KINGDOM OF CAMBODIA

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Standard Operating Procedure

BOOSTED CONTINUUM OF PREVENTION TO CARE AND TREATMENT FOR KEY POPULATIONS (B-CoPCT) IN CAMBODIA

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

2nd Revision, June 2021

FORWARD

The Royal Government of Cambodia with collective efforts of key country partners including multilateral and bilateral agencies partners, civil society organizations, and communities of people living with HIV and key populations has made tremendous progress in national HIV response, led Cambodia being one of the only seven countries globally to have achieved 90-90-90 target in 2017 Additionally, Cambodia has the highest treatment coverage in Asia and the Pacific region with approximately 84% of estimated number of people living with HIV on ART.

And yet, the progress Cambodia has made is fragile Cambodia HV epidemic remains concentrated among key populations, including female entertainment workers, gay men and other men who have sex with men (MSM) people who inject drugs (PWID) and transgender people, and HIV prevention and case detection are becoming difficult to target and reach higher risk and hard to reach key populations.

Recognizing the challenge of reaching higher risk and hard to reach key populations, in 2017, NCHADS/Ministry of Health updated Boosted COPCT SOP which included prioritizing approaches and interventions to maximize impacts by improving the targeting, relevance and frequency of services delivered, as well as its efficiency.

In the era of declining external resources and addressing emerging risk of key populations, the HIV prevention and testing programme should not be business as usual but differentiated HIV prevention combination and testing approaches and innovation should be implemented and their effectiveness and cost efficiency must be optimized. NCHADS has developed a new health sector strategic plan for HIV and STI 2016-2021 which has articulated a more focused/targeted and prioritized response, including priority geographic areas, venues/hotspot and subgroups of key populations for intensified HIV prevention programming among key populations Interventions for key populations will need to be more targeted to higher risk key populations. To prevent new HIV infections, behavior changes interventions must promote consistent condom use, and Pre-Exposure Prophylaxis have to be scaled up targeting key populations. In addition, HIV self-testing has been introduced and further scaled up to improve HIV case detection among high-risk key population, and for those who are HIV-positive, support for life-long ART adherence is vital The technical supports from partners, revisit B-COPCT SOP which was firstly developed in 2012 and updated in 2018 to reflect recent development including new and innovative strategies which are more targeted, cost-effective and efficient to optimize all service packages provided to key populations across cascade from prevention to treatment, care and support.

NCHADS would like to express our sincere thanks to all key partners who contributed to successful revision of this SOP and strongly hopes that all concerned stakeholders will implement updated SOP innovatively to contribute to efficiently using resource and achieving the goal of elimination of new HIV infections in Cambodia by 2025.

Phnom Penh, 19, July, 2021

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ACRONYM

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
B-CoPCT	Boosted Continuum Prevention to Care and Treatment
BIACM	Boosted Integrated Active Case Management
CAA	Community Actions Approaches
CAC	Community Action Counselor
CAW	Community Actions Worker
CBTx	Community-Based Drug Treatment
CMA	Case Management Assistant
CMC	Case Management Coordinator
DIC	Drop-In-Center
FBW	Facility-Based Worker
FEW	Female Entertainment Worker
FHC	Family Health Clinic
FS	Field Staff/Field Supervisor
GBV	Gender-Based Violence
GOC	Groups of Champions
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-testing
HTS	HIV Testing Service
IBBS	Integrated Biological and Behavioral Surveillance
KP	Key Population
MCH	Maternal and Child Health
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
MSM	Men who have Sex with Men
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGOs	Non-Governmental Organizations
NSP	Needles and Syringes Programme

OD	Operational District
OW	Outreach Worker
PEP	Post Exposure Prophylaxis
PLHIV	People Living With HIV
PNTT	Partner Notification, Tracing and Testing
PrEP	Pre-Exposure Prophylaxis
PSI/C	Population Services International/Cambodia
PWID	People Who Inject Drug
SBC	Social and Behavioural Change Communication
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
TG	Transgender
TWG	Technical Working Group
UUIC	Universal Unique Identifier Code
UIS	Unique Identifier System
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAW	Violence Against Women
VCCT	Voluntary Confidential Counseling and Testing
WHO	World Health Organization

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1. Background

To achieve ambitious goals of ending AIDS as a public health threat and elimination of new HIV infections by 2025 in Cambodia, comprehensive HIV services need to be delivered including through innovative approaches, to effectively reach and tailor to the needs of key populations at high risk and their subgroups. Even though Cambodia has been very successful in HIV response, with latest available data HIV prevalence remain high among key population at 3.2% among FEWs, 4% among MSM, 9.6% among TG and 15.2% among PWID. The prevalence is even higher within some geographic locations such as up to 4% in Phnom Penh for FEWs[1], almost 7% in Siem Reap for MSM[2], 17.7% in Banteay Meanchey for TG[3]) and sub-type of key populations (for example 5.9% among FEWs having partners < 2/week and 8.3% among FEWs having partners> 2/week and 11.8% for freelance FEWs[4], and 14.3% among MSM who had four or more casual sexual partners). Consistent condom uses among key populations remain concern especially with non-commercial or regular partners (27% for FEWs) and consistent condom use with main sexual partners and with casual, paid, and paying partners was low for both MSM and TG. In MSM, only about 50% used condoms consistently when they had sex with outside their primary relationship including casual, paid, and paying sexual partners. It was basically the same for TG with more than 50% only using condoms consistently when they had sex with partner outside their primary relationship. In addition, apart from low positivity yield through routine community-based testing and low percentage of disclosure on their key population identity, critical legal and structural barriers and stigma and discrimination towards key population remain, which continue to hamper their access to HIV, health, and non-health services.

Recognizing the challenge of reaching higher risk key populations, in 2014, NCHADS/MoH produced a series of key populations Boosted CoPCT (B-CoPCT) concept notes, including operational guidance notes on prioritizing B-CoPCT aiming at reaching unreached, hard-to-reach and different subgroups of key populations as well as prioritizing approaches and interventions to maximize impacts by improving the targeting, relevance and frequency of services delivered, as well as its efficiencies. Boosted COPCT SOP was also updated in 2018 to guide HIV prevention service delivery to respond to emerging needs of Key Populations, including emerging shift to social media platforms in particular among young key population.

[1] NCHADS IBBS EWs 2016
[2] NCHADS IBBS MSM 2019
[3]NCHADS IBBS TG 2019
[4]ibid

2. Rationale

With the changing context of key population nature in finding their sexual partners, including through social media and dating apps, and emerging issues for example ChemSex, the HIV response in particular prevention service delivery cannot use traditional approaches, however, innovative approaches including but not limited to virtual outreach and other combination prevention methods have to be put in place to maximize the effectiveness and cost efficiency of HIV programs and services, including those aim at preventing new HIV infections, improving new HIV case detection and linking to HIV services.

Interventions for key populations will need to be more targeted to higher risk key populations. To prevent new HIV infections, behavior changes interventions must promote consistent condom use, awareness and access to combination prevention such as PrEP; and for key population who are diagnosed as HIV-positive, support for life-long ART adherence is vital. Detection of undiagnosed cases in particular among key populations, which remain very low, requires intensification. A few significant challenges remain:

- higher risk members of key populations may be challenging to be identified and reached especially those who are hidden, freelancers, and those outside the program catchment areas.
- Stigma and discrimination may limit key population's access to HIV program interventions and services, including prevention and testing, and
- optimization of service delivery efficiency to maximize impacts remains limit.

To address those remaining challenges, innovative prevention interventions and testing modality have been introduced including but not limited to virtual outreach through online counselors, social media and dating apps, PrEP and HIV self-testing in addition to existing interventions. To reflect all changes in innovation and to provide clear guidance to identify, reach, intensify and retain key population along HIV prevention and treatment cascade, B-COPCT SOP needs to be updated. These innovative interventions can be considered as adapted HIV services while physical outreach cannot be conducted e.g., in context of COVID-19 pandemic, to ensure HIV service prevention is not interrupted.

3. Goal and Objectives

3.1 Goal: To contribute to achieving goals of Ending AIDS as a public health threat and Elimination of New HIV Infections by 2025 through improving health outcomes/status of key population.

3.2 Specific Objectives:

- Define approaches, including innovation for identifying and reaching different types and sub-groups of Key Populations, especially young, hidden, hard to reach and freelancers[5] who are considered at higher risk of HIV infection
- Define service package and frequency of HIV prevention service delivery for key populations as well as set standards for the effective implementation to optimize service uptakes, case detection, and retention along HIV cascade
- Establish implementation, coordination, and management mechanisms.

