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ASSESSMENT OF PROVIDER-INITIATED TESTING AND COUNSELING IMPLEMENTATION: CAMBODIA

AIDSTAR-One
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Abstract

In 2007, the World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention recommended provider-initiated testing and counseling (PITC)—an approach in which health care providers offer routine HIV testing and counseling services to persons attending health care facilities as a standard component of medical care. Cambodia initiated “Healthcare Provider-Initiated Testing and Counseling” in 2007: health care providers in specialty clinics recommend routine referral for HIV testing at a voluntary confidential counseling and testing site. The approach varies from WHO guidelines in that it offers routine “referral” and not routine “testing.” AIDSTAR-One conducted a rapid assessment of Cambodia’s approach to identify the following: 1) promising practices in HIV testing and counseling; 2) challenges experienced implementing routine referrals; 3) opportunities and barriers to the WHO PITC approach; and 4) opportunities to address unmet needs. Interviews were conducted with health care providers, senior managers, voluntary confidential counseling and testing staff, and clients. A variety of themes emerged. Challenges were identified to introducing the WHO-defined PITC approach, including a need for staff incentives. AIDSTAR-One provides recommendations that define activities aimed to fill current gaps and could lay groundwork for implementing the WHO’s PITC approach in Cambodia.

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ACRONYMS

ANC	antenatal care
ART	antiretroviral therapy
BSS	behavioral sentinel surveillance
BTB	Battambang
CDC	Centers for Disease Control and Prevention
CENAT	National Center for Tuberculosis and Leprosy Control
CoC	Continuum of Care
HTC	HIV testing and counseling
CUP	Condom Use Program
DFSW	direct female sex worker
ELISA	enzyme-linked immunosorbent assay
EW	entertainment worker
FHC	family health center
GBV	gender-based violence
HBCT	home-based care team
HC	health center
HCP	health care provider
HPITC	health care provider-initiated testing and counseling
HTC	HIV Testing and Counseling
IDU	injecting drug user
LR	Linked Response
MARP	most-at-risk population
MOH	Ministry of Health
MSM	men who have sex with men
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	nongovernmental organization
OD	operational district
OI	opportunistic infection
PEPFAR	U.S. President's Emergency Plan for AIDS Relief

PHD	provincial health department
PITC	provider-initiated testing and counseling
PLWH	people living with HIV
PMTCT	prevention of mother-to-child transmission
PNP	Phnom Penh
PPM	Public-Private Mix
PV	Prey Veng
RH	referral hospital
SM	senior manager
SOP	standard operating procedure
STI	sexually transmitted infection
SSS	STI sentinel surveillance
SW	sex worker
TB	tuberculosis
TG	transgender
TK	Takeo
UNAIDS	Joint U.N. Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USG	U.S. Government
VCCT	voluntary confidential counseling and testing
VCT	voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

HIV testing and counseling (HTC), long recognized as a critical component of a comprehensive HIV program, is the entry point for accessing needed HIV prevention, treatment and care, and support services. However, uptake of HTC remains low. A 2008 report from the World Health Organization (WHO) notes that among those in low- and middle-income countries, 10.9 percent of women and 10.3 percent of men had ever had an HIV test and received their test results, and a median of 20 percent of people living with HIV knew their HIV status (WHO 2008).

As part of a strategy to increase HIV testing uptake, WHO has recommended provider-initiated testing and counseling (PITC) whereby HIV testing is “recommended by health care providers to persons attending health care facilities as a standard component of medical care” (WHO 2007, 19). Each client must specifically decline, or “opt-out” of, the HIV test after receiving pre-test information, otherwise the test will be performed, followed by post-testing counseling. WHO has provided specific recommendations for the implementation of PITC in generalized and concentrated epidemics and on the legal and social context within which testing, treatment, and support services are available (WHO 2007). Likewise, the Centers for Disease Control and Prevention has provided PITC recommendations for the United States. WHO recommends that in countries with low or concentrated epidemics, such as Cambodia, health care providers (HCPs) offer HTC to all clients presenting with signs and symptoms of HIV infection and to all attending tuberculosis (TB), sexually transmitted infection (STI), and antenatal care (ANC) clinics. In 2008, WHO further recommended that countries introduce rapid HIV testing in clinics where clients are seeking care in order to reduce loss to follow-up, rather than refer clients to HIV testing sites (WHO 2008).

Cambodia’s HIV epidemic has evolved from a generalized epidemic in the 1990s to one concentrated among female spouses and regular partners of men infected during commercial sex (USAID 2008) and most-at-risk populations (MARPs) such as injecting drug users, sex workers, and men who have sex with men (MSM). The 2005 sentinel surveillance studies reported for the first time on HIV prevalence among MSM and male-to-female transgenders (TGs) and showed disturbingly high HIV prevalence in both groups: 9 percent among MSM and 17 percent among TGs living in Phnom Penh.

Cambodia introduced “voluntary confidential counseling and testing” (VCCT) in 1995. VCCT is offered at a variety of sites: in structures located on referral hospital (RH) grounds, as separate rooms in health centers (HC), or as stand-alone structures in the community. It expanded from 12 sites in 2003 to 217 sites by the end of 2008. The Ministry of Health (MOH) policy allows for blood testing using two different rapid HIV tests performed by trained laboratory technicians situated at the VCCT site or at laboratories attached to larger HCs and RHs.

In 2007, the same year that WHO released its guidelines on PITC, Cambodia initiated “Healthcare Provider-Initiated Testing and Counseling” wherein HCPs working in TB, STI, and ANC clinics (“specialty clinics”) recommend to all their clients that they seek HIV testing and provide the client with a referral to the nearest VCCT site. In practice, specialty clinics sites often provide pre-testing

information and a blood draw for a client, sending the sample to a VCCT site for HIV testing, and the client is referred to go to a VCCT site for test results and post-test counseling. The Cambodia MOH approach differs from the WHO-recommended PITC approach in that it promotes a *routine referral* not a *routine recommendation and provision* of HIV testing and post-test counseling at specialty clinics.

Cambodia was selected to be a part of AIDSTAR-One’s multicountry assessment of PITC implementation. The goal of this assessment is to understand how Cambodia’s routine referral strategy was being implemented in specialty clinics. In June 2009, a rapid assessment was conducted in the provinces of Takeo, Prey Veng, Battambang, and Phnom Penh. Phnom Penh and Prey Veng were chosen as provinces implementing an enhanced health care PITC “Linked Response”; Battambang, with some programs supported by the U.S. Government, and Takeo provinces were chosen because they were not implementing the Linked Response. Three operational districts (ODs) were randomly chosen in each selected province, and the RH and several HCs in those ODs were included in the assessment.

The specific goals of the assessment were to identify:

1. Good and promising programmatic HTC practices implemented in HCs and RH specialty clinical settings in Cambodia
2. Challenges experienced by specialty clinics implementing the routine referral strategy and potential opportunities and challenges of introducing the WHO-recommended PITC approach
3. Opportunities to address unmet needs or lost opportunities to provide HTC to MARPs.

Separate interview tools for senior managers (SMs) and HCP staff in the ANC, TB, or STI clinics were developed that included qualitative and quantitative questions that explored issues of consent, confidentiality, counseling procedures, and HIV testing and referral processes. Separate brief interviews were developed for specialty clinic clients and for owners/employees of private sector pharmacies. Interviews were conducted with pharmacies to understand if they refer customers with suspected STI or TB to the nearest public health clinic. Interviews were conducted with 38 HCPs from 25 specialty clinics and 19 SMs at provincial health departments, ODs, or RHs. Also, 16 interviews were completed with staff at 14 VCCT sites. In addition, a total of 46 clients and 24 pharmacy staff were interviewed.

FINDINGS

A number of consistent themes emerged from the interview data:

- Overall, 49 percent of HCPs report routinely referring “all” or “most” clients to a VCCT site for HTC; only 35 percent of HCP in STI clinics referred “all” or “most” clients.
- Eighty percent of ANC clients report receiving a recommendation for an HIV test, but only 67 percent of clients at the STI and TB clinics received a recommendation. Many opportunities are subsequently lost to reach high-risk individuals.
- MOH-approved strategies for increasing the uptake of VCCT by allowing specialty clinic staff to draw blood for HIV testing do not adequately ensure every client receives his or her test result and post-testing counseling. To receive their test results, clients must either go on their own to the VCCT site or return to the HC specialty clinic where their blood was drawn, creating high

opportunity costs to clients, and contributing to loss to follow-up for those who may be living with HIV.

- Transporting blood to and from the HC to the VCCT site for testing creates additional investments in time and cost, as well as waiting time for test results.
- Referral and follow-up processes from ANC, TB, and STI clinics to VCCT sites for HIV testing are not standardized, and staff gets little feedback on how the referral process is working or how to improve it.
- HCPs report that most people in the community do not know about VCCT or the benefit of knowing one's status, and men are not using VCCT or other health services.

With respect to introducing WHO-defined PITC into specialty clinics in Cambodia, respondents identified a number of challenges:

- **Need for staff incentives.** Some HCPs and SMs stated that without the same incentives provided to VCCT staff, STI, ANC, and TB clinic staff would not be willing to perform the additional task of HIV testing and post-test counseling (if rapid testing by nonlaboratory staff were introduced).
- **Quality assurance concerns.** Informants were concerned about ensuring the quality of counseling, particularly post-test counseling, by staff at ANC, TB, and STI clinics without adequate and ongoing training.
- **Training.** Many more training teams will be needed to prepare HCPs to provide quality pre- and post-test counseling and process rapid test kits.
- **Supply chain management issues.** A major concern of HCP and SM informants was that expanding HIV testing from VCCT sites into the specialty clinics would exacerbate the current problem of periodic stockout of test kits.

RECOMMENDATIONS

Efforts to address these challenges identified in the assessment present significant financial implications for the MOH. Providing rapid test training and staff incentives, and keeping HIV test kits stocked at HCs where ANC, STI, and/or TB screening and diagnosis occurs are major undertakings. AIDSTAR-One recommends the following discrete activities that could fill some current gaps and that could lay the groundwork for implementing PITC in Cambodia:

- **Revise policy.** Convene an expert consultation on policy and procedures to revise the current HTC policy that permits only laboratory technicians to perform rapid testing.
- **Develop and disseminate a unified protocol for implementing HTC in ANC, STI, and TB clinics in Cambodia.** National programs have different protocols for HTC for their target population.
- **Implement pilot projects to integrate same day, rapid HIV testing and post-test counseling in select high-volume HC TB and STI clinics, particularly family health centers.**

- **Consider piloting a task-shifting model.** In order to address the capacity concerns of HCPs, some or all HTC tasks could be performed by non-nursing staff, peer volunteers, or home-based care team volunteers already knowledgeable about HIV and available services in the community.
- **Facilitate follow-up discussions** to leverage lessons learned from the pilot projects for a broader strategy to implement PITC.
- **Standardize the referral system.** Strengthen processes to include client tracking and follow-up of referrals.
- **Develop training teams at the provincial health department level.**
- **Initiate steps to increase men’s awareness about HTC and utilization of services.**

STRENGTHS AND LIMITATIONS OF THE ASSESSMENT

The assessment was not intended as a rigorous evaluation of the implementation and quality of Cambodia’s routine referral process. The assessment’s major limitation was that most data were behavioral and self-reported. Convenience sampling of clients for exit interviews was used; because of the small number of clients at many of the sites visited during the assessment, clients could not be randomly chosen, so the experience reported by clients cannot be generalized to specialty clinic clients in other provinces or ODs. A small number of sites were included in this assessment, and therefore, the findings on PITC implementation may not be generalized to all sites in Cambodia.

CONCLUSION

Cambodia has been a leading innovator in expanding access to HIV prevention, treatment, and care and support services. The country is well positioned to expand on its current approach of offering routine referrals to VCCT sites to integrating PITC into specialty clinics and thereby make further gains in uptake of HTC, limiting loss to follow-up, especially among MARPs, and ensuring greater access to early treatment and care.

INTRODUCTION

HIV testing and counseling (HTC), long recognized as a critical component of a comprehensive HIV program, is the entry point for accessing needed HIV prevention, treatment and care, and support services. In recent years, access to HTC has been greatly expanded through establishing new testing sites, using rapid testing methods, and applying innovative approaches, such as mobile testing, community-based and home-based HTC, and community mobilization for HTC “events.” However, uptake of HTC remains low. A 2008 report from the World Health Organization (WHO) notes that among those low- and middle-income countries that conducted population-based surveys between 2005 and 2007, only 10.9 percent of women and 10.3 percent of men had ever had an HIV test and received their test results, and a median of 20 percent of people living with HIV (PLWH) knew their HIV status (WHO 2008.)

As a strategy to increase HIV testing uptake, WHO and the U.N. Joint Programme on HIV/AIDS (UNAIDS) have recommended provider-initiated testing and counseling (PITC). “With this approach, an HIV test is recommended 1) for all patients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection; 2) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and 3) more selectively in concentrated and low-level epidemics.” (WHO 2007, 5).

AIDSTAR-One, a U.S. Agency for International Development (USAID) global technical assistance program, conducted assessments on PITC implementation in several countries based on the WHO guidelines, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (WHO and UNAIDS 2007). The guidelines emphasize the Three Cs of HTC: consent, counseling, and confidentiality. These assessments aim to describe how the Three Cs are implemented when PITC is adopted in places with constrained resources and in concentrated and generalized epidemics.

In collaboration with USAID/Cambodia and USAID/Washington, Cambodia was selected to participate in a multicountry qualitative assessment of PITC in order to understand how the routine referral strategy was being implemented in specialty clinics. Cambodia was selected because since 2007, the national programs of the Ministry of Health (MOH), have implemented *routine referral strategies* to increase HIV testing among their target populations including clients in antenatal care (ANC), tuberculosis (TB), and sexually transmitted infection (STI) clinics (also referred to as “specialty clinics”). The assessment was intended to produce a snapshot of PITC implementation in Cambodia, looking at a limited number of provinces where U.S. Government (USG) partners are implementing HIV programs. In June 2009, the assessment was conducted in the provinces of Takeo (TK), Prey Veng (PV), Battambang (BTB), and Phnom Penh (PNP). Three operational districts (ODs) were randomly chosen in each selected province, and the referral hospital (RH) and several health centers (HCs) in those ODs were included in the assessment.

The specific goals of the assessment were to identify:

1. Good and promising programmatic HTC practices implemented in HCs and RH specialty clinical settings in Cambodia
2. Challenges experienced by specialty clinics implementing the routine referral strategy and opportunities for, and potential challenges to, introducing the WHO-recommended PITC approach

3. Opportunities to address unmet needs or lost opportunities to provide HTC to most-at-risk populations (MARPs).

The full concept note and protocol can be found in Appendix 1.

This report summarizes 1) the evolution of PITC; 2) current HTC approaches in Cambodia; 3) the methodology and findings from the AIDSTAR-One assessment from June 2009 in four Cambodian provinces; and 4) recommendations for introducing the WHO PITC approach in Cambodia.

