Consolidated data of health facilities and NGO implementers	Annual with quarterly updates
1.4		% of individual MARPs who received STI screening/test through outreach or at health facility	Numerator: # of individual MARPs who received STI screening/test through outreach or at health facility; Denominator: Total estimated # of individual MARPs in OD assessed based on mapping	By - OD/Commune - MARPs group/sub-group - Sex	Consolidated data of health facilities and NGO implementers	Annual with quarterly updates

2	Core Package Prevention Indicators – MARPs in general					
		Indicator name	**Definition**	**Disaggregation**	**Responsible source and tool**	**Reporting Frequency**
2.1	**Core package of prevention services for all MARPs**	**# of** individual MARPs who received the full package of core services	Count the number of individual MARPs who received, **at once, all** elements of the core package of services during the reporting period. Core package includes: 1. HIV -related education session 2. Provision of at least one sample condom (and lubricant if MSM/TG) 3. On-site provision/referral to HIV testing 4. On-site provision/referral to STI services	By - OD/Commune - MARPs group/sub-group - Sex	NGO implementers Consolidated data base of OW client log books	Quarterly
2.2	**HIV-related education through outreach work**	# of individual MARPs who attended HIV-related education sessions	Count the number of individual MARPs who attended at least one HIV-related education session during the reporting period	By - OD - MARPs group/sub-group - Sex	NGO implementers Consolidated data base of OW client log books	Quarterly
2.3		# of contacts in HIV-related education sessions	Count the total number of contacts, including repeat contacts with individuals that attended an education session during the reporting period	By - OD/Commune - MARPs group - Sex	NGO implementers Consolidated data base of OW client log books	Quarterly
2.4		# of individual MARPs who received at least one sample condom (and lubricant if MSM/TG) free of charge	Count the number of individual MARPs who received at least one sample condom (and water-based lubricant if MSM/TG) free of charge from an OW during the reporting period	By - OD/Commune - MARPs group - Sex	NGO implementers Consolidated data base of OW client log books	Quarterly

2.5	**Condoms and lubricant**	# of condoms with and without lubricant provided to MARPs free of charge through OW	Count the number of condoms with and without water-based lubricant distributed by OW to MARPs free of charge during the reporting period	By - OD/Commune - MARPs group - with/without lubricant	NGO implementers Consolidated data base of OW client log books	Quarterly
2.6		# of condoms sold/ distributed through social marketing	Count the number of condoms with and without lubricant sold/distributed as samples through sales representatives during the reporting period	By - OD - with lubricant/without lubricant	PSI	Quarterly
2.7	**HIV testing and results**	# of individual MARPs who (1) received an HIV test through outreach CPITC, (2) received the result and (3) tested positive	Count the number of individual MARPs who (1) received an HIV test through outreach CPITC, (2) received their results and (3) tested positive, during the reporting period	By - OD/Commune - MARPs group - Sex - tested/received results/tested positive	NGO implementers	Quarterly
2.8		# of partners of MARPs who (1) received an HIV test through outreach CPITC, (2) received the result and (3) tested positive	Count the number of partners of MARPs who (1) received an HIV test through outreach CPITC, (2) received their results and (3) tested positive, during the reporting period	By - OD/Commune - MARPs group - Sex - tested/received results/tested positive	NGO implementers Referral cards	Quarterly
2.9		# of individual MARPs who (1) received an HIV test at a VCCT site, (2) received the result and (3) tested positive #	Count the number of individual MARPs who (1) received an HIV test at a VCCT site, (2) received their results and (3) tested positive, during the reporting period	By - OD/Commune - MARPs group - Type of referral - Sex - Age - tested/received results/tested positive	VCCT records/Referral Cards	Quarterly
2.10		# of partners of MARPs who (1) received an HIV test at a VCCT site, (2) received the result and (3) tested positive	Count the number of partners of MARPs who (1) received an HIV test at a VCCT site, (2) received their results and (3) tested positive, during the reporting period	By - OD/Commune - MARPs group - Sex - Age - tested/received results/tested positive	VCCT registers/ Referral cards	Quarterly

2.11	**STI screening & Testing**	# of individual MARPs who received STI screening/test through outreach	Count the number of individual MARPs who received STI screening/test through outreach during the reporting period	By - OD/Commune - MARPs group - Sex	NGO implementers Consolidated data base of OW client log books	Quarterly
2.12		# of individual MARPs who received STI screening/test at health facility	Count the number of individual MARPs who period received STI screening/test at a health facility during the reporting	By - OD - MARPs group - Type of referral - Sex - Age	STI registers/ Referral cards	Quarterly
2.13		# of partners of MARPs received STI screening/test at health facility	Count number of partners of MARPs who received STI screening/test at health facility during the reporting period	By - OD - MARPs group - Sex - Age	STI records/ Referral cards	Quarterly
2.14	**Referral cards**	# of individual MARPs who received a referral card through OWs	Count number of individual MARPs who received at least one referral card from OW for personal/partner referral during the reporting period	By - OD/Commune - MARPs group and by their partners	NGO implementers Consolidated data base of OW client log books	Quarterly