4. Approaches and Services Packages

Different approaches can be used to identify and reach key populations depending on the nature and sub-categories of each key population for preventing new HIV infections and detecting HIV cases.

The approaches should include:

- **Physical outreach** where trained outreach workers go to physical locations to reach members of key populations or use a snowballing-like method that leverages the physical networks to reach those outside these spots. This is the first generation of outreach methods (which can also be called Outreach 1.0) and it remains the bedrock of most HIV programs today.
- **Virtual outreach** where HIV program staff or trained outreach workers use online platforms to navigate to virtual locations (for example, Facebook groups or pages or WhatsApp groups) and to engage their virtual networks to identify high risk key population and engage them in one-on-one chats that eventually lead to offline uptake of HIV services (this can be called Outreach 2.0); or outreach that extends the program to reach beyond one-on-one connections and has the potential to reach larger segments of the target audience through online targeted advertising and promotions by social media influencers or any other promotion messaging through social media (for example Facebook, YouTube, Instagram…) and dating apps (i.e.

4.1 Physical Outreach

❖ The physical outreach approach is ***Routine Face to Face Outreach which is conducted by trained outreach workers who should be qualified peers, or well qualified non-peers, on a regular basis at entertainment venues and hotspots and places where key population gather or find sexual partners, using SBC tools/messaging***. The physical outreach can be flexibly conducted during the daytime and/or night-time to maximize reach to key population and in particular attention should be put on identifying and reaching higher risk and hard to reach key populations to deliver defined core package of services. To tailor the outreach services to needs of specific key population, risk screening using tablet-based or paper-based questionnaires is conducted to identify level of risk of key populations and define more specific and effective interventions for addressing specific needs of key population individuals or sub-groups and prioritize for HIV testing.

Defined service packages (Core and Other Essential Services) for physical outreach include:

- **Services Packages:**
  - **Core service packages**
    - **Social and Behavioral Change communication (SBC):** aims to increase awareness of the risk behaviours and strategies and means available to reduce the risk of HIV transmission including promoting consistent condom uses, information and access to PrEP, HIV testing (including HIVST) and PNTT. SBC will be delivered by

OWs to key populations on quarterly basis (either individually or in group sessions) using SBC tools tailoring to identified risk behaviours of sub key population and promote HIV testing and other HIV services. Ideally, a SBC tool will be developed for each specific behaviour/risk-related topic, with tools and topics used with key populations changing on a quarterly basis if required. OWs should also provide information on other related services such as ART literacy to key population on top of preventive education to link prevention with treatment by promoting/reinforcing 'Treatment as Prevention', "Test and Treat", and Undetectable=Untransmittable (U=U) messaging.

- **Condoms and lubricants** are provided for free at every contact in each quarter. OWs will provide 27 or more condoms (and lubricants for MSM and TG) per quarter to key populations. Additionally, HIV prevention program will coordinate with social marketing condom program being implemented by PSI/C to ensure condom and lubricant availability at diverse points of sales, including high risk venues.

- **HIV Testing Service**: community-based HIV and syphilis testing services for high-risk/at-risk key population (to be more targeted based on risk identified from risk screening) will be offered by trained OWs or Field Supervisors. HTS referrals to health facilities (public, NGOs or private) will be made available for key populations if they prefer. HIV and syphilis testing will be regularly and consistently promoted and offered for every 6 months or more frequent based on request and/or exposure or risks. All key populations who get HIV reactive results will be referred to VCCT co-located with ART sites for confirmatory testing and immediately enrolled on ART if HIV positive results are confirmed. All individual key populations receiving an HIV positive result will be counselled to bring their partners for testing, or to provide a referral card to their partners. HIV Self Testing can also be promoted and provided to key population and their partners through physical outreach. *For more detailed guidance on HIV Self Testing, please refer to HIV Self Testing SOP adopted by the Ministry of Health in July 2020.*

  Note: Reward should be considered for outreach workers and frontline staffs who have high performance on detecting new HIV cases through community-based HIV testing.

- **STI screening**: At-risk key population are regularly referred for STI screening (including syndromic screening and questionnaire on STI symptoms) while referrals for such screening for low- or no-risk key population will be done on a case-by-case basis, when the client is symptomatic. STI testing (except syphilis which can be tested through community-based testing) will be conducted at health facilities, so OW will prepare plan for referring key population to Family Health Clinics, other public health facilities or other NGO clinics, and regularly

collect referral slips at health facilities where key population have been referred to count successful referrals.

- **Other Essential Services:** In addition to core service packages, key populations also receive referral support to other related services through coordination and collaboration with relevant health facilities and organizations. Such services include:
  - **Pre-Exposure Prophylaxis (PrEP):** In addition to PrEP information and awareness raising through outreach activities, key population should be referred by outreach workers and field staff to initiate PrEP at PrEP service delivery sites.

  - **Needle and Syringe Program (NSP)**: for key populations who inject drugs, OWs can refer them to NSP services which are being implemented by a few harm reduction NGOs. Collaboration and linkages are required between NGOs implementing harm reduction services and NGOs who are working with FEWs, MSM and TG to identify and refer key populations with overlapping risk behaviours to appropriate services.

  - **Methadone Maintenance Therapy (MMT):** referral to MMT is made if required. MMT is provided in accordance with the protocol established by the Ministry of Health. Regular referral or direct transportation support to MMT services may be provided to clients by NGOs. These NGOs should also regularly follow-up with MMT clients to minimize loss, non-adherence, and to support their access to other services, as needed.

  - **Community-Based Drug Treatment (CBTx):** for key populations who use drugs can be also referred to community-based drug treatment offered by the Ministry of Health through selected health facilities.

  - **Sexual and Reproductive Health Services:** during outreach, key populations with an unmet need for family planning will be referred to health facilities for contraceptive commodities. Clients will also be referred for sexual and reproductive health services as well as antenatal, delivery, child health and safe abortion services.

  - **Gender-Based Violence Services:** key populations who experienced gender-based violence will be immediately referred to comprehensive GBV response services (as described in national guidelines for managing VAW/C in health system). The immediate health related services for GBV survivors should include first line support (LIVES)[6], psycho-social counselling, pregnancy test, emergency contraception, Post Exposure Prophylaxis (PEP), HIV testing, STI testing and treatment and linking survivors to other essential GBV services (legal and social support and shelter).

[6] LIVES: Listening, Inquiries, Validation, Enhance safety, Support

- **Treatment Adherence and Retention in Care**: OW will need to collaborate with community case managers and the larger boosted IACM team, including the Group of Champions (GOC) and CAA team, to enrol and follow-up HIV+ key population on HIV treatment and regular counselling to ensure their adherence and retention in care till viral suppression and afterward. Detailed guidance is in Annex 1.

- **Psycho-social support:** Key Population who need psycho-social counselling and support will be referred psycho-social support and services through collaboration with non-HIV NGOs, and key population community networks.

- **Legal support:** Key Population who experienced human rights violation will be referred for legal advice and legal assistance provided by human rights NGOs (e.g. Cambodian Center for Human Rights, Women's Network for Unity) as needed.

Table 1: Summary of service packages for Physical Outreach

Components	Summary Service Packages for Physical Outreach
Female Entertainment Workers (FEWs)	➢ Service packages: ▪ Prevention education and counselling every 3 months using SBC tools (on topics including HIV and STI prevention, consistent condom use, promotion of HIV and Syphilis testing, PrEP, PNTT, HIV treatment literacy, family planning, GBV, PEP, stigma and discrimination, drug and alcohol abuse…etc.) ▪ Condom distribution (27 condoms or more /quarter), promotion and availability of condoms and lubricants can be also ensured through condom social marketing program. ▪ HIV and Syphilis testing every 6 months or more frequent based on request, exposure or risks[7] and referral of reactive cases for confirmatory testing and PNTT. ▪ Referral for STI check-up every 6 months or more frequent based on request, exposure or risks [8] ▪ Promotion and referral to PrEP ▪ Risk screening every 6 months ➢ Referral to other essential services when needed (VCCT, ART, SRH and MCH, NSP, MMT, GBV, CBTx, social and legal services, etc.) ➢ Service delivery channels:

[7] HIV testing can be offered for less than 6 months based on request and/or identified risks of KP
[8] STI check up referral can be conducted less than 6 months, based on specific needs of individual KP

