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STRATEGIC PLAN FOR HIV/AIDS AND STI PREVENTION AND CARE MINISTRY OF HEALTH, CAMBODIA 2011-2015

មជ្ឈមណ្ឌលជាតិប្រយុទ្ធនឹងជំងឺអេដស៍ សើស្បែក និងកាមរោគ

National Center for HIV/AIDS, Dermatology and STD

ឆ្នាំ ២០១០

STRATEGIC PLAN FOR HIV/AIDS AND STI PREVENTION AND CARE IN THE HEALTH SECTOR IN CAMBODIA, 2011-2015

Contents

List of Acronyms

ANC	Antenatal Clinic
AOCP	Annual Operational Comprehensive Plan
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BS	Birth Spacing
BSS	Behavioral Sentinel Surveillance
CENAT	Centre National Anti-tuberculeuse
CoC	Continuum of Care
CDHS	Cambodian Demographic and Health Survey
CoC-CC	Continuum of Care Coordinating Committee
CoPCT	Continuum of Prevention to Care and Treatment
CBPCST	Community-Based Prevention, Care and Support, Treatment
C/PITC	Community/ Peer Initiated HIV Testing and Counseling
CQI	Continuous Quality Improvement
CUCC	Condom-Use Coordinating Committee
CUP	Condom-Use Program
CUWG	Condom-Use Working Group
D-CoPCT CC	District Continuum of Prevention to Care and Treatment Coordination Committee
D-PCT	District Prevention to Care Team
DSW	Direct Sex Worker
DTOP	District Team on Outreach & Peer education
EES	Entertainment Establishment Services
EEW	Entertainment Establishment Worker
EPI	Enlarged Program Immunization
EWI	Early Warning Indicator
EW	Entertainment Worker
FBHSD	Facility Based Health Service Delivery
FHC	Family Health Clinic
HAART	Highly Active Antiretroviral Therapy
GNI	Gross National Income
HC	Health Center
HIV	Human Immunodeficiency Virus
HSD	Health Service Delivery
HSP	Health Strategic Plan
HSS	HIV Sentinel Surveillance
IBBSS	Integrated Bio-Behavioural Sentinel Surveys
IDSW	Indirect Sex Worker
IDU	Intravenous Drug User
IEC	Information, Education & Communication
IO	International Organization
IPD	In-Patient Department
IPT	Isoniazid Prevention Therapy
MARP	Most At Risk Population
MCH	Maternal Child Health
MMM	Mondol Mith Chouy Mith
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission [of HIV]
NCHADS	National Center for HIV/AIDS Dermatology and STD
NGO	Non-Governmental Organization
NIPH	National Institute of Public Health
NMCHC	National Maternal Child Health Centre
OD	Operational District
OI	Opportunistic Infection
PAC	Pediatric AIDS Care

PASP	Provincial AIDS and STI Program
P-CoPCT CC	Provincial Continuum of Prevention to Care and Treatment Coordination Committee
P-CoPCT SC	Provincial Continuum of Prevention to Care and Treatment Support Team
PE	Peer Educator
PF	Peer Facilitator
PITC	Peer Initiated HIV Testing and Counseling
PLHIV	People Living with HIV
PEP	Post Exposure Prophylactic
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
POC	Priority Operating Cost
POT	Provincial Outreach Team
PPP	Purchasing Power Parity
QC	Quality Control
RH	Referral Hospital
RPR	Rapid Plasma Reagent
RTI	Reproductive Track Infection
SAPAC	Safe Abortion and Post-Abortion Care
SOP	Standard Operating Procedure
SSS	STI Sentinel Surveillance
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TFR	Total Fertility Rate
VCCT	Voluntary Confidential Counseling and Testing
WHO	World Health Organization

PREFACE

This Strategic Plan was prepared by the National Centre for HIV/AIDS, Dermatology and STD Control in collaboration with all development partners local and international within the Ministry of Health Strategic Plan 2008-2015. It was prepared after a series of discussions, consultations and the results of two workshops involving Ministry of Health, development partners local and international, civil society, PLHIV-Networks, Provincial Heath Departments, and a number of internal meetings and reviews to response effectively to the current situation of the epidemic with the available resources.

The Strategic Plan is to be a framework for:

- Detailing the strategic objectives and targets to respond to HIV/AIDS and STI in the health sector for providing the direction of vision for program implementation in public health sector partners and civil society.
- Use in the preparation of AOCP for NCHADS, 24 provinces, and partners.
- Identifying resource needs that require filling in.
- Preparing the proposals and requests for funding to support the priority activities in the strategic plan in order to achieve the targets within the time-frame.

The Ministry of Health agrees and supports the strategic plan for prevention, treatment, and care and support for HIV/AIDS and STI (2011-2015) and Ministry of Health expects that all development partners will closely collaborate to ensure strong support for the successful implementation, and monitoring of this strategic plan.

Phnom Penh, 27/06/... 2011

Ministry of Health

Prof. ENG HUOT
SECRETARY OF STATE

ACKNOWLEDGEMENT

I would like to acknowledge the high quality contributions, enthusiasm and hard work from NCHADS technical units and all stakeholders that have gone into the successful review and updating of the Strategic Plan for HIV/AIDS and STI Prevention and Care 2011-2015 in the Health Sector.

This updated Strategic Plan for HIV/AIDS and STI Prevention and Care 2011-2015 represents a major achievement for the HIV/AIDS and STD program in the health sector, for three reasons. First, it is recognition of the value and contribution of all stakeholders and partners. The HIV prevention, care and treatment program is not just a program directed by NCHADS alone–Provincial Health Departments, Operational District and Health Centers 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 recognizes the importance of expressing the HIV/AIDS and STI strategy within the context of the overall Health Sector Strategy, and integrating the HIV/AIDS and STD program into the Health Sector program.

I would like to thank the staff of Planning Monitoring and Reporting Unit of NCHADS for coordinating this review and set the indicators and 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 PHD, PASP and OD staff for their practical contributions to ensure that this is a workable strategy; and most important the development partners local and international and members of the various Technical Working Groups, from other health departments, government institutions, and from civil society, local and international partners and PLHIV-networks for their unstinting contributions. I hope we will all be able to implement with the same enthusiasm and skill with which we have strategized.

Phnom Penh, 22/06/, 2011

Director of NCHADS

Dr. Mean Chhi Vun

STRATEGIC PLAN FOR HIV/AIDS AND STI PREVENTION AND CARE IN THE HEALTH SECTOR IN CAMBODIA 2011-2015

1. INTRODUCTION

1.1 General socio-economic situation

Cambodia is located in the centre of the Indo-china peninsula. The projection population is approximately 14 million in 2010 (7.4 million are female). The capital, Phnom Penh, had a population of about 1.5 million; there are also four other provinces with populations over 1,000,000: Battambang, Kampong Cham, Kandal and Prey Veng. There are only 3 other provinces with population over 100,000: Stung Treng, Ratana kiri and Oddar Meanchey (Population projections for Cambodia 1998-2020). According to 2008 census, population lives in 2.832.691 households, in 14,073 villages, in 1,621 communes, in 185 districts, and in 24 provinces. The population density is 75 per square kilometer, and the population density rates was vary widely and ranked from 10 to 12 people per square kilometer in 4 provinces (Preah Vihear, Ratanak Kiri, Stung Treng, and Koh Kong) to more than 100 people per square kilometer in seven (Banteay Meanchey, Kampong Cham, Kampong Speu, Kampot, Prey Veng, Svay Rieng and Kep). The capital city of Phnom Penh is the most densely populated area in the country with 4,571 people per square kilometer. The average household size is 4.7 people, with 80% of the population living in rural areas.

In 2010, Cambodia ranked 124th out of 166 countries on the Human Development Index, which was classified in the Medium Human Development. Some components of Human Development Index are the life expectancy at birth is 62.2 years, the mean years of schooling is 5.8 years, the expected years of schooling is 9.8 years, and the Gross National Income (GNI) per Capita (PPP in 2008) is US$ 1,868. Despite recent improvements, health status indicators are still low. The Cambodian Demographic and Health Survey (CDHS) 2005 estimated the maternal mortality rate is high, at 472 per 100,000 live births and remained unchanged between the last two CDHS in 2000 and 2005, the infant mortality rate decreased from 95 to 60 deaths per 1000 live births from 2000 to 2008, and under-five mortality rate decreased from 124 to 83 deaths per 1000 live births from 2000 to 2005, the total fertility rate dropped from 4.0 births per woman in 2000 to 3.4 in 2005, and further decreased to 3.1 in 2008 (Census data), and the annual population growth rate between 1998 and 2008 declined from 2.5% to 1.5%. 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. In 2008, the GDP per capita was US$640, with 31% of the total population still living below the official rural and urban poverty lines.

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.

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 behavior (eg. abstinence and faithfulness); and a large number of energetic social-development programs.

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% in 2008. Then the prevalence was further decreased from 0.9% in 2006 to 0.7% in 2010. The number of PLHIV in 2010 is estimated at 56,200 (29,500 women) of whom approximately 46,000 were suffering from AIDS and in need of ART. The reduction of the prevalence in Cambodia is due to the strong concerted effort for prevention activities (100% CUP) among entertainment workers since the early stages of the epidemic in 1998. Along with the decline in HIV prevalence among the general population, it is noted that most-at-risk populations (MARP) such as entertainment workers, drug users and men who have sex with men (MSM) are remain the target group that required special attention in the provision of prevention, care and treatment services.

These results of surveys (HSS and BSS) show a picture of the HIV epidemic in Cambodia is emerging of fairly rapidly changing behavior and declining prevalence. 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. According to the results of NCHADS-BSS in 2010, the trend of consistent condom use rates with clients reported by entertainment workers with clients are remained high at 89.2% from 2003 to 2010; however, the consistent condom use rate with sweethearts remained low at 50% during the same period. Some studies indicated that there had been a high (more than 20%) reported prevalence of abortion while working as EWs, and private clinics and buying drug from Pharmacy had been reported as the main place to induce abortion. High reported of any STI symptoms although high proportion of EWs went to STI clinics at least one time in the past months and high proportion of EW went to health facilities to get last STI symptoms treated.

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. Up to the end of 2010, Cambodia has provided antiretroviral treatment to 42,779 people, including 4,102 children, which covered more than 90 % of those in need. Recently, Cambodia is proud to be presented with the MDG award for its outstanding national leadership, commitment and progress towards achievement of Goal 6 (HIV/AIDS), particularly in working towards halting and reversing the spread of HIV, in which the health sector had played an important role. It has to ensure this strong commitment in order to sustain the high coverage of ART for adults and children, and to prevent the reverse of trend of the epidemic through focusing the prevention efforts to MARP.

2. PREVIOUS STRATEGIC PLANS

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

A National Strategic Plan for STD/HIV/AIDS Prevention and Care 1998-2000 was developed by National Center for HIV/AIDS, Dermatology and STD and development partners, which identified 12 strategic areas packages (prevention, care and treatment, strategic information and management packages) in which activities were to be undertaken.

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

Early in 2000, however, and as a result of the clarification of analysis of the epidemiological and behavioral data from the HIV Sero-surveillance (HSS), Knowledge on HIV/AIDS and

Behavioral Surveillance Surveys (BSS), the **National Centre for HIV/AIDS, Dermatology and STD** (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* (eg for Surveillance, for AIDS Care, for Outreach, for STD Management, etc), *Guidelines for the Introduction and Implementation* of various programs and interventions (eg 100% Condom Use, Home-based Care, Counseling and Testing, STD services), and *Training packages* (eg. Syndromic Management of STD, Strengthening Provincial HIV/AIDS Programs, etc). These were then used to establish activities and program at central, provincial and operational district level.

