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ឆ្នាំ ២០០៤-២០០៧

**STRATEGIC PLAN FOR  
HIV/AIDS AND STI PREVENTION AND CARE  
MINISTRY OF HEALTH, CAMBODIA  
2004-2007**

SECOND EDITION, SEPTEMBER 2004



មជ្ឈមណ្ឌលជាតិប្រយុទ្ធនឹងជំងឺអេដស៍ សើស្បែក និងកាមរោគ

Ministry of Health  
National Center for HIV/AIDS, Dermatology and STD

បោះពុម្ពលើកទី២ ខែកញ្ញា ឆ្នាំ២០០៤

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**KINGDOM OF CAMBODIA**  
**Nation Religion King**



**STRATEGIC PLAN FOR HIV/AIDS AND STI  
PREVENTION AND CARE,  
MINISTRY OF HEALTH, CAMBODIA  
2004-2007**



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## LIST OF ABBREVIATIONS

<b>ADB</b>	Asian Development Bank
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral
<b>AusAID</b>	Australian AID
<b>BCC</b>	Behaviour Change Communication
<b>BSS</b>	Behavioural Surveillance Survey
<b>CARE</b>	
<b>CAT</b>	Central Advisory Team
<b>CDC</b>	Communicable Disease Control
<b>CDC-GAP</b>	Centre for Disease Control-Global AIDS Program
<b>CMAC</b>	Cambodia Mines Advisory Committee
<b>CMS</b>	Central Medical Stores
<b>CoC</b>	Continuum of Care
<b>COTF</b>	Central Outreach Task Force
<b>CPA</b>	Complementary Package of Activities
<b>CSES</b>	Commercial sex and entertainment services
<b>CU</b>	Condom Use
<b>CUMEC</b>	Condom Use Monitoring and Evaluation Committee
<b>CUWG</b>	Condom Use Working Group
<b>DFID</b>	Department for International Development
<b>FAC</b>	French Cooperation
<b>FHI</b>	Family Health International
<b>HBC</b>	Home-based care
<b>HC</b>	Health Centre
<b>HFBC</b>	Health Facility Based Care
<b>HIS</b>	Health Information System
<b>HIV</b>	Human Immuno-deficiency Disease
<b>HSS</b>	HIV Sero-Surveillance
<b>IC</b>	Institutional Care
<b>IEC</b>	Information, Education and Communication
<b>INGO</b>	International Non-Governmental Organization
<b>ITF</b>	Interim Trust Fund
<b>Khana</b>	Khmer HIV/AIDS NGO Alliance
<b>MCH</b>	Maternal and Child Health
<b>MMM</b>	'Mondul Mith Chuoy Mith' – 'Friends help Friends' centre
<b>MoH</b>	Ministry of Health
<b>MPA</b>	Minimum Package of Activities
<b>MSF</b>	Medecins sans Frontieres
<b>NAA</b>	National AIDS Authority
<b>NBP</b>	National Blood Policy
<b>NBTC</b>	National Blood Transfusion Centre
<b>NCHADS</b>	National Centre for HIV/AIDS, Dermatology and STDs
<b>NCHP</b>	National Centre for Health Promotion
<b>NGO</b>	Non-Governmental Organization
<b>NIPH</b>	National Institute of Public Health
<b>OD</b>	Operational District

<b>OI</b>	Opportunistic Infection
<b>PAO</b>	Provincial AIDS Office
<b>PHD</b>	Provincial Health Department
<b>PLWHA</b>	Person/People living with HIV or AIDS
<b>PMTCT</b>	Preventing mother-to-child transmission
<b>POT</b>	Provincial Outreach Team
<b>PSF</b>	Pharmaciens sans Frontieres
<b>PSI</b>	Population Services International
<b>PTC</b>	Provincial Transfusion Centre
<b>QSA</b>	Quaker Services Abroad
<b>RH</b>	Referral Hospital
<b>SCF</b>	Save the Children Fund
<b>SG</b>	Support Group
<b>SSS</b>	STI Surveillance Survey
<b>STD</b>	Sexually Transmitted Disease
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>TBA</b>	Traditional Birth Attendant
<b>TOT</b>	Training of Trainers
<b>TWG</b>	Technical Working Group
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>UNICEF</b>	United Nations Children's Fund
<b>UP</b>	Universal Precautions
<b>US\$</b>	United States' dollars
<b>USAID</b>	United States Agency for International Development
<b>VCCT</b>	Voluntary Confidential Counselling and testing
<b>WG</b>	Working Group
<b>WHO</b>	World Health Organization