Components	Summary Service Packages for Physical Outreach
	▪ Outreach workers and field staff (peers and non-peers, including meka and other key informants and networks) o Venue-based outreach o Mobile outreach, including testing, for freelancers ▪ Drop-in-center and clubs if available
Men who have sex with men (MSM)	➢ Service packages: ▪ Prevention education and counseling every 3 months using SBC tools (on topics including HIV and STI prevention, consistent condom and lubricant use, promotion of HIV and Syphilis testing, PrEP, PNTT, treatment literacy, GBV, PEP, stigma and discrimination, drug and alcohol abuse) ▪ Condom and lubricant distribution (27 or more condoms and lubricant/quarter), promotion and availability of condoms and lubricants can be also ensured through condom social marketing program ▪ HIV and Syphilis testing every 6 months or more frequent based on request, exposure or risks [9] and referral of reactive cases for confirmatory testing and PNTT. ▪ Referral for STI check-up every 6 months or more frequent based on request, exposure or risks [10] ▪ Promotion and referral to PrEP ▪ Risk screening every 6 months ➢ Referral to other essential services when needed (VCCT, ART, SRH, NSP, MMT, GBV, CBTx, social and legal services, etc.) ➢ Service delivery channels: ▪ Outreach workers and field staff (peers and non-peers, including panpa and other key informants and networks, however, peer-OWs are preferred)) o Venue-based outreach o Mobile outreach at hotspots

[9] HIV testing can be offered for less than 6 months based on request and/or identified risks of KP
[10] STI checkup referral can be conducted less than 6 months, based on specific needs of individual KP

Components	Summary Service Packages for Physical Outreach
	▪ Drop-in-center and clubs if available ▪ Social gatherings
Transgender (TG)	➢ Service packages: ▪ Prevention education and counseling every 3 months using SBC tools (on topics including HIV and STI prevention, consistent condom and lubricant use, promotion of HIV and Syphilis testing, PrEP, PNTT, treatment literacy, GBV, PEP, stigma and discrimination, gender reassignment services, sexual orientation and gender identity and expression, drug and alcohol abuse) ▪ Condom and lubricant distribution (27 or more condoms and lubricant/quarter), promotion and availability of condoms and lubricants can be also ensured through condom social marketing program ▪ HIV and Syphilis testing every 6 months or more frequent based on request, exposure or risk, and referral of reactive cases for confirmatory testing and PNTT. ▪ Referral for STI check-up every 6 months or more frequent based on request, exposure or risk,[11] ▪ Promotion and referral to PrEP ▪ Risk screening every 6 months ➢ Referral to other essential services when needed (VCCT, ART, SRH, NSP, MMT, GBV, CBTx, social and legal services, sexual reassignment counseling and services, etc.) ➢ Service delivery channels: ▪ Outreach workers and field staff (peers and non-peers, including maephum and other key informants and networks, however, peer-OWs are preferred) o Venue-based outreach o Mobile outreach, including testing, for freelancers ▪ Drop-in-center and clubs if available ▪ Social gatherings

[11] STI check up referral can be conducted less than 6 months, based on specific needs of individual KP

4.2 Virtual Outreach

Virtual outreach is:
1) outreach conducted by trained outreach workers through mobile phone or any other online platforms (Messenger, Line, Dating Apps…) to engage key populations in one-on-one chats to deliver HIV prevention services and identify those who at high risk to eventually offline uptake HIV services, including but not limited to PrEP and HIV testing, or

2) virtual outreach can also be an outreach beyond one-on-one connections, but rather reach larger segments of key population through online targeted advertising and promotions by social media influencers, and through other online platforms

Virtual Outreach is complimentary to physical outreach as it can be reaching hard to reach and hidden key populations who quite often cannot be reached by physical outreach. Importance of virtual outreach are highlighted below:

- ***Broader Inclusion:*** Harnessing online platforms to expand access to previously unreached individuals facing high risks, and more conveniently reaching existing program beneficiaries who already use online and mobile platforms.

- ***Client-Centred Differentiated Services:*** *Providing* more options and entry points through which people can engage in HIV services will make HIV programs more accessible, relevant, and useful. However, to offer truly differentiated options that satisfy the preferences of a broader range of people, HIV programs need to create several pathways for clients to engage in HIV services that begin with outreach and extend through education, counselling, referral, and uptake of biomedical HIV services. To achieve this, we start by better understanding the populations we want to engage and their unique characteristics.

- ***Improved Efficiency:*** Due to the relatively low costs of engaging people online versus face-to-face interaction, as well as the ability to engage previously unreached people at high risk, programs are beginning to document efficiency gains through virtual engagement. Leveraging efficiencies of virtual communication, automated systems, and rich user data to bring the right information and services to the right people.

- ***Safe and Confidential Access:*** Building trust and protecting service users and providers through a secure online environment for confidential access to HIV information and services.

4.2.1 Approaches for effecive virtual outreach

Below are summary of key approaches which need to be considered for virtual outreach to ensure its effectiveness and impacts. Other detailed guidance and steps for virtual outeach can be found in Annex 2 and ICT concept notes.

Table 2: Summary of approahes and key considerations for virtual outreach:

Approaches for effective virtual outreach	Key considerations for virtual approach
Virtual mapping	- Lists of the places where the audience can be reached online via Facebook, Instagram, Line and Bigo Live and dating apps (Grindr, Blued …) - These online spaces may also be useful entry-points to introduce HIV prevention services to the audience if implemented carefully and with respect.
Creative content	- Create campaign name, logo, outreach worker profiles, educational posts, and engaging social media posts.
Chat in real time with friends	- People use social media to communicate and connect on a variety of topics like dating, socializing, and community building. - Send and receive messages - Stream live video - Facebook chatbot - Create or join a group around a shared interest. - Interact with posts on others' timelines (liking, commenting, sharing with others) - Engagement with posts (likes, comments, shares) to increases the chance that others will see your post. - Use hashtags to tie your content to larger conversations happening on Facebook., etc.
Practical tools for outreach workers	- Training and supportive supervision for all formal outreach workers with a scope of work and standard operating procedure. Simple guidance for peer mobilizers should also be developed. - Motivational interview or effective communication skills are essential. - Fun applications can help to attract attention, e.g. Video Clips or Story Episode. - Confidentiality is vital for creating trust. - Conversations should be friendly and respectful. - Develop message matrix, chat and call scripts, trackers, online reservation system, risk assessment tool, and WhatsApp, telegram group for team troubleshooting.

	- Budged technology for outreach workers such as a laptop, cell phone, mobile data plan, and apps for outreach. - A safe space with secure internet connection for outreach workers to conduct outreach that will allow privacy when engaging with clients and ensure safety for the outreach worker. - Ethical Standards: develop ethical code of conduct for health providers and outreach workers
Share and Post	- Customize your profile page with a cover photo, profile image, and personal information. - Post updates (text, photos, videos) on your own timeline or the timeline of a friend
Social influencer	- Collaboration with outstanding social influences to promote HIV status among Key Population, increasing HIV testing uptake.

In addition to virtual outreach approaches described above, few other virtual approaches can be conducted:

- Media campaign which will be done through:
  - Websites, Facebook pages, events, IEC materials, games, quizzes etc. are necessary to keep key population engaged.
  - Link to other NGO online pages and health referral, for examples:
    - TohTest website, including booking appointment.
    - Facebook page Kapeakh ("Protect Yourself")
    - Facebook page Met Laor
    - Website and Facebook pages of SMARTGirl, MStyle and Srey Sros
    - Facebook pages of Men's Health Cambodia (MHC), Men' Health Social Services (MHSS), Cambodian Women for Peace and Development (CPWD), AHF….

