KINGDOM OF CAMBODIA
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MINISTRY OF HEALTH

Phnom Penh, Date: 12 / July / 2011

No.....148...DGH.

To : Dr. Mean Chhi Vun
Director
NCHADS
#245, Str 6A, Phum Kean Klang,
Sankat Prek Leap,Khan Russey Keo,
Phnom Penh, Cambodia

Dear Dr. Mean Chhivun,

Subject: ***Approval for the implementation of the concept note on increasing the access to HIV Testing and Counseling through Community/Peer Initiated Testing and Counseling (C/PITC) among most at risk population (MARP).***

With reference to your letter No.0352 NCHADS, dated 17 March, 2011, the Ministry of Health has approved the implementation of this concept note on increasing the access to HIV Testing and Counseling through Community/Peer Initiated Testing and Counseling (C/PITC) among most at risk population (MARP).

Yours Sincerely,

Prof. ENG HUOT
SECRETARY OF STATE

KINGDOM OF CAMBODIA
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Ministry of Health

National Center for HIV/AIDS,
Dermatology and STDs

No. 0352.NCHADS

Phnom Penh, 17/03/2011

Prof. Eng Huot,
Secretary of State
Ministry of Health
#151-153, St. Kampuchea Krom,
Phnom Penh, Cambodia.

Excellency,

Subject: ***Request for approval the concept note on increasing the access to HIV Testing and Counseling through Community / Peer Initiated Testing and Counseling (C/PITC) among most at risk population (MARP).***

I would like to inform your Excellency that the National Center for HIV/AIDS, Dermatology and STD and its partners has prepared a concept note on increasing the access to HIV Testing and Counseling for MARP (EW, MSM) through Community / Peer Initiated Testing and Counseling (C/PITC).

NCHADS and its partners aim to increase access to testing and counseling for MARPs from 20% in 2010 to 80% by the end of 2015. The first implementation period will last for 12 months and aims to cover 30 target communities in Phnom Penh and some additional provinces. We will seek to improve and extend the implementation in Cambodia after 2012, based on an evaluation of the experience in the first phase of the implementation.

We, therefore request for approval from the Ministry of Health for the implementation of this concept note.

Please accept, Yours Excellency, the assurance of my highest consideration.

Yours Sincerely,

Dr. MEAN CHHI VUN

#245 H, Street 6A, Phum Kean Klang, Sangkat Prek Leap, Khan Russey Keo, Phnom Penh, Cambodia, E-mail: info@nchads.org, Website: www.nchads.org

KINGDOM OF CAMBODIA

Ministry of Health **Nation Religion King**

National Center for HIV/AIDS,
Dermatology and STDs

Concept Note on Increasing MARPs (EW and MSM) Access to HIV Testing and Counseling through Community/Peer Initiated Testing and Counseling (C/PITC), 2011 to 2015

C/PITC - Community/ Peer Initiated Testing and Counseling
EE - Entertainment Establishment
EW - Entertainment Worker
IDU – Injection Drug User
MARPS - Most At Risk Populations
MSM - Men who have Sex with Men
PE – Peer Educator
PF – Peer Facilitator
PITC - Provider Initiated Testing and Counseling
STI - Sexually Transmitted Infection
VCCT - Voluntary Confidential Counseling and Testing

1. Introduction:

Cambodia's HIV prevalence has fallen from an estimated peak of 2.0% in 1998 to 0.9% in 2006, with declines in new infections attributed largely to increased condom use in brothels through initiatives like the 100% Condom Use Program, which provided Sexually Transmitted Infection (STI) education to Female Sex Workers (FSW) through outreach workers and monthly STI check-ups. However since 2006, large numbers of non-brothel entertainment establishments (EEs) have opened, challenging the coverage of preventive services. Cambodia maintains a high prevalence of HIV among high risk groups: brothel-based female sex worker 14.7% in 2006, injecting drug user 24.4% in 2007, MSM living in the capital city 8.7%. Persistent high HIV prevalence in these populations could be the nidus for a second wave of HIV epidemic in the absence of robust preventive measures.

