2017

Strategic Direction Summary

Cambodia

Country Operational Plan

v3.1
March 9, 2017

1.0 GOAL STATEMENT

The Government of Cambodia has made significant progress in addressing HIV/AIDS for the past 25 years. In 2013, Cambodia announced its intent to eliminate new HIV infections by achieving the 90-90-90 targets by 2020 and going further to achieve 95-95-95 (and fewer than 300 new HIV infections annually) by 2025 – coming close to achieving an AIDS Free Generation. As of December 2016, Cambodia had diagnosed approximately 83% of the estimated population of PLHIV, placed 97% of diagnosed PLHIV on ART, and had documented viral load suppression on 81% of PLHIV on ART (Figure 2.1.2: National HIV Impact Cascade). The exisiting PEPFAR strategy has helped to drive this progress, particularly in ensuring ensuring that PLHIV are placed on ART, retained in care, and receive quality-assured viral load testing.

Although this success is promising, countries with much larger HIV burdens, including a number in sub-saharan Africa, are also rapidly approaching 90-90-90. If Cambodia wants to capitalize on its previous successs, then the primary barriers to sustained elimination in Cambodia must be addressed. Jointly with stakeholders, the PEPFAR team has mapped out how these barriers threaten the foundational elements needed for a sustained response, as described in PEPFAR's Sustainability model. While there are a number of barriers that need tackling, the PEPFAR team has identified inadequate domestic financing and insufficient case finding efforts, as the most important, while also recognizing the better use of more granular data as the most important opportunity to seize.

Therefore, in the COP17 implementation period, PEPFAR Cambodia will focus on two strategic outcomes intended to aggressively increase the pace of progress towards the overall goal of sustained elimination of new HIV infections:

1. Sustainable financing from the Cambodian government that has increased by 100% over 2 years using 2015 NASA as a baseline;
2. Strengthened national systems for:
    - Aggressive case finding to identify 6,000 undiagnosed PLHIV and link to treatment;
    - Use of granular data to rapidly identify and respond to new infections and programmatic gaps across the cascade

In order to achieve these outcomes, PEPFAR Cambodia is making major shifts in how it operates to focus exclusively on above-site impact intended to catalyze achievements throughout Cambodia. The specific change in operational modalities is outlined below in section 3.1. In order to focus on these above-site strategies, PEPFAR Cambodia will no longer support DSD or TA at site level.

With assistance of PEPFAR and The Global Fund for AIDS, TB and Malaria (Global Fund), Cambodia is on track to reach their stated goal of 95-95-95 and fewer than 300 new infections by 2025. The greatest barrier to reaching 95-95-95 is finding undiagnosed cases of HIV. The failure to find these individuals not only prevents achievement of the first 90 (or first 95), but also contributes to sustained HIV transmission in Cambodia. Conversely, more aggressive efforts to build sustainable systems for case finding would allow Cambodia to reach the 95-95-95 goal in advance of 2025, potentially saving many hundreds of new infections and prolonging the lives of undiagnosed individuals.

Given declining resources and a rise in competing health priorities, the Cambodian government, civil society, and development partners must adapt and become more efficient to remain an innovative leader in the global fight against HIV. The government has been leading these efforts, and continues to actively engage communities, civil society and other stakeholders

in how best to achieve Cambodia's ambitious HIV goals. If successful, lessons learned in the Cambodian context may help to inform other countries with similar epidemic profiles.

2.0 EPIDEMIC, RESPONSE, AND PROGRAM CONTEXT

2.1 SUMMARY STATISTICS, DISEASE BURDEN AND COUNTRY PROFILE

As of 2016, Cambodia's population reached 15.4 million, with an estimated 70,741 people living with HIV (Table 2.1.1). Cambodia has achieved substantial progress in reducing the spread of HIV, with an overall reduction of 98% in the estimated annual new HIV-infections, from 24,900 in 1995 to 590 new infections in 2016. By the early 2000's, the number of new HIV infections annually was equal to the number of AIDS related deaths, both because of rising deaths (2,154 in 2016) and declining new infections.

HIV prevalence likely peaked at 1.7% in 1998 and has been declining ever since, with an overall estimated prevalence for adults of 0.61% in 2016. Although the overall HIV prevalence in Cambodia is low, higher prevalence's are found in key populations: 2.3% among men who have sex with men (MSM), 14.0% among high-risk female entertainment workers (FEW), 5.9% among transgender women (TG), and 24.8% among people who inject drugs (PWID). However, none of these populations are particularly large; there are an estimated 31,000 MSM[1], 34,000 FEW, 3,000 TG, and 1,300 PWID in Cambodia (Table 2.1.1).

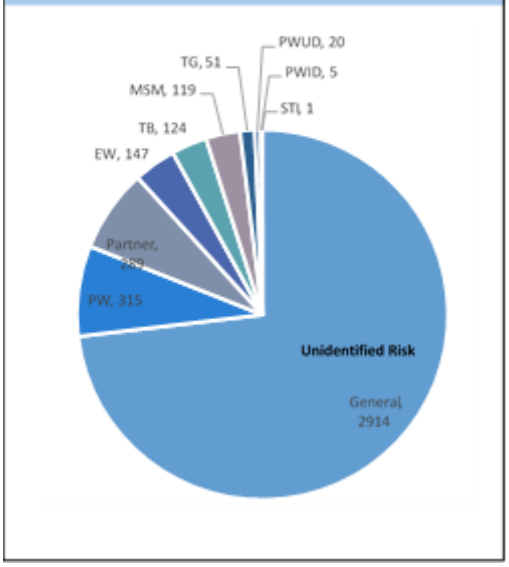
Table 2.1.1: Key National Demographic and Epidemiological Data

	Total		<15				15+				*Source, Year*
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	15,453,923	100	2,169,085	14.0%	2,271,973	14.7%	5,760,976	37.3%	5,251,889	34.0%	MOP, December 2016
HIV Prevalence (%)		0.61		NA		NA		0.64		0.58	Estimates for 2016, per 2014 AEM exercise, adults only
AIDS Deaths (per year)	2,182		NA		NA		NA		NA		Estimates for 2016, per AEM 2016 exercise
# of PLHIV	70,741		1,776		1,843		35,597		31,525		Estimates for 2016, per 2016 AEM exercise
Incidence Rate (Yr)		0.02		NA		NA		NA		NA	NCHADS/UNAIDS Spectrum/AEM estimates 2016, adults only
New Infections (Yr)	590						263		328		Estimates for 2016, per 2016 AEM exercise
Annual births	367,905										MOP, December 2016
% of pregnant women with at least one ANC visit	367,033	99.8%	NA	NA			NA	NA			NMCHC Linked Response Database, 2016
Pregnant women needing ARVs	879**	0.28%									NCHADS/UNAIDS Spectrum/AEM estimates 2016 (595 per program data)
Orphans (maternal, paternal, double)	8,161		NA		NA		NA		NA		NCHADS/UNAIDS Spectrum/AEM estimates 2016
Notified TB cases (Yr)	35,638		NA		NA		NA		NA		Data for 2015, WHO Global TB report 2016

[1] 31,000 MSM per 2014 IBBS, but NCHADS estimates that there are 20,000 "reachable" MSM, and UNAIDS estimates that there are 62,000 MSM based on a rough estimate that 1.5% of adult males are MSM.