- Facebook live can also be conducted which allow audiences to engage, includign through questions and answers

4.2.2 Service Packages:

Table 3: Service package for virtual outreach

Components	Summary Service Packages for Virtual Outreach
Virtual outreach through trained online outreach workers	➢ Service packages: ▪ Prevention education and counseling every 3 months using SBC tools (on topics including HIV and STI prevention, consistent condom use, promotion of HIV and Syphilis testing, PrEP, treatment literacy, family planning, GBV, PEP, stigma and discrimination, drug and

Components	Summary Service Packages for Virtual Outreach
	alcohol abuse, Chemsex, U=U…etc.), and promoting access to HIV prevention promotion websites and social media platforms, ▪ Consistent condom use promotion and dissemination of information where condoms and lubricants are available through condom social marketing program ▪ Promote access to HIV and Syphilis testing every 6 months or more frequent based on exposure or risks[12] through HIVST or linking to community HIV testing or testing at health facilities based on key populations' preference, and referral of HIV reactive cases for confirmatory testing. ▪ Promote and refer to PrEP ▪ Encourage for risk screening every 6 months through online risk screening tool. ➢ Referral to other essential services (VCCT, ART, SRH and MCH, NSP, MMT, GBV, CBTx, social and legal services, etc.) ➢ Service delivery channels: One-on-one communication through: ▪ Phone call ▪ Chats through other online platforms (Facebook/messenger, Lines, Bingo Live, Grindr, Blued and other online platforms)
Promotion/advertisement through Social Media/Dating Apps	➢ Service packages: ▪ Prevention education using defined/developed social media educational materials on topics including HIV and STI prevention, consistent condom and lubricant use, promotion of HIV and Syphilis testing, PrEP, treatment literacy, GBV, stigma and discrimination, drug and alcohol abuse) ▪ Promotion of consistent condom and lubricant uses , and dissemination of information where condoms and lubricants are available, including through condom social marketing program ▪ Promote access to HIV and Syphilis testing every 6 months or more frequent based on exposure or risks[13], and link to HIVST, community-based HIV testing and facilities-based testing, and referral of reactive cases for confirmatory testing. ▪ Promote access for STI services

[12] HIV testing can be offered for less than 6 months based on request and/or identified risks of KP
[13] HIV testing can be offered for less than 6 months based on request and/or identified risks of KP

Components	Summary Service Packages for Virtual Outreach
	▪ Promote access to PrEP services ▪ Encourage access to risk screening using online risk screening tool ➢ Referral to other essential services (VCCT, ART, SRH, NSP, MMT, GBV, CBTx, social and legal services, etc.) ➢ Advertisement/announcement about specific HIV related events. ➢ Service delivery channels: ▪ Online platforms: websites, social media (Facebook, Instagram…) ▪ Dating Apps

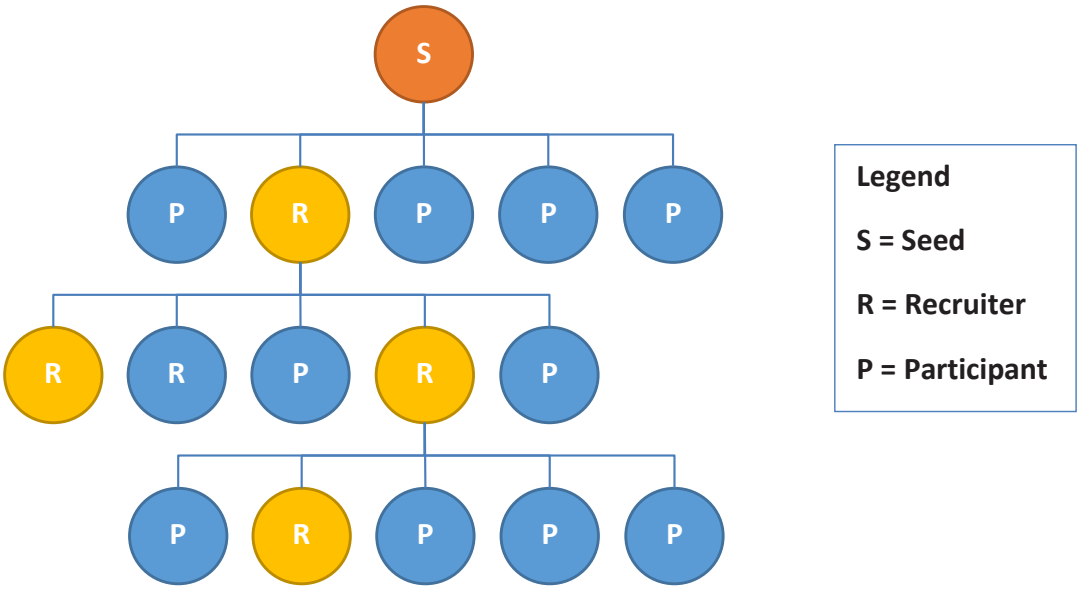
4.2.3 Code of Conduct

NGO and implementation agencies should establish a code of conduct for program staff and outreach workers. This code of conduct should clarify that program staff and outreach workers who deliver HIV prevention and testing services should not engage with sexual activities with their clients, e.g. having sex with clients to exchange for money or to get clients to access HIV prevention or testing services they provide; or engage in other inappropriate behaviors and wording with clients. Agencies should establish and enforce these boundaries to protect their staff and their clients, and to ensure clients receive high-quality HIV prevention and testing services. Since hidden and hard to reach key populations can be reached virtually, so confidentiality of clients' information, including their key population and HIV status and other personal information should be treated confidentially.

4.3 Peer Driven Interventions Plus (PDI+)

PDI+ is an incentive-based, peer-centered, snowballing approach where seeds are provided risk screening with coupons to recruit peers within their networks to offer HIV prevention, testing, and refer to treatment services through physical and virtual referral chain networks in ways that ensure the privacy of key population members. PDI+ is used as complimentary approach to outreach work for expanding access to HIV testing and improving HIV case detection among key populations, in particular reaching to those who are hard-to-reach network of key population or not have been reached by OWs for HIV testing as well as joining the prevention programs.This model allows the HIV prevention among key population program to reach at-risk key population beyond the existing program coverage to encourage HIV prevention and testing among key population to further boost new case detection efforts. It is required that PDI+ personnel coordinate their work effectively with the outreach personnel to ensure smooth linkage between the two approaches. In Cambodia, PDI+ is most successful in identifying and testing hidden/hard to reach MSM and TG.

❖ **Peer Driven Interventions Plus (PDI+) model**



The outreach model is expected to work in tandem with other existing models, especially those that focus on new case detection, such as PDI+. Therefore, indicator setting for this model needs to be responsive and complementary to avoid overlapping for data reporting. This also extends to the respective coverage of each model. Implementers need to ensure that coverage under each model does not overlap and lead to double counting.

Please refer to concept note on PDI+ for additional details.

4.4 Pre-Exposure Prophylaxis (PrEP)

PrEP is an HIV prevention strategy that currently involves taking a once daily pill as daily dose or 2 pills, 1 pill and 1 pill as event driven dose to reduce the chances of acquiring HIV. People who use PrEP must commit to taking the drugs based on prescription and seeing their healthcare provider for follow-up and additional testing every three months. PrEP is intended for HIV-negative people, especially those who may be in an ongoing relationship with a person living with HIV, does not consistently use a condom when having sex, or shares drug or hormone injecting equipment.

PrEP works best when taking as prescribed and when it is used with other prevention options. When combining options, the risk of getting HIV from another person will be further reduced.

PrEP is for people who are at very high risk of acquiring HIV. These include:

- Being an HIV uninfected sexual partner of a PLHIV who is not virally suppressed, or results of viral load testing are unknown (i.e., HIV discordant couples) and where condoms are not consistently used.
- Had condomless anal/vaginal/neovaginal sex in the past 6 months with more than one partner.
- History of any new sexually transmitted infection (STI) in the past 6 months.
- Used drugs for sexual pleasure during the past 6 months and there is condomless sex or inadequate access to sterile injecting equipment.
- Injected drugs in the past 6 months where injecting equipment shared or there is inadequate access to sterile injecting equipment.

- Received post-exposure prophylaxis (PEP) one or more times in the past 12 months.
- If the sexual partner of the person has one or more of the HIV risk factors listed above.

Please find detailed information in PrEP concept note.

4.5 Partner Notification Tracing and Testing (PNTT)

4.5.1 PNTT Definition

PNTT is defined as a voluntary process whereby a trained provider (including OW/field staff) counseled key population diagnosed with HIV about how to disclose his/her HIV status to their partners and encourage their sexual partners and/or drug-injecting partners for HIV testing.

PNTT has been implementing at ART sites by service providers who provide counselling and discuss with PLHIV for the best option to notify and bring their partners for testing. Key population living with HIV will be exposed to PNTT at ART sites, however, it is important to provide additional PNTT service at key population community given that it would require sometimes to have key population living with HIV accepted the PNTT and OW/field staff is more friendly and frequently meet key population at the community so then they can help in term of following up.

4.5.2 Principles

- ***Client-centered & informed choice***: partner notification services should be an informed choice for the best option for their circumstances focused on the needs and safety of the index client and his/her partner(s)
- Delivered in a ***non-judgmental manner.***
- ***Confidential:*** both the confidentiality of the index client and all named partners should always be maintained. The identity of the index client should not be revealed and no information about partners should be conveyed back to the index client (unless explicit consent is obtained from all parties).
- ***Voluntary, human rights-based and non-coercive***: participation should be voluntary for both the index client and his/her partner(s). Human rights of both index and the partners must be respected.
- ***Accessible and available to all***: partner notification should be available to all index clients regardless of where they are diagnosed.
- ***Comprehensive and integrative***: partner notification services should include strong referral and linkages to HIV treatment and prevention services.