BACKGROUND: THE EVOLUTION OF PROVIDER-INITIATED TESTING AND COUNSELING

The most widely available HIV testing service is voluntary counseling and testing (VCT), which depends on clients actively seeking HTC (“opt-in”) at a health facility, a stand-alone facility outside health institutions, or through other community-based approaches, such as mobile testing sites and home-based HTC. At a time when therapeutic and prevention interventions did not exist or were not widely available, VCT emerged as an important intervention, emphasizing pre-test individual risk assessment, the development of individual risk reduction strategies, and linkage to care (Bassett 2002; WHO and UNAIDS 2007).

A VCT service is based on ensuring the client’s autonomy. It requires that 1) testing be voluntary and done with the explicit consent of the client; 2) pre- and post-test counseling be provided to ensure that the client understands the implications of the test result and is provided with support for behavior change; and 3) the confidentiality of the client’s HIV status be protected due to widespread stigma and discrimination and human rights abuses of people living with or affected by HIV. According to UNAIDS, the Three Cs are the foundation on which all HIV testing should rest (UNAIDS and WHO 2004). The advent of rapid HIV testing in 1990 (WHO 2004) contributed to increased uptake of VCT, as getting same-day test results reduced cost, inconvenience for clients, and loss to follow-up (Morin et al. 2006).

In the United States in 2001, following the dissemination of findings from multinational randomized clinical trials that single-dose nevirapine given before and after delivery significantly reduced mother-to-child transmission of HIV, the Centers for Disease Control and Prevention (CDC) recommended making an HIV test a routine part of antenatal clinic services unless clients decided to “opt-out” or refuse to get the test (CDC 2001). By the mid-2000s, many other countries had introduced the opt-out approach into ANC services (Baek et al. 2009; Homsy et al. 2006). By the mid-2000s, with little change in HIV prevalence in most countries in sub-Saharan Africa and with alarming increases in HIV prevalence in many countries, debate emerged within the public health community about the efficacy of opt-in VCT. Critics of a strictly opt-in approach argued that the “calamity” of the HIV epidemic in sub-Saharan Africa required approaches that would greatly increase the opportunity of individuals interacting with the health care system to learn their HIV status and receive appropriate care and referrals. Advocates for new strategies argued that “HIV testing has been approached differently since the beginning of the epidemic in the 1980s. The ‘HIV exceptionalism’ and VCT paradigms developed in the United States separated HIV care from other medical care in the minds of providers and clients around the world for many years, and in this context, many people with a clear medical need for testing have not been tested”(Creek et al. 2007, 103).

WORLD HEALTH ORGANIZATION GUIDELINES ON HIV TESTING

In 2004, WHO and UNAIDS began promoting two models of testing: diagnostic HIV testing for all patients with symptoms consistent with HIV-related disease and a routine offer of HTC recommended as a standard part of health services to clients or patients at increased risk of HIV infection in STI clinics, ANC clinics, and other clinical settings who would benefit from knowing their HIV status. In all circumstances, WHO has emphasized that informed consent, counseling, and confidentiality, while adaptable to specific circumstances, must be observed. Adaptations might include providing pre-test education in an individual or group setting or through the use of posters, leaflets, or videotape presentations. While less emphasis and time are devoted to pre-test counseling, seen as a barrier to HTC uptake, WHO clearly stresses the importance and necessity of post-test counseling of all clients, regardless of test results (WHO 2004). There is some concern, however, that processes for ensuring consent, quality counseling, and confidentiality will erode as routine HTC is integrated into busy, understaffed health clinics (Brockway 2007; Yeatman 2007).

In 2004, Botswana became the first low-resource country to introduce routine HIV testing in medical services for TB, STIs, and persons receiving medical examinations (Cockcroft et al. 2007). Since then, a number of studies have been conducted to assess the implementation issues related to introducing PITC into a variety of clinical sites. While in most cases uptake of HIV testing increased and was found to be readily acceptable to clients, issues of organizational efficiency and additional workload for staff emerged as key constraints to routinely providing PITC (Chakaya et al. 2008; Iver, Freedberg, and Mukherjee 2007; Odhiambo et al. 2008; Steen et al. 2007; Van Rie et al. 2008).

In 2007, WHO and UNAIDS released *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities*. This document combined both diagnostic and routine HIV testing into a provider-initiated approach, and offered more detail for the rationale as well as basic operational guidance on introducing PITC into health facilities. It was intended for a wide range of audiences including policymakers, HIV program planners and managers, health care providers (HCPs), nongovernmental organizations (NGOs) providing HIV services, and civil society groups. The guidance recommends offering an HIV test as a standard component of medical care for all patients attending health facilities in generalized HIV epidemics and more selectively in concentrated and low-level epidemic countries. Clients must specifically decline the HIV test (WHO and UNAIDS 2007, 5) after receiving pre-test information; otherwise the test will be performed, followed by post-testing counseling. The guidance further reiterates that implementation “at country level will require an assessment of the local epidemiology” (p.6) and that PITC “should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services” (p.5) and implemented within the framework of a national plan to achieve universal access to antiretroviral therapy (ART) for all who need it. Simultaneous with implementation of PITC, “efforts must be made to ensure that a supportive social, policy, and legal framework is in place to maximize positive outcomes and minimize potential harms to patients” (WHO and UNAIDS 2007, 32). In 2008, WHO further clarified its recommendations and supports introducing rapid HIV testing in clinics where clients are seeking care, rather than referring clients to HIV testing sites; WHO further clarified that “HIV testing and counselling is more likely to be achieved when the test can be provided on site” (WHO 2008, 50).

The 2007 WHO recommendations for PITC based on the type of HIV epidemic are outlined in Table 1.

Table 1. WHO 2007 Guidance on PITC According to Type of Epidemic

Recommendations for all Epidemic Types

In all types of HIV epidemics, HCPs should recommend HTC as part of the standard of care to:

- All adults, adolescents, or children who present to health facilities with signs, symptoms, or medical conditions that could indicate HIV infection. These include, but are not necessarily limited to, TB and other conditions specified in the WHO HIV clinical staging system.
- Infants born to women living with HIV as a routine component of the follow-up care for these children.

Options for Concentrated and Low-level HIV Epidemics

Decisions about whether and how to implement PITC in selected health facilities in low-level and concentrated epidemics should be guided by an assessment of the epidemiological and social context. Consideration may be given to the implementation of PITC in the following health facilities or services:

- STI services
- Health services for MARPs
- Antenatal, childbirth, and postpartum services
- TB services.

Source: WHO 2007, 7-8.

CURRENT HIV TESTING AND COUNSELING APPROACHES IN CAMBODIA

THE COUNTRY'S HIV EPIDEMIC

Cambodia's HIV epidemic has evolved from a generalized epidemic in the 1990s to one concentrated among female spouses and regular partners of men infected during commercial sex (USAID 2008) and MARPs. In Cambodia, MARPs include sex workers (SWs) and entertainment-venue-based waitresses and hostesses (entertainment workers [EWs]); clients of SWs, such as police, military, and mototaxi drivers; men who have sex with men (MSM); male-to-female transgenders (TGs); and injecting drug users (IDUs).

Cambodia has an extensive epidemic tracking program in place: HIV data on ANC clients, SWs, EWs, and police (representing high-risk males) have been routinely collected at the national level since 1996 using a number of surveillance instruments. HIV risk behavior has been tracked since 1997 through behavioral sentinel surveillance (BSS) surveys, and STI incidence data are collected through the STI Sentinel Surveillance (SSS) Program (Vonthanak et al. 2004).

Cambodia has implemented a variety of HIV prevention programs. These interventions have focused on providing 1) STI education and treatment to SWs, EWs, and their clients; 2) HIV prevention education and condom promotion among the general population; and 3) intensive peer education outreach programs to SWs that include information about HIV, as well as condoms, lubricants, and condom-use negotiation skills. In 1999, a noteworthy prevention effort was made when a nationwide 100 percent Condom Use Program (CUP) was implemented within brothels and accompanied by an extensive media and outreach campaign. The 100 percent CUP was credited with significant decreases in incidence of syphilis and trichomonas and in reducing HIV prevalence from 43 percent in 1998 to 13 percent in 2006 among SWs.¹

The data indicate that HIV prevalence and some risk behaviors have been steadily decreasing over time: estimates derived at a consensus meeting held in PNP in 2007 showed that through 2012, HIV incidence in both males and females should continue to decline (MOH 2007b). As of May 2009, HIV prevalence among women visiting ANC clinics had declined to 0.7 percent from a high of 2.1 percent in 1999 (National Maternal Child Health Center 2009).

Cambodia continues to expand its HIV prevention, treatment and care, and support efforts. One of the goals of the Second Strategic Health Plan is to maintain HIV prevalence among adults aged 15 to 49 years under 0.9 percent and increase the number of voluntary confidential counseling and testing (VCCT) sites operating in public and not-for-profit sectors to 250 by 2010 (MOH 2008b). Additional prevention activities are being scaled up to better address the needs of vulnerable groups such as MSM, drug users, and street children.

¹ In 2008, the Suppression of Human Trafficking and Commercial Sexual Exploitation law was enacted in Cambodia. Many brothels have closed and there is concern that many direct female SWs have become EWs at karaoke bars, massage parlors, and beer gardens, which are not covered by the 100 percent CUP and will be harder to reach with prevention programs and commodities. As a result of the law, the 100 percent CUP and efforts to reach SWs through peer outreach have been compromised (United Nations 2008).

HIV AMONG MOST-AT-RISK POPULATIONS

The 2005 SSS and BSS reported for the first time on HIV prevalence among MSM and TGs living in PNP and in the two provincial towns of BTB and Siem Reap. Data showed disturbingly high HIV prevalence in MSM and TGs living in PNP. HIV prevalence among MSM living in PNP was 9 percent, compared with 0.8 percent in MSM living in the two provincial towns (similar prevalence as in the general population). HIV prevalence was 17 percent among TGs living in PNP, and there were no reported HIV cases among TGs in the provincial towns. However, STI prevalence remained high among both groups in PNP and in the provinces, with 21 percent of TGs and 5 percent of MSM infected with a bacterial STI (MOH 2008a).

An expert consultation convened by the National Authority for Combating Drugs in 2007 estimated that there were approximately 46,000 illicit drug users in Cambodia (Ministry of the Interior 2008). In 2007, a special study with IDUs and non-IDUs residing in rehabilitation centers or living in the community was conducted by the National Center for HIV/AIDS, Dermatology and STD (NCHADS) in four cities in four provinces (PNP, Siem Reap, BTB, and Banteay Meanchey). Data from this study showed that overall, 24 percent of IDUs were living with HIV (NCHADS 2008).

Interestingly, there appears to be high levels of HIV testing among MARPs in Cambodia. Assuming all HIV testing was voluntary, the 2007 BSS found that 68 percent of direct female sex workers (DFSWs) had been tested for HIV and knew their results, compared with 51 percent reported in the 2003 BSS. The percentage of EWs who had been tested and knew their results was 52 percent. The same study showed that more than half of MSM (58 percent) surveyed had at least one HIV test and knew their test results. Among all IDUs, 53 percent had been tested for HIV and 99 percent knew their results (NCHADS 2008). These testing levels are impressive given the low levels of HIV testing in the general population. According to the most recent Demographic and Health Survey report, by 2005, 10 percent of women and 14 percent of men in Cambodia had obtained an HIV test and received the results (National Institute of Public Health, National Institute of Statistics [Cambodia], and ORC Macro 2006). While these findings suggest high testing levels among MARPs, the high HIV prevalence rates indicate that HIV risk behavior remains a significant problem among MARPs in Cambodia.

HIV TESTING AND COUNSELING IN CAMBODIA

Cambodia introduced VCCT in 1995, expanding coverage from 12 sites in 2003 to 217 by the end of 2008. VCCT sites may be located at a provincial hospital, at ODs, RHs, larger HCs, or as stand-alone facilities. HIV testing was done using enzyme-linked immunosorbent assay (ELISA) until 2002, when the MOH adopted and implemented a serial two rapid test algorithm for HIV testing as the standard of care for HIV testing (WHO 2009). As of 2007, 18 percent of health care facilities in Cambodia have HTC facilities (WHO 2008). All VCCT sites, whether government- or NGO-run, must be licensed by the MOH and follow the national guidelines. The bulk of VCCT provided by the government is at VCCT sites located on the grounds of provincial RHs and HCs. Pre- and post-test counseling is provided by trained HCPs working at VCCT sites. Blood is drawn by VCCT staff or by laboratory technicians and tested in a laboratory co-located with the VCCT site or on the same grounds as the VCCT site. Only trained laboratory technicians are allowed to perform HIV rapid testing using a standard protocol. Ideally, VCCT clients should receive their test results and post-test counseling the same day they visit the VCCT site.

The Government of Cambodia began early on to integrate HTC into other care and support services. Beginning with ANC, prevention of mother-to-child transmission (PMTCT) services are now established at 263 ANC or maternity services sites around the country (National Maternal Child Health Center 2009). In 2002, the MOH and NGOs entered into a collaboration to deliver a Continuum of Care (CoC) package of services for PLWH, which entails referrals between and among clinic- and community-based services. Clients living with HIV and their families are referred by VCCT staff to clinical services for opportunistic infection (OI) therapy and ART. The OI/ART services staff coordinate and collaborate with NGO-supported home-based care teams (HBCTs), which provide peer- and community-based support programs to PLWH. The first CoC model was launched at the RH of Moung Russei OD in BTB province. Now available in most provinces in the country, the program covers more than 39,000 PLWH. Further expansion of the CoC approach is planned for up to 55 OI/ART sites by 2010 in order to improve access to treatment and care for families affected by HIV (MOH 2008b).

Cambodia has one of the highest TB rates in the world according to WHO, with 220 new cases per 100,000 people in 2006. In 2007, the National Center for Tuberculosis and Leprosy Control (CENAT) reported that HIV prevalence among patients with TB was 7.8 percent, and HIV-TB co-infections pose a challenge to providing treatment and care for both diseases. In 2005, NCHADS and CENAT issued a joint statement in support of the provision of care for clients with HIV and TB co-infection. According to the statement, “Health Centre staff in charge of TB DOTs [directly observed treatment short-course] (including all former District Hospitals) and TB service providers at Referral Hospitals will counsel TB patients to undertake a voluntary and confidential HIV test and will refer them to the nearby VCCT site...health service providers at HIV/AIDS VCCT sites will counsel people living with HIV/AIDS to screen for Tuberculosis and refer them to Health Centres (including former District Hospitals) or to nearby Referral Hospitals” (MOH 2005, 2). By 2007, nearly 40 percent of new TB patients were tested for HIV (MOH 2007b).