## **ABBREVIATIONS FOR PROVINCES IN CAMBODIA**

<b>BMC</b>	Bantey Meanchey
<b>BTB</b>	Battambang
<b>KCM</b>	Kampong Cham
<b>KCN</b>	Kampong Chhnang
<b>KDL</b>	Kandal
<b>KEP</b>	Kep
<b>KHK</b>	Koh Kong
<b>KPT</b>	Kampot
<b>KRT</b>	Kratie
<b>KSP</b>	Kampong Speu
<b>KTM</b>	Kampong Thom
<b>MDK</b>	Monduliri
<b>OMC</b>	Oddar Meanchey
<b>PLN</b>	Pailin
<b>PNP</b>	Phnom Penh
<b>PST</b>	Pursat
<b>PVG</b>	Preh Veng
<b>PVH</b>	Preah Vihear
<b>RNK</b>	Rattanakiri
<b>SHV</b>	Sihanoukville
<b>SRP</b>	Siem Reap
<b>STG</b>	Stung Treng
<b>SVG</b>	Svey Rieng
<b>TKV</b>	Takeo

## ACKNOWLEDGEMENTS

I would like to acknowledge the high quality contribution, enthusiasm and hard work from all stakeholders that has gone into the successful review and updating of the Strategic Plan for HIV/AIDS Prevention and Care 2004-2007 in the health sector.

This up-dated Strategic Plan for HIV/AIDS Prevention and Care 2004-2007 represents a major achievement for the HIV/AIDS and STD programme in the health sector in Cambodia, for three reasons. First, it is recognition of the value and contribution of all stakeholders and partners. The NCHADS programme is not just a programme directed by NCHADS alone – Provincial Departments and staff, and NGO partners, all have key roles to play. Secondly, it represents a determined effort to learn practical lessons from implementation, to listen to the advice of technical experts expressed through the Mid-term Assessment, and to respond to the changing epidemiological situation in the country. And thirdly, it recognises the importance of expressing the HIV/AIDS and STD strategy within the context of the overall Health Sector Strategy, and integrating the HIV/AIDS and STD programme into the Health Sector programme.

I would like to thank the staff of the NCHADS Technical Bureau for coordinating this review and revision of the Strategic Plan; the technical units for ensuring that the technical components are evidence-based and cost-effectively designed; the staff of the Monitoring, Reporting and Evaluation Unit of NCHADS for helping establish the targets for M&E; the OD, PAO and PHD staff for their practical contributions to ensure that this is a workable strategy; and most important the partners and members of the various Technical Working Groups, from other departments, donors and agencies, and from civil society, for their unstinting contributions. I hope we will all be able to implement with the same enthusiasm and skill we have strategized.

Thank you.

Phnom Penh, June 18, 2004  
Director of NCHADS



Dr. Mean Chhi Vun

## Preface

This Strategic Plan was originally prepared by the National Centre for HIV/AIDS, Dermatology and STD Control within the Ministry of Health in 2000. It was prepared after two workshops involving NCHADS and Ministry of Health staff and staff from Provincial Head Departments, including a number of Provincial Health Directors, and a number of internal meetings and reviews. A final draft was circulated to all the NCHADS' partners for comments, which have been incorporated.

This revised and updated version was prepared following the Mid Term Assessment of the Strategic Plan in July 2003, supported by CDC-GAP, USAID, DFID, WHO and UNSW. Component sections were drafted by NCHADS, and then extensively reviewed by all stakeholders in the Technical Working Groups for each component.