Towards the end of 2002, the Ministry of Health developed an overall **Health 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, Behavior 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 US-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 program 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, provincial and operational district staff and implementers.

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

The **NCHADS Strategic Plan 2004-2007** was an integral part of the **Health Strategic Plan 2003-2007(HSP)** 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 STD were grouped into four packages: 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 Counseling and Testing and Universal Precautions, as well as collaboration with other departments and Centers 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**.**

2.4 Strategic Plan for HIV/AIDS and STI Prevention and Care 2008-2010

The NCHADS' Strategic Plan for HIV/AIDS and STI Prevention and Care 2008-2010 was focused on three evidence-informed strategic priorities. These were derived from the epidemiological and behavioral 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 were that **targeted prevention remains the first priority**: prevalence fell faster than expected in Cambodia prior to 2008 reached very low levels in the general population (below 1%); but incidence appeared to remain relatively high in certain high-risk situations, especially the entertainment workers and the MSM population, and in what appeared to be emerging vulnerable groups–especially injecting drug users (IDU). Working closely with NAA and other partners, especially with civil society to focus intervention on entertainment places based upon the strategy for continuum for prevention to care and treatment (CoPCT) that has been implemented by NCHADS and partners. The other 'most at risk populations' (MARP) were focus on provision of continuum of prevention to care and treatment services at public, NGOs and private facilities.

The ravages of the epidemic in Cambodia over the last decade, based on the Asia Epidemic Model projected for 2006-2012, estimated that there were 67,200 Cambodians were living with the virus in 2008. With the advent, and subsequent dramatic scaling up of antiretroviral therapy (ART) by NCHADS and its partners, the burden of care became very significant: **addressing this burden of care within the constraints of the health care system constituted the second priority** for NCHADS. NCHADS was committed to integrating these activities within the existing public health care delivery system, and did so through building an increasing number of partnerships, with international and local NGOs, with other government departments, and with the private sector.

The **third priority related to the need to sustain the program continuum for prevention to care and treatment 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 developed an effective HIV/AIDS program as an integral part of the Health Sector Strategic Plan 2003-2007 (HSSP). Within the first 'core strategy' of the HSSP, Health Service Delivery, were five sub-strategies (p25 HSSP): the fourth is: 'Strengthen the management of cost-effective interventions to control communicable diseases'; HIV/AIDS and STD were placed under this sub-strategy (pp. 44, 55). This program has made significant contributions to achievement of the Ministry's strategic plan, especially in the areas of transparent and accountable consolidated financial management, development of procurement mechanisms for ARV drugs, building capacity at provincial level for effective planning, management and financial responsibility, development and sustainment of high-quality and credible surveillance and research with respect to HIV, models for effective program management based upon clear technical and operational guidelines and standard operating procedures (SOPs), introduction of high level clinical management into referral hospitals, and establishment of partnerships and working mechanisms with NGOs and other stakeholders. To ensure that NCHADS has sustainable contribution to the prevention, care and treatment of PLHIV within the health sector, it is necessary to maintain all of these effective programs.

2.5 Achievements of the implementation of the Strategic Plan 2008-2010

Under the plan considerable significant progress was made:

- Prevalence among general population aged 15 to 49 years decreased to an estimated 0.7% in 2010;
- Outreach Program was re-structured to meet wider needs within the entertainment services based on the SOP for a Continuum of Prevention to Care and Treatment for

Female Entertainment Workers in Cambodia which replaced the previous SOP for the Outreach and Peer Education and 100% Condom Use Program to Sex Workers;

- 32 special STI clinics with laboratory support are functioning, with 6,774 entertainment workers used these STI services monthly;
- 5 STI clinics have undertaken the continuous quality improvement of the services and 5 additional STI clinics will do this in the next five years;
- VCCT sites expanded from 197 to 246, with the numbers of clients tested rising from 78,922 to 668,675 by the end of 2010;
- Adult ART services were scaled up with 49 to 51 sites, with the numbers of adult patients on ART rising from 28,932 to 38,697 in 2010;
- Pediatric AIDS Care was scaled up from 29 to 32 sites, with 4,102 children on ART in 2010;
- In total 316 clinicians (Pediatric OI/ART: 114 and Adult OI/ART: 202) and 372 nurse counselors have been trained in OI/ART;
- Home-based care teams working within the CoC have expanded to 358 by the end of September 2010 covering 841 health centers and supporting over 26,000 PLHA;
- Up to the end of 2010, 62 ODs covering 835 health centers are implementing the linked response approach. 109,618 pregnant women attending the ANC services, and among them, there were 88,240 were accepted to do HIV testing, with the positive rate was 0.20%;
- The guideline for Implementation for Positive Prevention has been developed and will start to implement in 20 ODs during the last quarter 2010;
- Standard Operating Procedures for Implementing The “3’Is activities in Continuum of Care Setting were approved by MoH on 23 April 2010 and stated to implement in 25 OI/ART sites in April 2010;
- NCHADS partnerships (through signed Letters of Agreement) and inclusion in the Annual Comprehensive Work Plan expanded from 30 to 50 NGOs.

3. THE STRATEGIC PLAN FOR HIV/AIDS and STI PREVENTION AND CARE 2011-2015

3.1 Development of the Strategic Plan 2011-2015

The strategy development for 2011-2015 was joined by NCHADS’ partners, NCHADS Technical 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 with alignment to the Health Sector’s Strategic Plan of the Ministry of Health 2008-2015. This was shared in draft with development partners to review and comments and incorporated all relevant inputs into this document.

At the same time, NCHADS participated in the working group to develop of the National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV and AIDS 2011-2015 (NSPIII) to ensure full alignment.

3.2 Overall Goals within the MoH Health Strategic Plan 2 (2008-2015)

The goals of MoH HSP 2008-2015 is:

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

1. To reduce the HIV prevalence rate to between 0.9% and 0.6%;

2. To increase survival of People Living with HIV/AIDS in Cambodia to more than 85% after initiated ART for 12 months.

The NCHADS' Strategic Plan thus takes these two objectives, adds a third regarding program management, to produce three overall goals for HIV/AIDS and STI Prevention and Care for 2011-2015 as below:

1. To reduce the HIV prevalence rate to between 0.9 and 0.6% in 2015;
2. To increase survival of People Living with HIV/AIDS in Cambodia to more than 85%;
3. To ensure that NCHADS and provincial programs, including OD activities, are cost-effectively managed.

The third objective responds to the key MoH HSP2 **Strategies Areas**:

- **Strategy 1: Health Service Delivery**: consists of both public health measures against disease-organization of health promotion for reduction of risk behavior and health protection- as well as general strengthening of health service delivery through general and diseases specific policies and plans. Much emphasis is given the subject of quality improvement. An increase in health demand and empowerment of patients are underlined as important ways forward for improved quality and accountability in health services delivery. Stresses on consolidation of evidence-based data to develop policies, strategies and SOP of preventive, care, treatment and support 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**: address both increased in investments in health and efforts to remove financial barriers to quality health care. Government allocation to the health sector has increased every year but it is necessary to be contributed from development partners. Thus underlining issues around the balance of financing between donors and governments as well as efficient funding of operational levels. Strengthening of social health protection mechanism, and contribute to reduction of financial barriers to access health services and spend more on health problems. Stresses improved efficiency of government resource allocation, alignment of donor financing, decentralization 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 for Health Sector: covers a comprehensive range of intervention i) to ensure sufficient staffing levels with adequate professional profiles and competencies, ii) revising content of their training, iii) increasing the intake of students into schools and universities, and iv) strengthened measures to safeguard the quality of training and trainers. Midwives are particularly selected as a target group because of their key role for achieving the general goals of the HSP 2008-2015. Human resource programming also includes safeguarding professional ethnics. Special urgency is associated with implementation of salary reform for health services. Stresses on continuous building of NCHADS staff capacity at national, provincial and health center levels to keep up-to-date the policies, strategies, guidelines to support the prevention, care and treatment program more effectively with appropriate quality, and sound management systems for NCHADS' programme, through alignment of POC's Schemes approved by the Royal of Cambodia in 2010.

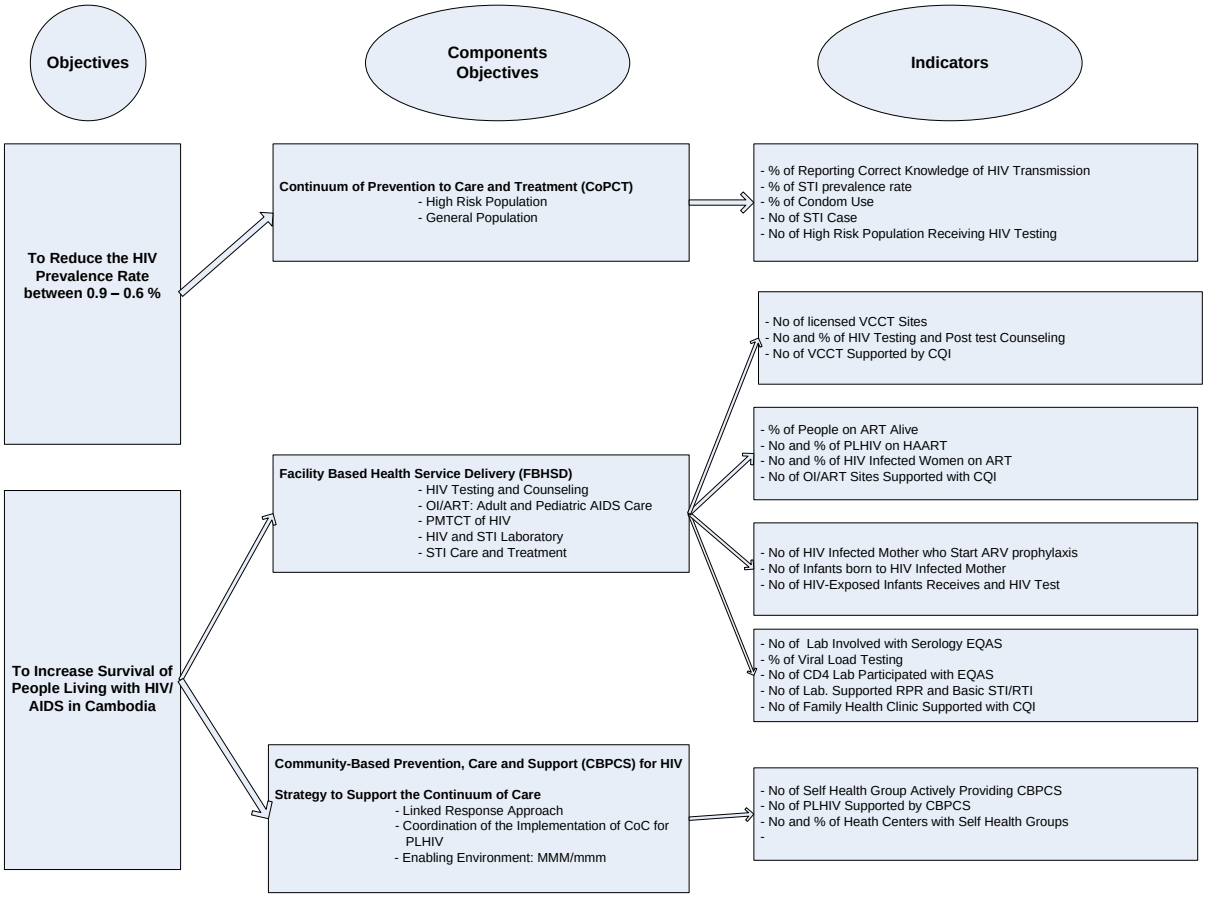
- **Strategy 4: Health Information Systems**: address the need for high quality, accurate, comprehensive and timely data to provide the basis for evidence-based updating policy, planning, performance monitoring and evaluation. It emphasizes improved coordination and collaboration both within and outside the health sector through data sharing, management, analysis, dissemination and use and including of private sector information, as well as tracking budgets and expenditures and expanded training to build HIS capacity. 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**: The government perspective of the HSSP2 focuses on decentralization and deconcentration. The regularization of internal and external contracting through Special Operating Agencies, as well as block grants from the national level and local resources mobilization will cover the financial needs of the policy. Increase autonomy at the operational level will be developed, together with stronger regulation and stewarding of the private sector. Harmonization and alignment for results is stressed to achieve a common policy framework between government and development partners for health development. The strategy will improve the comprehensive picture of the government and donor funding and strengthen harmonization (coordination, external support to follow national procedures, institutions and systems where possible) and alignment (ensuring that priority identified by Cambodia become the priority of donors) of aid architecture, in line with the government policies for decentralization and deconcentration and HSP 2008-20215 priorities. 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 implement the MoH strategy.