% of TB cases that are HIV infected	740	3.0%	NA	NA	NA	NA	NA	NA	NA	NA	Data for 2015, WHO Global TB report 2016
Estimated Pop Size of MSM*	31,000	-									IBBS 2014
MSM HIV Prevalence	-	2.3%									IBBS 2014
Estimated Pop Size of FEW	34,000	-									NCHADS/KHANA program data reviewed through AEM process in 2016.
FEW HIV Prevalence	-	14.0%									IBBS 2011
Estimated Pop Size of Transgender	3,000	-									Size estimation 2012
Transgender HIV Prevalence	-	5.9%									2016 IBBS
Estimated Pop Size of PWID	1,300	-									MOH, National Strategic Plan on Reduction of Harm Related to Drug Use 2016-2020, March 2016
PWID HIV Prevalence	-	24.8%									2012 IBBS

Figure 2.1.1: Client type of newly identified PLHIV identified through B-IACM Jan 2014–Sept 2016 for 14 operational districts (N = 3,985)



While AEM modelling suggests that the majority (53%) of new infections in 2016 were through heterosexual transmission among low risk men and women (data not shown), program data from Cambodia's case management program was unable to identify risk among 73% of newly identified PLHIV (Figure 2.1.1), and only 9% were identified as key population (MSM, EW, PWID/PWUD, or TG). Reports in February 2016 of a cluster of at least 14 infections in Kandal province suggest that some newly identified cases may be related to previous, but not current, sex work. A cluster of at least 242 newly identified HIV-infections in Battambang province in 2014 also suggests that there may be new HIV-infections resulting from use of unsafe injections and infusions by unlicensed medical practitioners[2]. Such diverse findings suggest that risk elicitation in Cambodia remains inadequate and needs rapid improvement.

There is substantial geographic variation in the epidemiology of HIV in Cambodia, with PLHIV thought to be largely concentrated in a small number of provinces, particularly Phnom Penh, Siem Reap, Battambang, Banteay Meanchey, and Kandal (Table 2.4.1). The majority of high-risk key populations also live in urban centers in these provinces, but with high rates of inter-provincial migration and migration to Thailand.

As outlined in the *Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector in Cambodia 2016-2020*, Cambodia is striving for virtual elimination of new HIV infections by 2025. Virtual elimination is defined as fewer than 3 new infections per 100,000

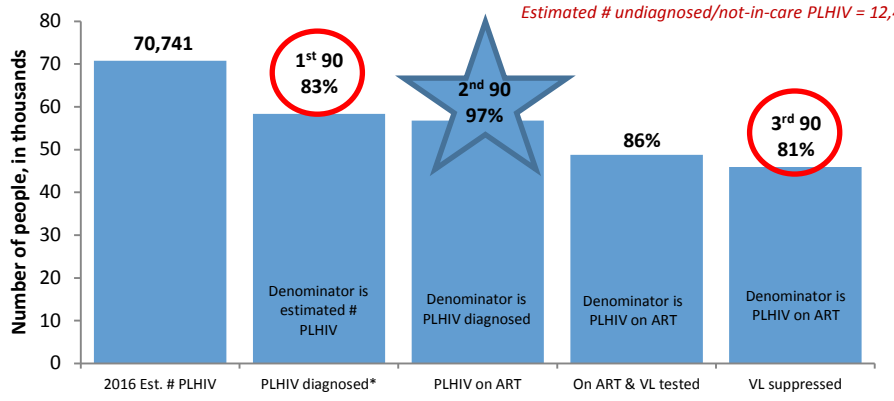
[2]Morbidity and Mortality Weekly Report (MMWR), 2016.

population a year and a mother-to-child transmission rate of 5% or less. In order to reach these goals, NCHADS has outlined three main strategies for the health sector HIV response:

1) *Boosted Continuum of Prevention to Care and Treatment (CoPCT):* key population prevention and links to services,
2) *Boosted Continuum of Care (CoC):* retention and improvement of quality for patients in care, and
3) *Boosted Linked Response (LR):* elimination of new infections among children while addressing the needs of their mothers.

The cornerstone activity bringing together all of these three strategies, along with a new strategy to identify, reach, intensify and retain (IRIR) key populations, is called Boosted Integrated Active Case Management (B-IACM). B-IACM strives to track individuals across the cascade through case management coordinators (CMCs) and assistants (CMAs), strengthened information systems, and improved use of individual level data. To date this activity has been introduced in 15 operational districts (ODs), with plans to scale up to all ODs over the next year. In essence, this is a frame shift for NCHADS from focusing interventions for specific populations, to focusing attention on specific individuals. As part of this, NCHADS is finalizing the Community Action Approach for B-IACM, which will consolidate and define the implementation approach for community work with both key populations and other at-risk populations. This new strategy will be essential for rapidly improving case finding at the community level, and supporting its accelerated implementation will therefore be an important focus of activities under strategic outcome 2.

Figure 2.1.2: National HIV Impact Cascade (Adult & Pediatric), as of Dec 2016



Sources: PLHIV estimate from NCHADS estimates based on AEM/Spectrum exercise conducted in Feb 2016, PLHIV in care, on ART and VL from NCHADS as of end Dec 2016.
*PLHIV diagnosed is calculated as: # of pre-ART + ART patients at end of period, per NCHADS request

An analysis of the national HIV impact cascade in Cambodia suggests that Cambodia's HIV strategy has been effective in helping Cambodia reach global 90-90-90 targets, although more so in ensuring that PLHIV are started and retained on ART. The proportion of PLHIV on ART who have received viral load testing continues to increase, and will likely reach targets with current efforts (Figure 2.1.2, Table 2.1.2). On the other hand, while progress has been made in finding undiagnosed cases, the pace of identification has room for significant acceleration. It is estimated that as of December 2016, 83% of all PLHIV have been diagnosed, 97% of diagnosed PLHIV are on ART, 86% of those on ART have received VL testing, and 81.0% of PLHIV on ART have documented viral load suppression. Furthermore, by the end of 2016, 90.6% of ANC attendees knew their HIV status, 76% of HIV+ pregnant women received

ART therapy, and 96% of exposed infants received anti-retroviral (ARV) for 6 weeks[3]. Cambodia's promising care cascade statistics are likely to show even further progress in 2017 following the continued nationwide implementation of Test and Treat, which will result in a continued increase in the proportion of diagnosed PLHIV on ART. The third viral load machine should reach an appropriate cachment area in 2017, which will result in continued progress in ensuring that all PLHIV on ART receive viral load testing. However, without aggressive increases in case finding efforts, reaching the first 90 will remain elusive.

Table 2.1.2: 90-90-90 Cascade: HIV diagnosis, treatment and viral suppression

	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Pop Size Estimate (#)	HIV Prev (%)	Est. Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage of est. PLHIV (%)	Viral Supp 12 Months (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	15,453,923[1]	0.61[2]	70,741[2]	58,338[3]	56,754[4]	80.2%	94%[5]	575,553	3,570[6]	4,030[7]
Population less than 15 years	4,441,058[1]	N/A	NA	NA	3,626[4]	NA	NA	NA	NA	371[7]
Population 15+ years old	11,012,865[1]	N/A	NA	NA	53,128[4]	NA	NA	N/A	N/A	3,659[7]
MSM	20,000[8]	2.3%[8]	460[9]	N/A	N/A	N/A	N/A	6,391[10]	45[10]	19[10]
FEW	34,000[11]	14.0%[12]	4,760[9]	N/A	N/A	N/A	N/A	15,496[10]	51[10]	9[10]
PWID	1,300[13]	24.8%[8]	322[9]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Pop Transgender	3,000[14]	5.9%[14]	177[9]	N/A	N/A	N/A	N/A	1,728[10]	39[10]	16[10]

Sources: 1. MOP, December 2016; 2. Estimates for 2016, as per 2014 AEM exercise; 3. NCHADS ART + pre-ART as of Q4 2016; 4. NCHADS ART as of Q4 2016; 5. VL lab database, % of all tests with <1,000 copies/ml. Approximately 86%% of all ART patients tested for VL and 81% of all ART patients VL suppressed through Q4 2016; 6. Sum of PMTCT + partners+ TB + STI + Gen pop + VCCT + KP, from Boosted LR 2016, VCCT Q1 – Q4 2016, KHANA Q4 2015 – Q32016; 7. NCHADS, ART data, Q1 2016-Q4 2016; 8. MSM IBBS 2014; 9. Population size estimate multiplied by HIV prevalence; 10. KHANA 2016 (Flagship and GF supported sites); 11. Program estimates validated by AEM process, 2016; 12. FEW IBBS 2011; 13. MOH, National Strategic Plan on Reduction of Harm Related to Drug Use 2016-2020, March 2016; 14. IBBS 2016.

