KINGDOM OF CAMBODIA
NATION RELIGION KING

MINISTRY OF HEALTH

Standard Operational Procedures on Boosted-Integrated Active Case Management (B-IACM)

July 2017

NATIONAL CENTER FOR HIV/AIDS, DERMATOLOGY AND STD (NCHADS)

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Abbreviations

ACM	Active Case Management
AEM	Asian Epidemiological Model software
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS Impact Model software
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
B-COC	Boosted Continuum of Care
B-COPCT	Boosted Continuum of Prevention, Care and Treatment
B-IACM	Boosted Integrated Active Case Management
B-LR	Boosted Linked Response
CBPCS	Community-Based Prevention, Care and Support
CBO	Community Based Organisation
CMA	Case Management Assistant
CMC	Case Management Coordinator
CMP	Case Management Provider
CMS	Case Management Supporter
C/PITC	Community/Peer-Initiated Testing and Counselling
CSV	Community Support Volunteer
eMTCT	Eliminate Mother to Child Transmission of HIV
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HC	Health Centre
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HPITC	Health Provider-Initiated Testing and Counselling
HSSP-HIV	Health Sector Strategic Plan for HIV/AIDS and STI Prevention & Control 2016-2020
HTC	HIV Testing and Counselling
IACM	Integrated Active Case Management
IRIR	Identify, Reach - Intensify and Retain
KP	Key Populations
MMM	Mondul Mith chuoy Mith
MMT	Methadone Maintenance Treatment
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	Non-Governmental Organization
OD	Operational District
PHD	Provincial Health Department
PLHIV	People Living with HIV
PNTT	Partner Notification, Tracing and HIV Testing
PPN+	Provincial Network of People Living with HIV

RH	Referral Hospital
RMAA	Rapid Monitoring, Analysis and Action
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TB	Tuberculosis
TOR	Terms of Reference
VCCT	Voluntary and Confidential Counselling and Testing
VHSG	Village Health Support Group
VL	Viral Load

Foreword

These Standard Operating Procedures (SOP) for Boosted-Integrated Active Case Management (B-IACM) **provide guidance on** the essential practices to support the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) achieve the objectives of the *Health Sector Strategic Plan for HIV/AIDS and STI Prevention and Control in Cambodia* 2016-2020 (HSSP-HIV).

B-IACM underpins activities across the HIV cascade by streamlining case-based surveillance for HIV and STI in order reach the global 90-90-90 targets by 2020, and maintaining this progress to achieve virtual elimination of HIV in Cambodia by 2025.

The Ministry of Health endorses the B-IACM-SOP and grants approval for its use and looks forward to the successes B-IACM will bring to the HIV/STI program.

Phnom Penh, 26 / 07 / 2017

For. Minister of Health

Prof. ENG HUOT
SECRETARY OF STATE

Acknowledgements

Phnom Penh, 19/07/2017

Director of NCHADS
Dr. Ly Penh Sun

1. BACKGROUND

In October 2103 the National Center for HIV/AIDS, Dermatology and STD (NCHADS) issued a Guidance Note as part of the *Cambodia 3.0 Initiative* for *Integrated Active Case Management and Partner Notification, Tracing and HIV Testing* (IACM/PNTT). This policy was soon introduced in a number of Operational Districts (OD) across Cambodia and by 2016 IACM/PNTT had been implemented in 23 OD.

Experience since 2013 suggests that while IACM/PNTT has been largely successful at OD level there have been shortcomings in achieving full coverage across the HIV care cascade.

This SOP for Boosted Integrated Active Case Management (B-IACM) addresses these limitations and supersedes earlier IACM/PNTT procedures.

1.1. SCOPE

B-IACM functions as a case-based surveillance system with regular tracking of cases, analysis of profiles of new cases, as well as acting as an alert system to signal potential HIV outbreaks.[1]

This B-IACM SOP describes the methodology to implement B-IACM as it applies to:

- NCHADS AIDS Care, Data Management and related Units
- Provincial Health Departments (PHD)
- Provincial AIDS and STI Program (PASP) team
- NGO and other implementing partners
- Referral Hospitals
- ART sites / VCCT sites
- Health Centers for HTC/ANC
- Related agencies such as local commune authorities, Police, Prison authorities

> This SOP should be followed in conjunction with the implementation strategies found in the *HTC/VCCT Guidelines (2017)* and the *Consolidated Operational Framework on Community Action approach to implement B-IACM toward achieving 90-90-90 in Cambodia* (draft 2017)

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[1] *Outline Concept Note: Integrated Case Surveillance of HIV infection in Cambodia,* NCHADS, draft, July 2015

1.2. RATIONALE

B-IACM under the IRIR approach – *Identify, Reach - Intensify and Retain* is intended to cover the whole HIV cascade, bridging the three core components of the HSSP-HIV along with Community Action strategies such as Community Based Prevention, Care and Support (CBPCS).

Three Core Components of the HSSP-HIV

1   Boosted Continuum of Prevention, Care and Treatment (B-COPCT)
2   Boosted Linked Response (B-LR)
3   Boosted Continuum of Care (B-CoC)

B-IACM focuses on **identifying and reaching** all infections (old new); **intensifying efforts** to ensure cases are brought into the HIV cascade to receive immediate treatment (Test and Treat); **retaining** all PLHIV on treatment to become stable through viral load suppression.

Based on 2015 data (Table 1) Spectrum-AIM and Asian Epidemiological Modelling (AEM) software estimated in 2016 around 15,000 people are infected with HIV in Cambodia who have not been yet identified or enrolled in the HIV care cascade[2].

Table 1: Estimates for HIV burden (end 2015)

Estimated number of PLHIV	72,607
PLHIV in care (ART and Pre ART)	57,651
Not in care	14,956
2020 target (90%)	13,460

Because new HIV infections were fewer than 1,000 in 2015 and are expected to steadily decrease in coming years, the approximation of 15,000 un-enrolled PLHIV cases is unlikely to grow. The B-IACM strategy aims to ensure over the next five years these 15,000 cases will be identified, enrolled, and retained in care to reach the global 90-90-90 targets set for 2020 and virtual elimination of HIV in Cambodia by 2025:

90% people with HIV know their status
90% of these are on treatment
90% of these have suppressed viral load

The HIV care cascade (Figure 1) forms the basis of the HSSP-HIV. While Cambodia has made significant progress both in reducing the number of new infections as well as

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[2] Data from NCHADS DMU 2015 reports & UNAIDS Spectrum-AIM & AEM modelling using 2015 data
[3] Consolidated operational framework on community action approach to implement B-IACM toward achieving 90-90-90 in Cambodia (draft 2017).

supplying a high rate of ART coverage to enrolled cases, loss to follow-up remains a persistent problem at each stage of the cascade. B-IACM is designed to reduce this risk by emphasizing a patient-centred approach to better respond to individual's needs throughout the cascade.