3.3 Structure of the Strategic Plan 2011-2015

The Strategic Plan for HIV/AIDS and STI Prevention and Care in health sector 2011-2015 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 nine (9) program elements under which activities are planned and budgeted in NCHADS, provinces and among stakeholders. It is important to note that the strategic plan for the “Continuum of Prevention to Care and Treatment” under the objective one: is an integrated core operational strategy for STI and HIV prevention and education that are provided for both high risk populations and the general population; and the strategic plan for the “Continuum of Care” under the objective 2: is an over-arching framework within the three main elements: 1) Facility-Based Health Service Delivery (including HIV testing and counseling, adult and pediatric AIDS care, PMTCT, HIV and laboratory to support HIV and STD treatment); 2) Community-Based Prevention. Care and Support (CBPCS); and 3) Strategy to Support the Continuum of Care (including linked response approach, MMM/mmm services and other strategies), which are separate components.

For each program 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 of the Strategic Plan:



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

4. OBJECTIVES AND STRATEGIES TO REACH THEM

Objective 1: TO REDUCE THE HIV PREVALENCE RATE TO BETWEEN 0.9% to lower than 0.6% by 2015

4.1 Component 1: Continuum of Prevention to Care and Treatment (CoPCT) for Most at Risk and General Populations

Objectives:

- To maintain high level of awareness on HIV/AIDS and STI and to promote HIV and STI care seeking behaviors among the general population;
- To strengthen access to quality HIV and sexual health services for MARP and their partners through the implementation of the Continuum of Prevention to Care and Treatment (CoPCT);
- To improve knowledge and behavioral change among PLHIV through positive prevention interventions.

Core strategy:

- To sustain high level of awareness on HIV and STI with a focus on MARP and most-at-risk groups (EW, MSM, DU/IDU,...), young people at high risk, and promote early HIV and STI testing and care seeking behavior;
- To implement nationwide the Continuum of Prevention to Care and Treatment (CoPCT) for MARP with special emphasis on entertainment workers, men who have sex with men (MSM), trans-genders, and Injecting Drug Users;
- To implement positive prevention among those who are already infected with HIV.

The awareness raising program among most at risk and general population will use targeted mass media message approaches (HIV/STI/RH; TB-HIV; HIV/harm reduction…) to increase knowledge on HIV and STI prevention. The program also aims to contribute to increase access to continuum of HIV and STI prevention and care services through the promotion of early HIV testing and health seeking behaviors among most at risk and general populations. The use of primary health care networks to carry out HIV and STI prevention activities will contribute to increase the coverage of interventions at the community.

Given the recent changes in Cambodia's policy environment and the subsequent change in the patterns of sex work with a shift from brothel to entertainment services, Standard Operating Procedures (SOP) on Continuum of Prevention to Care and Treatment (CoPCT) for Women Entertainment Workers was developed and approved by the Ministry of Health in late 2009 to enable stakeholders in the health sector to provide more adequate response. This approach can also be applicable to men who have sex with men (MSM). This CoPCT approach will be the main strategy for address HIV and STI issues among MARP over the next five years that are implemented within the health sector.

Adult PLHIV often become sexually active, and in many cases, they practice unsafe/ un-protected sex. This behavior puts them at risk of contracting other infections and HIV super-

infection. Studies from different parts of the world revealed that one in three PLHIV practice unprotected sex. In mature generalized HIV epidemics, a large proportion of HIV infections occur within HIV discordant couples. Positive prevention interventions among PLHIV will help them reduce the risk of HIV transmission to their sexual partners and potential future children. The implementation of this strategy in the next five years will be guided by the Guide for Implementation of Positive Prevention among PLHIV in Cambodia was approved by the Ministry of Health in April 2010 with supplemental support by the development partners from Joint Partners Agreement on "Making Birth Spacing and HIV Prevention Services Available at OI/ART Services to Support Positive Prevention for PLHIV", approved by the Ministry of Health in October 2010.

Innovative approach will be implemented to address the low uptake of HIV counseling and testing among MARP, especially EWs and MSMs. Through the Community/ Peer Initiated HIV Testing and Counseling (C/PITC) approach, peer networks assisted by the staff of existing VCCT centers will be participated in peer education and providing group pre-test counseling, and conduct HIV testing for volunteers, and give the results in closed envelop to be given to the clients at the end of meeting of PLHA Support-Group.

The recent BSS 2010 results found that, although condom use by EWs with clients is high (81.5%-89.2%), that with sweethearts remains low (39.4 to 48.3%). There had been report on a high prevalence of abortion among this group. Private clinics and buying abortion drugs from pharmacies had been reported as main entry point for abortion. These findings stress the need for providing birth spacing services for EWs. Access to birth spacing among EWs will be increased through the implementation of an innovative initiative in the next five years.

This strategic plan focuses on:

- To implement integrated (HIV/STI/RH, Mother and Child Health, TB/HIV, HIV/harm reduction…) mass media interventions and campaigns through identification and development of appropriate IEC/BCC (messages, contents, media, etc) to support the HIV and STI awareness campaign and promotion of HIV and STI care and treatment seeking behaviors among most at risk and general populations;

- To identify and develop appropriate IEC/BCC (messages, contents, media, etc) to support the implementation of CoPCT by addressing majors risk behaviors including the link between HIV and alcohol and drug use; increasing demand for HIV, STI prevention and care, and sexual reproductive health services for MARP; and promoting early access to these services;

- To develop and implement and evaluate a model of HIV and STI prevention at community level using existing primary health care networks;

- To improve coordination to support CoPCT for MARP at national, provincial and operational health district levels;

- To harmonize the implementation arrangement between Government institutions and NGOs working on CoPCT for MARP at national, provincial and district levels;

- To implement the Community/ Peer Initiated HIV Testing and Counseling (C/PITC) approach for EWs and MSM;
- To implement innovative approach to increase access of birth spacing services among EWs including HIV counseling and testing initiated by Health care providers (PITC);
- To implement continuous quality improvement for STI and HIV testing services for MARP, including PITC;
- To develop and implement models for linking existing health services to improve access of MARP to early HIV testing and CoC services and optimize internal referrals between key services, such as VCCT, STI, SRH/Birth spacing, TB, ANC; in harmony with the existing Linked Response approach;
- To improve HIV and STI prevention and care services for MSM and trans-genders;
- To improve coverage of CoPCT services for MARP and their partners by addressing stigma related to the use of services, including reducing barriers to access to services, linkage between health and non health sectors; establishing MARP friendly services to allow ease of access including making HIV preventive and birth spacing commodities available and accessible at the OI/ART clinics and HIV and STI care sites for MARP;
- To strengthening monitoring and evaluation of the implementation of CoPCT, with special emphasis on exploring the possibility of establishing a coding system to track MARP access to CoPCT services and regular size estimation of MARP;
- To use evidence from existing surveys including IBBSS and other innovative research findings to calibrate interventions among MARP.

INDICATORS AND TARGETS

Core Indicators		**Type**	**Baseline**	**Targets (Year)**					**Source**
				2011	**2012**	**2013**	**2014**	**2015**	
1	HIV prevalence among EWs who have sex > 2 partners per day	Impact	Preliminary result 10.7% (2010)			<8.5%		<7%	HSS 2010/ IBBSS
2	HIV prevalence among EWs who have sex ≤ 2 partners	Impact	Preliminary result 2.3% (2010)			<2%		<1.5%	HSS 2010/ IBBSS

3	HIV prevalence among MSM	Impact	2.1% (2010)			<2%		<1.5%	IBBSS Report
4	HIV prevalence among long hair MSM	Impact	N/A		<1.5%			<1.2%	IBBSS Report
5	HIV prevalence among short hair MSM	Impact	N/A		<1.5%			<1.2%	IBBSS Report
6	HIV prevalence among DUs	Impact	N/A	<2%				<1.5%	IBBSS Report
7	HIV prevalence among IDUs	Impact	N/A	<2%				<1.5%	IBBSS Report
8	GC prevalence rate among EWs	Impact	13.3% (2005)	10%				7%	SSS report 2011 and 2015
9	CT prevalence rate among EWs	Impact	13.7% (2005)	13%				10%	SSS report 2011 and 2015
10	Syphilis prevalence rate among EWs	Impact	3.6% (2005)	2.5%				<2%	SSS report 2011 and 2015
11	Percentage of general population that report correct knowledge of HIV transmission and prevention	Outcome	>80% (2005)					>90%	CDHS Report
12	Percentage of EW who received an HIV test result in the last 12	Outcome	N/A	30%	50%	60%	70%	80%	NCHADS report

	months								
13	Percentage of MSM who received an HIV test result in the last 12 months	Outcome	N/A	20%	30%	50%	70%	80%	NCHADS report
14	Percentage of EWs with more than 2 clients who reported consistent condom use in last 3 months	Outcome	83.7% (2010)			90%		>90%	BSS 2010 and IBBSS 2013
15	Percentage of EWs with less than 2 clients who reported consistent condom in last 3 months	Outcome	81.5% (2010)			85%		>85%	BSS 2010 and IBBSS 2013
16	Percentage of EWs with more than 2 clients who reported consistent condom use with sweetheart in last 3 months	Outcome	48.3% (2010)			60%		>60%	BSS 2010 and IBBSS 2013
17	Percentage of EWs with less than 2 clients who reported consistent condom use with sweetheart in last 3 months	Outcome	39.4%			50%		>60%	BSS 2010 and IBBSS 2013
18	Percentage of individual EWs who use STI services in quarterly basis	Outcome	N/A	50%	55%	60%	65%	70%	NCHADS report

19	Percentage of EWs who are new users of birth spacing services (P/D) at family health clinics	Output	N/A	10%	20%	30%	40%	50%	NCHADS Report
20	Percentage of EWs who are current users of birth spacing services (P/D) at family health clinics	Output	N/A	30%	40%	45%	50%	60%	NCHADS Report

Objective 2: TO INCREASE SURVIVAL OF PEOPLE LIVING WITH HIV IN CAMBODIA to > 85% by 2015

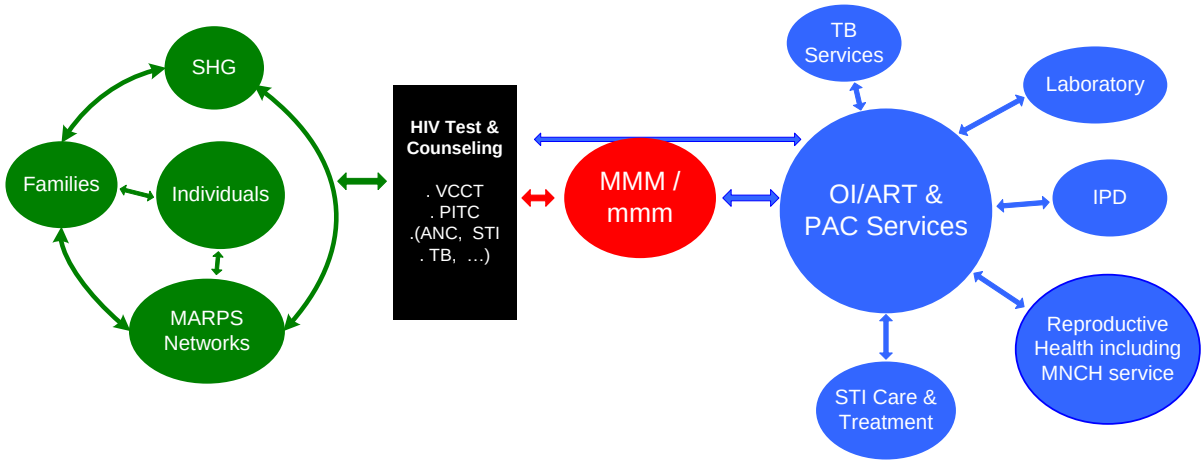
The Comprehensive Continuum of Care (CoC) for People Living with HIV

Objectives:

- To ensure and maintain Universal Access of PLHIV to a continuum of care for PLHIV;
- To ensure quality of care and treatment services, including life-long ART for PLHIV;
- To drastically reduce HIV transmission from mother to child to contribute to the elimination pediatric HIV infection by 2020 to < 2%.