Approaches for reaching and testing individuals at highest risk of HIV infection have been adapted in recent years to find remaining undiagnosed individuals. Despite this new approach, the number of undiagnosed individuals remains unacceptably high. While there are new approaches to accelerating case finding, including partner intiated testing and counseling, index case testing, and social networking strategies, these have not yet been scaled up throughout Cambodia. While KPs make up a minority of the newly identified cases, ensuring that these populations do come forward for testing remains important. Unfortunately, fear of stigma and discrimination remains a major barrier to KPs accepting HIV testing.

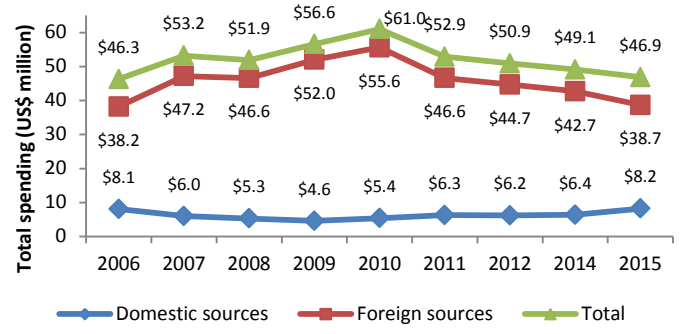
In 2016, Cambodia became a lower middle-income country with a per capita GNI of $1,070[4]. While government funding for health care has increased significantly, it remains at only 1.3% of GDP. Government expenditures on health as a share of total government expenditures were 6.5% in 2012. Out-of-pocket expenditures are high at over 60% of all health expenditures. Spending on pharmaceuticals accounts for 40% of total health expenditures, double the spending on salaries and other staff costs[5]. Such health spending statistics

[3] HIV status per NMCHC from Global Fund PUDR data for 2016, ART coverage per NMCHC from Global Fund PUDR data, infant data per NMCHC program data.
[4] http://data.worldbank.org/country/cambodia
[5] National Health Accounts, 2013

demonstrate the significant challenges to sustainable virtual elimination of HIV in Cambodia. A rapid increase in domestic funding for HIV will be essential for achieving and sustaining HIV elimination.

2.2 INVESTMENT PROFILE

Figure 2.2.1: Trend in Domestic and Foreign Sources of Spending for AIDS, 2006-2015 (excluding 2013)



Source: NASA, 2014-2015

Data from the latest National AIDS Spending Assessment (NASA V), (Figure 2.2.1) show total reported HIV/AIDS spending in Cambodia peaked at $61 million in 2010. Since that time, total spending has trended downwards, decreasing to $46.9 million in 2015. This represents an 11% decline from 2010 to 2015, or a compounded annual reduction rate of 2.3%. However, that annual decline doubled to 4.6% between 2014 and 2015.

The RGC has increased its domestic contribution to the HIV response. Between 2014 and 2015, RGC contribution increased by 21%, including funds (approximately US$1 million) for the purchase of ARV drugs for the first time. Domestic government spending on HIV/AIDS has increased 78% since 2009 from $4.6 million to $8.2 million. In 2015, the RGC spending accounted for 17.5% of total HIV/AIDS spending and 10.8% of key commodity procurements, including 10.4% of ARVs (see Tables 2.2.1 and 2.2.2.). The RGC also pays for drugs used for treatment of opportunistic infections.

Despite this increase in domestic funding, Cambodia's HIV response remains heavily reliant on external sources of funding at 83% in 2015. The USG remains the largest bilateral contributor to the HIV response in Cambodia and The Global Fund is the largest overall contributor in the HIV sector on an annual basis. When taken together, these two development partners contribute 70% of the total resources for HIV, including 89.6% of costs for ARVs, and all test kits and lab reagents. The PEPFAR program contributes significant assistance to the Global Fund program through active engagement in the Country Coordinating Committee (CCC) and technical working groups, support to develop and evaluate pilot programs prior to national scale-up, technical assistance to CSOs financed through the Global Fund and assistance in ongoing monitoring of the national program.

In addition to the USG and the Global Fund, other development partners active in Cambodia in the HIV sector include WHO, UNAIDS, and CHAI. Furthermore, there are a number of development partners that work in health systems strengthening, not specific to HIV, including the World Bank (WB), Australian Department of Foreign Affairs and Trade (DFAT), the German Embassy/GIZ/KFW, Korea International Cooperation Agency (KOICA), Japan International Cooperation Agency (JICA), Swedish Development Coorporation, Asian Development Bank and the French Embassy. PEPFAR, leveraging USG non-PEPFAR resources, works in coordination and collaboration with these development partners in the areas of health financing and social health protection, strategic information and health information systems, and supply chain strengthening, to ensure harmonization with these broader health-related efforts.

Table 2.2.1: Investment Profile by Program Area 2015*					
Program Area	**Total Expenditure**	**% PEPFAR**	**% Global Fund**	**% Host Country**	**% Other**
Clinical care, treatment and support	$14,698,992	13.5%	54.2%	23.9%	8.4%
Community-based care, treatment and support	$1,926,302	77.8%	8.8%		13.4%
PMTCT	$1,928,826	23.6%	45.6%		30.8%
HTC	$1,380,388	98.9%	1.1%		
Blood Safety	$827,429	48.2%		51.2%	0.6%
Infection Control	$3,662	100%			
Priority population prevention					
Key population prevention	$5,830,046	63.0%	18.1%	1.3%	17.7%
Laboratory	$3,272,543	9.5%	90.4%		0.1%
SI, Surveys and Surveillance	$1,391,359	66.5%	18.9%	0	14.5%
Health system strengthening (HSS)	$4,357,774	6.9%	7.1%	78.3%	7.7%
Other	$11,247,089	24.9%	50.3%	6.8%	18.0%
Total	**$46,864,409**	**$13,715,250 (29.3%)**	**$19,276,367 (41.1%)**	**$8,188,161 (17.5%)**	**$5,684,631 (12.1%)**

*Expenditures from 2015. Sources: 2015 NASA, NAA.

Table 2.2.2: Procurement Profile for Key Commodities, 2015*					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% Global Fund**	**% RGC**	**% Other**
ARVs	$7,702,571	0	89.6%	10.4%	0
Rapid test kits	$1,165,931	1.0%	99.0%	0	0
Other drugs*	$2,630,860	0.7%	76.7%	22.6%	0
Lab reagents	$493,762	2.3%	97.7%	0	0
Condoms	$571,075	0	0	0	100%
Viral load commodities	$848,259	10.5%	89.5%	0	0
Other commodities	$29,434	62.5%	0	0	35.5%
Total	**$13,441,892**	**$147,683 (1.1%)**	**$11,316,757 (84.2%)**	**$1,394,340 (10.4%)**	**$582,113 (4.3%)**

Table 2.2.3: USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$5.5M	$1.1M	4	$1.1M	Outcomes #1, 2
USAID TB	$5.0M	$2.8M	4	$1.1M	Outcomes #1, 2
USAID Malaria	$4.5M	0	0		
USAID FP	$5.0M	$1.4M	4	$1.1M	Outcomes #1, 2
Total			**4**	**$1.1M**	

Table 2.2.4: PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
PEPFAR Central Initiatives						
KP Challenge Fund	$0			1	$0	KPCF will finish this year
Global Fund CCI	$88,770			0	$0	GF CCI funds will be used to finalize GFL position through end of year.
Sustainable Financing Initiative	$1,000,000	$0	1	1	$400,000	
Injection Safety PPP	N/A	N/A			$0	The injection safety PPP will be ending this fiscal year.
Stigma Collaborative	$100,000	$0	0	0	$0	
TOTAL	**$1,100,000**	**$0**	**1**	**1**	**$650,000**	