In 2007, the same year that WHO released its guidelines on PITC, Cambodia expanded its recommendations for HIV referrals beyond ANC and TB clinics by introducing the concept of health care PITC (HPITC) wherein, “All health professionals (doctors, nurses, midwives, and dentists) should encourage clients to seek HIV testing and counseling at the nearest VCCT site. ANC and TB patients should be especially encouraged to be tested for HIV, as should those patients who show symptoms associated with HIV/AIDS” (MOH 2007a, 13). The MOH document introducing HPITC stated that:

Because health staff is often specialized (FP, STI management, ANC, etc.), they miss opportunities to provide comprehensive information and to refer patients to relevant health centers for appropriate treatment...ANC and TB patients should be especially encouraged to be tested for HIV, as should those patients who show symptoms associated with HIV/AIDS. Prior to testing, health professionals who work at maternity wards, STI clinics, tuberculosis, pediatric, and infectious wards should share information with patients about the benefits of knowing his or her HIV status. (MOH 2007a, 8)

When a client receives a referral, he or she is expected to initiate a visit to a VCCT site for blood testing and counseling. There may be one or more barriers to negotiate in order to act on the referral. If a referral is provided at a HC without a VCCT site, the cost of transportation to the site, inconvenience due to long wait times, and having to return to the clinic for results and post-test counseling are a few of the constraints clients face. In order to address some of these constraints, the 2007 MOH policy allows a number of options to be used by clinic staff to facilitate blood testing: 1) blood is drawn at the clinic and transported to the VCCT site (by clinic staff) for testing;

2) the client is advised by the HCPs to go to a VCCT site and transportation funds are provided; or
3) the client is asked by the HCP to return to the clinic on a specific day so he or she can be transported to the VCCT site for testing.

In 2007, NCHADS introduced a more comprehensive referral strategy, called the Linked Response (LR), which operationalizes the referral process “between HIV/AIDS, OI/[antiretroviral], STI, ANC, family planning, safe abortion, adolescent health, and maternal & newborn health” (11) and TB and HBCTs within a network of collaborating clinical and VCCT sites (MOH 2007a). This strategy, still in its early stage of implementation, has been introduced in a few ODs as of June 2009.

The Cambodian MOH HPITC approach differs from the WHO-recommended PITC approach in that its overall goal is to increase uptake of HIV testing by increasing the number of routine referrals made to VCCT sites for HTC, rather than implementing HTC as a routine component of clinical services at specialty clinics.

METHODOLOGY, FINDINGS, AND DISCUSSION

METHODOLOGY

An initial planning visit in April 2009 secured support from key stakeholders including USAID, CDC, and NCHADS. At that time, informal interviews were arranged by USAID/Cambodia with representatives of organizations collaborating with the MOH on HIV prevention, treatment and care, and support, such as Family Health International, University Research Co., WHO, UNAIDS, and the U.N. Children's Fund. These interviews provided contextual information regarding HTC in Cambodia.

Interview tools were developed by the HTC Team at AIDSTAR-One based on the WHO guidelines for PITC. They included qualitative and quantitative questions that explored issues of consent, confidentiality, counseling procedures, and HIV testing and referral processes. A purposeful sampling approach was selected to provide information on specific PITC issues from a variety of perspectives (Patton 1987). The following groups were interviewed:

1. HCPs working in ANC, TB, and STI² clinics
2. Senior managers (SM), provincial AIDS officers, and STI, TB, or ANC clinic heads
3. Maternal and child health provincial managers and provincial health department (PHD) directors who should be familiar with MOH policy and how services were being delivered
4. Clients from TB, ANC, and STI clinic services
5. VCCT site HCPs who may receive clients referred from ANC, TB, or STI clinics
6. Owners or staff at private sector pharmacies located within two kilometers of the VCCT sites.³

The interview tools also explored the opinions of HCPs and SMs about the feasibility of introducing HIV rapid testing into STI, ANC, and TB (specialty) clinics as described by the WHO 2007 guidance. Exit interviews were developed for clients leaving the same specialty clinics to determine if they had been told about and referred for an HIV test. Interviews with pharmacists focused on their ability to identify a local VCCT site and if they referred clients to the site for HIV testing.

In consultation with USG/Cambodia, the provinces of TK, PV, BTB, and PNP were identified for data collection. PNP and PV were chosen as provinces implementing an enhanced HPITC (LR); BTB (with some programs supported by USG) and TK provinces were chosen because they were

² Three of the STI sites included in the assessment were family health centers (FHCs) in PNP. In 2007, NCHADS established these FHCs in public health facilities and private clinics for diagnosis and treatment of STIs for DFSWs, EWs, and MSM. FHCs refer patients to a VCCT site, which is sometimes located at the same facility.

³ Pharmacies were included in the sample because NCHADS 2007 BSS data showed that for their last episode of STI, 11.3 percent of DFSWs, 20 percent of EWs, 7 percent of MSM, and 37 percent of mototaxi drivers sought treatment at a pharmacy (NCHADS 2007). In this assessment, AIDSTAR-One wanted to determine if pharmacy staff knew the location of a VCCT site and/or if they referred customers there for testing.

not yet implementing the LR. Three ODs were randomly chosen in each selected province, and the RH and several HCs in those ODs were included in the assessment. With approval from NHCADS, contact was made with each PHD and OD chief in order to request participation of his or her staff in the assessment.

On June 4 and 5, 2009, the five-member AIDSTAR-One team (consisting of three staff from AIDSTAR-One partners World Education International/Cambodia and John Snow Inc./USA and two local Cambodian consultants) reviewed and revised the tools and the protocol. All the tools were translated into Khmer. The field work was conducted from June 7 through 12 and June 14 through 18 with two teams each covering different provinces. A complete itinerary is provided in Appendix 2.

Team members met with the PHD, RH, and HC chiefs to introduce themselves and explain the interview goals and process. They then went directly to the specialty clinics. Where staff were available, at least one staff member from each specialty clinic was interviewed (often there were no staff or just one staff person in the clinic on the day of the visit). Clients were identified as they left a particular clinic; at many STI and TB clinics, there were no clients on the day the team visited.

The breakdown of interviews conducted by type of informant is provided in Table 2. Table 3 shows the types of clients interviewed by clinic and by province. After verbal consent of each SM and HCP, interviews were conducted with 38 HCPs from 25 specialty clinics and 19 SMs at PHDs, ODs, or RHs. Also, 16 interviews were completed with staff at 14 VCCT sites.

All clients exiting specialty clinics during the site visit were approached and asked if they would be willing to complete a short survey. A total of 46 interviews were completed. Clients gave verbal consent before being asked any questions and were provided a token gift (soap and toothpaste) at the completion of the interview. The team also approached 24 randomly chosen pharmacies within two kilometers of the HC or hospital, and one owner or staff member at each pharmacy was interviewed. All interviews were conducted in Khmer. Data were then translated into English. Quantitative data were compiled using an Excel spreadsheet, and qualitative data were compiled into a Word document.

On June 22, 2009, the AIDSTAR-One team presented preliminary findings to USG in Cambodia. The team was unable to debrief NCHADS due to scheduling difficulties.

FINDINGS⁴

PARTICIPANT CHARACTERISTICS

Table 2 shows the demographic characteristics of those interviewed. HCPs were predominantly women (82 percent), while SMs were predominantly men (76 percent). HCPs had on average 8 years of service in their current post; SMs had been in their position on average 12 years. SMs were older than HCPs (average of 50 years of age versus 40 years of age, respectively).

Table 3 summarizes client interviews by province and clinic type. Most of the clients interviewed (84 percent) were women, which reflects women's use of ANC services and higher overall utilization of health services. Of the 27 non-ANC clients interviewed, 9 (33 percent) were male and 18 (67 percent) were female (data not shown). By clinics, 57 percent of TB clinic clients interviewed were women and 43 percent were men; 92 percent of STI clinic clients were female and only 8 percent of clients were male.

⁴ Findings from the FHCs are incorporated into this report. Data specific to the FHC are provided in Appendix 3.

Table 2. Key Informant Demographics

	Total (N)	Women (%)	Men (%)	Age (average age in yrs)
HCPs	38	31 (82)	7 (18)	40
SMs	19	5 (26)	14 (76)	50
VCCT Site Staff	16	15 (94)	1 (6)	^^
Pharmacy Owners	24	^^	^^	^^

^^ = Data not collected

Table 3. Clients Interviewed by Clinic and Province¹

	BTB	PV	PNP	TK	Women	Men	Total Clients
ANC	3	6	8	2	19	0	19
STI	2	4	6	1	12	1	13
TB	3	6	2	3	8	6	14
Total Number of Clients by Province	8	16	16	6	39	7	46

BTB = Battambang; PNP = Phnom Penh; PV = Prey Veng; TK = Takeo.

CONSENT

All HCPs said that the client had to give consent to have an HIV test. Most (90 percent) stated that each client is asked to sign a consent form; 10 percent said the client is asked to orally accept or refuse the test. When asked how many clients are informed that they have the right to refuse the HIV test, 86 percent said “every” client is informed, 9 percent said “most” are informed, and 5 percent said “some” are informed. SMs concurred that either oral or written consent is obtained from all clients before testing.

COUNSELING

Nearly all HCPs reported that clinic staff provided pre-test information and recommended that clients visit a VCCT site. Only 44 percent of HCPs reported they had been trained to do counseling. At several sites, some staff had attended a formal five-day training sponsored by NCHADS or an NGO that uses an NCHADS-endorsed standardized training manual; others reported they were trained by staff from their own HC or RH who had attended a formal training (cascade training). A variety of methods were used to provide pre-test information to clients. Most HCPs said this information was provided one-on-one with clients; fewer HCPs said this information was provided to single-gender or mixed groups of men and women. About half of the HCPs said pre-test information was given only orally, with the remainder using videos, printed materials, or a combination of these approaches. All but two HCPs indicated that the pre-test information provided most often included why an HIV test is recommended, benefits of HIV testing, possible

risks of HIV testing (discrimination, violence), confidentiality of test results, and the client's right to decline the test.

Nearly all SMs stated that HCPs at ANC, TB, and STI clinics are required to recommend HIV testing to clients coming to the clinic and to provide pre-test information and a referral to the VCCT for all clients who agree to get an HIV test. Most SMs reported that staff could draw blood to be sent to the laboratory or VCCT site for testing.

CONFIDENTIALITY

Most HCPs reported that clients' confidentiality was protected by having a separate counseling room in their facility where one-on-one counseling and test results were provided. The AIDSTAR-One teams did observe separate counseling rooms with solid doors to protect privacy in all the clinics and VCCT sites visited.

Most HCPs said they were not allowed to share clients' test results with anyone. However, several HCPs noted that they would tell "the client's partner if the client requests it." Some mentioned that they would inform other staff about clients living with HIV so that "the staff could protect themselves" or that they would inform staff about which clients were not living with HIV.

When asked what clients could do if their confidentiality was breached, most HCPs said that the client could submit a complaint to the head of the OD. Few HCPs could articulate the actual process for redress. The most common response was that this problem had never presented itself at that clinic.

SMs mentioned that most staff are familiar with and respect the government policy on confidentiality. One SM stated that he reviews the policy during monthly meetings; others stated that every clinic has guidelines to follow. Confidentiality was protected through one-on-one counseling in a separate room and by using client identification numbers on blood specimens. Only one SM suggested that a client could complain to a PLWH representative in his or her district and PLWH can register the complaint with the joint HC-community committee, which would raise the issue with the HC director at a regularly scheduled meeting. Another SM, however, was skeptical of how confidentiality was being protected:

HCPs don't know clients' rights and also people don't know their rights to complain. If they knew their rights they would complain; many will complain to the court. When clients come to the hospital [for inpatient care] they don't want an HIV test; but HCPs get the blood without informed consent; blood is sent to a VCCT site for testing and client's results may be shared with many other HCPs—this is a violation against confidentiality of the clients.

Many HCPs and SMs said that it is up to clients to inform others of their HIV status. Given the availability of treatment and community-based services for families affected by HIV, several HCPs and SMs said they thought that clients are much more open about their status now than even a few years ago.

HIV TESTING

HCPs mentioned a number of strategies they used to facilitate HIV testing:

1. Almost 18 percent of HCPs said blood was drawn in their specialty clinic and transported to the nearest VCCT site by a staff person using his or her own motorcycle. The client would be told

either to go to the VCCT site for their results or to come back to the specialty clinic for the result.

2. Forty-four percent of staff report advising clients to go on their own to the closest VCCT site, which may be on the same grounds as the specialty clinic or at a different location.
3. Three percent (one HCP) reported that clients were asked to come back another day so they could be transported to a VCCT site by a member of the HBCT.
4. Thirty-five percent said the blood is drawn in the specialty clinic and taken to their own facility's VCCT lab. Clients were told to go directly to the VCCT site for their test results and post-test counseling.

A common concern across the strategies mentioned above by HCPs is the potential for large numbers of clients who are at high risk for HIV infection to be lost to follow-up by not returning for their test results or not following the HCP advice to go to the VCCT site.

WHO IS REFERRED FOR HIV TESTING?

HCPs were asked, "Of the clients who come to this clinic, how many are referred to the VCCT site?" (Table 4). Among TB clinic HCP informants, 40 percent said "all" clients were referred, 10 percent said "most" clients, 40 percent said "some" clients, and 10 percent were not sure what level of clients were referred. Some informants reported that they referred only clients with positive TB sputum results, while a few reported that they followed the CENAT policy and recommended the test to all TB clients.

In STI clinics, no HCP reported that "all" clients were referred, 36 percent reported "most" were referred, 27 percent reported "some" were referred, 18 percent reported "a few" were referred, and 18 percent "did not know how many clients were referred." In one STI clinic, an HCP mentioned that only clients who are positive for an STI (based on syndromic management) would get a recommendation for an HIV test.

In ANC clinics, 46 percent of informants said "all" clients were referred, and 18 percent of informants reported "most" or "some" clients were referred. No informants reported "a few" clients were referred, and 18 percent did not know the level of referrals made in their clinic.

Table 4. Referrals for HIV Testing by Clinic

HCPs were asked: "Of the clients that come to this clinic, how many are referred to the VCCT site?" Provider responses are categorized below according to clinic type.			
	TB Clinic	STI Clinic	ANC Clinic
All clients	40%	0%	46%
Most clients	10%	36%	18%
Some clients	40%	27%	18%
A few clients	0%	18%	0%
Don't know	10%	19%	18%

REFERRAL PROCESS

Most HCPs at sites with VCCT services said they fill out a referral form for the VCCT site and give it to the client. Several informants said they made oral referrals. Several other staff said because there was a laboratory on site, they did not need to refer the client to the VCCT site; in these instances, HCPs provided pre- and post-test counseling, staff drew the blood and took it to the VCCT laboratory, and the laboratory did the HIV rapid test. Three HCPs stated that they did not need a referral form because they escorted the clients to the VCCT site, which was on the same grounds as the clinic.

HCPs gave various reasons why a client would refuse a referral for an HIV test. When interviewed, HCPs responded that clients would say they were “too busy to wait for the test results and post-test counseling,” “trusted their spouse and so could not be HIV infected,” or were “too old to be bothered” with knowing their status. Also, they said clients knew their HIV status or did not agree that they needed an HIV test.

Only 6 percent of HCPs said that if a patient had to go on their own to the VCCT site, their clinic provided funds to pay for transportation; 60 percent reported their RH or HC had a HBCT that could take patients to the VCCT site for HIV testing. The majority of HCPs did not know how often the HBCT took clients to the VCCT site, and 24 percent said the HBCT took clients on an as-needed basis. Thirty-nine percent of HCPs said the clinic did not always have funds available for the HBCT to take clients to the VCCT site, and almost 48 percent did not know if the clinic always had sufficient funds for the HBCT to take clients to the VCCT site. These last data are not surprising because many HBCT are funded by local NGOs, and HCPs noted that they were not familiar with the process of funding the HBCT.