Figure 1: HIV care cascade in Cambodia (2015)
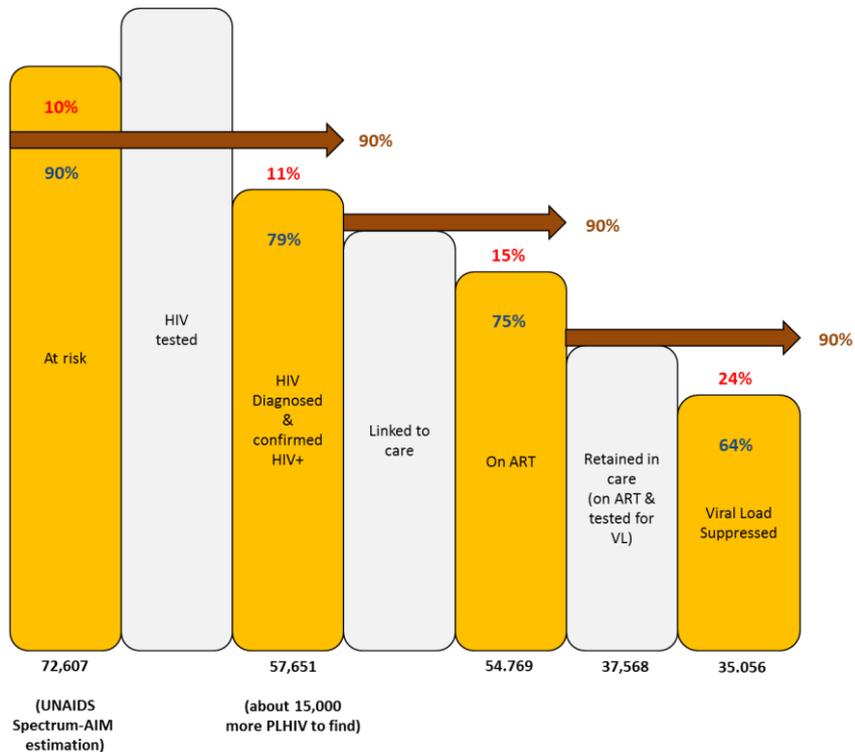
(Graph is representative and does not demonstrate direct relationships)

Figure 2: HIV care cascade with B-IACM
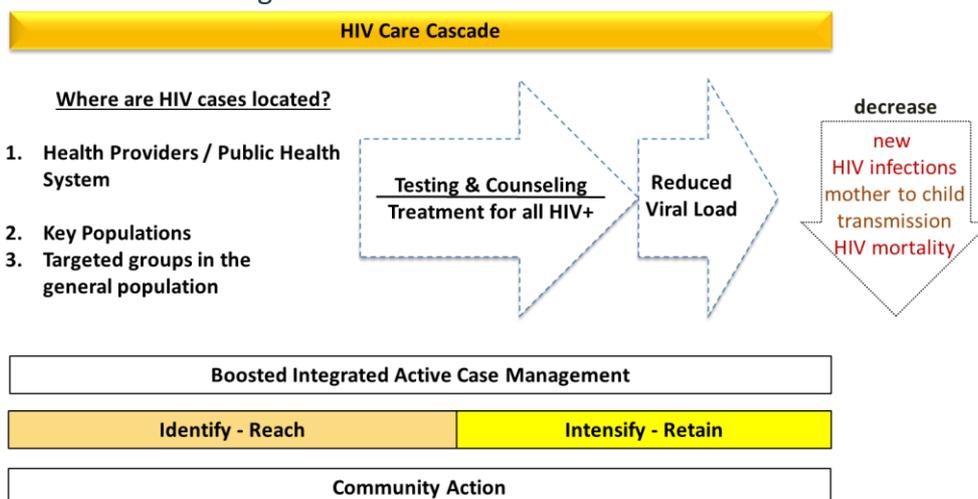
In practical terms the main differences between IACM/PNTT and the B-IACM is to achieve the objectives of the national HSSP-HIV by making B-IACM more efficient and cost-effective with improved and appropriate responses to local conditions.

For this reason B-IACM is adapted into four models to suit the different HIV care environments in Cambodia:

> B-IACM Models
> 1. Rural OD with ART/VCCT
> 2. Rural OD without ART/VCCT
> 3. Urban OD
> 4. Phnom Penh

Under each of these models the multiple levels of TWG at the provincial and OD level are now blended into a committee structure known as the Group of Champions (GOC) convened in each OD, with a further GOC committee located at the PHD.

The GOC make recommendations and provides information and advice to the PHD related the HIV program in each OD, and are able to involve all HIV stakeholders to tackle issues affecting the local situation to both increase the number of HIV cases enrolled and to prevent loss to follow-up at each stage of the cascade.

Each of the B-IACM models will more accurately be able to identify where the estimated 15,000 un-enrolled PLHIV are likely to be, and where and how to intensify the effort needed to reach these people.

All B-IACM models work across the current strategies and population channels to locate and bring all PLHIV into the HIV care cascade.

- HIV Testing and Counseling (HTC) is the process for finger-prick testing and follow up counseling, including referral to VCCT centers for confirmation of HIV/STI diagnosis
- HPITC Health Provider Initiated Testing and Counseling describes the source of cases referred from other national programs such as TB, ANC or MMT, and in referral hospitals (such as infectious disease wards, Family Health Clinics and maternity wards) B-LR (eMTCT) is incorporated as part of ANC services via health facilities/Health Centers (HPITC)
- B-COPCT is the strategy used to identify transmission risk among key populations through application of HTC
- CBPCS and Community Action strategies engage with PLHIV and community networks to locate new cases using HTC; help PLHIV to remain stable by ensuring their viral load is kept at an undetectable level

- B-COC monitors the care and treatment of all patients on ART with regular confirmation that viral load remains suppressed
- VCCT sites are generally co-located with ART sites at referral hospitals and provide confirmation of HIV diagnosis, and counseling to newly diagnosed HIV patients
- HIV clinical guidelines released in 2016 have authorized the Test and Treat policy where all confirmed HIV cases are immediately placed on ARV treatment regardless of CD4 count

Enveloping the HIV care cascade is B-IACM coordinated through an OD Case Management Coordinator (CMC) in collaboration with the Group of Champions.