Core Strategy:

Framework for continuum of care for PLHIV



Abbreviations:

- SHG : Self Help Group
- VCCT : Voluntary Confidential Counseling and Testing
- PITC : Provider Initiated Testing and Counselling
- IPD : Inpatient Department
- ANC : Antenatal Care
- MARPS : Most at risk populations
- MMM/mmm: Mundol Mith Chouy Mith
- PLHIV: People living with HIV
- OI-ART : Opportunistic Infection / Antiretroviral Therapy
- PAC : Pediatric AIDS Care
- MNCH : Maternal, Newborn and child health

The Continuum of Care (CoC) Framework for PLHIV has been the underlying framework upon which Cambodia's success in reaching Universal Access to treatment and care is based – aimed at providing a comprehensive set of integrated services for PLHIV at different stages and needs within a single context that links the family, the community and the health facilities. Various reviews of the CoC Framework have been conducted, and emerging needs have been incorporated in a revised Framework document in 2010.

The 2010 revised Continuum of Care framework comprises three components: Facility Based Health Service Delivery (FBHSD), Community Based Prevention, Care and Support

(CBPCS), and Strategy to support the implementation of the CoC including linked response approach, coordination and enabling environment through MMM/mmm. The Facility-Based Health Services Delivery include services available at MPA level such as ANC, birth spacing, HIV testing through VCCT and PITC for STI and TB patients and ANC attendees including HIV testing during labor, and services available at CPA level such as OI/ART for adult, Pediatric AIDS Care (PAC), laboratory support, STI services (in high-risk ODs) and delivery services for PLHIV. Nutritional support and palliative care will also be integrated in relevant service deliver points of the CoC.

Recently prevention strategies among PLHIV have been strengthened within the CoC as well as TB/ HIV collaborative activities (through the Three "I" strategy). The revised CoC framework also includes strong linkages, through the "linked response" approach to Maternal and Reproductive Health services and to TB services.

Pediatric AIDS Care will be further expanded during the current plan. With the Linked Response Approach, referrals across HIV-MCH/RH-TB services will be strengthened to improve the prevention of mother-to-child HIV transmission and decrease TB burden among PLHIV (Three "I"). The Linked Response Approach at OD level will also contribute to health system strengthening.

Community-based prevention, care and support (CBPCS) has the purpose to reduce stigma and discrimination associated with HIV prevention and care service delivery; to facilitate service linkage to ensure user-friendly HIV care and treatment services; to support successful ART through adherence support and close follow-up of the patients, and the implementation of other activities included in the revised CoC framework, such as positive prevention for PLHIV, Three "I" Strategy; and to assist PLHIV to access other social support. To ensure sustainability and to engage PLHIV in the delivery of services, home-based care team approach will need to be shifted to more community based support using self-help groups. Service provision within the CoC is based upon all individuals' rights to access quality health care, with user-friendly providers and non-discriminatory approaches. Emphasis is put on creating an enabling environment for PLHIV to take part in the process of providing health and social services for their peers. PLHIV are directly joining in as MMM/mmm coordinators, community based prevention, care and support volunteers, HIV testing counselors, drug counselors, and referring their peers to access services within health care facilities.

A strong logistic supply management system is required to ensure long-term uninterrupted supply of HIV reagents, consumables and drugs to all CoC sites. More reliable forecasting and stock monitoring tools will need to be further strengthened.

This strategic plan focuses on the three components of the CoC, is therefore to:

1. Expand and strengthen the CoC for adult and children living with HIV at OD level;
2. Building and maintaining the capacity of health staff in the continuum of care;
3. Integrate the Linked Response between HIV, STI, MCH/RH and TB into the CoC;
4. Integrate activities to support positive prevention for PLHIV including access to STI and birth spacing /condom services into CoC packages;
5. Work towards integration of the CoC into the health care system;
6. Strengthen the coordination of linkages within and among the various Health Services Delivery (HSD) and community based prevention, care and support (CBPCS) and health facilities based care;
7. Support PLHIV peer support activities;
8. Ensure access for MARP to the full CoC services; and
9. Coordinate with all partners for social support for PLHIV.

Each of the three components of the CoC is addressed separately in this Strategic Plan, with its own specific objectives, core strategies, focus and indicators and targets.

Indicators and Targets

Core Indicators		Type	Baseline	Targets (Year)					Sources
				2011	2012	2013	2014	2015	
1	Number of Adult OI/ART services	Output	49 (2010)	56	58	58	58	58	NCHADS Report
2	Number of Pediatric OI/ART services	Output	32 (2010)	40	50	55	58	58	NCHADS Report
3	Number of CoC at OD levels	Output	44 (2010)	48	52	56	56	56	NCHADS Report

4.2 Component 2: Facility Based Health Service Delivery (FBHSD)

FBHSD includes all health services at MPA and CPA levels available for PLHIV. HIV testing (entry point to care) and OI/ART services are essential parts of FBHSD. The number of PLHIV on ART has dramatically increased to 42,799 in 2010 including 4,102 children. Reaching Universal access to ART has required enormous efforts and investments in four primary areas within the health care system: (i) training clinicians to administer ART; (ii) strengthening laboratory services to support effective diagnosis and monitoring; (iii) developing procurement, logistics and supply, and data management systems that ensure uninterrupted consumption of drugs by those who need them; (iv) establishing community –based care and support and referral systems.

FBHSD for PLHIV has been recently strengthened with and integration of the Three "I" Strategy for TB-HIV and a package of positive prevention activities for PLHIV that include 1) advice and counseling on condom use; 2) counseling on ART adherence; 3) counseling on birth spacing/condom and safe abortion services; 4) TB infection control services; 5) STI prevention and case management.

Palliative care is integrated within IPD and linked to CBPCS. The National OI/ART program has develop a strong Quality Assurance system that 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 staff managing pediatric 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, measuring of the OI/ART team performance, and strengthening the patient monitoring to improve the implementation of their work. These systems need further strengthening, and expansion to all ODs that have CoC.

With the recent increase in the CD4 threshold to start ART at 350, the ART coverage will have to be readjusted. To encourage starting ART for PLHIV who have high CD4 level by strengthening of linkage between post-test counseling and Pre-ART care and shortening the time of Pre-ART care before starting ART.

In the context of increasing number of 2nd line treatment and complex clinical cases, "vertical referral and support mechanism" across OD-Province/National Levels need to be further strengthened.

To ensure better utilization of CoC services by MARP, efforts are being made to develop friendly health services in existing CoC where MARP are concentrated. In addition, MMM venues can be used as a drop-in center for MARP. To improve MARP referral from community based prevention, care and support services to CoC, the continuum of prevention to care and treatment (CoPCT) strategy is being implemented (See Prevention Component of this Strategic Plan).

Findings from the behavioral sentinel surveillance survey (BSS) 2010 among PLHIV confirmed high rate of sexual activity, including the use of commercial sex services and low

level of consistent condom use, and misconception about HIV transmission among PLHIV receiving OI/ART service (NCHADS, BSS 2010). Positive prevention intervention will need to be strengthened. In addition, making condoms and simple birth spacing commodities (pills, Depo-Provera) at OI/ART services will become a priority for the current strategic plan.

This strategic plan focuses on:

To consolidate the services and ensure their quality and to improve access for all including HIV infected children and MARP with:

- Increasing coverage of Facility Based Health Services Delivery including ART; particularly Pediatric ART coverage;
- Integrating the Three "I" Strategy into all HIV services;
- Integrating a package of activities for prevention among PLHIV all HIV services, and MMM's activities;
- Integrating positive prevention interventions including providing condoms and simple birth spacing commodities available at OI/ART services;
- Expanding the quality assurance system to improve the quality of care;
- Strengthen support to ensure adherence to ART and detect treatment failure using viral load, with a focus on newly identified clients including children;
- Expanding MARP friendly VCCT, STI, OI/ART services in CoC where MARP are concentrated.

4.2.1 Voluntary Confidentiality Counseling and Testing (VCCT)

Objectives:

- To strengthen and extend coverage of counseling and HIV testing services;
- To ensure quality of HIV counseling and laboratory testing in public and NGOs;
- 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 plan; from some 37 sites in 2003 to 246 in 2010– with an average case load nationally of 165 clients per month per each VCCT site. To achieve Universal Access targets and to ensure quality of HIV counseling and testing, new VCCT sites will need to be established in the next five years. In addition, to strengthening and ensuring the continuum of quality improvement of VCCT services, it needs to improve coordination with all development partners, especially strengthening the coordination with NGOs that manage VCCT services.

Innovative approach will be implemented to increase uptake of HIV counseling and testing among MARP, especially EWs and MSMs. Through the Community/ Peer Initiated HIV Testing and Counseling (C/PITC) approach (See the concept note on Community/Peer Initiated HIV Testing and Counseling).

This strategic plan focuses on:

Sustaining and expanding this major network of services with emphasis on:

- Increasing VCCT sites to 350 by 2015;
- Developing an integrated HIV/STI/RH, drug uses, and TB counseling curricula and training;
- Building capacity of VCCT staff (counselors and laboratory technicians);
- Improving the quality of counseling services through continuous quality improvement(CQI);
- Increasing the uptake of HIV testing and counseling services by MARP using C/PITC approach;
- Increasing and expand the implementation of HPITC at other appropriate health facilities including STI, ANC, TB, IPD for Pediatric services (Infectious Diseases-Nutrition support);
- Strengthening the integration of VCCT services within the MBA and CPA package;

- Strengthening and expand the implementation of linked response approach between the continuum to prevention, care and treatment of HIV, STI, RH, TB services to increase uptake of HIV testing among pregnant women and TB patients up to 90 to 95%;

- Increasing knowledge about VCCT (benefits, how to access, risk self-assessment, etc.);

- Improving monitoring and evaluation systems for VCCT with special emphasis on referral tracking system;

- Provide HIV test results to clients as soon as possible.

Indicators and Targets

Core Indicators		**Type**	**Baseline**	**Targets (Year)**					**Sources**
				2011	**2012**	**2013**	**2014**	**2015**	
1	Number of licensed VCCT sites operating in the public and NGOs	Output	246 (2010)	260	280	300	330	350	NCHADS Report
2	Number of adults (aged 15-49) who received HIV test result	Outcome	532,293 (2010)	750,000	800,000	850,000	900,000	1 million	NCHADS Report

4.2.2 OI/ART: HIV/AIDS Care and Treatment for Adults and Children

General objective:

- To reduce mortality and morbidity among people living with HIV (PLHIV).