4.5.3 Approaches

What is defined in this section is to provide different approaches of PNTT based on the national guidance for a trained outreach workers/field staff to provide this service to key population living with HIV at the community level.

- ***Non-Assisted HIV partner notification services*** refer to when HIV-positive clients are encouraged by a trained OW/Field staff to disclose their status to their sexual and/ or drug-injecting partners by themselves and to also suggest HTS to the partner(s) given their potential exposure to HIV infection.

- ***Assisted HIV partner notification services*** refer to when consenting HIV positive key population are assisted by a trained OW/Field staff to disclose their status or to anonymously notify their sexual and/or drug-injecting partner(s) of their potential exposure to HIV infection. The OW/Field staff then offers HIV testing to these partner(s) or refer them to VCCT. Assisted partner notification is done using contract referral, provider referral, or dual referral approaches.

  - Contract referral: HIV-positive key population enter into a contract with a trained OW/Field staff and agree to disclose their status and the potential HIV exposure to their partner(s) by themselves and to refer their partner(s) to HTS within a specific period. If the partner(s) of the HIV-positive individual does not access HTS or contact the OW/Field staff within that period, then the OW/Field staff will contact the partner(s) directly and offer voluntary HTS.
  - Provider referral: with the consent of the HIV-positive client, a trained OW/Field staff confidentially contacts the client's partner(s) directly and offers the partner(s) voluntary HTS .
  - Dual referral: A trained OW/Field staff accompanies/sit and provides support to HIV positive clients when they disclose their status and the potential exposure to HIV infection to their partner(s). The OW/Field staff also offers voluntary HTS to the partner(s).

Assisted HIV partner notification services (provider, contract or dual referral)	**Non- Assisted HIV partner notifications services**
- Trained OW/field staff provides counselling and offers HIV-positive key population assistance with disclosure and notifying their partner(s) through one of the 3 referral methods. - Trained OW/field staff contacts partner(s) either by phone, Internet, e-mail or an in-person home visit to inform them of their potential exposure to HIV infection and offers them voluntary HIV testing services (HTS). - Trained OW/field staff offers home-based HTS to the household (including partners and family members) of the HIV-positive individual based on patients' option.	- Trained OW/field staff delivers counselling and encourages HIV-positive key population to disclose their HIV status to their partner(s) and notify them of their possible HIV exposure, either in-person or by telephone call, text message, e-mail, etc. - Trained OW/field staff gives HIV-positive clients a letter or card inviting their partner(s) to attend the health facility. When the partners present themselves at the health facility, they are offered HTS. - HIV-positive clients may use anonymous messaging services such as a phone call, email, or Internet to notify their partner(s) on their own.

OW/field staff shall receive proper training on PNTT before offering this service with strictly follow the key principles. OW/field staff shall maintain regular follow up with HIV positive key population on his/her PNTT status, progress, and support needed.

OW/field staff have different options to provide HIV testing to partner(s) of key population based on their suggestions, either a rapid test at any confidential and convenient time and place or referral to VCCT, ART facility, or provide/ refer to HIV self- self-testing service.

OW/field staff shall keep proper recording and reporting of PNTT and building a strong connection with relevant HIV testing team (at VCCT, at ART facility /CAC team) and GOC team to support follow up and enrolment in ART for key population's partners who are positively diagnosed with HIV or referral to PrEP for the partners who are HIV negative.

Please see SOP of Partner Notification Tracing and Testing (PNTT), especially the 8 steps of PNTT, recording and reporting.

5. Implementation, Structure and Management

Service package will be delivered by outreach workers who will be monitored and supported by field staff contracted by NGOs. Below are suggested caseloads:

- Caseload: maximum 300 FEW per OW
- Caseload: maximum 260 MSM/TG per OW

5.1 Conditions/Criteria for OW

- OWs can be selected from the community they are to serve including peer or non-peer well known by key population and have vast networks of key population peers. However, for MSM and TG, peer outreach workers are preferred. While PLHIV and key population themselves should be prioritized for the recruitment, the process should also be open to applicants who are non-PLHIV/non-KP but are still well qualified for the job;

  Qualifications for non-peer OW should include:

  - At least high school or at least one year of experience in counselling or health social related works
  - Good communication skills
  - Willingness to do outreach work, including flexible hours

- Transparent selection criteria and methods should be employed, preferably through recruitment process, but social network analysis and nomination techniques would be also applied.
- OWs will receive regular training including comprehensive training at the beginning of service and other related training if required and available. OW must be equipped with correct knowledge of HIV/AIDS and STI (including treatment literacy).
- OW possess robust interpersonal communication skills, using various communication channels (in person, online via social media platforms) to keep in touch and follow up with KP.
- OWs will be provided with the necessary equipment (e.g., uniform/t-shirt, badge, bag, SBC materials) to carry out their role.

5.2 Responsibilities of OWs

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

- **Planning:**
  - Drafts a weekly activity plan for his/her defined outreach area (based the mapping)
  - Ensures s/he understands the quarterly SBC topic and how to use the tools with clients
  - Prepare for outreach activities including SBC materials, condoms, lubricants, HIV and Syphilis testing kits, referral slips, (and NSP kits for PWID)

- **Service delivery (Outreach):**
  - Conducts outreach in venues and hotspots (including Park and/or Street) and assigned DICs. Outreach will be conducted with individuals or groups. However, in some cases individual contact would be requested by KP.
  - Outreach worker should be flexible in term of working hours, including in the evening and

night-time to maximize reaching their target KP.
  - Another outreach approach through the use of virtual means, outreach workers provide virtual outreach, including information and counselling to promote access to testing and referral to other requested services;
  - Conduct risk screening for new KP before registering to the KP list in order to assess their level of risk. For old KPs are also required to screen at least two times per year at the beginning of the year and in the next 6 months to reassess their level of risk.
  - Conduct community finger prick testing at the outreach (ensuring individual KP have accessed to HIV testing at least once per 6 months)
  - Build and maintain good relationships with stakeholders, including establishment owners, health care providers, police, local authorities and clients as well as Group of Champions at OD level

- **Service Coordination/Referrals:**
  - Encourages clients to have HIV tests and STI screenings every six months
  - Refers, accompanies and follows up reactive case clients for confirmatory test and enrol in ART in coordination and collaboration with Group of Champions (CMC and CMA)
  - On every contact, provides KP with a referral card for STI screening and testing as well as other services as appropriate or relevant (e.g. VCCT, ART, SRH, FP, MCH, GBV, NSP, MMT, CBTx, PrEP, PEP, STI, Mental Health, legal assistance etc.)
  - Provides KP with a partner referral card for STI and HIV testing for the KP's primary partner or clients
  - Visits the health facilities (on a monthly basis) to collect referral cards and bring them to the implementing organization's office
  - Helps facilitate eligible KP to get IDPoor or register for HEF or to know how to use ID poor/post ID at points of services

- **Coordination, M&E, Reporting:**
  - Completes primary data collection tools (OW logbook) to record the delivery of Boosted CoPCT services daily and in a timely manner
  - Attends meetings and training, including those with other OWs and implementing organization staff to discuss issues, plan for upcoming activities, and to share progress and experience; and actively engage in BIACM mechanism at OD level

5.3 Service Linkage Coordination

- OWs inform field staff of new cases, and field staff then need to work closely with GOC to follow up new reactive test for confirmatory test and enroll them on ART as well as support in following up any lose-to-follow up clients;
- OWs work closely with community actions workers who provide care and support services as well as coordinate in term of referral of clients to other related services;
- OWs work closely with KP and PLHIV community networks, including representatives of joint Forum of Networks of PLHIV and MARPs (FONPAM) at OD level to reach out hard to reach and most vulnerable KP.

5.4 Payment for OW

It is proposed that each OW receive at minimum USD 200 allowance per month for their full-time work (7.5 hours/day, and 5days/week). The payment process (and any additional benefits, if applicable) shall be in accordance with the personnel policies of their respective contracting

organizations and the Cambodian labor law. The allowance and benefits should be regularly reviewed to ensure alignment with Cambodia's minimum wages, and any future revision of the Law.

