Cambodia

Operational Plan Report

FY 2010

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Operating Unit Overview

OU Executive Summary

Key Demographic and Socioeconomic Data

Estimated population in 2008: 13,395,682[1]
Percentage of the population living in rural areas: 80%[1]
Birth rate per 100,000 population: 25.6[2]
Percent of the population aged 15 to 29 years: 31.5[1]
Average life expectancy: male—59 years; female—67 years[3]
Per capita GDP: $597[4]
Adult literacy rate: male—85%; female—71%[1]

HIV/AIDS Epidemic in Cambodia:

HIV prevalence among adults in 2006: total—0.9%; urban—1.1%; rural—0.8%[5]
HIV prevalence among pregnant women in antenatal care in 2006: total—1.1%; urban—1.4%; rural—1.1[5]
HIV prevalence among young household adults in 2005, by years of age: 15-19—0.0%; 20-22—0.3%;
23-24—0.6%[2]
Number of adults (aged ≥15) living with HIV/AIDS in 2008: total—58,700; women—30,800; men—27,900[5]
Number of deaths among adults living with HIV/AIDS in 2008: total—3,600; women—1,800; men—1,800[5]
Estimated number of adults in need of ART in 2008: 30,500[5]
Number of adults on ART in 2008: 28,932[6]
Estimated number of adults in care, but not receiving ART: 8,880[6]

Program Description

Cambodia is one of the best-documented and most compelling success stories in the global fight against HIV/AIDS. From 1998 to 2006, HIV prevalence declined from 2% to 0.9%. More recently, the Royal Government of Cambodia (RGC) has expanded greatly access to care and treatment for people living with HIV. Since the first HIV Treatment

[1] General Population Census of Cambodia 2008, National Report on Final Census Results, August 2009
[2] National Institute of Public Health, National Institute of Statistics, and ORC Macro, Cambodia Demographic and Health Survey 2005. 2006, Cambodian National Institute of Public Health, National Institute of Statistics, and ORC Macro: Phnom Penh, Cambodia and Calverton, Maryland, USA.
[3] World Health Organization. World Health Statistics Information System 2008. 2008 [cited 03 October 2008]; Available from: http://www.who.int/whosis/en/index.html
[4] World Bank. Global Development Indicators Online. 2008 [cited 03 October 2008]; Available from: http://www.worldbank.org
[5] National Center for HIV/AIDS, Dermatology, and STDs, Report of a Consensus Workshop. HIV Estimates and Projections for Cambodia, 2006-2012. 2007, Cambodian Ministry of Health: Phnom Penh.
[6] National Center for HIV/AIDS, Dermatology, and STDs, Annual Report 2008. 2009, Cambodian Ministry of Health: Phnom Penh.

Continuum of Care (CoC) site was established with support from USG partners in 2003, Cambodia has extended HIV-related care to more than 70% of adults estimated to be HIV-infected. To date, more than 90% of individuals in need are receiving antiretroviral treatment (ART).

Yet, it has become increasingly clear that new approaches and a renewed vision are needed to sustain these historic achievements. For COP 2010, we have engaged in a broad, collaborative planning process with the RGC and other PEPFAR implementing partners. In keeping with the priorities of the next phase of PEPFAR -- efficiency, sustainability, and host country ownership -- Cambodia's FY 2010 COP supports two key objectives:

- We will enhance our focus on prevention, care, and treatment for both HIV-infected individuals and those most at risk for HIV infection in Cambodia. Specifically, we will deliver an integrated package of targeted, high-quality services at both the clinical and community levels.
- We will improve the impact of our HIV/AIDS program investments through greater integration of reproductive health and family planning investments. At the same time, HIV/AIDS funding will improve the sustainability of Cambodia's broader health delivery system and address maternal mortality and other health priorities.

Specific examples of new or enhanced activities aligned to these objectives in the 2010 COP include:

- Expanding access to HIV prevention, care, and treatment services beyond brothels to reach the growing pool of women working in other high-risk entertainment establishments (karaoke, massage, beer gardens, etc.).
- Expanding access to HIV testing and counseling among TB patients, sexually transmitted infections (STI) clients, inpatients, pregnant women, and their male partners.
- Implementing a more integrated, comprehensive package of "positive prevention" (prevention activities for HIV-infected individuals) at both the clinical and community levels.
- Initiating essential blood-safety activities.
- Increasing the number of women who receive quality antenatal care (ANC) services though expanded access to PMTCT services.

We have not been asked to submit a partnership framework this year. However, we have built a solid foundation for achieving many of the stated objectives of such frameworks. The FY 2010 COP will increase local leadership and ownership and capitalize on multilateral and other donor support to extend the reach of our HIV investments. In particular, USG's technical assistance aimed at improving policy and providing strategic information for decision making will extend the impact of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donor resources.

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Prevention: $8,605,844 (67% of prevention, care, and treatment budget)

The HIV epidemic in Cambodia remains concentrated in individuals whose behavior places them at high risk for acquiring or transmitting HIV. Historically, the epidemic in Cambodia has been driven by the high-risk behavior of men (clients) who engage in commercial sex and then serve as a bridge between a population of women with a high prevalence of HIV (sex workers) and women with low HIV prevalence (e.g., spouses of clients). Declines in HIV incidence and prevalence have been attributed largely to the 100% Condom Use Program (CUP), which increased condom use in brothels. Cambodia's PEPFAR program aims to build upon prior success to bring prevention services to people at high risk for HIV infection.

One challenge stems from the dramatic growth in estimated numbers of non-brothel-based entertainment venues and female entertainment workers in Cambodia. This challenges the capacity of prevention programs to ensure adequate coverage with relevant services. It is likely the result of many factors: a migration by men towards perceived, less risky venues to procure sex, a migration by women towards work in entertainment establishments driven by financial necessity and limited employment alternatives, and recent crackdowns on brothels following passage of the new law on human trafficking and sexual exploitation. The 2006 HIV Sentinel Surveillance (HSS) found that HIV prevalence among brothel-based sex workers remains high at 14.7%, while the 2003 HSS found HIV prevalence of 11.7% among beer promoters and karaoke workers.

Data on the burden of HIV among other high-risk populations (including male clients of sex workers, men who have sex with men (MSM), and injecting drug users (IDU)) are limited. Although surveys suggest high levels of risk behavior among subsets of urban men who have multiple (transactional and non-transactional) sex partners, reliable estimates of the HIV prevalence in this population and its actual size are limited. The same data gaps exist for MSM, although a USG-supported Ministry of Health (MoH) survey conducted in 2005 among MSM found 8.7% of MSM and 9.8% of transgenders in Phnom Penh were HIV infected. Other donors are addressing the needs of a small but high-risk population of IDU concentrated in Phnom Penh.

Condom security is an emerging area of concern in Cambodia. USG and partners are working closely with RGC to support socially marketed and free distribution of condoms to address forecasted gaps in donor support.

Linking members of high-risk populations to HIV Testing and Counseling (HTC) remains a persistent challenge to HIV prevention and treatment efforts. Protocols are needed to offer HTC routinely to clients in STI clinics or to hospital inpatients, although HTC coverage of TB patients and pregnant women has improved. Despite the use of rapid

HIV tests for HIV diagnosis, HIV testing can be performed only at a limited number of MoH-authorized testing sites in Cambodia.

The increase of HIV testing and counseling (HTC) at antenatal care sites is expected to improve testing rates among pregnant women and successful follow-up and treatment of those testing positive. A USG-supported demonstration project of point-of-care (POC) testing of pregnant women in three operational districts showed that tests were performed accurately by midwives, and acceptance rates were high among patients and partners. Few positives were identified, reflecting low prevalence; however, HIV prevalence among pregnant women is higher than among men and women in the general population. Successful implementation of POC testing in labor and delivery rooms by non-laboratory personnel in FY 2010 will inform HCT policy on same-day test result provision for other populations.

The National Blood Transfusion Center has policies in place to ensure blood safety; however, appropriate clinical use of blood is not being monitored, and donors with transfusion transmissible infections are not being notified, counseled, or referred. PEPFAR Cambodia received an additional $500,000 for blood safety activities in FY 2010, and plans to use the funding to enhance blood safety monitoring and quality assurance.

Cambodia's 2010 COP will enhance the reach and quality of prevention services for most-at-risk populations (MARPs) and ensure access to HIV/AIDS services for all. To achieve this goal, PEPFAR Cambodia will:

- Define and deliver, with the MoH and other partners, an essential package of services that includes: one-on-one and small-group peer education, access to condoms, HTC, STI, and Reproductive Health (RH) and Family Planning (FP) services, and linkages to other health and social services.
- Expand innovative venue-based education programs to high-risk urban men.
- Remove barriers to the use of HIV services by MARPs; facilitate referrals and improve referral tracking systems; and pilot mobile outreach approaches to bring HTC services to priority populations.
- Improve availability of RH/FP services at ANC, adult care and treatment, and other sites with a special focus on reaching female entertainment workers and other vulnerable populations.
- Ensure condom availability in high-risk settings (including and outside of brothels) and clinical sites serving HIV-infected and high-risk persons.
- Expand same-day HIV test result approaches to key settings, including ANC sites, labor and delivery sites, STI clinics, and other points of care.
- Support partner and couples HIV testing, prevention counseling for persons with HIV, RH/FP counseling, and referrals to services as needed.
- Provide technical assistance and policy support to increase the availability of safe blood in Cambodia.

Care: $2,685,550 (21% of prevention, care and treatment budget)

Care activities in Cambodia include adult care and support, pediatric care and support, programs for orphans and vulnerable children (OVC), and TB/HIV programs.

The RGC has made unprecedented progress in scaling up care and treatment services for HIV/AIDS. As stated previously, over 72% of adults estimated to be HIV-infected are receiving care at the 51 opportunistic infection/ antiretroviral (OI/ARV) clinics in Cambodia. In addition, two-thirds of these People Living with HIV/AIDS (PLHA) were receiving comprehensive care and support services from a total 337 home-based care teams throughout the country.

Cambodia's framework for delivery of HIV care, the Continuum of Care (COC), encompasses a network of services linking facility and community-based providers. By strengthening linkages within these networks to include reproductive health, TB, and STD services, the MoH is utilizing the HIV care infrastructure to strengthen major components of the health care system. In FY 2010, USG support will focus on reducing the number of OI patients lost to follow up, strengthening positive prevention, and increasing referrals to family planning services. The USG will expand opportunistic infection management services within the COC and will improve the quality of home-based care (HBC) services. The USG will also improve referral systems linking community and HBC services to COC services provided at referral hospitals.

OVC programs in Cambodia aim to provide high-quality, community-based services to children made vulnerable by HIV in Cambodia. In FY 2010, PEPFAR OVC programs will improve the quality of OVC services and increase referrals to other health, education, and social support systems. At the same time, efforts to address the long term needs of OVC with host country mechanisms and GFATM resources will continue. To this end, the USG will provide technical assistance at the national level for policy development and the development of a national OVC M&E framework and tools.

Cambodia has a high TB burden, with the highest estimated incidence rate in Asia. In 2007, HIV prevalence in TB patients was 8.6 times higher than in the general population, and only 50.5% of TB patients were tested for HIV. In 2010, the USG will continue working to increase HIV testing in newly diagnosed TB patients and will provide TB screening at OI/ART clinics. PEPFAR funds will support a new TB screening algorithm for HIV-infected persons developed by the USG in collaboration with MoH. To improve screening, an ongoing USG project to improve the sensitivity of TB culture will be completed. Finally, the monitoring and evaluation of TB/HIV interventions will be improved.

Treatment: $1,484,802 (12% of prevention, care and treatment budget)

Treatment programs in Cambodia include adult and pediatric treatment, and funding for laboratory infrastructure to ensure quality clinical services.

With 93% of the estimated number of individuals in need on ART, Cambodia's HIV treatment program is a success. The 2008 mortality rate of patients on ART was 1.8%, and 2.3% were lost to follow-up. Having already trained a sufficient healthcare workforce to staff its 51 HIV care and treatment facilities (OI/ART clinics), most of whom have provided HIV care for more than three years, the MoH has developed an HIV health care workforce infrastructure that is increasingly self-sustaining.

However, the rapid scale-up for ART in Cambodia has been accomplished through multiple donors, including PEPFAR, GFATM, DFID, the Asian Development Bank, Clinton Foundation, and UNICEF. These donors support more than 90% of the program, with minimal contribution from the RGC. In addition, with the growing number of patients receiving care for HIV infection, clinicians have less time to address other needs, including the reproductive health needs of HIV-infected women. The capacity to detect treatment failure is limited, as viral-load testing is not generally available, and more than 95% of persons on ART for four or more years are still on first-line therapy. Providers have limited experience with or access to second line ART drugs.

Cambodia's success, while primarily donor-driven, does present opportunities for improvement. Continuous Quality Improvement (CQI) has been an increasing priority for the HIV program. USG will continue to provide technical and other assistance to the MoH to determine how best to assist the OI/ART sites to use their clinical and programmatic data to improve the quality of the health care services they provide. The MoH and donors increasingly recognize the need for better coordination of available resources for efficiency and integration of HIV/AIDS programs into the general health sector.

Ongoing treatment activities in Cambodia support operations at eight OI/ART sites, including health care worker training and CQI programs. In FY 2010, we will strengthen linkages to family planning services at USG supported OI/ART sites and enhance detection of treatment failures with accurate viral-load monitoring. New treatment activities include strengthening positive prevention activities at the eight OI/ART clinics supported by the USG, including ensuring routine free access to condoms for PLHA, and training for clinicians and adherence counselors to incorporate positive prevention messages into their routine services.

Laboratory infrastructure activities in Cambodia will expand and enhance national laboratory quality assurance systems, provide laboratory support for HIV and STD surveillance, and improve the quality of diagnostic laboratories in testing to monitor HIV/ AIDS care and treatment.

Other Costs: $3,158,805 (17% of the total budget)

In addition to HIV prevention, care, and treatment, the PEPFAR budget will support strategic information (SI) and health systems strengthening (HSS) activities in FY 2010. While not attributed to a budget code, PEPFAR resources will also strengthen human resources for health and prioritize gender equity in all program areas. In the area of SI, the USG will work in partnership with the RGC to advance national priority SI and monitoring and evaluation (M&E) activities and identify resources to meet future SI and M&E needs. As previously noted, data gaps exist, especially in regards to the size and estimated HIV burden among most-at-risk populations. To address this need and help the RGC carry out its nationwide SI strategies, USG Cambodia will:

- Build capacity for improved collection and strategic use of data.
- Develop a more thorough understanding of the epidemic by including most-at-risk populations (MARPs) in routine sentinel surveillance or special surveys.
- Facilitate joint RGC-USG-partner assessments of the impact of national programs.

Similarly, in the area of HSS, the USG will provide technical assistance (TA) to strengthen the national program. In FY 2010, PEPFAR programs will strengthen capacity at the periphery, better align incentives to performance, and improve transparency. Seeking to achieve efficiencies through service integration (one-stop shopping), PEPFAR programs will pilot initiatives to reward improved provider performance and behavior. TA at the provincial and district health levels will improve quality and integrate service delivery, to increase demand for and access to quality health services. HSS activities will strengthen RGC health planning and budgeting procedures and foster more strategic public-private partnerships in health. Plans are underway to enhance the Health Information System (HIS) at all levels, which will improve inter-program data use and coordination.

Other Donors, Global Fund Activities, Coordination Mechanisms:

USG collaborates closely with the RGC, the UN, and other bilateral donors. Several USG partners also receive USAID reproductive health/family planning (RH/FP) funds. Their implementing mechanism narratives describe how this funding "wraps around" HIV/AIDS programming and GFATM support to enable them to expand coverage of integrated HIV/AIDS-RH/FP activities. Additionally, the USG and its partners participate on many RGC technical working groups and donor forums to strengthen collaboration.

The USG actively participates on both the GFATM Country Coordinating Mechanism (CCM) and CCM Sub-committee, which both demand a considerable amount of time. While the USG doesn't provide direct technical assistance for GFATM grants, it does assist in proposal reviews and works to ensure GFATM money is spent correctly. Many USG implementing partners have also received GFATM grants, which they use to expand activities started under USG support. USG has strengthened communications

with the GFATM country manager and Local Fund Agent to increase our involvement in grant implementation and to provide feedback on implementation from a GFATM donor perspective.

Given the significant bilateral/multilateral coordination challenges, the relative size of the Global Fund investments in HIV/AIDS – amounting to almost $30 million/year (excluding a pending $130 million Round 9 request) – and the fact that almost one-third of all Global Fund resources are provided by the USG, funding for a full-time, in-country Global Fund liaison will be extremely valuable to us.

Time Frame: Fiscal year 2010 – Fiscal year 2011

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women						

living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives
(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies
Redacted

Public-Private Partnership(s)
(No data provided.)

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
FHI - IBBS for High Risk Males	Behavioral Surveillance among MARPS	Other	Planning

FHI - MSM Qualitative Behavioral Survey	Qualitative Research	Men who have Sex with Men	Planning
HHS/CDC - IBBS for women who have commercial or transactional sex	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development
KHANA - DU/IDU Size Estimation	Population size estimates	Injecting Drug Users	Development
PSI - Cambodia (2009): HIV TRaC Study Evaluating Condom Use with Sweethearts among Female Entertainment Workers in Phnom Penh	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Other
PSI - TRaC Survey for High Risk Urban Males	Behavioral Surveillance among MARPS	Other	Data Review
PSI - TRaC Survey for MSM	Behavioral Surveillance among MARPS	Men who have Sex with Men	Data Review
PSI - TRaC Survey for Women Who Have Commercial or Transactional Sex	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Data Review

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
HHS/CDC		3,000,000	1,450,000		**4,450,000**
USAID			1,550,000	12,500,000	**14,050,000**
Total	**0**	**3,000,000**	**3,000,000**	**12,500,000**	**18,500,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency			Total
	HHS/CDC	USAID	AllOther	
HBHC	140,266	931,165		**1,071,431**
HKID		1,080,471		**1,080,471**
HLAB	398,900			**398,900**
HMBL	500,000			**500,000**
HTXS	140,266	595,000		**735,266**
HVAB		343,298		**343,298**
HVCT		573,294		**573,294**
HVMS	2,565,000	864,480		**3,429,480**
HVOP		5,824,193		**5,824,193**
HVSI	133,000	816,425		**949,425**
HVTB	276,900	105,935		**382,835**
IDUP		500,000		**500,000**
MTCT	212,900	652,158		**865,058**
OHSS		1,344,900		**1,344,900**
PDCS	41,384	151,929		**193,313**
PDTX	41,384	266,752		**308,136**
	4,450,000	**14,050,000**	**0**	**18,500,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

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Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	1,071,431	
HTXS	735,266	
Total Technical Area Planned Funding:	**1,806,697**	**0**

Summary:

Context and Background: "HIV Estimates and Projections for Cambodia 2006-2012," published in 2007, projected that 57,900 adults would be living with HIV/AIDS in Cambodia in 2009. Of these, 33,500 would need antiretroviral therapy (ART). A Consensus Workshop will be convened following the next HIV Sentinel Surveillance (HSS), scheduled for 2010, to develop new national HIV estimates and projections. By 30 June 2009, 31,018 adults > age 14 living with HIV/AIDS (PLHAs) were receiving ART at one of the Ministry of Health's (MoH) 51 HIV Clinics (called in Cambodia "OI/ART clinics") and 41,653 persons were receiving care. In addition to care services at the facility level, 337 home based care teams provided comprehensive care to 25,706 adult PLHA through home visits covering 716 health centers in 20 provinces. With 93% of estimated eligible HIV patients on ART, and 72% of the total estimated number of infected adults under care, the Royal Government of Cambodia (RGC) has made unprecedented progress in scaling up care and treatment services. It has accomplished this with support from many donors, including PEPFAR, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), DFID (whose support ended this year), the Asian Development Bank, Clinton Foundation, and UNICEF. However, long term sustainability will require increased contributions by RGC, which in FY2008 funded only 3 - 5% of Cambodia's multi-sectoral response to HIV. The National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS), which is responsible for HIV/AIDS programs within the MoH, recognizes the need to transform the investment made in Cambodia's HIV/AIDS care into a sustainable health systems. PEPFAR Cambodia will build upon this commitment to strengthen Cambodia's health care system and to increase government leadership. Details regarding harmonization of multiple donor funding are provided in COP09, and remain unchanged. Successful care and treatment of PLHAs requires comprehensive clinical services and strong community services as well as strong links between clinic-based and community-based

providers. To provide a comprehensive package of services for PLHAs, in 2003, the RGC developed a Continuum of Care (CoC) Framework organized at the operational district (OD) level. Each of Cambodia's twenty-four provinces is divided into two to seven ODs. The CoC is a network encompassing programs including counseling and testing, tuberculosis (TB) screening, antenatal care (ANC), PMTCT, Opportunistic Infection (OI) and ART treatment, and home care within communities. The CoC provides counseling, psychosocial and financial support for caregivers, nutritional support, family planning services, and prevention-with positives services. Some of these services (i.e., nutritional support) are subject to available resources. CoC services are delivered through facility-based and community-based institutions. Home based care (HBC) teams continue to be the primary provider of community services while the OI/ART clinic is the focal point for facility-based care. In 2006, Provider Initiated Counseling and Testing (PITC) was implemented nationwide to increase HIV testing in high risk groups. Because PITC introduction led to only marginal improvements in the testing of high-risk clients and pregnant women, the CoC Framework was modified to strengthen linkages between health centers and the various components of the CoC. In December 2007, the Standard Operating Procedures (SOP) to Initiate a Linked Response for Prevention, Care, and Treatment of HIV/AIDS and Sexual and Reproductive Health Issues, referred to as Linked Response, was officially adopted. The key modification to the original CoC system was that every health center in an OD was to be linked with a testing site and funds were to be made available for the regular transport of blood specimens from each health center to its designated, linked HIV testing facility. Lin kages were also strengthened between different reproductive health services (STD, Family Planning, ANC, maternity services), TB, and HIV treatment services as well as between community agencies—especially home based care—and the OI/ART treatment sites. Since COP09, PEPFAR partners provided key technical assistance in drafting the Standard Operating Procedures for a Continuum of Prevention, Care, and Treatment for Female Entertainment Workers in Cambodia, a document which further strengthens the CoC in reaching most at risk population. In addition to playing important roles in the development of Cambodia’s expanding definition of its CoC coverage area, PEPFAR has had a critical role in implementing the CoC, providing support to both facility and community-based components of the care package in 18 of the 51 CoCs in the country. In the four years between January 2004 and December 2007, the number of MoH OI/ART clinics expanded from 1 to 49. Since then, two more OI/ART sites have opened. During this time, USG supported the training of many clinicians, nurses, and pharmacists. To date, NCHADS has trained 181 clinicians, 165 nurses, and 149 pharmacists who care for adults with HIV in the 51 OI/ART adult clinics. While there is still a need for ongoing training of new HIV adult care providers, it is primarily to fill vacancies due to staff turnover as some sites are now more than five years old. PEPFAR funds are primarily supporting continuing medical education through quarterly regional network meetings, yearly national symposia, and Continuous Quality Improvement activities. Accomplishments since last COP: The percent of ART-eligible patients on ART and the percent of all HIV-infected persons