Specific objectives:

- To maintain rates of universal access to care and treatment (with earlier treatment initiation) for adults and adolescents, including MARP;
- To ensure the quality of OI/ART services.

Core strategies:

- To continue planned expansion of Adult OI/ART Sites;
- To build the capacity of OI/ART team in providing care and treatment for PLHIV, including TB/HIV co-infected patients;
- To support the implementation of CQI at OI/ART sites;
- To support the implementation of Linked Response approach;
- To strengthen monitoring and reporting system.

This strategic plan focuses on:

- To set up new OI/ART sites according to the expansion plan and maintain the functioning of existing OI/ART sites;
- To revise and print OI/ART training curriculum and clinical management guidelines for adult PLHIV;
- To provide trainings, refresher trainings, mentoring and network meetings to OI/ART team on OI management and ART for adult PLHIV;
- To strengthen and scale up the implementation of Three “Is” Strategy at OI/ART sites;
- To strengthen positive prevention for PLHIV by directly providing education and counseling, birth spacing services and free condoms to all PLHIV at OI/ART services;
- To establish and implement appropriate models for palliative care and nutrition support for PLHIV;
- To ensure appropriate PMTCT services using maternal triple ARV prophylaxis or HAART for pregnant women and ensure ARV prophylaxis for infants;
- To update database for OI/ART and print monitoring and reporting tools for OI/ART;

- To improve and maintain the quality and accessibility of care and treatment for PLHIV including nutritional support and palliative care;
- As a component of task shifting, adding nurses with Pediatric AIDS Care training to OI/ART sites that do not have PAC;
- To explore the partnership with NGOs and private sector providers. Activities include HIV testing at ANC, Three Is strategy, and referral to OI/ART services and data collection and sharing;
- To create linkages with birth spacing and directly provide birth spacing services within OI/ART services and free condoms distribution to all PLHIV;
- Explore the possibility of collaboration between OI/ART services with the management of other chronic diseases, such as diabetes, hepatitis B and/or C services.

HIV/AIDS Care and Treatment Services for Children

General objective:

- To reduce mortality and morbidity of HIV infected infants and children.

Specific objectives:

- To improve rates of universal access to care and treatment for HIV infected and exposed infants and children;
- To strengthen follow-up of HIV exposed infants for early HIV infection diagnosis and treatment;
- To improve quality of Pediatric AIDS Care services.

Core strategies:

- To continue planned expansion of Pediatric AIDS Care (PAC) sites, including integration of PAC service into adult OI/ART service where there are no pediatric services;
- To improve the quality of PAC, including nutrition monitoring and support, and strengthening the follow up and provide nutritional supports of HIV exposed infants and early infant diagnosis and treatment of HIV;
- To strengthen the monitoring and reporting system.

This strategic plan focuses on:

- To maintain the functioning of existing PAC sites and set up new PAC sites or integrate PAC service into existing OI/ART sites according to the expansion plan;

- To revise and print OI/ART training curriculum and clinical management guidelines for children living with HIV;
- To provide trainings, refresher trainings, mentoring and network meetings to the PAC teams on Early Infant Diagnosis/Early Infant Treatment, OI management and ART for infants and children;
- To expand the CQI process to monitor and improve quality provision of PAC services;
- To support the implementation of the Linked Response approach, including linkages with the nutritional program to ensure:
    - malnutrition assessment and screening for HIV-exposed and HIV-infected children and HIV screening for children who present at malnutrition services;
    - appropriate treatment for malnourished HIV-exposed and HIV-infected children;
- To ensure the follow up of HIV exposed infant including Cotrimoxazole prophylaxis, early infant diagnosis and treatment of ARV;
- To strengthen and scale up the implementation of Three “Is” Strategy at PAC services;
- To establish and implement appropriate models for palliative care support for children living with HIV;
- To update the database for OI/ART and print monitoring and reporting tools for Pediatric AIDS Care (PAC) Services;
- To explore the partnership with NGOs and private sector providers;
- Explore the possibility of collaboration between OI/ART services with the management of other chronic diseases, such as diabetes, hepatitis B and/or C services to PAC services.

Indicators and Targets

Core Indicators		Type	Baseline	Targets (Year)					Source
				2011	2012	2013	2014	2015	
1	Percentage of PLHIV on ART still alive after 12 months (Adult)	Impact	90.5% (2009)	90.5%	92%	92%	93%	95%	NCHADS Report
2	Percentage of PLHIV on ART still alive after 12 months (Children)	Impact	93.9% (2009)	94%	95%	95%	96%	96%	NCHADS Report
3	Percentage of PLHIV on ART still alive after 48 months (Adult)	Impact	N/A	85%	88%	90%	90%	92%	NCHADS Report
4	Percentage of PLHIV on ART still alive after 48 months (Children)	Impact	N/A	88%	91%	93%	94%	94%	NCHADS Report
5	Number of people with advanced HIV infection on ART(Adult)	Outcome	38,697 (2010)	39,100	39,600	39,900	40,500	40,900	NCHADS Report
6	Number of people with advanced HIV infection on ART (Children)	Outcome	4,102 (2010)	4,300	4,500	4,650	4,700	4,900	NCHADS Report
7	Percentage of people with advanced HIV infection on ART(Adult)	Outcome	92% 38697/ 42000 (2010)	93%	93%	95%	95%	97%	NCHADS Report
8	Percentage of people with	Outcome	91%	93%	93%	94%	95%	95%	NCHADS Report

	advanced HIV infection on ART (Children)		4102/ 4500 (2010)						
9	Percentage of pregnant women who were tested for HIV and received their test results	Outcome	39% (2010)	80%	85%	90%	93%	95%	NCHADS Report
10	Percentage of HIV-infected infants born to HIV + mothers (UA 14)	Outcome	10% (2010)	7%	6%	5%	5%	<5%	NCHADS Report
11	Percentage of HIV-infected pregnant women who received a complete course of triple ARV	Outcome	N/A	75%	85%	90%	95%	>95%	NCHADS Report
12	Percentage of PLHIV enrolled in OI/ART services who received positive prevention	Outcome	N/A	50%	70%	80%	90%	100%	NCHADS Report
13	Percentage of female PLHIV who are new users of birth spacing services (P/D) at OI/ART service	Output	N/A	20%	30%	40%	50%	60%	NCHADS Report

14	Percentage of female PLHIV who are current users of birth spacing services (P/D) at OI/ART service	Output	N/A	30%	50%	60%	70%	80%	NCHADS Report
15	Percentage of patients on ART lost to follow-up at 12 months (Adult)	Outcome	10% (2010)	6%	5%	5%	4%	< 4%	NCHADS Report (EWI)
16	Percentage of patients on ART lost to follow-up at 12 months (Children)	Outcome	10% (2010)	8%	<8%	< 8%	< 5%	< 5%	NCHADS Report (EWI)
17	Percentage of patients still on first line regimen 12 months (Adult)	Outcome	78% (2010)	82%	>83%	>83%	>85%	>90%	NCHADS Report (CQI)
18	Percentage of patients still on first line regimen 12 months (Children)	Outcome	N/A	82%	>83%	>83%	>85%	>90%	NCHADS Report (CQI)

4.2.3 Prevention of mother to child transmission of HIV

General objective

- To support virtual elimination of vertical transmission of HIV (prevalence less than 2%) by 2020.

Specific objectives:

- To improve access and coverage of HIV testing for pregnant women;
- To improve access and coverage of ART and ARVs prophylaxis for HIV positive pregnant PLHIV;
- To improve the follow up of HIV exposed infants.

Core strategies:

- To increase awareness and demand for HIV testing and PMTCT services among pregnant women and the male partners of HIV+ pregnant women;
- To implement health provider initiated HIV testing and counseling (HPITC) at ANC service, including HIV testing during labor;
- To increase access to birth spacing, ANC and safe delivery service among PLHIV;
- To ensure timely access to ARV prophylaxis or ART for HIV positive pregnant women;
- To support scaling up of VCCT, OI/ART, ANC, Delivery service and PAC service.

This strategic plan focuses on:

- To collaborate with community based prevention, care and support groups to provide information and education on HIV testing and PMTCT to the community;
- To provide training to ANC staff in HIV/AIDS counseling and blood drawing;
- To ensure consumables for blood drawing to health centers and provide transport support between health centers and laboratory;
- To implement positive prevention at HIV care settings and integrated into the birth spacing service available at OI/ART and STI service;
- To build strong linkages to birth spacing, ANC and delivery services;
- To provide trainings, refresher trainings, and mentoring to OI/ART teams, PAC teams, ANC and delivery midwives on PMTCT;

- To support community and home based care and support teams to do "active follow-up" and monitoring of pregnant PLHIV and HIV-exposed infants–with a focus on newly identified HIV+ pregnant women;
- To establish functioning coordination and referral and follow-up between VCCT, OI/ART, ANC, safe delivery and PAC services;
- To support nationwide scale up the implementation of linked response approach (prevention, care and treatment, STI-RH, MCH, and TB/HIV services).

Indicators and Targets

Core Indicators		Type	Baseline (2010)	Targets (Year)					Sources
				2011	2012	2013	2014	2015	
1	Percentage of pregnant women who received HIV testing between 14 and 16 weeks of gestation	Output	N/A	70%	75%	80%	85%	90%	NCHADS Report
2	Percentage of HIV-infected pregnant women who received ARV prophylaxis or ART.	Output	52.57% (2010)	80%	90%	>90%	>95%	98%	NCHADS Report
3	Percentage of newly exposed infant received ARV prophylaxis at maternity for 6 weeks	Output	87.5% 224/256 (2010)	90%	93%	95%	95%	98%	NCHADS Report
4	Percentage of HIV-exposed infants received test (DNA-PCR 1)	Output	61.04% 156/256 (2010)	90%	93%	95%	95%	98%	NCHADS Report

4.2.4 Laboratory to support HIV and STI treatment

Objective:

- To improve management of quality and functionality of laboratories to support prevention, care and treatment of HIV and STI in Cambodia, including HIV, CD4, Viral Load, Rapid syphilis, RPR, Gonorrhea and Chlamydia tests;
- To ensure high quality testing for HIV and STIs is available to all people in need in Cambodia.

Core strategy:

Laboratory to support HIV and STI care and treatment play a major role in HIV and STI diagnostics, monitoring and treatment programs. The number of clients in need of testing has increased over time and improved diagnosis and monitoring is essential, thus more quality laboratory testing is required. To achieve this objective, the HIV/STI laboratory will develop a quality management system for the laboratory network including quality assurance and quality control programs.

This strategic plan focuses on:

- To develop all documentation and tools for quality management system in the laboratory, including: SOPs, card files, testing guidelines, testing/monitoring forms and all other necessary laboratory documents;
- To strengthen and develop quality assurance and quality control to improve clinical testing and results through the EQAS program;
- To implement a system for quality control testing to improve quality through the Laboratory Network;
- to provide laboratory training to NCHADS' Laboratory Network for testing procedures (CD4, Viral Load, DNA PCR, and Serology), bio safety, laboratory management, and interpretation of results;
- To network and collaborate with International and National laboratories to understand and improve the quality management system of the Laboratory network;
- To provide technical support to produce forecasts for the needed equipment, materials and consumable for testing, and ensure ordering of the correct items;
- To perform specific tests such as: CD4, HIV-1 Viral Load, DNA PCR, at the NCHADS Laboratory, and conduct testing for research and surveillance purposes to improve the public health activities;
- To develop and strengthen the laboratory data management system, including laboratory database, log book, and forms to record all data in laboratory;
- To monitor laboratory inventory of reagents, consumables, and equipment, and update stock check list.