EWs and MSM subgroups have different HIV risks. Among EW, 13.3% report that they never had sex (2010 BSS). EWs can be mobile: changing both city locations (1/3 had been living in their current city for less than a year) and changing professional categories (karaoke workers, beer promoters, brothel workers). Within MARPs there are high risk subsets. Among EWs, the highest risk for acquiring HIV appears to be among young EWs in their first year of work. Among MSM, "long haired"/ transgendered MSM and "short haired" MSM differ in sexual risk and HIV prevalence (9.8% versus 2.6% in the 2005 STI survey and 5% versus 2% in the 2010 Bros Khmer). In the Young Women's Health Survey, the FSW who use drugs are at high risk of HIV. MARP networks provide an efficient communication channel to a mobile population and might help target HIV testing to those MARPS at highest risk.

HIV knowledge remains high among EWs and MSM, although HIV knowledge does not always translate into protective behaviors. Among EWs in the 2010 BSS, approximately 90% of EWs reported receiving HIV/ AIDS information. In the Bros Khmer, most MSMs correctly knew that using condoms could reduce the risk of HIV transmission (87.0%) and a healthy-looking person could have HIV (83.9%). Most respondents (83.3%) knew where to receive HIV testing. Among EWs, condom use with clients remains high: over 95% reported using a condom with the last client and overall 83% reported consistent use of condoms with clients in the past week. However, consistent condom use with husbands and sweethearts remains low: less than 20% reported consistent use with husbands and 40.5% reported consistent use with sweethearts over the past three months.

HIV Testing and Counseling is an important entry point for HIV prevention, care, treatment and support services. A relatively high percent of EWs reported that they tested for HIV in the past year (63.7% of EW's with ≤ 2 partners/ day and 81.5% of EW with more than 2 sexual partners per day, 2010 BSS). Of those who were tested, over 95% received counseling and the results of their HIV test. Among urban men in the 2010 Bros Khmer study, 50.6% of MSM had ever been tested for HIV. The 2007 BSS reported that 58% of MSM surveyed had had at least one HIV test and knew their test result.

HIV testing percent among EWs and MSM from routine program reports is less clear because HIV testing has been reported per visit, not by unique individual. In 2010, NCHADS estimated that the coverage of HIV testing and counseling among EWs at VCCT services was 20%. In addition, MSM or EW attending VCCT centers may not be recognized or tallied as MSM or EW, since this information is not routinely collected. The service delivery numbers for HIV testing also do not account for testing performed in private clinics or pharmacies, which have been identified by EWs and MSM as sources of HIV testing (TRaC survey 2009, Bros Khmer).

The 2002 law on HIV Prevention and Care HIV Testing and Counseling upholds that voluntary consent to testing, confidentiality of results and counseling are required for all HIV testing, consistent with the "Three Cs" (Consent, Counseling and Confidentiality) principle promoted internationally (UNAIDS/WHO 2004). Voluntary Confidential Counseling and Testing (VCCT), is available in all 24 provinces at a variety of sites: referral hospital grounds, health centers or NGO clinics in the community. VCCT has expanded to 239 sites at the end of 2010. The Ministry of Health policy allows for blood testing using a serial algorithm of two different rapid HIV tests performed by trained laboratory technicians situated at the VCCT or at laboratories attached to larger HCs and RHs. At the VCCT sites, self-referred clients are the most common type, although the VCCT also caters to STI, TB and patient from other services.

In 2006, Cambodia launched HPITC (Healthcare Provider-Initiated Testing and Counseling), an approach whereby healthcare providers recommend HIV testing to all clients of a target population (TB, STI, ANC clinic attendees, HIV exposed infants and patients in infectious disease wards). HPITC has been successful in increasing HIV testing among TB patients (70.6% in 2009, in approximately 78.3% in 2010) and ANC attendees (approximately 80 %), and is expected to begin increasing HIV testing among STI patients. HPITC is an effective model once patients enter the public health services but doesn't extend to populations in the communities or private clinics.