Figure 3: B-IACM by population channels
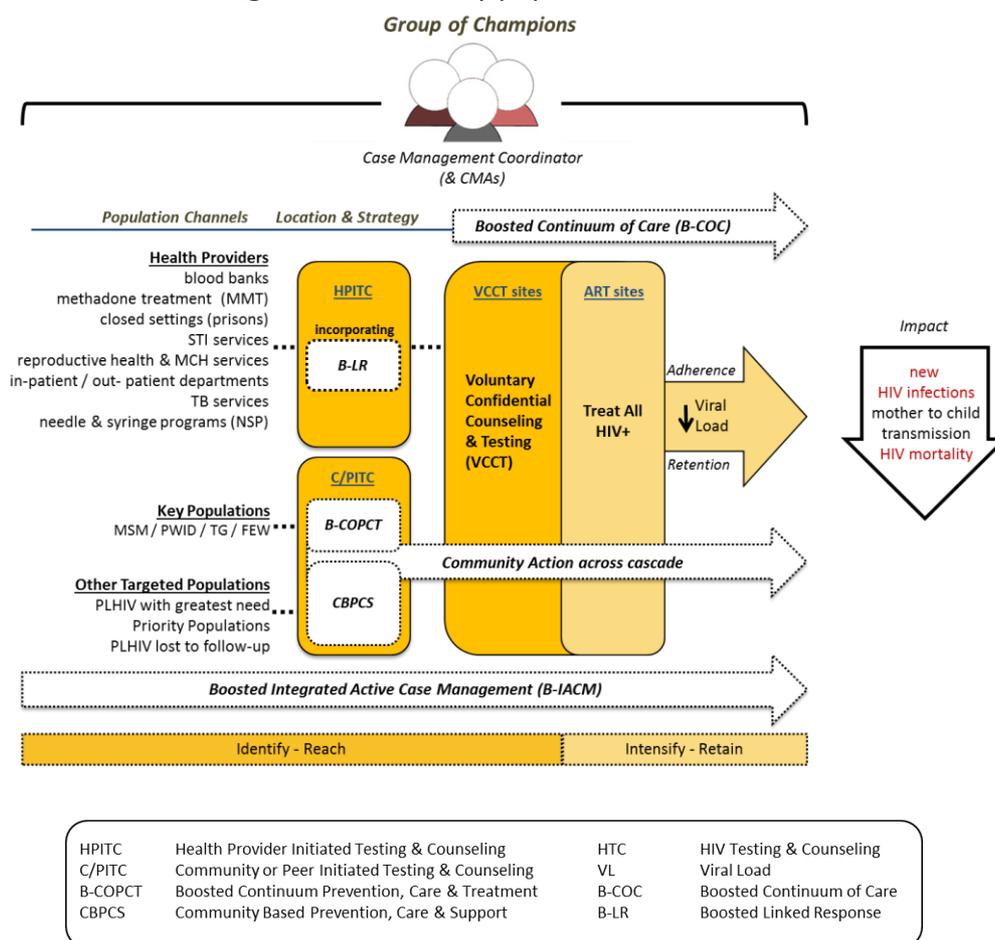
The GOC comprises members from all stakeholders and advocacy groups involved in HIV prevention and care services particularly those involved in implementation of the key HSSP-HIV strategies (COC, COPCT, B-LR and Community Action initiatives including COPTC).

B-IACM relies on the Case Management Coordinator and Case Management Assistants (CMC/CMA) in partnership with the GOC for hands-on monitoring and effective communication within the GOC to identify those cases that demand more specific follow-up at each stage, and to take action with appropriate interventions to retain these cases throughout the cascade.

2. B-IACM OBJECTIVES

The objective of B-IACM: To leverage existing strategies and approaches for case detection, early/immediate enrolment, and retention in HIV care and treatment to reach the following targets:

- By 2020: 90% people with HIV know their status; 90% of these are on treatment; and 90% of these have suppressed viral load; and
- By 2025: 95% people with HIV know their status; 95% of these are on treatment; and 95% of these have suppressed viral load

The following B-IACM activities are prioritized along the HIV cascade:

1. **Identify all PLHIVs who are still unaware of their status or lost to follow-up** among key populations (by providing the full package services for B-COPCT); and targeted general population as defined in the community action framework document[3]; HIV infection cases among pregnant women, TB and STI patients mostly identified at health facilities (HPITC at health centers, family health clinics, hospital wards).
2. **Trace and propose HTC to all partner(s) of newly detected HIV cases** according to the Partner Notification, Tracing and HIV Testing (PNTT) Guidance[4].
3. **Referral of all reactive HIV finger prick cases to VCCT for confirmation**; and to actively follow-up all identified cases for confirmatory tests, ensuring no cases are lost and are registered in the B-IACM system.

> For points 1-3 please refer to the implementation strategies found in the *HTC/VCCT Guidelines (2017)* and the *Consolidated Operational Framework on Community Action approach to implement B-IACM toward achieving 90-90-90 in Cambodia* (draft 2017).

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[3] Consolidated operational framework on community action approach to implement B-IACM toward achieving 90-90-90 in Cambodia (draft 2017).

[4] Guidance Note on Integrated Case Management and Partner Tracing and HIV Testing for Cambodia 3.0 Initiative, NCHADS/MOH, Oct. 2013

4. **Enroll all confirmed HIV infections at ART clinics**; and to actively follow-up individuals to ensure **no cases are lost**.

5. **Actively follow-up all newly enrolled patients in ART clinics** for early ART initiation according to current national ART guidelines[5&6].

6. Follow-up all patients on ART ensuring that ARV adherence is **carefully monitored helping identify and resolve problems of adherence**.

7. **Implement and monitor routine Viral Load (VL) testing** for all patients on ART according to current guidelines[6]; making sure VL testing is done on scheduled basis and results are obtained and included in the B-IACM dashboard system.

8. **Monitor the HIV cascade outcomes** regularly at sub-national and national levels using B-IACM monitoring tools (B-IACM dashboard) and the Rapid Monitoring, Analysis and Action (RMAA) process to minimize cases lost at each stage of the cascade and develop solutions for improvement.