5.5 Retaining for OWs

- Program management supports and builds capacity of outreach workers, including psycho-social support.
- Motivate outreach workers by establishing reward mechanism for outreach workers based on their performance.

To be able to retain KP in reach:

- OW is able to address emerging needs/questions of KP
- OW builds trust with KP
- OW provides quality service/provide counselling and support
- Maintain contact information (telephone/phone's number of their close friends).

6. Monitoring and Reporting

Definition of Reach by physical outreach: individuals who are reached by education and condoms/lubricants distribution through physical outreach activities.

Definition of Reach by virtual outreach: individuals who are reached by education through any virtual means, and condoms/lubricants promotion.

Virtually Reach: Firstly, reached via virtual means (no condom distribution nor HIV testing), but promote condom and lubricant uses and HIV testing, and later referral to HIV testing, including HIVST, and access to condoms and lubricants could be done.

Physically Reach: physically reached via outreach AND received condoms (and lubricants for MSM and TG) or HIV testing

Means of Reach	Reachable	Risk assessment	PrEP promotion	HIV Education	Condom and Lubricant**	Referral to other essential services	HIV testing
Virtual	Yes	Yes* (via online risk assessment tool)	Yes	Yes	Promoted	Yes (if indicated)	Promoted and Referred, or HIVST if indicated
Physical	Yes	Yes*	Yes	Yes	Given	Yes (if indicated)	At least every six months

**Baseline among new KP and every six months for existing reached KP*
***Lubricant for only MSM and TG*

Some individuals would be firstly reached through virtual means and later through physical outreach, so **MEAN OF FIRST CONTACT** will be considered as mean of reach of the **QUARTER**.

The following scenarios within SEMI-ANNUAL reporting period will define whether the outreach is categorized as physical or virtual.

Scenario	First Quarter Contact	Second Quarter Contact	Defined Mean of Reach
1	Communication is initiated using any virtual means: social media platform or phone contact (call, SMS) (VIRTUAL REACH)	Physical contact and reach to continue providing package of services. (PHYSICAL REACH)	**PHYSICAL**

2	KP reached via physical contact at the workplace or hotspots. (PHYSICAL REACH)	Physical contact and reach to continue providing package of services. (PHYSICAL REACH)	**PHYSICAL**
3	KP reached via physical contact at the workplace or hotspots. (PHYSICAL REACH)	Communication continues using the virtual means. (VIRTUAL REACH)	**VIRTUAL**
4	Communication is initiated using any virtual means: social media platform or phone contact (call, SMS) (VIRTUAL REACH)	Communication continues using the virtual means. (VIRTUAL REACH)	**VIRTUAL**

- Individual key population reached via physical outreach can be counted using U-UIC codes generated for each key population.
- Individual key population reached via virtual outreach can be counted using their usernames in social media platforms. However, each key population would have more than one username, so online outreach workers and counsellors would try their best to identify and reduce double counting.

6.1 Monitoring

Ensuring quality: To ensure the quality and appropriate frequency of outreach at the appropriate delivery time, the NGO field supervisor will conduct regular (at least monthly per OW) using a QA tool. This is particular true for high burden ODs. In addition, this supervision visit, NGO field supervisors will also provide support, mentoring and motivation to outreach workers to strengthen their knowledge and skills and encourage for quality of outreach performance.

Classifying ODs, Hotspots: Classification of hotspots within high burden ODs should be regularly updated, including appropriate delivery time (at least semi-annually) which would require a change in the intervention frequency.

6.2 Standard Recording

NCHADS will develop and disseminate standard recording and reporting forms to implementing partners. The implementing partners will need to provide training to OWs and NGOs field supervisors for daily record and regular reporting during the implementation of the program.

A Universal Unique Identifier Code (UUIC) will be continued to use for outreach and expand to health facilities to record individuals who are members of key populations and who are reached by outreach programs and who access HIV related services. A proper orientation/training on UUIC is required for healthcare provider e.g., VCCT, FHC, ART clinic. A Unique Identifier System (UIS) will be developed at the central level to store data, and to analyze coverage and the effectiveness of the interventions. Confidentiality and security of the individual client information collected by the UUIC/UIS will be assured through protocols to be established for the UUIC/UIS.

6.3 Reporting Flow

NGOs report monthly to NCHADS for HIV prevention database which is cleaned, entered and managed by NCHADS data management unit. Another reporting flow is that NGOs also report to OD-level Boosted IACM Sub-TWG/GOC. The OD-level GOC consolidates/compiles a report and submits it to the Provincial-level Sub-TWG on a quarterly basis. The provincial level then submits a report to the NCHADS on a quarterly basis.

6.4 Core Indicators to be employed to monitor the delivery of the service package

6.4.1: Core Indicators of the service package

1. # and % of key populations (disaggregated by population – FEW, MSM, TG and means of reach – virtual and physical) reached at least once per quarter with HIV prevention education package (SBC + condom)
2. # and % of key populations (disaggregated by population – FEW, MSM, TG, PWID) receiving HIV testing in the last six months
3. # and % of key populations (disaggregated by population – FEW, MSM, TG, PWID) having reactive tests in the last six months
4. # and % of key populations (disaggregated by population – FEW, MSM, TG, PWID) reactive tests confirmed positive in the last six months
5. # and % of confirmed HIV positive key population enrolled on ART in the last six months
6. # and % of key population living with HIV remain in care after 12 months of ART (it is possible to collect only from key population programme)
7. # and % of key population living with HIV on ART who have viral load suppressed (it is possible to collect only from key population programme)
8. # and % of key populations (disaggregated by population – FEW, MSM, TG, PWID) who received Syphilis testing in the last six months
9. # and % of key populations (disaggregated by population – FEW, MSM, TG, PWID) who had reactive Syphilis in the last six months
10. # and % of key populations (disaggregated by population – FEW, MSM, TG, PWID) who had reactive Syphilis and received treatment in the last six months
11. # and % of key populations (disaggregated by population – FEW, MSM, TG, , PWID) who received STI services other than syphilis treatment in the last six months

6.4.2: Additional indicators if needed and available:

1. # of FEWs, MSM, TG, and PWID referred to and receiving NSP services
2. # of FEWs, MSM, TG and PWID referred to and receiving MMT services
3. # of FEWs, MSM, TG and PWID referred to and receiving community-based drug treatment (ATS treatment)
4. # and % of FEWs (disaggregated by risk level) accessed to FP/SRH services
5. # of FEWs, MSM, TG and PWID referred to and receiving GBV services.

ANNEX 1: DETAILED GUIDANCE TO STRENGTHEN ENROLLMENT AND RETENTION IN CARE FOR KEY POPULATION LIVING WITH HIV.

The stronger collaboration between B-CoPCT and Community Action Approaches

❖ **Rationale:**

Sustaining access and maintain Key Population living with HIV in HIV prevention and treatment services cascade is crucial but is somehow challenging. Key population who are tested HIV reactive through community-based testing or via HIV self-testing will be referred for confirmatory HIV testing at VCCT co-located with ART site and immediately enrolled in HIV treatment and maintained in lifelong treatment. In some cases, key population would have missed or lost at each cascade. The gap of the current intervention is the weakness or lack of strong linkage mechanism between prevention (B-CoPCT) component and care and treatment component (CAA / B-IACM) to ensure key population living with HIV are supported and tracked across HIV service cascade.

According to program data from NCHADS, in 2019 there was 5% of PLHIV lost to follow up (LTFU) between reactive test result from the screening to confirmatory testing, and 9.5% between confirmatory testing and enrolment in ART. Retention in ART decreases with time, down to 85% at 12-months and to 77% at 24-months. The prevention data in 2020 showed improvement in ensuring confirmatory testing for those who had HIV reactive test results, and immediate enrollment in ART for those who had confirmed HIV positive. Yet, there is still room for further improvement (see table 1 below).

Table 1- Percentage drop out at each HIV service cascade Jan-Dec 2020

Key Population	HIV Reactive	Confirmatory HIV testing	Confirmed HIV Positive	Enroll in ART	LTFU of all PLHIV in ART (*)
FEW	82	79	75	75	Dropped 85% at 12-months and 77% at 24-months (NCHADS data 2019)
MSM	659	652	646	646	
TG	287	286	285	285	
PWID	1	1	1	1	
Total	1029	1018	1007	1007	

(*) There is no disaggregated data by key population, but this data is presented as proxy to conceptualize the situation.

❖ **Objectives:**

- Define approaches and provide guidance for implementation of the linkage mechanism between B-CoPCT and CAA/B-IACM to support Key Population living with HIV in accessing and

retention in HIV care and treatment

- Establish implementation, coordination, and management mechanisms.