The purpose of this Strategic Plan is to be a framework for:

- identifying medium-term, coherent and cohesive, cost-effective plans for shaping the response to HIV/AIDS and STIs
- the preparation of annual operational plans for implementation
- identification of resource needs, and gaps in available resources, both human and financial
- formulating requests for assistance, that match donors' priorities and mandates, but also fit with the needs and priorities of the Government of Cambodia
- coordination of activities, plans, strategies and resources of all kinds from all sources.

This Strategic Plan is also intended, on the one hand to clearly spell out the role of the Ministry of Health within the overall National Strategy for the HIV/AIDS Epidemic being coordinated by the National AIDS Authority, and on the other hand, clearly identify where responding to HIV/AIDS and STIs fits into the Ministry of Health's overall Health Sector Strategy Plan for Cambodia.

Phnom Penh, June 21, 2004 ✱



**Prof. Eng Huot**  
**Director General for Health**

**MINISTRY OF HEALTH**  
**STRATEGIC PLAN for HIV/AIDS and STI PREVENTION and CARE**  
**in CAMBODIA, 2004-2007**

## **1. INTRODUCTION**

### **1.1 Background**

Cambodia is a small country in the centre of the Indo-china peninsula. The population of approximately 15 million (11.4 million at the 1998 Census) lives in 2.2 million households, in 13,406 villages in 24 provinces. The capital, Phnom Penh, has a population of 999 804; there are only 3 other towns over 100,000 population: Battambang, Sihanoukville and Siem Reap. While the population is predominantly rural (84%), population density rates vary widely, from under 12 people per square kilometre in six provinces (Oddar Mean Chey, Stung Treng, Rattanakiri, Preah Vihear, Mondolkiri and Koh Kong) to over 100 per square kilometre in seven (Kampong Cham, Kampot, Kandal, Prey Veng, Sihanouk Ville, Svay Rieng and Takeo); and 3448 in Phnom Penh itself.

Health status indicators are still low: the recent Joint Annual Health Sector review of the MoH gives MMR at 437/100,000, IMR at 95/1000, UFR at 124/1000, TFR at 3.8, and a population growth rate of 2.5%. Poverty indicators are similarly poor: Female adult literacy rate is 57%, Net enrolment in primary school is 67%, average household monthly expenditure is only US\$104, with average household monthly expenditure on health at 22% of total household monthly expenditure.

### **1.2 HIV/AIDS in Cambodia**

#### ***1.2.1 The Epidemic in Cambodia***

A programme of sero-surveillance surveys has been conducted in the country since 1995; and behavioural surveys since 1997. From these surveys a picture of the epidemic in Cambodia is emerging of changing behaviour and declining prevalence. Prevalence in high risk situations, such as among brothel-based sex workers, by 2002 was nationally 28.8%, down from 31.5% in 2000, and 42.6% in 1998. There are estimated to be between 10,000 and 20,000 'direct' sex workers in the country; and possibly a further 10,000 indirect sex workers - among whom the prevalence rate was 14.8% in 2002. Incidence rates halved between 1999 and 2001 for brothel-based sex workers, from 13.9% to 6.45% per year; among 'indirect' sex workers from 5% to 2.87%, and more dramatically among police from 1.74% to 0.26% per year. Consistent condom use rates are reported by brothel-based sex workers to have risen from 51% in 1998 to 96% in 2003. The proportion of urban policemen who have purchased sex has fallen from 75% in 1997 to 47% in 2003. Overall prevalence in the general population, among adults aged 15-49 years, is estimated to have fallen from 3.3% in 1998 to 2.6% in 2002.

These decreases in prevalence have been matched, however, with a significant increase in the numbers falling ill and progressing to AIDS. Projections suggest that in 2002 164,000 people in Cambodia were infected with HIV; by the end of that year over 94,000 young people had already died as a result of HIV infection; and currently over 25,000 were living with AIDS. During 2003 another 22,000 developed serious AIDS related illnesses requiring medical care. It is estimated that in Cambodia over 50% of all deaths among men, and 46% among women, are HIV-related.

