KINGDOM OF CAMBODIA

Nation-Religion-King

MINISTRY OF HEALTH

STRATEGIC PLAN

FOR HIV/AIDS AND STI PREVENTION AND CARE

IN THE HEALTH SECTOR IN CAMBODIA

2008-2010

National Centre for HIV/AIDS, Dermatology and STD

November 2008

ACKNOWLEDGEMENTS

This up-dated Strategic Plan for HIV/AIDS Prevention and Care 2008-2010 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 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 2008-2010 in the health sector.

I would like to thank the staff of Planning Monitoring and Reporting unit of NCHADS for coordinating this review and set the targets for M&E of the Strategic Plan; the technical units for ensuring that the technical components are evidence-based and cost-effectively designed; 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, 28 / 11 / , 2008

Director of NCHADS

Dr. Mean Chhi Vun

CONTENTS

LIST OF ACRONYMS

ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Sentinel Surveillance
CENAT	National TB Programme
CoC	Continuum of Care
CoC-CC	Continuum of Care Coordinating Committee
CUCC	Condom-Use Coordinating Committee
CUP	Condom-Use Programme
CUWG	Condom-Use Working Group
DHS	Demographic and Health Survey
DSW	Direct Sex Worker
DTOP	District Team on Outreach & Peer education
EES	Entertainment Establishment Services
EEW	Entertainment Establishment Worker
HAART	Highly Active Antiretroviral Therapy
HC	Health Center
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IDSW	Indirect Sex Worker
IDU	Intravenous Drug User
IEC	Information, Education & Communication
IO	International Organisation
MCH	Maternal Child Health
MMM	Mondol Mith Chouy Mith
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission [of HIV]
NGO	Non-Governmental Organisation
NIPH	National Institute of Public Health
NIS	National Information System
NMCHC	National Maternal Child Health Centre
OD	Operational District
OI	Opportunistic Infection
PAO	Provincial AIDS Office
PBIS	Performance Based Incentive Schemes
PLHA	People Living with HIV/AIDS
PEP	Post Exposure Prophylactic
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
POT	Provincial Outreach Team
QC	Quality Control
RH	Referral Hospital
RPR	Rapid Plasma Reagin
SSS	STI Sentinel Surveillance
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization

ACKNOWLEDGEMENTS

This up-dated Strategic Plan for HIV/AIDS Prevention and Care 2008-2010 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 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 2008-2010 in the health sector.

I would like to thank the staff of Planning Monitoring and Reporting unit of NCHADS for coordinating this review and set the targets for M&E of the Strategic Plan; the technical units for ensuring that the technical components are evidence-based and cost-effectively designed; 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, , 2008

Director of NCHADS

Dr. Mean Chhi Vun

1. CONTEXT

1.1 General socio-economic situation

Cambodia is located in the centre of the Indo-china peninsula. The population of approximately 14 million (11.4 million at the 1998 Census) lives in 2.5 million households, in 13,406 villages in 24 provinces. The capital, Phnom Penh, had a population of about 1.044 million in 2004; there are only 3 other towns with populations over 100,000: Battambang, Sihanouk Ville and Siem Reap. While the population is predominantly rural (85%), population density rates vary widely, from 12 people per square kilometre in five provinces (Kratie, Mondul Kiri, Preah Vihear, Ratanak Kiri, and Stung Treng) to more than 100 people per square kilometre in six (Kampong Cham, Kampot, Kandal, Prey Veng, Svay Rieng and Takeo). The city of Phnom Penh is the most densely populated area in the country with 3,783 people per square kilometre.

In 2006, Cambodia ranked 129th out of 177 countries on the Human Development Index. Despite recent improvements, health status indicators are still low. The 2005 Cambodian Demographic and Health Survey (CDHS 2005) estimated the MMR at 472/100,000, the IMR at 65/1000, the UFMR at 143/1000, the TFR at 3.4, and the population growth rate at 1.81%. Poverty indicators are similarly poor: female adult literacy rate is 69.4%, net enrolment in primary school is 77.3%, and average household monthly expenditure is only US$104, with average household monthly expenditure on health at 22% of total household monthly expenditure.

With regard to the HIV epidemic, Cambodia shows typical vulnerabilities: a post-conflict situation, significant poverty, low education coverage, high rural-urban migration and poor health outcomes. Its institutions need strengthening; there is very weak coverage of social welfare services; and a largely unregulated private sector.

It also demonstrates, however, a series of underlying strengths, which tend to resist a wide-spread HIV epidemic: late age of marriage and first sex (c. 19 years for both males and females), strong family structures with strong social norms for acceptable behaviour (eg abstinence and faithfulness); and a large number of energetic social-development programmes.

1.2 HIV epidemic

Cambodia appears to have shown what is emerging as a classic Asian pattern for HIV. After HIV was first found in the country in 1991, there was a sharp rise in infection rates, fuelled largely by a booming sex industry, between 1995 and 1998, when prevalence nearly doubled from 1.2% to 2%. But prevalence then slowly reduced in the following seven years, falling to 1% in 2005 as knowledge about HIV, and condoms became widespread, and risk situations were saturated with interventions. The current estimate is 0.9% for 2006. Infection rates are estimated to be slightly higher in urban than rural areas (0.8% rural, 1.1% urban) and roughly equally distributed between men and women.

This prevalence has been tracked through a programme of sero-surveillance surveys conducted in the country since 1995 and behavioural surveys since 1997. From these surveys a picture of the HIV/AIDS epidemic in Cambodia is emerging of fairly rapidly

changing behaviour and declining prevalence in response to the initial dramatic, if limited, spread of infection. 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 had purchased sex fell from 75% in 1997 to 47% in 2003.

Even with declining prevalence rates, the need for HIV/AIDS treatment, care, and support will continue to increase, however, as previously infected people progress to advanced and symptomatic stages of the disease. In 2006, 67,200 adults (aged 15+) were living with HIV/AIDS of whom approximately 30,000 were suffering from AIDS and in need of ART. In 2010, it is projected that more than 35,000 adults will need ART.

2. PREVIOUS STRATEGIC PLANS (before 2008)

2.1 National Strategic Plan for STD/HIV/AIDS Prevention and Care for PLHA 1998-2000

The **National Policy and Priority Strategies for HIV/AIDS Prevention and Control in the Kingdom of Cambodia from 1998 to 2003**, developed by the National Center for HIV/AIDS Dermatology and STD in collaboration with all NGOs. These were promoting knowledge and understanding on HIV/AIDS, 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; and 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** was developed by National Center for HIV/AIDS/STI and Dermatology of Ministry of Health.

2.2 Strategic Plan for HIV/AIDS and STD Prevention and Care for PLHA 2001-2005

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. This led to 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* (e.g. for Surveillance, for AIDS Care, for Outreach, for STD Management, etc), *Guidelines for the Introduction and Implementation* of various programmes and interventions (e.g. 100% Condom Use, Home-based Care, Counselling and Testing, STD services), and *Training packages* (e.g. Syndromic Management of STDs, Strengthening Provincial HIV/AIDS Programmes, etc). These were then used to establish activities and programmes both at central and Provincial level.

Towards the end of 2002, the Ministry of Health developed an overall **Health Sector Strategic Plan**. This was based on a comprehensive Policy Statement, a detailed situation

analysis and annual health sector reviews, and spelled out goals, targets, and with 6 core strategies: Health service delivery, Behaviour change, Quality improvement, Human resource development, Health financing and Institutional development. 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.

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, USAID 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. These developments fed into a review and up-dating of the Strategic Plan. This had 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 also drew 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.

2.3 Strategic Plan for HIV/AIDS and STI Prevention and Care for PLHA 2004-2007

The **NCHADS Strategic Plan 2004-2007** was an integral part of the **Health Sector Strategic Plan 2003-2007 (HSSP)** under the strategy: "*Strengthen the management of cost-effective interventions to control communicable diseases*" which mentioned HIV/AIDS specifically.