❖ **Collaboration, Operation and Communication Implementation**

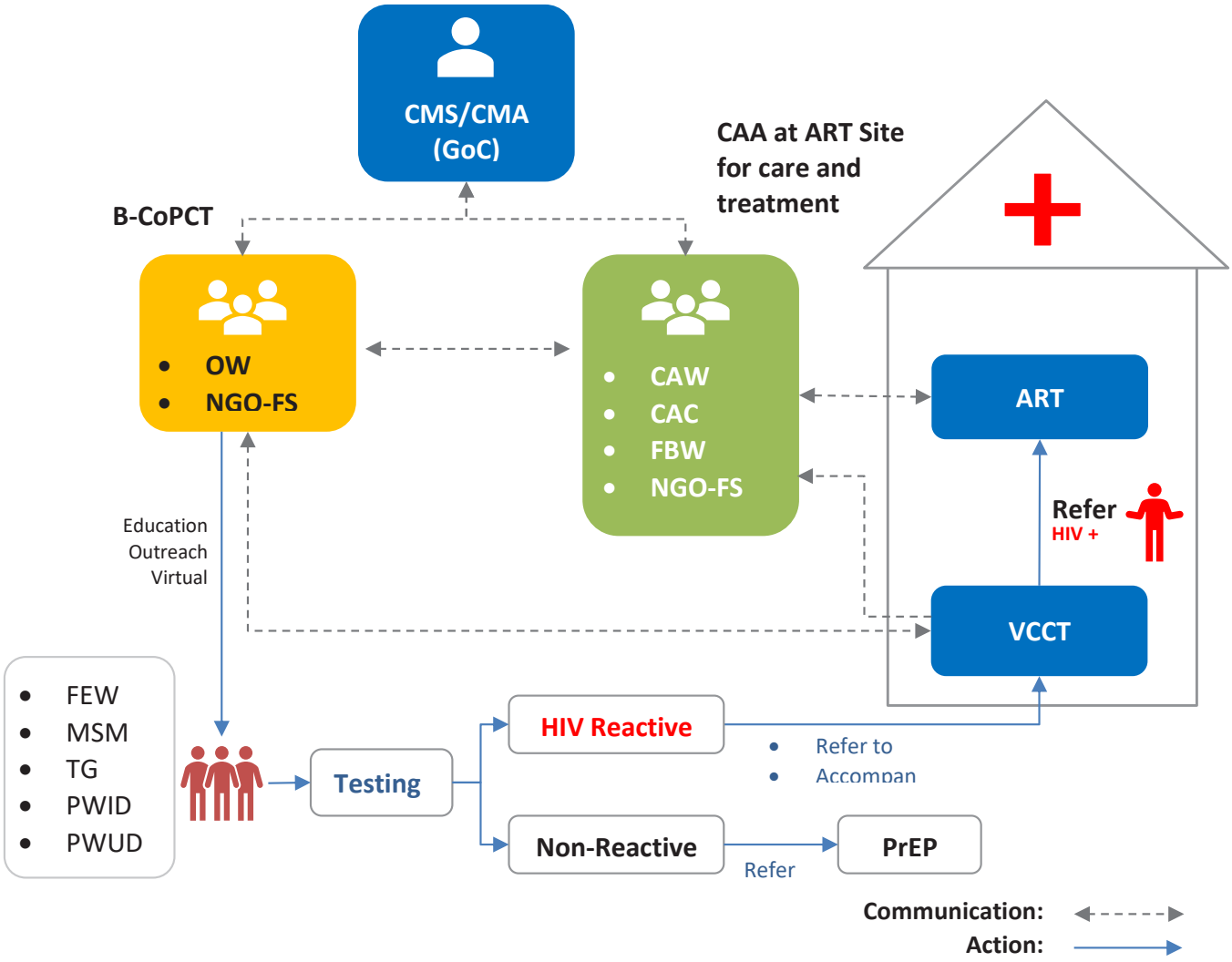


Figure 1; Operation and collaboration B CoPCT, CBPCS under CAA/B-IACM

Activities	Where	Who	How	Note
Refer FEW, MSM, TG, PWID/PWUD who were tested HIV reactive to confirmatory testing at VCCT	➢ At Community, Entertainment Establishment, Hotspot, DIC, by virtual outreach, HIV Self testing, At VCCT service	➢ **B-CoPCT -** NGO staff/ field supervisor and Outreach workers CMC, CMA, NGO staff, CAW of care/treatment NGOs	➢ OW or Field supervisor accompanies KP to VCCT **or** ➢ OW or Field supervisor refers reactive cases to VCCT by collaborating/communicating with CMC/CMA under B-IACM and, VCCT staff, CAW/Field Staff of NGO working for care/treatment support through: ▪ Phone contact ▪ Signal using 115 hotlines. ▪ Using Referral slip/UIC card ▪ Keep following up and support ▪ Take/ share phone number of reactive case for VCCT/ CMA to further communicate while she/he does not come as per referral.	➢ List of contact OW/Field supervisor, CMC/CMA, and CAA team, VCCT staff should be available per each Referral Hospital (Share the list of contacts to all relevant persons) ➢ Confidentiality shall be maintained
Enrol in ART of HIV confirmed positive FEW, MSM, TG, PWID/PWUD	➢ At VCCT/ART services	VCCT staff, data entry staff, FBW/CAC/CAW /OW for key populations	➢ Accompany confirmed HIV positive key population (by VCCT, OW, CAA team) to ART site for registration and initiate treatment: ▪ Accompany confirmed HIV positive key population with test result to ART or VCCT staff call CAW/FBW /CAC to accompany those key population to ART site for registration in B-IACM system and enrolment in ART. ▪ At the end, FBW shall update the information on status of the enrolment back to OW for key population/VCCT/ CMC/CMA/data entry staff	➢ VCCT staff or CAC shall identify and record HIV status of key population because the information is important to ensure key population are supported, traced back and maintained in each HIV cascades until viral suppression. OW informs service delivery team about movement of key population living with HIV and

			▪ In case of loss or drop out, FBW/CAW shall work with OW working with key population to track and re-engage key population living with HIV to ART.	support them for re-engagement in ART.
Retention Adherence, Reduce LTFU and Reengagement for key population living with HIV in ART service.	➢ At ART sites ➢ At key population community	**OW/ Field Supervisor/staff for key population. service delivery, and CMA/CMA**	➢ Data entry staff print out list of appointment with remark of key population (before date of appointment for services) then FBW record PLHIV who came to access services. FBW identifies PLHIV, including key population living with HIV who missed appointments per each day. Missed appointment/LFTU cases wil be shared with OW, CAW, CAC, and FBW for immediate actions to follow up. ▪ FBW/CAW/CAC contact key population living with HIV for ART clinic visit or re-appointment. ▪ FBW calls to OW to provide support in follow up with key population living with HIV to re-engage in ART. ▪ FBW works with CAW to trace back key population living with HIV in the community for re-engagement. ▪ A list of LTFU cases, issues, challenges will continue to be discussed during the B-IACM GOC meetings and other mechanism including monthly/bi-monthly/quarterly meetings of service providers to find solutions and take actions accordingly.	➢ Some key population move out from their current HIV prevention coverage areas and try to keep confidentiality of their HIV status after getting infected by HIV. FEW may stop working in same entertainment venues, thus the NGOs working for care and treatment will play an important role to re-engage LTFU. ➢ Ensure that the clients' addresses and contact number are updated every visit. ➢ Some KP remains under their same NGO coverage or same entertainment venues, but confidentiality of their HIV status is required; thus OW/ FS will play a crucial role to keep KP living with HIV retention in ART. ➢ When data of PLHIV by KP is available, it is feasible to generate KP living with HIV by geographic location for identifying miss appointment, LTFU, VL

				appointment date, and support for retention.

Note:

- The detailed roles and responsibilities of NGO FS, OW of B -CoPCT can be found in the B -CoPCT SOP updated in 2021
- For description of roles and responsibilities of NGO FS, CAW, CAC, FBW for care and treatment, please refer to the consolidated Operational Framework on Community Action Approach to implement B-IACM, 2017
- For detailed roles and responsibilities of CMC and CMA , please refer to B-IACM SOP, 2017

List of contact	OD/zone	Name	Phone
Component B-CoPCT			
Field staff			
OW			
Component B-IACM			
CMC			
CMA			
Component CAA (care and treatment)			
NGO FS- care and treatment			
FBW			
CAC			
CAW/Data staff			

ANNEX 2: DETAILED GUIDANCE ON VIRTUAL OUTREACH

Steps for planning and implementation of virtual outreach

- ***Learn and Plan:*** Learn about online populations at risk for HIV, engage them in the program and align online outreach strategies and HIV service options to meet their preferences and needs. There are two kinds of activities to learn about audiences:

  (a) **"social listening"** approaches that help the program learn more about audiences' technology use, risk behaviours, and preferences and

  (b) **"mapping approach**," used to learn where audiences can be reached via online and mobile platform.

