Kingdom of Cambodia

National Religion King

Ministry of Health

Guidance Note on Integrated Case Management and Partner Tracing and HIV Testing for Cambodia 3.0 Initiative

October 2013

National Center for HIV/AIDS Dermatology and STD

CONTENTS

PREFACE

The Ministry of Health is conscious of the necessity of reduction of loss to follow up newly identified HIV cases and the need to ensure immediate antiretroviral therapy (ART) for people living with HIV, especially HIV infected pregnant women TB-HIV patients and HIV infected children under 2 years of age. Active Case Management is crucial to support immediate initiation of ART . In addition, partner tracing and HIV testing is considered as part of ART as prevention.

The Ministry of Health sets specific targets for elimination of new HIV infection especially from mothers to infants. To achieve these ambitious targets the Ministry recommended all concerned national centers including the National Center for HIV/AIDS, Dermatolgy and STD (NCHADS), the National Mother and Child Health Center (NMCHC) and the National Center for Tuberculosis and Leprosy Control (CENAT), and all development partners to review achievements, gaps and experiences in HIV prevention, care and treatment over the past 15 years, collect experiences from the United Nations and other countries, and use these evidences in developing major strategies including the boosted strategies to support the Cambodia 3.0 Initiative aiming at eliminating new HIV infections by 2020. The Ministry grant its official approval of the use of this Guidance Note and expects from all concerned national centers and development partners successful implementation.

Phnom Penh, 18 October 2013

Prof. ENG HUOT
SECRETARY OF STATE

ACKNOWLEDGEMENTS

Active Case Management and Partner Tracing and HIV Testing is an integral part of boosted strategies of the Cambodia 3.0 Initiative aiming at eliminating new HIV infections by 2020. In deve,oping this Guidance Note, a Core Group spent significant amount of time reviewing relevant documents and global and regional experiences.

On behalf of the Nationa Center for HIV/AIDS, Dermatology and STD, I would like to thank the Core Group that worked tirelessly on the development of this important document. My special thanks to NCHADS staff (Dr Seng Sopheap, Dr Samreth Sovannarith, Dr Ngov Bora and Mr Keo Vannak) and experts from development partners (Dr Masami Fujita from WHO; Dr Dora Warren, Director of US-CDC/GAP, Dr Perry Killam from US CDC/GAP; Ms Emily Welle from CHAI; Ms Chin Sedtha from UNICEF Ms Marie-Odile Edmond, UNAIDS Country Coordinator, Dr Bob Verbruggen and Dr Tea Phauly from UNAIDS; Dr Sok Bunna from USAID; Dr Laurent Ferradini, Mr Pav Chettana and Ms Amy Weissman FHI 360; and Dr Kaoeun Chetra from KHANA) who have provided relevant documents and shared experiences to ensure successful development of the Guidance Note.

Phnom Penh, ...17...October...2013

Dr MEAN-CHHI VUN

1. Introduction

Cambodia, facing in the mid-1990s one of the fastest growing HIV epidemics in Asia, became within five years one of the few countries to have reversed its trend. In 2010, Cambodia received a millennium development goal (MDG) award from the United Nations as a global recognition of the country's efforts on HIV that resulted in a decline of HIV prevalence from an estimated 2 % (among adults aged 15-49) in 1998 to a projected 0.7 % in 2010. The country has also achieved the universal access target for treatment, with around 80% of adults and children in need receiving antiretroviral therapy (ART).

In line with the global "Three Zeros" and "Treatment 2.0" initiatives, the National Center for HIV/AIDS, Dermatology and STI (NCHADS), Ministry of Health (MOH) launches a new strategic framework with targets, known as "Cambodia 3.0" which aim to eliminate new HIV infections by 2020. In order to operationalize the initiative, a series of national guidance documents have been developed, including SOPs for Continuum of Prevention to Care and Treatment (COPCT) for most-at-risk populations (MARPs), SOPs for HIV Testing and Counseling (HTC), SOPs for Boosted Linked Response (LR) towards elimination of mother-to-child transmission (eMTCT), SOPs for Continuum of Care (COC) for PLHIV, and Concept Note on HIV Treatment as Prevention.

This document aims to provide guidance for implementing two innovative activities, namely Integrated Active Case Management and Partner Tracing and HIV Testing. These activities are cross-cutting across several SOPs and a concept note mentioned above.

The implementation of these innovative activities requires engagement of a Case Management Coordinator (CMC) at OD level and Case Management Providers (CMP).

- The Case Management Coordinator is an OD HIV, TB, MCH Coordinator in most ODs while its task is performed by PASP staff in ODs located in provincial capitals. In high burden ODs, the Case Management Coordinator will be complemented by an assistant, who will be recruited to work specifically on active case management and partner tracing and HIV testing.
- The case management providers refer to existing service providers working in the OD. They include: midwife and HTC providers working at health centers, assigned nurse counselors, clinicians, data entry clerk at Pre-ART/ART sites of the provincial/district referral hospitals, and NGO supervisors.