### ***1.2.2 Current Responses and Resources***

The Government established its National AIDS Programme in 1993. In 1998 this was upgraded to be the National Centre for HIV/AIDS, Dermatology and STDs. In 1999 the National AIDS Authority was established, to provide coordination and policy support, and resource mobilisation, at the highest level. A variety of other players are involved. International NGOs have been active in the field for many years, with increasing numbers of local NGOs getting involved. Some of these INGOs (eg FHI, MSF, PSF, CARE, Centre of Hope, PSI, World Vision, MdM, URC, POLICY) operate on a large scale, many funded by USAID, and are significant partners with government, as are local NGOs such as RACHA, RHAC, and Khana. The UN System, through both UNAIDS, and also directly through WHO and UNICEF, has been supporting the government programme for many years. A previous World Bank credit, and current Asian Development Bank and World Bank Grants along with DFID and CDC-GAP grants provide the bulk of government's input – though National Budget support, through the PAP, has increased significantly over the last few years. Other bi-lateral donor support has come from French Cooperation, the European Union and AusAID, with additional support from ITM, UNSW and Roche. The newly established Global Fund for AIDS, TB and malaria is becoming a significant donor, with three rounds of grants already approved.

Current expenditures in support of the Strategic Plan in the health sector are currently approximately US\$22 million a year; the National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS), under the Ministry of Health, is the lead coordinating agency, and itself manages a budget of some \$8 million.

## **2. DEVELOPMENT OF POLICY AND STRATEGIES FOR HIV/AIDS and STI PREVENTION and CARE in the HEALTH SECTOR**

### **2.1 The National Policy**

The **National Policy and Priority Strategies for HIV/AIDS Prevention and Control in the Kingdom of Cambodia from 1999 to 2004**, developed by the National AIDS Authority in 1999, identified five areas in which the Ministry of Health has an important role to play. These were:

- promoting knowledge and understanding on HIV/AIDS both for the general population and for vulnerable populations;
- the establishment of the 100% condom use programme focusing on situations of high risk of transmission of HIV;
- ensuring that the population has access to efficient and effective prevention services such as blood safety, and prevention of mother-to-child transmission;
- ensuring that persons living with HIV/AIDS have access to a range of care services in an atmosphere of tolerance and respect for human rights;
- strengthening health information systems and conducting research.

In line with the Policy and Strategies, a **National Strategic Plan for STD/HIV/AIDS Prevention and Care 1998-2000** was developed by the Ministry of Health, which identified 12 strategic areas in which activities were to be undertaken.

## **2.2. Review of the National Strategic Plan**

Early in 2000, however, and as a result of the clarification of sectoral roles for various Ministries by the **National AIDS Authority** (NAA), and analysis of the epidemiological and behavioural data from the HIV Sero-surveillance (HSS) and Behavioural Surveillance Surveys (BSS), the **National Centre for HIV/AIDS, Dermatology and STDs** (NCHADS) undertook a review of the National Strategic Plan. In this review, NCHADS reduced the number of strategic areas to 8, reviewed the objectives within each in the light of what has been achieved so far, and the experience of the last five years, and sharpened the activities, or Strategic Goals necessary to achieve the objectives. This became the health sector **Strategic Plan for HIV/AIDS and STD Prevention and Care, 2001-2005**. Under this Strategic Plan, NCHADS developed a series of specific *Policies* (eg for Testing, for STDs, for Blood Safety, etc), *Strategies* (eg for Surveillance, for AIDS Care, for Outreach, for STD Management, etc), *Guidelines for the Introduction and Implementation* of various programmes and interventions (eg 100% Condom Use, Home-based Care, Counselling and Testing, STD services), and *Training packages* (eg Syndromic Management of STDs, Strengthening Provincial HIV/AIDS Programmes, etc). These have all been used to establish activities and programmes both at Central and Provincial level.