Indicators and targets

No	Core Indicators	Type	Baseline	Target					Source
				2011	2012	2013	2014	2015	
1	Number of laboratory implemented LQMS (OI/ART sites)	output	N/A	20	40	50	55	60	NCHADS Report
2	Number of Viral load test	output	N/A	7,000	15,000	43,300	43,900	44,500	NCHADS Report
3	Number of VCCT Lab participated with Serology EQAS	output	219 (2010)	250	260	280	310	330	NCHADS Report
4	Number of CD4 Lab participated with EQAS	output	7 (2010)	7	10	10	10	10	NCHADS Report
5	Number of integrated laboratory services conducting adequate QC testing	output	7 (2010)	20	58	58	58	60	NCHADS Report
6	Number of STI laboratory services participated in QC	Output	N/A	32	32	32	32	35	NCHADS Report
7	Percentage of STI laboratory services implemented QC	Outcome	N/A	25%	45%	60%	80%	100%	NCHADS Report

4.2.5 STI Care and Treatment

Objectives:

- To improve the quality of STI/RTI care and treatment services (Family Health Clinics) for general population, high-risk population (EWs, MSM, DUs& IDUs etc) and people living with HIV (PLHIV) integrated in CPA's referral hospital and existing STI/RTI care and treatment integrated in MPA's health centers;

- To strengthen the collaboration between family health clinics, VCCT, OI/ART services and the existing reproductive health services such as birth spacing (BS), safe abortion and post abortion care (SAPAC), and antenatal care trough referral and follow up mechanism within relevant services of referral hospitals.

Core strategy:

The STI/RTI component is the main part of the Continuum of HIV and STI Prevention to care and treatment (CoPCT). As STI/RTI services become more established and acceptable in Cambodia, greater attention is being paid to quality of care and sustainability, and coverage to the general population, especially to most- at-risks populations (MARP), including EW, MSM, DUs and IDUs, drawing on the wide range of partners providing services. The linking health services should be applied at the referral hospital (RH) where the family health clinic (FHC), VCCT and other sexual and reproductive health services are already integrated.

Therefore, the roles of STI/RTI care and treatment component are to:

- Ensure that targeted STI/RTI care and treatment services are effective, efficient, accessible and acceptable, especially for MARP and PLHIV;

- Continue to provide STI/RTI care and treatment as special interventions on most-at-risk populations (MARP) such as entertainment workers (EW) and men who have sex with men (MSM);

- Strengthen the monitoring of STI/RTI integrated services at health centers (HCs) and expand the coverage to other HCs, especially for syphilis screening among pregnant women who visited antenatal care (ANC) service;

- Encourage non-governmental organizations (NGOs) and the private sector to be involved in STI/RTI care and treatment;

- Build capacity for the sustainability of STI/RTI care and treatment in collaboration with international development partners, civil society, and the private profit and non-profit sectors;

- Encourage and collaborate in STI/RTI surveillance and research to monitor the status of, or trends in STI/RTI in Cambodia the effectiveness of prevention and control activities;

- Update knowledge of STI/RTI management in the private sector, and integrate STI/RTI case management into curricula of the University of Health Sciences and Nursing Schools;

- Strengthen the link between STI/RTI prevention and care and VCCT, HIV/AIDS and sexual and reproductive health services (e.g. BS, SAPAC, ANC) through linked response approach;

- Scale-up syphilis screening among MARP such as pregnant women at ANC services in order to eradicate congenital syphilis among newborns.

The linking family health clinics (STI/RTI clinics) to other HIV/AIDS and reproductive health services at linked response sites should be applied at the referral hospital (RH) where the STI clinic and VCCT are already integrated. The main priorities of health care services to be selected for linking health care services:

- STI/RTI care and treatment
- VCCT
- OI/ART
- Birth Spacing (BS)
- Safe abortion and post-abortion care (SAPAC)
- Antenatal care (ANC).

This strategic plan focuses on:

1. Integration of health care services

- Family health clinic (FHC) and VCCT are integrated into the referral hospital;

- Counseling room of VCCT is in the same building of family health clinic;

- STI/RTI and HIV testing are integrated into referral hospital laboratory.

2. Capacity building of health care providers

- Support staff capacity building to improve quality of service delivery specifically for STI and BS/SAPAC services and adapted to MARP and PLHIV;

- Specific skill of health care providers working at family health clinics and VCCT is improved including update skill on STI/RTI case management, HIV testing;

- Basic knowledge of OI/ART and the reproductive health care such as BS, SAPAC and ANC should be provided to the FHC and VCCT staffs;

- Basic knowledge of HIV/AIDS/STI/RTI should be provided to health care providers working at reproductive health care services at RH.

3. Strengthening patient record keeping and data management

- Client's register at FHC, VCCT, OI/ART, BS, SAPAC and ANC should be identified MARP (EW and MSM) and PLHIV. Identity code of EW, MSM and PLHIV should be used in referral slip in order to keep the confidentiality;

- MARP groups such as EW and MSM and PLHIV should be included in the existing quarterly report format of each linking service;

4. Referral mechanism

- The main entry points for MARP to health care services within the RH is VCCT counseling service integrated into STI services (Family health clinics) to other linking services (BS, ANC, SAPAC, OI/ART service and TB ward) within the referral hospital;

- The use of the existing **referral card system** that is already used within the Linked response approach is appropriate for such RH internal linkages (but might have to be slightly revised). Similar data collection and reporting processes for the implementation of the linked response could also be used by the RH.

5. Linking between health care services and community networks

- Linking MARP and PLHIV to health care services is through outreach teams, peer facilitators (PF), peer educators (PE), home based care teams and PLHIV support groups. They play an important role to motivate, encourage and refer EWs, MSM and PLHIV to seek care regularly at linking health care services in referral hospital.

Indicators and targets

Core Indicators		Type	Baseline	Targets (Year)					Sources
				2011	2012	2013	2014	2015	
1	Percentage of ANC attendees with positive RPR test (all LR sites)	Impact	0.7% (2010)	0.5%	0.2%	0.2%	0.1%	<0.1%	NCHADS Report
2	Prevalence of syphilis among antenatal care women	Outcome	N/A	0.5%	0.4%	0.3%	0.2%	<0.2%	NCHADS Report
3	Proportion of women accessing Antenatal Care (ANC) services screened for syphilis (at all LR sites)	Output	N/A	50%	55%	60%	65%	70%	NCHADS Report
4	Number of Family Health Clinics participated in CQI	Output	N/A	4	15	25	30	35	NCHADS Report

4.3 Component 3: Community-based prevention, care and support (CBPCS) For people living with HIV (PLHIV)

Objective:

- To strengthen cost-effective and sustainable community-based services to support PLHIV's increased access, uptake to HIV prevention, care, treatment and support.

Core strategy:

Since 2005, Cambodia has been able to expand the CoC service, including OI/ART service to most PLHIV who need it. Based on OI/ART report in 2010, 42,799 PLHIV adults and children (Adults: 38,697 and children: 4,102) are on ART and 10,217 PLHIV adults and children were on OIs. HIV disease is a chronic disease that requires intensive and close management and follow-up by health care providers and community-based workers to ensure all PLHIV access to CoC services. The CoC services are integrated into the MPA and CPA, requires the involvement from the community and PLHIV-networks. This is stress to the need for revising the roles and responsibilities of home and community-based care and support to be able to respond to the current needs of PLHIV. Cost-effectiveness, sustainability, engagement of people living with HIV, gender sensitivity and emphasis on health sector approach will form the principles for the current core strategy for community-based prevention, care, treatment and support. Home-based care team approach will need to be shifted to more community based support using self-help groups that involve PLHIV in the delivery of care and treatment service. The implementation of this core strategy from 2011 to 2015 will be guided by the Standard Operating Procedures (SOP) for Community-Based Prevention, Care and Support for PLHIV and their affected families.

This strategic plan focuses on:

- To strengthen and expand PLHIV's self-help groups nation-wide through CPN+ and NGO/CBO networks;
- To improve quality and effectiveness of MMM/mmm activities;
- To strengthen coordination between CoC services for PLHIV, and community and home based care services to ensure the effectiveness of referral and follow-up for PLHIV;
- To strengthen coordination with relevant services to ensure access to user-friendly HIV care and treatment services;
- To establish mechanism for cross-checking referral and follow-up PLHIV, requires close collaboration between the community and home based care and CoC services at health facilities based care.

Indicators and Targets

Core Indicators		Type	Baseline	Targets (Year)					Sources
				2011	2012	2013	2014	2015	
1	Number of Self Help Groups (SHGs) actively providing CBPCS services at community	Output	939 (2010)	1,700	2,000	2,100	2,300	2,500	NCHADS Report
2	Number of PLHIV supported by SHGs.	Output	32,252 (2010)	36,000	39,000	42,000	46,000	50,000	NCHADS Report

4.4 Component 4: Strategy to support the Continuum of Care

4.4.1. Linked Response Approach

General objective:

- To support health system strengthening and linkage among HIV care and treatment services between referral hospital and community based care services.

Specific objectives:

- To improve access and coverage of comprehensive PMTCT services;
- To improve linkage between HIV prevention, care and treatment, sexual and reproductive health, Mother and child health, and TB services;
- To explore opportunities to implement the linked response approach to support and improve access to services of other health programs, including EPI, and Malaria.

Core strategies:

- To implement the Linked Response approach at relevant health services of the operational districts nationwide;
- To expand the Linked Response Approach to support health system strengthening through links with TB service, prevention, care and treatment service for MARP and health service at closed settings;
- To establish coordination mechanism among relevant programs, including HIV prevention care and treatment, MCH, TB, relevant departments of MoH, and all partners at all levels.

This strategic plan focuses on:

- To implement expansion of the LR strategy at all ODs nationwide;
- To expand the package of LR to include the linkage between reproductive health, MCH, and TB (“3 interlinked approach”);
- To improve local capacity of health care providers who are responsible for CoC program at provincial level, (some provinces can be selected as Hub) to provide technical assistant in monitoring the implementation of the Linked Response approach through on-site training, mentoring, and network meetings;
- To strengthen Monitoring & Evaluation of the LR including cross referral check, harmonization of data collection tools, local data collection and use of data at provincial and OD level;

- To strengthen linkages within and between community-based services and health facility based services to support follow-up and compliance of PLHIV to HIV/AIDS care and treatment;

- To strengthen referral and follow-up linkages within health facilities, including VCCT, OI/ART, TB, PMTCT, STIs, reproductive health, MCH and nutrition services;

- To strengthen and support the referral and follow-up linkages of CoC across different health services;

- To expand the Three "I" Strategy (intensified TB case finding among PLHIV, isoniazid preventive therapy for PLHIV unlikely to have active TB and TB infection control including PEP for health staff);

- To support community groups and PHC network to provide education and referral clients to relevant health services;

- To establish the public-private partnership to implement linked response approach.

4.4.2. Coordination of the Implementation of TB/HIV (Three I's strategy)

Objective:

- To maximize the opportunity to diagnosis and treat TB as soon as possible among HIV patients enrolled at OI/ART site;

- To reduce TB incidence among PLHIV without symptoms of active TB, by providing at least 6 month or 36 month course of IPT to PLHIV who are negative to TST test;

- To reduce the risk of TB transmission at CoC services.

Core Strategy:

- To strengthen and expand the Three I's strategy nationwide to support health system strengthening through links with TB services to other health facility services in operational district;

- To participate to strengthen the coordination between HIV prevention, care and treatment service and TB/HIV to reduce the risk of TB transmission.