The component interventions for control of HIV/AIDS and STDs were grouped into four packages, with a number of components in each: the **Prevention Package** (including BCC/IEC, outreach and peer education, 100% condom use and STI management); **the Continuum of Care Package,** which included establishing the Continuum of Care itself, Health Facility Based Care including ART, Home-based Care, Voluntary Confidential Counselling and Testing and Universal Precautions, as well as collaboration with other departments and Centres of the MoH for TB/HIV and PMTCT; the **Research and Surveillance Package;** and the **Management package** (which included planning, reporting, monitoring, administration, logistics, and data management). This Plan has been implemented up to December 2007, when this revised and up-dated Plan has been developed**.**

The NCHADS Plan was also an integral part of the **National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS in Cambodia 2006-2010**, prepared by the National AIDS Authority (NAA). Within this Plan, NCHADS was specifically charged with:

- scaling up coverage of targeted interventions for sex workers and their clients under the 100% Condom Use Programme;
- with NGOs continuing to scale up coverage and quality of VCCT services in the public, commercial and non-profit health sector;
- continuing to scale up coverage and comprehensiveness of the CoC services at health facilities, including medical and nursing care for opportunistic infections and antiretroviral treatment;

- with NGOs and WFP continuing to scale up coverage and quality of community-based and home-based care, including HCT, nutritional support and PLWHA support groups;
- with CENAT and NGOs continuing to scale up coverage and quality of HIV/TB services.
- with CDC, DFID and WHO providing technical assistance to MoH departments for HIV/AIDS related health services;
- continuing to implement and report on national surveillance, including serological, behavioural and STI surveillance and Behavioral Sentinel Surveillance;
- with MoH and NIS including HIV/AIDS-related questions in the national demographic and health survey (NDHS);
- with the M&E Advisory Group, NIPH and NAA expanding the national coordination mechanism for HIV/AIDS-related biomedical research at NCHADS to include non-medical research;
- undertaking and coordinating evaluation research into the effectiveness of prevention and care interventions;
- organising annual conferences on HIV/AIDS-related research.

2.4 Achievements of the Strategic Plan for HIV/AIDS and STI Prevention and Care for PLHA 2004-2007

Under the plan considerable significant progress was made:

- Prevalence fell from 2% in 1998 to 0.9% in 2006
- Outreach Programme was re-structured to meet wider needs within the entertainment services
- STI programme was assessed and re-focused: 90% of brothel-based sex workers and 17% of non-brothel based sex workers regularly access STI services
- VCCT sites expanded from 74 in 2004 to 197 in 2007, with the annual numbers of clients tested rising from 59,000 in 2004 to 259,917 in 2007.
- ART services were significantly scaled up: from 11 sites in 2004 to 49 sites in 2007, with the numbers of patients on ART rising from 5,974 in 2004 to 26,664 in 2007.
- Paediatric AIDS Care was introduced, and scaled up from 3 sites in 2004 to 22 sites in 2007, with 2,372 children on HAART by the end of 2007.
- Altogether 245 clinicians, 249 nurse counsellors have been trained in ART in 18 courses since 2004 until now.
- Home-based care teams working within the CoC have expanded to covering from 255 HCs in 2004 to 683 health centres in 2007 and supporting over 26,000 PLHAs.
- NCHADS partnerships (through signed Letters of Agreement) and inclusion in the Annual Comprehensive Work Plan expanded from 4 organizations to 37.

3. NCHADS STRATEGIC PRIORITIES FOR HIV/AIDS and STI Prevention and Care for PLHA in the Health Sector 2008-2010

The NCHADS' Strategic Plan for HIV/AIDS and STI Prevention and Care for PLHA 2008-2010 is focused on evidence-informed strategic priorities derived from the epidemiological and behavioural data and analyses collected and conducted by NCHADS over the years, under the National HIV/AIDS Surveillance System; and further informed by other national surveys, such as the Cambodia Demographic and Health Surveys (2000 and 2005), health

sector reviews and surveys, and reviews and research studies conducted by a wide range of stakeholders in Cambodia.

The primary findings from these analyses are that **targeted prevention remains the first priority**: prevalence has been falling faster than expected in Cambodia over the last few years and has now reached very low levels in the general population (below 1%); but incidence appears to remain high in certain high-risk situations in Cambodia, especially the sex industry, the MSM population and injecting drug users (IDU). Working closely with the NAA and other partners, prevention in the sex entertainment services is based upon strategies tried and tested over the years by NCHADS and partners. The other 'most at risk groups' (MARPs) are a new focus for the HIV response in Cambodia; but present a particular public health challenge. In addition, the long-term effects of 'endemic HIV', where very low levels on infection remain quiescent within the population, are still quite unclear.

The ravages of the epidemic in Cambodia over the last decade have, however, created a very significant burden of disease on care and treatment (HSS Projection 2006-2012: some 67,200 Cambodians are living with the virus in 2006). A**ddressing this burden of care within the constraints of the health care system constitutes the second priority** for NCHADS. 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, with the private sectors, and as well as with PLHA network.

The **third priority relates to the need to sustain the programme effectiveness** of NCHADS as a department within the Ministry of Health – responding the 'cross-cutting strategies' developed by the ministry of health under the HSP2 . Over the years NCHADS has developed an effective HIV/AIDS programme as 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). This programme has made significant contributions to achievement of the Ministry's strategic plan, especially in the areas of transparent and accountable consolidated financial management, developing procurement mechanisms for ARV drugs, building capacity at provincial level for effective planning, management and financial responsibility, developing and sustaining high-quality and credible surveillance and research with respect to HIV, models for effective programme management based upon clear technical and operational guidelines and standard operating procedures (SOPs), introducing high levels of clinical management into referral hospitals, and establishing partnerships and working mechanisms with NGOs and other stakeholders. Ensuring that this contribution can be sustained within the Ministry by maintaining NCHADS' programme effectiveness is vital –see also section 4.2, below.

4. THE STRATEGIC PLAN FOR HIV/AIDS and STI PREVENTION AND CARE FOR PLHA 2008-2010

4.1 Development of the Strategic Plan for HIV/AIDS and STI Prevention and Care for PLHA 2008-2010

As a strategy developed for previous plans, under NCHADS' partnership' approach, during 2007 NCHADS Units worked with stakeholders in the relevant Technical Working Groups to review achievements under the previous plan, to prepare necessary new approaches and plans, and to set targets for the next period. A series of consultation meetings were held to

review the overall situation, the epidemiology and dynamics of the epidemic given the latest data, and to consolidate the component plans into this Strategic Plan. This has been shared in draft with stakeholders.

At the same time NCHADS participated in the Task Force for the development of the Ministry of Health's Strategic Plan 2009-2015 to ensure full alignment.

4.2 Overall Goals within the MoH Health Strategic Plan 2 (2009-2015)

Within the MoH HSP2 the second Strategic Goal is:

"Reduce mortality and morbidity of communicable diseases" – with two Objectives:

1. To reduce the HIV prevalence rate from 0.9% to 0.6%
2. To increase survival of PLHAs on ART after 12 months initiation to more than 85%

The NCHADS' Strategic Plan thus takes these two objectives, adds a third regarding programme management, to produce three overall goals for HIV/AIDS and STI Prevention and Care for 2008-2010 which fir within:

1. To reduce the HIV prevalence rate from 0.9% to 0.6%
2. To increase survival of PLHAs on ART after 12 months initiation to more than 85%
3. To ensure that NCHADS and provincial programmes, including OD activities, are cost-effectively managed

The third objective responds to the key MoH HSP2 **Strategies (2009-2015)**:

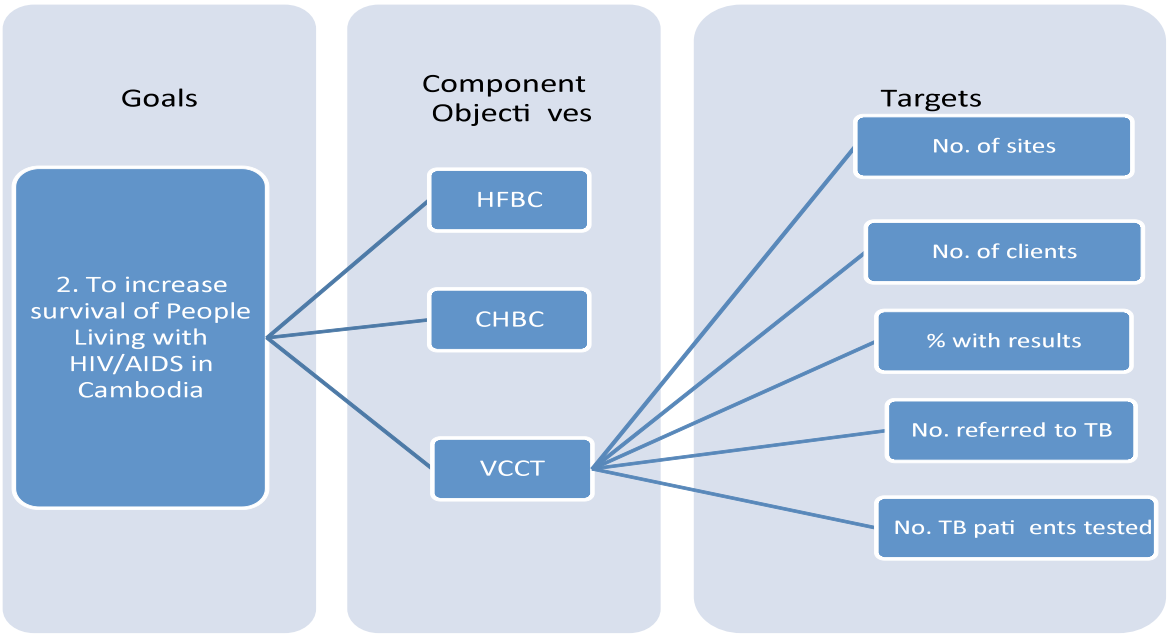
- **Strategy 1: Health Service Delivery**: stresses consolidation of evidence-based packages of preventive and curative services delivered in an integrated manner within the public health system; the emphasis on integration and linkages in the NCHADS' core strategies responds and contributes to this;
- **Strategy 2**: **Health Financing**: stresses improved efficiency of government resource allocation, alignment of donor financing, decentralisation of expenditures, and public-private partnerships; NCHADS has emphasized similar strategies within its AOCP processes and outcomes, and thus responds and contributes significantly to this strategy;
- **Strategy 3**: Human Resource Development: stresses staff performance management; NCHADS has been in the forefront of this for the last few years with the development of its Incentive scheme; this is continued under the Strategic Plan;
- **Strategy 4: Health Information Systems**: stresses improvements in surveillance, data management reporting and use, and inclusion of other partners; NCHADS responds and contributes to the strategy through its surveillance and data management systems and their integration under Strategy 1;
- **Strategy 5**: **Health System Governance**: stresses harmonization and alignment, partnerships, development of clear policies and regulations, and strengthened planning and management systems; NCHADS has again been in the forefront of these developments and continues to emphasize them in its third Overall Goal – cost-effective management – contributing useful models and experience to the MoH strategy.

4.3 Structure of the NCHADS Strategic Plan 2008-2010

The NCHADS' Strategic Plan for HIV/AIDS and STI Prevention and Care 2008-2010 is based upon a series of goals and objectives, and the core operational strategies by which these objectives will be met; and is structured around ten (10) programme elements under which activities are planned and budgeted in NCHADS and provinces. It is important to note that the 'Continuum of Care' is an over-arching framework, and the three primary elements (HFBC, CHBC, VCCT) are separate components.

For each programme area there are also a set of output and outcome indicators, for which **targets for the Plan** are set, and by which NCHADS will monitor and assess progress in the implementation of the plan; this is described in the final section of the Plan.

The diagram below suggests the structure:



In addition, a section of the Strategic Plan deals with implementation and management arrangements.

5. PROGRAMME OBJECTIVES AND STRATEGIES TO REACH THEM

Goal 1: TO REDUCE THE HIV PREVALENCE RATE FROM 0.9% TO 0.6%

5.1: Behaviour Change Communication (BCC)

Objectives:

1. To ensure 100% CU with all Entertainment Service Workers (ESWs) targeted
2. To promote access for targeted ESWs to VCCT and regular STI services
3. To strengthen outreach and peer education activities among ESWs targeted
4. To contribute to the improvement of OR/PE program among other Most at Risk Populations (MARP): MSM, DUs, IDUs and their Clients
5. To ensure appropriate IEC materials for supporting program components

Core strategy:

The main strategy for achieving the BCC objectives remains based upon the proven effective 100% Condom Use framework – ensuring that condoms are available and used in all high risk sexual encounters, and providing a range of user-friendly services (outreach, education, STI, referral, counselling, etc) for risk situations where incidence remains relatively high – Entertainment Establishment Services (EES). In 2006 the programme and its outreach component were re-designed to adjust to the recommendations of the reviews, to broaden the scope and scale of partnerships involved, and to make better use of available resources in the government sector within national budget – other funding supports, and civil society for effective outreach and ensuring condom availability. Condom availability in this sector is largely ensured through social marketing – primarily managed by one of NCHADS' oldest partners, PSI. In addition, the Plan enlarges the scope of effort beyond sex workers (both brothel-based and others) to other Most At Risk Populations (MARPs), particularly MSM, IDUs, DUs and those in 'closed settings'. Specific strategies for reaching these additional MARPs with appropriate, culturally-sensitive and user-friendly services are being developed with the NAA and other partners.

The focus for the current Plan therefore is to:

1. Promote and strengthen the functioning of the Condom Use Working Group and the Provincial Outreach Team CUWG/PST-OP and DTOP
2. Collaborate with all relevant services to ensure condom availability and accessibility, primarily through social marketing by PSI, in all EES targeted
3. Promote consistent and correct condom use among clients, regular partners and sweethearts of ESWs
4. Motivate ESWs to use VCCT/STI and client friendly services
5. Improve access to VCCT/STI through referral system by strengthening partnerships between CUWG, DTOP and EES owners
6. Strengthen quality of OR and PE activities
7. Revise the SOP-OPC
8. Strengthen collaboration, coordination and partnership with relevant institutions and organization in HIV prevention, care and support among MARP
9. Improve national understanding on HIV prevalence and behaviour among MARP to support program development

10. Review and identify appropriate IEC including messages, media, etc… for supporting program components
11. Develop and distribute IEC materials through the appropriate channels
12. Conduct monitoring and evaluation of the IEC materials used
13. Strengthen program management and implementation including monitoring and evaluation at all levels.

Core Programme Indicators		Type	Baseline	Targets (Year)			Source
				2008	2009	2010	
1	HIV prevalence among ANC women (15-24 years)	Impact	0.45% (2006)		0.3%		HSS
2	Percentage of general population that report correct knowledge of HIV transmission and prevention	Outcome	>80% (2005)			95%	CDHS
3	Percentage of brothel-based sex workers who reported consistent & correct condom use with clients	Outcome	93% (2007)			96%	BSS
4	Percentage of non brothel-based sex workers who reported consistent & correct condom use with clients	Outcome	Beer girls: 84% Karaoke: 56% (2007)			90%	BSS
5	Percentage of brothel-based sex workers who reported consistent & correct condom use with sweetheart	Outcome	62% (2007)			68%	BSS
6	Percentage of non brothel-based sex workers who reported consistent & correct condom use with sweetheart	Outcome	Beer girls: 61% Karaoke: 57% (2007)			65%	BSS
7	Percentage of brothel-based sex workers received HIV/AIDS & STI prevention messages	Output	93.8% (2007)			95%	BSS

5.2: STI prevention and care

Objectives:

1. To strengthen, promote and monitor existing 'Targeted' STI services for populations in high-risk situations (ESWs, MSM, ect) and existing 'Integrated' STI care for the general population and link to additional reproductive health services.
2. To ensure adequate dissemination of information related with STI control among all partners in the national health response to STI/HIV/AIDS in Cambodia.

Core strategy:

The STI component of NCHADS is also well-established, tried and tested. Like the 100% CUP, it continues to evolve in response to reviews, surveys, lessons learned, and the changing dynamics of the epidemic in Cambodia. As STI services become more established and acceptable in Cambodia, greater attention is being paid to quality of care and sustainability, and coverage to other at risks populations, including ESWs, MSM, DUs and IDUs, drawing on the wide range of partners providing services.

The focus for the current Plan therefore is to:

1. Assure that targeted STI prevention and control services are effective, efficient, accessible and acceptable
2. Continue to implement special interventions on STI prevention and care targeted at high-risk populations such as ESWs and men who have sex with men (MSM)
3. Strengthen the monitoring of STI integrated services at health centres (HCs) for the general population
4. Encourage non-governmental organizations (NGOs) and the private sector to be involved in STI prevention, care and treatment.
5. Build capacity for the sustainability of STI prevention and care in collaboration with international development partners, civil society, and the private profit and non-profit sectors.
6. Strengthen the link between STI prevention and care and VCCT, ANC and family planning
7. Promote a good understanding of STIs among the general public and among high risk groups as well, to encourage them to change their risk behaviours through information, education and communication (IEC) materials
8. Encourage and collaborate in STI surveillance and research to assure that the status of or trends in STI in Cambodia is well informed as well as the effectiveness of prevention and control activities
9. Update knowledge of STI management in the private sector, and integrate STI case management into university of health science, nursing school curriculum.
10. Scale-up syphilis screening among pregnant women at ANC services.