2. Integrated Active Case Management

2.1 Background and rationale

Loss to follow-up from the cascades of HIV diagnosis and care, TB/HIV and PMTCT is a major concern for Cambodia and many other countries. Cambodia demonstrated very high ART coverage and retention while substantive dropouts appear to occur in other parts of the cascades, which undermines effectiveness and efficiency of the services. Also, partner tracing and HIV testing is a new approach which requires close follow-up of individuals.

Taking into account the decreasing trend of new case load and building on the linked response approach which successfully connected various services at different levels, Cambodia 3.0 plans to introduce an integrated active case management approach to optimize the cascades.

Active case management is a specific client-oriented approach to better respond to individual needs along the HIV service cascades. It is a proactive activity under the coordination and responsibility of the OD Case Management Coordinator in collaboration with CoC, LR and COPCT networks. Active Case Management aims to provide appropriate support to individual cases to receive needed HIV services across the CoC, LR and COPCT. It requires proactive monitoring and communication mechanisms to identify cases in need of specific follow-up and share the information through the Case Management Coordinator.

2.2 Objectives

The integrated active case management approach is expected to maximize retention and adherence to treatment along the HIV cascades and thus increase service effectiveness and efficiency significantly to improve patient morbidity/mortality and ensure patient HIV Viral Load control.

2.3 Strategies

A Case Management Coordinator at operational district level will play a central role to ensure active follow-up of individuals throughout HTC to pre-ART, during pre-ART/ART, TB/HIV, PMTCT and partner tracing and HIV testing processes in a cross-cutting manner, mobilizing and coordinating concerned service providers, CBPCS teams and outreach workers.

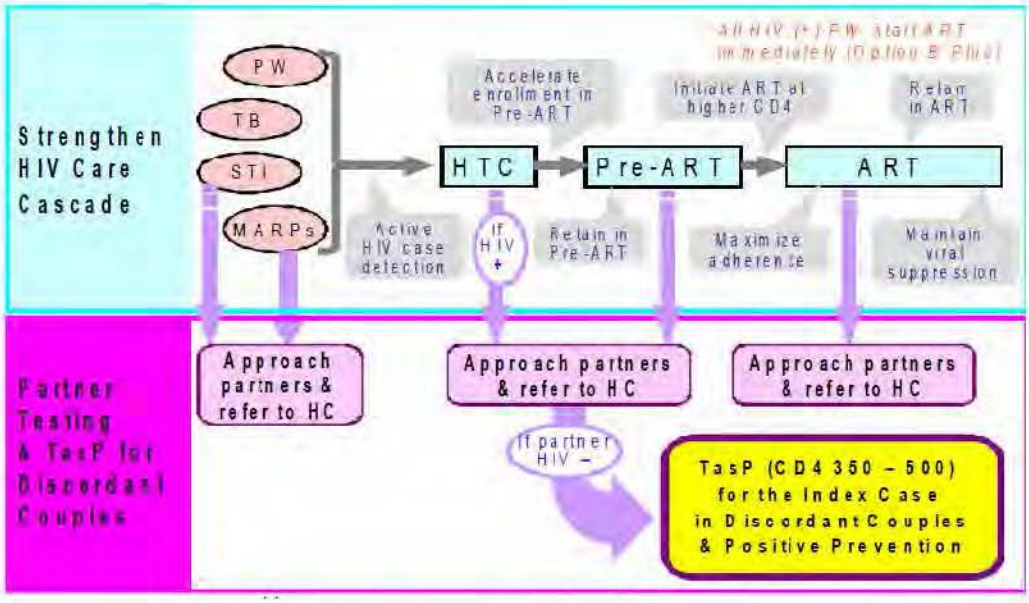


Figure 1: Care and Treatment Cascade, Partner Testing and TasP

2.1.1 The integrated active case management approach includes the following 6 major activities;

2.3.1.1 Initial agreement of active case management procedures in OD TWG on Cambodia 3.0 initiative

2.3.1.2 Identification and notification of cases requiring active follow-up by concerned service providers (Case Management Providers) supervised by the Case Management Coordinator

2.3.1.3 Creation and updating of the list for active follow-up coordinated by the Case Management Coordinator (on appropriate register tools)

2.3.1.4 Mobilization of those who should be involved in active follow-up for each individual case and establishment of communication mechanisms

2.3.1.5 Active follow-up of individual cases coordinated by the Case Management Coordinator

2.3.1.6 Recording and reporting on the process and outcome of the active follow-up

2.3.2 Cases requiring active follow-up include the following;

2.3.2.1 All cases with first HIV test found to be positive at HTC sites (i.e. VCCT, PITC for TB, PITC for EID, VCCT and CIPTC for MARPs);

2.3.2.2 PLHIV newly enrolled in pre-ART (Adult and Pediatric ART sites) and their partners and children of unknown status.

2.3.2.3 Sexual partners of PLHIV on pre-ART/ART who have not been tested in the last 6 months;

2.3.2.4 HIV+ pregnant women and their HIV-exposed children; PLHIV on ART at risk of poor adherence and LTFU and those referred to TB diagnosis.