## **2.3 The Health Sector Strategy for HIV/AIDS and STI Prevention and CARE (2001-2005)**

The Health Strategy for HIV/AIDS and STI Prevention and Care (2001-2005) was based upon three concepts:

- That a series of high risk situations for HIV transmission exist in the country: these situations arise from the behaviour of large numbers of both married and single men, who continue to buy large amounts of commercial sex. This behaviour is confirmed by the recent round of the BSS, where over 50% of men in all main groups (except students) have visited a commercial sex worker in the last one year; in 20% to 30% of these encounters condom were specifically not used. At the same time, large concentrations of commercial sex services exist at a number of places in the country, in which HIV prevalence rates among sex workers are high - often over 40% as confirmed by the HSS. These concentrations of sex services, the behaviour of men, and the high HIV prevalence levels, create situations of high risk of transmission of HIV, and thus significant pools of infection.
- That the HIV prevalence rates among men throughout the country are already sufficiently high that the spread, via their wives and girl friends, into the general population, and eventually into children, is already taking place.
- That sufficient numbers of HIV infections already exist in the country that a significant burden of increased morbidity and mortality is inevitable.

The strategy responded to these three concepts directly by focusing on three elements:

- The need to reduce transmission in high risk situations through targeted STI care and increased condom use
- The need to provide awareness-raising, counseling, and testing services to the general population
- The need to equip the health system to cope with the increased demand for care.

These three elements were expressed in eight (8) areas of primary focus:

1. HIV/AIDS and STI Awareness and Education; which includes both IEC and Outreach activities for high risk situations
2. 100% Condom Use
3. STI Services
4. Blood Safety
5. Preventing Mother-to-Child-Transmission (PMTCT)
6. AIDS Care; which includes Institutional and Home-based Care, Hospices and Self-help Groups, Counseling, Testing, and Universal Precautions
7. HIV/AIDS and STI Surveillance and Research
8. Strengthening the Planning and Coordination of Programme Management; which includes both horizontal technical support for other sectors and institutions, and vertical support for decentralization to Provinces, and integration within the health sector

Within each area of focus a number of critical Objectives and Strategic Goals were identified, and Targets established for the first three years of the five year period.

#### **2.4 The National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS in Cambodia 2001-2005 (NAA)**

In 2001 the National AIDS Authority developed a comprehensive, national strategic plan, based on two complementary approaches in support of decreasing the vulnerability to HIV/AIDS at the individual, community and societal level. The first approach concentrates on influencing individuals to understand that safer behaviour is a more attractive option, whereas the second strategy focuses on changing aspects of the existing socio-economic context to support individuals to protect themselves from HIV infection and to cope with the consequences of HIV/AIDS. This Plan elaborated seven strategies to ensure that the goals of the national strategic plan were met. These are:

- Empowering the individual, the family and community in preventing HIV and dealing with the consequences of HIV/AIDS through the promotion of a social, cultural and economic environment that is conducive to the prevention, care and mitigation of HIV/AIDS.
- **Enhancing legislative measures and policy development.**
- Strengthening the managerial structures, processes and mechanisms to increase the capacity for coordinating, monitoring, and implementing HIV/AIDS actions, and enhance cooperation with stakeholders at national and international levels.
- Strengthening and expanding preventive measures which have proved to be effective and piloting other interventions.
- Strengthening and expanding effective actions for care and support which have proved to be effective and piloting “new” interventions.
- Strengthening national capacity for monitoring, evaluation and research.
- Mobilizing resources to ensure adequate human capacity and funding at all levels.

The National Plan indicates the roles and responsibilities of various sectoral ministries in achieving the overall goals of the national strategy.

## **2.5 The Health Sector Strategic Plan 2003-2007**

Towards the end of 2002, the Ministry of Health developed an overall health sector Strategic Plan. This Strategic Plan is based on a comprehensive Policy Statement, a detailed situation analysis and annual health sector reviews, and spells out goals, targets, and with 6 core strategies:

- Health service delivery
- Behaviour change
- Quality improvement
- Human resource development
- Health financing
- Institutional development.