In 2009, the Standard Operating Procedures (SOP) for Continuum of Prevention to Care and Treatment (COPCT) for Women Entertainment Workers in Cambodia was approved by the MOH and sought to ensure consistent preventive measures (condom use, HIV and STI testing, birth spacing) and strengthen the monitoring, coordination and collaboration between network support groups and health services for EWs. The SOPs were scaled nationally; however, there has not yet been a dramatic improvement in HIV testing and counseling among the EW and MSM groups.

In Entertainment Establishments (EEs), EW networks have been established by NGO's such as FHI (SmartGirl), KHANA and RHAC. M-Style is a network for MSM. The SmartGirl network covers 10 provinces and approximately 12,000 EWs and KHANA covers 10 provinces and approximately 7,000 each for EW and MSM (Table 1). On a regular monthly basis, the network members meet to discuss knowledge, skills and experiences in sexual health and HIV prevention facilitated by Peer educators (PE) and Peer Facilitators (PF). Some of the recruitment and education sessions occur at the EEs and some of the sessions occur at meeting points (called a "safe space" or a Drop in Centers). PEs are selected from the target populations and receives training from the NGO outreach staff. Each PE is responsible for 10 - 20 EWs/ members. Peer Facilitators (PF) are recruited among the PEs to organize and facilitate the educational sessions. A Me-Kar has connections to the EE owners and may be the EE manager. The Me-Kar supports the coordination and implementation of the educational sessions at the EE and meeting points. The PE/ PF report their activities to the DPCT (District Prevention to Care Delivery Team) on a quarterly basis.

Table 1 MARP network coverage by NGO and EW/ MSM participants

NGO	EW	MSM
FHI	12,000	7,000
KHANA	7,000	7,000+
AFESIP	5,600	
ACTED PSF-Cambodia	4,468	
RHAC	10,000	
CWPD (GFATM Round 7)	8,000	

2. Rationale: *Why P/CIPT is needed?*

The Community/ Peer Initiated Testing and Counseling approach addresses the low uptake of HIV testing services among EWs and MSM recognized through the public health VCCT centers. Peer networks have been used in a number of settings to increase uptake of clinical services among low-literacy and difficult to reach populations. The peer networks will educate and mobilize their members to improve the demand for HIV testing and counseling and to attend meetings at the Drop in Centers. Drop in Centers will be used as a MARPS-friendly venue for outreach VCCT provision by health center staff. In addition, clients served through this C/PITC will be recognized as an EW or MSM.

Once the EWs go for HIV testing, over 90% percent report receiving posttest counseling and their HIV result. It's unknown, but will be asked in the upcoming STI Survey, whether EWs found to be HIV-infected actually enroll in the OI/ ART clinic and enter promptly into care and treatment. In addition, we don't know whether HIV-infected EWs and MSM continue to have sexual risk behavior with clients and partners. There is evidence from HIV-infected general populations that an HIV diagnosis results in reduced sexual risk taking and transmission to others, although the PLHIV in the 2010 BSS reported continued sexual risk: 3.9% – 9.0% had a sweetheart in the past 6 months and consistent condom use with the sweetheart was 50% or less. Of sexually active PLHIV men, 9.0% (OI) - 13.3% (ART) reported having paid sex, and only 52.4% (OI) to 72% (ART) reported using a condom with a sex worker at last sex.

There are other approaches for providing MARPS-friendly services. EW or MSM-friendly clinics (Chhouk Sar clinic in Phnom Penh for example) have been set up by FHI and run by peer support groups to provide HIV testing, HIV care and treatment. However these separate services are NGO-funding dependent and relatively expensive compared to use of existing government facilities and staff.

Although IDU represent an important MARP group at high risk of HIV infection and transmission, there are no existing IDU peer networks. At this time, the scope of the C/PITC will be for EWs and MSM.