2.3 National Sustainability Profile

Since the 2015 SID, the RGC, in collaboration with key stakeholders has taken a number of measures towards a more sustainable HIV response. In addition to the increasing HIV contributions described in section 2.2, the government increased the health portion of the national budget from six percent to eight percent and made health a national priority. In response to declining external funding and the desire to be more self-sufficient, the National AIDS Authority established a Sustainability Technical Working Group (TWG) and developed an investment case. NCHADS, with TA from CHAI and PEPFAR, completed a costing analysis of implementing Test and Treat nationwide. The government delivered its first year payment of their 3 year commitment for ARVs to UNICEF, the Global Fund procurement agent. The government also agreed to cover salary costs of their staff responsible for management and implementation of the Global Fund-funded grant activities. Government health facilities have taken on the management of the Health Equity Fund, with many facilities being reimbursed through HEF for PLHIV consulting fees. The logistics management information systems (LMIS) feasibility study led to the MOH's decision to upgrade its current system and make it web-based to reduce drug/ARV expiry and stock-outs.

In December 2016, an inter-ministerial consultation put forth a set of initial concrete actions for increasing RGC's engagement in the management and financial support of the national HIV, TB, and malaria programs, all of which are largely funded by the Global Fund and other donors to date. These initial agreements were further confirmed in an official letter from the Minister of Economy and Finance to the Senior Minister, Chair of the National AIDS Authority, documenting the following:

- Agreement of the Ministry of Economy and Finance (MOEF) to stand as a candidate for the next Chair of the CCC and Principal Recipient for the next Global Fund grant cycle;
- Agreement that MoEF would act as Principal Recipient as a signatory represting RGC in signing the financing agreement with the Global Fund; with the implementation of the grants delegated to the Ministry of Health;

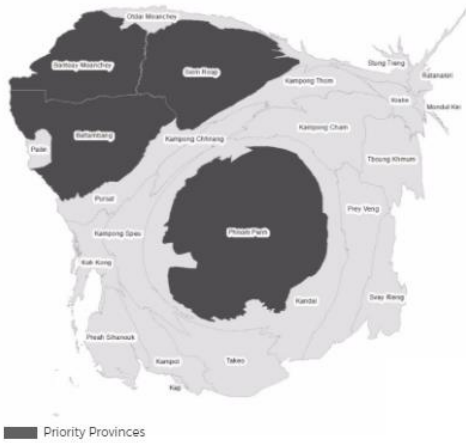
- Agreement to use national budget ($1.1M/year) for contract officials' engaged in managing Global Fund activities' salary and travel costs; and
- Agreement to allocate an annual earmark for counterpart funding ($1.5M/year) for the purchase of ARV drugs.

The above agreements demonstrate MOEF's initial interest in more direct engagement with Global Fund processes and in the Global Fund funding flowing through the standard government system, versus the current parallel system, evolved from interest to concrete action. To expedite this, in November 2016, the CCC requested TA from PEPFAR to conduct a brief study to review potential future funding flow options. Preliminary findings have been discussed with preferred options identified. While more work is needed to fully define exact roles and responsibilities between MOEF, MOH and the national programs, this is a step towards sustainable financing as well as towards greater accountability and ownership for the HIV program by both MOH and MOEF.

All civil society HIV activities are currently externally funded. Given the decline in donor funding, the financing of civil society remains a key challenge to sustainability of the national response.

2.4 ALIGNMENT OF PEPFAR INVESTMENTS GEOGRAPHICALLY TO DISEASE BURDEN

Figure 2.4.1: Cartogram for Cambodia



COP15 and COP16 aligned PEPFAR activities more closely with the burden of disease in Cambodia through a deepened engagement in six of 25 provinces. In COP17 PEPFAR Cambodia plans to pivot further by eliminating all site-level support, and focusing on supporting NCHADS to scale up priority activities nationally. Recognizing that implementation of new activities requires phasing, PEPFAR has decided that 4 provinces Banteay Meanchey, Battambang, Phnom Penh, and Siem Reap, will be PEPFAR "priority provinces" (Figure 2.4.1). These four provinces have the greatest estimated number of PLHIV and are 4 of the top 5 provinces with the greatest estimated number of new HIV infections (Table 2.4.1) . These provinces also account for 73% of estimated key populations of MSM, TG, EW and PWID, 47% of PLHIV, 41% of estimated new infections, and 21% of estimated ART need. Activities that require phased implementation will be started in these provinces, which will allow NCHADS to gain experience in advance of national scale up while at the same time having maximum impact on reaching national-level targets.

It is expected that the government, with technical assistance from PEPFAR Cambodia staff and TA partners at the national level, will be able to rapdily scale up activities from the four PEPFAR priority provinces to reach national scale.

Table 2.4.1: Key data for Cambodia by Province						
Province	**Est # PLHIV 2016**	**Est # new infections 2016**	**# ART clients Q4 2016**	**% of PLHIV on ART**	**# on ART if 90/90 goals met**	**# new ART clients needed to reach 90/90 goals**
Phnom Penh	15,583	76	18,322	117.6%	12,622	NA
Siem Reap	6,692	55	4,283	64.0%	5,421	1,138
Battambang	6,643	71	5,071	76.3%	5,381	310
Banteay Meanchey	4,754	39	3,516	74.0%	3,851	335
Kandal	4,380	20	3,927	89.7%	3,548	NA
Kampong Cham	4,028	39	2,766	68.7%	3,263	497
Prey Veng	3,676	24	2,565	69.8%	2,978	413
Takeo	3,425	29	1,817	53.1%	2,774	957
Kampong Speu	2,804	37	1,786	63.7%	2,271	485
Tbong Khum	2,442	28	1,414	57.9%	1,978	564
Sihanouk Ville	2,376	17	1,894	79.7%	1,925	31
Pursat	2,089	24	1,233	59.0%	1,692	459
Svay Rieng	2,088	17	1,340	64.2%	1,691	351
Kampong Thom	1,925	29	942	48.9%	1,559	617
Kampot	1,730	20	2,091	120.9%	1,401	NA
Koh Kong	1,318	9	924	70.1%	1,068	144
Kampong Chhnang	1,283	13	784	61.1%	1,039	255
Oddor Meanchey	977	13	434	44.4%	791	357
Kratie	781	8	573	73.4%	633	60
Stung Treng	566	5	378	66.8%	458	80
Pailin	441	4	376	85.3%	357	NA
Preah Vihear	312	5	279	89.4%	253	NA
Rattanakiri	272	4	140	51.5%	220	80
Mondulkiri	103	2	21	20.4%	83	62
Kep	53	2	67	126.4%	43	NA
Total	70,741	590	56,943	80.5%	57,300	7,195

2.5 STAKEHOLDER ENGAGEMENT

PEPFAR Cambodia is committed to regular, in-depth engagement with a broad range of stakeholders. At the start of COP17 planning, PEPFAR Cambodia and NCHADS co-facilitated a formal consultation with broad stakeholder participation. The USG team presented on guidance provided by S/GAC for COP17, the overarching strategy for PEPFAR Cambodia and data from COP15 APR. Input from stakeholders stressed the importance of finding undiagnosed through peer driven interventions (PDI+), gaining a better understanding of risk factors, moving away from site support to provincial level support, scaling up of pilots or innovations, activities for people who inject drugs, and the need to ensure harmonization and alignment between Global Fund and PEPFAR. This input has been systematically addressed in COP17 development. The PEPFAR team also shared the draft SDS document with stakeholders for input prior to submission to the in-country Ambassador for endorsement.