The Plan also outlines a series of implementation issues, covering resources and legislation, change management, financing, planning and budgeting, monitoring and evaluation, and the various partnerships important to the Ministry. HIV/AIDS and STDs are included in the core Health service delivery strategy, under 'Strengthening the management of cost-effective interventions to control communicable diseases', in this Plan.

## **2.6 Mid Term Assessment of the NCHADS Strategic Plan**

Within this developing institutional context, in 2003 NCHADS undertook a Mid-Term Assessment of its Strategic Plan, with technical assistance from CDC-GAP, WHO, the University of New South Wales and DFID. This Mid-Term Assessment considered the changing epidemiological situation, technical aspects of strategy design and implementation, and administrative and managerial aspects of programme implementation. It found significant changes in all four main areas.

Epidemiologically the escalating HIV epidemic in Cambodia since the early 1990s is now producing an expanding need for HIV/AIDS care, as people progress to advanced and symptomatic HIV disease. This is producing changes in morbidity and mortality patterns in the country, and an overall increase in "demand" for health care, compared to any previous baseline. The increased number of people dying partly explains the reduction of the overall prevalence of HIV in the country, as people already infected start to disappear. However, the number of new HIV infections each year has also dropped, particularly among young people, as prevention strategies take effect. Coupled with the increasing availability and affordability of HAART, these changes are being reflected in an increasing emphasis on improving access to, and provision of, quality treatment and care for people living with HIV and AIDS (PLHA).

Managerially NCHADS itself has developed greatly in the three years since the Strategic Plan was approved. In late 2003 NCHADS reformed its management structure, revised and updated the Functional Task Analysis, and introduced a scheme for Performance Based salary incentives for staff, with DFID funding.

Technically, there has been a significant development with the formation of a number of Technical Working Groups (TWGs), involving all partners and stakeholders, to identify, assess and inform strategic planning. This has not only increased the level of technical input into planning and design of the programme; it has also greatly increased the interest and willingness of partners to work together. A formal mechanism has been

introduced, for example, whereby partners with NCHADS develop Memoranda of Understanding which are jointly signed, laying out cooperative agreements for collaboration. These are then reflected in the Annual Comprehensive Work Plan NCHADS develops, which reflects all budget sources.

The emergence of a consolidated and comprehensive framework, both within the health sector, under the Health Sector Strategic Plan, and in the 'HIV sector', under the NAA National Strategy, has helped NCHADS integrate its HIV/AIDS programme more clearly within overall planning, implementation and M&E frameworks, nationally. This strengthens NCHADS own programme, strengthens the decentralisation process toward provincial and Operational District implementation, and strengthens the collaboration with partners which is key to effective HIV/AIDS responses.

## **2.7 The updated and revised Strategic Plan for HIV/AIDS Prevention and Care 2004-2007**

All these developments have fed into the current review and up-dating of the Strategic Plan. This has the primary objectives to respond to the changing epidemiological situation, to align with the new Health Sector Strategic Plan 2003-2007, and to incorporate the findings and lessons learned from the Mid-term Assessment. The process for this up-dating has also drawn on lessons learned from the past – to seek technical input from a wide variety of sources, to involve the active participation of stakeholders and partners, but also to ensure the active 'ownership' of the plan in its details by NCHADS and provincial staff and implementers.

The process has taken seven steps.

- Review of the recent epidemiological data, the findings of the Mid-term Assessment, and the new MoH Strategic Plan by NCHADS Units, drawing on existing in-house TA as well.
- Drafting the revised sections of the Strategic Plan
- TWG meetings for all programme areas and components to review these drafts
- Collation of these drafts into the revised Plan
- A Consultative Workshop with selected stakeholders and provincial staff to review the new draft Plan
- A final Consensus Workshop with all stakeholders to endorse it
- Submission to MoH for formal approval.