Core Programme Indicators		Type	Baseline	Targets (Year)			Sources
				2008	2009	2010	
1	STI prevalence rates among female brothel-based SWs (GC and/Ct)	Impact	GC:13% Ct:14% (2005)	<14%			SSS
2	Proportion of visiting brothel-based SWs diagnosed with cervicitis during monthly follow-up consultation at STI clinic	Outcome	15.9% (2007)	< 15%	<14%	<14%	Program Report
3	Number of Special STI Clinics with laboratory support to perform RPR and basic microscopy	Output	22 (2007)	24	28	31	Program Report
4	Percentage of entertainment service workers identify by 100% CUWG who recieved STI check up at STI clinic every month	Output	DSW: 85% IDSW: n/a (2007)	DSW: 95% IDSW: 50%	DSW: 95% IDSW : 50%	DSW: 95% IDSW : 50%	Program Report
5	Proportion of women accessing Antenatal Care (ANC) services who are tested for syphilis (UA 35)	Output	11.2% (2007)	50%	60%	70%	Program Report
6	Percentage of ANC attendees with positive syphilis test (UA 36)	Outcome	0.7% (2001)	0.5%	0.4%	0.3%	Program Report

Goal 2: TO INCREASE SURVIVAL OF PLHAs ON ART AFTER 12 MONTHS INITIATION to > 85%

5.3: The Continuum of Care (CoC)

Objectives:

- To ensure Universal Access of PLHA to a continuum of care for PLHA at OD level
- To ensure quality of care and treatment, including ART, for PLHA.

Strategy:

The Continuum of Care (CoC) Framework for PLHA has been the underlying framework upon which Cambodia's signal success in expanding treatment and care to all who need it is based – aimed at providing a comprehensive set of integrated services for PLHA at different stages and needs within a single context that links the family, the community and the health facility. Various reviews of the CoC Framework and a major external assessment have been conducted in late of year 2007; and the experience of various partners working within the framework, and emerging needs as treatment and care scale up, have been incorporated in a new Framework document. This provides the framework to extend existing services to ensure Universal Access.

Service provision is based upon all individuals' rights to health care, in terms of the accessibility to appropriate quality of services, with user-friendly providers, with non-discriminatory approaches. Emphasis is on creating an enabling environment for PLHA to take part in the process of providing health and social services for their peers. Currently, for example, PLHA are directly joining in as MMM coordinators, home based care volunteers, HIV testing counsellors, drug counsellors, and referring their peers to access services within health care facilities. Furthermore, the service users have the right to complain and give suggestions by providing feedback to the CoC services by placing their suggestions in the box which is available in the hospital. Their comments are taken into account during the monthly CoC, and MMM meetings at OD level.

The focus for the current Plan, through the various components of the CoC, is therefore to:

1. Expand and strengthen the CoC for PLHA at OD level
2. Integrate the CoC fully into the health care system
3. Build capacity of CoC components
4. Integrate activities to support treatment adherence into CoC components
5. Coordinate linkage within and among different CoC components within health facilities and community and home based care
6. Support PLHA peer support activities
7. Ensure access for MARPs to the full CoC
8. Coordinate with all partners for social support for PLHA

The Continuum of Care comprises three components: Health facility Based Care (HFBC), Community Home Based Care (CHBC), and Voluntary Confidential Counselling and Testing (VCCT). Each component is addressed separately in this Strategic Plan, with its own specific objectives and core strategies (below).

Core Programme Indicators		Type	Baseline	Targets (Year)			Sources
				2008	2009	2010	
1	Total number of Operational Districts with a full Continuum of Care	Output	39 (2007)	40	43	45	Program Report
2	Number of CoC sites with ARV services	Output	49 (200)	50	53	55	Program Report

5.4: Voluntary Confidential Counselling and Testing (VCCT)

Objectives:

1. To strengthen and extend coverage of counselling and HIV testing services
2. To ensure quality of HIV counselling and laboratory testing in public and private sectors
3. To strengthen and support linkages between different health care services and community within the CoC.

Core strategy:

VCCT has expanded the most dramatically over the course of the previous strategic plan 2004-2007; from some 37 sites in 2003 to over 194 now – with an average case load nationally of 165 clients per month. It is estimated that a total of 250 sites are required by 2010 to support the achievement of Universal Access targets. Establishing so many new VCCT sites, ensuring supplies of reagents and consumables, and introducing Quality Assurance systems to sustain high quality testing and counselling has been a major achievement in Cambodia; as well as ensuring quality and coordination with the large number of VCCT sites run by NGOs and the private sector.

Sustaining and expanding this major network of services will be the focus for the current Plan therefore, with emphasis on:

1. Increasing VCCT sites to 250 by 2010
2. Building capacity of VCCT staff (counsellors and laboratory technicians)
3. Strengthening the integration of VCCT within the CPA and MBA package
4. Increasing knowledge about VCCT (benefits, how to access, risk self-assessment, etc.).
5. Improving monitoring and evaluation systems for VCCT.

Core Programme Indicators		Type	Baseline	Targets (Year)			Sources
				2008	2009	2010	
1	Number of licensed VCCT sites operating in the public and non-profit sectors	Output	197 (2007)	220	235	250	Program Report
2	Number and percentage of adults (aged 15-49) who received HIV counseling and testing	Outcome	259,917 (3.4%) (2007)	320,000 (4.3%)	380,000 (5.0%)	400,000 (5.2%)	Program Report
3	Percentage of people HIV tested who received their result through post-test counselling	Outcome	96% (2007)	98%	98%	98%	Program Report
4	Number and percentage of HIV (+) Clients who were referred to OI/ART sites	Output		80%	90%	95%	Program Report

5.5: Health Facility Based Care (HFBC)

Objectives:

1. To improve and maintain the quality and accessibility of care and treatment for PLHA (adults and children), including nutritional support to children through the CoC
2. To strengthen and support the referral and follow-up linkages of CoC within different health care services
3. To strengthen linkages with community home based care.

Core strategy:

During the period of the previous Strategic Plan, 2004-2007, the number of PLHA on ART rose from some 5,974 in 2004 to 26,664 in 2007; this has been accompanied by an equally impressive extensive of paediatric services. This dramatic scaling up has required enormous efforts and investments in four primary areas within the health care system: training clinicians to administer ART, strengthening laboratory services to support effective diagnostics, developing procurement, logistics and data management systems that ensure uninterrupted consumption of drugs by those who need them, establishing community and home-based support and referral systems, and effectively resource allocation and mobilisation to support these activities. These systems need further strengthening, and extending, to ensure full access for all, including MARPS, who may have been marginalised to some extent earlier. In addition, as the recent external assessment of the health facilities stressed, the HFBC/CoC system continues to need specific support to ensure full integration into the overall health care system.

The focus for the current Plan therefore is to consolidate the services and ensure their effective and sustainable integration into the health care delivery system, with:

1. Increasing coverage of health facility based care services including ART
2. Developing, revising and ensuring implementation of continuum of care policies, strategies and guidelines
3. Building the capacity of health staff in the continuum of care
4. Using monitoring, reporting and evaluation and other data to improve the quality of care
5. Integrating Paediatric AIDS Care into paediatric care services and nutritional support operated at the Referral Hospital
6. Strengthening linkages within and between community-based services and health facility based services to support follow up and compliance of PLHA to HIV/AIDS treatment and care
7. Strengthening referral and follow-up linkages within health facility based (VCCT, OIs and ART services, TB, PMTCT, STIs, reproductive health and nutrition).