under care as of June 30, 2009, as noted above, are 93% and 72%, respectively, up from 87% and 64% reported in 2008. The mortality rate of patients on ART during calendar year 2008 was 1.8% with an additional 2.3% lost to follow-up. Since COP09, NCHADS has completed a 12 month Linked Response pilot in five operational districts (OD), which resulted in increasing HIV testing rates in pregnant women from a baseline of 7% to 68%, with minimal loss to follow-up of identified HIV-infected pregnant women. Based on these results, scale-up of linked response is planned and is expected to greatly increase the number of pregnant women and other at-risk groups who will be tested. This will further increase the percentage of HIV infected Cambodians diagnosed and under care. Progress was also made in the area of Continuous Quality Improvement (CQI) with approval of a CQI Standard Operating Procedure that was developed with major technical assistance from the PEPFAR team and launched at four CoCs with PEPFAR funds. Three of the sites have gone through one CQI cycle and have made significant improvements in targeted indicators. Further scale-up is planned during the coming year. Cervical cancer screening is available at 19 PEPFAR-supported RHAC clinics in 16 of Cambodia's 76 operational districts (in 8 of 24 provinces), but is not generally available to women cared for at government OI/ART clinics. Linkages between RHAC sites and existing OI/ART sites in the eight provinces will be established so that as many HIV-infected women as possible can be screened for cervical cancer. In 2008, PEPFAR partners provided safe water and nutritional support to more than 10,000 PLHA and OVC families with more than 1.7 million dollars of food provided by the WFP and distributed by home based care teams. Additionally, PEPFAR partners have trained village leaders and religious leaders in the community to provide psychological support and care in the past year and will continue to support these activities. PEPFAR Accomplishments: The following bullets highlight PEPFAR accomplishments against targets for FY08 (Oct 07-Sep 08): • 156 service outlets providing HIV-related palliative care (Targets exclude TB/HIV; results include TB/HIV. In Cambodia, it is not possib le to disaggregate HIV-related palliative care service outlets from service outlets that contribute to TB/HIV care.) Target was 150 • 20,049 individuals provided with HIV-related palliative care(excluding TB/HIV). Target was 16,500 • 2,074 individuals trained to provide HIV-related palliative care (targets exclude TB/HIV; results include TB/HIV).Target was 1,300 • 21 service outlets providing ART. Target was 20 • 2,078 individuals newly initiating ART during reporting period. Target was 2,000 • 9,327 individuals who ever received ART during the reporting period. Target was 12,300 • 7,580 individuals receiving ART at end of reporting period (24.6% of all patients on ART in Cambodia). Target was 10,700. Goals and Strategies for the Coming Year PEPFAR partners will continue their present level of support for facility based and community based HIV care and treatment, incorporating support for Linked Response initiatives in 16 operational districts in six provinces, which is described in detail in the PMTCT Technical Area Narrative. In addition, they will focus on the following key strategies: o Reducing the number of patients enrolled for OI care who are lost to follow-up prior to initiating ART: o In 2008, for every three new patients registered for care, one was lost prior to initiating ART (3,187 vs 9,781). The consequences are that

those who are lost are likely to be transmitting HIV, are at increased risk for TB, and are likely to return for care in an advanced stage of AIDS with OIs that could have been prevented. The interruption in care results in missed opportunities for earlier initiation of ART with associated lower mortality risk and longer response to first line therapy. To reduce loss to follow-up prior to ART initiation, emphasis will be placed on offering compassionate care, implementing Isoniazid Preventive Therapy (IPT) as a "hook" into care (discussed in greater detail in the TB/HIV Technical Area Narrative), utilizing PLHA peers and PLHA support groups to encourage ongoing participation at OI/ART clinic, and provision of tangible benefits such as free condoms or linkage to nutritional services and safe water. o Strengthening positive prevention: o Emphasis will be placed on positive prevention messages to be provided at every visit to an OI/ART clinic, testing of spouses with counseling and condoms provided to discordant couples, routine access to condoms at the OI/ART clinics as well as at patient support meetings and VCCT sites, testing of children of positive mothers, strengthening links to family planning, and outreach to PLHA support groups. o Strengthening linkages to family planning services: o The 2005 maternal mortality ratio in Cambodia is 472 per 100,000—almost one in 200—and probably higher among PLHA. Preventing unplanned pregnancies will save lives as well as reduce the number of exposed infants born at risk for HIV. o Detecting treatment failure: o The inability of clinicians reliably to detect first-line treatment failure increasingly threatens the success of the HIV treatment program. Fewer than 5% of patients on ART for more than four years have been switched to second line therapy. While this may reflect outstanding patient adherence, it is also likely that in the absence of access to viral load testing, treatment failure has been under-diagnosed. USG is actively working with the MoH to overcome obstacles to viral load testing and develop guidelines for its use. PEPFAR will support implementation of viral load guidelines, including training clinicians in detection of virological failure and use of second line ART as well as support for transport of specimens for viral load testing. o WHO and NCHADS are conducting drug resistance surveillance utilizing ARV resistance testing and genotyping provided by the Public Health Laboratory of Canada; surveys will be used to modify protocols for first and second line treatmen t as needed. o Supporting Continuous Quality Improvement PEPFAR partners will: o Continue their support of CQI activities and participate in ongoing efforts to refine them. o Improve quality of life for PLHA by providing nutritional support for seriously malnourished PLHA, vocational training and livelihood skills training, promotion of savings plans, and training of religious leaders, village leaders, PLHA support group leaders, and home based care teams in physical and psychological care of PLHAs, as well as provide support for caregivers and volunteers. Costing of Care and Treatment Programs The PEPFAR team will be able to compare dollars budgeted and allocated for particular care and treatment activities with outcomes achieved. However, PEPFAR is not the sole donor for care and treatment services, nor the largest. The Global Fund provides the most care and treatment resources in country. This makes it difficult to estimate the marginal benefit per PEPFAR dollar invested. PEPFAR will continue to work closely with the MoH and other partners to identify best practices in the

Cambodian context to promote country ownership and sustainability. The Cambodia PEPFAR team is committed to building on successful investments to mitigate the impact of HIV/AIDS in Cambodia.

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HMBL	500,000	
IDUP	500,000	
Total Technical Area Planned Funding:	**1,000,000**	**0**

Summary:

Technical Area Narrative Biomedical Prevention Injecting and Non-Injecting Drug Use The HIV/AIDS epidemic in Cambodia is predominantly driven by male sexual behavior, with drug use increasing risks among some high-risk individuals. A 2007 estimation of the size of the drug-using population conducted by the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) concluded that there are fewer than 3,000 injecting drug users (IDU) in Cambodia, most use heroin, about 90% are male, and almost two-thirds reside in Phnom Penh. The study also estimated that nationwide more than 13,000 individuals (25% of whom live in Phnom Penh) use other illicit drugs. Amphetamine-type stimulants (ATS) are the most commonly used drugs, but inhalant use is becoming more common among street youth. Heroin is inexpensive, very pure, and widely available in cities. Another survey conducted by NCHADS in 2007 estimated HIV prevalence in IDU in Phnom Penh was 24% and 1.1% in non-injecting drug users (DU). HIV prevalence is low among DU in Cambodia, but small drug use surveys in urban areas suggest some association between drug use and high risk behavior for most at risk populations (MARPs). A survey among karaoke women with sweethearts found that 83% have tried drugs, 84% consume alcohol daily, 6% have ever injected drugs, and 20% have more than one regular sex partner. Data from a targeted survey among sexually active urban men sampled from entertainment venues found that 18% were married, 16% had more than one regular sexual partner, 85% paid for sex in the past 12 months, and that 16% reported having ever trying illicit drugs USG has supported the development of the National Authority for Combating Drugs (NACD)'s National Strategic Plan (NSP) for Illicit Drug Use Related to HIV/AIDS which lays out 5 objectives: 1. Expand access to HIV prevention information, services and commodities for people who use or are at risk for illicit drug use, their sex partners and families; 2. Expand access to HIV treatment, care and psychosocial support services for drug users; 3. Provide a range of options for treatment of drug dependence and associated mental illness using evidence-based strategies; 4. Create support for

interventions to prevent and treat HIV/AIDS among drug users. 5. Develop the capacity of the Illicit Drugs Related HIV/AIDS working group, secretariat and implementing partners. Funding for implementation of the strategic plan is being provided by multiple donors, including USG, AusAID, SIDA, the Global Fund and several UN agencies. With limited bilateral resources, and against the backdrop of substantial investments though the Global Fund, AusAID and others to address the HIV risks associated with injecting drug use, USG continues to focus its efforts on technical assistance and linkages to address potential gaps in the continuum of care for IDU, and on integration of addictions-related education and services into programs already targeting female entertainment workers (EW), men who have sex with men (MSM), and other MARPs. Focused activities to address gaps in services for IDU include drug use prevention, harm reduction, addiction counseling, drug user support groups, needle and syringe exchange (funded by the Global Fund and AusAID), and referrals to HIV and drug use care and treatment services. These efforts are coordinated with substantial programming for this population already provided by Mith Samlanh (Friends), AusAID, Global Fund, and others. In 2009, methadone maintenance substitution therapy was initiated at the National Centre for Drug Dependence Treatment at the Khmer Soviet Friendship Hospital in Phnom Penh with support from the Global Fund. This pilot methadone program will be evaluated after o ne year, and if successful, will be expanded to reach more opioid-dependent individuals who volunteer for the service. Dispensing of methadone at different sites, including community-based and mobile methadone clinics will be investigated pending the results of the evaluation. USG partners support capacity building for addictions counselors and case managers to ensure access to HIV, aftercare, social support, and relapse prevention services for both methadone clients and others with relevant needs. The Law on the Control of Drugs in Cambodia states that people arrested for the consumption of illicit drugs, and those found to be dependent on illicit drugs, must appear before the court and may be ordered to enter treatment or detoxification centers, with expenses paid for by the state. As of May 2009, the Drug Information Center (DIC) of the NACD's Secretariat-General, was aware of 14 “drug treatment and rehabilitation centers” operating in nine provinces or municipalities in Cambodia run by government entities in closed locations, plus at least three NGO-run centers and two private-run facilities. There are also several quasi-NGO run drug treatment and rehabilitation centers, mainly around Phnom Penh. A rapid assessment conducted in 2009 by colleagues from the PEPFAR program in Vietnam suggested that the vast majority of individuals in these centers are not IDU, that many pay for the services they receive, and that these services seldom meet international standards for treatment. By making limited investments in training and capacity building to support evidence-based drug treatment models, USG resources may help to foster demand for higher quality alternatives to the rehabilitation centers. Beyond activities specifically targeting IDU, USG partners will continue to integrate addiction education and referrals into HIV prevention initiatives already targeting MARPs. Programs targeting female EW, their prospective male clients, and MSM will incorporate education about alcohol, other drug and HIV risks, and work to facilitate relevant linkages to

clinical and community addiction services. Awareness raising and sensitization activities will target the broader community – including key influential leaders, parents, and local authorities – to promote action to mitigate drug-related HIV risk. Technical assistance will also continue to be provided to local organizations and others working with drug-using MARPs, including training on ATS use and methadone maintenance treatment. Local NGOs will continue to provide mobile HIV testing and counseling and sexually transmitted infection services to DU/IDU populations, and OI/ART, clinical care, and supportive services to PLHA drug users. USG-supported activities are implemented in collaboration with the NACD, the Ministry of Interior, UN agencies and other stakeholders. USG partners actively participate on the Illicit Drugs related HIV/AIDS Working Group, co-chaired by NACD and the National AIDS Authority, to help monitor minimum standards in targeted drug rehabilitation centers and prisons. Intervention activities are coordinated with AusAID's HIV and AIDS Regional Program (HAARP), which aims to improve the quality and effectiveness of harm reduction approaches in the region and scale-up harm reduction responses in Southeast Asia. In Cambodia, HAARP is implemented through four NGOs, three of which are funded by USG. Blood Safety The National Blood Transfusion Services (NBTS), centrally coordinated by the National Blood Transfusion Center (NBTC), was established in 1983. Along with 21 Provincial Blood Transfusion Centers (PBTC), NBTS is responsible for donor recruitment, blood collection and testing. In addition, there are 11 blood depots capable of storing blood. In 1994, the Ministry of Health (MoH) issued a policy on safe blood management, and in 1999, national guidelines on the use of blood were sent to all hospitals. Screening of all blood collected for HIV, hepatitis B and C, syphilis and malaria (in endemic are as) before release for clinical use was mandated in 2003. Of 68 hospitals, only five have functional transfusion committees. Although the actual blood requirement for Cambodia is unknown, there appears to be a substantial gap between supply and demand. In 2008, 36,121 units of blood were collected and 13,575 persons received blood. With a population of 13.4 million, this represents 2.70 units collected/1000 population, compared to WHO estimates that resource-limited countries should begin to fulfill baseline clinical demand if 10 - 20 units/1,000 population are collected each year. Demand for blood is increasing due to an increase of major trauma cases at newly opened private hospitals in both urban and rural areas. More than 70% of current blood donations are family replacement, although NTBS encourages volunteer and repeat voluntary non-remunerated donation (VNRD). In 2008, NBTS sought the cooperation of national hospitals to ban paid donors. This resulted in a small increase in the proportion of blood units from VNRD (22.5% in 2006, 24.1% in 2008 and 29.4% as of June 2009), but greater progress needs to be achieved. HIV positivity prevalence in screened blood units decreased from 1.5% in 2006 (compared to 0.9% in the general population) to 0.6% in 2008 (UNAIDS 2008 report). The seropositivity of other transfusion-transmissible infections (TTIs) in screened blood units are 7.1% for hepatitis B, 1.2% for hepatitis C, and 1.5% for syphilis. With GFATM, WHO conducted an assessment of the NBTS in April 2008, which found that while policies were in place, systems to ensure blood safety were progressing very slowly. There was a lack of

monitoring of appropriate clinical use of blood, a weak linkage between NBTS and hospital services, and a lack of notifications, counseling and referral of donors with TTIs. Staff shortage in provincial blood banks was common and capacity was limited. Management capacity and use of information at all levels needed strengthening. Using pre-PEPFAR funds, USG provided support to NBTS for improved infrastructure and computerized information systems. The use of the computerized system is hampered by the lack of a unique identification number and contact details for each potential donor, resulting in a lack of donor traceability and inefficiency of documenting deferred donors by category. The information system needs validation checks on the reliability of the data entered. USG gained GFATM support for VNRD recruitment through training on donor recruitment for youth volunteers, organizing meetings with donor group leaders and producing leaflets for four PBTCs. NBTC and Battambang PBTC initiated a school-based donor recruitment and retention project. To improve the effectiveness of mobile blood donation drives, audio visual equipment was purchased. Laboratory technical and quality capacity also improved. A document control system had been set up and all PBTCs received a copy of the 16 technical procedures, 18 quality procedures and NBTC's quality manual. Internal auditor training has also been conducted. Three participants are now capable of conducting quality assessment of blood banks. Under GFATM, NBTS upgraded its laboratory with new medical equipment; provided training to all staff in four PBTS and NTBS; developed IEC and conducted campaigns; developed clinical guidelines for improving rational use of blood and blood components; hired a blood safety consultant to improve quality management systems, and to conduct external quality assurance (EQA). With additional support, management systems can be substantially improved, and gains that were made sustained and enhanced. In FY10, USG will continue to strengthen NBTS capacity in the following areas: Technical and management support: USG, with WHO and other partners, will assist NBTS to lead the blood safety program. Technical assistance will be provided to NBTS to implement a total quality management system in laboratories. Support will be prov ided to analyze and use program data, to collect information on adverse reactions, to capture information on TTI positive blood donors for referral, and to estimate blood supply and equipment needs. Quality Assurance: USG will continue to support quality assurance program and monitoring in NBTS and the Complementary Package Activity 2 (CPA2) hospitals. Increasing availability of safe blood: USG will continue to advocate for stronger enforcement of policy banning paid donation and will support NBTS to identify new ways to collect blood from low risk groups such as monks and students through GFTAM. "Donor Clubs" in community schools will be established to increase and retain VNRD. USG will strengthen knowledge and skills of blood collection counselors and support NBTS effectively to schedule blood collection drives in schools and pagodas. Lack of blood contributes to mortality from accidents, obstetrical hemorrhage and other emergencies in rural areas; USG will also support MoH to implement the CPA2 Guidelines, whereby the CPA 2 hospitals can manage blood collection and usage by training hospital staff how properly to collect and transfuse blood and also provide consumables, reagents and rapid tests. Upgrade facility and laboratory equipment:

USG will support the expansion of NBTS laboratories and upgrade essential equipment at the NBTC and in some PBTC. Along with MoH and GFATM, strategies to ensure the constant availability of reagents, equipment and, maintenance contracts will be developed. Policy and Legislation: USG will continue to participate in the sub-Technical Working Group for Blood Safety to advocate for policy enforcement, greater RGC involvement and leadership, and increased resources for blood safety in Cambodia. With the rise of private sector institutions, it is essential that the MoH develop policies and procedures to monitor blood safety in the private sector.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	573,294	
Total Technical Area Planned Funding:	**573,294**	**0**

Summary:

Technical Area Narrative HIV Counseling and Testing

Voluntary Counseling and Testing (VCT) sites are managed and supervised by the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) with financial support from USG, UNICEF, Global Fund, Clinton Foundation and various NGOs. VCT centers operated by NGOs are accredited by NCHADS and follow national guidelines and reporting procedures. VCT is an important entry point to the Continuum of Care (CoC) network. As described in the Adult Care and Treatment Technical Area Narrative, the CoC is the national network that links care and support services at all levels. It includes VCT, prevention of mother to child transmission (PMTCT), opportunistic infections/antiretroviral treatment (OI/ART), and community and home-based palliative care. For HIV testing, NCHADS endorses a national algorithm using two rapid tests: the first screening test is highly sensitive (Determine) and the confirmatory test is highly specific (Uni-Gold or Stat-Pak). NCHADS has also approved the use of a tie-breaker test (Serodia) at reference laboratories for discordant HIV tests results. NCHADS has a comprehensive and updated national standard VCT training curriculum, and provides ongoing training to counselors and laboratory technicians in counseling and HIV rapid test protocols and procedures. A quality assurance program has been implemented with technical support from the USG in partnership with the National Institute of Public Health Laboratory (the National HIV Reference Laboratory), the Pasteur Institute of Cambodia, and Clinton Foundation. Since the first VCT site was established in Cambodia in 1995, testing sites have rapidly expanded. As of March 2009, 216 VCT sites were providing counseling and testing services in all 24 of Cambodia's provinces. The number of people seeking VCT services has increased from about 65,000 per quarter in 2007, to 119,543 for the first quarter of 2009, including 82,373 who self-

referred, 5,151 referred from TB, and 32,019 whose blood specimens were sent from PMTCT (26,602 pregnant women and 5,417 partners). Of the self-referred patients, 55.7% were women, and 3% were HIV-positive. Of those who tested positive, 51.3% were women; 84.8% were between 15-49 years; and 9.7% were = 14 yrs. To improve the uptake of testing among most-at-risk groups, the MOH has introduced provider-initiated testing and counseling (PITC) and recently expanded the Linked Response (LR) approach which aims to strengthen linkages between HIV and reproductive, TB and sexual health services and community based programs. The USG has played a significant role in helping NCHADS expand VCT services by supporting the establishment of over 70 public VCT sites in 14 provinces, and 19 VCT sites operated by the Reproductive Health Association of Cambodia (RHAC), an indigenous NGO, and one pediatric hospital. To this end, USG supported renovation of facilities to create secure and confidential counseling spaces, and gave equipment and technical support to ensure quality services were provided. The USG continues to provide technical assistance to strengthen the capacity of counselors and lab technicians, ensure quality assurance and fund other costs of service delivery. Operational costs have been supported mainly by the Global Fund and other donors through their support to NCHADS. In COP10, the USG's objectives are to support the national program to increase uptake of HIV testing in the highest burden clinical settings, including STI clinics, TB clinics, and in-patient settings, and to integrate HIV testing into health services, especially targeting most at risk populations (MARPs), who are at high risk and can be difficult to reach. Specific activities include: Increased utilization: the USG will continue effort s to increase uptake of VCT by MARPs, couples (including discordant couples), TB patients, pregnant women and youth through support for outreach testing through mobile VCT, new testing sites, education and referral "centers." PEPFAR partners will work within community structures, including community and home based care teams, Village Health Support Groups, community volunteer groups, and organizations that provide outreach to entertainment workers, men who have sex with men, and IV drug users to reach at risk populations and link them to HIV testing and necessary follow-up services. The USG will also support the expansion of the Linked Response initiative to increase screening of TB patients and pregnant women and high risk groups, and support the development of information, education, and communication (IEC) materials that explain the benefits of early testing and identify mechanisms for transportation and social support. Quality improvement: the USG will continue to provide technical assistance to various levels of the health care system to ensure VCT services are linked to prevention, care, and treatment and other programs under the CoC. It will work with the National Institute of Public Health, Pasteur Institute of Cambodia, Clinton Foundation and NCHADS to expand the quality control system, to ensure accurate HIV rapid test results; and to strengthen capacity of national and provincial staff in conducting monitoring and supervision of VCT centers. This includes the use of monitoring data to improve service delivery. Capacity building: At the national level, the USG and implementing partners actively participate on VCT technical working and advisory groups as well as provide technical assistance for the

development/revision of national policies, strategies, and training curricula. The USG will continue to support primary and refresher training of counselors and laboratory staff as well as regular regional counselor network meetings. The USG will also continue to promote improved couples counseling in an effort to mitigate negative outcomes related to disclosure, especially those faced by women, and training for counselors to improve the quality of counseling provided to discordant couples. Integration into the Health System: VCT has been integrated into 61 testing sites of the Linked Response (LR) satellites in health centers or referral hospitals in 21 Operational Districts. The LR satellite offers reproductive health services and HIV testing to partners of women accessing reproductive health. LR staff can prescribe ARV prophylaxis for HIV infected women with CD4 >350 starting at 28 weeks gestation, provide safe delivery care for HIV-infected pregnant women, provide cotrimoxazole prophylaxis to infected babies, and collect dried blood spots for early infant diagnosis at six weeks. Services include follow up for both mothers and infants. Among the 61 LR satellite sites, 33 have been supported by the USG. Referral linkages have been established between all VCT sites under the Satellite sites to refer all positive clients to OI and ART treatment at the Hub of the LR, where the hospital provides one-stop service. Through the LR initiative, the district health organization has been empowered to play an overall coordinating role by bringing together the operational district HIV/AIDS and Maternal and Child Health District Coordinators, the TB District Coordinator, the Continuum of Care teams, health center staffs, and community structures. This referral network is coordinated by the CoC committee and home based care teams. NCHADS, with support from the USG and other development partners, has developed Standard Operation Procedures (SOP) to strengthen referral linkages within and between community and health facility based services. The USG team and its partners participated in the development of the SOP and support its implementation. In addition, the 19 USG funded VCT sites (operated by RHAC) provide an integrated package of services that includes family planning/reproductive health, se xually transmitted infection (STI) treatment, and provision of ARV prophylaxis for HIV infected women with CD4 >350. Through its clinics, RHAC provided 14.5% of the total national PMTCT screenings of pregnant women in 2008. Despite the rapid expansion of testing sites over the past few years, the uptake of these services is still limited due a variety of factors, including HIV stigma and discrimination, and high transportation costs to access services. Supply chain problems, including shortages and delays in receiving test kits from the Center Medical Store present challenges. Reaching most-at-risk and often hidden populations is a challenge, but one that programs in FY 2010 will remedy by providing outreach testing. Finally, we will strengthen referral linkages and follow up between services provided under the CoC, especially for individuals with a positive HIV test result. In FY 2010, the USG and other donors will continue to work closely with the NCHADS and the National AIDS Authority (NAA) to address these challenges.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	1,344,900	
Total Technical Area Planned Funding:	**1,344,900**	**0**