When asked, “Does this clinic have the standard operating procedure (SOP) available in the clinic for implementing client referrals to the VCCT site?” most (61 percent) indicated that no, they did not have a SOP for referrals. When asked if they had received any training or orientation on how to do referrals from their clinic to a VCCT site, 44 percent said yes and 56 percent said no. By province, 83 percent of HCP in PV, 18 percent in TK, 33 percent in BTB, and 38 percent in PNP said that they had received training or an orientation on how to implement referrals to VCCT sites. The high response in the ODs in PV visited by the team is probably because several ODs in that province have been implementing the more comprehensive LR since 2007 and had received orientation from NCHADS on how to develop a referral network between most specialty clinics and VCCT sites.

Most informants reported there were a few barriers to referring clients from their clinic to the VCCT site. The barriers identified included 1) insufficient staff to handle new tasks such as pre-test counseling and drawing blood; 2) lack of coordination and communication between clinic and laboratory or the VCCT site where the HIV test was being done; 3) poor morale related to not getting an incentive to do counseling and blood drawing or delays of up to six months in getting an incentive⁵ to TB, STI, and ANC staff who are expected to do pre-test counseling and blood drawing; 4) staff having less time to counsel clients because the results come late in the day and the clients wish to go home; 5) stockout of HIV rapid test kits at either the VCCT site or the RH or HC laboratory; and 6) lack of coordination between VCCT sites and clinics. HCPs also expressed the

⁵ In the early days of the HIV epidemic in Cambodia, financial incentives were provided to HCPs in order to motivate staff to work at VCCT sites; at the time of the assessment, several informants told us that the incentive was U.S.\$60 per month (on top of the usual U.S.\$25/month salary) or U.S.\$7 per trip to transport blood to an off-site VCCT site.

following needs: more rooms for counseling, training in counseling skills, and a steady supply of general supplies.

SMs had many of the same concerns. One SM in TK said:

The referral forms were developed and distributed to the clinics; then we are supposed to coordinate among the clinics. This is what has happened. We need collaboration first, then implementation.

Another SM in PV mentioned:

Some HCs are not familiar with the referral process and don't implement it well. The Chief of the HC and other senior provincial staff should be included in training or orientation. There is a need to strengthen the reporting system and we need summary tables or charts posted at the HC for staff to see how well the referral process is going. Right now we have no information about how it is working.

Only 36 percent of HCPs said they received feedback on how many patients are completing the referrals made by their clinic. Almost 52 percent said they never received any feedback, and the rest (12 percent) were unsure.

HCPs and SMs expressed concerns that the community is not involved enough in promoting HIV testing. Several suggested the need for media campaigns promoting HIV testing and informing people that when they attended public health clinics they would be offered an HIV test, and why. This publicity is especially important so that men, who rarely use public health services, will be informed about where they can get free HIV testing, and are made aware that their pregnant spouse/partner would be offered HIV testing by the ANC clinic.

Post-test Counseling

Staff were asked who provided post-test counseling to clients; staff were not asked to differentiate between counseling HIV-positive and negative clients, although several HCPs stated that they could only provide post-test counseling to clients with negative HIV test results. Clients whose results were HIV-positive were usually referred to the nearest VCCT center for their test results and counseling; staff had no way of knowing if clients attended the VCCT site for post-test counseling. At a few HCs, HCPs reported that staff who had received formal HTC training from NCHADS, an NGO, or by a trained co-worker were allowed to do post-test counseling with clients living with HIV. Overall, 36 percent of HCPs agreed that "staff in this clinic do the counseling," 48 percent said, "staff at VCCT do the counseling," 3 percent said, "a member of the home-based care team does the counseling," and 6 percent said, "staff from the VCCT site come to the clinic to do the counseling."

One SM noted that it is difficult for TB staff to do counseling for clients living with HIV because their counseling skills are not strong; TB clinics often refer these clients to VCCT sites for post-test counseling. In one OD, the SM noted that NCHADS had trained several TB staff on general counseling skills, but did not include counseling for people living with HIV, for coaching the client about disclosure, or for other serious issues that arise during post-test counseling.

VOLUNTARY CONFIDENTIAL COUNSELING AND TESTING SITE HEALTH CARE PROVIDER RESPONSES

Referrals

Except for one, all HCPs working in VCCT sites said they had a register to track referrals they received from the STI, ANC, and TB specialty clinics (although one register was with the OD coordinator and not at the VCCT site at the time of the assessment). We asked staff to show us their data for May 2009. The available data for the month of May showed that among the 14 VCCT sites, each received a median of:

- Ten referrals from STI clinics, with a range of 0 to 27
- Four referrals from TB clinics, with a range from 0 to 25
- Thirty-six referrals from ANC clinics, with a range from 2 to 70.

Eight of the VCCT sites reported having a register in which they tracked referrals they made to the specialty clinics. A lot of data were missing in these registers, making it difficult to determine if these referrals were being made. Also, 8 of the 16 VCCT staff members said VCCT staff went to the specialty clinics to do counseling either on an as-needed basis or a routine schedule ranging from every day to a few times a week or a few times a month. VCCT staff reported very few challenges going to the specialty clinics to do counseling. Barriers mentioned by staff included shortages of blood collection tubes, which required a client to return another day; shortage of transportation funds, making it difficult for clients to follow up on a referral to VCCT; lack of funds to buy supplies; and long waiting times for laboratory test results.

INTRODUCING PROVIDER-INITIATED TESTING AND COUNSELING AND RAPID HIV TESTING IN ANTENATAL CARE, TUBERCULOSIS, AND SEXUALLY TRANSMITTED INFECTION CLINICS

In general, HCPs and SMs in all four provinces were familiar with the MOH policy to provide routine referrals for an HIV test to all clients coming into ANC, TB, and STI clinics. SMs and HCPs were asked their opinion about the feasibility of introducing the 2007 WHO PITC strategy whereby rapid HTC was done in the specialty clinics rather than referring clients to the VCCT sites. Most HCPs thought it was a good idea to do rapid HIV testing and post-test counseling in the clinics. Most comments in support of clinic-based testing focused on reducing time and transportation costs for clients, reducing loss to follow-up, and reducing HIV transmission. Typical comments by HCPs included:

- “We are already doing all the counseling. If the clients are willing to do [the] HIV test, we are willing to do it. We will be able to refer quickly to the opportunistic infection clinic if results are positive. We have a separate room we could use for counseling to protect confidentiality. We would need clear instructions for staff and training to do counseling and testing appropriately.”
- “This should happen in each HC because in this province HCs are far from VCCT sites.”
- “It would make it easy for every client that comes to clinic to get HIV testing.”

SMs mentioned the following:

- “This would benefit the clients. They will not have to spend time to go to the VCCT site. It would increase the number of people getting HIV tests, getting test results, and getting referred to ART.”
- “It would be good for clients because confidentiality would be better than if they were referred. It would be easy for staff as well: no need to send blood or fill out [a] form or wait for test results.”
- “HIV tests should be available everywhere, especially at HCs where services are closest to the community.”

HCPs did mention the following potential challenges to implementing rapid testing in clinics:

- “This would increase the workload on staff. We not only work in STI clinic[s], we have other duties as well, covering four positions at the same time.”
- “Too many tasks are given to HCP[s] but without any increase in salary. We need incentives just like the VCCT site staff get.”
- “We are busy not only during the daytime but also in the evening—we meet in [the] evening with peer outreach workers, make appointment[s] with brothel[s] to do monthly check-ups, do monthly rotation for [brothel check-ups]. When a sex worker comes to [the] clinic (brought by a peer outreach worker), we have to be available to provide free STI treatment.”

SMs identified the following additional challenges:

- “We should not allow staff to do testing until they have had training on pre- and post-test counseling. Training is really important. Also some clinics are already very busy and this would be extra work for staff.”
- “It will be difficult for government or NGOs to supply equipment or training for all HCs.”
- “I’m afraid [that staff of] many clinics working near each other and doing HIV testing will share information with each other about the status of clients so we need to train staff on confidentiality because clients will tell their friends not to come to this clinic.”

USERS OF SERVICES

In the interviews with HCPs at TB and STI clinics, AIDSTAR-One explored the question of who was using the services the most—men or women. Women by far use the services most often. When asked why more men do not use the services, informants offered a variety of replies:

- “Men are busy working.”
- “Wives get drugs for their husbands. Husbands are busy. We are open to them (women) bringing their partners, even if they have three or four partners, they (women clients) can get free drugs for their partners.”
- “Men are shy; they don’t want other people to see them coming to the STI clinic with a suspected STI. Or men deny they have an STI.”
- “Men always go to private clinics and the pharmacy.”

When asked what could be done to increase male utilization of clinics, the most common theme was that more should be done to encourage women to bring in their partners.

CLIENT EXIT INTERVIEWS

The purpose of the exit interviews was to determine the extent to which clients were being referred for HIV testing by the HCPs. In addition, AIDSTAR-One wanted to determine if clients received pre-test counseling and had blood drawn at the clinic they had visited that day.

Of the 46 clients responding, 35 said that they had previously visited the RH or HC where the assessment was being done. Of these clients, 31 (89 percent) said that during a previous visit, staff had recommended they have an HIV test. When asked if they had received any information about the reason for getting an HIV test during a previous visit, 29 said yes and 6 said no. During a previous visit, 24 of the 35 clients had blood drawn at the clinic for an HIV test, and 27 (77 percent) said they were referred to a VCCT site.

For those visiting the RH or HC for the first time on the day of the interview, 5 of the 11 (45 percent) stated that an HIV test had been recommended to them, 4 of the 5 had blood drawn for an HIV test, and all 4 were referred to the VCCT site to get their test results and post-test counseling.

For those receiving ANC services (either for the first or additional visits), 18 out of 19 clients interviewed at the RH or HC reported getting a recommendation for an HIV test, and 15 had blood drawn for the test. Twelve of the fifteen clients reported going to the VCCT site.

Of those receiving STI services, 8 out of 12 reported getting a recommendation for an HIV test, and 5 had blood drawn for an HIV test. Of the eight recommended for an HIV test, six reported going to the VCCT site.

Of the 15 total clients visiting the TB clinic, 10 reported getting a recommendation for an HIV test, 9 of the 10 had blood drawn, and 9 of the 10 reported going to the VCCT site.

Clients were not asked about barriers to seeking HTC or following up on a referral in order to 1) keep the exit interview focused on whether or not a referral was given to the client, and 2) avoid potentially sensitive topics with vulnerable clients (e.g., an ANC client not following up on a referral due to fear of gender-based violence [GBV] from her partner).

PHARMACY INTERVIEWS

Data collected by NCHADS showed that pharmacies are an important source for medical treatment for a portion of the population. Twenty-four brief interviews were conducted at pharmacies located within two kilometers of the VCCT sites visited during the assessment to determine if pharmacy staff referred customers with suspected STI or TB for HIV testing and to where they were referred (pharmacies are not permitted to do HIV testing). Of the pharmacy informants, most (82 percent) reported having customers with suspected STI or persistent cough that might indicate TB; 71 percent reported that most of their customers with suspected STI were women and that most of their suspected TB customers were men; and 45 percent said that equal proportions of men and women customers came in with suspected TB. Also, 70 percent of pharmacy informants reported referring customers with suspected STI to an STI clinic, and 87 percent referred customers with

suspected TB to a TB clinic.⁶ Most (73 percent) correctly identified where the VCCT site was, and 68 percent reported referring customers to a VCCT site.

BARRIERS TO HIV TESTING FOR CLIENTS

All HCPs and SMs were asked, “What do you see as the biggest challenges that clients face when wanting to get an HIV test?” Responses included:

- Poverty
- Transportation costs for testing and obtaining results
- Clients do not feel at risk for HIV so do not get tested
- Wait time for test results is long
- Women are aware their partners are not monogamous and fear getting an HIV test
- Men refuse to allow their wives to get tested
- Clients face other problems that take priority over HIV
- Negative attitudes from health care staff
- Limited time for staff to provide counseling
- Lack of electricity in health facilities at night, which prevents services from being provided in the evening.

DISCUSSION

The first case of HIV was detected in Cambodia when the country was rebuilding its devastated health care system after decades of civil war and occupation. For the two decades since then, Cambodia has had a remarkable track record in increasing access to HIV prevention, treatment, and care and support services. It is one of the few countries in the world that can claim success in reducing HIV incidence in the general population. Cambodia has been an early adopter of innovative strategies to increase access to HIV testing: establishing new VCCT sites around the country every year; implementing PMTCT programs as early as 2000; introducing rapid HIV testing technology, rather than ELISA testing, as the standard of care in VCCT sites; linking TB and HIV testing services in 2005; and in 2007 introducing routine referrals to VCCT sites from HCPs to clients visiting specialty clinics. Staff at clinics without co-located VCCT sites are allowed to 1) draw blood and take it to the VCCT site for rapid testing; 2) draw blood and transport it to off-site VCCT sites for testing and referring clients to the VCCT sites for post-test counseling; and 3) transport blood to off-site VCCT sites and ask clients to return to the TB, STI, or ANC clinic to get their test results and post-test counseling.

The goal of this assessment was to characterize Cambodia’s efforts to increase access to HTC using a routine referral strategy. The results show that HCPs and SMs in the ODs that the AIDSTAR-One team visited were familiar with NCHADS guidelines in that they knew to recommend an HIV test to clients of STI, TB, and ANC clinics. All recommendations for HIV testing do not necessarily lead

⁶ The high number of pharmacy owners/staff referring customers to TB clinics may be related to the Public-Private Mix (PPM) program being implemented in several of the ODs in TK and BTB visited by the AIDSTAR-One team. The PPM is a joint CENAT and international donor effort that trains pharmacy owners/staff to refer customers to TB clinics.

to a referral to a VCCT site; referrals can be made only to clients who agree to an HCP recommendation to get an HIV test. Clients may refuse a recommendation for an HIV test outright, already know their status, or face barriers such as time and funding constraints that would make it difficult for them to act on a referral.

The routine referral approach in Cambodia demonstrated several good HTC practices at most, but not all, HCs and RHs specialty clinics in several areas:

- **HIV testing at the sites assessed was largely being recommended, as reported by HCPs, SMs, and clients.**

Routine recommendations for HIV testing occurred most often in ANC clinics. This may reflect MOH efforts since 2000 to establish PMTCT programs in every province. A majority of HCPs report routinely referring clients to VCCT sites or facilitating HIV testing by providing pre-test counseling, drawing blood, and transporting blood to VCCT labs for testing as per MOH policy.

- **HCP asserted that oral or written consent for HIV testing was obtained from all clients.**
- **A great majority of clients get pre-test information.** Most (83 percent) clients completing the exit interviews reported receiving pre-test information about why they should get an HIV test.
- **Confidentiality** was protected in all the sites visited by having a separate, private room available in the RH or HC for HIV counseling. Also, a sample number, not the client's name, was on blood samples and test results.