Core Programme Indicators		Type	Baseline	Targets (Year)			Source
				2008	2009	2010	
1	Percentage of people on ART alive 12 months after initiation	Impact	87.6%** (2007)	>85%	>85%	>85%	Program Report
2	Percentage of donated blood units screened for HIV in a quality assured manner (UA 15)	Output	97.3% (2007)	100%	100%	100%	Program Report
3	Number of OD with at least one centre that provides public ART services	Output	38 A: 38 C:22 (2007)	38 A: 38 C:28	38 A: 38 C:29	40 A: 40 C:30	Program Report
4	Percentage of Pediatric AIDS Care that use virological testing services (eg PCR) for infant diagnosis (UA 2)	Output	100%	100%	100%	100%	Program Report
5	Percentage of health facilities with PEP services available (UA 17)	Output	100%	100%	100%	100%	Program Report
6	Number and percentage of people with advanced HIV infection on HAART	Outcome	26,664 A: 24,123 C:2,541 (2007)	33,344 A: 29,344 C:4,000	35,644 A: 31,344 C:4,300	39,044 A: 34,244 C:4,800	Program Report
7	Number of OD with at least one centre that provides public PMTCT services	Output	58 76% (2007)	64 (85%)	68 (90%)	76 (100%)	Program Report
8	Number and percentage of pregnant women who were tested for HIV and received their test results	Outcome	(16.4%) (2007)	40%	50%	75%	Program Report
9	Number of HIV-infected infants born to HIV-infected mothers (UA 14)	Outcome	1050 (2006)	700	500	250	Program Report
10	Number and percentage of HIV-infected pregnant women who received a complete course of ARV	Outcome	11.2% (2007)	30%	40%	60%	Program Report

11	a) Cumulative number clinicians trained to provide ARVs	Output	A: 181 C: 64 (2007)	A: 181 C: 80	A: 181 C: 80	A: 181 C: 80	Program Report
	b) Cumulative number nurses trained to provide counseling for ARVs	Output	A: 165 C: 84 (2007)	A: 165 C: 100	A: 165 C: 100	A: 165 C: 100	Program Report
	c) Cumulative number pharmacists trained to manage OI/ARVs	Output	149 (2007)	164	179	194	Program Report
12	Percentage of patients on ART lost to follow-up at 12 months after initiation	Outcome	<10% (2006)	< 10%	< 10%	< 10%	Program Report
13	Percentage of patients still on first line regimen 12 months after initiation	Outcome	82.9%*** (2007)	>80%	>80%	>80%	Program Report
14	Number and percentage of individuals newly enrolled in HIV care who were screened* for TB at the first visit	Output	Not available	Not available	90%	95%	Program Report
15	Percentage of individuals enrolled in HIV care who were screened for TB at last visit	Output	Not available	Not available	90%	95%	Program Report
16	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Output	Not available	Not available	80%	90%	Program Report

****Note: According to survival data from cohort studies in other countries including developed countries, the one year survival reaches about 85% for adult and 90% for children. Therefore, we aim to maintain similar level of performance over time. The 2007 baseline was higher because it represents large cohorts at national sentinel ART sites with high standard quality of care.**

***** >70% is the WHO target for Early warning indicator for HIV drug resistance.**

5.6: Community Home Based Care (CHBC)

Objectives:

1. To increase and maintain access of PLHA & their families to quality CHBC services
2. To increase access of PLHA to treatment, care and support services within the CoC
3. To ensure referral, linkage, follow up and adherence of PLHA to HIV/AIDS care and treatment including VCCT/OI/ART/STI/RH, Safe Abortion, etc
4. To reduce stigma and discrimination towards PLHA and their families.

Core strategy:

Home based care has expanded widely across the country: by the end of 2007 there were 255 home based care teams, covering 596 health centres, and reaching more than 26,000 PLHA. NCHADS has decided that home-based care is best provided by NGOs; indeed, has contracted a number to provide HBC services; but coverage is still relatively low. With a number of slightly different NGO models of HBC being implemented, NCHADS has a key role to play in coordinating and monitoring HBC services, and ensuring they are well-linked within the CoC referral system. NCHADS has also developed the Mondul Mith Choy Mith (MMM = Friend Help Friend Center) approach for both adults and children (integrated with Paediatric AIDS Care), which allows PLHA to play a key role in supporting and linking various elements of the CoC. This approach also allows more 'client-friendly' approaches to services between consumers and health care providers , and for PLHA from MARPs to be developed.

The focus for the current Plan therefore is to:

1. Support the extension & expansion of HBC in identified areas of need based on the CoC sites
2. Work with partners to build capacity of HBC teams
3. Coordinate sustainable and effective financing for the HBC services
4. Coordinate with all partners for psycho-social and socio-economic support for PLHA
5. Integrate activities to strengthen follow up and adherence/compliance of PLHA to HIV/AIDS treatment and care
6. Strengthen referral and follow-up linkages within and between community-based services and health facility based services
7. Strengthen and integrate nutritional support in CHBC and the CoC
8. Support PLHA groups to manage MMMs
9. Support expansion and extension of community and home based care, and PLHA SG network
10. Coordinate with programmes for community counselling and support activities
11. Strengthen monitoring, supervision and reporting systems for the HBC programme.

Core Programme Indicators		Type	Baseline	Targets (Year)			Sources
				2008	2009	2010	
1	Total number of HBC teams actively providing home-based care and support services to PLHA according to the National SoP	Output	253 (2007)	300	300	300	Program Report
2	Number of PLHA supported by HBC teams	Output	25,395 (2007)	27,000	28,000	30,000	Program Report
3	Number and percentage of health centers with HBC team support	Output	683 (72%) (2007)	720 (76%)	750 (80%)	780 (83%)	Program Report

Goal 3: TO ENSURE THAT NCHADS AND PROVINCIAL PROGRAMMES ARE COST-EFFECTIVELY MANAGED

5.7: Surveillance

Objectives:

1. To monitor epidemiological changes with regard to HIV/AIDS prevalence and incidence in Cambodia
2. To monitor trends in STI prevalence and antibiotic sensitivity
3. To monitor HIV Drug Resistance prevalence in Cambodia
4. To monitor behaviour changes with regard to HIV/AIDS and STIs among identified target groups
5. To promote the use of epidemiological and behavioural data for programming.

Core strategy:

Cambodia's surveillance system is acknowledged as one of the best in the region; and it has played a major role in keeping the programme evidence-informed.

Adapting to the changing dynamics of the epidemic, the focus for the current Plan therefore is to:

1. Conduct epidemiological (HSS) surveillance tri-annually
2. Conduct STI (SSS) surveillance tri- or quadri-annually
3. Conduct HIV Drug Resistance Threshold Survey on *ad hoc* basis
4. Conduct behavioural surveillance (BSS) and household male survey bi-annually
5. Compile and disseminate the epidemiological, behavioural and STI sentinel surveillance findings
6. Build the capacity of the Surveillance Unit staff;
7. Build the capacity of program management teams at national, provincial and OD levels for using the data.

Core Programme Indicators		Type	Baseline	Target (Year)			Sources
				2008	2009	2010	
1	Number of HSS conducted with result applied to program	Output	9 (Since 1995 to 2006)	0	10	0	HSS Report
2	Number of SSS conducted with result applied to program	Output	3 (Since 1996 to 2005)	4	0	0	SSS Report
3	Number of BSS and other survey of identified groups conducted with results applied to program	Output	7 (Since 1997 to 2007)	0	0	8	BSS Report

5.8: Research related to HIV/AIDS and STI

Objectives:

1. To provide scientific evidence to design NCHADS intervention programs
2. To evaluate scientific soundness of HIV/AIDS/STD related research conducted in Cambodia
3. To build capacity to understand/conduct/use research in support of NCHADS programme

Core strategy:

NCHADS Research Unit aims to ensure that scientific evidence underpins the design NCHADS intervention programs by both conducting specific research studies, and coordinating and linking with other research institutions and programmes, both inside and outside Cambodia. As HIV-related prevention and care interventions tend to become more and more focused, and as such a new and innovative clinical programme as ART expands, the need for good quality research to inform the design and direction of programmes is critical.

The focus for the current Plan therefore is to:

1. Conduct HIV/AIDS and STIs related research
2. Set up a mechanism to review the scientific aspect HIV/AIDS and STD related research in Cambodia and to make recommendation to NEC
3. Conduct training/workshops to build capacity of NCHADS, PAOs, NGOs working on HIV/AIDS and STD related research
4. Send researchers to get training and exchange research experience abroad
5. Establish an information sharing system between local and international researchers.

Core Programme Indicators		Type	Baseline	Targets (Year)			Sources
				2008	2009	2010	
1	Number of research studies conducted	Output	6 (2006-2007)	2	2	2	Program Report

5.9: Planning, Monitoring & Reporting

Objectives:

1. To ensure a coordinated and comprehensive response to the HIV/AIDS and STI epidemic in the health sector
2. To monitor and provide feedback for NCHADS Program implementation
3. To coordinate the revision and evaluation of the NCHADS program components
4. To improve the capacity for monitoring reporting and evaluation of programmes.

Core strategy:

A considerable part of NCHADS' success lies in its robust, transparent and accountable planning, monitoring, and reporting and quality assurance systems. With the very large amounts of funding accruing to HIV, and the large number of civil society partners who participate in the programme, this has been critical, and will be sustained.