On a regular basis the PEPFAR team engaged with the host country government, Global Fund, other health development partners, civil society and the private sector through existing coordination structures such as the Global Fund CCC and national TWGs on HIV, Health Partners' Meetings and Government-Donor Joint TWG on HIV/AIDS. During the regular meetings of these existing platforms, the PEPFAR team provided updates on COP development and implementation.

The PEPFAR team is heavily engaged with NCHADS and Global Fund in the consultative process of developing the next HIV funding requests, which are due in May 2017. The team has endeavored to ensure that COP17 activities are aligned with the Global Fund and other development partners. The USG team will remain highly active in the CCC and other coordination mechanisms over the coming cycle to ensure smooth implementation of both COP17 and Global Fund-funded activities.

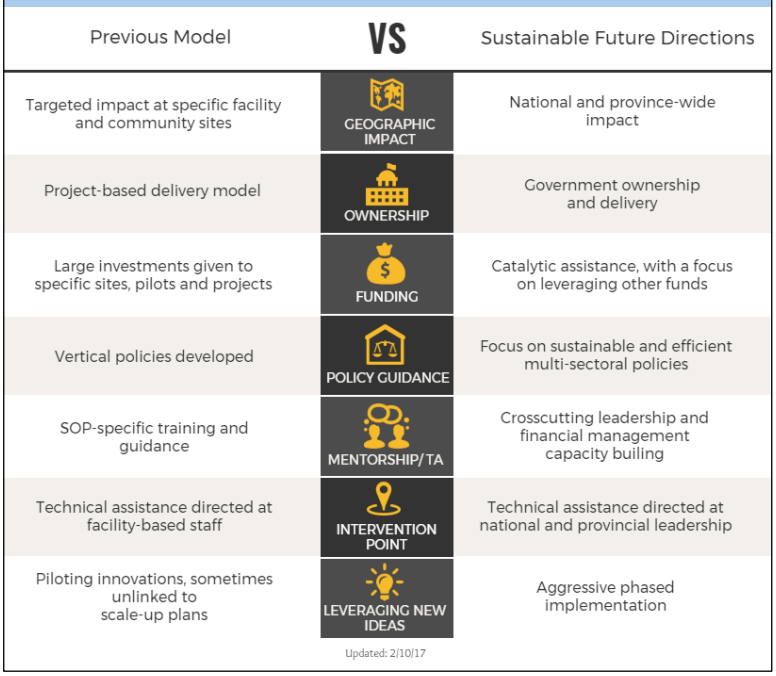
USG staff participated in a number of engagements with civil society partners, all of which were led by the national HIV program. These engagements have included discussion of the Community Action Approach for B-IACM and the revision of the community outreach strategy. Furthermore, USG has provided support to building capacity of key populations' engagement in Global Fund and PEPFAR processes through an activity funded jointly with Global Fund.

3.0 PROGRAM ACTIVITIES FOR EPIDEMIC CONTROL

While Cambodia has achieved significant success in the HIV response over the past 25 years, there remains much to be done in order to achieve the goal of sustained elimination of new HIV infections. Achieving this goal requires a simultaneous, multidimensional approach that works towards addressing many, if not all, of the remaining barriers. While some specific investments may seem modest, they are all critical in order to ensure that the transition from HIV control to sustained elimination is achieved.

The PEPFAR Sustainability Position Statement has outlined four areas deemed critical for a sustain able HIV response: enabling environment, services, systems, and resources. The barriers faced by the Cambodia HIV program range across all four of these areas and include: unclear impact of decentralization of governance to provincial levels; limited influence over the private sector; lack of long-term funding transition plan; significant structural and legal barriers (including discrimination and stigma) which discourage key and priority populations from using HIV services; inconsistent provision of high-quality, efficient HIV services; vulnerable vertical programming with rising chronic disease burden within an already weak health system; inadequate profiling of new cases to allow strategic targeting of testing services; HTS policies that are insufficiently focused, promoted and implemented to find the remaining undiagnosed; inadequate forecasting; weak and fragmented logistics management systems resulting in inefficiencies and

Figure 3.0.1: PEPFAR Cambodia: How We Work
"What got us here will not get us there"



leakages; limited ability to use strategic information (SI) systems and service delivery data for program planning and implementation; increasing cost of case identification; an insufficiently compensated and poorly prepared health workforce; insufficient quality of laboratory management functions and services; and inadequate integration of KP prevention efforts into the national HIV response.

While these barriers are all important, PEPFAR needs to use its limited reesources to have maximum impact in bending the curve of the epdimic more aggressively downwards by focusing on the issues of increasing domestic financing, case finding, and use of granular data

In order to best address these barriers, PEPFAR is further refining its operational modalities to maximize impact. As shown in Figure 3.0.1, a number of tactical adjustments are being undertaken in our operational modalities.

3.1 DESCRIPTION OF STRATEGIC OUTCOMES

3.1.1 Strategic Outcome 1: Sustainable financing from the Cambodian government that has increased by 100% over 2 years using 2015 NASA as a baseline

Now that Cambodia has become a lower-middle income country, it must be prepared to meet the demands of its emerging economy and to address systemic challenges that make progress fragile. National health priorities include: universal health coverage (UHC) through social health protection schemes; modernizing government systems; decentralizing funding flows and program oversight; more efficient health spending; and sustaining critical health services, particularly understanding how to ensure donor dependent vertical health programs such as HIV can be made sustainable. Currently, the MOEF, with TA from development partners, is developing the architecture of institutional arrangements and policies that will establish a social protection framework and pave the way for UHC aimed at reducing catastrophic medical expenditures.

In 2016, the MOH, with co-funding from the World Bank and pooled donor funding, began the Cambodia Health Equity and Quality Improvement Project (H-EQIP) to support the third Health Strategic Plan. H-EQIP fully institutionalizes the Health Equity Fund and provides performance-based financing to health facilities, PHDs and ODs.

PEPFAR will support Cambodia to pursue sustainable financing for its HIV response, including accelerating the allocation of domestic resources for HIV through three overall components including:

1. Development and implementation of a national HIV Sustainability Strategy for domestic resource mobilization;
2. Mobilizing domestic resources for commodities and services to support achievement of 90-90-90 goals; and
3. Improving efficiency and effective use of available resources for HIV.

These strategies will be achieved through COP-funded activities as well as complimentary activities through the Sustainable Financing Initiative (SFI).

In 2016, the government made strides toward increased domestic resource mobilization for HIV/AIDS including completing an investment case, and helping guarantee domestic government funding for positions previously paid for by the Global Fund and an ARV earmark request for $1.5 million annually. These critical decisions move the HIV program towards greater financial sustainability; however, there is still a need for a long-term strategy to further transition support for the HIV response to the government. Through direct engagement of USG

staff and targeted TA, PEPFAR will engage with government, development partners and civil society through the newly-formed HIV Sustainability TWG to develop and implement a national HIV Sustainability Strategy for domestic resource mobilization. PEPFAR will work with NAA and UNAIDS to stimulate stakeholder engagement around the strategy and undertake an updated Sustainability Index and Dashboard exercise to understand trends and identify additional challenges towards sustainability. PEPFAR will also conduct the National Health Accounts and analysis of HIV expenditures to further track progress toward increasing domestic resource allocations for HIV.

In support of the HIV Sustainability Strategy, PEPFAR technical staff will actively engage government and development partner working groups and lead policy dialogue to advocate and provide technical guidance for increased government financing for HIV activities and services. PEPFAR will also conduct analyses, advocacy efforts and generate evidence to mobilize domestic resources for HIV services and ensure coverage of HIV services by HEF and social health insurance schemes. PEPFAR TA will conduct further critical financial and actuarial analyses that will pave the way for long-term government financing and inclusion of HIV in social health insurance and support the channeling of HIV funding through government financial systems. PEPFAR will also conduct analysis of HIV beneficiaries (KP and PLHIV) coverage by and use of HEF and other health insurance schemes, increasing the number of health facilities where HEF reimburses PLHIV transportation costs, and conducting activities that will lead to sustained, incremental increases in ARV funding by the government. PEPFAR will provide TA to facilitate the approval and roll-out of a costed HIV service package within the Health Equity Fund and other social health insurance schemes. PEPFAR will also support the continued expansion of HEF coverage to all poor PLHIV and inclusion of PLHIV in the patient management and registration system (PMRS) of facilities with ART clinics to increase government revenues that can be used to fund HIV services. CSOs and community workers play a critical role in the HIV response but have been historically supported by the Global Fund and PEPFAR. In support of services to reach 90-90-90, PEPFAR will work with government and civil society to develop an investment case, policy analysis and transition strategy to advocate for domestic resources for civil society and community workers.