HTC practices should be strengthened in the areas of:

- **Training in HIV post-test counseling.** It appears from the responses of HCPs that some of the post-test counseling, especially for clients not living with HIV, is being provided in the specialty clinics by staff who have not received training to do so. A limited number of staff who have participated in a formal training have been designated in some of the clinics to provide post-test counseling for clients living with HIV. If these staff members are absent from the clinic, clients either have to return to the HC on another day or travel to the VCCT site where their blood was tested. This may result in loss to follow-up, as clients may not have the funds or the time to travel to and from the HC or VCCT sites. A client returning to a specialty clinic whose HIV test is positive may receive post-test counseling from staff that have not been trained appropriately. It was outside the scope of this assessment to determine the quality of pre- or post-test counseling but concern with the quality of counseling was raised by HCPs, SMs, and NCHADS informants (Mean Chhi Vun, 2009).
- **Clarifying the meaning of confidentiality.** While the great majority of HCPs responded that they were not allowed to share a client's HIV status, two mentioned that they did share a client's HIV-negative status with others. This suggests that the concept of confidentiality—not sharing information about if and why a client was at the HC or RH with those not involved in his or her care, or without the client's permission—is not completely understood by staff.

CHALLENGES TO IMPLEMENTING THE ROUTINE REFERRALS STRATEGY

In almost all sites visited by the assessment team, HCPs and SMs articulated a number of challenges to implementing the routine referral strategy. Those challenges include the following:

- **There is no single HTC strategy in use by all facilities.** Some sites provide only referrals. Other sites draw blood and provide a referral. Some sites do post-test counseling; some do not. The different national programs have developed their own HTC strategies, which play out in different ways at the facilities.
- **Repeat trips for test results.** To receive their test results, clients must either go on their own to the VCCT site or return to the RH or HC specialty clinic where their blood was drawn, creating high opportunity costs to clients and contributing to loss to follow-up.
- **Missed opportunities to recommend HIV testing to most-at-risk clients.** According to client and HCP informants, not all clients in TB and STI clinics were getting a referral for an HIV test. As a result, many opportunities are lost to reach high-risk individuals. Some TB clinic staff were referring only clients who were TB-sputum positive, which is not consistent with the CENAT guidance. Likewise in the STI clinics, some HCPs reported recommending an HIV test only to those who were positive for an STI.
- **Blood transport costs.** In some ODs, transporting blood to and from the HC to the VCCT site for testing creates additional costs in HCP time and transport expenses, as well as waiting time for test results. These transport costs, often paid for by NGO or donor-funded programs in select provinces, are unsustainable over time.
- **Inconsistent referral processes.** Referral processes from ANC, TB, and STI clinics to VCCT sites for HIV testing are not standardized. How referrals are made varies widely, tracking of referrals appears to be minimal, and there does not appear to be systematic follow-up of clients to determine if they obtained testing or received their test results. Communication between the health facilities seems to be lacking and without a system for coordination, staff get little feedback on how the referral process is working or how to improve it. Strengthening record keeping and standardizing referral procedures will enable NCHADS and the MOH to assess how well the routine referral strategy is being implemented.
- **Low community awareness about HIV testing.** Many HCPs report that most people in the community do not know about VCCT or the benefit of knowing one's status, and men are not using VCCT or other health services.

TRANSITIONING FROM ROUTINE REFERRALS TO PROVIDER-INITIATED TESTING AND COUNSELING IN SPECIALTY CLINICS

Clients face numerous social, economic, and gender-related barriers that make it difficult for them to get their HIV test results and post-test counseling services. These barriers are not adequately addressed through a routine referral strategy. The current routine referral strategy implemented in Cambodia has succeeded in increasing the number of blood tests that are being done but does not ensure that all clients get their test results and have access to post-test counseling and referrals for treatment, as well as social and legal resources, as recommended by WHO. This is especially problematic in STI and TB clinics that experience high loss-to-follow-up rates (Kanara et al. 2009).

Most HCPs and SMs were supportive of the idea of introducing rapid HIV testing into ANC, STI, and TB clinics. The most common reason cited was convenience for clients: they would get their results sooner, be able to be referred to OI/ART clinics sooner if needed, and not have to spend scarce resources to pay for transportation to and from the RH, HC, and/or VCCT site.

Several challenges were identified related to introducing a PITC approach in specialty clinics in Cambodia:

- **Need for staff incentives.** Some HCPs and SMs stated that without some incentive, STI, ANC, and TB clinic staff would not be willing to perform the additional tasks of HIV rapid testing and post-test counseling.
- **Need for training of staff to perform rapid testing (if allowed) and pre- and post-test counseling.** With training centralized at NCHADS or done by a few NGOs, the need for training will outstrip the capacity to do training around the country.
- **Quality assurance concerns for counseling.** Informants were concerned about the quality of post-test counseling by staff at ANC, TB, and STI clinics. For PITC to be rolled out, staff members need to be trained to provide quality counseling, particularly post-test counseling. Also, quality assurance is constrained by the fact that supportive supervision is poorly funded at the PHD and OD levels, and it is provided infrequently. Addressing quality assurance from the training perspective and through instituting quality control measures and monitoring could strengthen PITC.
- **Supply chain management issues.** A major concern of HCP and SM informants was ensuring rapid test kit provision to a large number of HCs, given the recurrent problem of stockouts at VCCT sites.

GENDER CONSIDERATIONS

Male underutilization of health care facilities is a global phenomenon. Men are more likely to deny their risk behavior and delay seeking health services. This assessment found that women were the predominate users of the health facilities visited by the team. Encouraging men to accompany their pregnant wives to HIV testing at ANC clinics is one strategy to expose men to HTC. Given the gender power imbalance in Cambodia, however, for the majority of women who are not pregnant but using reproductive health, pediatric, postpartum, STI, TB, or other clinical services, the advice to motivate their husbands or partners to receive HTC or visit an STI clinic will remain inadequate. Truly acceptable services for couples require a comprehensive reorientation of services toward both men and women (Aarnio et al. 2009).

Studies in other countries show that, without extensive community mobilization, men underutilize health clinics that are perceived by men as female-oriented (Ford et al. 2009; Kalmuss and Tatum 2007). Targeted information and skills building helps enable men to make informed choices on HTC participation and support their female partners. Community outreach directed at men and supported by community leaders is critical to empowering men to use health services alone or as a supportive partner (Aarnio et al. 2009). Access and uptake of HTC among men may also reduce HIV-related mortality, as earlier referral to OI/ART clinics will be provided to men living with HIV. A recent study in Cambodia demonstrated that men were more likely to die after six months on ART than women, which may be explained in part by men not being tested or seeking treatment until they are at a more advanced stage of HIV. “By promoting an opt-out strategy for HIV testing and earlier access to care, patients who are not yet eligible for ART will make up a larger part of the patient population,” a larger proportion of which may be men (Thai et al. 2009, 1056).

Currently, no accommodations are being made in public health sites in Cambodia to make services more attractive to men in the form of men’s health clinics, afternoon/early evening hours set aside just for men, or through work- or community-based mobile sites (Lisle 2009). Creating access to

male-friendly services may also appeal more to men who do not identify as MSM, or men who have sex with men and with women, and who would therefore not visit FHCs providing MSM-friendly services.

FHCs are not likely to be used by female spouses and regular partners of men infected during commercial sex, who now account for the majority of new infections in Cambodia (UNAIDS 2009). All married or cohabiting women who attend STI clinics should be offered HTC and screened for the potential for GBV, and, where services are available, offered referrals to NGOs providing services to women experiencing GBV.

STRENGTHS AND LIMITATIONS OF THE ASSESSMENT

The study's major limitation was that all data were behavioral and self-reported. HCPs and SMs may be over-reporting the degree to which referrals for HIV testing are being made. Determining the actual level of referral was also complicated by the inconsistency in referral data. A small number of sites were included in this assessment, and therefore, the findings on PITC implementation may not be generalized to all sites in Cambodia. The limitations were addressed in part by: 1) using a purposeful sampling approach whereby information on the process of referrals, pre-test education, and blood drawing for HIV testing came for a variety of informants (providers, SMs, and clients); and 2) randomly choosing ODs and HCs for inclusion in the assessment (i.e., high- or low-performing sites were not purposively chosen). A high proportion of clients reported receiving pre-test information and a recommendation for an HIV test, which supports the self-reported data provided by HCPs and SMs.

The number of client exit interviews was small due to the lack of clients at several sites visited, a typical experience at many public health specialty clinics in Cambodia. Because of the small number of clients at the assessment sites, clients could not be randomly chosen. Therefore, the experience reported by clients cannot be generalized to all clinic sites.

RECOMMENDATIONS

Health staff are widely aware of the MOH/NCHADS policy of referring patients for HIV testing. In 2008, WHO further clarified its recommendations on PITC to reduce the loss to follow-up that results from referring patients for HTC. WHO is now encouraging countries to introduce rapid HIV testing in clinics where clients are seeking care, rather than refer clients to HIV testing sites (WHO 2008). Cambodia could continue to expand access to rapid HTC by implementing PITC in its public health specialty clinics. Efforts to address these challenges identified in the assessment present significant financial implications for the MOH. Providing rapid test training and staff incentives and keeping HIV test kits stocked at HCs where ANC, STI, and/or TB screening and diagnosis occurs are major undertakings. Based on the findings of this assessment, AIDSTAR-One recommends the following discrete activities that could fill some current gaps and that could lay the groundwork for implementing PITC in Cambodia:

- **Revise policy.** Convene an expert consultation on policy and procedures to revise the current HTC policy that permits only laboratory technicians to perform rapid testing.
- **Develop and disseminate a unified protocol for implementing HTC in ANC, STI, and TB clinics in Cambodia.** National programs have different protocols for HTC for their target population.
- **Implement pilot projects to integrate same day, rapid HIV testing and post-test counseling in select high-volume HC TB and STI clinics, particularly FHCs.** In general, public sector TB and STI clinics do not handle large client numbers, making it feasible to do same-day rapid testing and reducing missed opportunities and loss to follow-up of high-risk clients.
- **Consider piloting a task-shifting model.** In order to address the capacity concerns of HCPs, some or all HTC tasks could be performed by non-nursing staff, peer volunteers, or HBCT volunteers already knowledgeable about HIV and available services in the community. PLWH and HBCT volunteers, who may have experienced stigma and discrimination, may be much more sensitive to the importance of confidentiality than HCPs.
- **Facilitate follow-up discussions** to leverage lessons learned from the pilot projects for a broader strategy to implement PITC.
- **Standardize the referral system.** Strengthen processes to include client tracking and follow-up of referrals.
- **Develop training teams at the PHD level.** These teams would have responsibility for training RH and HC staff, peer volunteers, or HBCT in quality pre- and post-test counseling and should be responsible for quality assurance and supportive supervision activities.
- **Initiate steps to increase men's awareness about HTC and utilization of services.** Activities could include: integrating messages about where and why men should get HIV testing into existing community-based programs; conducting targeted messaging to high-risk males; and providing partner notification with informed consent for those at risk.

Cambodia has been a leading innovator in expanding access to HIV prevention, treatment and care, and support services. The country is well positioned to expand on its current approach of offering routine referrals to VCCT sites to integrate PITC into specialty clinics and thereby make further gains in uptake of HTC, limiting loss to follow-up especially among MARPs, and ensuring greater access to early treatment and care.

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APPENDIX I

AIDSTAR-ONE CONCEPT NOTE, DATA COLLECTION PROTOCOL, AND TOOLS

ASSESSMENT OF PROVIDER INITIATED TESTING AND COUNSELING EFFORTS, CONCEPT NOTE, 3-09

BACKGROUND

Counseling and testing has long been recognized as a critical component of a comprehensive HIV program. It is essential for determining an individual's HIV status and referring him or her for appropriate prevention and treatment services. Initial HIV testing and counseling (HTC) efforts focused primarily on individuals voluntarily seeking out testing opportunities at stand-alone or integrated testing sites. Extensive safeguards were built into programs to ensure volunteerism, consent, and confidentiality, and to minimize stigma. In recent years there has been increased focus on developing and implementing different HTC service delivery models, including mobile testing and provider-initiated testing and counseling (PITC). PITC programs target individuals seeking health services and thus can significantly increase the number of people who know their HIV status and are provided with the opportunity to access appropriate programs to either remain uninfected or to receive treatment. However, programs have struggled with how best to implement PITC, resulting in few patients having access to HIV testing, and counseling and testing services of variable quality.

ASSESSMENT GOALS

AIDSTAR-One will conduct a comprehensive assessment of PITC programs in three countries, focusing on issues related to implementation and scale-up. The assessment will focus on the three “Cs” of a human rights-based HTC program: 1) consent, 2) confidentiality, and 3) counseling related to HIV testing. In addition, the assessment will examine the implementation of referrals that link patients to prevention, care, treatment, and support services.

Specific goals include:

1. Identify promising programmatic practices in the area of PITC.

2. Identify cross-cutting challenges related to the development and implementation of PITC programs, focusing on policy, program practice, and addressing unmet demand and need for PITC.
3. Summarize legal and regulatory approaches, including issues of policy development, dissemination, and regulation, and rights of most-at-risk and special populations including children, couples, and the disabled, as well as criminalization of HIV transmission.
4. Assess implementation practices at hospital and health center service delivery sites, identifying approaches for replication and areas of concern that should be addressed.
5. Identify unmet demand and need for expanded PITC, including barriers to expansion.
6. Assess provider and patient attitudes regarding implementation of PITC.