2.4 The Terms of Reference for the Case Management Coordinator and his/her Assistant are provided below:

2.4.1 Terms of Reference for Case Management Coordinator (CMC)

- Appointment by PHD
- Reporting to PHD and National Program Focal Point
- Reporting to OD TWG on Cambodia 3.0 initiative
- Record all new HIV cases reported by Case management Providers at HTC sites, including VCCT facilities collocated with ART sites, and report directly to data manager and NCHADS.
- Conduct weekly follow up calls and visits to all facilities not submitting their HIV case reporting forms.
- Review HIV case reporting forms each week for completeness and aggregate all data on new cases requiring follow up with a view to accounting for all identified newly identified HIV cases, HIV-infected pregnant women and HIV exposed infants in specified OD.
- Communicate regularly with CBPCS teams and NGOs to activate follow up of HIV cases in the community on missed appointments notified by the HIV case providers
- Identify sites where new HIV cases, including mother-infant pairs, have been lost to follow up or other issues have been identified through the data review.
- Report all new HIV cases to ART staff, PHD and NCHADS.
- Submit report of active follow up activities to Technical Working Group each quarter.

2.4.2 Terms of Reference for Assistant to Case Management Coordinator (A-CMC)

Appointed by PHD and under the supervision of the Case Management Coordinator (CMC), the A-CMC will perform the following;

- Support the CMC to prepare for OD TWG on Cambodia 3.0 initiative meetings to discuss detailed active case management procedures in the OD;
- Serve as acting CMC in performing the task of CMC stipulated in the Guidance Note on Integrated Case Management and Partner Tracing and HIV Testing for Cambodia 3.0 Initiative issued by NCHADS. These tasks of CMC includes activities for: (i) Identification and notification of cases requiring active follow-up; (ii) Creation and updating of the list for active follow-up; (iii) Mobilization of those who should be involved in active follow-up for each individual case; (iv) Coordination of active follow-up of individual cases; and (v) Recording and reporting on the process and outcomes of the active follow-up;
- Regularly report the progress and challenges related to active case management to the CMC and seek advice and support;
- Perform other relevant duties assigned by the CMC.

2.5 Operations

2.5.1 Initial agreement of active case management procedures in OD TWG on Cambodia 3.0 initiative

Case management will be implemented at the OD level and the whole procedures for each site will be approved by the OD TWG on Cambodia 3.0 initiative. Mechanisms for Case identification, information flow and communication, active measures for case support using existing HCP and CBCS network, shared confidentiality principles (See Annex 1) as well as monitoring of case management itself will also be agreed at the OD level.

The OD Technical Working Group consists of the following members:

– OD Director	Chair
– OD Deputy Director	Vice Chair
– HIV OD Coordinator(Case Management Coordinator)	Secretariat
– Assistant to CMC	Secretariat
– HIV OD Coordinator with no pre-ART/ART services	Member
– Director/Deputy Director of RH	Member
– OD MCH Coordinator	Member
– OD TB Supervisor	Member
– Team Leader of the Pre-ART/ART (Adult/PAC) service	Member
– Data Manager of Pre-ART/ART service	Member
– Chief of Family Health Clinic	Member
– VCCT Counselor of the referral hospital	Member
– Chief of Maternity	Member
– Representative of NGO working on CBPCS, Prevention	Member
– Representative of Entertainment Establishment Owners	Member
– Representative of DPN+	Member
– Representative of MARP Networks	Member

- ***Representatives of relevant authorities (Police Commissioner and Women Affairs) will be invited for a specific meeting as appropriate.***

The TWG holds its meeting every six months.

2.5.2 Identification and notification of cases requiring active follow-up by concerned service providers

Precise mechanisms should be in place to allow rapid and effective identification of the cases requiring close follow-up:

2.5.2.1 Newly found first HIV test reactive cases at HTC sites (VCCT, PITC, CPITC)

- **An HTC provider (Case Management Provider)** who informs the client of the first HIV test reactive is responsible for:
  - Assisting the case for the referral to confirmatory testing at HTC sited co-located with ART sites;
  - Discussing with the case the sharing of the case information among the OD Case Management Coordinator and other relevant Case Management Providers such as counselors at confirmatory testing sites, and
  - Reporting the case to the OD Case Management Coordinator every service day when his/her informed consent is obtained.
- **A VCCT counselor (Case Management Provider)** who informs the client of the confirmatory test result is responsible for:

- Reporting on a weekly basis all the cases for confirmatory testing to the OD Case Management Coordinator.

- **A Case Management Coordinator** is responsible for:

  - Calling HTC sites which have not reported first test reactive cases in the past week;
  - Calling VCCT sites which have not reported confirmatory testing cases in the past week;
  - Ensuring the follow-up of each case until his/her enrollment in pre-ART care by coordinating relevant Case Management Providers including CBPCS network .
  - Reminding the VCCT providers to provide feedback on HIV test to HTC sites and report on summary of reactive results to relevant HTC providers;

2.5.2.2 PLHIV newly enrolled in pre-ART (Adult and Pediatric ART sites) and their partners and children of unknown status.