2.1. Roles and Responsibilities

Table 2 shows the roles and responsibilities for activities for the B-IACM process.

Table 2: Roles and responsibilities during the B-IACM process

Activity	Who	Where
• Outreach efforts are intensified to ensure identification of infections (old and new) in KP and targeted general populations (pregnant women, suspected HIV cases, sero-discordant couples, exposed infants, TB, STI, symptomatic cases, and other vulnerable populations)*	NGO staff and Outreach Workers as Case Management Supporter (CMS); CBPCS: NGO staff and Village Health Support Group/Community Support Volunteers (VHSG/CSV as CMS)	Community
• Infections (old and new) among key and targeted general populations are identified and referred to the VCCT for confirmation; individual follow-up is used to ensure newly identified infections are confirmed (or otherwise)*	NGO staff & Outreach Workers as CMS; CBPCS: NGO staff & VHSG/CSV as CMS	Community VCCT service
• Efforts are made to contact the partner(s) of new cases (PNTT)*	NGO staff & Outreach Workers as CMS;	Community

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[5] Concept Note on Treatment as Prevention (TasP) as a Strategy for Elimination of New HIV Infections in Cambodia, NCHADS, December 2012

[6] Cambodian National HIV clinical management guidelines for Adults and Adolescents, and Guidelines for Diagnosis and Antiretroviral Treatment of HIV Infection in Infants, Children and Adolescents in Cambodia, both were revised in 2016.

Activity	Who	Where
	CBPCS: NGO staff & VHSG/CSV as CMS; VCCT staff	
• All infections detected at health facility level (Health Center-HC, Family Health Clinics-FHC, hospital wards) are referred to the VCCT for confirmation; individual follow-up is used to ensure identified infections are confirmed (or otherwise)	CMP & CMS	HC Referral Hospital FHC Community
• National ART guidelines developed by NCHADS apply consistent with the *Test & Treat* policy	ART Team	ART service
• At the VCCT all referred reactive cases are registered in the B-IACM system, and confirmed (or otherwise)	CMP	VCCT service
• All confirmed infections are referred to ART services for enrolment; individual follow-up is used to ensure enrolment of confirmed cases	CMP & CMS	VCCT service pre-ART/ART service NGO clinics
• All patients enrolled in ART services are followed up individually to ensure appropriate initiation on ART according to the *Test and Treat* policy*	CMP & CMS ART Team	ART service Community,
• All patients on ART are monitored to ensure adherence; individual follow-up is used to identify and resolve problems of adherence*	CMP & CMS ART team	ART service Community
• Viral load testing is used for all patients on ART; results are included in the B-IACM system	ART team, RH Laboratory Staff	ART service & NCHADS Lab
• Data for each stage of the cascade identified above are entered in the B-IACM database and regularly monitored	GOC (CMA, CMC, ART team etc.)	OD/PHD
* Please refer to the *Consolidated operational framework on Community Action Approach to implement B-IACM towards achieving 90-90-90 in Cambodia* (draft 2017)		

3. IRIR OPERATIONAL STRATEGY

Identify-Reach; Intensify and Retain (IRIR)

Assessments of IACM and B-IACM to date suggest that the majority of newly detected cases are found in specific groups within the general population. [7 & 8] Further information about these groups will come from HIV case profiling as part of ART enrolment. This finding highlights the importance of engaging community based groups and networks to help identify and locate un-enrolled PLHIV cases within the general population.

Identify-Reach, Intensify and Retain is an operational strategy that provides direction for B-IACM for identifying new HIV cases; reaching PLHIV with HIV services; strengthening referrals; intensifying access to care; and retaining all PLHIV in care to become stable by achieving a suppressed viral load.[9]

IRIR applies to all partners working within the HIV cascade:

- *NGO Partners working with key populations* and used to identify and reach undetected cases, will have to **intensify** access to services and **retain** newly identified HIV infected KP cases in the ART program so they can reach viral load suppression.
- *NGO Partners, like* CBPCS *teams working in the general community* will have to **intensify** support for those PLHIV in need to **retain** them in care, but also to **identify** undetected HIV infections in the general populations and **reach** them to provide HTC and referral to HIV services.[10]

For IRIR to be effective NCHADS with implementing partners must make sure that geographical coverage with B-IACM in each OD is complete and coordinated.

4. IMPLEMENTATION & MANAGEMENT OF B-IACM

4.1. Four models for B-IACM

To accommodate the different challenges in controlling HIV prevention and transmission in Cambodia four models have been developed for B-IACM:

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[7] Report on an assignment for Operationalization of the Active Case Management and Partner Notification, Tracing and HIV Testing before nationwide scale-up under the GFATM. June-December 2015, Dr. Mean Chhi Vun & Dr. Peter Godwin

[8] The Rapid Monitoring Analysis and Action report (October 2016)

[9] For details, please refer to the Consolidated SOP on Community Action Approach to Operationalize IRIR Strategy Towards achieving 90-90-90 in Cambodia

[10] Streamlining the Community-Based Prevention, Care and Support (CBPCS) Model for PLHIV in Cambodia, Draft Nov, 2015

1. *Rural OD with ART/VCCT:* The ART and VCCT are located in the RH within the OD. All B-IACM activities will be managed through the OD GOC, with reporting to the PHD/PASP and NCHADS

2. *Rural OD without ART/VCCT:* The HIV/STI OD Coordinator will collaborate with the closest OD GOC where ART and VCCT services are present

3. *Urban OD:* The RH where VCCT and ART services are administered by the PHD. B-IACM activities will be managed by the PASP through the OD GOC with reporting to PHD and NCHADS

4. *Phnom Penh:* The ART/VCCT services are provided by National Hospitals. B-IACM will be coordinated by OD GOC in close collaboration with relevant national hospitals and NGO clinics. (For example: Khmer-Soviet Friendship, Calmette, Preah Kosamak, Preah Ketomealea, etc. OD RH or NGO clinics such as Sihanouk Hospital Center of Hope and Chhouk Sar Clinics etc.)

4.2. Management of B-IACM through the Group of Champions

Under B-IACM, the Technical Working Groups and Sub TWG for B-COPCT and B-COC/LR at provincial and OD levels are replaced by a *Group of Champions* (GOC).

The GOC is composed of a core group of people who manage and oversee the B-IACM process. Additional GOC members can be included as necessary contingent on their respective involvement in the OD as part of the HIV care cascade.