Complementing activities to mobilize additional resources for HIV, PEPFAR will also help to find cost efficiencies to reduce the overall cost of the HIV program. To help access performance-based financing provided by the H-EQIP Project, PEPFAR will provide TA to integrate HIV into quality assessment tools and assist health facilities in the four PEPFAR priority provinces to strengthen hospital management and leadership to improve the quality of HIV services. PEPFAR will continue to provide TA to MOH for an enhanced, integrated LMIS that reduces product loss and wastage and therefore increase government confidence in the value of increasing government contributions. The development and piloting of this strengthened LMIS, that will for the first time include ARVs and HIV test kits, is being funded through Global Fund with TA from WHO, PEPFAR and USG non-PEPFAR sources. PEPFAR will also work with the MOEF and MOH to ensure that ARVs and commodities are procured within competitive international pricing. PEPFAR will also collaborate with NCHADS and MOH to explore approaches for sustainable HIV service delivery such as within a chronic disease model.

The government recognizes that one crucial step toward mainstreaming HIV financing is to better harmonize funding for HIV service delivery, currently provided by the Global Fund, with other sources of funding for the health system. PEPFAR commissioned an options analysis to explore alternative avenues of HIV/AIDS funding through the Global Fund, away from

vertical grants and towards a more sustainable approach. Current Global Fund funding flows and management structure also go against government policies and have inefficiencies that do not maximize the use of dwindling resources for HIV. The MOEF has expressed a willingness to take on the PR role, which would result in an important paradigm shift that will allow HIV/AIDS funding to flow through standard government channels. In addition, PEPFAR will provide TA to MOEF and MOH as they operationalize revised financial flows for HIV funds. The channeling of Global Fund funding to CSOs working at the community-level and limited clinical sites is also being discussed.

3.1.2 Strategic Outcome 2: Strengthened national systems for:

• Aggressive case finding to identify 6,000 undiagnosed PLHIV and link to treatment

• Use of granular data to rapidly identify and respond to new infections and programmatic gaps across the cascade

Finding undiagnosed PLHIV is of critical importance as Cambodia strives to reach the first 90 by 2020 and the first 95 by 2025. As noted earlier (Figure 2.1.1), the risk factors associated with the majority of newly identified PLHIV are not yet known. Such information becomes increasingly important as the country approaches virtual elimination, as the remaining cases are more likely to be hidden or hard to reach with standard programmatic interventions. Current challenges in Cambodia in finding undiagnosed cases include failure of the traditional outreach worker model to reach and test those at highest risk, and therefore find new cases, persistent stigma and discrimination towards key populations that discourages their use of HIV testing services, and inadequate HIV information systems which limit understanding of the epidemic. At the same time, there is a tremendous opportunity to scale up other approaches to case finding, including provider initiated testing and counseling, index-case based testing, and the use of recency assays to identify ongoing chains of infection.

Therefore, in COP17 PEPFAR will prioritize the following above-site activities to achieve Strategic Outcome 2:

- Sustained improved capacity for use and visualization of granular data for decision-making at national, provincial, and district levels
- Optimize targeted PITC to increase capture of PLHIV coming through facilities
- Optimize index case testing (including partner notification) to facilitate finding networks of undiagnosed PLHIV
- Development of a system for rapid recency testing into routine clinical practice for more effective index case based testing
- Optimize community-based activities in support of B-IACM that aggressively find new cases through social networking, contact tracing and other targeted approaches, link them to treatment and support health facilities in approachs as follow-up activities

Support includes development, dissemination, and capacity building for revised policies, guidelines and SOPs and using data to improve implementation.

In addition, in COP17 PEPFAR will be working at the national level to find undiagnosed cases of HIV. As noted earlier, Cambodia's Community Action Approach strives to improve strategies to identify PLHIV in key and other priority populations, and B-IACM aims to track individuals across the cascade. PEPFAR will provide TA to the RGC in the implementation of the Community Action Approach for B-IACM to identify and reach undiagnosed cases through a TA project, LINKAGES. These community oriented activities will work hand-in-hand with

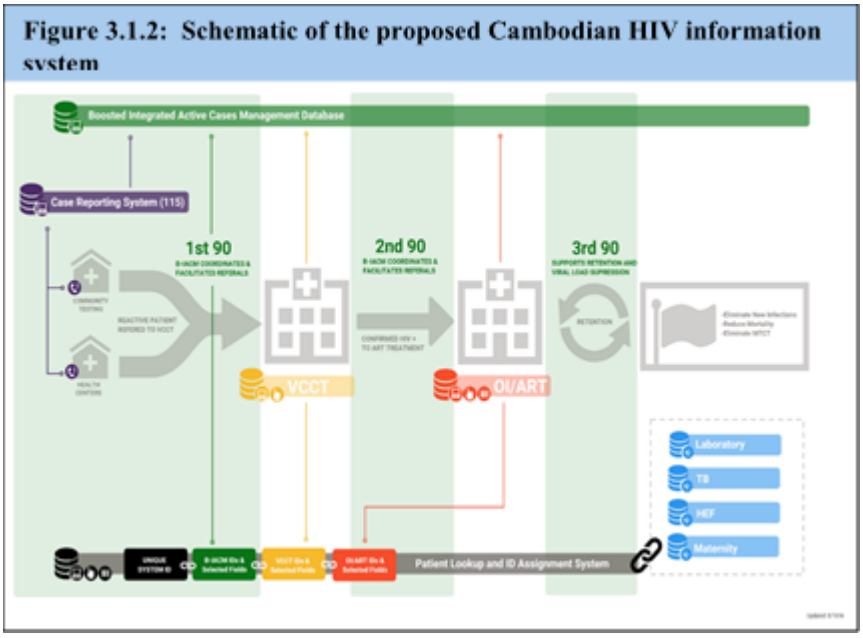
other PEPFAR technical assistance aimed at strengthening NCHADS capacity to oversee facility-based systems to intensify case finding.The LINKAGES project will provide TA to finalize and scale up the Community Action Approach through building a system of data-driven adaptive management that allows flexibility in refining SOPs to accelerate case finding, links to enrollment and retention.

Technical support at the provincial level will also be provided to organizations implementing the Community Action Approach to accelerate case detection, partner notification and index tracing, link newly diagnosed to HIV treatment, and support ART adherence and retention. PEPFAR will provide technical support to better establish and track granular information by age, by sex and specific risk factors to identify community networks, individuals and venues where there is known HIV transmission. Other proven intervention to be scaled up include HIV self-testing, virtual contact and leveraging of popular social media platforms to promote/facilitate testing for undiagnosed cases.

Key to increased testing among undiagnosed will be the reduction of stigma and discrimination at the health facility and in the community. PEPFAR will provide TA for the training of healthcare workers in stigma and discrimination free services that will include sexual orientation and gender diversity, KP-competent services and care for KP victims of gender-based violence. PEPFAR will collaborate with NCHADS, the provincial HIV program authorities and CSOs to demonstrate effective approaches to partner notification, index tracing and testing.