The focus for the current Plan therefore is to:

1. Coordinate the development of the Strategic Plans, and Operational and Comprehensive Work Plans and set the targets for NCHADS programme
2. Coordinate the harmonization of HIV/AIDS and STI programmes into other National Health Sector Programmes and Institutions
3. Provide the technical guidance and support to provinces for developing Annual Comprehensive Operational Plans
4. Coordinate the identification and allocation of resources in support of Strategic Goals, and Annual Operational Comprehensive Plans
5. Establish and maintain transparent and accountable fund allocation mechanisms for decentralisation of activities at Provincial and ODs levels
6. Establish and maintain coordination mechanisms with all partners
7. Maintain an up-to-date Monitoring, Reporting and Evaluation System for the programme
8. Conduct routine monitoring and develop NCHADS comprehenive reporting
9. Coordinate and collaborate M,R&E within the National M,R&E System for HIV/AIDS programme and with others partners (both government and non-government) in health sector
10. Organize and manage periodic review/evaluation of specific program components
11. Build the capacity for Monitoring, Reporting & Evaluation within the program

Core Programme Indicators		Type	Baseline	Target (Year)			Sources
				2008	2009	2010	
1	Percentage of major funding sources included in the Annual Comprehensive Work Plan	Output	80% (2007)	>90%	>90%	>90%	Program Report
2	Number of NGOs and partners with signed Letters of Agreement for annual work plans on HIV/AIDS & STI programme	Output	35 (2007)	40	45	50	Program Report

3	Number of NCHADS quarterly and annual program reports produced and disseminated	Output	5 (2007)	5	5	5	Program Report

5.10: Data Management

Objectives:

1. To strengthen the reporting system and data usage for HIV/AIDS and STI Program

Core strategy:

Data management is a new area for the NCHADS programme. It underpins the whole ART programme, where good quality patient data is essential.

The focus for the current Plan therefore is to:

1. Develop methods and set up systems to gather information and monitor the entire spectrum of AIDS-related morbidity and mortality.

Core Programme Indicators		Type	Baseline	Target (Year)			Sources
				2008	2009	2010	
1	Number of provinces with data management units	Output	11 (2006)	11	20	20	Program Report
2	Number of Comprehensive Reports compiled	Output	5 (2007)	5	5	5	Program Report

5.11: Logistics Management

Objectives:

1. To strengthen consumption reporting and distribution for OI/ARV drugs, and reagents/consumables for VCCT,STD
2. To monitor OI/ARV & STD Drug and Reagents for all OI/ART sites
3. To establish quantifications for all required items including OI/ARV drugs, reagent, and consumable, related to HIV/AIDS and STI care and treatment
4. To ensure effective coordination and collaboration between the NCHADS programme and CMS and other relevant MoH departments to ensure effective and un-interrupted supplies of OI/ARV & STD Drug and Reagents for all sites
5. To build human resource capacity at the national, provincial, referral hospital and Operational district level by training.

Core strategy:

Logistics management is another new area for NCHADS, but one which is crucial to sustain the scaling up of VCCT, care and treatment. NCHADS' supply and management systems have recently been integrated into the CMS system, but more still needs to be done to ensure the two systems are fully matched for long-term un-interrupted supply to all CoC sites in the country.

The focus for the current Plan therefore is to:

1. Conduct and Collect Consumption Reports and Distribution to all sites
2. Establish quantifications for all required items including OI/ARV drugs, reagent, and consumable, related to HIV/AIDS and STI care and treatment
3. Collaborate with all relevant units within NCHADS and all sites and partners that form part of the NCHADS Programme
4. Initial training and refresher training for Logistics management to all relevant health care workers.
5. Monitoring and supervision on OI/ARV and commodity management to all sites.

Core Programme Indicators		Type	Baseline	Targets (Year)			Sources
				2008	2009	2010	
1	Number and percent of ART sites with one or more stock-outs of essential ARVs	Outcome	0%	0%	0%	0%	Program Report

6. IMPLEMENTATION ARRANGEMENTS

6.1 Shared responsibilities

The experience of the successive previous Strategic Plans has shown that the key to effective implementation in the public health 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, developing the AOCP, mobilisation and resource allocation to support the programme.
- PAOs and PHDs develop operational plans, based on these national guidelines
- ODs implement, with the support on both the province and NCHADS.

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

Other MoH's Departments and the National 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 closely with Health Information System on the passive surveillance; the NBTC, who have the primary responsibility for Safe Blood; CMS for drug and commodity supplies; Hospital Services; 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 HIV/AIDS and STI research; and the MoH Planning Department, for development and integration of NCHADS' AOCP into the MoH's AOP.

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 UNAIDS, UNICEF, WFP, and WHO to support implementation of this strategic plan. 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/PEPFAR, World Bank, US-CDC, and GFATM.
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.

6.2 Linked Response and collaboration for TB/HIV

The Linked Response

The current health system in Cambodia provides access to HIV/AIDS, OI/ART, STI, ANC, family planning and maternal and newborn health services. However, these closely related services are not always available at the same health facility, and some operational districts do not offer the full package of services. Because health staff is often specialized (FP, STI management, ANC etc.), they may miss opportunities to provide comprehensive information and to refer patients to relevant health centres for appropriate treatment. As a result, the linkages between related health services need to be strengthened, as well as those between health services and the community at large.

NCHADS is working with the National MCH Centre to pilot an approach to the Linked Response which aims to:

- Contribute to the strengthening of Cambodia's overall health care system;
- Strengthen existing reproductive health services;
- Increase access to comprehensive HIV prevention education, VCCT, care and treatment.

Elements of the Linked Response will be:

- **Furthering Education**: Health care providers (doctors, nurses, midwives etc.) will be informed on how best to use the Linked Response to provide comprehensive care for patients. This will be accomplished by updating current literature, as well as through orientation and training workshops. Health care providers and home-based care teams at new Linked Response network sites will receive formal training on VCCT testing and counselling, PMTCT (prophylaxis, infant feeding, etc) and DBS collection for early infant diagnsosis.
- **Integration of IEC materials**: IEC materials should be consistent with one another.
- **Strengthening patient record keeping and data management** throughout the Linked Response network, especially with regards to HIV-positive pregnant women and HIV-exposed infants.
- **Strengthening referrals** between OI/ART, STI, ANC, family planning, safe abortion, adolescent health, and maternal & newborn health, as well as strengthening logistics and data management. Starting with core packages, experience can be gained about how they can be expanded to include other services. Details of these core packages and how they can be used for the Linked Response are in the Joint Statements and draft SOP being developed by the three Centres.
- **HBC teams (Home Based Care)** will work closely with Referral Hospitals and Health Centers to scale up referrals and initiate follow-ups.
- **HPITC (Health Provider Initiated Testing and Counselling)** is vital to providing complete care to clients who visit health facilities. All health professionals (doctors, nurses, midwives and dentists) should encourage clients to seek HIV testing and counselling at the nearest VCCT site. ANC, STI and TB patients should be especially encouraged to be tested for HIV, as should those patients who show symptoms associated with HIV/AIDS. If the patient is being seen at a health care facility, blood should be taken from the patient and then tested at the nearest VCCT laboratory site. As always, post-test counselling is of the utmost importance and should be performed in a counselling room by a trained professional.

- **Outreach** to village health volunteers, traditional birth attendants (TBA) and unofficial medical practitioners plays an important role in bringing patients into health care facilities for testing, counselling, care and treatment. By working closely with these individuals, facility-based providers will be able to identify more patients in need, and increase their patients' incentives to seeking care in the Linked Response network.

HIV and TB

Similarly, responding to the need to address TB/HIV co-infection, the National Centre for HIV/AIDS, Dermatology and STI (NCHADS) and the National Centre for Tuberculosis and Leprosy Control (CENAT) have created frameworks for implementing TB/HIV activities and the Continuum of Care (COC) for people living with HIV/AIDS and TB. With the Ministry of Health endorsement, these policies were implemented nationally in 2002 and 2003.

In order to effectively implement these programs and preventing them from overlapping one another, NCHADS and CENAT have agreed to release a joint statement which includes the following:

- **Provision of care and treatment for TB-HIV/AIDS co-infection**: Care and treatment of TB-HIV/AIDS co-infection shall include DOTS and Continuum of care services to be delivered within the existing public health system at the operational district level.
- **Supply of drugs-equipment and test kits**: Regular supply of materials and reagents is under the responsibility of the two National Centres (NCHADS and CENAT) and provisions should be included in their respective quarterly/yearly plans of action.
- **Training of health personnel:** The two national centres will collaborate to develop and implement training activities for health service providers to enhance their knowledge and capacity to provide services for TB-HIV/AIDS co-infection.
- **Awareness on TB-HIV/AIDS treatment and care TB-HIV/AIDS care and treatment promotion:** The two national centres through their networks and agents will promote TB-HIV/AIDS care and treatment services and educate TB-HIV/AIDS patients to use such services.