3	Prevention Indicators – Specific MARPs Groups					
		Specific for PWID				
3.1	**NSP and MMT**	# of PWID who received sterile needles and syringes	Count number of individual PWID who received at least one set of sterile needles and syringes during the reporting period	By - Site - Sex - Age	NSP service provider registers	Quarterly
3.2		# of contacts made with PWID at NSP service sites	Count number of contacts made with individual PWID where at least one set of sterile needles and syringes were provided during the reporting period	By - Site - Sex - Age	NSP service provider registers	Quarterly
3.3		# of sterile needles and syringes distributed to PWID	Count number of needles and syringes distributed to PWID during reporting period	By - Site	NSP service provider registers	Quarterly
3.4		# of opioid dependent drug users currently enrolled in Methadone Maintenance Treatment Programmes	Count the number of opioid dependent DU currently enrolled in the Methadone Maintenaance Treatment program on the last day of the reporting period	By - Site - Sex - Age	MMT clinic patient register	Quarterly
		Specific for Female MARPs				
3.5	**Reproductive health services**	# of female MARPs who received reproductive health services	Count the number of individual female MARPs who received reproductive health services (including family planning, safe abortion, ANC and PMTCT services) at a health facility during the reporting period	By - OD - MARPs group - Type of referral - Age	Health facility records/ Referral cards	Quarterly

4	**Treatment Indicators – All MARPs Groups**					
4.1	**Treatment**	# of HIV+ MARPs who enrolled in pre-ART/ART care	Count the number of individual HIV+ MARPs who enrolled in pre-ART/ART care during reporting period	By - OD - MARPs group - Pre ART/ART - Type of referral - Sex - Age	ART registers/ Referral cards	Quarterly
4.2		# of HIV+ MARPs with advanced HIV infection on ART	Count the number of HIV+ individual MARPs eligible for treatment who were on ART at the end of the reporting period	By - MARPs group - Sex - Age	ART registers	Quarterly
5	**Enabling Environment Indicators – All MARPs**					
5.1	**Enabling Environment**	# of cases the Rapid Response Team was called out by MARPs to assist with	Count number of cases the Rapid Response Team was called out by individual MARPs to assist with	By - OD - MARPs Group - Sex	Rapid Response Team records	Quarterly
5.2		% of cases the Rapid Response Team took action on in response to a call for assistance by a MARPs	Numerator: number of cases the Rapid Response Team took action on in response to a call for assistance by an individual MARP Denominator: total number of calls for assistance by individual MARPs	By - MARPs group - Sex	Rapid Response Team records	Quarterly

6		**Indicators that require a Unique Identifier System**				
6.1		# and % of individual MARPs who received the minimum package of prevention services including monthly education sessions with sample condoms (and lubricant), HIV tests and results and STI screens/tests	Count number of individual MARPs who received/accessed all of the following core package services during the reporting period: - 6 education sessions with condoms (and lubricant for MSM/TG) – one per month - 1 HIV test in six months - 1 STI screen/test per quarter (2 in 6 months)	By - OD - MARPs group - Sex - Age	NGO implementers Consolidated data base of OW client log books	Every 6 months
7		**National Indicators measured with data from surveillance**				
7.1		**HIV prevalence in MARPs**	% of individual MARPs who are HIV infected.	by MARPs, by sex, by age	IBBS	Every 3/4 years for each MARPs
7.2		**Consistent condom use by MARPs**	% of individual MARPs reporting consistent use of condoms with partners.	by MARPs, by sex by age	IBBS	Every 3/4 years for each MARPs
7.3		**Condom use with last male partner by MSM and TG**	% of MSM and TG women reporting the use of a condom the last time they had anal sex with a male partner.	By age	IBBS	Every 3/4 years for each MARPs
7.4		**Condom use with last client by EW**	% of EW reporting consistent condom use with their most recent clients.	By age	IBBS	Every 3/4 years
7.5		**Condom use at last sex by PWID**	% PWID reporting the use of a condom the last time they had sexual intercourse.	By sex, by age	IBBS	Every 3/4 years
7.6		**Use of sterile needles and syringes at last injection by PWID**	% of PWID reporting use of sterile injecting equipment the last time they injected.	By sex, by age	IBBS	Every 3/4 years

9.4 Mapping and Micro-planning

9.4.1 Mapping

9.4.1.1 The purpose of the mapping is to:

- Enumerate entertainment establishments (EE) and other venues (e.g., streets, parks) in hotspot locations, member of MARPs frequenting each hotspot, and the type of health and non-health service providers and services provided. Maps should also record sites of condoms availability and service hours to assess if they are suitable for MARPs to access services.
- Produce estimates and inform micro-planning. Based on a good understanding of the needs and gaps, service providers can jointly plan well targeted and coordinated interventions.
- Complement and triangulate with results from national population size estimates carried out in connection with integrated biological and behavioral surveillance (IBBS) conducted every 3 years for each MARPs to produce mutually agreeable denominators for use as part of the M&E Framework.