## **3. OBJECTIVES AND OUTCOMES OF THE STRATEGIC PLAN 2004-2007**

### **3.1 Within the Health Sector Strategic Plan 2003-2007**

The NCHADS Strategic Plan is an integral part of the Health Sector Strategic Plan 2003-2007 (HSSP). Within the first 'core strategy' of the HSSP, Health Service Delivery, are five sub-strategies (p25 HSSP). The fourth is: 'Strengthen the management of cost-effective interventions to control communicable diseases'. HIV/AIDS and STD are placed under this sub-strategy (pp. 44, 55).

### **3.2 Four Packages**

The component interventions for control of HIV/AIDS and STDs are grouped into four packages, with a number of components in each:

**Prevention Package:**

- Behaviour Change Programme, including the 100% Condom Use package (condom promotion, targeted STI care, outreach to sex workers), interventions for non-brothel-based sex workers, outreach for other high risk group, and IEC
- Two complementary STI Services for high and low risk groups

**Continuum of Care Package**

- The Continuum of Care for PLHA; which includes establishing the Continuum of Care itself, Health Facility Based Care including ART, Home-based Care, Voluntary Confidential Counselling and Testing and Universal Precautions; this includes collaboration with other departments and Centres of the MoH for TB/HIV and PMTCT

**Research and Surveillance Package**

- HIV/AIDS and STI Surveillance and Research

**Management package**

- Planning, Resource Management and Coordination of the Programme; which includes decentralization to Provinces, and integration within the health sector
- Monitoring, Reporting and Evaluation of the Programme and its components

**3.3 Outcomes**

According to the Health Sector Strategic Plan five Outcomes are expected from this strategy. These expected outcomes form the basis of the NCHADS Strategic Plan.

<i>HSSP Outcome</i>	<i>NCHADS Outcomes</i>
Improved coverage	<ol style="list-style-type: none"> <li>1. Improved coverage of preventive behaviour change programmes for all high risk situations</li> <li>2. Improved coverage of HIV/AIDS and STI awareness for the whole population</li> <li>3. Improved coverage of STI for both high and low risk groups</li> <li>4. Improved coverage of Continuum of Care programmes to all ODS</li> </ol>
Increased utilization of preventive and curative services especially by the poor	<ol style="list-style-type: none"> <li>5. Increased utilization of appropriate STI services.</li> <li>6. Increased access to appropriate treatment, including ART and management of OI, for all PLHA and especially the poor</li> <li>7. Increased access to appropriate HIV/TB services</li> <li>8. Increased utilization of appropriate PMTCT services</li> </ol>
Reduction of prevalence rates	<ol style="list-style-type: none"> <li>9. Reduction in the HIV prevalence rate to &lt;2%</li> </ol>
Increased availability of supplies and functioning equipment	<ol style="list-style-type: none"> <li>10. Increased availability of drugs for STIs, OI management and ART, reagents, supplies and functioning equipment in all STI clinics, VCCT services, HC and RHs</li> </ol>
Effective referral system	<ol style="list-style-type: none"> <li>11. A referral system that enable PLHA to access appropriate counselling, diagnosis, treatment and support</li> </ol>

### **3.4 Objectives**

To achieve these outcomes, the revised and up-dated NCHADS Strategic Plan has three overall objectives:

- To reduce the HIV prevalence rate to  $\leq 2\%$
- To increase survival of People Living with HIV/AIDS
- To ensure that NCHADS and provincial programmes are evidence-based and managed cost-effectively.

### **3.5 Priority Focus**

The priority focus of activities for achieving these objectives remains fundamentally unchanged from the original Strategic Plan for 2001-2005.

Although prevalence is declining, and the relative roles of different transmission routes are changing, NCHADS remains committed to vigorous prevention efforts aimed at three main target groups: brothel-based sex workers, among whom incidence, though declining, remains unacceptably high; other non-spousal female partners of urban men; and the wives and regular partners of infected men.

With respect to the increasing burden of illness and death arising from the epidemic, increasing access to quality care for PLHA is the primary goal. Cambodia is committed to the WHO '3X5' initiative, and has been given challenging targets for introducing antiretroviral therapy.