Summary:
Technical Area Narrative Health Systems Strengthening
Cambodia's health system mirrors the country's centralized and hierarchical political structures. Health delivery systems are characterized by weak human and institutional capacity, low quality, and corruption. The social sectors are further weakened by extremely low spending – the Royal Government of Cambodia's (RGC) budget is very low – resulting in an underpaid and poorly motivated public sector work force, limited and poor quality public services, an excessive reliance on donor assistance to carry out many inherently government functions, and a burgeoning and unregulated private commercial health sector. In 2008, total government spending was 15.1% of GDP but this included 4.3% from foreign grants and loans. The RGC's contribution to HIV/AIDS programs is estimated to be approximately 3-5%, and 2008 data suggests that RCG commitments are declining.
Transparency International's 2008 corruption index ranked Cambodia as the 11th most corrupt country in the world. As there are few incentives for good performance and little relationship between an employee's performance and compensation, the public health system has developed an extraordinary range of incentive schemes. Current incentive-based donor programs, of which the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the largest, reinforce vertical programming and have effectively built national HIV/AIDS, TB, and Malaria programs parallel to the Cambodian public health delivery system. Cambodia has made significant strides in strengthening human capacity following the conflicts of the 1970s -1990s, but leadership and mid-level managerial capacity is weak across government, the private sector, and civil society. Although universal education has been re-established (85% boys and girls at primary level), secondary school attendance drops significantly (29% and 26% respectively), and participation in higher education is the lowest of all ASEAN countries (1.2% compared to ASEAN's 20.7% average). Nearly two-thirds of Cambodia's 13.8 million people are under the age of 30 and there is an acute shortage of health professionals with good or specialized training and experience. Health providers tend to have multiple jobs moving back and forth between the public and private sectors to make a living wage. Despite significant weaknesses, the public health delivery system has made significant improvements in its planning and budgeting processes and has had notable achievements in the past few years. Improvements in the health sector demonstrate that the RGC can deliver results in partnership with donors and non-government players. Perhaps Cambodia's greatest success has been the reduction of HIV prevalence from over 2% to 0.9% in the adult population and the achievement of

universal access to antiretroviral therapy (ART). Cambodia has also developed a vibrant community and civil society sector, which provides excellent prevention and care services with donor support. However, these early and significant successes were achieved outside and at the expense of a sector-wide approach. NCHADS established and gave adequate resources to a system of parallel services, which were then unburdened by the systemic and chronic problems of the national health system. Parallel practices have high transactional costs for HIV patients, donors, and the government. In the long term, they fail to achieve the full benefits of sustainable, accessible, and quality services. USG program approaches will concentrate on comprehensive health reforms. We will use results-based contracting and financing to strengthen capac ity at the periphery; better align incentives to performance; and improve transparency. Health systems strengthening will focus technical assistance at the provincial and district health levels to improve service quality, integrate service delivery, strengthen planning and budgeting procedures, increase demand and access for health services, and increase strategic public-private partnerships in health. In FY10, PEPFAR programs will identify efficiencies through service integration (one-stop shopping); it will pilot initiatives that encourage service provision in a holistic manner and reward improved provider performance and behavior. Strengthening the Health Information System (HIS) at all levels and improving inter-program data use and coordination will support the planning and budgeting components of the overall health system. USG will continue to develop and build the capacity of Cambodian civil society to ensure greater sustainability, increase Cambodian leadership, and promote RGC stewardship of the national health system. USG partner organizations are involved at all levels of the health system, and they are encouraged to provide support to the RGC to encourage improvements in efficiency and coverage of interventions. HSS priorities for FY10 include: • Using the USG role in key public sector institutions and USG participation on national technical working groups to shape national health sector priorities and policies. • Advancing the development of public systems to better address the high-risk male behavior that is a significant driver of the epidemic. • Improving the integration of HIV, TB and STI services, and the integration of prevention of mother to child transmission (PMTCT) into existing maternal and child health services. Through PEPFAR support to the MoH's individual, vertical health programs, the USG has an opportunity to bring together these elements to unify the health system. In FY10, The USG will identify and address obstructions to improved service delivery, program integration, and improved public sector performance. Through partnership with the RGC, PEPFAR will build consensus on new service delivery methods. However, these tasks will require time, technical insight, and political space. Any such reorientation will require increases in RGC leadership and funding in the coming years. HSS reforms must be tied to government-wide, public financial management and civil service reforms as well as the future directions of decentralization and deconcentration. In FY 2010 the USG will take pragmatic steps in line with this longer-term HSS strategy to: • Strengthen Cambodian's policy, planning and management capacity in the public sector, local non-government sector, and civil society; • Improve the quality of national

surveillance systems and effective use of data for HIV/AIDS policymaking and program decisions and rebalancing technical assistance towards skill transfer and mentoring; • Create demand strategies to engage communities around maternal, newborn health, TB, STI, and HIV issues. Improving referral linkages at all levels; • Support widespread and accessible antenatal care that integrates PMTCT services and addresses the continuing needs of HIV treatment and care of the mother and baby in the post-partum period; • Support health financing arrangements (Health Equity Funds, community-based health insurance, work-based health insurance) within a broader health financing framework, to improve HIV service uptake, particularly by women of reproductive age; • Strengthen human resources in public and private sectors and fostering government leadership. • Work in partnership with the RGC to enhance sustainability and host-country funding in line with the new vision of PEPFAR; • Ensure good stewardship for Global Fund to Fight AIDS, Tuberculosis, and Malaria resources; • Work with other donors and stakeholders to encourage the RGC to increase the percentage of money budgeted to health generally and HIV/AIDS specifically.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	398,900	
Total Technical Area Planned Funding:	**398,900**	**0**

Summary:

Technical Area Narrative Laboratory Infrastructure Context and Background: In support of Cambodia's National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS, 2006-2010, the USG supports the National Institute of Public Health (NIPH), the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS), and provincial laboratories in the National Public Health Laboratory Network, to expand and enhance national laboratory quality assurance systems, provide laboratory support for HIV and STD surveillance, and improve the quality of testing to monitor HIV/ AIDS care and treatment. The USG has recently approved a five-year cooperative agreement with the National Tuberculosis Program (NTP) to strengthen its capacity reliably and rapidly to diagnose tuberculosis in patients with HIV and prevent the spread of multi-drug resistant Mycobacterium tuberculosis. The Cambodian national laboratory system remains weak. Many facilities are in poor condition and lack essential equipment and supplies to perform even basic diagnostic tests. Because of limited capacity to perform diagnostic tests and lack of reliable test results, clinical providers do not utilize the laboratories to make diagnoses and guide treatment. Laboratories located at referral hospitals providing ARV treatment services have received the most support to date and have stronger capacity than

others; however, the capacity of Cambodia's HIV laboratory services has not expanded as rapidly as the expansion of ARV treatment sites. In some locations, the laboratory provides CD4 count testing but has difficulty, or is unable to conduct reliably tests such as blood counts, electrolytes, liver function tests, routine bacteriological cultures, or even Gram stains. Expired reagents and inadequate supplies provided through the Ministry of Health (MoH) Central Medical Stores (CMS) remain a major obstacle to quality laboratory services. Laboratory equipment is often donor provided, and the equipment and supplies are not standardized. Ongoing equipment maintenance and supplies of reagents, including quality control reagents, are not provided by either the MoH or donors on a regular basis, resulting in stock outs and expired reagents. In procurement decisions about MoH laboratory supplies, the MoH CMS does not include staff trained in laboratory testing, and the final decision for procurement of laboratory supplies is usually made at a level above the national health programs. In contrast, the USG provides the required elements for a sustainable public health laboratory system in the HHS/CDC focus provinces. USG provides hematology and biochemistry testing, essential for monitoring ARV toxicity, and supports the enrollment of referral hospital laboratories in international external quality assessment schemes to monitor their testing performance. Outside of the USG supported laboratories, quality assurance of laboratory services is weak. Laboratory capacity is further limited by segregation of services in line with national vertical programs. TB smear staining and reading may share laboratory space with VCT, ARV monitoring, blood bank, and other programs, or each program may maintain distinct laboratories with separate personnel. In either case, the staff, supplies, and equipment is program-specific, resulting in multiple programs duplicating effort, services, and resources. To address some of these issues, the MoH is beginning discussions on the concept of integrated laboratories. USG will continue to advocate strongly in national technical working groups for laboratory integration and will support the integrated laboratories with technical assistance and, to a limited extent, essential equipment and reagents. Working within the sub-TWG for Blood Safety and Laboratory Services, HHS/CDC has played an active role in developing National Policy for Medical Laboratory Services. It is anticipated that this policy will be ap proved in calendar year 2010. The NIPH Laboratory (NIPHL), Clinton Foundation, and HHS/CDC have also drafted the "Management of Referral Hospital Integrated Laboratories" Standard Operating Procedure which describes the relevant responsibilities of the various national health programs in relation to integrated laboratories. Approval and implementation of this document will require the agreement of the directors of the national programs and the Minister of Health. There is a tiered public health laboratory network structure in Cambodia. The NIPHL has been designated as the national HIV Reference Laboratory by the MoH. The NIPHL is responsible for: (1) assessing training needs and developing the necessary training to respond to these needs; (2) carrying out regular laboratory supervision; (3) setting standards for equipment; (4) testing protocols and laboratory design; (5) serving as a reference laboratory for national hospitals; and (6) providing quality assurance programs for laboratories throughout the country. Recognizing the pivotal role the

national laboratory system has for HIV/AIDS treatment and care and the health system in general, the USG has supported essential equipment and supplies and provided TA to the NIPHL to support increased capacity of laboratories throughout the country. With USG support, the NIPHL will perform a wide gamut of HIV testing services including 1,640 HIV screening tests, and approximately 40,000 CD4 counts and viral load testing in 2009. The NIPHL also performs DNA PCR for the diagnosis of HIV in infants using dried blood spots. There are now 23 dried blood spot collection sites in 16 provinces. Supported by USG, the NIPHL is enrolled in a viral load proficiency testing program with panels sent from the Thai National Institutes of Health. The NIPH has additional sources of support. For example, the NIPH was awarded Global Fund support to expand quality assurance systems that were initially established by the USG. The Clinton Foundation supports testing for CD4 with seven FASCount machines in Cambodia. One is at the NIPHL, one is at the NCHADS STD clinic, and five are in provincial laboratories. NIPH, with technical assistance from HHS/CDC, is strengthening the national public health laboratory network. The objective of the laboratory network is to increase availability of a minimum package of laboratory tests across Cambodia, decrease dependence on the NIPHL in Phnom Penh for such tests, and reduce the proportion of samples that need to be sent to NIPHL for testing. HHS/CDC supports five referral hospital laboratories in four northwestern provinces, three district hospital laboratories and Poipet Health Center in Banteay Meanchey Province on the border with Thailand. USG funds two Cambodian laboratory specialists who provide technical assistance in laboratory quality management to these hospital laboratories. USG also provides laboratory reagents for laboratory tests for HIV infected patients not supported by the MoH in these laboratories. The National TB Reference Laboratory (NRL) is housed at the National Center for Tuberculosis and Leprosy and is a part of the National TB Program; it is not a part of NIPHL. There are three national laboratories which are capable of performing cultures for TB. Drug susceptibility testing is only available at the NRL. Sputum smears prepared at the health centers nationwide are transported to one of 207 microscopy units located in district or provincial hospital laboratories. USG will work closely with the National TB Program, TBCAP, and the WHO on TB laboratory issues at the national and provincial levels. Additionally, the National TB Program has a National TB Laboratory Strategic Plan 2007-2010. Among the activities planned is the upgrading of TB culture capability. The NTP has been awarded a Cooperative Agreement with the HHS/CDC to further strengthen the laboratory diagnosis of TB in PLHA, and to support the introduction of liquid culture at the NRL and in the Battambang Referral Hos pital laboratory. Adequate pre-service training of laboratory staff is the most significant unmet need in the national laboratory network. The subject matter content in the present curriculum is inadequate and the length of hands-on practicum too short to produce skilled technicians able to fill the many vacancies. As part of the PEPFAR strategy to increase host country capacity and contribute to health system strengthening, the USG will provide a Pre- Service Curriculum Development program to the Cambodian Technical School for Medical Care (TSMC) in conjunction with the American Society of Clinical

Pathology (ASCP). Forty-five students are expected to graduate every year from TSMC. Quality assurance needs to be improved throughout the network and this includes the need for better laboratory management, equipment maintenance, uninterrupted supply of quality control reagents, communication with clinicians and shorter turn-around time for specimen processing. For example, positive sputum smear examination results may take seven to ten days to reach the ordering clinician. Accomplishments since last COP • HHS/CDC successfully implemented a demonstration project in Battambang province which utilized midwives and nurses to conduct HIV rapid testing for pregnant women and during labor at health centers. • As part of the global assistance program from the Thai NIH, the NIPHL staff has been trained to analyze the results of the EQAs program for HIV testing in VCT sites. • Four staff members from provincial laboratories were trained in pipette calibration at the National Institute of Metrology in Bangkok, Thailand. • Technical assistance has been provided to prepare the NIPHL for international accreditation. • Mongkoul Borei and Pursat referral hospital laboratories have been renovated as part of laboratory integration efforts. • USG has expanded support, equipment purchase and TA from the HHS/CDC laboratory analyst, to the Thmol Koul district hospital laboratory in Battambang province and the Thmol Pouk district hospital laboratory in Banteay Meanchey province. • After receiving training and technical assistance from HHS/CDC, NIPHL performed 577 HIV DNA tests for early infant diagnosis. • USG has funded the enrollment of laboratories in a proficiency testing program in basic biochemistry and hematology. Beginning in February 2009, panels are sent three times each year to the NIPHL and then distributed to provincial laboratories. • The number of FASCount machines in the public sector in Cambodia has been increased to seven. These machines have been upgraded with software to provide the CD4 percentages in specimens from children. • A second laboratory analyst providing TA in the focus province referral hospital laboratories has been hired. • Renovation and expansion of the TB laboratory in Battambang Referral Hospital have been completed. • A Cooperative Agreement between HHS/CDC and the National TB Program has been awarded. • USG has provided funding to the ASCP for the development of a pre-service training curriculum for TSMC. Goals and Strategies for the coming year USG PEPFAR strategy for sustainable laboratory support is to strengthen the MoH's public health laboratory system at all levels (national, regional, and provincial) to provide quality assured testing for diagnosis and monitoring of HIV care, HIV surveillance, and TB/HIV diagnosis; to strengthen laboratory management; and to strengthen both in-service and pre-service laboratory technician capacity. At the national policy level, USG will: • Continue to participate actively in the sub-TWG for Blood Services and Laboratory Services to promote and encourage the approval and implementation of the National Policy for Medical Laboratory Services. USG will further promote the appointment of a national laboratory coordinator and the integration of laboratory services within the provincial referral hospitals. • Continue to advocate for and support the implementation of the National Strategic Plan for Laboratories developed in 2007. • Continue to provide policy input at the TWG for the TB Laboratory. At the NIPHL and national public health

laboratory network, USG will strengthen quality assurance activities and laboratory management capacity. Specific PEPFAR-supported staff and programs will: • Continue to fund a global assistance program from the Thai NIH. A microbiologist from the Bamrudas Institute of Infectious Diseases will provide training at the NIPHL in the diagnosis of opportunistic infections. • Continue to develop quality management systems in the laboratories it supports by training laboratory directors, training in infection control, providing biosafety equipment, and monitoring the functionality of the newly developed laboratory information system at NIPH. • Expand and monitor the proficiency testing (PT) program in basic biochemistry and hematology in two district hospital laboratories and the CD4 PT program in the laboratories where new FACSCount machines have been installed. • Work to implement a Laboratory Training Unit within the NIPH. • Support and actively participate in the implementation of the "Strengthening Laboratory Management Toward Accreditation" curriculum developed by the HHS/CDC, Clinton Foundation, and the American Society of Clinical Pathology. This program is designed to strengthen laboratory management, achieve laboratory improvement, and accelerate the stepwise process toward accreditation such as ISO-15189. Through this task-based management training, USG will address the essential elements of quality systems, which will strengthen the quality of laboratory services in Cambodia. • Continue to partner with other donors such as the Clinton Foundation to provide technical assistance to the NIPHL to improve the quality and expand the capacity for HIV viral load testing and DNA PCR for infant diagnosis. USG will provide HIV viral load and BED incidence test kits to the NIPHL to maintain proficiency as appropriate for a HIV National Reference Laboratory. • Strengthen laboratory management and laboratory testing at the National Blood Transfusion Center and in the blood banks and blood depots at the provincial level (see blood safety section). To expand capacity for provincial referral laboratories, USG will: • Work with the National TB Program to implement liquid culture in the Batttambang Laboratory and the National TB Reference Laboratory. • Expand efforts to integrate the laboratory in the referral hospital in Banteay Meanchey province. USG will support pre-service laboratory human capacity building through: • Supporting development of a training program for lab technologists at the Cambodian Technical School for Medical Care.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	3,429,473	
Total Technical Area Planned Funding:	**3,429,473**	**0**

Summary:
(No data provided.)

Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	1,080,471	
Total Technical Area Planned Funding:	**1,080,471**	**0**

Summary:

Technical Area Narrative Orphans and Vulnerable Children Context and Background: Cambodia remains one of the poorest countries in Southeast Asia. Over 80% of Cambodians live in rural areas, and the country has no formal social welfare system. This leaves many orphans, children, and families economically and socially vulnerable. The 2005 Cambodia Demographic and Health Survey indicated that 8.8% of children 0-17 years of age, or an estimated 553,000 children, were orphans in Cambodia. These children have lost one or both parents due to a range of causes, and an unknown proportion are orphans due to HIV. Identifying and distinguishing HIV OVC from the multitude of other children, orphaned or made vulnerable from other factors, is not possible. There are no current estimates of the number of Cambodian children orphaned or vulnerable as a result of HIV/AIDS. However, clinical data from HIV treatment facilities indicate that as of June 2009, 5,211 HIV-infected children 0-14 years old registered for HIV treatment, of whom 3,366 have already received ART. Based on program data from home based care (HBC) teams, PEPFAR Cambodia estimates there are approximately 60,000 children living within PLHA families in Cambodia. This figure should be seen as a very rough estimate as no studies have validated whether OVC in these communities are over-estimated (although the partner works to identify and target HIV-affected children) or under-estimated, which occurs when a parent dies and there is no longer a PLHA in the family. As of June 2009, through PEPFAR-supported integrated HBC and OVC interventions, 38,052 children affected and infected with HIV/AIDS received care and support in Cambodia. This indicates a substantial gap in service coverage for OVC, even using what is likely to be a conservative estimate of their numbers. Most OVC programs in Cambodia aim to alleviate poverty and provide children with access to health care and schooling. While community and family-based assistance is appropriate for OVC, it would ideally be part of a broader framework of rural development and poverty alleviation, including efforts to enhance food security and provide income generation opportunities. In Cambodia, increasing food prices are affecting vulnerable populations in both urban and rural areas. Funding from the Global Fund and other donors, including food support from the World Food Program (WFP), helps to meet this need. Future provision of WFP support is uncertain given global demands and heightened food insecurity worldwide. Some USG partners are able to combine OVC care and support with micro-enterprise initiatives funded by other donors.

However, in order for OVC to access education and not be stigmatized, work to engage schools and teachers is needed. Accomplishments since FY09 COP Since 1998, the USG has been a major supporter of OVC programs through an integrated HBC-OVC approach. These programs focus primarily on children who have lost one or both parents due to AIDS; who live with HIV-infected parents; or who, because of HIV/AIDS, live with extended family, with caregivers in their communities, or in institutional settings. In FY 2008, the most recent year for which statistics are available, the USG surpassed its targets for direct service provision to OVC, with 15,453 OVC served and 5,829 providers/caretakers trained. Goals and Strategies for the Coming Year In COP FY10, USG will modestly expand PEPFAR support for OVC programs to 7.3 percent of the overall PEPFAR budget, from 6.2 percent in FY09. PEPFAR-supported OVC programs will provide: • High quality, community-based services for OVC infected and affected by HIV/AIDS; • Referral linkages with health care services such as VCCT, OI/ART and PMTCT; • Linkages with legal, educational and economic support services; • Technical assistance at the national level for policy development, resource mobilization and development of a national OVC M&E fram ework and tools. The USG is making strategic choices to move long-term care and support programs, such as OVC and HIV care and treatment, to other funding sources, primarily the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). Efforts to move current OVC activities to host country mechanisms and GFATM resources will continue where possible. PEPFAR-supported partners take a comprehensive, child-centered and family-focused approach. They provide technical leadership to the National AIDS program in the design and adoption of Standard Operation Procedures for good community and family-based care. Through integrated HBC and OVC programs, PEPFAR partners build the capacity of HBC teams to deliver HIV care and social support services to OVC. Specifically, PEPFAR-supported OVC programs will empower communities, extended/foster families, and caretakers to: • Assess OVC health status, educational, psychosocial, nutritional and basic needs; • Provide referrals for medical and support services; • Provide HIV prevention counseling and legal protection for OVC; • Enhance parenting skills; • Reduce stigma against HIV-positive OVC and their families. These community-based interventions will link to health facilities to ensure OVC access to VCCT, PMTCT, Opportunistic Infection (OI) treatment, antiretroviral drugs (ARV) and pediatric AIDS treatment. This coordinated approach will also increase identification of OVC and follow-up for HIV testing of newborn children. In FY10, PEPFAR will work with the University Research Corporation, LLC (URC) to create of a new type of Health Equity Fund (HEF) (a social health protection program similar to Medicare), for Cambodian OVC. URC's program will permit existing HEF beneficiaries, supported by URC with non-PEFAR funding, to pay for transport and food for OVCs receiving HIV/AIDS care from RGC health facilities. HIV/AIDS care is offered free by the facilities, but by paying for transport and food costs, the HEFs will lower the financial barriers to these "free" services. The USG will also continue to support Faith Based Organizations' programs in pagodas, mosques and churches as they provide cost-effective, community-based, non-clinical OVC services. The USG collaborates with the Ministry of Health, the

Ministry of Social Affairs, Veterans and Youth Rehabilitation, and the National AIDS Authority to implement OVC activities in accordance with the National Multi-Sectoral HIV/AIDS Strategy. With partners as technical leaders in OVC policy making, the USG works with the National OVC Task Force to develop national policy as well as a monitoring and evaluation system for OVC. The USG works with the Global Fund and UNICEF, enabling implementing partners to expand OVC services to additional provinces and support additional interventions (e.g. food provided by WFP). Collaborative relationships with Global Fund and UNICEF will also continue at the national and provincial policymaking, advocacy and program coordination levels.

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	193,313	
PDTX	308,136	
Total Technical Area Planned Funding:	**501,449**	**0**

Summary:

Technical Area Narrative Pediatric Care and Treatment Context and Background Cambodia's prevention of mother to child transmission (PMTCT) program has detected only a relatively small percentage of HIV-infected pregnant women. An even smaller percentage of exposed-infants have been tested for HIV at 18 months, making estimation of the size of the country's HIV-infected pediatric population problematic. Based upon antenatal care (ANC) HIV prevalence estimated from HIV sentinel surveillance conducted routinely since 1996, a Consensus Working Group estimated that, in the absence of antiretroviral treatment (ART), 2,800 children were living with HIV/AIDS in 2008. Unfortunately, estimates of the number of HIV-infected children, factoring in the impact of pediatric ART care, could not be made using existing models. As reported in COP 09, as of June 30, 2008, 2,805 children were receiving ART services and an additional 1,854 HIV-infected children were receiving care at pediatric OI/ART sites. In the four quarters since that report, an additional 647 children (an additional 23%) have begun ART. As of June 30, 2009, 3,366 children age 0-14 yrs were receiving ART, with an additional 1,845 children receiving pre-ART services. Thus, 5,211 HIV infected children are under care. A total of 29 OI/ART sites provide pediatric services, with additional scale-up planned. USG has directly contributed to the establishment / continuation of six of these pediatric sites. Cambodia's rapid scale-up of pediatric care and treatment represents the collaborative response of the National Center for HIV/AIDS, Dermatology and STDs (NCHADS), the Clinton Foundation, which provides pediatric ARVs, technical assistance, and training to pediatric clinicians, and

USG, UNICEF, and Global Fund, which support the service delivery at both facility and community levels. Until 2007, the diagnosis of HIV in infants required waiting until 18 months of age to perform an HIV-antibody test. The result was that many exposed infants were lost to follow-up, and those who were HIV-infected and survived, often started care in a severely immunocompomised state. In 2007, with PEPFAR funds and USG technical assistance and supervision, a molecular laboratory capable of DNA PCR testing was constructed at the National Institute of Public Health (NIPH) in Phnom Penh. Laboratory technicians were trained in PCR technique, and dried blood spot preparation was introduced at all pediatric HIV clinics. As a result, the NIPH molecular lab is able to offer testing of HIV-exposed infants throughout Cambodia. USG has collaborated with UNICEF, which covers the cost of transporting specimens to Phnom Penh, and Clinton Foundation, which supplies the reagents and consumable supplies, to harmonize support of this activity. In addition to providing ongoing technical oversight of the molecular laboratory, USG funds community services in its target provinces to assure that mothers and infants are supported following birth, including the cost of transport to the pediatric care site, if necessary. FY2008 was the first year the benefits of early infant diagnosis could be achieved in Cambodia. Accomplishments since last COP During FY 2008, PEPFAR was responsible for starting 359 children, aged 0-14 (189 males and 170 females) on ART, compared to 284 in FY 2007. The number of children on ART at sites supported by PEPFAR rose from 863 in FY 2007 to 1,141 by the end of FY 2008 (593 males and 548 females). In FY 2008, the molecular laboratory at NIPH performed DNA PCR tests on specimens from 329 exposed infants and identified 45 infected infants. In the first 10 months of FY 2009, an additional 452 tests have been performed, and 57 infected infants identified. All infants have been enrolled into care and started on ART as per the current Cambodian treatment guideline. Goals and strategies for the coming year In COP 2010, the PEPFAR team and partners will continue working with N CHADS, the National Maternal and Child Health Center (NMCHC), and other partners to increase the coverage of HIV-infected children and their follow-up in pediatric health facilities. USG will continue to build the capacity of health care providers to deliver quality OI/ART services for pediatric AIDS within the Continuum of Care (CoC) framework. USG supports a network of services including home based care, a pediatric patient support group called Friends Helping Friends (Mendul Met chouy Mit or “MMM” in Khmer), TB screening, nutritional support, as well as outpatient care and in-patient care (when needed). USG will also strengthen the referral linkages with community-based care services. USG will continue to support a care and treatment package that includes provision of ART, prophylaxis and treatment of OIs, psycho-social support, food, and training family care givers of HIV-infected children. Assuring that exposed infants are tested at 6 weeks and again at 6 weeks post-weaning and assuring that infected infants start treatment as soon as diagnosis is established will remain a key strategy. Despite improvements that have resulted from early infant diagnosis, children under the age of two years continue to be under-represented among the cohort followed at pediatric HIV clinics. To strengthen follow-up from PMTCT to infant follow-up, PEPFAR team and partners will work with