- **A nurse counselor (Case Management Provider)** at pre-ART enrollment is responsible for:

  - Asking the case about the HIV status of his/her partners and children;
  - Facilitating the case to disclose HIV status to his/her partners and helping the partners to access HTC according to the Partner Tracing and HIV Testing procedures (Page 16);
  - Arrange immediate initiation of ART according to the TasP protocol and other relevant SOPs once a partner of the newly enrolled PLHIV is found HIV negative (discordant couple) and if the patient is pregnant, co-infected with TB, or is the children aged under 2 years;
  - Discussing with the case the sharing of the case information among the OD Case Management Coordinator and other relevant Case Management Providers;

- **A data entry clerk** is responsible for:

  - Creating a list of newly enrolled HIV positive cases and report it directly to OD data manager;
  - Adding the name and contact information of partners and children of unknown status of these newly enrolled cases once the information is obtained (a link between the newly enrolled case and his/her partner to be specified);
  - Sending the list to the Case Management Coordinator weekly.

- **A Case Management Coordinator** is responsible for:

  - Actively remind the ART site in case the above list is not submitted in time;
  - Ensuring the follow-up of the PLHIV newly enrolled in pre-ART until ART initiation
  - Ensuring the follow-up of the partners and children for disclosure and HIV testing by coordinating relevant Case Management Providers including CBPCS network;
  - Ensuring immediate initiation of ART according to the TasP protocol and other relevant SOPs once a partner of the newly enrolled PLHIV is found HIV negative (discordant couple) and if the patient is pregnant, co-infected with TB, or is the children aged less than 2 years.

2.5.2.3 Sexual partners of PLHIV on pre-ART/ART (Adult ART sites) who have not been tested in the last 6 months

- **A data entry clerk** at the ART site is responsible for:

- Reviewing the record of PLHIV on pre-ART/ART once a month to identify their partners who have not been tested in the last 6 months and create a list;
- Send the list to the Case Management Coordinator every month

• **A Case Management Coordinator** is responsible for:

- Actively reminding the ART site in case the above list is not submitted in time;
- Ensuring the follow-up of the partners for testing by coordinating relevant Case Management Providers;
- Ensuring immediate ART initiation when a partner of PLHIV on pre-ART is found HIV negative (discordant couple) according to the TasP protocol.

2.5.2.4 HIV+ pregnant women and HIV-exposed infants

• **An HTC provider** is responsible for reporting pregnant women who are newly found first test reactive and referring them for confirmation and **a nurse counselor at pre-ART enrollment** is responsible for reporting newly enrolled in pre-ART, respectively, to a Case Management Coordinator, according to the procedures specified in sections 2.5.2.1 and 2.5.2.2 above.

• **A nurse counselor (Case Management Provider) at an Adult ART site** is responsible for:

- Informing the Case Management Coordinator of female PLHIV who become pregnant as soon as their pregnancy status is confirmed;
- Assisting the referral of HIV positive pregnant women to ANC and follow-up for PMTCT (i.e. referral to pediatric ART site) and life-long ART;

• **An HIV focal midwife (Case Management Provider) of a maternity service** is responsible for:

- Informing the Case Management Coordinator of HIV+ pregnant women and their HIV-exposed infants immediately after the cases are identified;
- Assist the referral to Pediatric ART sites

• **A nurse counselor (Case Management Provider) at a Pediatric ART site** is responsible for:

- Informing the Case Management Coordinator of HIV+ pregnant women and their HIV-exposed infants immediately after the cases are identified;
- Follow-up of the mother-baby pairs until the confirmation of HIV negative status or ART initiation of babies

• **A Case Management Coordinator** is responsible for:

- Reminding Adult and Pediatric ART sites and maternity sites which have not reported HIV positive pregnant women and HIV-exposed infants in the past week;
- Ensuring follow-up throughout the PMTCT cascade using a list of HIV positive and exposed infants coordinating Case Management Providers including CBPCS network.

2.5.2.5 PLHIV on ART at risk of poor adherence and LTFU and those referred to TB diagnosis

- **A nurse counselor (Case Management Provider) at an Adult or Pediatric ART site** is responsible for:
  - Listing PLHIV at risk of poor adherence and LTFU and forwarding to a data entry clerk every clinic day;

- **A data entry clerk** is responsible for:

  - Creating the list of patients who have missed appointment and have been referred to TB diagnosis every clinic day;
  - Adding PLHIV at risk of poor adherence, treatment failure, and LTFU provided by a nurse counselor to the list every clinic day;
  - Send the complete list to a Case Management Coordinator every clinic day.

- **A Case Management Coordinator** is responsible for:

  - Reminding Adult and Pediatric ART sites which have not reported the cases in time;
  - Ensuring the immediate follow-up of patients at risk of poor adherence and LTFU including those missed appointment coordinating Case Management Providers including CBPCS network;
  - Ensuring the weekly follow-up of patients referred to TB diagnosis;

A rapid assessment will be conducted to identify the risk factors for lost to follow up. Findings from this assessment will be used to establish criteria for targeting patients at risk for loss to follow-up. Also operational criteria of ART patients at risk of poor adherence (missing appointments, drug side effects, suspicion of treatment failure, switched to second line, etc.) will be developed. While waiting for the criteria to be developped, inrterim risks identified in the published scientific litterature and from field experience, will be used to determine if a patients is at risk for loss to follow up.