All urban OD will have a GOC while rural OD will establish a GOC depending on the local situation (for example the absence of ART or VCCT services; or the relative burden in KP). The GOC manages B-IACM in the OD with regular review of the HIV care cascade data to identify issues and find appropriate local solutions for improvement.

4.2.1. Membership of the GOC

- **The GOC is chaired by the OD Director or person nominated and agreed by OD Director**
- **GOC-core group:** are people who are directly responsible to coordinate and monitor B-IACM. The GOC-core group members for each OD should be confirmed with NCHADS at the initiation of B-IACM.

Suggestion for GOC core group composition:
1 CMC
2 CMA (government staff &/or NGO)
3 VCCT team leader
4 ART team leader
5 Senior NGO case manager working with KP
6 Senior NGO case manager working with targeted groups in the general population

Figure 4: GOC provincial & OD
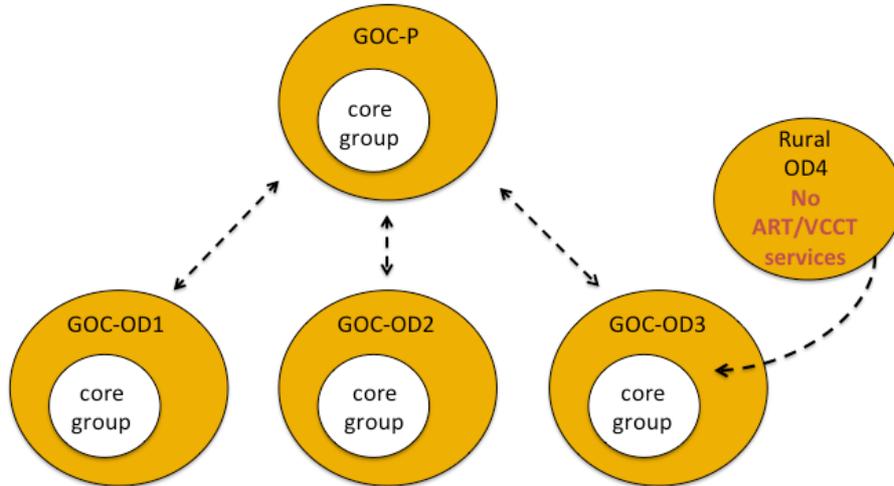
- **GOC membership:** Membership is flexible depending of OD configuration and the partners involved along the HIV care cascade. An inventory list of GOC members should be defined and shared for each OD at the initiation of B-IACM. OD NMCH, TB OD Coordinator, Blood Bank and prison staff should be included within the GOC.

- **GOC membership at the Province:** The provincial membership will consist of representatives from all core group GOC-OD in the province and will meet on a regular quarterly basis to review data and compare experiences

The GOC members will work together to better understand:
- Where most new HIV cases are detected
- How to identify and reach high risk KP and who to target in the general population
- The reasons for people dropping out of the cascade at various points
- Solutions for reducing loss to follow up

4.2.2 Roles and Responsibilities for B-IACM GOC members

B-IACM does not make use of additional government staff, and only limited additional or re-deployed NGO staff. B-IACM roles and responsibilities involve the designation of specific B-IACM *functions* using existing staff.

Case Management Coordinator (CMC)

is a senior member of the current OD/PASP team with respect to the four different models of B-IACM; urban, rural (with or without VCCT/ART services) or Phnom Penh. The primary responsibility of the CMC is to manage the B-IACM and ensure that all the key players are working effectively together.

Case Management Assistant (CMA)
is primarily responsible for collecting and entering the B-IACM data in the system (B-IACM Dashboard), and preparing documentation (charts, graphs and reports). Under the streamlined system, an existing government staff in the OD will be designated to this function as CMA. Roles and responsibilities of CMA can be found in the Annex 1 of this document. A further CMA should be recruited as contract staff or NGO staff to work in the OD to help the government CMA and mentor him/her for the first year or two. For rural OD, the CMA as government staff will be nominated by PHD or OD.

PASP Manager
is responsible for overall functioning and oversight of B-IACM in the province and supervises the CMC and GOC in each OD, and is also responsible for Rapid Monitoring and Analysis for Action (RMAA) activities at provincial and municipal levels.

Case Management Providers (CMP)
play the key roles of identifying and referring cases to the HIV services. CMP are government staff working at different levels in the health care system; they may also be NGO staff working in NGO health facilities and programs.

NGO case managers
are the key link between the Outreach Workers, MMM Facilitators, and Community Service Volunteers (all CMS) and CMC. Their role is to supervise and coordinate the work of the CMS with other CMP, and work with the CMC and CMA to ensure that follow-up for lost cases takes place.

Case Management Supporters (CMS)
are responsible for following up new cases where there is delay in new cases reaching different points in the system. CMS are for example NGO case managers or CBPCS team supporting active case management at different stages of the cascade.

NGO/CBO Outreach Workers, MMM Facilitators (from PLHIV network), and CSV
may function as CMP, when they identify and refer new cases; they also function as CMS, when they follow-up PLHIV in need (within CBPCS). Many NGO/CBO outreach workers, facilitators and volunteers are by default already serving as CMS.

PLHIV Networks:

The provincial network of people living with HIV (PPN+) currently have two officers per province[11] and provide additional support in working closely with ART clinics and OD CMC and CMA, and supports the supervision and coordination of CSV.[12]

RMAA at Provincial and National levels

At provincial level the Group of GOC function as the RMAA group in charge of analysing HIV case profiles and situation analysis. At national level NCHADS convenes RMAA meetings to monitor B-IACM and provide advice on specific cases or situations particularly HIV outbreaks to the GOC.

OD TB Coordinator

The OD TB Coordinator ensures referrals of TB patients from the TB services at the health facilitates to HIV services. TB care providers are the CMP who have the role to identify and refer cases to HIV services.

OD MCH Coordinator

OD MCH Coordinator ensures the smooth coordination of the referrals between HIV and MCH services including the ANC and PNC providers, birth delivery attendants etc.

Blood Bank Coordinator

The Blood Bank Coordinator ensures referrals between the HIV services and blood donations within the blood bank or during external campaigns.

Prison Health Post Staff

Within the OD where the prisons are located, at least one representative of the prison department will be engaged as a member of the GOC and will have a critical role in coordinating the referrals between the HIV services and the prisons.