STAKEHOLDERS

In order to gather a comprehensive base of information and experiences, AIDSTAR-One will interview a broad range of stakeholders responsible for supporting PITC in selected countries. An illustrative list of individuals/organizations that will be contacted include:

1. Government officials, including national HIV coordinating committee, Ministry of Health (MOH) and Ministry of Justice (MOJ)
2. PEPFAR
 - a. USG (USAID, CDC)
 - b. Implementing partners
3. Health facility service delivery providers
 - a. Urban
 - b. Rural
4. Providers (physicians, medical and clinical officers, nurses, counselors)
 - a. PMTCT and ANC
 - b. Outpatient care
 - c. Inpatient care
 - d. Pediatric wards and well-baby/under five clinics
 - e. STI
 - f. TB
 - g. Surgical services
 - h. Laboratory technicians
5. Professional associations (Physician, Nursing, Midwives, Laboratory)
6. Patients and PLWH, with particular attention will be paid to women being tested in ANC settings that implement opt-out HIV testing programs, focusing on adherence to the three “Cs,” access to testing, and referrals
7. Community leaders

8. Legal/Human rights organizations

ASSESSMENT METHODOLOGY

AIDSTAR-One will implement a comprehensive assessment methodology, using quantitative and qualitative data collection methods. Specific tasks include:

1. *Creation of a PITC policy matrix:* In order to strategically select countries for participation in the assessment, AIDSTAR-One will create a policy matrix of PITC efforts in select countries (PEPFAR focus, mini-Country Operational Plan, and Compact). Using WHO guidance to standardize definitions, the matrix will capture critical information regarding a range of policy activities, including inclusion of PITC in national HIV strategies, creation of separate policies, other related policies and laws enacted, development of guidelines, and sector-specific guidelines (e.g., Workplace, NGO).
2. *Literature and desk review:* AIDSTAR-One will conduct a general literature review of PITC, as well as any specific literature regarding development and implementation of this initiative in selected countries including existing cost and cost effectiveness studies.
3. *Review hospital and health facility service delivery protocols:* Prior to conducting key informant interviews and site visits, assessment teams will review national service delivery protocols as well as site specific materials. National-level materials will be reviewed in comparison to WHO/UNAIDS Guidance on Provider-Initiated Counseling and Testing in Health Services. Site-specific protocols will be assessed in comparison to national guidelines.
4. *Conduct site visits:* In each selected country, a series of site visits will be conducted. A mix of sites—public, private, and NGO/FBO health facilities—will be visited in urban and rural settings. In addition to the key informant and focus group activities described below, the assessment teams will review operating procedures (including how and where testing is conducted), consent, data collection and patient education materials related to PITC in general and to application of the three “Cs.” Where feasible and appropriate, actual practice will be observed. Site-specific data on the proportion of providers trained in PITC, proportion of patients tested, and percent HIV positive will be collected.
5. *Key informant interviews:* We will conduct a series of key information interviews with policy leaders and service providers using a structured interview guide. Separate interview guides will be developed for policy leaders and service providers. The primary focus of the interviews will be on the three “Cs” within the context of PITC, and on recommendations regarding policy, practice and addressing unmet demand or access and opportunity to expand PITC.
6. *In-depth interviews:* It will be critical to gain better understanding of patients’ perspectives—both PLWH and patients who have tested HIV-negative. In facilities where AIDSTAR-One is conducting key informant interviews and observing practice, the team will also conduct focus groups and/or **in-depth interviews** with patients, some of whom may be PLWHs, using a standardized guide/questionnaire across all sites and countries, and solicit information regarding actual implementation of PITC and adherence to the three “Cs,” as well as access to testing and referral for appropriate services.

PROPOSED TIMELINE FOR CAMBODIA

To further explain the work of AIDSTAR-One and the goal of this PITC assessment, Kai Spratt, AIDSTAR-One staff, will meet with stakeholders in Cambodia during the week of April 6–9, 2009.

Once this activity has been approved and logistics arranged, Kai Spratt will coordinate data collection in Cambodia and will hire local consultants for this task tentatively scheduled for 3–4 weeks from May 25 to approximately June 15.

DELIVERABLES FOR CAMBODIA

A final assessment report will be developed and submitted to USAID. Each country will receive a report with specific assessment findings that identify areas for strengthening. Country-specific recommendations will be made to improve implementation of PITC and to identify strategic opportunities to initiate or enhance PITC to capture those most at risk for HIV. A comprehensive report will capture cross-cutting issues identified in more than one country/setting. The report will also detail recommendations for consideration by USAID, the TWG, Office of the Global AIDS Coordinator, and other stakeholders.

NEXT STEPS

1. Malawi, Kenya, and Cambodia USAID/CDC staff to share concept note with stakeholders
2. Once activity has been approved, each country to identify sites to be included in assessment
3. Assessment tools to be reviewed, adapted, and translated.

ASSESSMENT OF PROVIDER INITIATED TESTING AND COUNSELING (PITC) IN CAMBODIA, DATA COLLECTION PROTOCOL AND TOOLS, 5-09

Voluntary confidential counseling and testing (VCCT) was introduced into Cambodia in 1995 and expanded from 12 sites in 2003 to more than 200 by 2008. Provision of ART is currently widely available and VCCT is integrated within the Continuum of Care for HIV/AIDS. The demand for HIV testing has increased through a range of demand creation strategies, including through mass media, outreach activities at the village level, and referrals from health clinics, referral hospitals, and nongovernmental organizations (NGOs).

In 2004, WHO/UNAIDS began promoting expanding access to voluntary testing and counseling by integrating a routine offer of HIV testing by health care providers (or provider-initiated testing and counseling, PITC) to all patients with symptoms consistent with HIV-related disease and to those seen in sexually transmitted infection clinics, antenatal clinics, and other sites. In 2007, WHO/UNAIDS disseminated the “*Guidance on provider-initiated HIV testing and counselling in health facilities*,” which provided more detail for the rationale and process for integrating PITC into health services. For countries experiencing concentrated epidemics, like Cambodia, the WHO Guidelines suggest implementation of provider-initiated HIV testing and counseling should additionally be considered in:

- STI services
- Services for most-at-risk populations
- Antenatal, childbirth, and postpartum health services
- TB services

In 2005, PITC was initiated into select antenatal clinics to prevention of mother-to-child HIV transmission (PMTCT); in 2005 CENAT and NCHADS issued a joint “Statement Provision of care and treatment for TB-HIV/AIDS co-infection” introducing the routine offer of and process for HIV testing or referrals to VCCT sites into TB clinics. This statement was followed in 2006 with a “Standard Operating Procedure for Prompt Testing of TB-HIV and Rapid Access to Treatment and Care Services” between NCHADS and CENAT. In 2007, the “*Standard Operating Procedures (SOP) to Initiate a Linked Response for Prevention, Care, and Treatment of HIV/AIDS and Sexual and Reproductive Health Issues*” was issued to strengthen collaboration for PITC or the “Linked Response.”

Now, after almost three years of implementation in Cambodia, it is an opportune time to assess the current status of PITC implementation in health care sites recommended by the WHO. AIDSTAR-One, a USAID Technical Assistance project, proposed to conduct such an assessment in collaboration with the Ministry of Health (MOH), NCHADS, and USAID and CDC (USG) Cambodia. The specific goals include:

1. Identify promising programmatic practices implemented in health centers and hospital outpatient clinical settings in Cambodia
2. Identify cross-cutting challenges across different clinical services related to the implementation of PITC
3. Identify opportunities to address unmet need for, or lost opportunities to, provide PITC to most at risk populations.

Information derived from this health services assessment will provide information to the MOH on the PITC process as well as be made available through the AIDSTAR-One website so that other countries can learn from the promising practices being implemented in Cambodia.

DATA COLLECTION PROCESS

AIDSTAR-One will implement a comprehensive assessment methodology, using quantitative and qualitative data collection methods including **review of MOH documents** related to HIV testing and counseling, such as the National Strategic Plan 2008-2013, policy statements, and services statistics.

Conduct key informant (KI) interviews with healthcare providers and managers working in ANC, PMTCT, STI, and TB clinics in the public and private sector where PITC is being implemented. All questions in the interview guide will be specific to the implementation of PITC (see Key Information Interview Guide). Prior to arriving at the healthcare site, clinic or hospital administrators will be informed by phone or in person by AIDSTAR-One consultants about the proposed date to visit the site and adjustments will be made as needed.

Once at the health care setting, the following staff will be invited to participate in the key informant interview:

- Hospital/clinic supervisors or administrators
- Nurses, physicians, midwives

Efforts will be made to interview a variety of staff at each site, that is, AIDSTAR-One will try not to interview only physicians or only nurses, unless that is the only cadre of staff available at the site. Only clinic staff directly involved in implementing PITC will be interviewed. Clinic supervisors will

be interviewed to understand the process by which PITC was integrated into services and lessons learned from that process. Anyone approached to participate in the interview will be free to refuse or to stop the interview at any time.

Depending on the number of staff working in clinics doing PITC, AIDSTAR-One aims to interview a minimum of two persons at each site.

The interview will take approximately 45 minutes and will be conducted in Khmer by Cambodian consultants working with AIDSTAR-One. The interview form will be in Khmer. A team of two consultants will conduct the interview: one to lead the interview questions and one to take detailed notes of the conversation. No personal identifying information will be collected about the KI other than gender, province, OD, kind of clinic site, and cadre. (see “Key Informant Interview Guide: Healthcare Providers”.)

Conduct exit interview with patients leaving TB, ANC, PMTCT, STI sites. In order to understand if healthcare staff are implementing PITC as recommended, it is important to assess if patients were offered an HIV test or given a referral to VCCT. Therefore, all adults 18 years of age leaving the site within the period that the data collection team is present will be asked to voluntarily answer the following several Yes/No questions. No other information will be asked of clients and no personal information of any kind, other than gender, clinic OD, and clinic type will be recorded. (see “Client Exit Interview”)

The team will also do site observations while in the clinic to assess factors such as if there is privacy to do pre- or post-test HIV counseling. The team will NOT observe any counseling or listen to counseling other than to determine if voices can be heard in other parts of the clinic and will collect samples of typical referral and data collection forms.

Conduct KI interviews with Provincial AIDS Office Manager, Provincial PMTCT Coordinator, and Provincial TB Program Managers, policymakers and implementing partners at the provincial or national level to understand the organizational, financial, and human resource issues involved in implementing, monitoring, and supervising PITC. (see “Key Informant Interview: Senior Government Staff/Implementing Partners/Community Leaders”.)

This instrument is for use in individual interviews with key informants from the following groups/organizations:

- MOH (e.g., senior managers of HIV, ANC, STI, TB departments at the national level and provincial level)
- Senior managers at the facility level
- Senior managers of HIV prevention, treatment, and care and support programs
- NGOs, community-based organizations and community leaders/advocates working in HIV

The health service assessment will be conducted in Takeo, Prey Veng, and Battambang, and Phnom Penh provinces. At least three operational districts will be chosen randomly in each province and the referral or provincial hospital(s) in each OD will be included in the assessment. Therefore, a minimum of 12 clinical sites will be visited and at least 24 health care providers will be interviewed, at least 12 managers/senior staff will be interviewed, and at least 3 provincial managers will be interviewed.

One of the key issues arising in increasing access to HIV testing and counseling is to increase the uptake of the services by most-at-risk populations such as sex workers (indirect and entertainment-based), men who have sex with men, male sex workers, and injection drug users. Whereas female sex workers may interact with the health care systems by using family planning, reproductive health, or STI services, men have much lower rates of health service utilization. Some studies have shown that up to 70% of men with suspected STIs go to pharmacies first to buy drugs to self-medicate and only visit health care services when their infection does not resolve, or if they are very ill. Pharmacies are not allowed to do HIV testing. **AIDSTAR-One proposes to interview at least 5 independent pharmacy owners** in each province to ask them:

- Their knowledge of HIV testing and location of VCCT sites in their vicinity
- What proportion of their customers are male and female
- The proportion of their customers who come in with symptoms of TB or STI
- How often the pharmacist refers customers to TB, STI, or VCCT sites
- If they would be willing to do such referrals.

Interview forms will be translated into Khmer and translation-checked by the senior Cambodian consultant on the team. All the original Khmer forms will be taken to the USA by the AIDSTAR-One senior technical advisor. Quantitative and qualitative data analysis will be conducted in the USA by the technical advisor with input and review by the senior Cambodian consultant. A draft of the findings will be shared with USG Cambodia for their review and comments and then provided to the MOH for their review.

CLIENT EXIT INTERVIEW
Provider Initiated Testing and Counseling (PITC) Assessment

The purpose of this brief interview is to ask patients attending ANC, STI, TB or other appropriate clinics if they were: 1) advised to have an HIV test by a health care provider and/or 2) provided with a referral to a VCCT site as per NCHADS standard operating procedures for provider initiated testing and counseling. All patients over the age of 18 years will be approached. No information will be gathered on a person's identity, including: name, medical record number or any other direct identifiers. A person's gender and age (within the appropriate 5-year category) will be recorded. Interviews will be conducted outside the specific clinic or facility. Interview participants may decline to answer any question at any time.

Interviewer:

Hello. My name is _____. I would like to ask you a few questions about the quality of services you received today. Your name and other personal information will not be recorded. None of your answers will be shared with staff at this facility. The information will be collected and summarized in a general report. You are free to refuse to answer any question at any time but each question is an important area that we would like to get your feedback on. Your participation and your answers will not affect in any way your ability to access and utilize the services at this health facility.

Do you have any questions?

Would you like to participate in this interview?

The patient has verbally agreed to participate in this interview.

Signed by Interviewer

Print Interviewer Name

Date

If the person agrees to be interviewed let her/him decide where the interview should be conducted.

AIDSTAR-ONE PITC Assessment

OD # _____

Name of person conducting interview: _____

Name of site: _____

Location: _____

Province: _____

Type of site: _____

_____ TB

_____ STI

_____ ANC

_____ Other _____

(Interviewer: mark responses below)

C.1	Gender <i>[interviewer check one that applies]</i>	Male	Female	
C.2	What is your age? (Estimate if not sure)	[] years		
C.3	Have you ever been to this clinic before?	Yes	No (GO TO C.9)	
C.4	When you came to this clinic <u>before</u> did anyone ever recommend that you have an HIV test?	Yes	No	
C.5	When you came to the clinic before did you ever receive any information about the reason to get an HIV test?	Yes	No (GO TO C.7)	
C.6	Was this information given to you in private or in a group with other people?	Alone	In a group	
C.7	When you came to this clinic before did you ever have blood drawn for an HIV test?	Yes	No	I don't know
C.8	When you came to this clinic before did anyone ever refer you to a VCCT site for HIV testing?	Yes	No (GO TO C.10)	
C.9	Did you go to the VCCT site?	Yes (go to C9a)	No (go to C9b)	
C. 9A	Why did you go to the VCCT site?	Yes	No	
	a) did you go because a staff person recommended you to go?	Yes	No	
	b) Did you go because you wanted to know your HIV status?			
	c) Other reason (please explain)	<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px;"></div>		
C.10	Today, did anyone recommend that you have an HIV test?	Yes	No	
C.11	Did you receive any information today about the reason to get an HIV test?	Yes	No	
C.12	Was this information given to you in private or in a group with other people?	Alone	In a group	
C.13	Did you have blood drawn today for an HIV test?	Yes	No	I don't know

AIDSTAR-ONE PITC Assessment

OD # _____

C.14	Did anyone refer you today to a VCCT site to get an HIV test?	Yes	No
C.15	Which staff talked with you today about having an HIV test? <i>(read list and check all respondent mentioned)</i>	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Nursing supervisor <input type="checkbox"/> Midwife <input type="checkbox"/> Lab technician <input type="checkbox"/> Other (please specify): <input type="checkbox"/> No one spoke to me today about an HIV test	

Thank you for taking the time to do this interview

**PHARMACY INTERVIEW:
Provider Initiated Testing and Counseling (PITC) Assessment**

Interviewer:

Hello. My name is _____. Today I am here on behalf of AIDSTAR-One, a USAID project providing technical assistance to HIV programs around the world. I would like to ask you just a few questions about the kinds of customers you see at your pharmacy.

P1. First, please tell me how long has this pharmacy been open?

_____ Years

P2. What are the most common problems people come to get medicine for?

(If STI mentioned go to P4)

(If STI not mentioned ask)

P3. Do you get many customers coming here with symptoms of STI ?

_____ Yes

_____ No

_____ Don't know

P4. Are most of your STI customers male or female:

_____ Male

_____ Female

_____ Equally male and female

(If TB mentioned in P2 go to P6)

(If TB not mentioned in P2 ask)

P 5. Do you get many customers coming here with persistent cough that might indicate TB?