2.5.3 Creation and updating of the list for active follow-up by the Case Management Coordinator

- Items to be included in the list are name, sex, age, address, telephone number, key contact persons, record of contacting, info about partner(s), children
- By target group :

  - Existing formats (HIV+ PW and HIV-exposed infants; TB-HIV co-infected patients and IPT) regularly updated by Case Management Providers will need to be used to generate the list compiled by the Case Management Coordinator.
  - New forms (Newly found first HIV test reactive at HTC sites; PLHIV newly enrolled in pre-ART PLHIV and their Partners; Sexual partners of PLHIV on pre-ART/ART who have not been tested in the last 6 months; PLHIV on ART at risk of LTFU, poor adherence, treatment failure and death) will be developed to support active case managent and partner tracing and HIV testing.
  - The Case Management Coordinator will be responsible for regularly establishing and updating the summary list for active case management and partner tracing and HIV testing on a weekly basis.

- Data from electronic database, tailoring to the needs of Case Management Coordinator.
- Tools to update the list including newly and previously reported cases.

2.5.4 Mobilization of those who should be involved in active follow-up for each individual case with support from Case Management Coordinators and establishment of communication mechanisms

- A Case Management Coordinator is authorized to contact and mobilize those to be involved in active follow-up including ART site counselor, MMM/mmm coordinators, PLHIV workers, HC staff, CBPCS, MARP outreach workers.

2.5.5 Active follow-up of individual cases coordinated by the Case Management Coordinator ("Follow-up of Follow-up")

The preferred method is the use of CBPCS network to conduct active follow-up. If this approach fails, the Case Management Providers can use telephone call and even conduct home visits to the patients.

The use of SMS to strengthen communication between CBPCS network and HIV Care Team was piloted in Battambang and Siam Reap. This method will be revitalized with strengthened monitoring by umbrella NGO working on community based prevention, care and support for PLHIV (KHANA).

- Continue to motivate reporting of LTFU
- The Case Management Provider will follow up each case as soon as possible but no later five working days.

2.5.6 Recording and reporting on the process and outcome of the active follow-up

- A Case Management Coordinator will report the progress and challenges of active follow-up activities in quarterly meetings of "Sub Working Groups on ACM and PTT"(Case Management Coordinator being the secretariat) and in 6-monthly meetings of OD Technical Working Group
- OD Technical Working Group will send technical reports on its work to the Provincial Technical Working Group on Cambodia 3.o Initiative on a quarterly basis.
- Provincial Technical Working Group will send technical reports on its work to the National Provincial Technical Working Group on Cambodia 3.0 Initiative a quarterly basis.
- A format and content of the technical reports from OD and Provincial Technical Working Group on Cambodia 3.0 Initiative will be advised by the National Technical Working Group on Cambodia 3.0 Initiative.

Table 1. Summary of Operations for Active Case Management

Target group	(A) CMP for informed consent on shared confidentiality and follow-up	(B) Report to CMC	(C) Additional people for follow-up	(D) Points of follow-up	(E) When CMC to stop follow-up of follow-up	(F) Report format to be submitted
(i) Newly found first HIV test reactive at HTC sites	HTC provider VCCT counselor	HTC provider 1/day	CBPCS network	Access to confirmatory testing at VCCT and enrollment in pre-ART	Enrollment in pre-ART	New HIV Case Follow Up Register [New, see draft]
(ii) PLHIV newly enrolled in pre-ART PLHIV and their Partners and children	Nurse counselor in pre-ART enrollment	Data entry clerk 1/week	CBPCS network,	For PLHIV, attendance to pre-ART care, Timely initiation of ART, For partners and children, HTC	For PLHIV, ART initiation, For partners and children, HTC	New HIV Case Follow Up Register [New, see draft]
(iii) Sexual partners of PLHIV on pre-ART/ART who have not been tested in the last 6 months	N/A	Data entry clerk 1/month	Nurse counselor, CBPCS network 2nd line	HTC	HTC	New HIV Case Follow Up Register [New, see draft]
(iv) HIV+ PW and HIV-exposed infants	For female PLHIV on pre-ART/ART becoming pregnant, nurse counselor in pre-ART/ART site For HIV-exposed infants, nurse counselor of pediatric ART site and HIV focal midwife of maternity	For female PLHIV on pre-ART/ART becoming pregnant, nurse counselor in pre-ART/ART site For HIV-exposed infants, nurse counselor of pediatric ART site and HIV focal midwife of maternity	Depending on case: Adult/pediatric ART nurse ANC nurse CBPCS network 2nd line	ART, Delivery, ARV prophylaxis, HID, Pediatric ART	Confirmed HIV negative of infants Pediatric ART	Linked Response Follow Up Sheet
(v) PLHIV on ART at risk of poor adherence and LTFU and those referred to TB diagnosis	Nurse counselor in pre-ART/ART site	Nurse counselor in pre-ART/ART site 1/day	ART nurse 1st line CBPCS network 2nd line	Prevention of LTFU ART adherence	Risk of LTFU addressed ART adherence addressed	New HIV Case Follow Up Register [New, see draft]