9.4.1.2 Populations covered by Mapping

The populations covered by mapping are:

- EW – in EEs and other hotspots
- MSM – in EEs and other hotspots
- TG – in EEs and other hotspots
- PWID – in hot spots

In addition, the mapping team will document the organizations in the area that provide services from the service package to MARPs. This will include, but is not limited to:

- Health facilities providing services from the complete minimum package (public, NGO and private)
- Legal service providers
- Drop-in Centers
- MMT and NSP providers

9.4.1.3 Locations for Mapping

- Priority ODs that will be determined by NCHADS based in part on HIV prevalence.
- EEs and open-air hotspot venues, such as streets, parks etc. within the identified ODs.

9.4.1.4 Mapping Methodology

Mapping will be undertaken by the Provincial AIDS and STI Programme (PASP), NGO service providers, local authorities/PCPI and other stakeholders including representatives of MARPs. The District Steering Committee will be responsible for conducting the mapping, with technical and financial support from the PASP. In general mapping should be conducted during the 4th quarter of each year.

- **Training.** A national training workshop will gather representatives from each PASP and from NGOs providing outreach services. The PASP will be responsible for carrying out the mapping at the provincial level. At the workshop, training is

provided to the provincial representatives on how to properly conduct the mapping. Representatives are also guided in the planning and preparation of the mapping, as the level of effort involved with the mapping will vary from district to district, depending on size and the number and geographic distribution of EEs, the number of MARPs, and available services targeting MARPs.

- **Disseminate/Prepare for the Process.** The PASP representative will hold an initial meeting at the provincial level upon return, to relay the information from the national training to representatives of the District steering Committees and other stakeholders from the priority ODs within the province.
- **Form Mapping Teams.** After their return to the District level, the representatives of the PASP in cooperation with the District Steering Committee representatives who have received training begin mapping preparations. This entails convening meetings to establish Mapping Teams (MTs), comprised of representatives of the PASP and the District Steering Committee, NGO service providers (staff or OWs), MARPs representatives, establishment owners and local authorities/PCPI. This team's task is to collect the information in EEs and other hot spots.
- **Conduct Mapping.** MTs mark EEs and other hotspots on paper maps (previously drawn to represent the geographic area). The team then establishes a data collection plan and divides into smaller MTs to collect primary data from EEs and other hotspot venues.

Notes:

Data in EEs, where the target population are recorded by OWs, will be collected by the MTs from log books. In other EEs where there is no formal register, often in cases where the target population are the customers (e.g. saunas for MSM and TG and bars frequented by MARPs), the traffic through the venue will have to be estimated by key informants, such as the establishment owner or manager and the OW working in the particular venue. Data will be validated through separate interviews with local authorities and other key informants.

Data in hotspot locations other than EEs (e.g. parks and streets) will be collected in close consultation with outreach workers, community members and service providers. OWs providing outreach in these locations will estimate the number of individuals within target populations in each site. Where necessary, these figures can be supported and supplemented with information from other parties including local authorities.

Each NGO working in a particular district will allocate money to fund their own participation in the mapping process.

- **Compile data.** The data from different EEs and other hotspots are compiled into a master sheet and processed by NGO service providers to distinguish between high and low risk venues.
- **Validate data.** The master sheets from each District are sent to the PASP to check and validate the data and revert to MTs where necessary to obtain additional information or to seek validation or clarification.
- **Consult with stakeholders.** The PASP will arrange a meeting with representatives of the mapping teams within the province to discuss the initial

results and compile the data. The PASP will then draft a final report which will be sent to NCHADS, using the template and guidelines provided by NCHADS.

- **Discuss at national level.** Once the data has been compiled, they will be reviewed and discussed at a national workshop among provincial and District representatives. This workshop will be held to discuss problems faced during the mapping process and to identify potential solutions.

9.4.1.5 Quarterly Reporting

The District Steering Committee will also carry out a quarterly update on whether there has been closure or opening of EEs or other hotspots in their target areas and report on the number of individuals working/attending the establishments, according to the NGOs working in the area. A reporting tool will be created by NCHADS for this purpose.

9.4.2 Micro-planning

9.4.2.1 Once the data are validated, MTs at the District level will conduct micro-planning.

9.4.2.2 Micro-planning sessions involve the PASP, service providers, and other stakeholders including representatives of MARPs. Micro-planning entails planning how the package of services will be provided to each MARP, in each District, through a collaborative effort of service providers.

9.4.2.3 Main outputs of the micro-planning sessions are an agreement on denominators (number of various EEs and hotspots in need of services) and coverage targets for each service provider (number of EEs and hotspots to be reached by a specific package of interventions and by whom).

9.4.2.4 Achievement of results is measured by each service provider against its specific coverage target.

9.4.2.5 More specific and detailed information and instructions for mapping and micro-planning processes, including the tools to be used, will be provided at the national/regional training workshops. These workshops will draw from the experiences of those involved in prior mapping exercises carried out under the EW SoP for CoPCT.

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