  Monitoring and evaluation: Follow-up, monitoring and evaluation of care and treatment for TB-HIV/AIDS co-infection will be included in the plan of action of the two national centres and will remain under their individual responsibilities. Activity reports will be included within the reports made by the two national centres.

Full details are in the Joint Statement between NCHADS and CENAT which can be found on the NCHADS web-site.

More recently, NCHADS and CENAT have drafted a TB HIV framework and SOP that include:

- HIV testing of TB patients: all TB patients have to be tested using either patient's referral to nearest VCCT or by blood draw at HC level and blood transportation to nearest VCCT.
- The 3Is Approaches:
    - Intensified TB case finding among PLHAs: using a symptom based screening algorithm, VCCT counsellors, OI/ART staff, and HBC staff will screen PLHAs for TB at the time of initial HIV diagnosis and at every follow up before and after ART start. PLHAs with at least one symptom will be further assessed by OI/ART clinicians using a diagnosis algorithm based on physical examination,

chest x ray, sputum smear and culture if available.

- Isoniazid Preventive therapy (IPT) : will be prescribed to PLHAs for whomTB has been ruled out (with a negative symptom screen) according to the SOP for IPT.
- Infection control measures (including room ventilation, masks and separation of sputum smear positive TB patients from other PLHAs) will be implemented in all HIV care settings, including VCCT services, OI/ART sites, places for PLHAs support-group meetings and MMM.

Positive prevention

NCHADS together with TWG is in the process of developing guidelines for positive prevention in order to best support PLHAs in accessing care and treatment including re-inforcing HIV prevention counseling, adhere to treatment and make informed choices regarding their sexual and reproductive health (including the use of condoms, contraception, safe abortion and PMTCT) in order to reduce the risk of HIV transmission to their sexual partners and potential future children, and to reduce the risk of HIV and STI re-infection.

The staff working at health centers, OI/ART services, VCCT centers, PMTCT sites, maternities, and STI clinics, are responsible for enforcing HIV prevention messages including:

- discussion on safer sex with provision of condoms,
- contraception or PMTCT for PLHAs who want to conceive
- and early detection and treatment of STIs

. Home based care, PLHA SG and MMM should also promote positive prevention messages and psychological support and promote access and referrals to health care services within the CoC.

Quality Assurance:

The OI/ART services Quality Assurance programme contains a number of elements: i) monthly CoC Coordination Committee Meetings, mentoring from a national core mentors to be extended to all sites, special emphasis on newly established sites; ii) regional network meetings every 6 months for clinicians and counselors for OIs & ART for adults and national meetings every 6 months for clinicians and counsellors for paediatric care – these will be extended to regional/provincial network meetings as sites increase; iii) development of standardized HIV drug resistance Early Warning Indicators monitoring and HIV drug resistance thresholds surveys; and iv) roll out of a Continuous Quality Improvement (CQI) strategy, under which ODs are supported to collect indicators measuring the quality of patient management across the CoC, measure their own performance against these, and monitor and improve on these as an integral part of their work.

6.3 NCHADS Annual Operational Comprehensive Plan (AOCP)

NCHADS is the department of the Ministry of Health whose mandate is to coordinate and develop Policies, Strategies, and Guidelines for implementation of HIV/AIDS and STI Prevention and Care activities within the health sector in Cambodia. The Centre plays an important role in mobilizing and allocating resources for implementation of activities to achieve the objectives of NCHADS Strategic Plan, within the Ministry of Health's overall

sector strategy. The NCHADS Strategic Plan for HIV/AIDS and STI Prevention and Care clearly identifies how to respond to HIV/AIDS and STIs, and how to align with the Ministry of Health's overall Strategy for Health Care for Cambodia 2003-2007. Under this plan, with the permission from Ministry of Health, NCHADS is responsible for supporting and coordinating provincial AIDS programs to develop Annual Operational Comprehensive HIV/AIDS and STI Plans by conducting planning workshops with all partners, collating these into a Comprehensive Work Plan for the HIV/AID Programme, and aligning this planning process with the cycle, procedures and formats of the Annual Operational Plan (AOP) of the Ministry of Health.

The NCHADS Annual Operational Comprehensive Plan (AOCP) aims annually to:

- develop national targets for HIV/AIDS and STI control for the year within the health sector
- identify all partners working at each OD, province, and at National level
- identify available funds for HIV/AIDS and STI control for the year
- allocate available funds for the year
- develop the Annual Comprehensive Operational Plan for HIV/AIDS and STI Prevention and Care in the health sector
- incorporate this ACOP for HIV/AIDS and STI into the MoH AOP, for coordination and monitoring of implementation of activities
- develop three year rolling plans and submit to MoH for the MTEF.

Stakeholders from the whole country are involved to develop the AOCP: HIV/AIDS Management teams (PHD or Deputy PHD Director, PAO and PHD Accountant), PHD Planning Officer, Provincial CoC Coordinator, NCHADS technical officers, and participants from more than 95% of HIV/AIDS care and prevention partners, donors, technical advisors, the National AIDS Authority, other National Programmes and MoH departments, and PLHAs networks.

Besides NCHADS, inputs are sought from:

- **NMCHC**, to share and update on the implementation of PMTCT programmes;
- **CENAT**, to share concerns and view points of the coordinated TB/HIV activities between NCHADS and CENAT;
- **National AIDS Authority (NAA)**, to update on the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2006-2010 and to outline the NAA Annual Operational Plan;
- **MoH Planning Department** to share the MoH planning cycle, procedures and formats, and suggest how to incorporate NCHADS' AOCP into the MoH's Annual Operational Plan through provincial health department plans.

Preparation of the NCHADS AOCP involves the following steps:

- The Planning Monitoring and Reporting (PM & R) Unit of NCHADS organises an 'achievement reviewing and issues' workshop with all provinces to review achievements made, constraints in the year, and to define targets and indicators for the coming year. The outputs of the provincial planning workshops are compiled from all provinces into a single database: the provincial targets for the year are identified, as well as provincial partners who are implementing HIV/AIDS prevention and care programmes.

- A series of preparation meetings and communications between NCHADS technical officers and related key institutions are held to be ensure that the workshop is participated in by a large number of participants;
- During the Annual Planning Workshop, a series of presentations and discussions are made to facilitate the planning exercise: provincial targets for they year, PMTCT, TB/HIV, the Ministry of Health AOP planning processes, work plan formats, indicators for monitoring and reporting of the achievements, and updates on NCHADS' structure and functions. All participants and interested representatives from partners are then divided into groups of 4-5 provinces and work according to the NCHADS Strategic Plan Components: IEC-BCC-100%CUP, STI, CoC, VCCT and Planning, Monitoring and Reporting with the assistance of the relevant NCHADS Units; guidance is also provided as to how to integrate the HIV/AIDS and STD plans into provincial AOPs for the Ministry of Health AOP.
- In addition, two or three selected provincial AOCP work plans are usually selected for presentation to the plenary sessions, to generate discussion, comments and suggestions to improve the process and the plans.

The outcome of these workshops are the drafts of 24 provincial Annual Comprehensive Work Plans (AOCP) which are submitted to NCHADS for reviewing to ensure that the provincial AOCP is in line with NCHADS' strategies, guidelines, and SOPs, as well as adjusted with funding allocated. In addition, the plans show the integration of partners' HIV/AIDS work plans into NCHADS' AOCP at all levels (OD/PHD and NCHADS). The final NCHADS Annual Operational Comprehensive Work Plan shows what all partners are contributing to the programme, and how.

As also laid down in NCHADS Standard Operating Procedures (SOP), mid-year programme coordination meetings are organized every year. These meetings provide a forum for review and discussion of progress, to find solutions to implementation, coordination, management and financial management problems related to the overall NCHADS programme, to make any adjustments necessary to the Annual Work Plan, and to review work plans, allocated budget and targets in the coming year for HIV/AIDS programmes.

6.4 Financing the Strategic Plan and budgeting the AOCP

The Strategic Plan has been costed.