2.6 Monitoring and evaluation

- Monthly/quarterly reports
- Use indicators for the cascades
- According to target group
- Issue of duplication, unique identifier code (UIC)

3. Partner tracing and testing

3.1 Background and rationale

The 2010 HIV projection and estimation in Cambodia indicated at least one third of new HIV infections would occur between sexual partner relationships, which include husband-wife and MARPs-sex partners. One of the major innovations of the Cambodia 3.0 is the introduction of partner tracing and HIV testing to address this remaining challenge towards the virtual elimination of new HIV infections by 2020.

Some developed countries such as Australia have been implementing partner tracing and testing for cases of STI including HIV for decades, while little have been documented on the experiences of developing countries.

A recent study in Malawi indicated 'provider referral' and 'conditional referral' were more effective in bringing sexual partners to HTC than 'client referral'. In Cambodia, although formal guidance has not been provided for partner tracing and HIV testing, counselors, PLHIV workers and peers, and HBC teams have been supporting disclosure of HIV status of PLHIV in care to their partners. Furthermore, couple counseling of pregnant women and their spouse/partners has been implemented to some extent in ANC settings in Cambodia.

This guidance note focuses on sexual and drug injecting partners of PLHIV on pre-ART and ART including those who are EW, MSM/TG, PWID/PWUD, pregnant women and TB cases.

3.2 Objectives

This approach will accelerate and maximize access to HTC and ART among those at highest risk and enable Treatment as Prevention (TasP) among discordant couples.

The partners of PLHIV will also serve as an entry point to roll-out snow-ball approach, which is potentially a very effective and efficient way of reaching those at high risk in the setting where HIV incidence is declining to a low level.

3.3 Strategies

3.3.1 Targeting all sexual partners and drug injecting partners of PLHIV

3.3.2 Supporting timely disclosure to partners and their access to HIV testing based on CoC, LR and COPCT outreach network;

3.3.3 Introducing "shared confidentiality" in managing PLHIV and their partners

3.3.4 Social mobilization and campaign to create supportive environment (for example with a slogan "Partner Testing Saves Lives", "Targeting more than 1/3 of new HIV infections in Cambodia", etc.)

3.3.5 Adapting existing tools to operationalize and monitor partner tracing and testing

3.3.6 Exploring innovative "snow-ball" approaches using identified partners as entry points

3.4 Operations

3.4.1 Targeting all sexual partners and drug injecting partners of PLHIV

- 'Sexual partners' include spouse, sweetheart, regular customers of EW
- Upon enrollment in pre-ART care, PLHIV will be asked the number of frequent sexual partners and drug injecting partners and their HIV status. If agreed, their names and contact will also be obtained.

3.4.2 Supporting timely disclosure to partners and their access to HIV testing based on CoC, LR and COPCT outreach network

- PLHIV will be encouraged to disclose HIV status to their partners. As needed, a range of options and possible support will be offered and time frame will be discussed.
- Options include client referral, provider referral, conditional referral
- Possible support include peer counseling, mobilization of human resources in CoC, LR and COPCT network
- Optimal time frame for disclosure is 1 month
- HTC for partners include referral to VCCT, CPICT, couple HTC, home-based testing

- Strengthening counseling skills on disclosure, couple counseling, couple conflict mitigation..
  - Roll-out of the new counseling curriculum
  - Addressing specific needs of SW sweethearts and regular customers, MSM couples.

- "MMM for partners" "Peer support groups of partners"

3.4.3 Introducing "shared confidentiality" in managing PLHIV and their partners

Annex 1 of this guidance note explains principles on share confidentiality that everyone involved in active case management and partner tracing and HIV testing, will need to adhere to in implementing the two innovative approaches.

3.4.4 Social mobilization and campaign to build supportive environment

- **Mobilizing PLHIV and MARP network and other social/internet network** to raise awareness and create positive atmosphere on partner tracing and testing
- **Materials: Positive messaging** – helping people access ART early to save life!
- **Advocacy and campaign mobilizing most influential figures** (e.g. First Lady, Red Cross, TV stars) to promote self and partner testing

3.4.5 Adapting existing tools

- Form for follow-up visits (form B) will need to be adapted by adding partner disclosure, new partners.
- Linking the PLHIV and their partners in the database