Operational District PMTCT coordinators to improve their capacity to track HIV-exposed infants from identification during pregnancy to birth at a PMTCT maternity site to follow-up at the Pediatric AIDS clinic. Home based care teams will also be supported to intensify their follow-up of HIV-infected mothers and their infants as well as increasing case detection of positive children by referring children of HIV-infected clients to VCCT for testing. Strengthening the linkages between community services and pediatric HIV clinics is also expected to improve the loss to follow-up rate among children who are receiving pre-ART services. In the last 12 months, of the 2,228 children receiving pre-ART services over the course of the year, 17.2% have been lost to follow-up. In addition, the PEPFAR team and its partners will continue working with national technical working groups on the development of guidelines and policies to strengthen OI/ART pediatric services, support quality improvement activities at care sites, and support a package of community services provided through integrated HBC and orphans and vulnerable children (OVC) activities. The services will include psychosocial support, spiritual support, food, shelter repair, clothing, mosquito nets, and preparation for funerals and provisions for surviving family members.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	865,058	
Total Technical Area Planned Funding:	**865,058**	**0**

Summary:

Technical Area Narrative Prevention of Mother to Child Transmission (PMTCT) Context and Background: Historically, the scale-up of PMTCT services in Cambodia has lagged behind the implementation of other HIV/AIDS-related care and treatment activities. In 2006, Cambodia tested only 7.4% of pregnant women (PW) for HIV and provided prophylaxis for only 7.0% of the estimated number of HIV-infected pregnant women, while exceeding the 2007 target for the number of HIV-infected persons receiving antiretroviral therapy. In 2007, the percent of PW tested and the percent of estimated HIV-infected women provided with prophylaxis rose to 16.4 and 11.2, respectively. Based on 2008 census data, a change in the official crude birth rate, and new projections of HIV prevalence of PW (1.1% in 2006; 0.8% in 2008), the estimated number of HIV-exposed infants born in 2008 was 2,900 (of 342,766 births), compared with previous estimates of 402,000 births and 4,422 HIV-exposed infants, that were used to assess coverage in 2006 and 2007. Based on 2008 estimates and projections, 33% of PW were tested for HIV and 27% of infected women and exposed infants were provided with prophylaxis. Of the 112,950 women who were tested and received their results, the National PMTCT Program under the National Maternal and

Child Health Center (NMCHC) accounted for 53.4%; RHAC accounted for 14.5%, while a private hospital accounted for 20.3% of women tested. In addition, two new PMTCT initiatives, "Linked Response," by the National Center for HIV/AIDS, Dermatology, and STDs (NCHADS) and a demonstration project funded by HHS/CDC accounted for the remaining 11.8%. National Scale-up As reported in COP09, NCHADS has been piloting a testing strategy in which coverage of an entire operational district (OD) is assured by establishing linkages between the few health centers (HC) that have a co-located testing facility and nearby HCs without such a facility. Providers at HCs without testing available at their site are given a transportation allowance for weekly transport of blood specimens to the nearest testing site. These providers are also trained in Provider-Initiated Testing and Counseling (PITC). In 2007, the WHO and UNAIDS issued guidance on PITC in health facilities, recommending a shift from a system where individuals must actively seek an HIV test to one where their provider offered a test to them routinely, with the option to opt-out of HIV testing. PEPFAR programs will support PITC and also establish linkages with community agencies that provide support to assure that those found to be HIV-infected are successfully referred into the Continuum of Care (CoC). These ODs have achieved testing rates of 68% of PW in the community (and 80% of ANC clients) and excellent follow-up of those identified as HIV infected. With its demonstrated success, Linked Response has been adopted by the Ministry of Health as the official strategy for improving testing of PW and follow-up of mothers and their infants. USG and its partners are playing a key role in scaling up the model, supporting this activity in 19 ODs covering 250 HCs in COP10, while also providing technical assistance and piloting more patient-friendly and cost-effective approaches. HHS/CDC, in partnership with the NMCHC, also completed a pilot project to evaluate point-of-care HIV testing by midwives at ANC and during labor and delivery. Preliminary analysis demonstrates that testing at ANC and labor and delivery is both feasible for midwives to perform and acceptable to clients. Of PW presenting at ANC or at maternity units, 96% and 98%, respectively, were offered testing, and 95% of ANC clients and 99.7% of maternity clients not previously tested during the pregnancy accepted testing and received their results. Approximately 80% of the estimated number of PW in the catchment areas of the HCs have been tested at ANC. Accuracy of testing has been as good as that achieved in dedicated laboratory settings. The official MoH policy continues to be transport of blood specimens to be tested at a dedicated HIV testing laboratory, and because of concerns regarding training costs and supervision, the Linked Response service delivery model will be used for scale-up activities to achieve universal access. The MoH intends to have implemented Linked Response in 25 of Cambodia's 76 ODs, by the end of 2009. Until universal access to testing at ANC is achieved, the Ministry will scale up testing during labor at PMTCT maternity sites for pregnant women with unknown HIV status. HHS/CDC has been asked by the MoH to assist with this scale up. The success of the point-of-care demonstration project has generated much interest among PEPFAR partners and the MoH, and as scale up of this model in labor and delivery rooms proceeds, it is anticipated that point-of-care testing at ANC will become an alternative model.

Accomplishments since last COP Due to efforts by NCHADS, with the assistance of USG and other implementers, an estimated 33% of Cambodia's PW were tested for HIV in 2008. This accomplishment exceeded the National PMTCT Secretariat's target of 25%. Cambodia also provided prophylaxis for 27% of estimated HIV-infected PW, up from 11.2% in 2007 and coming close to achieving its 2008 target of 30%. In FY08, PEPFAR support resulted in 52,162 PW undergoing HIV testing and 353 women being provided with prophylaxis, exceeding USG targets of 43,341 and 284, respectively. PEPFAR provided training or retraining for 882 health workers (target was 900) and provided direct support to 32 PMTCT facilities (target was 35). COP 08 targets for FY09 included testing 18,000 pregnant women at 81 health centers and six referral hospitals participating in a PEPFAR-supported demonstration project evaluating HIV-testing at point-of-care. Because of limited staff available to oversee the point-of-care demonstration project, the scope was reduced to 15 health centers and two referral hospitals. As of the first 10 months of FY09, 8,808 women had been tested at the demonstration project sites. Data are not yet available regarding total number of pregnant women tested, number of HIV-infected women identified, and number of infections estimated to have been averted at PEPFAR- supported government PMTCT sites and RHAC sites in 2009. However, the number of HIV-infected women identified as a result of testing during pregnancy has been lower than anticipated, reflecting the fact that ANC HIV prevalence in 2008 (0.84%) continues to decline, and more than two-thirds of Cambodia's infected adult women are estimated already to know their HIV status, so if pregnant, they would not have required testing. Goals and strategies for the coming year PEPFAR will support the overall strategy of the MoH to accelerate testing of PW and carefully follow-up those found to be HIV infected. The targets in Cambodia's National Strategic Plan are to achieve 50% testing rate of PW in 2010 and 55% in 2011 and to provide prophylaxis to 50% of HIV-infected pregnant women in 2010 and 55% in 2011. Until the introduction of Linked Response, PEPFAR support of a single PMTCT HC site had very little impact on prevention of mother-to-child transmission, as the investment resulted in testing only those pregnant women receiving ANC at that health center. With the establishment of linkages to expand the coverage of testing to several health centers for each site where testing occurs, the impact of every dollar spent will be multiplied several-fold. In addition to expanding testing coverage, women diagnosed with HIV will be cared for more efficiently; blood will be sent from the HIV testing site for CD4 count, and those with CD4 > 350 will be provided AZT prophylaxis without having to be referred to another treatment facility. With these improvements in the overall national PMTCT strategy, USG will play a major role in the scale-up of Linked Response, while continuing to advocate for point-of-care HIV testing and harmonization of N CHADS's and NMCHC's combined efforts. USG will coordinate its activities with those of UNICEF, the Clinton Foundation, and activities supported by Global Fund--the three other major funders of PMTCT-- to maximize their combined impact. PEPFAR will further help assure universal access to prophylaxis for exposed infants by supporting testing during labor for women of unknown status, as endorsed by the MoH. PEPFAR partners and staff will continue to work at every level from the

community to the national program level to strengthen uptake and effectiveness of PMTCT services. At the community level, activities that provide increased demand for testing, such as comedy performances and village health support group education sessions, will continue to be supported; village-based traditional birth attendants will continue to receive incentives to refer their clients to government sites for testing. PEPFAR will continue to fund community support activities including home based care and peer-support groups At the facility level, PEPFAR will continue to pay for transportation for patients. PEPFAR will also pay for coordination meetings for staff that promote communication between PMTCT service, OI/ART clinics, and home based care teams. Finally, programs will strengthen linkages to family planning services and infant follow-up care (including PCR testing at 6 weeks and 6 weeks post-weaning). OD management staff will be mentored by PEPFAR partners and staff to monitor the OD's relatively small cohort of HIV-exposed infants from in-utero identification to birth and infant follow-up. Provincial Health Department management teams will continue to receive mentoring in M&E to strengthen their capacity to identify and respond to gaps in program performance. At the national level, representatives from PEPFAR partners and the USG team will provide technical assistance to NMCHC and NCHADS in the revision of PMTCT guidelines, policies and procedures, and training curricula. In the coming year, the USG team will assist NCHADS in developing guidelines for provision of ART for HIV-infected mothers who practice exclusive breastfeeding. Based on studies reported at the 5th IAS Conference on HIV Treatment, Pathogenesis, and Prevention in Cape Town in July 2009 (1,2), the USG team will actively promote exclusive breast feeding and discourage the practice of those NGOs that currently supply infected mothers with infant formula. Also, protocols for "fast-tracking" pregnant women referred to OI/ART clinics to assure timely implementation of ARV prophylaxis or ART, will be refined, and the M&E system used by NCHADS and NMCHC to monitor the national PMTCT program will be unified. PEPFAR resources will also be used to increase access to family planning services within HIV care settings by training PMTCT midwives in family planning services at one pilot site so they will be able to provide the full package of reproductive health needs, not simply antenatal and maternity services. Family planning commodities will be provided on-site, and OI/ART staff will be trained to routinely refer sexually active HIV-infected female patients for birth spacing consultation and supplies. Effectiveness of "on-site" integrated family planning services in reducing pregnancy rates at the co-located OI/ART clinic will be reported to NCHADS and NMCHC with the hope that if effective, this expansion of "one-stop shopping" will be scaled up. Finally, PEPFAR will collaborate with UNICEF to fund a policy forum on Infant Feeding as a follow-up to one conducted in 2008. At the 2008 forum, UNICEF presented an overall recommendation to promote exclusive breastfeeding (EBF) while Cambodia-based NGOs shared their data on safety and feasibility of providing formula. The outcome of the meeting was a clearer delineation of AFASS criteria to be used better to counsel patients about either option. In 2008, 28% of HIV-infected mothers who delivered at a PMTCT site intended to pract ice EBF, while 72% planned exclusive formula feeding (EFF). Monitoring to determine whether these choices were informed

by an AFASS assessment has not been done. Since the 2008 forum, it has become clear from previously cited studies that risk of HIV transmission from breast feeding can be greatly reduced with concurrent administration of ART. Implications of these results for the national program and for implementers will be highlighted at the policy forum. Funding Issues: While the scale-up of Linked Response is expected to improve testing rates of pregnant women and successful follow-up of those testing positive, concerns have been raised regarding cost estimates made by the Clinton Foundation, which has supported a major portion of the initial pilot of Linked Response. The use of venipuncture rather than finger-stick, the transport of specimens to distant testing sites, and the costs associated with following up with patients who test positive result may have been underestimated. The USG and three PEPFAR partners (RHAC, RACHA, and FHI) are supporting Linked Response scale-up. All PEPFAR supported organizations will carefully monitor their costs as well as their outcome indicators. In addition, a careful analysis of the cost of the point-of-care testing by the midwives demonstration project conducted by HHS/CDC will allow for useful cost comparisons to Linked Response. These cost analyses will be shared with the Ministry of Health to inform policy decisions. (1) Kesho Bora Study Group, Triple-antiretroviral prophylaxis during pregnancy and breastfeeding compared to short-ARV prophylaxis to prevent mother-to-child transmission of HIV-1: the Kesho Bora randomized controlled clinical trial in five sites in Burkina Faso, Kenya and South Africa. 5th International (2) Shapiro P et al. A randomized trial comparing highly active antiretroviral therapy regimens for virologic efficacy and the prevention of mother-to-child transmission among breastfeeding women in Botswana (The MMa Bana Study). 5th IAS Conference on HIV Treatment, Pathogenesis, and Prevention, Cape Town, abstract WeLLB101, 2009

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	343,298	
HVOP	5,824,193	
Total Technical Area Planned Funding:	**6,167,491**	**0**

Summary:

Technical Area Narrative Sexual Prevention (This summary includes AB with condoms and other prevention.) Male risk behavior remains the driving force behind the concentrated HIV/AIDS epidemic in Cambodia. The implementation of a predominantly structural intervention –the 100% Condom Use Program – contributed to substantial declines in adult HIV prevalence from 2% in 1998 to less than 1% in 2006, and to a 66%

reduction in HIV prevalence among brothel-based female sex workers from a peak of 44.7% in 1996 to 14.7% in 2006. But continued changes in the settings in which men can procure sex, and gaps in programming for men engaging in multiple and/or concurrent sexual partnerships and for men who have sex with men (MSM), represent threats to Cambodia's renowned prevention successes. Sexual prevention activities in the 2010 Country Operational Plan aim to enhance programming for high-risk male populations. This will rectify a historically disproportionate focus on women to prevent the spread of HIV, which relied on women to mitigate the infection risks they faced from their male sexual partners. Activities will also strive to integrate donor and other health resources to enhance the quality, comprehensiveness and sustainability of HIV prevention programs for both high-risk male and female populations, despite rising costs. The 2005 Demographic and Health Survey (DHS) found that among 20-24 year olds, 73% of never-married males, and 99% of never-married females, have never had sex. The median age at first sex in Cambodia is 20.4 years for women and 21.5 years for men, and HIV prevalence in the general population peaks among women between the ages of 25-29, at 1.2%, and among men between the ages of 35-39, at 1.3%. HIV prevalence is higher in urban populations than in rural populations (1.1% versus 0.8%, respectively), and entertainment venues that serve as "hotspots" for meeting high-risk sexual partners are more prevalent in urban settings. Despite observed declines in HIV rates among brothel-based sex workers, the 2006 HIV Sentinel Surveillance (HSS) found that prevalence in this population remains high at 14.7%. The 2003 HSS also found HIV prevalence of 11.7% among beer promoters and karaoke workers, suggesting even higher infection rates among the subset of these women engaging in transactional sex. Despite the late median age of sexual debut, there is evidence that segments of the male population engage in higher-risk behaviors. Among 15-24 year old sexually active men surveyed in the DHS, 36% reported sex with a non-marital, non-cohabiting partner, 19% reported two or more partners, and 6% of all men in this age group reported paying for sex in the past year, among whom 96% reported using a condom at last paid intercourse. In a 2008 household study among more than 1,300 15 to 29 year olds in six provinces including Phnom Penh, 73% of sexually active single males reported ever paying for sex. Available data support the premise that people are more likely to engage in risk-reducing behaviors in contexts in which they perceive there to be greater risks. In relationships and settings perceived as low risk, they are less likely to change their behavior. For example, although reported rates of consistent condom use at last paid sex are higher (99%) among brothel-based sex workers surveyed in the 2007 Behavioral Surveillance Survey (BSS) and among beer garden workers (at 88%), reported rates of condom use with "sweethearts" (defined as non-commercial and non-cohabitating partners) are much lower in both of these groups. In addition, the fact that more than 30% of both brothel-based sex workers and beer garden workers surveyed in the 2007 BSS had an abortion in the past year could suggest bias in the direction of over reporting condom use and considerable gaps in both actual condom use and in utilization of other modern contraceptive technologies among women at high risk for HIV. Maternal mortality has remained persistently high in

Cambodia, and efforts to improve access to family planning services for EW could have important HIV and maternal health benefits. In the past decade, Cambodia has witnessed dramatic growth in estimated numbers of non-brothel based entertainment venues and female entertainment workers, challenging the capacity of prevention programs to ensure adequate coverage with relevant services. The National Center for HIV/AIDS, Dermatology and STDs (NCHADS) now conservatively estimates that there are more than 35,000 female entertainment workers (EW) in Cambodia, up from an estimated 10,000 in 1997. This change is likely the result of many factors: general economic development and population growth, migration by men toward perceived less risky venues to procure sex, a migration by women toward work in entertainment establishments driven by financial need and limited employment alternatives, and recent crackdowns on brothels following the promulgation of a new law on human trafficking and sexual exploitation. Prior to the recent brothel closures, an estimated one-third of female EW were brothel-based and two-thirds primarily worked as other EW, such as beer promoters, karaoke workers, casino and restaurant staff, and masseuses. The 2007 BSS found that the median age of brothel-based EW is 25, half are divorced, and nearly half have had no schooling. On average these individuals have more than 100 clients per month, and charge US$1.80 per client (half of which may to go to the establishment owner). Half also have “sweethearts.” Sexual activity among other EW varies widely, but on average they have less than 15 paying clients per year and those who sell sex typically make about US$20-30 per night on top of their salaries. A PEPFAR-supported survey of female karaoke workers in Phnom Penh and Siem Riep also found that 84% reported consuming alcohol daily, 83% reported using ever using other drugs, and that 6% reported ever injecting drugs. Available data indicate high levels of HIV risk behavior among a subset of men, predominantly the sex partners of EW in urban settings. In a survey of 20 to 40 year-old sexually active men sampled from entertainment establishments in Phnom Penh, participants on average reported having more than eight sexual partners in the past year. While 94% reported consistent condom use with commercial partners, only 48% reported consistent use with sweethearts. The last measurement of HIV prevalence in a male subgroup (police) was in the 2003 HSS, and was estimated to be 2.5%. Because of the difficulties in sampling high risk men, limited HIV prevalence data are available. NCHADS estimates that there may be more than 200,000 male clients of sex workers. With this in mind, sexual risk reduction among these high risk men has the potential to prevent HIV infections among spouses and other lower-risk female partners, and thereby reducing rates of mother-to-child transmission of HIV. According to UN estimates, Thailand recently surpassed Cambodia as the country with the highest adult HIV prevalence in the Asia region, ostensibly due to a failure to devote sufficient attention to the HIV prevention needs of MSM. In Cambodia, available data suggest the levels of HIV risk faced by MSM vary considerably but warrant additional attention to prevent a resurgence of the local epidemic. The 2005 Sexually Transmitted Infections (STI) Prevalence Survey conducted in three cities indicated that 70% of MSM had multiple male partners, 19% had multiple male partners in the past week, 15% bought sex from men, 46% sold sex

to men, 52% had unprotected sex with men, 41% had sex with women, 25% had unprotected sex with women, 15% had unprotected sex with FSW, 10% had sex with female sweethearts, and 5% sold sex to women. HIV prevalence among transgendered MSM in urban settings was 9.8%, and prevalence was 2.6% among other MSM in these settings. MSM in Phnom Penh had much higher rates of HIV infection than in the other two cities. To focus limited resources efficiently on the sourc es of the most new infections in Cambodia, USG prevention activities primarily target most at risk populations (MARPs), including female entertainment workers, their prospective male clients and sweethearts, MSM, and injecting drug users (IDU). In FY 10, USG-supported activities under both the Abstinence and Being Faithful (HVAB) and Condoms and Other Prevention (HVOP) budget codes will build upon prior investments to: 1) enhance the engagement of beneficiaries and communities in identifying and addressing the needs of MARPs; 2) improve access to a client-friendly package of clinical and community services that includes peer education, HIV testing and counseling (HTC), STI treatment, family planning (FP) services, HIV care and treatment (including post exposure prophylaxis for victims of rape), and appropriate linkages to care and treatment and services to address livelihoods, addiction, human trafficking, gender-based violence, and sexual exploitation, and; 3) provide technical assistance to coordinate better with other USG and donor investments and put systems in place to stretch these resources further. Specifically, USG partners will continue to play a leading role in the implementation and refinement of a new national program called the "Continuum of Prevention, Care and Treatment," which represents an evolution of the 100% Condom Use Program by expanding coverage beyond brothels to include other entertainment venues. The USG-supported SmartGirl initiative supports this program by empowering peer educators with the predominant focus on HIV risk reduction, including content addressing drug abuse, FP and a variety of other topics. The program aims to keep participants engaged while reducing HIV risks. USG-supported programs targeting EW are also using their presence in entertainment venues to identify and combat human trafficking and sexual exploitation; our technical support to the Ministry of the Interior has resulted in a sectoral HIV/AIDS strategy that promotes community policing and social services linkages to reduce vulnerability to HIV, trafficking and exploitation. USG-supported partners conduct quarterly mapping and enumeration of entertainment venues, entertainment workers, and prospective male clients in their catchment areas, and use this information to address regularly potential gaps in coverage. Enhanced efforts to address HIV among high-risk male populations include brief interventions conducted by outreach teams with male patrons at urban entertainment venues. Using an approach adapted from local private sector strategies of marketing beer and cigarettes through promoters that move from table to table, mixed-sex pairs of outreach workers will deliver education, condoms, and service referrals to men in beer gardens, karaoke, and other hotspots. One strategic information activity described in this COP is a behavioral survey of urban men which includes mobile outreach with rapid HIV testing and counseling. Data collected may suggest how interventions might be improved. USG also supported a weekly reality TV show called "You're the Man!" which followed a

group of young men learning about health and safer behavior and about gender sensitivity. The M-Style program is among a number of USG-supported initiatives aimed at better understanding and addressing the HIV-prevention needs of a diverse MSM population in Cambodia. The effort provides peer education, linkages to STI, HTC and other services, entertainment-education events, and a website where individuals can anonymously access education and service information. Partners are also working closely with clinical providers to mitigate stigma and discrimination and ensure that services are friendly to MSM and other MARPs. Prevention programs targeting female EW also strive to provide education, commodities and other services to transgendered MSM, as these populations share elevated HIV and other risks. National health networks, composed of sex workers or MSM, give voice to marginalized populations to advocate for their health-related needs. Limited data are available on the HIV risks faced by migrant and mobile populations in Cambodia, but a number of USG and other partners are receiving support from the Asian Development Bank and other sources to implement programming for these groups. However, activities targeting Vietnamese customers, casino workers, and other EW will be continued along the Cambodia-Vietnam border and in larger cities with sizable Vietnamese populations. These activities are implemented in partnership with PEPFAR/Vietnam and jointly funded by PEPFAR in Cambodia and Vietnam. PEPFAR partners will also continue to provide technical support to the Ministry of Defense to enhance and sustain its HIV prevention programs for military populations. USG continues to work closely with DFID on a jointly funded USAID-DFID social marketing/behavior change communications activity, to which DFID provides condoms and other FP commodities. A key element of this program is the total market approach designed to enhance condom security by enhancing supply and demand for free, subsidized and non-subsidized commodities. USG also works with the Ministry of Education, Youth and Sport through USAID's Education Program. A revised National Basic Education Curriculum has been developed which includes HIV/AIDS as a health topic, and pre-service training on this curriculum is also provided to future teachers. All activities are developed in collaboration with the relevant RGC partner (National AIDS Authority (NAA), NCHADS, National Authority for Combating Drugs (NACD), the UN family, and other donors). The majority of USG prevention partners receive USAID FP funds to wraparound their HIV/AIDS programming, and many partners also receive Global Fund support enabling them to extend further coverage of integrated HIV/AIDS-RH/FP activities. USG staff and implementing partners are active members of government-donor working groups and the Global Fund Country Coordinating Mechanism (CCM) and CCM-sub-committee, and USG hosts monthly meetings of its own partners to coordinate implementation.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount

HVSI	949,425	
Total Technical Area Planned Funding:	**949,425**	**0**

Summary:
Technical Area Narrative Strategic Information Context and Background The USG plays a substantial role in helping the Royal Government of Cambodia (RGC) gather strategic information (SI) by collaborating with the National Center for HIV/AIDS, Dermatology, and STDs (NCHADS), the National AIDS Authority (NAA), and other government organizations, major international donors, local and international partners, and civil society. By working closely with the RGC and other partners, the USG's SI program will continue to advance the RGC's priorities in this area. Cambodia has a well-established system of second generation HIV surveillance, which has long been supported by the USG. HIV sentinel surveillance (HSS) has been conducted regularly since 1996 (eight survey rounds completed). In addition to seroprevalence testing, specimens from four HSS rounds have been tested for recent HIV infection to estimate HIV incidence. Behavioral surveillance surveys (BSS) have been conducted regularly since 1997 (seven survey rounds completed). The Demographic and Health Survey was conducted in 2000 and 2005, and the 2005 survey included HIV testing. After each HSS round, RGC has invited an International Consensus Working Group (ICWG) to a workshop to discuss survey results and develop national HIV prevalence estimates and projections. In 2007, the ICWG used 2006 HSS and 2005 DHS HIV testing results and Cambodian census data to update adjustment factors needed for estimating national HIV prevalence. Workshop outcomes included revised national HIV prevalence estimates and projections through 2012 of the number of PLHA, AIDS-related deaths, new HIV infections, and HIV-infected persons in need of antiretroviral treatment (ART). The USG SI team has successfully built the technical capacity of the NCHADS Surveillance Unit in areas such as survey protocol and field guidelines development, training, quality assurance of laboratory results and survey data, consideration of ethical issues (including confidentiality and return of HIV and STI test results), implementation of new testing technologies, and report writing and presentation. The USG SI team initially provided almost total financial support but now has primarily a technical advisory role. USG Cambodia will continue to build capacity by funding improved collection and strategic use of data, developing a more thorough understanding of the epidemic by including most-at-risk populations (MARPs) in routine sentinel surveillance or special surveys, and conducting joint RGC-USG-partner assessments of the impact of national programs, e.g., the Linked Response initiative (described in PMTCT, TB, and Adult Care and Support Technical Area Narratives). Accomplishments and Supporting Information Historically, the HIV epidemic in Cambodia has been driven by the high-risk behavior of men who engage in commercial and transactional sex and serve as a bridge between a population of women with a high prevalence of HIV (women who provide sex for money) and women with low HIV prevalence (e.g., their spouses). USG funded PSI

to conduct surveys among women who engage in commercial and transactional sex and their male clients. FHI has also conducted surveys of sex-seeking behavior among the military and police, previously considered proxies for male clients of commercial sex workers. Because the sex- seeking risk behaviors of men in the general population are not well understood, FHI will conduct an Urban Male Study in 2010 to survey the prevalence of HIV and risk behaviors of men in the 11 cities and provincial towns containing the largest numbers of urban men. In 2005, NCHADS, with USG and Asian Development Bank support, conducted an integrated biological and behavioral survey among men who have sex with men (MSM) in three urban cities. The survey found a high prevalence of risk behavior and sexually transmitted infections (STIs) among MSM in all three cities and a high prevalence of HIV among MSM, especially transgendere d MSM, in Phnom Penh. Since then, USG-implementing partners (FHI and KHANA) have conducted projects to improve previous estimates of MSM population size in a few cities. At the 2009 HIV Implementers Meeting, FHI reported that between 0.5-1.9% of the male population in six Cambodian cities were sexually active MSM. Almost half the men surveyed reported also having female sex partners within the past 30 days. Injecting drug use is another high risk behavior of concern in Cambodia. The RGC, with support from WHO, conducted a survey in 2007 among injecting and non-injecting drug users to estimate the size of the two populations and the prevalence of HIV, hepatitis B, and hepatitis C. The prevalence of HIV was high (25.1%) among the 231 injecting drug users (IDU) surveyed in Phnom Penh. The contribution of this risk population toward Cambodia's HIV burden, however, may be currently small, with an estimated population of 1,200-2,200 IDUs in Phnom Penh. The estimated number of non-injecting drug users was much higher (9,100-20,100 nationwide) but HIV prevalence was much lower (0.7% in Phnom Penh, and 1.4% among those in 11 rehabilitation centers in four cities). In July 2009, NCHADS and the National TB Program (CENAT) hosted a country review of its TB/HIV recording and reporting activities. The USAID-supported Tuberculosis Control Assistance Program (TB CAP), along with WHO, funded the review, which was conducted by WHO consultants. A series of specific recommendations to allow for more accurate monitoring of key performance indicators were made, and USG will support these improvements during FY10. Implementation of these changes in the M&E system will help improve the ability to assess whether the country meets stated targets regarding TB screening of people with HIV. RGC is developing an antiretroviral (ARV) resistance surveillance system with financial and technical support from WHO and TA from USG, as needed. In 2008, NCHADS developed a protocol and tool for collection and analysis of ARV resistance early warning indicators and began data collection for an HIV drug resistance threshold survey. Although USG has not provided financial support, USG SI team members are providing TA to RGC for the National AIDS Spending Assessment (2007-2008) and the AIDS 2031 Initiative, two projects that examine HIV-associated expenditures and costs. Goals and strategies for the coming year: Surveillance Cambodia's success in reducing HIV incidence and prevalence has largely been attributed to the 100% condom-use program, which increased protective behavior among brothel-based female sex workers and their clients. Interpretation of a

recent anti-trafficking law has resulted in brothel closings and prosecutions for commercial sex work. Because condoms are less readily available outside of brothels, and are not available or sold in entertainment establishments, this enforcement may reduce condom use among sex workers and their clients, resulting in an increase in HIV incidence among sex workers, clients, and their partners. In 2011, the USG SI team will provide TA to the RGC to conduct a BSS among female entertainment workers, moto-taxi drivers, and possibly youth, to assess the impact of this major change in the commercial sex environment. TA will also be provided to RGC to conduct other projects to supplement the evidence base in Cambodia, including special surveys on the health seeking behavior of PLHA and those vulnerable to HIV, and public sector service delivery to HIV and STI services. USG will promote other projects to answer questions not directly answered by surveys, such as national size estimates of MSM, injecting drug users, and entertainment workers. As mentioned above, NCHADS and its partners routinely convene an International Consensus Workshop to develop national HIV estimates and projections after each round of HSS. USG-supported SI staff have participated in prior consensus workshops, and USG will continue to provide TA and ensure continuity of USG-supported member ship on the ICWG (e.g., supporting participation of previous FHI and CDC participants). In addition, TA from an expert in statistical modeling of HIV data may be requested from HHS/CDC Headquarters in Atlanta. In FY 2010, the USG SI team will work with NCHADS and key multilateral agencies (e.g., UNAIDS and WHO) to re-invigorate the national Surveillance Technical Working Group. The mission of the Surveillance Technical Working Group should include establishing, guiding, and supporting a national agenda for second generation HIV surveillance, other relevant surveys, and special projects. In 2007, NCHADS and WHO collaborated on a project to compile an inventory of all studies and surveys conducted in Cambodia and identify gaps, with the objective of developing a research agenda. A meeting of all stakeholders, including USG and its partners, was convened to discuss the findings and propose future directions. The USG SI team will work with NCHADS to build on the previous research agenda and help develop new priorities.
M&E USG HIV/AIDS SI activities in Cambodia continue to follow the priorities set in the National Strategic Plan for HIV/AIDS and STIs in the Health Sector in Cambodia and provide support to the national program for evidence-based guidance for strategic decision making about the country response to the epidemic. The USG SI team supports national capacity-building to collect, manage, analyze, and use data. The USG SI team, in collaboration with partners (e.g., WHO, UNAIDS) will provide ongoing TA to the government for all data collection activities and will continue to work with key stakeholders to address the many donor and RGC reporting requirements, including those of PEPFAR, through the creation of unified, coordinated monitoring systems. Additionally, the USG SI team will play a much greater quality assurance and quality improvement role. The USG SI team will analyze routine information reported by NCHADS and USG implementing partners to ensure activities continue to address the needs of the country. The USG SI team will strengthen its internal processes for monitoring the quality of program results collected by all partners (RGC cooperative

agreement recipients and NGO/CBO implementing partners) and will conduct regular data quality assessments and institute an annual PEPFAR partner portfolio review process. USG will promote special projects to answer questions not addressed by surveillance or routine reporting to help understand program effectiveness and identify service delivery gaps. Special project priorities for the USG are assessments of HIV/AIDS service delivery to clients and joint evaluations of: (1) Linked Response, PMTCT, and PITC using the evaluation framework being developed in FY 2010 by the USG SI team; and (2) the HIV/STI/TB referral reporting system. HMIS The USG SI portfolio is currently focused on surveillance and monitoring and evaluation activities. USG is funding URC in health system strengthening to work with the Ministry of Health (MoH) to integrate vertical program reporting (including HIV, TB, STI and malaria) into the broader MoH reporting system. Integration of the national health information system (HIS) will assist provincial and district level MoH managers to better plan for resources through the Decentralization and Deconcentration initiatives of RGC. The USG SI team will closely monitor these implementing partner health system strengthening activities and provide TA as needed. SI Human Capacity Building Building M&E capacity within RGC (NCHADS, NAA, National Institute of Public Health [NIPH]) and especially local NGOs is an essential component of the PEPFAR program to ensure sustainability. Strengthening government partners will ensure that the leadership is in place to plan national SI/M&E activities. Enhancing civil society's local M&E capacity will ensure that NGO implementing partners collect high quality information for use in program planning and quality improv ement. SI human capacity is an ongoing challenge for Cambodia. The USG SI team will continue to work with RGC and NGO partners to develop the next cadre of public health professionals for careers in surveillance, M&E, and health informatics. Potential SI activities include promoting staff exchange programs between different government departments and provincial health offices to work on technical projects, learn new skills, and transfer knowledge; establishing scholarships for existing staff to attend certificate courses or trainings to build new technical skills; and work with schools of public health or MPH programs to create advanced training programs in health informatics, surveillance, and M&E. USG PEPFAR SI Team Staffing REDACTED

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	382,835	
Total Technical Area Planned Funding:	**382,835**	**0**

Summary:

Technical Area Narrative TB/HIV Summary Statistics on TB and HIV: In 2007,

Cambodia had the third highest incidence of tuberculosis (TB) among the world's high TB burden countries and had the highest estimated incidence (495/100,000) in Asia. In 2008, the national TB program, reported that DOTS coverage was 100% and smear-positive case-detection rate was 69%. Treatment outcomes of patients newly diagnosed with smear positive TB in 2007 were: 91% cured, 3% died, 2% transferred out, 1% defaulted, and 0.2% had treatment failure. Preliminary data from a TB drug-resistance survey performed in 2007 found that 1.7% of new TB patients and 8.7% of re-treatment patients had multidrug-resistant TB. In 2007, HIV prevalence in TB patients was 8.6 times higher than in the general population. In 2008, 50.5% of TB patients were tested for HIV, and 9,781 HIV-infected patients were newly registered for care. Of 5,980 HIV-infected patients referred to a TB clinic for screening from either a voluntary counseling and HIV testing (VCCT) site, a home based care service, or an OI/ART site, 2,159 (36%) were diagnosed with TB. While TB screening is part of the routine protocol for patients entering into care at Cambodia's HIV clinics, data are not available to determine precisely what proportion of these patients actually were screened. Likewise, data about uptake of antiretroviral therapy (ART) and co-trimoxazole preventive therapy (CPT) in HIV-infected TB patients are difficult to obtain. These difficulties reflect a remaining challenge of harmonizing data from TB and HIV programs regarding screening of TB patients for HIV, screening HIV patients for TB, and treatment of TB/HIV co-infection. These monitoring issues will be addressed in the proposed activities for Cambodia PEPFAR's FY10 COP. TB/HIV is a priority for the USG in Cambodia, but as a non-focus country with a limited budget, it is not possible to address all aspects of TB/HIV. In line with the new PEPFAR vision of host country ownership, the plan focuses on policy and coordination activities at the national level. It supports specific TB/HIV-related activities in selected areas of the country (currently Pursat, Battambang, Banteay Meanchey, Pailin and Kampong Cham), and uses wraparound funds from non-PEPFAR USAID TB activities to strengthen programs. The geographic areas were chosen in collaboration with the national TB and HIV programs. They complement support provided by other donors, of which Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFTAM) is the largest. To implement these activities, the USG will work with the National TB Program (CENAT), the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) and USAID's TB Control Assistance Program (TB CAP). Current Status of National Policy and Program Activities: Following a 2007 WHO regional meeting in Cambodia, CENAT and NCHADS, with technical assistance from USG, assembled a working group tasked with developing a revised Framework for TB/HIV Joint Activities. The working group was to incorporate WHO recommendations emphasizing intensified case finding of TB among people with HIV, improving access to liquid culture for diagnosis, implementation of isoniazid preventive therapy (IPT), and strengthened infection control procedures, including avoiding referral of infectious TB patients to settings in which there is significant contact with immune-compromised patients (such as at VCCT sites). The working group was to incorporate provider initiated testing and counseling (PITC) of TB patients into the revised framework. The recommendations from this framework are currently being

implemented or are planned to be implemented with USG playing key roles. Intensified case finding of TB among people with HIV: In June 2009, results of a USG study conducted in three SE Asian countries including Cambodia, identified an evidence-based algorithm that provides both a simple symptom screen to rule out TB disease in HIV-in fected persons, and a diagnostic algorithm for evaluation of symptomatic patients. These guidelines have been incorporated into the Revised Framework, and PEPFAR partners supporting HIV care facilities will implement the algorithm in FY10. CENAT, with support from MSF-France and PEPFAR, is increasing access to liquid culture. MSF France has already implemented MGIT liquid culture capacity in eastern Cambodia. PEPFAR has renovated and is equipping the TB laboratory and training the staff to perform MGIT liquid culture in the Battambang Referral Hospital, in northwest Cambodia. During FY10, PEPFAR will support the implementation of liquid culture at the National TB Reference Laboratory (NRL) in Phnom Penh once renovations are made to meet internationally accepted biosafety standards. This renovation will require joint funding with multiple partners. PEPFAR will provide reagents in the Battambang laboratory until sustainable funding through Global Fund is available. These three laboratories will serve the TB culture requirements for the entire country, contributing significantly to health systems strengthening and greatly improving Cambodia's capacity to diagnose and treat TB more efficiently in HIV-infected persons. These laboratories will also provide the infrastructure for future MDR TB surveillance. USG will fund the hiring of a TB laboratory specialist to provide onsite technical assistance in the NRL. Implementation of Isoniazid Preventive Therapy (IPT): In accordance with the Revised TB/HIV Framework, IPT will be implemented in FY10. USG will play a key role in its implementation in USG's partners' focus provinces, including careful monitoring and evaluation. Strengthening Infection Control: In addition to recommending that TB patients no longer be referred in-person for HIV testing at a VCCT site, the Revised Framework for TB/HIV Joint Activities includes specific infection control measures to be implemented at HIV outpatient clinics, in-patient units, TB wards, TB labs, home based care services, HIV peer meetings, and closed settings. Monitoring tools will be developed to assess progress in implementation, and partners will be asked to support renovations where needed to reduce nosocomial transmission. TB/HIV in Closed Settings: FHI is utilizing non-PEPFAR resources (TBCAP) to implement TB-HIV activities within prisons in two provinces. Lessons learned will inform national policy. Improving Provider Initiated Testing and Counseling (PITC) of TB Patients: In 2005, only 2.9% of TB patients were tested for HIV in Cambodia. This increased to 38% in 2007 and 50.5% in 2008. Two initiatives have been implemented in Cambodia to improve HIV testing rates of TB patients. The first is called "Promotion of Option 2"; the second is called "Linked Response." Both rely upon transport of specimens to testing sites, as this is the current Ministry of Health policy. USG is providing funding for both initiatives. Promotion of Option 2 refers to the change in policy wherein blood specimens rather than patients are referred from TB clinics to HIV testing sites. This is an infection control strategy and reduces the inconvenience to the patient, and therefore it is expected to improve testing

rates. USG partners and TBCAP are supporting implementation of 'Option 2' in 26 of Cambodia's 76 operational districts. The second new initiative, Linked Response, was initiated by NCHADS to strengthen the linkage between health centers and HIV testing sites. This was originally intended to improve the uptake of testing of pregnant women but will be expanded to improve testing rates of TB patients. These two initiatives are complementary because 'Option 2' is a "push" directed at health centers without HIV testing capacity to send blood to testing sites, while Linked Response is a "pull" from testing sites to assure that the health centers to which the testing sites are linked in fact send specimens as directed. These testing sites a re held accountable for assuring coverage of the geographic area of their linked health centers. Support for these two initiatives gives the USG and its partners operational knowledge of and proximity to the projects necessary to evaluate their cost and effectiveness and identify opportunities for potential savings. We will also work with RGC to improve patient outcomes. USG partners have committed to supporting Linked Response in 19 operational districts covering 250 of Cambodia's 960 health centers. Option 2 and Linked Response activities will be harmonized to avoid duplication and assure efficient use of resources. COP09 highlighted the success USG has had in achieving HIV testing rates of TB patients of 80% in one province, Banteay Meanchey in 2007, and proposed expansion of the activities accounting for that success to three additional focus provinces. In calendar year 2008, efforts were focused on improving rates in Battambang Province, where the 2006 baseline testing rate was 17%. The 2008 testing rate for Battambang Province was 61.2% while Banteay Meanchey continued to test 78% of TB patients. The other two focus provinces had testing rates of 44% and 38% in 2008. It is expected that scale-up of both 'Option 2' and 'Linked Response' will result in the 80% target being reached in all focus provinces. Monitoring and Evaluation (M&E) Assessment: In July 2009, CENAT and NCHADS hosted a country review of its TB/HIV recording and reporting activities. The USG funded the review, which was conducted by WHO consultants. A series of specific recommendations to allow for more accurate monitoring of key performance indicators were made, and USG will support these improvements during COP FY10. Without undertaking the recommended changes in the M&E system, it will not be possible to assess accurately whether the country meets stated targets regarding TB screening of people with HIV. Accomplishments of PEPFAR HIV/TB since COP09: The USG team and partners have provided key technical assistance in the development of policy measures described above. Accomplishments as measured by program level indicators are as follows: • Twelve service outlets providing TB treatment to HIV-infected individuals in a palliative care setting (Target was 10.) • 1,355 (712 males and 643 females) HIV-infected clients attending HIV care/treatment services are receiving treatment for TB disease (Target was 1500.) • 274 individuals trained to provide TB treatment for TB to HIV-infected individuals: (PEPFAR team had anticipated no contribution in this area so target was 0.) • 734 registered TB patients received HIV counseling, testing, and their test results at a USG-supported TB service outlet. (Target was 1200.) FY 2010 COP Proposed Activities: Ongoing activities planned for FY 2010 include the following: • Ongoing technical assistance to CENAT and NCHADS for

strategic planning for TB laboratory services, including liquid culture, and TB/HIV policy • Support for implementation of TB screening/diagnosis and IPT in HIV care facilities in Pursat, Battambang, Banteay Meanchey, Pailin and Kampong Cham, the combined focus provinces supported by the USG. This will include funds for training, diagnostic testing (including TB culture) as well as funds to cover clinical monitoring of patients on IPT. • Support for transport of blood for HIV testing of TB patients in Pailin, Battambang, Banteay Meanchey Province, Kampong Cham, and Kampong Speu Provinces • Assistance and support for implementation of revised HIV clinic forms designed to align with key monitoring and evaluation indicators; support will also be provided for trainings needed to implement changes at USG focus provinces. • Continuation of FHI's TB/HIV activities within prisons in two provinces by combining PEPFAR funds with those of TBCAP • Support for training in TB/HIV case detection, management, and prevention for TB and HIV care providers • Cont inued support for liquid culture in the Battambang and CENAT TB laboratory. • Partial support for the upgrading of the NRL to meet internationally accepted biosafety standards for TB laboratory diagnostic procedures New and ongoing activities for PEPFAR and TB CAP during FY10: • Development of communications strategies, messages, materials and associated capacity building; • Validation of the clinical algorithm that has been included in the Cambodia's Revised TB/HIV Framework of Care; • Clinical TB/HIV management training and support; • Operational research to evaluate risks and benefits of IPT as it is scaled-up in Cambodia; • Strengthening linkages with community based care to improve skills of village health support groups and home based care teams in delivering TB messages. Assistance in treatment adherence and referral of suspected cases. • In addition, PEPFAR and TBCAP will share costs of transporting blood specimens of TB patients from health centers to HIV-testing facilities. USG activities in the coming year are complementary with those supported by other donors including the GFATM. PEPFAR supports increasing early TB and HIV diagnosis and getting patients to care. The GFATM supports HIV care and treatment at government ARV clinics and supports HIV testing costs. GF funds also covers the costs of TB treatment at government facilities and the basic costs of TB diagnosis, including chest radiography and sputum smear microscopy. PEPFAR Cambodia's TB HIV activities are focused on enhanced sustainability. PEPFAR support in this area will improve government health care infrastructure and policy, while developing human resources to meet the challenges of TB and HIV.

Technical Area Summary Indicators and Targets

REDACTED

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
5352	National Institute of Public Health	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	200,000
5371	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHCS (USAID)	1,000,000
5372	Reproductive Health Association of Cambodia	NGO	U.S. Agency for International Development	GHCS (USAID)	1,497,187
5373	Reproductive and Child Health Alliance	NGO	U.S. Agency for International Development	GHCS (USAID)	478,551
5376	Population Services International	NGO	U.S. Agency for International Development	GHCS (USAID)	2,259,782
5377	National Centre for HIV/AIDS, Dermatology and STDs	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease	GAP, GHCS (State)	800,000

			Control and Prevention		
7215	Family Health International	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	5,250,000
9438	CENAT - National Center for Tuberculosis and Leprosy Control	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	200,000
9439	Association of Schools of Public Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP	85,000
9440	ASCP	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP	100,000
12254	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12255	TBD	TBD	U.S. Agency for	Redacted	Redacted

			International Development		
12256	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 5352	Mechanism Name: National Institute of Public Health.v22.KH.mech005730.xls
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Institute of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This implementing mechanism is unchanged from last year. National Institute of Public Health (NIPH)

Comprehensive Goals and HIV-specific Objectives

The National Institute of Public Health (NIPH) is a semi-autonomous research institute designated by the Ministry of Health (MoH) as the HIV national reference laboratory (NRL). It works closely with other institutions and national centers as well as with the provincial health departments (PHD). The NIPH aims to become the Center of Excellence for the Cambodian MoH. Its comprehensive goal is to improve the public health system, to assist in the implementation of the Health Care System Reform through training and operational research. The NIPH is dedicated to improving laboratory capacity and infrastructure to support HIV/AIDS programs in Cambodia.

With FY10 PEPFAR dollars, the NIPH will continue to strengthen the NIPH capacity in its role as the HIV NRL, and to develop a network of provincial and district laboratories capable of supporting of HIV testing, care and treatment, and surveillance. The NIPH

will implement quality assurance programs, and will mentor staff through supportive supervision and training.

Target Populations
NIPH activities will target to improve the health of the 13.4 million inhabitants of Cambodia.

Geographic coverage
Although the NIPH supports USG-funded laboratories in the provinces of Battambang, Banteay Meanchey, Pursat and Pailin, it also uses USG funds to provide services including training to health care workers in Phnom Penh and other provinces. For example, not all of the 218 VCCT labs and blood banks for which NIPH prepares external quality assurance (EQA) panels are in USG focus provinces. Specimens tested at the NIPH for HIV early infant diagnosis are collected from 23 sites in 16 provinces.
Making the Most of HIV Resources
The NIPH uses funds from the Global Fund, the Asian Development Bank (ADB), the Clinton HIV/AIDS Foundation (CHAI), and the CDC Influenza program to conduct training and procure equipment. CHAI pays the rent for CD4 machines and pays for EQA programs. UNICEF pays for the transport of specimens to NIPH for HIV early infant diagnosis while CHAI procures the consumables for fingersticks and GF finances the reagents. The CDC Influenza program has renovated the molecular laboratory which is used for HIV early infant diagnosis and HIV viral load testing as well as influenza diagnosis. CDC Headquarters provides several EQA programs as does the US National Institutes of Health which uses NIPH as a site for HIV Clinical trials. Leveraging resources from WHO and the CDC Influenza Program, the NIPH will be capable of conducting opportunistic infection diagnosis and has hired a microbiology laboratory supervisor and two technicians in FY09. The CDC Influenza Program financed the renovation of the microbiology laboratory and will pay the salary of contract staff while developing capacity for respiratory diseases surveillance and bacterial culture in FY10. WHO has provided reagents to support surveillance and emergency response for infectious disease outbreaks.