This strategic plan focuses on:

- To expand and strengthen the package of the Three I's strategy of TB screening and diagnosis among PLHIV, reduction of TB incidence among PLHIV, and reduction of risk of TB transmission at CoC service within OD;

- To improve health personnel capacity to implement and monitor the Three I's strategy through training, mentoring, and network meetings;

- To supply of drug-equipment and test kits and consumable by NCHADS and CENAT.

- To strengthen Monitoring & Evaluation of the Three I's implementation, including cross referral check and check registers, records of health related services;

- To strengthen linkages between TB and health related services including community-based services to support referral and follow-up and compliance of PLHIV to TB treatment and care.

Indicator and Target

Core Indicators		Type	Baseline (2010)	Targets (Year)					Sources
				2011	2012	2013	2014	2015	
1	Percentage of OI/ART sites implementing the 3 Is (ICF, IPT and TB-HIV infection control)	Output	28 (2010)	35	52	58	58	58	NCHADS Report
2	Percentage of adults newly enrolled in HIV care who were symptom screened for TB at the first visit *(at sites where 3Is is implemented)*	Output	N/A	90%	95%	95%	95%	95%	NCHADS Report
3	Percentage of adults newly enrolled in HIV care starting IPT *(at sites where 3Is is implemented)*	Output	N/A	20%	25%	30%	30%	30%	NCHADS Report
4	Percentage of adults enrolled in HIV care who were symptom screened for TB at last visit *(at sites where 3Is is implemented)*	Output	N/A	80%	85%	90%	90%	90%	NCHADS Report

4.4.3. Coordination of the Implementation of Continuum of Care for PLHIV

Objective:

- To improve coordination and foster partnership in the implementation of the comprehensive continuum of care for PLHIV.

Core Strategy:

- To promote leadership, ownership of all leaders at all levels to response to HIV within the health sector.

This strategic plan focuses on:

- To revitalize and strengthen coordination and technical structures at national, provincial and OD levels (CoC Steering Committees, TWGs, P-CoPCT CC, P-CoPCT SC, D-PCT, D-CoPCT CC, CoC CC);

- To review role of HIV and STI Prevention, Care and Treatment Structures at national, provincial and OD level to support the implement of the HIV and STI prevention, care and treatment Strategic Plan in the Health Sector (review of functional task analysis for NCHADS, Terms of reference of the Provincial AIDS and STI Program (PASP) and OD CoPCT Coordinator to support the implementation of revised CoC framework).

4.4.4. Enabling Environment: MMM/mmm

Objective:

- To facilitate service linkage to ensure enabling environment for the provision of comprehensive CoC framework for PLHIV.

Core strategy:

- To strengthen the CPN+ network to support the implementation of comprehensive CoC framework for PLHIV.

This strategic plan focuses on:

- To expand MMM/mmm activities for adults and children to all OI/ART sites through CPN+ network;

- To review MMM/mmm package of activities to support the implementation of additional interventions that are added to the revised comprehensive CoC package and to support newly identified PLHIV;

- To engage PLHIV in the support for the delivery HIV care and treatment at OI/ART sites and community network.

4.4.5. Maximizing the Synergies between Health Service (MPA and CPA) and other Services of National Programs, Including HIV prevention, care and treatment and Overall Strengthening Health System

Objective:

- To maximize the synergies among the efforts to strengthen overall health system and to address specific health needs for PLHIV, TB, Malaria, MCH and EPI.

Core strategies:

- Encourage the participation from the departments and institutions engaged in overall health system strengthening, other specific health and disease control programs (e.g. TB, MCH, Malaria, EPI) to jointly review the epidemic, the current situation, and to develop and operationalize common action plans;

This strategic plan focuses on:

- Conducting joint reviews on the interface between specific disease prevention programs and care and treatment diseases programs to contribute to overall health system strengthening efforts;
    - Identifying health system bottlenecks which may hinder performance of specific health and disease programs including HIV prevention, care and treatment program, followed by identifying solutions to overcome them successfully;
    - Documenting, and sharing lesson learnt to support and to contribute the implementation of disease prevention and treatment programs, including HIV prevention, care and treatment that is fully integrated into the overall health system;
    - Identifying the process of integrating specific disease care and prevention program and health care programs including HIV prevention, care and treatment program into overall health system.
- Developing common action plans based on the joint review.

4.4.6 The Implementation of Positive Prevention among PLHIV

Objective

- To improve access to the positive prevention message as soon as possible among HIV patients who enrolled at all OI/ART sites;
- To improve knowledge and change behavior of PLHIV to reduce or avoid the transmission of HIV from them to other people;

Core Strategy

- To promote positive prevention messages and psychological support to PLHIV through health care workers working at health services including OI/ART, PMTCT ANC and SRH, VCCT, CHBC, PLHIV SG, and MMM;

- To promote the integration of HIV prevention counseling and referrals PLHIV to health care services within CoC;

- To promote condom use, contraception, safe abortion and PMTCT among PLHIV.

This strategic plan focuses on:

- To support PLHIV in accessing to care and treatment services in order to re-enforcing HIV prevention counseling at all health care and treatment services in OD level;

- To provide messages on positive prevention among PLHIV focusing on HIV transmission and re-infection by health care providers at all health services including OI/ART service, MMM, STD Clinic, drug store or pharmacy, pediatric AIDS care, TB wards, ANC, birth spacing.etc;

- To promote consistent condom use among PLHIV and HIV infected stable couple and availability of condom at all health services;

- To improve health personnel capacity to implement and monitor the implementation of positive prevention at all health services;

- To develop and printing booklets for Positive prevention.

OBJECTIVE 3: TO ENSURE THAT NCHADS AND PROVINCIAL HIV AND STD PROGRAMS ARE COST-EFFECTIVELY MANAGED

4.5 Component 5: Surveillance Related to HIV and STI

Objectives:

- To monitor epidemiological changes with regard to HIV/AIDS prevalence and incidence in Cambodia;
- To monitor behaviour changes with regard to HIV/AIDS and STIs among sentinel groups;
- To better understand underlying barriers to behaviours among sentinel groups and to monitor effectiveness of implemented programs;
- To monitor trends in STI prevalence among sentinel groups and antibiotic sensitivity;
- To conduct population size estimates of sentinel groups;
- To monitor the prevalence, pattern and characteristics of HIV Drug Resistance in Cambodia;
- To use case reported data for the HIV/AIDS and STI surveillance;
- To promote the use of epidemiological prevalence and behavioural data for program planning and implementation.

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 program evidence-informed.

Adapting to the changing dynamics of the HIV/AIDS epidemic in Cambodia, there is need for a major shift of the surveillance systems. In the past decade, biological and behavioral data from any single sentinel group were collected separately and there had been very little use of data collected from health facilities through routine reporting systems. In order to improve the richness of the data as well as, to increase the efficiency of the surveillance systems, core strategies for HIV surveillance will be modified.

This strategic plan focuses on:

- To conduct HIV Sentinel Surveillance (HSS) among Pregnant women;
- To conduct IBBS & STI Surveys among one sentinel group (entertainment worker, men who have sex with men, drug user and moto-taxi driver and other emerging HIV/AIDS high risk groups) per year;
- To conduct a systematic review of study on the incidence/prevalence of HIV and behaviours towards HIV/AIDS in Cambodia;
- To conduct antibiotic susceptibility for STI cases on periodic basis;
- To collect Early Warning Indicators related to HIV Drug resistant annually;
- To conduct HIV/AIDS estimation and projection every 5 years;
- To conduct population size estimates of sentinel groups;
- To promote the use of surveillance data to updating HIV and STD prevention, care and treatment programs;
- To evaluate the current HIV/AIDS surveillance system;

- To assess and to collect scientific evidence for the readiness of using reported data for HIV/AIDS and STI surveillance purposes;
- Build the capacity of the Surveillance Unit staff;
- Build the capacity of data management team and technical staff at all levels for using the data.

Indicators and Targets

Core Indicators		**Type**	**Baseline**	**Target (Year)**					**Sources**
				2011	**2012**	**2013**	**2014**	**2015**	
1	Number of IBBSS conducted with result disseminated	Output	N/A	1 (DU)	1(MSM)		1(EW)		Report IBBSS
2	Number of HSS conducted with result applied to the implementation of strategic plan	Output	N/A			ANC			HSS Report
3	Number of SSS conducted with result applied to the implementation of strategic plan	Output	N/A	1				1	SSS/NCHADS Report
4	Special study (new group)	Output	N/A			1			Special Study Report
5	Number of OI/ART sites (Adults and Children) participated in EWI	Output	59 (2010)	60	70	85	95	118	EWI/NCHADS Report

* (ANC & General population)

4.6 Component 6: Research related to HIV and STI

Objectives:

- To provide scientific evidence to design and improve quality of NCHADS prevention and CoC programs;
- To coordinate HIV/AIDS research agenda setting in Cambodia;
- To build capacity to understand/conduct/use research in support of NCHADS strategic plan or other approaches.

Core strategy:

NCHADS Research Unit aims to ensure that scientific evidence underpins the design NCHADS strategic plan by both conducting specific research studies, and coordinating and linking with other research institutions and programs, both inside and outside Cambodia. As HIV-related prevention and care strategies tend to become more and more focused, and as such a new and innovative clinical program as ART expands, the need for good quality research to inform the design and direction of programs is critical. In addition, Research Unit will work together with other units in NCHADS and development partners to develop continuous quality improvement program for CoC for HIV and STD.

This strategic plan focuses on:

- Conduct HIV/AIDS and STI operation research;
- Conduct training/workshops to build capacity of NCHADS, PASPs, Local and NGOs, & NGOs working on HIV/AIDS and STD related research;
- Send researchers to get training and exchange research experience abroad;
- Establish an information sharing system between local and international researchers.

Indicators and Targets

Core Indicators		Type	Baseline	Target (Year)					Sources
				2011	2012	2013	2014	2015	
1	Number of research studies conducted	Output	8 (2006-2010)	3	3	3	3	3	NCHADS Report
2	Coverage of CQI for CoC program launched (%)	outcome	36%	50%	70%	80%	90%	100%	NCHADS report

4.7 Component 7: Planning, Monitoring & Reporting

Objectives:

- To ensure a coordinated and comprehensive response to the HIV/AIDS and STI epidemic in the health sector;
- To monitor and provide feedback for NCHADS Prevention, Care and Treatment HIV and STI Program implementation;
- To coordinate the revision and evaluation of the NCHADS prevention, care and treatment for HIV and STI program components;
- To improve the capacity of technical staff for monitoring reporting and evaluation of prevention, care and treatment HIV and STI programs.

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 program, this has been critical, and will be sustained.

This strategic plan focuses on:

- Coordinate the development of the overall Strategic Goals, Strategic Plans, and Operational and Comprehensive Work Plans and set the targets for HIV/AIDS and STI prevention, care and treatment program in health sector within technical support from NCHADS;
- Coordinate the harmonization of HIV/AIDS and STI programs into other National Health Sector Programmers and involving Institutions;
- Provide the technical guidance and support to district and provincial AIDS and STI program and districts for improving program management and developing Annual Comprehensive Operational Plans, and Monitoring, and Reporting & Evaluation of the implementation of the strategic plan;
- Coordinate the identification and allocation of resources in support of Strategic and Annual Goals, targets and Plans;
- Establish and maintain transparent and accountable fund allocation mechanisms for decentralization of activities at Provincial and ODs levels;
- Establish and maintain coordination mechanisms with all partners;
- Update the letter of agreement between NCHADS and partners on HIV/AIDS and STI prevention, support, and care and treatment program in health sector;
- Maintain an up-to-date Monitoring, Reporting and Evaluation System for the program;
- Conduct routine monitoring and develop NCHADS comprehensive reporting;
- Coordinate and collaborate M,R&E within the National M,R&E System for HIV/AIDS program and with others partners (both government and non-government) in health sector;
- Organize and manage periodic review/evaluation of specific program components;
- Build the capacity to relevant staff for developing activity plan, Monitoring, and Reporting & Evaluation within the program.