3.4.6 Exploring innovative "snow-ball" approaches

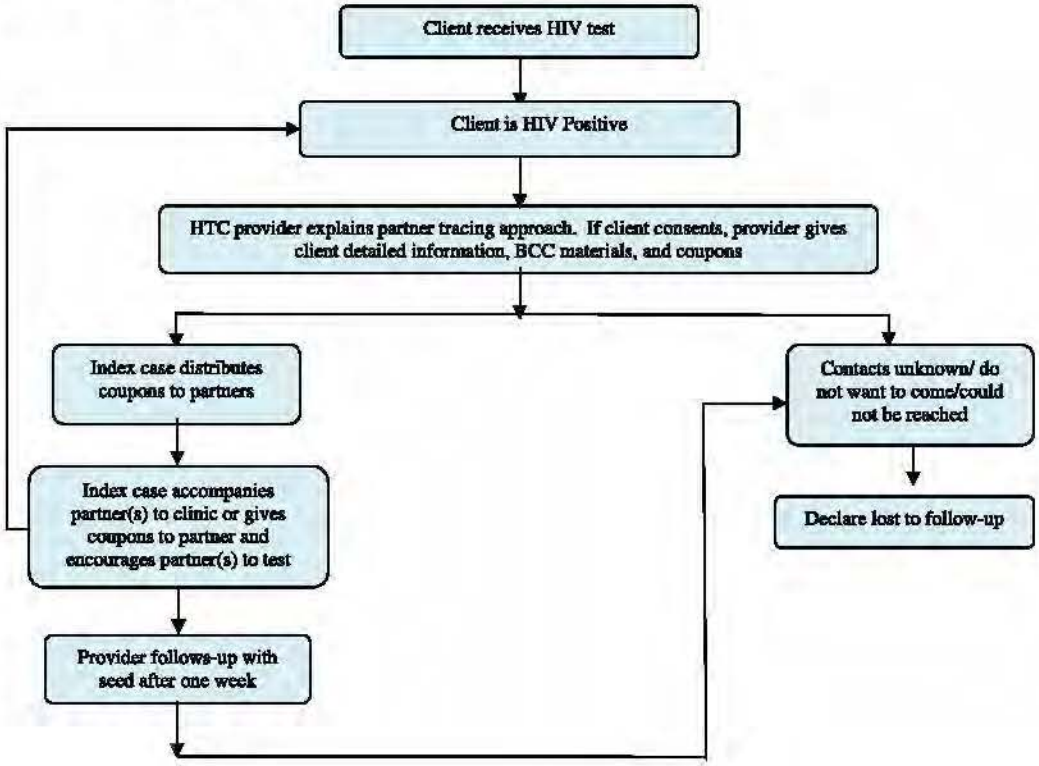
The purpose of the partner tracing snowball approach is to increase the detection of people with HIV. This will be done through a snowball partner tracing strategy, whereby individuals with a recent HIV diagnosis identify their partners (spouses first, clients, sweethearts) and close friends and refer them for testing.

Description of the approach

Each newly diagnosed HIV+ client will be considered as 'seeds'. Each seed will receive an explanation of the approach, including the benefits, and will be given 5 coupons that they use to recruit their partners/sweetheart/clients or close friends (so called 'partner') to have an HIV test. The 'seeds' refers his/her partner(s) for testing by providing them with a coupon that has a unique serial number. If the partner comes to the clinic for testing, the 'seeds' may become eligible for a reimbursement for their referral effort. The referred client may also be eligible for a reimbursement.

If the referred partner is HIV positive, s/he will be considered as a new 'seed' and will be provided with information and coupons. Participation in this snowball approach is to be purely voluntary. Further, anonymity is preserved as the coupons never mentioned the name of the 'seed' or partner but only the original number provided to the linked 'seed'.

HIV Partner Tracing Flow Chart:



ANNEX 1: SHARED CONFIDENTIALITY

1. Background

HIV care, treatment, and prevention services are confidential, meaning that what the service provider and the person discuss will not be disclosed to anyone else without the expressed consent of the person being tested.

It is also important to note access to HIV prevention, treatment, care and support should be recognized as fundamental to realizing the universal right to health, and these services should be implemented based on core human rights and ethical principles (WHO 2013).

Although confidentiality should be respected, it should not be allowed to reinforce secrecy, stigma or shame. Counselors or other relevant health workers should raise, among other issues, whom else the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner or family members and trusted others and with health care providers is often highly beneficial.

In Cambodia, HIV related services are offered by a wide range of service providers across the continuum of the community, health centers, and referral hospitals including their different departments and clinics. These services should not only benefit PLHIV but also their partners. To maximize the effectiveness of these services, the provision of referral and follow-up as well as partner tracing and HIV testing is critical. It requires the sharing of the client information among these service providers and PLHIV's partners while confidentiality should be fully protected and informed consent should be always obtained.

2. Aims of shared confidentiality

To promote better care, treatment, support and prevention for individuals, partners, families and communities affected by HIV

To ensure that a rights-based approach is implemented throughout the process of HTC,pre-ART, ART, TB/HIV and PMTCT as well as partner tracing and HIV testing.

3. Shared confidentiality in practice

In the Integrated Active Case Management (IACM) and Partner Tracing and HIV Testing in Cambodia, shared confidentiality should implemented according to the Table 1 on Page14);

- For each target population, a Case Management Service Provider is assigned to discuss with the client the sharing of the client information among the concerned service providers and obtains the informed consent (Column A).
- The client information will be forward to the Case Management Coordinator at the OD level (Column B)
- The Case Management Coordinator will identify who should receive the case information for the client follow-up ensuring confidentiality (Column C)

For the Partner Tracing and HIV Testing, particularly for the disclosure to the client's partners, specific procedures should be followed as stipulated in the Partner Tracing and HIV Testing Section of this document.