Cross-cutting Areas
NIPH, in collaboration with NCHADS, will leverage GFATM monies by providing proficiency testing panels to 22 provincial blood transfusion service, 218 VCCT and 17 PMTCT sites. Supervision and training provided by NIPH to provincial laboratories will benefit vertical national programs and ADB infectious disease programs. NIPH

contributes to the prevention of HIV/AIDS, TB, and decreases mortality from outbreaks of emerging infections. By conducting reference testing, NIPH helps to strengthen the quality and credibility of surveillance data.

Enhancing Sustainability and Country Ownership
NIPH will contribute to a sustainable laboratory infrastructure by developing staff capacity through training in quality laboratory management and by organizing quarterly laboratory network meetings with the provincial health departments. Over time, these laboratories will be able to conduct internal audits and rely less on NIPH for supervision. These laboratories will be able to give technical support to national surveillance programs.

NIPH works directly with partners to obtain other resources. NIPH participates in research studies with other donors. Establishing a national policy to address the deficiencies of the laboratory system is another strategy to creating a sustainable laboratory infrastructure. As the lead of the sub-technical working group for blood safety and laboratory services, NIPH, in collaboration with different stakeholders, organizations, and the national programs will finalize and submit to the MOH the national laboratory policy, the standard operating procedure for management of integrated laboratories, and the national laboratory strategic plan.

Monitoring and evaluation
To monitor and evaluate the progress of activities, USG laboratory staff participate in regular meetings with NIPH senior management and the quality assurance unit team. NIPH submits quarterly, semi-annual and annual reports to USG. Any request for budget reprogramming is reviewed by USG. To ensure the quality of equipment and supplies to be purchased, USG laboratory staff reviews the technical specifications before and during the bidding process.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
(No data provided.)

Budget Code Information

Mechanism ID:	5352		
Mechanism Name:	National Institute of Public Health.v22.KH.mech005730.xls		
Prime Partner Name:	National Institute of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	200,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 5371	**Mechanism Name: University Research Corporation, LLC**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHCS (USAID)	1,000,000

Sub Partner Name(s)

New Hope for Cambodian Children		

Overview Narrative

This implementing mechanism is unchanged from last year. University Research CO., LLC (URC)

Overall Goals and HIV-Specific Objectives

URC has worked for over 40 years to help clients use scientific methods and research findings to improve program management and outcomes and to achieve organizational and behavioral change. URC has worked with the Royal Cambodian Government's (RCG) Ministry of Health (MOH) since 2003 to strengthen the public health system's capacity to deliver high quality health services in the areas of HIV/AIDS, maternal, neonatal and child health and nutrition, reproductive health, and infectious diseases.

With FY10 PEPFAR dollars, URC will continue its Health System Strengthening (HSS) work in integrating HIS systems and working to increase links and referrals between HIV/AIDS services and other related services (FP, MNCHN, etc.). URC will expand its HSS work by piloting mechanisms to include HIV-affected or at-risk populations in the RCG's Health Equity Fund (HEF) system of Social Health Protection (inclusion is currently based solely on income). URC will also include HIV/AIDS services in the results-based financing (RBF) approach that it is piloting in three Provinces in Cambodia. Furthermore, building on past successes in health sector technical assistance, URC is expanding its HIV technical focus to include services for orphans and vulnerable children (OVC) through a sub-contract with the local NGO New Hope for Cambodian Children (NHCC). This direct support for OVC is linked to the HEF work, as it will look to define OVC as a HEF-eligible population based on risk status rather than income.

Target Populations

In the area of HSS, URC's target population includes health workers in public facilities in the 10 Provinces supported by the USG and the population using these health facilities. An estimated 200 Entertainment Workers will become HEF beneficiaries in Poipet, as well as an estimated 2,000 HIV-affected family members in Phnom Penh. In OVC care, URC will inherit an existing cohort of beneficiaries served by NHCC. 500 children will receive OVC services with another 1,000 family members included in the family-based approach to OVC services.

Geographic coverage

URC will work in 11 Provinces implementing existing strategies (HIS integration,

PMTCT/ANC integration), but focus the new initiatives (hospital service integration and internal referrals, HEF beneficiary definitions, RBF) in four of those Provinces (Banteay Meanchey, Battambang, Pursat, and Phnom Penh/Kandal).

Making the Most of HIV Resources
URC applies funding from the World Bank, the Asian Development Bank, and the Health Sector Support Project 2 (pooled donor funds) for its work with health equity funds, which provide health protection and subsidies to the poor. The results based financing work is closely integrated with an Annual Operating Plan process that is funded by a Global Fund Rd. 5 grant. As a leader in strengthening RGC capacity in MNCHN and RH/FP, URC is uniquely qualified to place its HIV systems strengthening work within a supportive network of health wrap-around services. Its HIV funds also improve existing MNCHN and RH/FP programs by paying for training to providers on referrals for HIV-specific needs.

Cross-cutting Areas
As part of its HIV programs, URC supports the cross-cutting areas of gender and human resources for health. URC subcontractor NHCC works to ensure significant male (husband) participation in their OVC work, and their family-based approach has been successful at keeping families intact. URC's training programs will reach approximately 200 people. URC's PEPFAR funds will also address many of this year's priority issues including all of the health wrap-arounds by working to link patients accessing hospital-based HIV services to RH/FP and MNCHN services.

Enhancing Sustainability
Improving administrative, managerial and financial sustainability has been at the core of URC's work in Cambodia over the past seven years. URC's model of partnership with the MoH public health service delivery network enhances both its programs' sustainability and the RGC's capacity to provide high-quality health care for the Cambodian people. URC's strategies for creating a sustainable program, rooted in host country leadership are as follows:

• Build upon its partnership with the MoH to strengthen health systems at all levels (National Centers, Tertiary Hospitals, Referral Hospitals, District Hospitals, and both Operating District and Provincial health management units).
• Use its work pioneering social health protection services to link to other relevant government ministries and councils (Council of Ministers, Council of Administrative

Reform, Ministry of Labor, Ministry of Social Affairs)
• URC is a leader in the coordination of social health protection mechanisms and service delivery integration. Partners include WHO, UNICEF, UNFPA, GTZ, etc. URC is the only "project" to be regularly invited to the RGC's monthly Donor Coordination meetings.
• Continued training of health care workers to add to Cambodia's cadre of trained, local health care staff.
• Working with sub-grantees to enhance their capability to find additional funding sources and properly monitor and manage existing resources.

M&E

FHC will ensure proper M&E of PEPFAR old and next generation indicators for HSS and OVC. As URC regularly collects program data, and is the RGC's lead partner in HIS development, it routinely uses HIS and non-HIS information to inform and shape ongoing project design and implementation. Its monitoring and evaluation plan will thus be programmatically relevant and based upon ongoing inputs. It will utilize staff expertise for data collection and data-driven interventions.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	15,000
Human Resources for Health	20,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	5371		
Mechanism Name:	University Research Corporation, LLC		
Prime Partner Name:	University Research Corporation, LLC		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	300,000	

Narrative:

This is a new activity. URC will work with OVC in two ways: through a contract with a local NGO, New Hope for Cambodian Children (NHCC) whose mission is to work with NGOs and the Royal Government of Cambodia to assist children living with HIV/AIDS and their families; and 2) through the creation of a new type of Health Equity Fund (HEF) beneficiary, HIV/AIDS orphans and their families, that will permit existing HEFs supported by URC with non-PEFAR funding to pay for transport and food for OVCs receiving HIV/AIDS care from RGC health facilities. HIV/AIDS care is offered free by the facilities, but by paying for transport and food costs, the HEFs will lower the financial barriers to access these "free" services.

The NHCC project has five components:

1. Social support to Pediatric Programs in Phnom Penh: NHCC provides transportation expenses so that children can access pediatric ARV clinics for OI and ART care. The program also gives support to families to provide for the nutrition needs of children on ARVs and pays school fees so that OVCs can continue their education.
2. The NHCC Transitional House: NHCC has learned that when HIV positive children are very sick, their families frequently have trouble taking care of them, have trouble getting them to scheduled medical appointments, and lack the resources to provide the 24-hour care necessary to keep them alive. The transitional house, staffed by a small team of full-time care providers who live in the facility, provides a place where very sick children who need intensive care can come and be restored to health. When they recover their health, these children return to their families.
3. Support to the pediatric ARV clinic at Chey Chumneas Referral Hospital home-based care (HBC) program: This is the principal ART hospital in southern Phnom Penh and many of their patients are very poor. NHCC field workers provide direct HBC to

pediatric HIV/AIDS patients at the Chey Chumneas Referral Hospital and provide technical assistance to the hospital on how to manage the hospital's HBC program.
4. The Early Childhood Development Day Care Center: This center provides day care and support so that men and women with HIV/AIDS will not have to abandon their children in order to work. The center provides a safe place for working mothers/fathers to leave their children while they work. The center also provides a safe place and loving environment for the children and provides nutritious meals to the children. An NHCC staff doctor attends to any medical needs of these children.
5. The HIV widows' income generation project: This project aims to provide income generation for a small number of HIV-positive mothers who do not have another job by giving them a job making baby quilts to sell. They are paid a monthly salary, and the quilts are sold both in Cambodia and abroad. The project currently recoups about 80% of its costs through the sales of quilts; the goal is to make it fully self-sustaining. While the mothers work, their children are at the day care center described in point four.

This program has been designed in an integrated manner with the intention of trying to provide the best care possible to OVC within the context of their families and the context of the Cambodian health care system, which is often fragmented and diffuse. URC proposes to expand an existing social health protection mechanism, health equity funds (HEF), to cover OVC. HEFs can be thought of as a simpler, Cambodian version of Medicaid. The HEF patient record system assigns a unique patient identifier to track benefits and payments; it can be applied to OVCs, which will lead the RGC to change the definition of beneficiaries to cover a vulnerable group, parallel to the current beneficiary group (those living in poverty). This will provide insight into the full range of services that OVC and their families are (or are not) accessing, which will surpass anything that can be currently collected outside of specific surveys.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	700,000	

Narrative:

This activity is unchanged from last year.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 5372	Mechanism Name: Reproductive Health Association of Cambodia.v22.KH.mech005750.xls
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Reproductive Health Association of Cambodia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,497,187	
Funding Source	**Funding Amount**
GHCS (USAID)	1,497,187

Sub Partner Name(s)

Angkor Hospital for Children		

Overview Narrative

This implementing mechanism is unchanged from last year.
Reproductive Health Association of Cambodia (RHAC)
Overall Goals and HIV-Specific Objectives
Established in 2006, Reproductive Health Association of Cambodia (RHAC) is a Cambodian NGO whose goal is to enable Cambodian people to exercise their right to achieve quality of life through model services, gender-sensitive health communication, and training focused on family health, including sexual and reproductive health, maternal and child health, and HIV/AIDS.

With FY10 PEPFAR funding, RHAC will continue to provide and/or support the provision of Prevention of Mother-To-Child Transmission (PMTCT), Voluntary Confidential Counseling and Testing (VCCT), STI treatment, Post-Exposure Prophylaxis (PEP), ARV prophylaxis for HIV + pregnant women (PW), integrated RH and HIV/AIDS education, OI/ARV prophylaxis and treatment, and Orphans and Vulnerable Children (OVC) support. New activities in FY10 are TB/HIV and cervical cancer screening for HIV+ women.

Target Populations

Target groups for VCCT include sex workers, men who have sex with men (MSM), beer promoters, karaoke, massage workers, waitresses, casino workers, migrant workers [factory workers (FWs), construction workers (CWs), fishermen], youth, and the general public. PMTCT targets PW, HIV+ PW, and their newborns. PEP targets rape victims and RHAC clinical staff. Cervical cancer screening targets HIV + women. Targets for RH and HIV/AIDS education are youth in-school and in villages, migrant workers, married couples and STI clients. Pediatric care and treatment is provided to children infected and affected by HIV/AIDS at Angkor Hospital for Children (AHC). TB patients are targeted for TB/HIV.

In total, 56,874 individuals will receive VCCT; 28,366 PW receive HIV C&T; 175 HIV+ PW will receive ARV prophylaxis; 161 rape victims and RHAC clinic staff will receive PEP; 284,857 individuals will be reached with other prevention (112,241 received STI treatment, 3,736 FWs, 3,091 CWs and fishermen, 74,463 married couples and 91,326 young people); 490 HIV+ children receive ARV; 120 OVC will be supported; and 3,277 TB patients tested for HIV.

Geographic coverage

The 18 RHAC clinics are in 15 ODs in Phnom Penh, Kampong Cham, Siem Reap, Kampong Speu, Battambang, Sihanouk, Takeo and Svay Rieng provinces. The 20 RHAC supported satellite sites are in 6 ODs in Kampong Cham, Kampong Speu, Sihanouk and Battambang. In 2011, 12 of the 18 RHAC clinics will start ARV prophylaxis for HIV+ PW.

Pediatric HIV care and treatment will continue in Siem Reap with some patients coming from other provinces.

RH and HIV/AIDS education for youth will take place in 755 villages and 38 schools in Battambang, Pailin, Siem Reap, Phnom Penh, Kampong Cham and Sihanouk. Programs for migrant workers will occur in eight factories in Sihanouk, 25 construction sites in Sihanouk, Phnom Penh and Siem Reap, five fishing sites in Sihanouk and Siem Reap provinces and 3961 rural villages in Battambang, Pailin, Kampong Cham, Kampong Speu and Sihanouk.

Making the Most of HIV Resources

RHAC applies funds from the Global Fund (GF) for HIV test kits and STI drugs in all of its clinics. It also uses this funding for BCC on HIV/AIDS and RH for MARPs and youth; home-based care (HBC) projects; and Community DOTS (C-DOTS). Additional funding comes from Plan International (PLAN) for BCC for youth and the European Commission (EC) for BCC for FWs in additional provinces.

GF supports HIV education for MARPs in 246 entertainment establishments in Phnom Penh, Sihanouk, Siem Reap, Svay Rieng, Mondulkiry and Kandal; BCC for youth in 511 villages in Takeo, Svay Rieng, Kampong Cham, Mondulkiry; C-DOTS in Takeo and Prey Veng and HBC in Sihanouk, Svay Rieng and Kampong Cham provinces. PLAN supports in 126 villages in Kampong Cham and Siem Reap and EC in 30 factories in Phnom Penh, Kampong Cham and Kampong Speu.

RHAC also uses its HIV funds to improve its extensive MCH and RH programs by integrating programs.

Cross-cutting Areas

RHAC supports the cross cutting areas of gender and human resources for health. RHAC promotes gender equity by having gender-balanced peer educators (PEs) and promoting equal opportunity and rights with regard to training, jobs and roles and responsibilities. RHAC has expanded its program reporting form to collect the number of beneficiaries by gender and will closely monitor gender participation. RHAC will train health care workers and PEs on different HIV/AIDS subjects through pre-service and in-service training in collaboration with relevant national programs of MoH.

Enhancing Sustainability

RHAC collaborates closely with government and private institutions to implement activities and promote sustainability. RHAC works closely with national programs such as National Center for Maternal and Child Health (NMCHC), the National Center for HIV/AIDS, Dermatology and STD (NCHADS) and the National Tuberculosis Program (CENAT) to incorporate RH/FP, HIV/AIDS, and TB activities in national planning, guidelines and training curricula. RHAC actively involves beneficiaries, marginalized groups and government partners in all activities from the start to ensure ownership,

commitment and integration of programs within the existing structure.

M&E

RHAC will ensure proper M&E of PEPFAR indicators for all relevant implementing program areas. As RHAC routinely collects program data, it will use this information to inform and shape ongoing project design and implementation. RHAC's monitoring and evaluation plan will thus be programmatically relevant, based upon ongoing inputs and utilizing staff expertise for data collection and data-driven interventions. RHAC will conduct a study to determine risk behavior among migrant workers.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	57,974
Human Resources for Health	113,700

Key Issues

Addressing male norms and behaviors
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**5372**
Mechanism Name:	**Reproductive Health Association of Cambodia.v22.KH.mech005750.xls**
Prime Partner Name:	**Reproductive Health Association of Cambodia**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	51,259	

Narrative:

This is a new activity.

Care and support services for people living with HIV/AIDS (PLHAs) refers to cervical cancer screenings provided to HIV+ women at RHAC clinics. RHAC conducts two types of cervical cancer screening tests: VIA (Visual Inspection Acid Acetic) and PAP smear. RHAC has 18 clinics located in 15 Operational Districts (ODs) of 8 provinces of Siem Reap, Battambang, Kampong Speu, Preah Sihanouk, Kampong Cham, Phnom Penh, Svay Rieng, and Takeo. All clinics can perform VIA on-site and collect samples for PAP smear reading, which is performed in Phnom Penh. RHAC will continue to coordinate with other partners and OI/ART sites to refer HIV+ women for cervical cancer screening at its clinics. RHAC will work with NCHADS and the provincial health departments to identify OI/ART sites under its coverage that can refer HIV+ women to RHAC clinics for screening. Cryotherapy service is provided for HIV+ women identified as having pre-cancerous lesions in 12 RHAC provincial and Phnom Penh clinics. RHAC will discuss with relevant national programs (NCHADS, NMCHC) to identify OI/ART/PMTCT sites appropriate to provide cervical cancer screening. It will conduct training for medical staff and monitor HIV+ women referred and screened. Through this activity, RHAC will determine the prevalence of cervical cancer among HIV+ women and share the results with government and other partners to fill knowledge gaps on the issue.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	30,028	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	92,906	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	19,429	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	36,752	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	143,298	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	715,893	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	334,687	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	72,935	

Narrative:

This is a new activity.
TB/HIV activities implemented through the RHAC program include: HIV counseling and testing among registered TB patients under RHAC support; Community DOTS; and referral of HIV+ clients identified through RHAC clinics for TB screening by TB units. These activities follow Standard Operational Procedures (SOPs) of NCHADS and CENAT. RHAC implements community DOTS in eight ODs: (Battambang, Sangke, Maung Russey, Kampong Speu, Kong Pisey, Tbaung Khmum, Prey Chhor and Srey Santhor) of three provinces: (Battambang, Kampong Speu and Kampong Cham). In the ODs in which RHAC supports Community DOTS, RHAC collaborates with CENAT to train health center (HC) staff on HIV counseling (training conducted by CENAT). HC staff provide HIV counseling for identified TB patients and take blood for testing at VCCT sites with consent. RHAC pays transportation costs for HCs to take blood to VCCT sites for testing. HC staff provide post-test counseling and refer HIV+ TB patients

identified to other services such as OI/ART and home-based care. RHAC-supported TB/HIV activities are linked with the Continuum of Care activities of the Ministry of Health and PHD/OD. RHAC clinics refer HIV+ clients identified through its VCCT services to TB units for TB screening. The clinics support transportation for referred clients and coordinate with TB units for follow up of clients. TB units will provide treatment for identified TB patients. RHAC will support ODs and HCs to collect, review and analyze information about the number of TB and HIV patients referred and screened/tested for TB/HIV. It will document prevalence of TB and HIV among these groups. RHAC has developed reporting forms that can track progress indicators, as in the TB/HIV framework and revised indicators, which will ensure data quality and accuracy. In FY10, 2,259 TB patients are expected to receive counseling and testing for HIV and will know their results.

Implementing Mechanism Indicator Information
(No data provided.)

Implementing Mechanism Details

Mechanism ID: 5373	**Mechanism Name: Reproductive And Child Health Alliance**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Reproductive and Child Health Alliance	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 478,551	
Funding Source	**Funding Amount**
GHCS (USAID)	478,551

Sub Partner Name(s)
(No data provided.)

Overview Narrative

This implementing mechanism is unchanged from last year. Reproductive and Child Health Alliance (RACHA)

Overall Goals and HIV-Specific Objectives

RACHA provides a broad range of reproductive and child health activities in rural communities of Cambodia. Its comprehensive goal is to contribute to the achievement of Cambodia's Millennium Development Goals by 2015, with specific interim targets for 2013 of reducing maternal and under-5 mortality by 25%; increasing modern contraceptive prevalence to at least 33%; reducing TB prevalence by 20%; and reducing HIV prevalence in the sexually active population by 10%. With support from PEPFAR, RACHA intends to contribute to this last objective by expanding its HIV program to include home based care (HBC) for people living with HIV/AIDS (PLWHA), TB/HIV patients, and services for orphans and vulnerable children (OVC).

The FY 2010 PEPFAR funding will support continued activities in the areas of prevention of mother to child transmission (PMTCT) and voluntary confidential counseling and testing (VCCT) interventions, including capacity building and services strengthening, referral and linkages, and awareness raising in the community. New activities for FY10 include care for PLWHA by promoting Most at Risk Populations (MARPS) -friendly HIV services and providing a minimum package of Prevention with PLHIV (PwP) interventions; routine HIV testing and counseling for TB patients, and support for OVC. RACHA's other sexual prevention activities for FY10 will integrate a peer-education HIV component into couple/gender relationship strengthening, comedies for health performances for community awareness and behavior change, a Community Based Service (CBS) program through village shops sellers and a joint advocacy campaign.

Target Populations

RACHA will take on an existing group of 919 PLWHA and 716 OVC who were previously served by an organization no longer receiving USAID funds. It has targeted 1,150 PLWHA, entertainment and commercial sex workers (CSW), and TB patients in the five ODs where it supports CDOTS; 5040 pregnant women, their partners and newborns for PMTCT activities; and 17,800 men and women for VCCT services.

Geographic Coverage

RACHA's Adult Care and OVC projects cover two Operational Districts (OD) in Koh

Kong province. Currently, RACHA supports HIV testing for all TB patients in five ODs located in Pursat and Siem Reap provinces. RACHA will expand this program to cover seven ODs in FY10. RACHA supports four PMTCT and seven VCCT sites in Siem Reap, Pursat, and Phnom Penh and intends to cover nine health facilities for VCCT in the next fiscal year.

Making the Most of HIV Resources

RACHA integrates STI/HIV/AIDS and Family Planning (FP) into its Reproductive Health (RH) activities. It has the ability to scale up its program at a lower cost through its participatory approach. RACHA provides inter-institutional coordination among international organizations (IOs) and local NGOs and with agencies such as UNICEF, UNFPA, etc. RACHA also collaborates with the Ministry of Health (MoH) and its agencies/departments, commune councils and religious leaders.

The adult care and OVC programs will continue to receive support from the Global Fund to cover the treatment of PLWHA and Mondul Mith Chouy Mith (MMM) activity until 2010. The HIV funds will support capacity building and strengthening of health providers. RACHA will also undertake fund raising activities locally and implement a credit-for-health program in the area to generate income from the community to support the PLWHA

Cross-cutting Areas

RACHA's health related wraparound programs include RH, FP, maternal, newborn and child health (MNCH) and TB. RACHA supports cross-cutting activities in the areas of gender, human resources for health, economic strengthening, mobile populations, and renovation. It ensures involvement of males in reproductive health programs to reduce sexually risky behavior and HIV/STD transmission both for themselves and for their female and male sexual partners. It provides training and strengthening of PMTCT counselors, lab technicians and other staff on PMTCT and VCCT to more than 400 health care workers, community volunteers and local comedians. Plans for FY10 include renovating existing clinics to improve on-site testing access.

Enhancing Sustainability

RACHA, as a strong partner of the MoH, will continue to provide TA and establish partnerships and referral systems at the local, OD and PHD levels. In FY10 RACHA will: collaborate closely with the community, religious leaders, social welfare institutions, NGO, CBO, and self-help groups; ensure the PLWHA self-help group network is

institutionalized in the community; strengthen the role of the family as primary caregiver; mobilize and sensitize the community about HIV/AIDS; integrate the program activities into the Commune Integrated Plan (CIP) for cost contribution; ensure coordination of program teams with community representatives to address any limitations in policy and administration; and mobilize Village Health Support Groups (VHSGs) to strengthen the community network at the grassroots level.