Indicators and targets

Core Indicators		Type	Baseline	Target (Year)					Sources
				2011	2012	2013	2014	2015	
1	Percentage of major funding sources included in the Annual Comprehensive Work Plan	Output	90% (2010)	>90%	>90%	>90%	>90%	>90%	NCHADS Report
2	Number of NGOs and partners with signed Letters of Agreement for annual work plans on HIV/AIDS & STI program	Output	45 (2009-2010)	50	55	60	65	70	NCHADS Report
3	Number of NCHADS quarterly and annual program reports produced and disseminated	Output	5 (2010)	5	5	5	5	5	NCHADS Report

4.8 Component 8: Data Management

Objectives:

- To strengthen the reporting system and use of data for HIV and STI Prevention, Care and Treatment Program;

Core strategy:

Data management is one of NCHADS' Unit that has started functioning since 2005, is responsible for managing prevention, care and treatment of HIV and STI data, including data from VCCT, OI/ART for adults and children, STI, TB, Linked Response Approach etc.

This strategic plan focuses on:

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

Indicators and targets

Core Indicators		Type	Baseline	Target (Year)					Sources
				2011	2012	2013	2014	2015	
1	Number of provinces with data management units	Output	20 (2010)	20	20	22	22	24	NCHADS Report
2	Number of Comprehensive Quarterly Reports compiled	Output	4 (2010)	4	4	4	4	4	NCHADS Report

4.9 Component 9: Logistics and Supply Management

Objectives:

- To strengthen consumption reporting and distribution for OI/ARV drugs, and reagents/consumables for VCCT, STD, CD4, Viral Load, Biochemistry and Hemato-analyzer;
- To monitor OI/ARV & STD Drugs and Reagents for all OI/ART sites and STD Clinics;
- To establish quantifications for all required items including OI/ARV drugs, reagent, and consumable, related to HIV and STI care and treatment;
- To ensure effective coordination and collaboration between NCHADS program and CMS and other relevant MoH departments to ensure effective and un-interrupted supplies of OI/ARV & STD Drug and Reagent for all sites;
- To build human resource capacity at the national, provincial, referral hospital, Operational district and Health Center level.

Core strategy:

Logistics management is one of NCHADS' Units that has roles and responsibilities to managing OI/ARV drugs, reagents and consumables related to HIV and STI Treatment. NCHADS' logistics management system has been integrated into the CMS system since 2007. At the meantime, efforts have been made to ensure the logistics management systems are mutually supports to avoid the delay in supplying to all CoC services.

This strategic plan focuses on:

- Conduct and Collect Consumption Reports and Distribution of OI/ARV drugs, reagents and consumables to all relevant sites;
- Establish quantifications for all required items including OI/ARV drugs, reagent, and consumable, related to HIV and STI care and treatment;
- Collaborate with all relevant NCHADS' units and all relevant sites and partners;
- Initial training and refresher training on Logistics management to all relevant health care workers who manage logistics at all levels;
- Monitoring and supervision on OI/ARV drugs, reagent and commodity management to all relevant sites.

Indicators and Targets

Core Indicators		Type	Baseline	Target (Year)					Sources
				2011	2012	2013	2014	2015	
1	Percentage of adult ART sites without one or more stock-outs of essential ARVs	Outcome	97% (2010)	100%	100%	100%	100%	100%	EWI/NCHADS Report
2	Percentage of pediatric ART sites without one or more stock-outs of essential ARVs	Outcome	83% (2010)	100%	100%	100%	100%	100%	EWI/NCHADS Report

5. IMPLEMENTATION ARRANGEMENT OF THIS STRATEGIC PLAN

5.1 Shared responsibilities

The experience of the successive 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 (PASP), 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 program components, developing the AOCP, mobilization and resource allocation to support the implementation of the strategic plan;
- PASPs and PHDs develop operational plans, based on national guidelines;
- ODs implement, with the support from the provinces, NCHADS and development partners.

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

Other MoH's Departments and the National Centers of the Ministry of Health: the National MCH Centre is the primary player in the implementation of the linked response approach to strengthen collaboration of all services of PMTCT; CENAT is a key partner with NCHADS in developing shared responses to the interconnections between HIV and TB. NCHADS has closely collaborated with:

- the Health Information System, with whom NCHADS works on the passive surveillance system;
- the National Blood Transfusion Center, who have the primary responsibility for Blood Safety;
- the CMS, for drugs, reagent, and consumable supplies to Health facilities;
- the university of Health Science and other Training Institutions for integrating much of the training envisaged under this Plan;
  the National Health Promotion Center for shared work on IEC;
- the National Institute of Public Health for shared work on research on HIV and STI;
- the MoH Planning Department, for development and integration of NCHADS' AOCP into the MoH's AOP;
- Laboratory Office of the Hospital Department to ensure the supply of reagents, consumables to the referral hospital laboratory;
- **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);
- **NGOs and other organizations**: who have their own HIV/AIDS activities and programs, 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 community-based prevention, care and support and treatment (CoPCST) activities. Also there are local and International NGOs, such as PSF, World Vision, CARE, FHI, CHAI, PSI, RHAC, SCA, URC, CHEC, WOMEN, FI, PACT, CRS, CARITAS, CHC,...and International NGOs such

as UNAIDS, UNICEF, WFP, and WHO that actively participated to support the implementation of this strategic plan. A number of both local and international academic institutions have important roles to play, such as ITM-Belgium through its technical assistance to NCHADS and the University of New South Wales led Research Consortium, and University California, San Francisco, ITM-Belgium and other local research organizations that support and conduct the research related to HIV and STI. Finally there are the donors: multi-lateral, bi-lateral and private: UNAIDS, USAID/PEPFAR, US-CDC-GAP, and the 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.

5.2 Quality Assurance:

The OI/ART services Quality Assurance program contains a number of elements:

5.2.1. monthly or bi-monthly CoC Coordination Committee Meetings, mentoring from a national core mentors to be extended to all CoC sites, special emphasis on newly established sites;

5.2.2 regional network meetings every 6 months for clinicians and counselors for OIs & ART for adults and national meetings every 6 months for staff managing pediatric care – these will be extended to regional/provincial network meetings as sites increase;

5.2.3 development of standardized HIV drug resistance Early Warning Indicators monitoring and HIV drug resistance thresholds surveys; and

5.2.4 roll out of a Continuous Quality Improvement (CQI) strategy to CoC, 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.

5.3 NCHADS Annual Operational Comprehensive Plan (AOCP)

NCHADS is the department of the Ministry of Health whose mandate is to coordinate and develop Policies, Strategic Plan, 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 2008-2015. With the permission from Ministry of Health, NCHADS is responsible for supporting and coordinating provinces 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 Program, 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 to the provinces;
- 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 Ministry of Economic and Finance.

Stakeholders from the whole country are involved to develop the AOCP: HIV/AIDS Management teams (PHD or Deputy PHD Director, PASP and PHD Accountant), PHD Planning Officer, 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 Programmers and MoH departments, and PLHA networks.

Besides NCHADS, inputs are sought from:

- **NMCHC**, to share and update on the implementation to drastically reduce and move towards the elimination of the transmission of HIV from mother to child;
- **CENAT**, to share concerns and view points of the coordinated TB/HIV activities;
- **National AIDS Authority (NAA)**, to update on the National Strategic Plan for a Comprehensive and Multi-sectoral 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 (PMR) Unit of NCHADS organizes an 'achievement reviewing' workshop with all provinces to review achievements made, constraints in the year, and to develop activity plan with defining 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 development partners who are implementing HIV/AIDS and STI prevention and care programs;
- 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 the 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, 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 HIV and STI prevention, care and treatment program.

As also laid down in NCHADS Standard Operating Procedures (SOP), mid-year program 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 program, 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 programs.

5.4 Financing the Strategic Plan and budgeting the AOCP

In addition, each year the AOCP is budgeted and funded from other sources including from NCHADS, donors, and international and local NGOs who are working with HIV and STI program in health sector. NCHADS uses a single, integrated, computerized 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 the implementation. Details of how these can be used are in the "Standard Operating Procedures for Implementation of NCHADS Program Activities" approved by the Ministry of Health in February 2006.

5.5 Functional Task Analysis of NCHADS

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 the NCHADS' FTA need to be revised to align with current NCHADS' updated of the Strategic Plan for HIV/AIDS and STI Prevention and Care in the health sector in Cambodia 2011-2015, with the introduction of the Royal Government of Cambodia POC's Scheme in July 2010.

The management arrangements within NCHADS are now relatively robust and by routinely updating. 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 program to Provincial and OD levels;
- Increased emphasis on expanded access to CoC for PLHIV through the introduction of OI/ART services;
- Re-structuring of NCHADS' Units to respond to the demands of the expanded CoC program by updating the prevention program and improving the quality of data.

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.

The FTA for national and provincial levels has started since 2001, and then revised in 2004 and then in 2007. The updating of FTA in 2010, however it has not yet approved by MoH. The updated FTA is to support the implementation of the Strategic Plan for HIV/AIDS and STI prevention and Care Program in Health Sector 2011-2015 by focusing on:

- Strengthened decentralization of the NCHADS program to Provincial and OD levels;
- Expanded access to prevention, care and treatment for MARP through the implementation of CoPCT;
- Maintain the provision of appropriated quality of OI/ART, STI, and VCCT/PMTCT services to PLHIV, MARP and general population; through the implementation of the linked response approach by establishing strong referral and follow-up linkages between health facilities-based and community-based prevention, care and treatment and support;
- Expanded the continuous quality improvement (CQI) for CoC services for HIV and STI including OI/ART, STI clinic, and VCCT sites;
- Strengthen and expand the integrated laboratory for HIV and STI testing to support care and treatment for PLHIV and STI at the referral hospitals;
- Re-structure of provincial AIDS and STI Program (PASP) and operational districts for HIV/AIDS to align the implementation of strategic plan for HIV/AIDS and STI prevention, care and treatment in health sector 2011-2015.

The functional task analyses and the Performance Based POC Schemes have played complementary roles in the steady improvement in management performance within NCHADS. On one hand, the FTA has 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 POC 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 POC payments. Thus a beneficial synergy has been created between the FTA processes.

POC's Schemes introduced by the RGC to support national, provincial, district and health center staff for their performance in implementation of HIV/AIDS and STI prevention, care and treatment at all levels regarding to policies, strategies and guidelines of HIV/AIDS and STI program in health sector. NCHADS will implement the POC’s schemes by discussing with partners.

6. MONITORING AND ASSESSMENT OF ACHIEVEMENT OF THE STRATEGIC PLAN

The primary tools for monitoring the achievements of this strategic plan are the epidemiological and behavioral surveillance systems and the data management systems established by NCHADS in collaboration with all development partners. Through both **active surveillance** which is primarily the regular HIV, Behavioral 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 Program for HIV/AIDS and STI Prevention, Care and Treatment in the Health Sector"*.

The active surveillance system, managed by NCHADS' Surveillance Unit, generates data every two to three years, enabling NCHADS to assess regularly on the trend and pattern of HIV epidemic. The findings from the Consensus Workshop on HIV Estimation for Cambodia (June 2007), BSS (Behavioral Surveillance Survey) results for 2010 and SSS (STI Surveillance Survey) for 2005 are used as baseline of this strategic plan.

The passive surveillance system, managed by NCHADS' 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