Strategic Plan Summary cost estimates

	US$	US$	US$
Programmes	**2008**	**2009**	**2010**
BCC			
IEC	185,720	195,006	204,756
Outreach	46,500	48,825	51,266
100%CU	78,630	82,562	86,690
Sub-total	**310,850**	**326,393**	**342,712**
STI Services			
Running Costs (FHC and HC)	424,806	589,068	622,978
Renovation Costs			

	830,000		
Lab costs	125,419	166,035	232,450
PBIS	10,000	10,000	30,000
National Clinic	42,800	44,940	47,187
Sub-total	**1,433,025**	**840,043**	**932,615**
VCCT			
Lab Procurement (incl. equip)	1,765,776	2,769,531	3,025,390
VCCT	429,195	464,184	510,158
VCCT PBIS	450,000	600,000	600,000
CD4 PBIS	21,000	21,000	21,000
Sub-total	**2,665,971**	**3,854,715**	**4,156,548**
OI/ART			
Drugs (ARVs and OI)	6,027,235	6,723,382	7,114,869
HFBC Care	541,413	627,590	804,050
HBC	4,000,000	4,000,000	4,000,000
PBIS	1,200,000	1,500,000	1,500,000
Sub-total	**11,768,648**	**12,850,972**	**13,418,919**
Surveillance and Research	132,000	138,600	145,530
Planning, Monitoring & Reporting	212,429	223,050	234,203
Data Management	157,200	157,200	157,200
Logistic & Supply Mgt	123,584	129,763	136,251
Administration and Finance	435,749	457,536	480,413
PBIS	204,528	204,528	204,528
PBIS (Provincial Management Team)	201,600	201,600	201,600
Sub-total	**1,467,090**	**1,512,278**	**1,559,726**
TOTAL	**17,645,584**	**19,384,401**	**20,410,520**

Annual inflation rate 5%

In addition, each year the AOCP is budgeted. NCHADS uses a single, integrated, computerised accounting system for all funds managed by itself within the AOCP from all sources. This includes both funds spent at central level by NCHADS, and funds advanced to provinces and ODs for their own implementation. Details of how these can be used are in the "Standard Operating Procedures for Implementation of NCHADS Programme Activities" approved by the Ministry of Health in February 2006.

6.5 Functional Task Analysis (FTA) and Performance Based Incentive Scheme (PBIS)

Functional Task Analysis (FTA)

NCHADS maintains an up-to-date statement of the functional arrangements within the National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS) in the form of its Functional Task Analysis. The Functional Task Analysis, July 2007, is the latest in a series of functional analyses which began in 2001 and were followed by subsequent reviews in 2003 and 2005. The initial review in 2001 was aligned to the development of the NCHADS Strategic Plan for HIV/AIDS and STD Prevention and Care 2001-2005 and contributed to the management strengthening being undertaken in NCHADS. Later reviews assisted with aligning NCHADS Strategic Plan with the Health Sector Strategic Plan 2003-2007, and with the introduction of performance Based Incentive Scheme (PBIS).

The management arrangements within NCHADS are now relatively robust and their intermittent updating has become more a matter of routine than exception. However, it is because the management system within NCHADS has become fairly sophisticated and is continually evolving to meet new operational needs, that it is appropriate from time to time to review and record any changes. As with the review in 2005, the latest update (July 2007) also takes into account:

- Strengthened decentralization of the NCHADS programme to Provincial and OD levels;
- Increased emphasis on expanded access to treatment and care for PLHA through the introduction of OI and ART;
- Re-structuring of NCHADS' Units to respond to the demands of the expanded treatment and care programme, changes in the delivery of the prevention programme and the increased demands for improved data management.

Modifications made as a result of this Functional Task Analysis bring the organogram, Unit terms of reference and individual job descriptions into line with current practice and provide a benchmark against which the need for subsequent revisions can be measured.

Performance Based Incentive Scheme (PBIS)

A Performance Based Incentive Scheme was introduced in NCHADS in 2003 to reinforce the process of management reform and development throughout NCHADS and to stimulate performance. It provides supplementary payments to NCHADS permanent staff working as members of unit teams. The incentives are awarded in accordance with pre-determined criteria which measure team outputs on a quarterly basis and reward performance on a sliding scale according to achievement. The scheme also provides similar incentives for designated staff implementing HIV/AIDS programme activities in Provinces and Operational Districts. The detailed arrangements for the central and provincial schemes are set out in separate Standard Operating Procedures that specify the scales of payment as well as the means of assessment and verification that underpin the transparency of the arrangements.

The functional task analyses and the Performance Based Incentive Scheme have played complementary roles in the steady improvement in management performance within NCHADS. On one hand, the FTAs have had wide significance for management development within NCHADS. They have enabled the progressive evolution of better management practices across the range of NCHADS activities and in particular have introduced greater clarity about the roles of units and their staff, about accountability and about concepts of personal responsibility. On the other hand, the Performance Based Incentive Scheme has helped to reinforce the importance of these issues and has encouraged staff to take them more seriously than might otherwise have occurred. Staff now appreciate much better that attention to these matters is likely to be a prerequisite for maintaining a high performance

and hence the receipt of Performance Based Incentive Scheme payments. Thus a beneficial synergy has been created between the FTA process and the Performance Based Incentive Scheme.

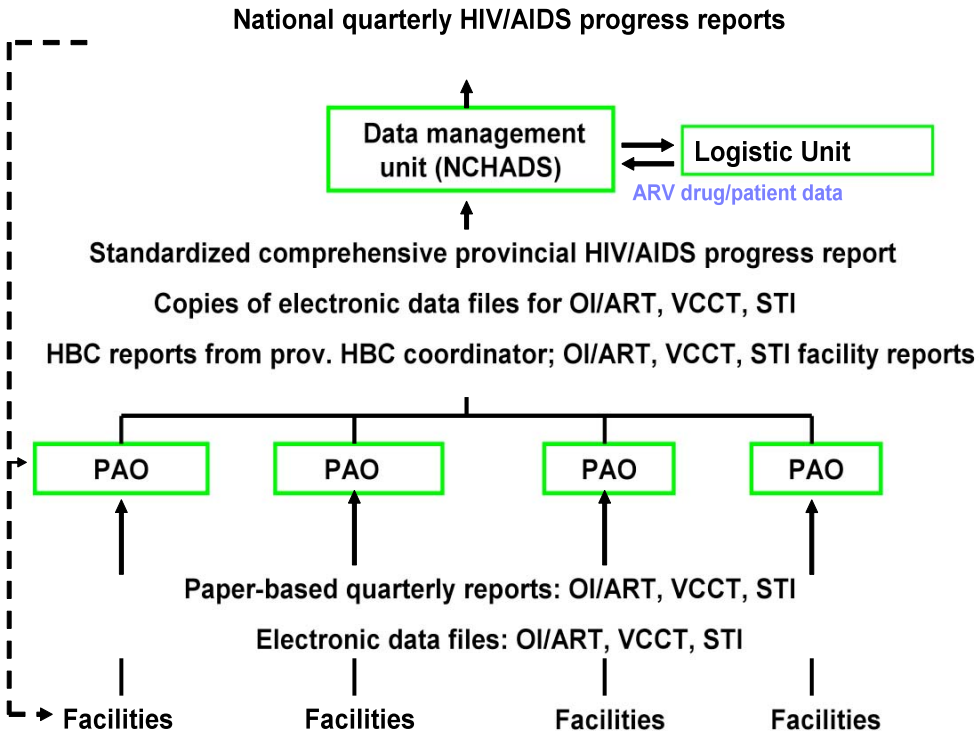
7. MONITORING AND ASSESSMENT OF ACHIEVEMENT

The primary tools for monitoring the achievements of this Plan are the epidemiological and behavioural surveillance systems and the service data systems 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 service data, NCHADS can assess how far it is succeeding in halting the spread of the epidemic, and caring for those affected by it. The indicators for these systems are described in the NCHADS' *"Core indicators and Targets for Monitoring and Evaluation of the Programme for HIV/AIDS and STI Prevention and Care in the Health Sector"*.

The active surveillance system, managed by the Surveillance Unit, generates data every two to three years, enabling NCHADS to make this assessment regularly. For the period of this Plan, the findings of the Consensus Workshop on HIV Estimation for Cambodia (June 2007), BSS (Behavioural Surveillance Survey) Results for 2007 and SSS (STI Surveillance Survey) for 2005 can be taken as the Baseline.

The passive surveillance system, managed by the Data Management Unit, generates data quarterly against a set of specific **Output and Outcome Targets** set for each of the components of this Strategic Plan; monthly data reports are consolidated by NCHADS into Quarterly and Annual Reports[1]. Financial data are also generated by the financial management system, and included in the Quarterly and Annual Reports.

[1] See www.nchads.org for NCHADS Quarterly and Annual Reports from 2003 to present



Details of indicators and targets can be found in the NCHADS "Core indicators and Targets for Monitoring and Evaluation of the Programme for HIV/AIDS and STI Prevention and Care in the Health Sector". A list of indicators by component is integrated here.