ANNEX 2: CURRENT DRAFT SECTION ON PARTNER TRACING AND TESTING IN SOPS FOR B-COPCT

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.

4. Strategies:

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

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) see A
- Method (D): *Client referral without disclosure*: Client promotes HIV testing to their partners without disclosing their own status by using a partner referral card see A

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)

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 get a test and to contact her/his partner(s) to encourage uptake of HIV testing via:

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

2. Implementation of the methods:
For HIV positive index cases, Method (A) is to be offered first see above. 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).

2.1 Guidance for implementing each Method is as follows:

2.1.1 Method (A) Provider referral and Method (C) Conditional referral (in case provider needs to contact the partner(s))

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

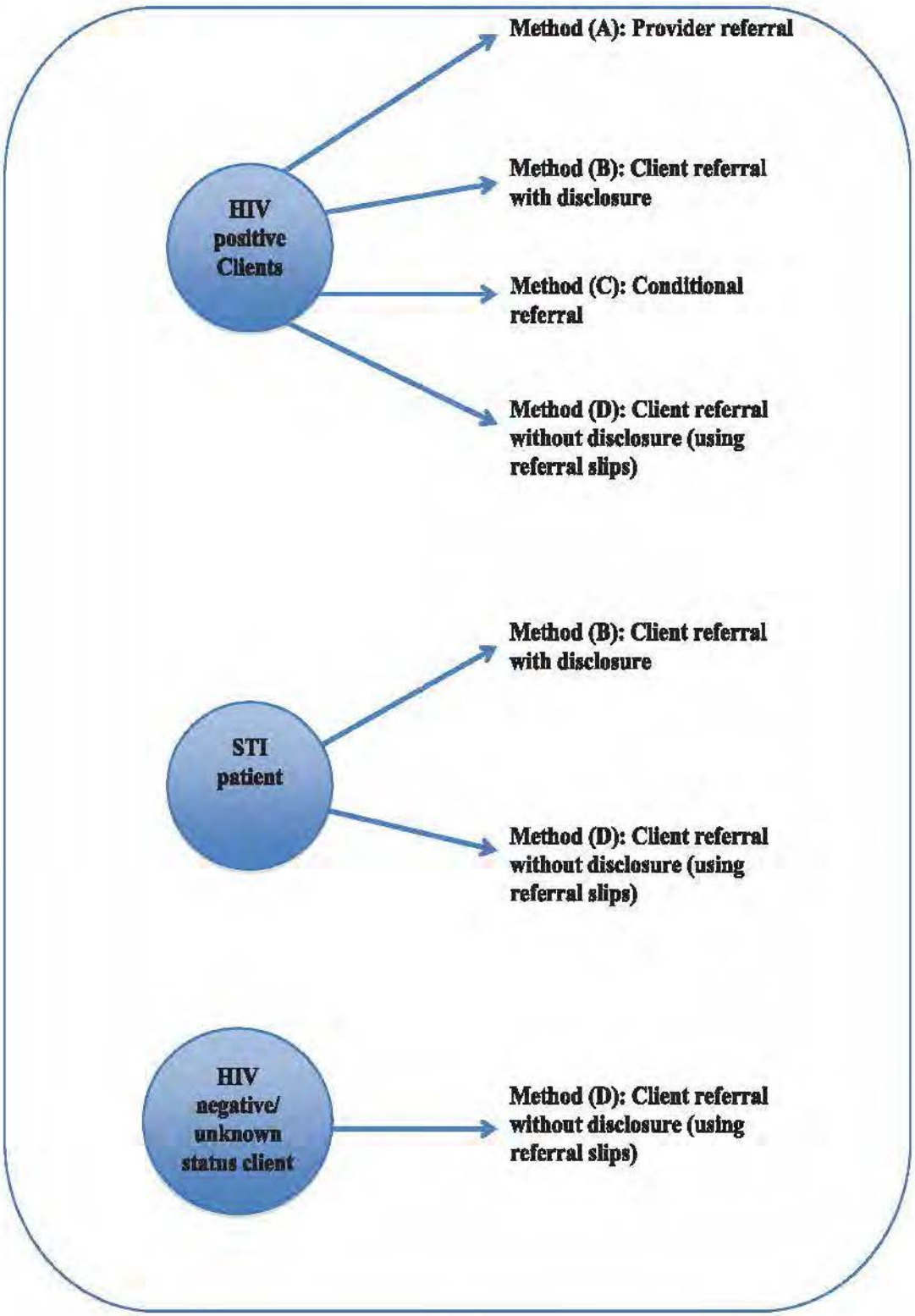
2.1.2 Method (B): Client referral with disclosure

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.

2.1.3 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.

Figure 2: Partner Tracing and Referral Strategies



2.2 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