4.3 IMPLEMENTATION OF B-IACM

The following activities are necessary for implementation of B-IACM:
- **Coordination with partners** and **mobilization of resources** (people and financial) to support the scale-up of B-IACM in their respective provinces.
- Establish the **list of GOC members** according to the assigned B-IACM model.
- Provide appropriate **orientation and training** to GOC members to instill a thorough understanding of the HIV care cascade and especially in how to analyze and use data effectively to identify and minimize losses at each stage.

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[11] Not all provinces have two CPN+ staff, during the time this SOP is developed there are only 10 provinces who have two CPN+ staff for the support and facilitation of the ART activities.

[12] From: "Concept Paper; Streamlining the Community-based Prevention, Care and Support (CBPCS) Model for People Living with HIV in Cambodia", draft Nov. 2015

- Establish and organize regular GOC meetings that are minuted and disseminated among GOC members
- Estimate with the GOC core group the **targets for B-IACM at the provincial level** including the estimated number of people who are HIV positive and not yet in the system following sub-national data supplied by the AEM 2016 exercise.
- Establish a strong **monitoring and surveillance system using B-IACM tools and dashboard:**
  - Provide training to the GOC members on the correct use of B-IACM tools for data collection and reporting
  - Provide training to the GOC core group and people involved in data management to use the dashboard for reporting and to interpret data for gap analysis and remedial action
- **Advise NGO partners to adapt their strategies** according to B-IACM using the IRIR approach and consistent with the Community Action SOP:
  - *Implement the IRIR operational strategy by NGO partners with* review and re-categorization of risk assessment, and review of methodology for reaching the highest risk populations and targeted general populations as described in the framework for the Community Action Approach.
  - *Ensure coverage across the HIV cascade* by strengthening coordination among Implementing Partners previously working on KP (NGO-KP) and those working on targeted general populations (under CPBCS model).
- Establish a strong and effective **collaboration, coordination and cooperation** between the members of the GOC working along the HIV cascade to increase efficiency of case identification, and reinforce individual follow-up at each stage along the cascade.
- Implement **case profiling** for **newly enrolled HIV patients** at VCCT or ART sites to better understand the background of newly detected cases and optimize case detection strategies.
- Ensure adequate **geographical coverage** of NGO/CBO working with KP and targeted general populations and their networks to detect new HIV cases and manage all follow-up of losses and cases in need along the HIV, PMTCT and TB cascades.
- Provide training to **reinforce PNTT** for all HIV cases (newly identified as well as old).

5. MONITORING AND EVALUATION

5.1. GOC meetings

- GOC meetings should be organized by the GOC Core Group and scheduled each month
- Other ad-hoc meetings are convened as needed including by phone or email
- The GOC-Core Group should meet on a weekly basis to review and update dashboard data and send weekly to PASP/NCHADS

5.2. Coordination of B-IACM at the provincial and national levels

- PASP manager will be in charge to coordinate the implementation of B-IACM in all OD (urban and rural) in the province
- Provincial GOC will meet quarterly and include nominated members from all OD-GOC Core Group in the province
- PASP will coordinate biannual provincial GOC meetings including all GOC core group members in the province to review the HIV cascade
- NCHADS coordinate the regular RMAA national meetings to analyze B-IACM issues and propose solutions
- NCHADS will organize annual regional GOC meetings to build GOC network and review the HIV cascade in each region

5.3 Data Management and Analysis

- Data from B-IACM database will be sent to NCHADS on a regular basis set by DMU at NCAHDS for further analysis and backup purpose.
- The Dashboard produced by B-IACM database will be used to monitor the situation and progress of B-IACM activities.
- The RMAA process aims to review OD data and specific cases and provide feedback to the GOC
- Especially any sudden changes in the data (e.g. a sudden increase in new cases in a particular area, or a sudden increase in loss at some particular part of the cascade) will be carefully considered and managed to detect HIV outbreaks and failures in the system (alert system)
- Figure 3 shows the data management flow for the B-IACM
- For urban OD the data management flow is similar, except that PASP manages the B-IACM data and dashboard for the OD(s) covered

5.4. Reporting

- GOC will report:
    - weekly to PHD and NCHADS about B-IACM data
    - quarterly to PHD about achievements
- PHD/PASP will report quarterly to NCHADS-PR about GOC achievements

5.5. Key indicators

- Key indicators for B-IACM are used to describe the HIV cascade at the OD and province (A detailed list of key indicators is provided in Annex 2)

Figure 5: Example of Rural OD data management flow for B-IACM

NCHADS
Data Management Unit (DMU)

RMAA oversight of B-IACM data

Provincial Health Department (PHD)

PASP team collates OD data
Enters combined OD data into
B-IACM data

Operational District(s) (OD)

CMC/CMA collects B-IACM data &
completes OD B-IACM data

VCCT
ART

Health Centers (HC)
PMTCT (ANC/Delivery)
EID

Outreach Workers (OW)

HC 1   HC 2   HC 3   OW 1   OW 2   OW 3
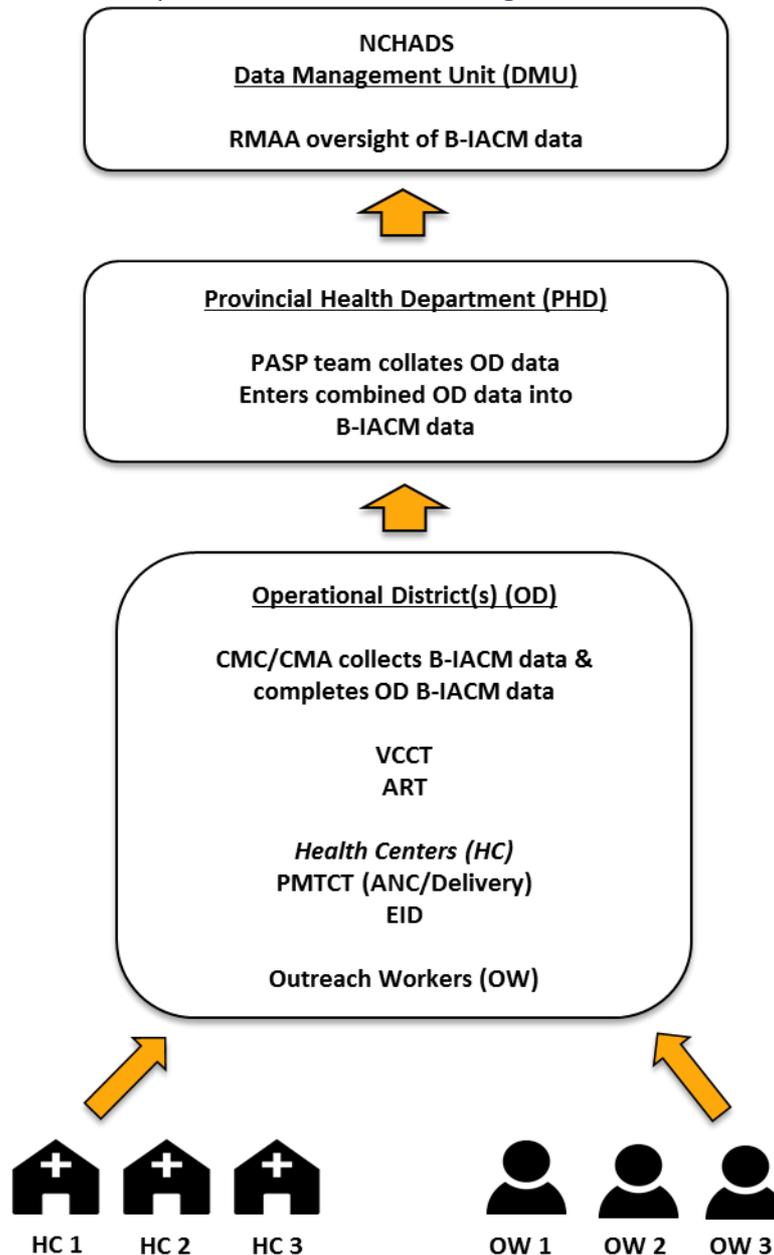
6. B-IACM SCHEDULE