In addition to this work, it remains critical for PEPFAR to build on work from COP16 to strengthen HIV strategic information systems. In COP16, PEPFAR supported NCHADS to develop a vision for a national HIV information system that would allow the program to track individuals throughout the cascade (Figure 3.1.2). Work to develop the national strategic information structure and a model for site level HIV information systems is currently underway, including incorporation of HIV reporting into the existing communicable disease mobile-phone case reporting system (which was originally developed with non-USG funding), a patient lookup and ID assignment system to link the various HIV databases to each other and allow interconnectivity with other programs, and a VCCT line-listed database to allow enhanced understanding of the differences between clients infected with HIV and those not infected. These modifications, once fully rolled out, are expected to improve tracking of patients through the cascade and provide guidance for evidence-based HTS strategies. In addition, PEPFAR's support has contributed to efforts to scale-up the system for hospital registration identification assignment, contributed to a national evaluation of how to move

Figure 3.1.2: Schematic of the proposed Cambodian HIV information system



towards a unique identifier for health, supported improvement of annual reporting by the Department of Planning and Health Information (DPHI), and developed minimum standards for health information to improve interoperability.

Therefore, in COP17, PEPFAR plans to move to the next level of support for robust HIV information systems that are interconnected with a stronger health information system. To strengthen the broader health information platform, PEPFAR Cambodia will work both with partners and with government to manage and operationalize HMIS and a national unique health identifier system as it transitions from USG partner support to full and sustainable national ownership.

In addition, in order to strengthen national capacity to conduct research previously supported largely by development partners, PEPFAR will work to strengthen National Institute of Public Health (NIPH) capacity for country-owned ongoing evaluation of adaptive implementation to improve case finding and sustained elimination.

Key to improving effective and efficient HIV case finding will be PEPFAR's support to partner notification to ensure that at least 50% of partners are tested by the end of year 2 of the biennial COP cycle in PEPFAR-supported provinces. PEPFAR will collaborate with NCHADS, the provincial HIV program authorities and CSOs to demonstrate effective approaches to partner notification, tracing and testing.

3.2 Site Level (Rationale, Geographic and Population Prioritization)

In COP17, in keeping with the strategic shift to above site activites that can be taken to national scale through phased implementation, PEPFAR will not provide any site level support.

3.3 Critical Above-Site Systems Investments for Achieving Sustained Epidemic Control

Because the overwhelming majority of PEPFAR Cambodia's activities are intended to build a sustainable nationally-owned HIV response that can attain and sustain virtual elimination, critical above-site systems investments have already been discussed in detail in section 3.0.

3.4 Description of How PEPFAR Will Support Greater Sustainability

As is clear from the PEPFAR Cambodia strategy (shown in Figure 1.1), the overarching priority of the PEPFAR team is to promote greater sustainability of the national HIV response. Section 3.0 above outlines in detail how PEPFAR supports a focused and coherent approach to sustainability.

4.0 MANAGEMENT AND STAFFING CONSIDERATIONS

PEPFAR Cambodia has a team which provides high quality technical assistance and support to Cambodia. A number of key shifts were made in COPs15/16 to ensure the team was focused on areas of greatest need for the sustainable elimination goal. This includes adjusting the SI Advisor position to ensure a significant level of effort on long-term capacity building within the national program, the repurposing of the HIV Prevention Advisor to support sustainable systems, and the consolidation of the Global Fund Liaison and the PEPFAR Coordinator. For COP17, the team reviewed and ensured that all staffing is aligned to the overall PEPFAR strategy and the specific outcomes. While there are no staff that are seconded

specifically to any national entities, a large portion of staff time is dedicated to providing TA to the national program. As the Cambodia program pivoted from epidemic control to elimination, the need for USG TA has intensified. PEPFAR staff actively participate on national TWGs, donor coordination groups and the Country Coordinating Mechanism in order to encourage innovation and the adoption of best practices and policies. Staff also provide direct assistance with the development and revision of national HIV guidelines and SOPs, the provision of technical guidance and direction through active involvement in program decisions, including encouraging the use of novel and evidence-based approaches to accelerate progress.

For CDC, all funding to government partners is coupled with intensive technical support by CDC staff. Significant staff time is spent with the national program and in the field at the province and operating district levels, co-facilitating training workshops, undertaking joint monitoring and supervision visits with national staff to sub-national units, providing hands-on coaching and mentoring of laboratory staff, and building management capacity and oversight through participation on government procurement and human resource selection committees for supplies and personnel funded by PEPFAR resources. In COP17, CDC will increasingly focus on its 'cascade of TA' approach whereby CDC staff strengthen the national level and provincial levels to not only implement quality services, but to become mentors and TA providers to their subordinate levels (national to provincial, provincial to operating district, etc.).

In addition to the technical assistance and participation in HIV national fora mentioned above, engaging and building critical relationships with the MOEF and leading donor working groups related to HIV financing is a key area for USAID staff. USAID staff time dedicated to HIV financing and domestic resource mobilization has increased significantly as the RGC formulates its social protection framework and policies that include HIV and health. USAID is the lead technical assistance agency and contributes significant time on the feasibility work, implementation plan and developing specifications for the enhanced LMIS, which will for the first time include HIV commodities.

With COP17, the total amount of funding toward PEPFAR's cost of doing business has increased. This increase is a result of an increase in the ICASS charges as well as local staff salary increases that went into effect in 2016. Additionally, CDC will be purchasing one new vehicle during the COP period and undertaking critical technology upgrades. Given the importance of maintaining a strong USG voice within the national program to continue to advocate for sustainability, innovations and adoption of policies towards 90-90-90, and 95-95-95, it is likely that the PEPFAR staffing footprint will remain constant for the medium term, with PEPFAR staff declining at a more gradual rate than the funding provided to partners.

APPENDIX A

A.1 PLANNED SPENDING IN 2018

Table A.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$US 91,571	**$US 10,908,429**	**$US11,000,000**

Table A.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$98,639
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$201,268
IDUP	Injecting and Non-Injecting Drug Use	$5,189
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$2,339,684
HBHC	Adult Care and Support	$138,584
PDCS	Pediatric Care and Support	$30,228
HKID	Orphans and Vulnerable Children	$0
HTXS	Adult Treatment	$1,255,407
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$105,608
HVTB	TB/HIV Care	$0
HLAB	Lab	$463,620
HVSI	Strategic Information	$1,207,059
OHSS	Health Systems Strengthening	$2,341,552
HVMS	Management and Operations	$2,721,595
TOTAL		**$10,908,429**

A.2 Resource Projections

The first step for calculating COP17 resource needs was to come to agreement on critical activities needed to achieve the strategic outcomes. The second step was to establish a process for allocation of budgets by activities and implementing mechanisms. As PEPFAR is a targeted assistance country without large scale service delivery activities, the PBAC tool was not useful in budget setting. In addition, with six new awards starting in COP17, and a significant shift away from site level support towards greater above-site work, the expenditure analysis data from FY2016 was of limited use for budgeting. In addition, given that most targets were dropped for COP17, there was no way to do any target-based budgeting.

Therefore the team reviewed a number of data sources to set budget figures. Historic budget and EA figures were one input used for continuing activities, including those that would shift from IMs that were ending to new IMs. For activities that were being significantly changed, or were new, the components of each activity were costed. For example, activity budgets were constructed based on whether they were expected to include: training; equipment/furniture; travel/transportation; personnel; other supplies; or other recurrent costs. Activity

Managers/Project Officers considered these inputs to allocate reasonable budget figures for each activity in the FOIT tool. The interagency team then reviewed the proposed activity budgets, along with the overall implementing mechanism budgets and allocation to program areas and budget codes, to ensure that allocations were reasonable and consistent with the prioritization of activities.

The activity budget setting was an iterative process between Activity Managers/Project Officers and the interagency team. At agency discretion, the activity budgets were then shared with existing implementing partners for review, discussion and agreement. Given that there are six new awards being undertaken as part of COP17, these new implementing mechanisms could not have a budget allocation check with partners.