3. Objective

In order to reduce HIV transmissions among MARPS groups, C/PITC will seek to:

- Increase the HIV testing and counseling coverage among EW and MSM
- Increase the number of HIV infected EW or MSM accessing HIV care and treatment services
- Reduce risk-taking behaviors such as unprotected sex, especially sweethearts

C/PITC will be one approach in a combination prevention strategy which will include the existing self-referred VCCT, HPITC from STI/ RH clinics, mass media messages, substance use education and behavioral interventions for male sweethearts.

4. Implementation

The activities and reporting described in the Standard Operating Procedures (SOP) for Continuum of Prevention to Care and Treatment for Women Entertainment Workers in Cambodia will continue as described in the SOP.

*Preparation for the implementation of the C/PITC*Conduct situational analysis/mapping of PE/PF networks to assess suitability of the venues to C/PITC and the scope of MARP networks

Provide training to VCCT staff in EW and MSM groups to improve MARPS-friendly attitudes and reduce stigma or discrimination.

Organize orientation/sensitization of PE/PF and VCCT staff on the 3C principles (consent, counseling and confidentiality) and the C/PITC approach to principles of HIV testing and counseling will be organized.

Identify VCCT Centers (nearest to the drop in centres/meeting points) that will be responsible for staffing, Logistics logistics and supplies management (LSM) including HIV tests and consumables.*Strengthen EW/MSM Networks (PF/PE) to support C/PITC*

EW and MSM Networks will develop the annual meeting plan and share it with NCHADS Team, PHD, OD, RH and HC where VCCT are available

Pre-test counseling

VCCT staff (trained counselors and laboratory technicians) will attend the network meetings at the drop-in centers/meeting points and will provide group pre-test counseling on HIV testing (process, benefits, risks alternatives).

*HIV Testing*VCCT staff will provide HIV testing at the meeting points/drop in centres for those who voluntarily accept. The National HIV testing and counseling protocols will be used.

No name will be recorded but instead an ID code number will be issued. Each participant will be requested to provide personal phone number.

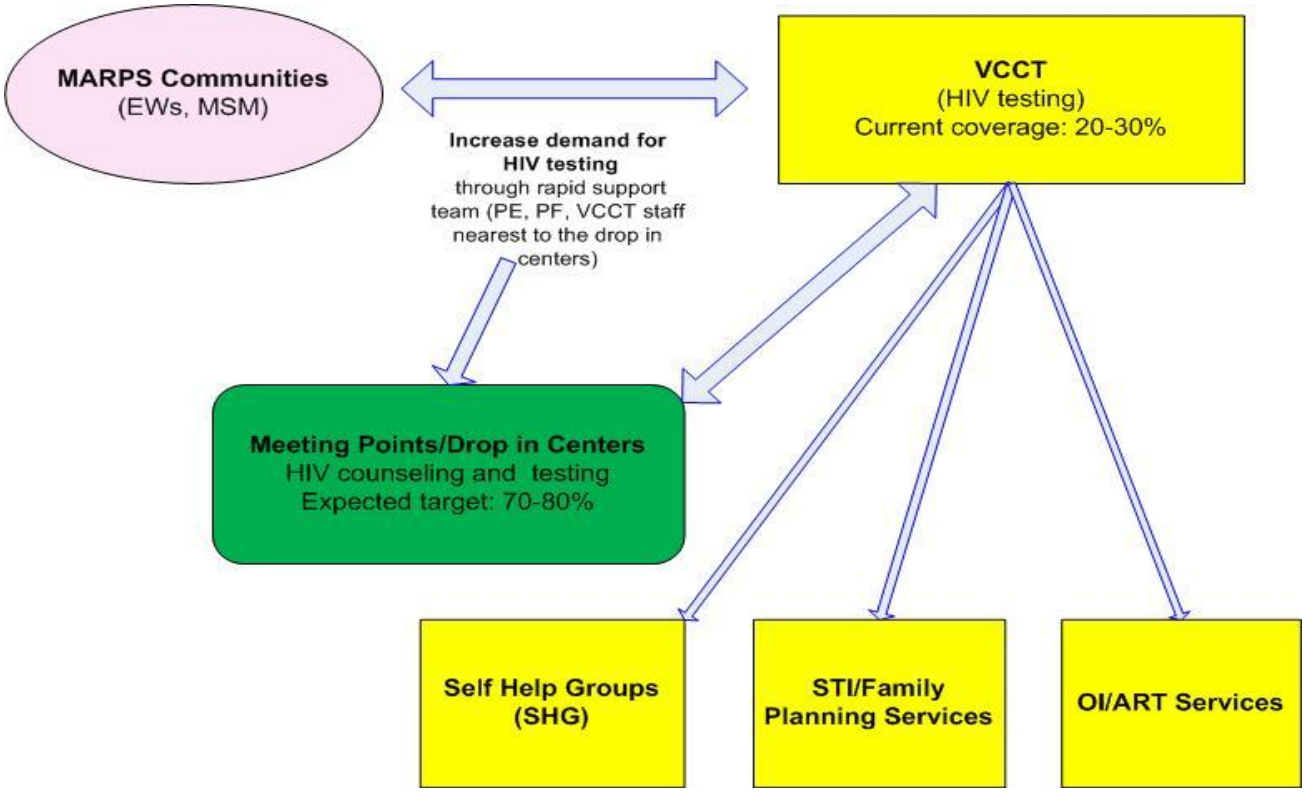
Group post-test education/counseling will be provided to all participants, regardless of test results. All participants will be provided with the counselor's phone for further information regarding HIV testing.