The scale-up of the B-IACM is according to the following schedule where an expected 47 OD will begin implementing B-IACM during 2017 to compliment the 23 OD already applying B-IACM.

A further schedule will be established for 2018 and beyond based on an assessment of the completed B-IACM activities and lessons learned from the process.

Table 3: Schedule for B-IACM Scale-Up in 2017

Province	Remaining adult PLHIV at start of B-IACM	# OD	Q4 2016	Q1 2017	Q2 2107	Q3 2017	Q4 2017
			B-IACM	B-IACM	B-IACM	B-IACM	B-IACM
Battambang	1337	5					
Kampong Cham	1331	9					
Pailin	64	1					
Siem Reap	2577	4					
Oddor Meanchey	650	2					
Phnom Penh*	-3713	7					
Banteay Meanchey	1045	4					
Pursat	851	4					
Sihanouk Ville	320	1					
Koh Kong	240	2					
Kampong Speu	1083	4					
Kampong Thom	936	4					

7. ANNEXES

Annex 1: Terms of Reference for Case Management Assistant (CMA)

Terms of Reference: Case Management Assistant (CMA)

The CMA is located in the OD office under the supervision of the CMC has two main roles:

1. Assist the CMC to coordinate and collaborate with all stakeholders to ensure the reactive cases reach all the required services in the cascade in a timely manner

2. Function as a key member of the GOC to ensure the effective implementation of B-IACM

1. Assist the CMC to coordinate and collaborate with stakeholders to ensure the reactive case reach all the required services in the cascade in the timely manner

1.1 Play an active role to coordinate and collaborate with all stakeholders (HTC, VCCT, NGOs, OI/ART service, PMTC etc.) within the coverage area to ensure that the reactive cases from HTC get through all the required services in the HIV cascade in a timely manner .

1.2 Ensure that all the data collected and entered the B-IACM database system are on time, completed and accurate.

1.3 Ensure that all the individual data are kept secured and all the information should not be disclosed without the authorization from their supervisor.

1.4 Assist CMC on data utilization and interpretation.

1.5 Regularly report the progress and challenges related to B-IACM data to the CMC and seek advice and support.

2. Functioning as a key member of the Group of Champions to ensure the effective implementation of B-IACM in the OD

2.1 Support the CMC to prepare for GOC Core Group and full meetings to discuss/manage B-IACM procedures in the OD
2.2 Keep records and minutes of all GOC meetings

2.3 Present and interpret data during GOC meetings to ensure that all members of the GOC understand the situation, purpose and action(s) for B-IACM

2.4 Serve as acting CMC where necessary for the following tasks:
- Identification and notification of cases requiring active follow up
- Creation and updating the list for active follow up
- Mobilization of those who should be involved in active follow up for each individual case
- Coordination of active follow up of individual cases
- Recording and reporting on the process and outcomes of the active follow up

2.5 Perform other duties as assigned by the CMC

Annex 2: Indicators for B-IACM

Key Indicators for B-IACM along the HIV cascade:
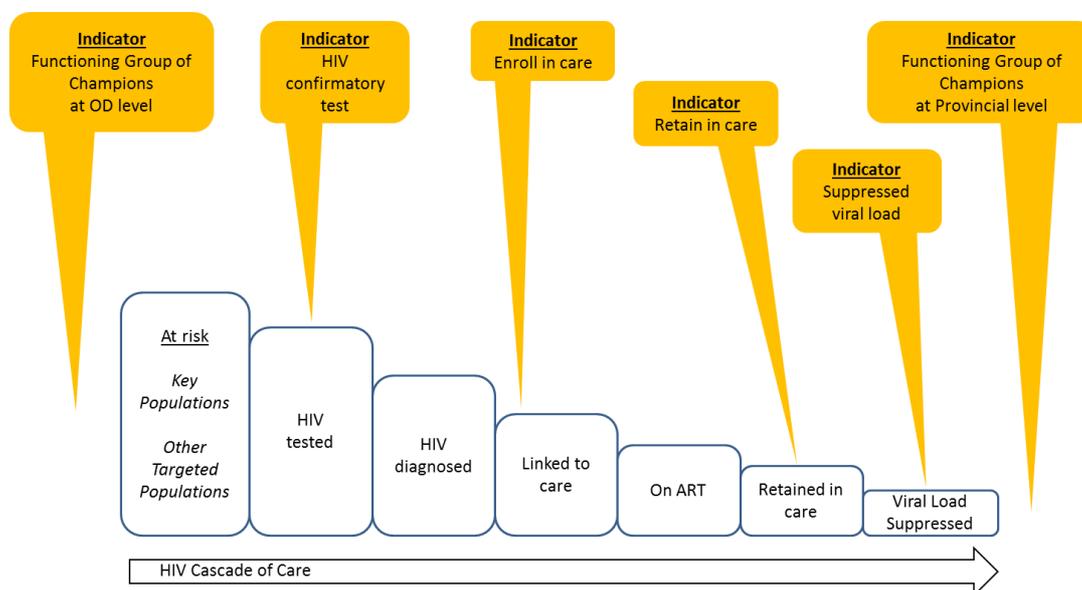
HTC indicators