_____ Yes

_____ No

_____ Don't know

P6. Are most of your customers with suspected TB male or female?

_____ Male

_____ Female

_____ Equally male and female

P7. Do you ever refer customers with suspected STI to a government or NGO STI clinic?

_____ Yes

_____ No

P8. Do you ever refer customers with suspected TB to a government or NGO TB clinic?

_____ Yes

_____ No

P9. Do you know where the nearest VCCT site is?

_____ Yes

_____ No

If Yes: How far is it from your pharmacy: _____ km

P10. Do you ever refer customers with suspected STI or TB to a VCCT site?

_____ Yes

_____ No

AIDSTAR-ONE PITC Assessment

Health Care Provider

June 12 2009

AIDSTAR-One PITC Assessment

Informant # _____

KEY INFORMANT INTERVIEW: HEALTHCARE PROVIDERS

Provider Initiated Testing and Counseling (PITC) Assessment

Interviewer:

Hello. My name is _____. Today I am here on behalf of AIDSTAR-One, a USAID project providing technical assistance to HIV programs around the world. The purpose of the interview is to understand in more detail the HIV counseling and testing approaches being implemented in Cambodia. Since 2005, Cambodia has implemented provider initiated testing and counseling, or PITC, in antenatal clinics and then introduced PITC into STI and TB clinics. We would like to learn more about the process of implementing this testing and counseling approach in the clinical setting and to learn lessons Cambodia could share with other countries planning to implement PITC. The information you provide will be collected and summarized in a general report and your name will not be identified anywhere in the report. You are free to refuse to answer any question at any time but each question is an important area that we would like to get your feedback on.

Would you like to participate in this interview?

The informant has verbally agreed to participate in this interview.

Signed by Interviewer

Print Interviewer Name

Date

Do you have any questions before we start the interview?

If the person agrees to be interviewed let her/him decide where the interview should be conducted.

AIDSTAR-ONE PITC Assessment

Health Care Provider

June 12 2009

AIDSTAR-One PITC Assessment

Informant # _____

Informant Information

Location: (Phnom Penh/Province).....

Operational District:

Referral Hospital Name _____ Health Center Name _____

Provincial/National Hospital Name: _____

Kind of Clinic:

a) Public facilities

_____ ANC _____ TB

_____ STI

_____ Other: _____

Respondent information

Title:

Years at this organization: _____

Years in current position: _____

Age: _____

____ Male _____ Female

AIDSTAR-ONE PITC Assessment

Health Care Provider

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Informant # _____

KEY INFORMANT INTERVIEW: HEALTHCARE PROVIDERS Provider Initiated Testing and Counseling (PITC) Assessment

All Sites

I would like to learn from you about the implementation of provider initiated testing and counseling, or Linked Response, in Cambodia. The first implementation of PITC began in 2005 in ANC clinics to prevention mother to child transmission of HIV and then in 2006 it was expanded to TB and STI clinics. In Cambodia, health care providers in STI, TB, and ANC clinics are encouraged to advise all patients to undertake an HIV test at the nearest VCCT site as part of the Linked Response to increasing the number of people getting HIV testing.

H.1 Clinics can use several options to help patients get an HIV test and it is possible that this clinic uses more than one option. So please start by explaining the process and patient flow from the time the patient enters the clinic until they leave the clinic.

H.2 Which staff are supposed to advise the patient about getting HIV testing? (*Check those that are mentioned*) *PROBE: Anyone else?*

- _____ Nurses
- _____ Midwives
- _____ Medical Officers
- _____ Doctors
- _____ Laboratory Technicians
- _____ Nursing supervisor
- _____ Other: _____
- _____ Don't know

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Health Care Provider

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Informant # _____

H.3	Once the advice about HIV testing is given to the patient, what happens next?
<i>If pretest education is <u>not</u> mentioned above ask</i>	
H.4	<p>Is pretest information given to patients in this clinic?</p> <p>_____ Yes</p> <p>_____ No (go to H.9)</p> <p>_____ Don't know (go to H.9)</p>
H.5	<p><i>If pretest information <u>is</u> mentioned ASK:</i></p> <p>How is pre-test information provided here? <i>Read list and check all informant says apply)</i></p> <p>_____ One-on-one</p> <p>_____ Single sex-groups (only women OR only men)</p> <p>_____ Mixed Group (both women and men together)</p>
H.6	<p>Who gives the pretest information? <i>(Probe: Anyone else?)</i></p> <p>_____ Clinic staff</p> <p>_____ Home based care team member</p> <p>_____ Staff from VCCT site who comes to this clinic</p> <p>_____ Other: _____</p>
H.7	<p>How is pretest information given?</p> <p>_____ Pamphlet or other written materials</p> <p>_____ Video</p> <p>_____ Verbally</p> <p>_____ Don't know</p>

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Informant # _____

H.8	<p>What information is given to the patient as part of pretest education? (<i>Read list and check all informant says apply</i>).</p> <p>_____ Why HIV test is recommended</p> <p>_____ Benefits of HIV testing</p> <p>_____ Possible risk of HIV testing (discrimination, violence)</p> <p>_____ Confidentiality of test results</p> <p>_____ Patient's right to decline the test</p> <p>_____ If positive disclose status to partner/support person</p> <p>_____ Kinds of services available for HIV positive persons</p> <p>_____ Opportunity to ask questions</p> <p>_____ Other information: Specify: _____</p> <p>_____ Don't know</p>
H.9	<p>a. Where is blood drawn to do the HIV test?</p> <p>_____ Blood is drawn here and transported to VCCT site for testing (GO to b.)</p> <p>_____ Blood is drawn here and tested in our laboratory</p> <p>_____ Patient is advised to go on his/her own to VCCT site for blood testing (GO TO H.13)</p> <p>_____ Patient is asked to come back another day so he/she can be transported to the VCCT site (GO TO H.13)</p> <p>_____ Other:</p> <p>_____ Don't know</p> <p>b. Do you always have the money you need to transport blood to the VCCT site.</p> <p>_____ Yes</p> <p>_____ No</p> <p>_____ Don't know</p> <p>c. If NO, what are obstacles to having funds to transport the blood?</p> <p>PROBE: any other problems, any other issues</p>
H.10	<p>How is consent obtained from a patient for the HIV test?</p> <p>_____ If patient does not refuse, I assume patient consented to HIV test</p> <p>_____ Patient is asked to sign a form</p> <p>_____ Patient is asked to verbally accept or refuse test</p> <p>_____ Not sure / don't know</p> <p>_____ Other: SPECIFY</p> <p>_____ Don't know</p>

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Health Care Provider

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H.11	<p>How many patients are informed they have the right to refuse the HIV test? Would you say...</p> <p>_____ Every patient is informed</p> <p>_____ Most patients are informed</p> <p>_____ Some patients are informed</p> <p>_____ No patients are informed</p> <p>_____ Not sure/don't know</p> <p>_____ Other: PLEASE EXPLAIN</p>
H.12	<p>On average, how long does it take to get the patient's test result?</p> <p>_____ < 1 hr</p> <p>_____ one hour or more</p> <p>_____ # days</p> <p>_____ Don't know</p>
H.13	<p>What is the process of referring patients to the VCCT site? For example, is a referral form given?</p>
H.14	<p>Of the patients that come to this clinic how many are referred to the VCCT? Would you say:</p> <p>_____ All are referred</p> <p>_____ Most are referred</p> <p>_____ Some are referred</p> <p>_____ A few are referred</p> <p>_____ Not sure/don't know</p>
H.15	<p>What are some of the reasons why every patient would not received a referral to the VCCT?</p>
H.16	<p>Do you ever get feedback on how many patients are following up on the referrals given by this clinic?</p> <p>_____ Yes</p> <p>_____ No</p> <p>_____ Not sure/don't know</p>
H.17	<p>What is the distance to the closest VCCT to this clinic?</p> <p>_____ less than one kilometre</p> <p>_____ more than one kilometre: _____ how many km?</p>

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Informant # _____

H.18	<p>a. If a patient has to go on their own to the VCCT site does this clinic provide them funds to pay for transportation?</p> <p>_____ Yes: How much? _____</p> <p>_____ No: Why not?</p> <p>b. Does the clinic usually have enough money available to give to all patients to go to the VCCT?</p> <p>_____ Yes</p> <p>_____ No</p> <p>c. If NO, what are the obstacles for clinic to get money to give the patients for transport to VCCT</p>
H.19	<p>a. Does this clinic/hospital have home based care teams that take patients to the VCCT for HIV testing?</p> <p>_____ Yes</p> <p>_____ No</p> <p>_____ Don't know</p> <p>b. If yes: how often do HBC teams take patients to the VCCT</p> <p>_____ Every day, Monday through Friday</p> <p>_____ Most days</p> <p>_____ A few times a week</p> <p>_____ A few time a month</p> <p>_____ Only if needed</p> <p>_____ Don't know</p> <p>c. Do you always have enough funds for the HBC Team to transport all the patients?</p> <p>_____ Yes</p> <p>_____ No</p> <p>_____ Don't know</p> <p>If NO, why are enough funds not available? What are the obstacles?</p>
H.20	<p>When the HIV test result is ready, who provides post-test counseling in this clinic to the patient?</p> <p>_____ Clinic staff here</p> <p>_____ Home based care team member</p> <p>_____ Staff from VCCT site who comes to this clinic</p> <p>_____ Staff at the VCCT site (GO TO H. 32)</p> <p>_____ Other: _____</p>

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Informant # _____

H.21	<p>Where is post test counseling done?</p> <p>_____ Separate counseling room</p> <p>_____ Exam room</p> <p>_____ Other: _____</p>			
H.22	<p>a. Does <u>every</u> patient who has his/her HIV test done <u>at this facility</u> receive post test counseling?</p> <p>_____ Yes</p> <p>_____ No</p> <p>_____ Don't know</p> <p>b. If NO, please explain why post test counseling is not provided to every patient.</p> <p>PROBE: Any other reasons?</p>			
H.23	<p>IF ANC CLINIC STAFF SKIP TO H.25</p> <p>I am going to read a list of information that might be given during post test counseling to a patient who is HIV NEGATIVE. Could you tell me YES or NO or DON'T KNOW if this information is provided to patients at this clinic:</p>			
		Yes	No	Don't know
		1	2	3
a.	Meaning of test result	1	2	3
b.	Explanation of the window period	1	2	3
c.	Need for retesting	1	2	3
d.	Methods to prevent HIV transmission	1	2	3
e.	Patient is given condoms	1	2	3
f.	Guidance on use of condoms	1	2	3

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Health Care Provider

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Informant # _____

H.24	I am going to read a list of information that might be given to a patient who is HIV POSITIVE during post test counseling. Could you tell me YES or NO or DONT KNOW if this information if provided to patients at this clinic: (<i>read list and check all that apply</i>)			
		Yes 1	No 2	Don't know 3
a.	Discuss disclosure of test result	1	2	3
b.	Identify social support network for patient	1	2	3
c.	Methods to prevent HIV transmission to others	1	2	3
d.	Given condoms	1	2	3
e.	Guidance on use of condoms	1	2	3
f.	Healthy nutrition	1	2	3
g.	Use of bednets	1	2	3
h.	Cotrimoxazole to prevent opportunistic infections	1	2	3
i.	Assess risk of violence, suicide	1	2	3
j.	Provide specific date and time for follow-up	1	2	3
k.	Description of follow up services available at this site	1	2	3
l.	Description of follow up services in the community	1	2	3
m.	Encourage HIV testing for partner and children	1	2	3
n.	Referral to the ART/OI clinic	1	2	3
o.	Referral to the Home Based Care Team	1	2	3
p.	Information about the possibility of getting infected again with HIV	1	2	3

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Informant # _____

H.25	What actions are taken in this clinic to protect the confidentiality of a patient's HIV test result? _____ Don't know
H.26	Who are you allowed to tell about a patient's HIV test result?
H.27	What can a patient do if their HIV test results have been shared in an inappropriate way? For example, is there some sort of administrative process? Can they file a complaint?
H.28	In your opinion why don't patients follow up on referrals from this clinic? Probe: Any other reasons?

IF NOT ANC SKIP TO H.32

PREGNANT WOMEN (ANC ONLY) Read the list to the informant and circle their answer (Yes/No)				
			YES	NO
H.29	Is any of the following information is given to pregnant women before testing for HIV?	1. The risk of transmitting HIV to infant	1	2
		2. What can be done to prevent transmission from mother to infant	1	2
		3. Benefits of early diagnosis of HIV for infant	1	2
		4. Why HIV test is recommended	1	2
		5. Benefits of HIV testing	1	2
		6. Possible risks of HIV testing (discrimination, violence)	1	2
		7. Services available for HIV positive	1	2
		8. Confidentiality of test result	1	2
		9. Patient's right to decline a HIV test	1	2
H. 30	Is any of the following information is given to HIV POSITIVE PREGNANT	1. Meaning of the HIV test result	1	2
		2. Childbirth plans	1	2
		3. ARV can help prevent mother to child transmission	1	2
		4. Infant feeding choices	1	2
		5. Nutrition	1	2

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	WOMEN in post-test counseling?	6. Discuss partner HIV testing	1	2
		7. Discuss HIV testing for infant and follow-up	1	2
		8. Identify social support network for patient	1	2
		9. Provide referral information for support services for patient and/or family	1	2
		10. Provide information on treatment services for patient	1	2
		11. Methods to prevent HIV transmission	1	2
		12. Provision of condoms	1	2
		13. Guidance on use of condoms	1	2
		14. Healthy nutrition for pregnant woman	1	2
		15 Use of bednets	1	2
		16. Cotrimoxazole to reduce opportunistic infections	1	2
		17. Discuss disclosure of test result	1	2
		18. Assess risk of violence, suicide	1	2
		19. Provide specific date and time for follow-up	1	2
H.31	Do you refer HIV positive pregnant women to any of the following services?	1. HIV treatment at this facility	1	2
		2. HIV treatment at another location	1	2
		3. HIV support services at this facility	1	2
		4. HIV support services in the community	1	2
		5. Religious/spiritual advisor	1	2
		6. Infant feeding support services	1	2

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TRAINING/ORIENTATION TO Linked Response		YES	NO	
H.32	Does this clinic have the standard operating procedure for implementing the Linked Response?	1	2 (SKIP TO H.34)	
H.33	Can you show me a copy of the SOP? <i>(Circle yes only if informant can actually show you the document)</i>	1	2	
H.34	What changes were made in the clinic to implement the Linked Response? For example, did a counseling room have to be found or built? <i>(Probe: Any other changes?)</i>			
		YES	NO	Don't remember
H.35	Were you trained or given an orientation on how to implement the Linked Response?	1	2 (GO to H.38.)	3
H.36	What of these topics were included in your training for Linked Response?	1	2	3
	a. Pretest information that should be provided to the patient	1	2	3
	b. How to practice confidentiality and privacy	1	2	3
	c. The patient's right to refuse HIV testing	1	2	3
	d. How to make referrals to the VCCT site	1	2	3
	e. How to make referrals to TB, ANC or STI clinics	1	2	3
	f. Post test counseling information that should be provided to the patient with the HIV test result	1	2	3
	g. Referrals for HIV positive patients	1	2	3
	h. How to address stigma and discrimination	1	2	3
	i. Specific skills for addressing children	1	2	3
	j. Specific skills and information for addressing pregnant women	1	2	3
k. Other information PLEASE SPECIFY				

Informant # _____

H.37	a. Do you think that the training or orientation you received for Linked Response was sufficient?	1	2
	b. If NO, what information do you wish that you had received in that training?		
H.38	<p>The World Health Organization is recommending that HIV testing done in ANC, TB, and STI clinics rather than refer patients to VCCT sites. This change would increase the number of people who get tested and know their test results and get treatment early.</p> <p>a. How could this approach be implemented in this clinic?</p> <p><i>(PROBE)</i> What else could be done to implement doing HIV testing and giving test results in this clinic?</p>		

WRAP UP (ALL INFORMANTS)

H.39	<p>What do you think would be the advantages of doing HIV testing in this clinics?</p> <p>Probe: What other advantages could there be?</p>
H.40	<p>What do you think would be the disadvantages of doing HIV testing in this clinic?</p>

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Health Care Provider

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H.41	Has your clinic experienced any barriers to implementing the Linked Response ?
	IF <u>NOT</u> ANC CLINIC ASK:
H.42	<p>Are most of the patients who come here men or women?</p> <p>_____ Men (GO TO H.44)</p> <p>_____ Women</p> <p>_____ About equal (GO TO H.45)</p>
H.43	<p><i>(IF MOSTLY WOMEN ASK)</i></p> <p>a. Why do you think fewer men come to this clinic?</p> <p>b. What kinds of changes could be made at the clinic to encourage more men to come here?</p>
H.44	<p><i>(IF MOSTLY MEN ASK)</i></p> <p>a. Why do you think fewer men come to this clinic?</p> <p>b. What kinds of changes could be made at the clinic to encourage more women to come here?</p>
H.45	What do you see as the biggest challenges that patients face when wanting to get an HIV test?