- **Test results** will be returned to all each clients in a sealed envelope at the end of the event. In case of HIV positive results, a relevant pre-paid mobile phone card/telephone voucher (USD 2) will be included in the seal envelope. The client will be requested to contact the counselor for detailed discussion and further post test counseling. In the event that the positive client does not return the call, the counselor will be responsible

for contacting her the client for post-test counseling

- **Referral of clients to other services:** HIV positive clients will be referred by trained counselors to relevant services (OI/ ART site, self-help groups, STI/FP services).

Diagram of peer networks and service delivery centers



5. Monitoring and reporting

Monitoring and reporting tools used by the MARPS networks will be used to record information on CoPCT including HIV counseling and testing (Annex A- available tools used by the networks).

6. Support to VCCT Staff:

Partners involved in the implementation of the C/PITC initiative will provide support (transportation fees and other incentives through existing mechanisms including site promotion award-SPA scheme) to VCCT staff involved in the implementation of C/PITC.

7. Proposed roadmap

Activity	Timeline	Responsibility
• Conduct situational analysis/mapping of PE/PF networks to assess suitability of	21-25 February 2011	• KHANA • FHI

the venues to C/PITC and the scope of MARP networks and develop the annual meeting • KHANA (10 EW/10 MSM groups) • FHI (10 EW/10 MSM groups)		
• Orientation of VCCT staff in EW and MSM groups to improve MARPS-friendly attitudes and reduce stigma or discrimination.	25 March 2011 (Phnom Penh)	• VCCT Unit of NCHADS
• Organize orientation/sensitization of PE/PF and VCCT on the 3C and C/PITC principles of HIV testing and counseling	16 March 2011 (Phnom Penh)	• VCCT Unit of NCHADS • KHANA • FHI
• Logistics and supplies management (LSM) including HIV tests and consumables.	28 March 2011 (Phnom Penh)	• LSM, VCCT, Lab Units of NCHADS
• Launch the implementation of C/PITC at selected sites (one EW group and one MSM group)	18 March 2011 Phnom Penh	• NCHADS • KHANA • FHI
• Implement C/PITC at meeting points/ drop in centers of selected sites	31 March 2011	• NCHADS • KHANA • FHI
• Review of the progress and lessons learned through a review meeting	15 November 2011	• VCCT Sub-Committee
• Nationwide scale-up of C/PITC	from 2012	• VCCT Sub-Committee

Phnom Penh..16../..March..2011..

Dr. Mean Chhi Vun
Director of NCHADS