1. Number and rates of HIV reactive tests by type of services, by type of clients, by gender, by age groups in the whole province *[Numerator: number of reactive test; Denominator: number of finger prick tests delivered]*

2. Number and rate of HIV reactive tests receiving confirmatory tests at VCCT by type of services, by type of clients, by gender, by age groups **(not for dashboard)** *[Numerator: number receiving confirmatory test at VCCT; Denominator: number of reactive cases]*
   a. Number and rate of those confirmed positive: *[Numerator: number confirmed positive, Denominator: number receiving confirmatory test]*
   b. Number and rate of those confirmed negative: *[Numerator: number confirmed negative, Denominator: number receiving confirmatory test]*

3. Time between reactive test and confirmatory test

4. Number of tests performed at all VCCT sites in the province (including walk-in and confirmatory tests) by type of services, by type of clients, by gender, by age groups and number found positive

5. Number and rate of successful enrollment at ART sites among all positive cases identified in the province *[Numerator: Number of newly confirmed positive cases enrolled in ART. Denominator: Number of newly confirmed positive cases at VCCT in the province]*

6. Time between HIV positive confirmatory test at VCCT and enrollment at ART sites (the same day, < week, 1-2 week, 3-4 weeks, > 4 weeks)

ART indicators

7. Number and rate of ART initiation among those successfully enrolled at ART sites in the province
8. Number of HIV cases on ART (new and old) actively followed up at the end of the period
9. Number and rate of HIV cases on ART with suppressed viral Load *[Numerator: Number found with suppressed VL, Denominator: Number who received a VL test]*

Key Indicators for B-IACM along the PMTCT cascade

HIV positive pregnant women indicators
1. Number of HIV positive pregnant women identified by type of services and by age groups
2. Number of newly identified HIV positive pregnant women enrolled at ART service
3. Number of HIV positive pregnant women already enrolled and on ART
4. Number of HIV positive PW who need ART
5. Number of HIV positive pregnant women who received at least one ANC
6. Pregnancy outcomes of HIV positive pregnant women:
    a. Number of induced abortions
    b. Number of spontaneous abortions
    c. Number of lost to follow up (enroll to expected delivery date)
    d. Number of maternal death during pregnancy
    e. Number of deliveries
    f. Number of pending deliveries

HIV exposed infant indicators:
7. Number of HIV exposed infants (HEI) born
    a. # live birth
    b. #stillbirth/neonatal death
8. Number and rate of born HIV exposed Infant who received ARV prophylaxis according to current PMTCT guidelines *[Numerator: number of born HEI who were imitated on ART prophylaxis, Denominator: number of HEI born]*
9. Number and rate of DNA PCR tests performed at birth for HIV exposed babies *[Numerator: number of PCR tests at birth, Denominator: number of HIV-exposed children born]*
    a. Number and rate of DNA PCR tests at birth found positive *[Numerator: number of positive PCR tests at birth, Denominator: number of PCR tests at birth performed]*

10. Number and rate of DNA PCR tests performed at 6-8 weeks for HIV exposed babies *[Numerator: number of PCR tests at 6-8 weeks, Denominator: number of HIV-exposed children born who did not have a DNA PCR at birth or had a DNA PCR negative at birth]*
    b. Number and rate of DNA PCR tests at 6-8 weeks found positive *[Numerator: number of positive PCR tests at 6-8 weeks, Denominator: number of PCR tests at 6-8 weeks performed]*
11. Number and rate of HIV-exposed children who were initiated on Cotrimoxazole prophylaxis at 6-8 weeks *[Numerator: number of HEI who were imitated on CTX at 6-8 weeks, Denominator: number of HEI born]*
12. Outcomes of HEI
    a. Number and rate of born HEI found DNA PCR (at birth or at 6-8 weeks) HIV Positive *[Numerator: number of born HEI with a DNA PCR positive (at birth or at 6-8 weeks), Denominator: number of HEI born]*
    b. Number and rate of born HEI found HIV Result Negative *[Numerator: number of born HEI with a DNA PCR negative (at birth or at 6-8 weeks), Denominator: number of HEI born]*
    c. Number and rate of born HEI still waiting for their HIV test result *[Numerator: number of born HEI still waiting DNA PCR results (at birth or at 6-8 weeks), Denominator: number of HEI born]*
13. Outcomes of HEI found HIV positive:
    a. Number and rate of HEI born found HIV positive who were enrolled in PAC
    b. Number and rate of HEI born found HIV positive who were lost to follow-up (not enrolled in Pediatric AIDS Care)
    c. Number and rate of HEI born found HIV positive who were initiated on ART

Annex 3: Terms of Reference for the GOC

The GOC members work together to implement B-IACM at OD level to identify and enrol newly detected cases; bring back lost to follow-up cases into the HIV care cascade; reduce loss at each stage of the HIV cascade; and retain cases in care up to viral load suppression.

The members of the core group of the GOC will play the coordinating and organizational role to ensure the efficient running of the GOC to achieve the B-IACM objectives.

Specifically, the GOC members will:
- Support each other to find as many HIV cases (unaware of their status or lost to follow-up) as possible; specifically among KP and targeted general population
- Cooperate to ensure that data from all newly detected cases are entered and maintained in the B-IACM dashboard system
- Cooperate to regularly review the B-IACM dashboard to ensure that any losses at any stage are detected early, and that appropriate actions are initiated, followed-up and reported with resolution
- Support each other to strengthen B-IACM to ensure all HIV cases are enrolled and retained in care and treatment
- Review and profile all new HIV cases in the B-IACM system to better understand where those new HIV cases are detected
- Cooperate to maximize use of all available resources to achieve the B-IACM objectives and to resolves problems and challenges that may arise
- Conduct regular Rapid Monitoring and Analysis for Action (RMAA) meetings at sub-national level and report specific cases or situations to the national RMAA group
- Report B-IACM achievements to PHD/PASP who then reports collated results to NCHADS

The members of the GOC core-group will:
- Organize regular weekly meetings to review the data dashboard before sending the weekly report to PHD/PASP
- Develop other reports as requested
- Organize regular monthly meetings of all GOC members to discuss cases, achievements and find solutions for potential issues encountered in implementing B-IACM