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THANK YOU FOR YOUR TIME TO PROVIDE THIS IMPORTANT INFORMATION

ADDITIONAL NOTE PAGES

AIDSTAR-ONE PITC Assessment

Senior Staff

OD _____

Informant # _____

June 5 2009

KEY INFORMANT INTERVIEW: SENIOR GOVERNMENT STAFF

Provider Initiated Testing and Counseling (PITC) Assessment

Interviewer:

Hello. My name is _____ . Today I am here on behalf of AIDSTAR-One, a USAID project providing technical assistance to HIV programs around the world. The purpose of the interview is to understand in more detail the HIV counseling and testing approaches being implemented in Cambodia. Since 2005 Cambodia has implemented provider initiated testing and counseling in antenatal clinics. In 2007 the Linked Response introduced into STI and TB clinics. We would like to learn more about the process of implementing the Linked Response. The information you provide will be collected and summarized in a general report and your name will not be identified anywhere in the report. You are free to refuse to answer any question at any time but each question is an important area that we would like to get your feedback on.

Would you like to participate in this interview?

The patient has verbally agreed to participate in this interview.

Signed by Interviewer

Print Interviewer Name

Date

Do you have any questions before we start the interview?

If the person agrees to be interviewed let her/him decide where the interview should be conducted.

AIDSTAR-ONE PITC Assessment

Senior Staff

OD _____

Informant # _____

June 5 2009

Informant Information

Location: (Phnom Penh/Province).....

Operational District:

Referral Hospital Name _____ Health Center Name _____

Provincial: _____

Kind of Clinic:

a) Public facilities

_____ ANC

_____ TB

_____ STI

Respondent information

Title:

Years at this organization: _____

Years in current position: _____

Age: _____

____ Male _____ Female

AIDSTAR-ONE PITC Assessment

Senior Staff

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Informant # _____

June 5 2009

KEY INFORMANT INTERVIEW: SENIOR GOVERNMENT STAFF Provider Initiated Testing and Counseling (PITC) Assessment

Background				
I would like to learn from you about the implementation Linked Response, in Cambodia. In Cambodia health care providers in STI, TB, and ANC clinics are encouraged to advise all patients to undertake an HIV test at the nearest VCCT site as part of the Linked Response to increasing the number of people getting HIV testing.				
M.1	What is your role right now in responding to HIV in this province?			
M.2	<p>Have you ever heard of the term “Linked Response”?</p> <p>_____ Yes _____ No</p> <p>If YES: Tell me in your own words the meaning of the linked response?</p> <p>If NO: Say to respondent: LR is encouraging staff in ANC, STI, and TB clinics to refer all patients to VCCT or to give pre-test education, draw the blood for HIV testing, and in some cases, do post-test counseling. Is that process going on in clinics in this province?</p>			
M.3	Which institutions and organizations are involved in implementation of the Linked Response?			
M.4	During the planning for implementing Linked Response was there any discussion about how women or men might be affected differently based on how it was to be implemented?	Yes 1	No 2	Don't Know 3

AIDSTAR-ONE PITC Assessment

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	<p>If YES, what kinds of issues came up?</p>
	<p>If NO, why do you think gender was not discussed?</p>
<p>Implementation of LINKED RESPONSE</p>	
<p>M.5</p>	<p>For HEAD OF REFERRAL</p> <p><i>When a patient comes to an STI, ANC, or TB clinic what is the procedure for recommending an HIV test?</i></p> <p>SKIP TO M.9</p>
<p>M.6</p>	<p><i>If Manager of TB clinic ask:</i></p> <p>When a patient comes to a TB clinic, what is the procedure now for recommending an HIV test?</p> <p>_____ Don't know</p> <p>SKIP TO M.9</p>
<p>M.7</p>	<p><i>If Manager of ANC clinic ask:</i></p> <p>When a patient comes to an ANC clinic, what is the procedure for recommending an HIV test?</p> <p>_____ Don't know</p> <p>SKIP TO M.9</p>

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M.8	<p><i>If Manager of STI clinic ask:</i></p> <p>When a patient comes to an STI clinic, what is the procedure for recommending an HIV test?</p> <p>_____ Don't know</p>		
M.9	<p>Many patients don't follow up on referral to the VCCT site. Do you have any suggestions on how to improve referrals between clinics and VCCT sites?</p>		
M.10	<p>Can you share with me any success stories of implementing Linked Response in your OD or province?</p>		
M.11	<p>Are any of the following factors barriers to the implementation of LINKED RESPONSE in your hospital/district/OD?</p>		
	(Read the list and circle Answer)	Yes	No
	1. Staffing	1	2
	If yes, please explain.		
	2. Supplies	1	2
	If yes, please explain.		
	3. Training	1	2
	If yes, please explain.		
	4. Monitoring	1	2
	If yes, please explain.		

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Senior Staff

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	5. Funding	1	2
	If yes, please explain.		
	6. Community Support	1	2
	If yes, please explain.		
	7. Other MOH programs	1	2
	If yes, please explain.		
	8. Are there any other groups or individuals who are opposed to the implementation of LINKED RESPONSE?	1	2
	If yes, please explain.		
<i>The 3 C's of HIV C&T</i>			
M.12	What are staff in the clinics doing to protect the confidentiality of a patient's HIV test result? (Probe: Anything else?) ____ Don't know		
M.13	Are there any policies or laws regarding protecting a patient's confidentiality? ____ Yes ____ No ____ Not sure/don't know		

AIDSTAR-ONE PITC Assessment

Senior Staff

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M.14	<p>What can a patient do if they feel their HIV status has been shared without their consent?</p>
M.15	<p>How is <u>consent</u> for HIV testing currently obtained in STI, TB, and ANC clinics? (Probe: Anything else?)</p> <p>___ Don't know</p>
M.16	<p>Which clients are getting counseling before and after HIV testing is done?</p> <p>If not ALL, then ask "What are the reasons not all patients are getting counseling?"</p>
M.17	<p>The World Health Organization has recommended that routine HIV testing and counseling be offered and performed at the STI, TB, and ANC clinics to increase access for patients for HIV testing. This would mean the patient would receive their results immediately, fewer patients would be lost to follow-up, and more patients referred to care sooner.</p> <p>In your opinion, how could the WHO recommended HIV testing approach be introduced at these clinic sites?</p> <p>PROBE: What else would have to be done to follow WHO recommendations?</p>

AIDSTAR-ONE PITC Assessment

Senior Staff

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M.18	<p>Right now only laboratory technicians do the rapid blood test. Would any policies need to be changed to allow nurses, midwives, or other staff to do the rapid test?</p> <p>___ Yes ___ No ___ Don't know</p>
M.19	<p>If this approach was introduced in Cambodia, do you think the following groups would be supportive or not supportive <i>(Read the list and check informant's answer)</i></p>
	<p>1. PLWHA groups _____ Supportive _____ Not supportive; Why not?</p>
	<p>2. General public _____ Supportive _____ Not supportive; Why not?</p>
	<p>3. Health Care Providers _____ Supportive _____ Not supportive; Why not?</p>
	<p>4. NCHADS _____ Supportive _____ Not supportive; Why not?</p>
	<p>5. CENAT _____ Supportive _____ Not supportive; Why not?</p>
	<p>6. NMCHC _____ Supportive _____ Not supportive; Why not?</p>
M.20	<p>How would you protect confidentiality in the clinic if the WHO recommendation was implemented?</p> <p>___ Don't know</p>

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M.21	<p>How would <u>counseling</u> be done in the clinic if the WHO recommendation was implemented?</p> <p>___ Don't know</p>
M.22	<p>How would <u>consent</u> for HIV testing be ensured if the WHO recommendation was implemented?</p> <p>___ Don't know</p>
M.23	<p>Is there anything else you would like to tell me about the Linked Response in your province?</p>

Thank you for taking the time to speak with me today.

AIDSTAR-ONE PITC Assessment

Senior Staff

OD _____

Informant # _____

June 5 2009

ADDITIONAL NOTES

APPENDIX 2

PROVIDER-INITIATED TESTING AND COUNSELING ASSESSMENT ITINERARY

June 2009						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
31	1	2	3	4	5	6
				Meeting with Kai Testing with Health providers in PP		
PNP → 7 Leave for BTB (morning)	OD North 8 Sampeou Loun	OD South 9 Thmar Kaul	OD West 10 Battambang	MCH, NCHARD, 11 TB/STI Pharmacy, Health Care providers	12 Return to PNP	13 Dr. Kem Ley + Socheata
- Takeo → 14 - Prey Veng → Leave PNP (afternoon)	Kirivong 15 Preah Sdech	Ang Roka 16 Prey Veng	Daun Keo 17 Neak Loeung	Independent 18 Pharmacies Pharmacies + Prov. Health Dept	19 Return to PNP	20 Dr. Kem Ley + Socheata
21	22	23	24	25	26	27
28	29	30				

APPENDIX 3

FINDINGS FROM FAMILY HEALTH CENTERS

Three of the STI sites included in the assessment were FHCs in PNP. In 2007, NCHADS established these FHCs in public health facilities and private clinics for diagnosis and treatment of STI for DFSWs, EWs, and MSM. FHCs refer patients for VCCT, which is sometimes located at the same facility. The findings from the FHCs were incorporated into the findings overall and have been disaggregated here.

In 2007, NCHADS established a number of specialty STI clinics, called FHCs, for DFSW, EW, and MSM. These clinics are set up in public health facilities and in NGO private sector clinics. They provide diagnosis and treatment of STIs and make referrals to VCCT sites, some of which are located at the same facility as the FHC. Three of the STI sites visited by the AIDSTAR-One team in PNP were FHCs. Six clients, three staff, and four VCCT staff were interviewed. Given that these are specialty clinics for MARPs, the frequency of referrals may be higher than at other sites included in this assessment. Data for these sites are presented in the following section.

HEALTH CARE PROVIDER RESPONSES

Two of the three HCPs said they provided pre-test information to clients. Two of the three HCPs stated that they refer clients to the VCCT sites, and one HCP reported that clients are asked to return another day to be transported to the VCCT site. When asked how referrals are made, HCPs said: “staff fill out a referral card and send clients to the VCCT site,” “we get the clients consent and have them sign a consent form, then we refer them to the VCCT site,” and “we don’t fill out a referral form, we tell them to go to the VCCT site directly.” Two of the three HCPs said that “most” clients are referred to the VCCT site and one HCP said “a few” were referred. When asked why not all clients were referred, responses included, “Because the client is already positive so there is no need to do so” and “staff only refer clients with STI symptoms.” At the time of the assessment, two of the three HCPs reported getting routine feedback on the referrals they made to the VCCT site.

When asked about the feasibility of introducing rapid HIV testing into the FHC, one HCP said, “It is not really needed, FHC and VCCT services are established. We need to expand education about services to the population.” Another noted, “Doing rapid testing here would make it easy for every client that comes to the clinic to get HIV testing.”

When asked what the disadvantages might be of providing HIV testing in FHCs, one HCP said there were no disadvantages. One HCP said the disadvantages were, “Staff are already busy. We work not only in the daytime but also in the evening. We have hours when we work with peer outreach workers and visit brothels to make appointments for DFSW to come for monthly STI check-ups.” Another HCP said, “The workload is already high, if we did testing the clients would

have to wait for a long time to get their results. We don't have many staff and in Phnom Penh, STI clinic staff also work in other clinics and have other duties as well, for example giving out food supplements to pregnant women. We are covering four positions not just the STI clinic."

When asked what the barriers were for clients to follow-through on the VCCT referral, one FHC staff replied that, "All the clinic services work at different times; when VCCT staff come in, the STI staff may not be in the clinic. When STI staff refer clients to the VCCT site, staff are not there. Coordination between clinic staff is not good, except for a few hours in the morning." The other two informants thought there were no barriers.

When asked about the challenges clients experience getting an HIV test, one HCP said, "The behavior of some health care providers is a challenge in terms of how they talk to the clients, sometimes they speak rudely to the clients." Another HCP said, "Men go out at night so there is no trust between the couple and then husbands refuse to get an HIV test. When they do decide to get tested, they have a serious illness so then they cannot travel [to a VCCT site]."

In the three FHCs visited by the AIDSTAR-One team, HCPs reported that women were the majority of clients using the services.

FAMILY HEALTH CENTER CLIENT RESPONSES

All clients were female, with an average age of 30 years. Four of the six clients (67 percent) had been to the FHC before, and of those four, three (75 percent) had received a recommendation to get an HIV test. During a previous visit, all FHC clients had received one-on-one pre-test information. Three of four who had visited the clinic previously were given information about why they should get an HIV test. Three of the four who had attended the clinic before had had their blood drawn for an HIV test, and all those who had blood drawn were referred to the VCCT site. When asked if they went to the VCCT site, three of four said yes.

During this current visit, four of the six clients (67 percent) received a recommendation to get an HIV test, and three of the six received information about why to get an HIV test. All three clients agreed to have their blood drawn for an HIV test and were referred to the VCCT site to collect results and get post-test counseling.

For more information, please visit aidstar-one.com.

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