For implementation and management of this programme, NCHADS is committed to integrating these activities within the existing public health care delivery system, but with an increasing number of partnerships, with international and local NGOs, with other government departments, and with the private sector.

An emerging challenge for NCHADS is the financing of increased access to care. While the availability of funds at the central level is largely secure for the period of this plan, the implications of managing these funds at decentralised level are profound. More importantly, however, is the development of appropriate mechanisms for meeting the direct and indirect costs to PLHA and their families and communities of their care needs.

### **3.5 Implementation**

Experience has suggested that the key to effective implementation in the public sector lies in a shared responsibility between the central level (primarily the MoH) and the Provincial and Operational District level: primarily the Provincial Health Department (PHD) and the OD. In practice this is generally between NCHADS and the Provincial AIDS Office (PAO), though with increasing emphasis on OD-level planning and implementation.

- NCHADS is primarily responsible for the development of overall strategy and Guidelines for implementation of programme components
- the PAOs and PHDs develop operational plans, based on these guidelines
- ODs implement, with the support on both the province and NCHADS.

There are a number of other players and partners, however, who have a role in this Strategic Plan.

- Other Departments and Centres of the Ministry of Health: the National MCH Centre is the primary player in the development of PMTCT; CENAT is a key partner with NCHADS in developing shared responses to the interconnections between HIV and TB; the HIS, with whom NCHADS works on the passive surveillance system; the NBTC, who have the primary responsibility for Safe Blood; CMS, for drug supplies; Hospital Services for UP; the Medical Faculty and other Training Institutions for integrating much of the training envisaged under this Plan; the NHPC for shared work on IEC; NIPH for shared work on research.
- Other Government Institutions: primarily the National AIDS Authority (NAA), and its Policy and Technical Boards, of which the Ministry of Health is a member; the Departments who are members, with the PHD, of the Provincial AIDS Committees (PACs) and Provincial AIDS Secretariats (PAS); the members of the POTS - Provincial Outreach Teams; the Governors and Administration Officials, who form the CUMECs (Condom Use Monitoring and Evaluation Committees).
- NGOs and other organizations who have their own HIV/AIDS activities and programmes, or with whom the Ministry of Health works jointly. These may be small, local NGOs and Community-based Organizations (CBOs), such as those supported by Khana with funding from the Ministry and other donor sources, and those working with NCHADS and PHDs on home-based care teams. Also there are International NGOs, such as MSF, PSF, World Vision, CARE, FHI, OXFAM, the International AIDS Alliance, and Hope, and the UN Agencies, such as UNICEF, WFP, and WHO. A number of both local and international academic institutions have important roles to play, such as ITM through its technical assistance to NCHADS and the University of New South Wales-led Research Consortium, and CAS and other local research organizations. Finally there are the donors: multi-lateral, bi-lateral and private: ADB, DFID, EU, JICA, USAID and the World Bank.

This Strategic Plan does not attempt to spell out the specific role that each of these have to play; rather it provides the framework, within which each can find their most appropriate role.

### **3.6 Monitoring and Assessment of Achievement**

The primary tool for monitoring the achievements of this Plan is the epidemiological and behavioural surveillance system established by NCHADS. Through both active surveillance (which is primarily the regular HIV, Behavioural and STI surveys conducted by NCHADS), and the passive surveillance systems for AIDS and STIs being established under this Plan, NCHADS can assess how far it is succeeding in halting the spread of the epidemic, and caring for those affected by it. This surveillance system generates data annually, enabling NCHADS to make this assessment regularly. For the period of this Plan, the HSS (HIV Sero-surveillance Survey) and BSS (Behavioural Surveillance Survey) Results for 1999, and the SSS (STI Surveillance Survey) Results for 2000 can be taken as the Baseline, updated with the HSS and BSS 2003, and the SSS 2004.

In addition, a set of specific Output and Outcome Targets have been set for each of the components of the Plan.