M&E
RACHA will conduct proper M&E of PEPFAR old and next generation indicators for PMTCT, OVC, TB/HIV, and HBC. It will ensure that the six elements of minimum Prevention with Positives package are provided to PLHIV at last visit. Baseline surveys when necessary will be conducted. Semi-annual evaluation will be conducted along with the SAR for USAID. A mid-term correlation study will measure the extent to which the activities have reached the target group and the magnitude of these programs' effect on beneficiaries' wellbeing. RACHA's Central Reporting System (RCRS) and Health Information System (HIS) will be upgraded for easy monitoring of data from the community.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	100,000
Economic Strengthening	2,000
Education	3,000
Food and Nutrition: Commodities	3,000
Human Resources for Health	184,927

Key Issues
Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
Mobile Population
Safe Motherhood
TB

Family Planning

Budget Code Information

Mechanism ID:	**5373**		
Mechanism Name:	**Reproductive And Child Health Alliance**		
Prime Partner Name:	**Reproductive and Child Health Alliance**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	79,906	

Narrative:

This is a new activity. HIV care and support services
RACHA's HBC and support activities aim to provide comprehensive and compassionate care for PLWHA and a minimum package of PwP interventions. Specifically, RACHA will promote coverage and utilization of VCCT and PMTCT services; refer for OI/ART and CD4 count; support monitoring and supervision of HBC teams by Provincial AIDS Offices (PAO) and OI/ART physicians; provide family planning counseling; and access to condoms and other contraceptives. RACHA will provide continuous behavioral counseling to reduce risky behaviors; begin livelihood skills training for PLWHA; and provide refresher training to village caregivers on home based palliative care.

Coverage area and target population
RACHA's HBC project covers the Koh Kong province and provides a minimum one care service to 1,150 PLHA including entertainment workers and CSW, pregnant and lactating women and other PLWHA eligible adults. RACHA has targeted 650 PHLA to receive a minimum package of PwP intervention.

Client retention and referrals
RACHA will pay for transportation of blood specimens of pregnant women for HIV testing and fund PLWHA travel to ART facilities. It will provide adequate training and supervision as well as physical, social and psychological support to caregivers and volunteers for HBC. It will promote greater involvement of PLWHA in peer counseling and formation of support groups and acknowledge of their special contribution to the program. RACHA promotes a savings fund program to help improve the economic

status of PLWHA and works to strengthen self help groups. RACHA hopes to use its well-managed HBC program to also improve clinical management, including TB diagnosis and adherence to treatment.

Linkages
RACHA will further integrate HIV/MCH/FP programs for HBC and will establish a referral system at all levels. It will collaborate closely with the community, faith-based organizations, social welfare institutions, NGOs, and CBOs. It will establish linkages with Cambodian People Living with HIV/AIDS Network (CPN+) to institutionalize self-help groups in the community.

Monitoring and evaluation
RACHA will monitor the quality of care and services along with the indicators and targets: 650 PLHA reached with a minimum package of PwP intervention; 420 adults provided with a minimum of one care service.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	10,443	

Narrative:

This is a new activity. Geographic coverage and target population:
RACHA's OVC project covers the two Operational Districts (ODs) of Koh Kong province. This new project was handed over by CARE International. Currently, there are 716 OVC, 80 percent of whom are covered by HBC groups.

Priority action:
RACHA's priority action is to promote coordination of care at all levels in order to meet the needs of OVC in their catchment area. As a successor of CARE, it will continue to provide economic, nutritional, educational and psychosocial support to the most vulnerable of children. In the area of child protection, RACHA will support child birth registration and protection from child labor, trafficking and sexual exploitation. To this end, RACHA will advance advocacy to create a supportive environment for all children. It will adopt CARE's income generating program and skills training for youth.

Community support and coordination:
RACHA will strengthen family and community support and coordination. It will involve and link with government agencies, POs, NGOs, schools, Pagodas, clinics/health

facilities, commune councils and the local community to provide comprehensive support for OVC. It will train and strengthen the family as primary caregivers (including village and religious leaders) on physical and psychosocial care for PLWHA. It will coordinate with other NGOs for support of travel costs of OVCs to HCs for ARV, and provide training to caregivers in HIV prevention, HBC and OVC care. It will coordinate with Provincial Department of Fine Arts to train OVCs as performers for the comedy for health.

M&E considerations:
1. Counting the number of eligible children provided with a minimum of one care service disaggregated by sex and age. For FY 2010-2011, RACHA has targeted 730 OVC.
2. Counting the number of eligible children who received food and/or other nutritional services. RACHA has targeted 249 OVC.

Lessons Learned and challenges:
RACHA has considered the lessons learned and challenges shared by CARE as a springboard for its new HBC and OVC project. It will carry on the best practices of CARE and will work with the community holistically to strengthen collaboration and linkages with various stakeholders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	140,388	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	97,343	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	117,471	

Narrative:

This activity is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	HVTB	33,000	

Narrative:

This is a new activity.
Alignment of activities with national policy:
RACHA's TB/HIV activities will be undertaken parallel to the Ministry of Health's continuum of care strategy. Following the national policies for TB and HIV, RACHA will focus on increasing TB treatment access through VCCT centers and increasing access to and use of VCCT services by general TB patients.
Coordination across partners:
RACHA will strengthen its collaboration and referral of HIV testing and counseling of TB patients; strengthen collaboration to introduce antiretroviral therapy (ART) to patients who meet the ART eligibility criteria; collaborate with health institutions for timely referral and treatment of TB clients; and ensure HIV care and support at home-based care sites. RACHA will also assist CENAT/MoH in conducting surveillance of HIV prevalence among tuberculosis patients.

Human Resource Capacity and Sustainability:
RACHA links traditional healers to increase the TB detection rate and regular and/or proper TB treatment. It will support the implementation of MoH TB-HIV screening in the health center and/or nearby VCCT centers within RACHA-focus ODs. It will strengthen the VHSGs to support CDOTS implementation. It will provide training to medical personnel, health workers, and community workers on TB-HIV, educate volunteers and family members on preventive measures against TB, and facilitate administration of DOTS.

Monitoring and Evaluation:
M&E will focus on the number and percentage of all registered TB patients who were referred to VCCT and tested for HIV and the number of people who will be trained in TB-HIV.

Accomplishments:
In the five ODs where RACHA supports CDOTS and HIV testing, 1,873 TB patients have registered for treatment and 897 have volunteered to receive an HIV test. Case data shows that 48% of TB patients received VCCT in a six month period (23 cases were found HIV-positive and 4 positive cases were referred to receive ARV). RACHA will expand TB-HIV program coverage to seven ODs in FY 10 and expects more TB

patients to utilize VCCT services. Linking TB with HIV services will increase TB case-finding and reduce treatment delay. VCCT services could be an entry point to TB screening to reduce TB morbidity and HIV associated mortality.

Implementing Mechanism Indicator Information
(No data provided.)

Implementing Mechanism Details

Mechanism ID: 5376	**Mechanism Name: Population Services International.v22.KH.mech005754.xls**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,259,782	
Funding Source	**Funding Amount**
GHCS (USAID)	2,259,782

Sub Partner Name(s)

Association for Development (AFD)	Buddhist Development Association and Supporting Environment	Cambodian Children Against Starvation and Violence Association
Cooperation for Social Services and Development (CSSD) former of Unbar Sector Group (USG)	Khemara	Khmer Development of Freedom Organization
Khmer Women's Cooperation for Development (KWCD)	Men's Health Cambodia (MHC)	Men's Health Social Services
National Prosperity Association	Partner in Compassion (PC)	Phnom Srey Association for Development (PSAD)

Rural Economic Development Association	VBNK	

Overview Narrative

This implementing mechanism is unchanged from last year.

Overall Goals and HIV Specific Objectives

In Cambodia, Population Services International's overall goal is to improve the health of low income and vulnerable Cambodians through social marketing (SM) models. PSI implements programs that support the Government of Cambodia's national policies and strategies to increase sustainable access to health products, services and healthy behaviors related to HIV/AIDS, reproductive health (RH), child survival (CS) and malaria. PSI implements a highly targeted approach to HIV prevention programming with implementing partners to reach MARPs with evidence based behavior change messaging, improved access to products and services and increased national capacity to implement sustainable programming. PSI aims to reduce the number of new HIV infections by:

• delivering an essential package of prevention and services supporting a structural approach to HIV prevention messaging; addressing the specific needs of MARPs; improving knowledge & awareness through evidence-based behavior change interventions (BCI) to reduce high risk behaviors;

• increasing access to affordable, quality condoms (and lubricant) through targeted distribution to hot spots and high risk venues such as beer gardens, guesthouses, karaoke bars, and massage parlors;

• increasing Cambodian national capacity to manage and sustain results over the long term with reduced dependence on donors; and

• fostering an increased knowledge and evidence-base among partners for effective and efficient HIV programming, SM and BCI targeting MARPs.

Target Populations

Interventions will target MARPs including sex workers (SW), entertainment workers (EW -beer girls, karaoke women, massage girls); clients of SW and/or EW; males who have sex with males (MSM), persons living with HIV/AIDS (PLHA) and their sexual partners; and drug users/injecting drug users (DU/IDU).

PSI will reach 162,036 MARPs through its HIV prevention programming.

Geographic coverage

Social marketing of condoms and lubricant occurs nationwide. Targeted condom SM

and BCI for prevention take place in high risk/hot spots in urban and peri-urban areas, focusing on areas with high rates of HIV and a high concentration of MARPs including Phnom Penh, Sihanoukville, Kampong Chnang, Battambang, Kampot, Banteay Meanchey, Kampong Cham, Kandal, Srey Reing, Kampong Thom, Pursat, Prey Veng, Takeo, Kampong Speu & Siem Reap.

Making the Most of HIV Resources
PSI uses funding from the Global Fund to increase the reach of its HIV behavior change interventions targeting MSM & clients, and support for social marketing of condoms and lubricant for MSM and SW. GF also supports PSI malaria prevention & treatment SM interventions in the private sector. KFW and other foundations support SM of short and long term family planning contraceptives, while USG and complementary funding also supports health systems strengthening. PSI supports private sector providers, improve their knowledge, ability, and willingness to deliver high quality and affordable referral services and products supporting multiple health areas, including RH/FP, child survival (CS), malaria, and HIV, including improved FP knowledge & skills for midwives at PMTCT sites. A unique DFID/USAID partnership supports SM for HIV and RH interventions.

Cross-cutting areas
PSI supports gender equity in HIV programming through the involvement of men & women in the development of BCI. PSI uses evidence-based messaging to improve male subjective norms, while complimentary messaging reaches EW to improve condom negotiation skills. PSI works with organizations that work with PLWA to include USAID-funded safe water treatment in comprehensive home based care packages. Diversified funding described above enables PSI to better support its CS, FP, malaria and HIV programs.

Enhancing Sustainability
PSI project objectives are achieved through fostering sustainable markets using a Total Market Approach (TMA). The principles of TMA guide all programmatic decisions—from targeted BCI to drive demand for all products and services to better consumer segmentation for donor subsidized commodities. Improved targeting of subsidies through the public and social marketing sectors ensures access to those who cannot afford to pay commercial prices, while programs create opportunity in the commercial sector for affordable products for wealthier populations. Carefully managed pricing strategies emphasize cost recovery for SM condom brands, while maintaining

affordability among target populations, and thus towards reduced reliance on donor subsidies.

Sustainability of activities is also enhanced through the transition of PSI to a locally governed social marketing entity led by Cambodians. Capacity building programs have been developing staff's technical and leadership skills to prepare for localization. PSI's program also relies on a partnership model, building the capacity of the United Health Network (UHN) of local NGOs who work directly with MARPs to implement program activities. PSI provides training and technical assistance in BCI and condom social marketing to 22 UHN members, with the aim of creating sustainable program operations through a strong network of local NGOs.
M&E
PSI monitors programs through a robust MIS, M&E and operational research plan. This includes output tracking surveys, surveys among MARPs to measure changes in behavior determinants and behaviors over time. These studies are linked to intervention exposure and measurement of product access.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	136,000
Human Resources for Health	784,630
Water	250,000

Key Issues
Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	5376
Mechanism Name:	Population Services International.v22.KH.mech005754.xls
Prime Partner Name:	Population Services International

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	76,425	

Narrative:

This implementing mechanism is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	22,400	

Narrative:

This implementing mechanism is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	2,160,957	

Narrative:

This implementing mechanism is unchanged from last year.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 5377	**Mechanism Name: National Center for HIV/AIDS Dermatology and STDs v22.KH.mech005755.xls**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Centre for HIV/AIDS, Dermatology and STDs	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 800,000	
Funding Source	**Funding Amount**
GAP	250,000
GHCS (State)	550,000

Sub Partner Name(s)
(No data provided.)

Overview Narrative
This implementing mechanism is unchanged from last year.
National Center for HIV/AIDS, Dermatology, and STDs (NCHADS)

The National Center for HIV/AIDS, Dermatology, and STDs (NCHADS) is the focal point within Cambodia's Ministry of Health for developing and implementing Cambodia's HIV prevention, care, and treatment services. Under NCHADS's guidance and leadership, a continuum of care for persons living with HIV has been developed that has expanded from an initial pilot in one operational district in 2003 to 51 HIV clinics in 20 of Cambodia's 24 provinces and 39 of Cambodia's 76 operational districts by the end of 2008. VCCT sites have been expanded from 12 in the entire country in 2000 to 216 at present. NCHADS is responsible for the training of physicians and associated staff, the procurement of HIV test kits, drugs, and supplies, the strengthening of laboratories and hospitals to diagnose opportunistic infections and monitor response to HIV treatment, and the development of information systems to monitor the success of the program. As of June 30, 2009, 72% of Cambodia's estimated HIV-infected adults were under care, and over 92% of estimated adults eligible for antiretroviral therapy were receiving it. In addition to scaling up diagnostic and treatment services, NCHADS has implemented a successful prevention program centered on a brothel based 100% condom use initiative and expanding recently to focus on prevention services for other MARP groups. It has also conducted a number of HIV and STI surveys that have been critical to understanding Cambodia's epidemic.

NCHADS receives support from GFATM Rounds 2, 4, 5, and 7, and both financial and technical assistance from WHO, World Bank, Clinton Foundation, and USG. NCHADS's 2008 expenditures were $8.5 million dollars. The NCHADS Cooperative Agreement Implementing Mechanism, while funding only a portion of NCHADS's activities, has had a major impact, particularly in support of national surveillance activities, strengthening of

laboratories, and improving HIV clinical services, the three core focus areas of US CDC GAP. The Cooperative Agreement has enabled US CDC GAP to provide technical assistance at the national level and "on the ground" assistance to NCHADS in four focus provinces in northwest Cambodia, Banteay Meanchey, Battambang, Pursat, and Pailin, where 16% of Cambodia's population resides and 17% of Cambodia's HIV patients enrolled at government HIV clinics receive their care. In those provinces, the NCHADS Cooperative Agreement has contributed to the expansion of VCCT services, improved PMTCT services, implemented Continuous Quality Improvement activities at HIV treatment sites, remodeled and upgraded laboratories, provided a regional laboratory analyst to help strengthen referral hospital laboratory capacity, improved testing rates of TB patients for HIV and strengthened capacity of HIV clinicians and TB clinicians to diagnose TB in HIV-infected patients.

In FY2010, the NCHADS Cooperative Agreement Implementing Mechanism will continue to support PMTCT, Adult Treatment, Pediatric Treatment, Laboratory Infrastructure, TB/HIV, and Strategic Information at funding levels similar to those provided in FY2009. In addition, two new budget codes will be added, Adult Care and Support and Pediatric Care and Support. Adult Care and Support is being added to strengthen Prevention with Positive activities (PwP)at HIV clinics. Pediatric Care and Support is being added to improve follow-up of HIV exposed infants to Pediatric HIV Clinics for PCR testing at six weeks and at six weeks post-weaning. This activity, an expansion in geographic coverage of PDTX Budget Code in COP09, will improve our ability to assess the impact of the PMTCT program and assure that HIV-infected infants are provided early care and treatment.

We hope that the addition of these two budget codes to the NCHADS Cooperative Agreement implementing mechanism will produce cost savings over time. If strengthening PwP activities works, infections will be averted, and money for care and treatment saved. Strengthening PwP services also is likely to encourage volunteer activities among PLHA, who will be the country's best ambassadors for behavior change among at-risk groups. Improving testing rates of HIV-exposed infants, while resulting in a cost, will also save the lives of infants who would otherwise have gone undiagnosed, and will also give NCHADS an improved monitoring tool to assess the impact of PMTCT services and adjust those services as needed. We anticipate that the exposed-infant visit at six weeks will be used to counsel mothers regarding optimal feeding practices, which may result in reduction in breast feeding-associated HIV transmission.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
(No data provided.)

Budget Code Information

Mechanism ID:	**5377**		
Mechanism Name:	**National Center for HIV/AIDS Dermatology and STDs**		
Prime Partner Name:	**v22.KH.mech005755.xls National Centre for HIV/AIDS, Dermatology and STDs**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	140,266	

Narrative:

This is a new activity. The NCHADS Cooperative Agreement contributes to adult care and support through support of five care and treatment facilities in two northwest provinces of Cambodia (Banteay Meanchey and Pursat). The target is the HIV-infected population in the two provinces and their families. The strategy of Cambodia's Ministry of Health is to organize HIV care and treatment at the operational district level around a Continuum of Care (CoC) in which the VCCT serves as the entry point, the OI/ART clinic serves as the focal point for facility based care, and home based care team is focal point for community based services. Referral between services (VCCT, OI/ART clinic, STD, FP, TB, PMTCT, home based care, in-patient care, and peer support groups) is supported through standard operating procedures, use of referral forms, and regularly scheduled CoC meetings. A patient booklet containing critical information including drugs and quantity prescribed and next visit date is given to every patient registered at the OI/ART clinic. This booklet is a communication tool that allows home based care teams to monitor adherence and remind patients about follow-up appointments and assist with transportation when needed. The NCHADS Cooperative Agreement provides the funds through which critical components of the Continuum of Care are implemented and strengthened in the HHS/CDC focus provinces. In addition,

funds are reserved for use centrally by NCHADS to cover monitoring and evaluation and supervision visits by NCHADS.

The Adult Care and Support portion of the NCHADS Cooperative Agreement for FY2010 will fund positive prevention activities at the five focus care and treatment facilities. Specifically, adherence counselors will receive training in incorporating responsible sexuality messages into their routine counseling sessions including impact of alcohol on practice of safe sex; they will also be responsible for determining whether patient has disclosed his/her HIV status to spouse or primary partner and if not, assisting in disclosure. Condoms will be made available for all adult patients receiving care at OI/ART clinics, and pharmacists will be instructed to offer a supply of condoms with every refill of medication. Clinicians will record whether spouse or primary partner has been tested for HIV, and records will be modified so that this can be easily monitored; partners of unknown status and children of female patients will be strongly encouraged to undergo HIV testing. Finally, there will be a focus on prevention of unplanned pregnancies; clinicians will be responsible for referring all women patients of child bearing age to family planning services for birth spacing counseling and supplies, and are to incorporate monitoring of family planning choices as a routine component of every visit.

Positive Prevention will be added to the agenda of regularly scheduled clinical care meetings, during which time staff can discuss problem patients—patients who feel unable to disclose status to primary partner, or patients known to be engaged in risky sexual behavior. This will provide both an opportunity for sharing opinions about how best to deal with these challenging patients as well as keep positive prevention as a major focus of the staff. Meetings can also be used to consider new approaches to positive prevention that the staff may wish to adopt. Monitoring tools will be developed to evaluate positive prevention activities, which will help inform national policy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	140,266	

Narrative:

This activity is unchanged from last year

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	41,384	

Narrative:

This is a new activity. Until 2008, diagnosis of HIV in children could not be reliably determined until 18 months of age. This delay in diagnosis of infants known to be exposed, and the relative ineffectiveness of the PMTCT program in identifying the majority of HIV-exposed infants resulted in very few HIV-infected children under two years of age receiving care and treatment at Pediatric AIDS Clinics in Cambodia. The result is that many infants probably died of HIV-related opportunistic infections without ever being tested for HIV. COP09 described activities intended to strengthen links between PMTCT and Pediatric AIDS care sites to assure close infant follow-up of HIV-exposed infants so that treatment can be initiated as soon as the diagnosis is established.

In FY10, the NCHADS Cooperative Agreement implementing mechanism will fund measures to assure infant follow-up of 80% of exposed infants identified during antenatal care in seven operational districts in three provinces (Banteay Meanchey , Battambang, and Pursat). This will require strengthening the capacity of the Operational District (OD) Maternal Child Health (MCH) Supervisor to monitor the cohort of HIV-infected pregnant women identified during antenatal care or during labor to make sure each infant is followed by home based care, that home based care teams successfully refer these infants for PCR testing at six weeks and at six weeks post-weaning, and that all infants with positive PCR test are registered for OI/ART care at the Pediatric OI/ART Clinic. This will be facilitated by introduction of a cohort-based register organized around expected date of delivery, which will allow the OD MCH supervisor to track all HIV-exposed infants as they are identified during ANC or at delivery, and anticipate dates of expected six week and post-weaning visits so that active steps can be taken to prevent patients being lost to follow-up.

In a related activity, the NCHADS Cooperative Agreement will fund Continuous Quality Improvement activity at the Pediatric OI/ART Clinic to assure that all HIV-exposed infants registered at the clinic are started on Cotrimoxazole Preventive Therapy at six weeks and maintained on it consistently until HIV is definitively ruled out six weeks post-weaning, or maintained on it indefinitely if infant is diagnosed with HIV.

The target population for these activities are: HIV-exposed infants and HIV-infected children in Banteay Meanchey Province, one operational district of Pursat Province, and two operational districts of Battambang Province.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDTX	41,384	
Narrative:			
This activity is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	133,000	
Narrative:			
This activity is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	170,400	
Narrative:			
This activity is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	98,900	
Narrative:			
This activity is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	34,400	
Narrative:			
This activity is unchanged from last year.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7215	**Mechanism Name: Family Health International**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract

Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 5,250,000	
Funding Source	**Funding Amount**
GHCS (State)	1,550,000
GHCS (USAID)	3,700,000

Sub Partner Name(s)

AHEAD	Association of ARV Users	Ban Danh Chaktomuk
Cambodian Red Cross	Cambodian Save Children Network	Cambodian Women for Peace and Development
Chhouk Sar	Homeland (Meahto Phum Ko' Mah)	Kanhnha
Khemara	Khmer Development of Freedom Organization	Khmer Rural Development Association
Khmer Youth Association	Men's Health Cambodia	Men's Health and Social Service
Ministry of Interior	Ministry of National Defense	NYEMO Counseling Center for Vulnerable Women and Children
Pharmaciens Sans Frontieres (PSF - CI)	Phnom Srey Association for Development	Poor Family Development
Provincial Health Department - Battambang	Provincial Health Department - Kampong Cham	Provincial Health Department - Pailin
VBNK		

Overview Narrative

This implementing mechanism is unchanged from last year. Implementing Mechanism Name: TASC III Prasit (FHI)

Overall Goals and HIV-Specific Objectives

FHI will continue to support the Cambodian response to HIV and AIDS and to strengthen and make more cost-efficient the RCG health care system as a whole by implementing the following broad sets of activities:

• Target prevention and treatment activities to persons engaged in high risk behaviors.

• Strengthen the quality of HIV and AIDS treatment and positive health and dignity programs; and further the integration of VCCT, STI treatment and family planning into sites that address the health needs of most-at-risk populations (MARPs).

• Provide advanced surveillance and monitoring support to identify current and future modes of high transmission in addition to providing support to see what models of integration work.

• Provide health system strengthening support by the following: incorporating incentive and performance-based efforts into HIV/AIDS prevention and treatment programs; identify areas where cost-efficiency can be improved; and provide support to IA partners so they can be more financially and managerially sustainable.

Target Populations

FHI will reach 18,650 entertainment workers (EWs), men who have sex with men (MSM) and injecting drug users (IDUs). FHI will also plan to reach 70,000 at-risk men and 1,000 drug users (DUs). Furthermore, 33,000 will receive testing and counseling services and receive their test results and 8,000 will be provided with at least one care services.

Geographic Coverage

FHI activities will take place predominantly in Phnom Penh, Banteay Meanchey, Pailin, Kompong Cham and Battambang Provinces because these are the provinces where there is the greatest population of MARPs and highest HIV seroprevalence.

Making the Most of HIV Resources

FHI currently receives over 1.5 million dollars per year in funding from GFATM for an expansion of HIV and TB prevention and treatment activities targeting MARPs in areas where FHI already works with USG funding. FHI receives $500,000 per year in funding from the Asian Development Bank for HIV activities targeting MARPs along certain transport corridors where FHI already has a minor presence secondary to USG funding. FHI also currently receives $100,000 in funding from AUSAID for expanding USG-

funded efforts for DU/IDUs. All of these funding sources are expected to increase in value by FY 2010.

FHI will expand its current health system strengthening activities by the following:
• Better collaborate with the URC-managed Better Health Services (BHS) Project so that financial and performance-based incentives can be incorporated into HIV/AIDS prevention and treatment programs.
• Provide technical assistance support to the RCG especially in areas of making the HIV/AIDS treatment system more cost efficient and higher quality.
• FHI will work with health centers targeting MARPs and Family Health Clinics so that family planning (FP), voluntary counseling and testing (VCT), and sexually transmitted infections (STI) services can be fully integrated into locations where MARPs receive their health care.