- ***Reach and Link:*** Create an online presence for the HIV program using online outreach approaches and refer clients for HIV services integrated with motivational messaging and interesting contents.

  (a). **Developing an Online Brand and Content:** By brand, we mean the look of HIV program expressed online including a logo, tagline, and colour scheme. The HIV program will need to develop content for each outreach approach, including the key messages and graphics used by online outreach workers, social media influencers, or online ads. Each outreach approach will then link clients to an online place (for example, website or social media page) where clients can learn more about HIV or sexual health, find HIV services, or book/ pay for services and products directly. All messages should present clear and accurate information about HIV or sexual health and should be pre-test with community audiences.

  (b). **The virtual outreach is categorized into three methods:**

  - **Social Network Outreach:** Use online networks to reach and engage populations at risk for HIV through one-on-one chats on online or virtual platforms.
  - **Social Influencer Outreach:** Engage influential, credible, and well-connected individuals as important partners in online outreach.
  - **Social Profile Outreach:** Use online advertising across social media, dating apps, websites and search engines to reach populations at risk for HIV with increasing precision based on their demographics, interests, and the content of their online activity. Use the built-in analytics of social media platforms to track how specific subgroups respond to different targeted messages and how frequently they act by getting tested and entering treatment.

Social Network Outreach	**Social Influencer Outreach**	**Social Profile Outreach**
FEATURES		
• High engagement with clients • Contributes to high conversion to uptake of HIV services • Limited in reach • Effectiveness depends on outreach workers' skills and existing networks	• Low to medium engagement with clients • Effective for breaking down complex topics for broad audiences • Effective for establishing brand identity and trust among broader target audiences	• High reach, low engagement with clients • Effective for attracting clients outside known networks • Can support brand awareness and credibility • Effectiveness depends on pre-existing knowledge about

	• Effectiveness depends on authenticity, dedication, reach, and skill of influencers	HIV and demand for HIV services
INPUTS		
• Social media mapping results showing where audience members can be reached online • Survey results of popular apps and websites • Density mapping showing locations and times of popular dating app use	• Social media mapping results listing influencers with large followings among audiences • Time for the program to follow and engage relevant influencers and develop trust	• A social profile for each target audience, developed through focus group discussions and community advisory teams • Partnership with dating apps to learn how best to place ads on their platform
ACTIVITIES		
• Develop creative content that can be shared through social networks (videos, memes, quotes) • Train outreach workers to conduct online outreach through targeted social media postings and one-on-one chats with clients (require a message matrix) • Create content to share among audience that encourages people to use services	• Pay per post for influencers with established brand and price list • Develop creative campaign content for interested influencers to post • Host meet-up to engage influencers and secure support for campaign • Pair influencers with proven social marketing skills as consultants to HIV clinics interested in improving their social media image and attracting more clients	• Schedule ads on dating apps to users in your program's coverage area • Target ads on dating apps to areas where there are many online users to advertise nearby services • Use social profiles to input topics and attributes into social media ad managers and send ads to target audience • Link internet users' related search terms to ads for HIV services or clinics (using Google Ad Words)

(c). **Linkage Online to Offline:** For most HIV service delivery programs, measures of uptake of HIV services are among the most important indicators for assessing success. Therefore, online HIV programs will need a robust system to link clients who are reached online to uptake offline services.

There are three methods for linking clients to HIV prevention, testing, and treatment services.

Meet in Person	Online Referral	Appointment Booking
A simple method to link people to services can be to continue the conversation offline. This process, also called "offlining," may be best suited for social network outreach where an outreach worker can counsel clients through a virtual chat and ask the client to meet physically in	An online referral can occur simply through a one-on-one chat with an online peer worker who may send details to the client of a clinic's location and appointment time with the unique code. Clinics will need to record the referral code from incoming clients and provide this information back to the HIV	Clients can use a website (TohTest) to complete their own HIV risk assessment, find nearby HIV services, and book an appointment. Clients are linked to an appointment booking tool using unique links that are captured on the online reservation application (ORA) backend,

a safe setting to complete counseling, provide prevention services, and make a referral, or provide navigation support, to clinical services.	program to connect with original outreach data to monitor the outcomes of their efforts.	which allow the program to categorize and monitor each of their online outreach streams separately. Upon arrival at the facility, clients should mention their referral for the staff to mark the client as "arrived" on the reservation system.

- ***Engage and Support:*** Engaging and supporting clients involves following up with people previously reached and referred for HIV services and continuously building relationships with them. There are three online engagement and support services that we are using are described below.

  (a). Virtual Education and Support: Clients reached by an online advertisement or through influencer promotion may need additional support understanding their sexual health needs or service options, or those reached by an outreach worker may require counseling support for psychosocial issues or treatment navigation (for known PLHIV). For those accessing HIV services from a previous referral, a human interaction, if even virtually, can (1) help clients understand their test results and next steps and (2) assist in collecting client feedback on the services they received.

  (b). Virtual Reminder: Virtual reminders involve the use of messaging platforms (like SMS reminders ex: TohTest ORA) to send simple notifications to clients of upcoming events (like HIV testing service online booking reminders) and other healthy behaviors. These can be automated or sent manually by an outreach team or counselor.

  (c). Peer and Partner Referrals: Clients who receive HIV services may also be engaged to refer their friends and partners. HIV programs can implement peer referral online by providing simple messages that clients can pass on to their friends and partner(s), which can be used by clients regardless of their HIV status. These messages recommend that friends/partners check out the HIV program's website to book an HIV test or find more information.

- ***Assess and Improve:*** Online systems can be used to collect data on uptake and quality of HIV services accessed by clients; gain insights from data by understanding cascade progress; and identify which methods are more effective than others. There are three indicators to assess the impact of online approaches described below.

Outreach		Referral	Service Uptake	
Clicks	**Chats**	**Reach/Referral**	**Test**	**Link to Treatment**
Number of interactions with public content posted by the	Number of 1-on-1 engagements	Number of unique individuals who have been	Number of individuals who received HIV testing services	Number of PLHIV linked to an antiretroviral

campaign or program (such as likes, comments, shares, video views, etc.)	with clients on the topic of HIV	counseled on their HIV or sexual health needs, provided targeted HIV services, and referred for HIV testing or other services based on their needs (such as appointment booking)	and received their test results	treatment regimen

ANNEX 3: GLOSSARY

Key Populations

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

Female Entertainment Workers (EWs)

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

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

Definition: The term men who have sex with men describes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men.

Transgender (TGs)

Definition: Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, transsexual, or other culturally specific transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways. This SOP targets transgender who were biologically male at birth because they are the transgender population in Cambodia at high risk of contracting HIV.

People Who Inject Drugs (PWID)

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

People Who Use Drugs (PWUD)

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

Freelancers

Definition: Refer to key population (EWs, MSM and TG) who are not belong to any entertainment establishments and sell sex by finding sexual partners/clients at public parks, streets or through phone call or online app (street based and freelance sex workers). This includes those who have other occupations and sell sex occasionally.

Gender-Based Violence (GBV)

Gender-based violence "describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender." It encompasses acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty.

"The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with violence against women. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they challenge (or don't conform to) prevailing gender norms and expectations (e.g. they may have a feminine appearance), or to heterosexual norms"

HIV Testing Service: The 5 Cs are essential for all HTS: consent, confidentiality, counselling, correct test results and connection to HIV prevention, treatment, and care.

HIV self-testing (HIVST) is the process by which a person who wants to know their HIV status performs an HIV test and interprets the result by his/herself. This is generally conducted using rapid test kits, such as fingerstick tests (on whole blood) or mouth swab tests (on oral fluid).

Pre-exposure prophylaxis (PrEP) is medicine that people at risk for HIV take to prevent HIV from sex or injecting drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

Post-exposure prophylaxis (PEP) means taking medicine to prevent HIV after a possible exposure to HIV. PEP should be used only in emergency situations and must be started within 72 hours after a possible exposure to HIV.

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