Cross-cutting Areas
FHI uses the "platform" concept with branded initiatives such as the SmartGirl program (targeting EWs) and its websites, SMS messaging, and traditional outreach and peer education models. It expands upon these to include family planning, safe motherhood, increasing women's legal rights and protection, and increasing women's access to income to enable them to mollify the harmful aspects of the entertainment industry. The expansion of the SmartGirl platform will include working with the anti-trafficking partners so that anti-trafficking efforts are supplemented by those who are closest to it. The "You're The Man!" "platform" (an existing initiative to address male norms and behaviors) will also be expanded to include more gender- based activities, such as increasing women's legal rights and protection and women's access to income and productive resources. It is estimated that approximately $400,000 will be spent on gender activities and $100,000 on economic strengthening.

Enhancing Sustainability
FHI strategies for creating a sustainable program, rooted in host country ownership are as follows:
• FHI will provide technical leadership in the support of RCG strategic HIV plans by its ongoing work on numerous technical committees (EW, MSM, DU/IDU, HIV costing, etc). In addition, FHI will continue to assist the RCG and its partners in accessing GFATM and other resources so that funding sources can be diversified.
• FHI will continue to work with its approximately 30 sub-grantees to enhance their capability to find additional funding sources and properly monitor and manage existing

resources. FHI will continue its work of "nationalizing" its sub-grantee efforts whereupon local organizations will provide more and more sub-grantee supervision and monitoring

M&E
FHI will ensure proper M&E of PEPFAR old and next generation indicators. FHI will continue its work of providing data so that information gaps on where high risk behaviors (or series of high risk behaviors) can be linked to recent HIV acquisition. FHI will work to evaluate where efforts described in the "enhancing sustainability" section have worked. As importantly, FHI will continue its existing efforts to improve partner organization's abilities to collect, monitor and use data for programming. The use of data from other programs will be put into the context of setting benchmarks so that an incentive and performance based system can eventually be rolled out.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	50,000
Economic Strengthening	100,000
Education	20,000
Gender: Reducing Violence and Coercion	400,000
Human Resources for Health	70,000

Key Issues
Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
TB

Budget Code Information

Mechanism ID:	**7215**
Mechanism Name:	**Family Health International**
Prime Partner Name:	**Family Health International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	200,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	240,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	595,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	340,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	62,500	
Narrative:			
This implementing mechanism is unchanged from last year.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	230,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	590,000	

Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	142,500	
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	2,400,000	
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	250,000	
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	200,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9438	**Mechanism Name: CENAT v22.KH.mech009701.xls**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: CENAT - National Center for Tuberculosis and Leprosy Control	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000

Sub Partner Name(s)
(No data provided.)

Overview Narrative
This implementing mechanism is unchanged from last year.
CENAT- National Center for Tuberculosis and Leprosy Control or the National Tuberculosis Program

Goals and Activities
The goals of this implementing mechanism are to strengthen the capacity of the Cambodian National Tuberculosis Program (NTP) reliably and rapidly to diagnose tuberculosis in people with HIV and prevent the spread of multi-drug resistant Mycobacterium tuberculosis.

WHO endorses the use of liquid culture for M. tuberculosis in resource limited, high TB burden settings. The advantages of using liquid culture, including reduced time to detection as well as an increase in the yield of M. tuberculosis when compared to solid media have been well documented. Rapid differentiation of M. tuberculosis from nontuberculous mycobacterium (NTM) using cost effective identification methods is also critical. This mechanism will implement the MGIT liquid culture system and an immunochromatographic assay for identification of M. tuberculosis in the Battambang Referral Hospital. Battambang province, with a population of nearly 1,000,000, is one of the CDC/GAP's focus provinces. These methods will also be introduced at the national reference laboratory (NRL). Drug sensitivity testing (DST) using the MGIT system will be implemented at the NRL, the only government laboratory providing DST for M. tuberculosis, when the NRL meets international biosafety standards. This mechanism will fund the hiring of a TB laboratory specialist to work with the Cambodian staff to build capacity and sustain the ability of the NRL to perform TB diagnostics.

This mechanism will strengthen the capacity of the NTP to detect more rapidly TB in PLWHA and other patients. Staff will be trained in this advanced technique at both the provincial and the national levels. More rapid detection of infectious cases of TB will help reduce the TB burden in Cambodia. Prompt detection of M. tuberculosis in HIV and TB co-infected individuals can lead to more rapid initiation of treatment.

This mechanism supports TB/HIV activities and measures to prevent the spread of MDR TB in the laboratory and hospitals in the four CDC/GAP focus provinces. Renovation of the NRL will take place to ensure that the laboratory meets international standards for laboratory safety.

Procurement of laboratory supplies has been a challenge for the NTP under the existing national structure. However, the NTP is the principal recipient for Global Fund Round 7 funds and will gain direct experience in procurement of laboratory supplies and equipment. CDC/GAP will work closely with the NTP to ensure that the appropriate materials are purchased and supplied to the laboratories. The CDC/GAP has been instrumental in implementing and animating a technical working group for TB laboratories. This TWG meets monthly and includes public and private organizations with a stake in the laboratory diagnosis of tuberculosis. The NTP, through the TWG, has developed an Action Plan for TB laboratories for 2010-2014 based on the Strategic Plan for the TB Laboratory Network.

Where liquid culture is introduced, contamination of the media is initially a major challenge. Technical assistance will be provided to ensure that appropriate sputum decontamination techniques are used to reduce the contamination rate. Culture yield and contamination rates will be monitored on a monthly basis.

Target Populations and Geographic Coverage
The NTP provides services for the entire population of Cambodia. The laboratory in Battambang provides services to the provinces of Banteay Meanchey, Battambang, Pailin and Pursat. The target population is all persons with tuberculosis, with an emphasis on those TB patients coinfected with HIV.

Making the Most of HIV Resources
The NTP is seeking a long-term supply of reagents for liquid culture through the Global Fund. In addition, MSF has funded liquid TB culture at the regional TB lab in Kompong Cham.

Enhancing Sustainability
By building liquid culture capacity at the national reference laboratory, the NTP will be better able to supervise regional and provincial TB labs. As noted above, it is expected that reagents for liquid culture will come through the Global Fund in the future, making this a self-sustaining program.

M&E
Progress will be monitored by tracking the rate of contaminated cultures, which for a well functioning liquid culture lab should be approximately 10 percent.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
TB

Budget Code Information

Mechanism ID:	**9438**		
Mechanism Name:	**CENAT v22.KH.mech009701.xls**		
Prime Partner Name:	**CENAT - National Center for Tuberculosis and Leprosy Control**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	200,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Implementing Mechanism Indicator Information
(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9439	**Mechanism Name: Association of School of Public Health.v22.KH.mech009702.xls**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Schools of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 85,000	
Funding Source	**Funding Amount**
GAP	85,000

Sub Partner Name(s)
(No data provided.)

Overview Narrative
This implementing mechanism is unchanged from last year. Association of Schools of Public Health
Goals and Objectives
Activities to increase HIV testing in maternity hospitals in the focus areas of Battambang, Banteay Meanchey, Pailin and Pursat began in 2008. Also in 2008, a project to institute liquid TB culture at the Battambang Provincial Laboratory to improve the yield in TB culture in HIV positive patients was started. This will be expanded to the National TB Reference Lab. It is critically important to implement these projects professionally and successfully, and to be able to expand the scope of the projects as successful results are demonstrated.

An Association of Schools of Public Health (ASPH) Fellow will assist with both activities. The Fellow will assist primarily in monitoring and evaluating progress of the projects. In addition, the Fellow will assist in developing standard operating procedures, implementation plans, and reports. Finally, the Fellow will provide technical assistance in the implementation and quality assurance assessment of these projects.

Target Populations and Geographic Coverage
The primary populations and geographic coverage will be in women of unknown HIV status attending maternity hospitals and in TB suspects in the provinces of Banteay Meanchey, Battambang, Pailin and Pursat. In addition, the National TB Reference Lab provides culture for the national program, thereby providing a national scope to this activity.

Making the Most of HIV Resources
The fellow will assist in developing proposals for Global fund resources, particularly in the area of TB culture supplies. This, in turn, will assist with the sustainability of TB liquid culture in Cambodia.

Enhancing Sustainability
The Fellow will work directly with government staff of maternity hospitals and TB labs. By doing so, the Fellow will bring new concepts to bear on monitoring and evaluation in these areas, but will also assist in skills building of the workers involved in these projects.

M&E
The primary focus of the fellowship is to improve monitoring and evaluation of HIV testing at maternity hospitals and to monitor TB culture contamination rates at the two liquid TB culture sites. Improved data for these two indicators will demonstrate success of this fellowship.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
TB

Budget Code Information

Mechanism ID:	9439
Mechanism Name:	Association of School of Public Health.v22.KH.mech009702.xls
Prime Partner Name:	Association of Schools of Public Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	42,500	

Narrative:

This implementing mechanism is unchanged from last year.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	42,500	

Narrative:

This implementing mechanism is unchanged from last year.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9440	Mechanism Name: ASCP - Pre-Service Curriculum Development.v22.KH.mech009703.xls
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: ASCP	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GAP	100,000

Sub Partner Name(s)
(No data provided.)

Overview Narrative
This implementing mechanism is unchanged from last year. American Society for Clinical Pathology (ASCP)
Overall Goals and HIV-Specific Objectives
The American Society for Clinical Pathology (ASCP) has created a successful 24-month package for pre-service curriculum development and was awarded a five year cooperative agreement with the CDC in September 2008 for a training program, which will include the Cambodian Technical School for Medical Care (TSMC).

TSMC provides training to 40-45 medical technology students annually. A newly built TSMC complex includes lecture rooms, demonstration laboratories and a library. The facilities are in place, but the teaching methods and the content of the material taught need improvement. Of the programs at the TSMC, the medical laboratory technology program has received the least assistance and needs strengthening. Pre-service training for medical technologists through the TSMC medical technology program is essential for developing medical laboratory capabilities in Cambodia. There are ten full time teachers of medical technology and 15 part time teachers from various institutions in Phnom Penh. Only two of the full time teachers have had any recent refresher training. There are insufficient qualified tutors for laboratory technology training in Cambodia. Although a Cambodian medical technology society has been formed, it has yet to begin holding meetings and providing continuing education.

Skilled medical technologists were executed or died during the genocidal Pol Pot regime, so there has been no continuity in the development of medical laboratory staff. There is a serious shortage of qualified laboratory personnel in the country. The goal of this mechanism is to improve the curriculum and teaching style in the medical technology training program at the TSMC.

Medical technology educators from ASCP will assess the curriculum at the TSMC and some of the laboratories in the country. The ASCP will develop a curriculum appropriate to local conditions. Effective teaching methods will be presented to the faculty and students will learn study skills. Modules have been created in areas including clinical chemistry, hematology, CD4 testing and parasitology. Strengthening the content and presentation of this material should improve laboratory testing for HIV care and

treatment and medical care in general.

Target Populations
The intent of this activity is to train 40-45 medical technologists who will over time provide improved services to the entire population of Cambodia.
Geographic coverage
The impact of improved training of medical technologists would be national in scope.

Making the Most of HIV Resources
This activity is currently underfunded, and the USG is seeking funding from other sources to supplement this investment.

Cross-cutting Areas
This activity entirely supports human resources for health. 100% of funds apply to the HRH cross-cutting area.

Enhancing Sustainability
The new curriculum developed under this cooperative agreement will become the national curriculum for medical technologists. Implementing the curriculum will likely take some USG resources, but it is expected that this will become self-sustaining at the TSMC.

M&E
Upon the successful implementation of this curriculum, graduates of the program will be reported against the HRH indicator of medical personnel completing a pre-service training program.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

Key Issues
(No data provided.)

Budget Code Information

Mechanism ID: 9440 Mechanism Name: ASCP - Pre-Service Curriculum Development.v22.KH.mech009703.xls Prime Partner Name: ASCP			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	100,000	
Narrative:			
This implementing mechanism is unchanged from last year.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12254	**Mechanism Name: SIFPO/MSI v22.KH.new001.xls**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new activity. Goals and Objectives

This is a proposed new behavior change communication (BCC) activity. The TBD

partner will be expected to have expertise in mass and interpersonal communication design, production, and dissemination. The partner will provide direct technical assistance to the government in its design of a National BCC Strategy for HIV/AIDS. Technical assistance will also focus on improving the quality and coordination of communication, advocacy, and education campaigns among current USG implementing partners.

Target Populations and Geographic Coverage
This implementing mechanism will develop behavior change communications to reach a national audience.

Making the Most of HIV Resources
We plan to supplement PEPFAR support with USAID population and child survival funds to ensure an integrated program of communications and education addresses key health program priorities.

Program design will begin in FY2010 so specific information on the implementing mechanism will appear in future COPs.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
(No data provided.)

Budget Code Information

Mechanism ID:	**12254**		
Mechanism Name:	**SIFPO/MSI v22.KH.new001.xls**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	Redacted	Redacted

Narrative:
This is a new activity. This TBD implementing mechanism will help design behavior change communication for PEPFAR implementing partners and coordinate their BCC activities. BCC messages will be predominantly focused in the area of other sexual prevention. This is in line with Cambodia's FY10 COP key objective to enhance the reach of prevention messages for most-at-risk populations. We plan for TBD implementer to generate additional messages to address related care and treatment priorities -- such as treatment literacy, improved uptake of clinical services, and integration of family planning and HIV/AIDS services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12255	**Mechanism Name: KHANA v22.KH.new002.xls**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This implementing mechanism is unchanged from last year.
In June 2009, USAID issued an RFA for an organization to serve as an umbrella supporting a number of implementing agencies in the areas of prevention and care, national level advocacy, and leadership. The RFA for Community Based HIV/AIDS

Prevention and Care Program has not yet been awarded. The purpose of this new agreement is to build the capacity of RGC and other local stakeholders to identify and sustainably address the prevention and care needs of underserved most-at-risk populations through community-based services. The program is intended to facilitate the development, implementation, and evaluation of community-based interventions that address key gaps in current prevention and care service coverage, and that serve as focal points for advocacy and leadership to improve the quality and efficiency of service delivery supported through other mechanisms.

Comprehensive Goals and Geographic Reach:
The program has three main components:
• Component 1: Improving the coverage, quality and sustainability of home- and community-based care services for individuals infected or affected by HIV, including orphans and vulnerable children (OVC): These activities should cover Phnom Penh, Battambang, Pailin, Banteay Meanchey, Pursat, Siem Reap, Takeo, and Kampong Cham.
• Component 2: Identifying and addressing critical gaps in HIV prevention programming for underserved or neglected most-at-risk populations: These activities should cover Phnom Penh, Battambang, Siem Reap, and Sihanoukville
• Component 3: Providing technical leadership, advocacy and capacity building to advance the quality, impact, and sustainability of community-based services for MARPs. This activity should include technical assistance and capacity building with local NGO/CBO implementing partners, national and local networks of PLHA, MSM and IDU, and other national and local stakeholders.
The partner should fully collaborate with other USAID-funded programs focusing on strengthening health systems and building institutional capacity at the national, provincial and service delivery levels.

Target Populations:
It is anticipated that the TBD implementer will focus much of its emphasis on meeting the care and support needs of those who are most vulnerable, including children affected by AIDS, people experiencing illness or adherence challenges, and those for whom the impact of HIV/AIDS puts them at risk of going into debt and/or having to dispose of the family assets. In terms of HIV prevention activities, it is anticipated that the program will place much of its emphasis on MSM, IDU, persons who exchange sex for money, and on preventing re-infection and ongoing transmission among individuals living with HIV. Potential beneficiary populations include: People Living with HIV/AIDS

(PLWHA), Men who have sex with men (MSM), Injecting Drug Users (IDU), and Entertainment Sector Workers (ESW).

Cost-effectiveness Strategy:
The CBPD award will have a strategy in place to reduce costs over time and create a sustainable program. Efforts to sensitize local authorities to the needs of people in relation to HIV/AIDS and raise awareness of how they can play a role in community investment planning will also contribute to sustainability. As will ensuring the participation of MARPs, PLHA and OVC in the development, implementation and monitoring of the program. Shifting the emphasis of HCBC from NGO-provided support to community-based self help will contribute to the sustainability of HCBC services. On-going organizational technical and management capacity-building will affect the sustainability of the program. The TBD implementer will clearly outline how they will maintain and increase the state-of-the-art technical and management skills and capacity of their own organization, as well as any local NGO/CBO implementing sub-partners and/or networks.

M&E Plan:
The CBPC award will be responsible for developing and executing a Monitoring and Evaluation (M&E) plan, in consultation with the AOTR. Expected program results with illustrative indicators, mid-term milestones/benchmarks, end-of-project results should be elaborated in the M&E plan. Data sources and collection methodologies should also be noted.

Cross-cutting Program/Key Issues--Gender:
The approved activity must address the following two guiding questions in relation to gender:
1. Are men and women involved or affected differently by the context or work to be undertaken?
2. If so, how will this difference be addressed in order to manage for sustainable program impact?
The CBPC award should address these questions by taking into account not only the different roles of men and women in Cambodia, but also the relationship and balance between them and institutional structures that support them.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
(No data provided.)

Budget Code Information

Mechanism ID:	**12255**		
Mechanism Name:	**KHANA v22.KH.new002.xls**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	PDCS	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Other	OHSS	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	Redacted	Redacted
Narrative:			
This implementing mechanism is unchanged from last year.			

Implementing Mechanism Indicator Information
(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12256	**Mechanism Name: TBD - Blood Safety v22.KH.new003.xls**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)
(No data provided.)

Overview Narrative
This is a new activity.
Goals and Objectives
This TBD partnership with the USG will improve the availability and access to safe blood in Cambodia, reducing the risk of HIV transmission through transfusion. Our USG sponsored activities will strengthen the capacity of the Ministry of Health's (MoH) National Blood Transfusion Services (NBTS) to lead and manage the national blood program and will enhance laboratory quality for blood safety. Through ongoing USG technical support to NBTS, projects funded from other sources, such as the Global Fund's (GFTAM) activities to increase volunteer donation and improve rational use of blood, will be strengthened.

In FY10, USG support will: a) provide technical mentorship and training programs to improve management, monitoring and planning at NBTS and other blood banks; b) strengthen quality assurance and quality control practices; c) increase post donation counseling and referral; d) support infrastructure improvement through ensuring proper maintenance of laboratory equipment and assisting with equipment upgrades; e) provide technical support to NBTS for GFTAM Round 5 (and 9 if successful) activities; and f) assist NBTS to operationalize the Hospital Transfusion Committees (HTC) and develop a forum for sharing best practices from institutions and blood banks across Cambodia.

Target Populations

Through this mechanism, blood supply and safety will be improved for the population requiring blood or donating blood throughout Cambodia. All blood collected will be screened for HIV and 4000 prospective donors with transfusion transmitted infections (TTI) will have access to improved counseling and referral. The capacity of 75 blood bank personnel and 500 clinicians prescribing blood or blood products in the 22 national

and provincial blood banks will be strengthened.

Geographic Coverage

Blood safety activities will have nation-wide coverage and take place in Phnom Penh and in the areas served by the 21 provincial blood transfusion services (PBTS).

Key Contributions to Health Systems Strengthening

The NBTS is responsible for ensuring access to safe blood for all Cambodians. This requires a quality system and adequate supply of blood or blood product when and where it is needed. A strengthened NBTS will help prevent mortality and morbidity associated with lack of blood and will help prevent adverse transfusion reactions from improper use of blood. For example, fewer women will die during childbirth as a result of obstetrical hemorrhage. By making safe blood and blood products more available in all geographic areas and supporting capacity building of health care providers for rationale use of blood, the risk of transfusion related transmission of other TTI's besides HIV (syphilis, malaria, and Hepatitis B and C) will also be reduced

Enhancing Sustainability

This mechanism will assist the NBTS to become more cost efficient over time as a result of improved management capacity, more effective tracking of inventory, more rational use of blood, and limiting blood manufacturing and distribution in the private sector.

Through regular review of data and better forecasting of blood supply and equipment inventory needs, costly emergency purchases which are common today can be avoided. NBTS managers will be trained to adopt new, cost-efficient ways of forecasting supply needs for the whole year and organizing a staggered delivery of test reagents and consumables. Procurement under this mechanism will take into account and complement procurement by the GFTAM and the MoH. Communication at NBTS will be enhanced through regular staff meetings.

USG will encourage NBTS to organize regular blood bank and blood depot network meetings to review program activities and to share 'best practices'. Coordination between hospitals and health providers and NBTS will be strengthened by supporting

the Hospital Transfusion Committees established under the National Blood Strategy (2007). USG will advocate with NBTS, Bureau of Medical Laboratory, and the sub- sub technical working group for blood safety in the MoH to ensure that the committee meetings are functional.

Cambodia does not have a formal system to regulate the use and safety of blood and blood products in the private sector. To minimize the expansion of unsafe practices in the private sector, some PTBS have begun offering blood products to private hospitals and clinics for a small fee. NBTS also provides training to clinicians in both the public and private sectors. This IM will support NBTS to establish additional systems and strategies for a safe blood supply in the private sector.

Monitoring and Evaluation Plans

Activities in this mechanism will be monitored using data from the existing information system established with funding from GFTAM Round 5. Site visits will be carried out to directly observe quality control practices and infrastructure strengthening results activities. USG will convene regular meetings with NBTS senior management and TBD to review results reports, identify issues, track progress and review budgets and work plans.

Cross-Cutting Budget Attribution(s)
(No data provided.)

Key Issues
(No data provided.)

Budget Code Information

Mechanism ID:	**12256**		
Mechanism Name:	**TBD - Blood Safety v22.KH.new003.xls**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HMBL	Redacted	Redacted

Narrative:

This is a new activity.

Basic approaches
TBD will provide a blood safety expert to be based at National Blood Transfusion Services (NBTS) to support the implementation of quality management plans and provide technical support to the NBTS. TBD will assist NBTS to strategically manage and maximize USG and GFTAM resources.

Coverage and scope of activities
TBD will organize training for the staff in 22 provinces on transfusion transmitted infections, immuno-hematology, quality assurance, and laboratory auditing. TBD will procure quality control materials for the PBTS in the CDC focus provinces and for NBTS, a re-agent grade water system and other essential equipment. NBTS will increase component manufacturing so that patients with specific transfusion requirements can be treated accordingly. The NBTS and PBTS in these focus provinces will be enrolled in international EQA.

TBD will assist NBTS to improve information management and re-organize quality assurance documents for easier access. To trace donors and increase post-donation counseling the use of national ID and the verification of donor's contact information will be reinforced. TBD will support NBTS in the implementation of GFATM-supported activities. For example, designing creative mobile blood drives using innovative technologies has proved to be successful in the past, and is a good model for future programming.

Integration with other HIV/AIDS services
HIV-positive prospective donors will be referred to VCCT for counseling and follow-up. NBTS will continue to collaborate with NIPH in the national quality assurance program.

Fostering Sustainability
Strengthening the organization and management of blood transfusion services, building capacity for quality assurance and better forecasting will lead to cost reductions and more sustainable systems. USG will work the Ministry of Health and participate in the

Technical Working Group for Blood Safety to support the development of regulatory framework.

Health Care Worker Salary Report: Please estimate the number of health care workers (your agency and sub-partner staffs, and community workers/volunteers) who received salary support from PEPFAR (HIV fund) for the following categories: (Please see the definition and instruction in the COP guidance)

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.
Redacted
2.
Redacted
3.
Redacted
4.
Redacted
5.
Redacted

Agency Information - Costs of Doing Business
U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services					42,500	42,500
ICASS					122,700	122,700
Non-ICASS Administrative Costs					205,400	205,400
Staff Program Travel					90,850	90,850
USG Staff Salaries and Benefits					403,030	403,030
Total	**0**	**0**	**0**	**0**	**864,480**	**864,480**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (USAID)		42,500

ICASS		GHCS (USAID)		122,700
Non-ICASS Administrative Costs		GHCS (USAID)		205,400

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing			191,827			191,827
Computers/IT Services			30,000			30,000
ICASS			335,486			335,486
Non-ICASS Administrative Costs			480,472			480,472
Staff Program Travel			145,000			145,000
USG Staff Salaries and Benefits			1,382,215			1,382,215
Total	**0**	**0**	**2,565,000**	**0**	**0**	**2,565,000**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		191,827
Computers/IT Services		GAP		30,000
ICASS		GAP		335,486

Non-ICASS Administrative Costs		GAP		480,472