For continuing mechanisms, the current monthly burn-rate and pipeline was reviewed to ensure implementing mechanisms would not be building up pipeline and that new allocations were sufficient to cover anticipated monthly expenditures for the implementation period.

APPENDIX B: FOCUSED OUTCOME AND IMPACT TABLE

See separate Excel document

Focused Outcome and Input Table (FOIT)
Cambodia

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome 1: Sustainable financing from the Cambodian government that has increased by 100% over 2 years using 2015 NASA as a baseline							
Systems: Governance (including policy)	TA to incorporate HIV services into MOH's performance-based financing and strengthen hospital management and leadership to increase domestic resources for HIV services, increase efficiency and improve outcomes	At least 50% of health facilities with ART clinics in the 4 PEPFAR-supported provinces receiving H-EQIP performance-based incentives	At least 50% of health facilities with ART clinics nationwide recieving H-EQIP performance-based incentives				$450,000
Systems: Governance (including policy)	Foster financial management, leadership and program management skills to improve efficiences	Leadership and management syllabus and approach developed	Training undertaken in 4 PEPFAR-supported provinces				$75,000
Systems: Health Financing	Continue TA to improve and complete roll-out HIV service package within the Health Equity Fund and other social health insurance schemes	90% of facilities with ART centers being reimbursed for HIV services through HEF and other social health insurance schemes	100% of facilities with ART centers being reimbursed for HIV services through HEF and other social health insurance schemes				$200,000
Systems: Health Financing	In collaboration with MOEF conduct actuarial analyses to determine the long-term financing requirements of HIV services under social health insurance schemes	Analytical report and costing completed and shared with RGC; agreed upon recommendations initiated	1-2 key recommendations from the report implemented with the RGC				$150,000
Systems: Health Financing	Provide intensive TA to MOEF and MOH to create and operationalize a financial flow model for HIV funds (including GF resources) using government systems	Operational model with metrics for revised HIV funding established and approved by the MOH and MOEF initiated	Year 1 results measured and model adjusted as needed				$200,000
Systems: Health Financing	TA support to conduct an investment case, analyze the policy environment and develop an HIV CSO and community health worker domestic financing strategy and implementation plan that moves away from GF and PEPFAR financing	Government and key stakeholders develop investment case and initiate implementation of CSO domestic financing strategy	Government agreement to fund HIV CSOs and community health workers				$250,000
Systems: Strategic information	Support DPHI and NCHADS to increase enrollment of HIV patients into PMRS and HEF for the purpose of increasing domestic resources	50% of HIV+ patients registered in PMRS in 4 PEPFAR-supported provinces	70% of HIV+ patients registered in PMRS in 4 PEPFAR-supported provinces				$80,000
Systems: Supply chain and essential medicines	TA to pilot, evaluate and scale up an enhanced, integrated MOH LMIS, including ARVS, to reduce wastage and increase efficiencies in support of increased DRM	Develop and pilot an updated, integrated LMIS	LMIS pilot assessed, refinements made to LMIS, and MOH approval for national scale up				$350,000
Other: specify in activity description	Develop options for sustainable HIV service delivery within a chronic disease model, in collaboration with MOEF and MOH	TOR and SOW developed and foundational research started	white paper developed on models				$30,000
Systems: Supply chain and essential medicines	TA to MOH and MOEF on efficient commodity pricing	options analysis for procurement options	ARVs produred within acceptable international competitive pricing (from SID)				$124,429
Systems: Health Financing	TA to increase transport cost reimbursement for HIV services to health facilities with ART clinics.	25% increase of facilities reimbursing for patient transport costs over baseline	50% increase of facilities reimbursing for patient transport costs over baseline				$200,000
Systems: Health Financing	Funding for National Health Accounts (NHA)	development of protocol and data collection for NHA	compile, analyze and produce NHA report for 2016/2017				$350,000

Focused Outcome and Input Table (FOIT)
Cambodia

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome 2: National systems are able to: Use aggressive case finding to identify 6,000 undiagnosed PLHIV and link to treatment; Through the use of real-time granular data, rapidly identify and respond to new infections and programmatic gaps across the cascade to maintain epidemic control							
				POPULATION ESTIMAT_NAT/SUBNAT HIV PREVALENCE ESTIMATE_NAT/SUBNAT PLHIV ESTIMATE_NAT/SUBNAT KP ESTIMATE_NAT/SUBNAT DIAGNOSED_NAT TX_CURR_NAT/SUBNAT VL_SUPRESSION_NAT (& subnat)		# of sites with satisfactory PT results Coverage, #, yield of HTC testing through community action, PMTCT, STI, TB, and other strategies Condom use among KP HIV prevalence among KP % of new PLHIV whose partner knows their HIV status % of newly identified PLHIV with identified risk % of ART facilities implementing the unique ID system % of ART facilities implementing VCCT electronic system % of ART facilities implementing ART electronic system % of HMIS queries responded to by DPHI # of units implementing the B-IACM dashboards # labs with ISO accreditation	
Service delivery and quality improvement: general population	Accelerate scale up of B-IACM to improve case finding and elicitation of risk	Risk of infection identified in 50% of newly identified PLHIV	Risk of infection identified in 75% of newly identified PLHIV				$231,207
Systems: Laboratory	Support NCHADS capacity around facility and community POC testing quality assurance and laboratory strengthening to support accurate HIV diagnostics for sustained elimination	all HTC sites in 2 PEPFAR-supported provinces are participating in HIV related diagnostics quality assurance programs	All HTC sites in all 4 PEPFAR-supported provinces are participating in HIV related diagnostics quality assurance programs				$335,000
Systems: Laboratory	Support the national referral laboratories to develop robust laboratory quality management systems and finalize attainment of ISO accreditation to support accurate HIV diagnostics for sustained elimination.	Over 80% of facilities meet proficiency standards for HIV confirmatory testing in 2 PEPFAR-supported provinces	Over 80% of facilities meet proficiency standards for HIV confirmatory testing in 4 PEPFAR-supported provinces				$115,000
Systems: Strategic information	Build DPHI capacity to implement new national health unique identifier system to allow tracking of patients through the cascade.	At least 50% of HIV facilities implementing the unique ID system	At least 80% of HIV facilities implementing the unique ID system				$220,000
Systems: Strategic information	Complete transition HMIS to DPHI and ensure quality of HIV data	DPHI responds to 100% of technical queries on HMIS	Will end in year 1				$100,000
Systems: Strategic information	Strengthen NIPH capacity for country-owned ongoing evaluation of adaptive implementation to improve case finding and sustained elimination	Ongoing evaluation of risk elicitation to revise HIV screening strategy	Ongoing evaluation of risk elicitation to revise HIV screening strategy				$135,000

Focused Outcome and Input Table (FOIT)
Cambodia

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Strategic information	Support NCHADS to assess and operationalize data systems for active case reporting, outbreak identification and investigation, linked electronic HIV data systems, and interoperability with other health information systems to move from aggregate to line listed data	Revised HIV SI system rolled out in 2 PEPFAR-supported provinces	Revised HIV SI system rolled out in 4 PEPFAR-supported provinces				$100,000
Systems: Strategic information	Improve capacity for use and visualization of granular data for decision-making at national, provincial, and district levels to make best use of intensified case detection data and identify programmatic gaps	develop SOPs and implement in 2 PEPFAR-supported provinces	implemented in all 4 PEPFAR-supported provinces				$90,000
Service delivery and quality improvement: general population	Optimize targeted PITC to increase capture of PLHIV coming through facilities	50% of referral hospitals (CPA3) implementing optimized PITC	100% of referral hospitals (CPA3) implementing optimized PITC				$120,000
Demonstration site: general population	Optimize index case testing at facilities, including counseling related to partner notification and linkage to community, to facilitate finding networks of undiagnosed PLHIV	50% of newly identified PLHIV for whom index testing is conducted in 4 PEPFAR provinces	80% of newly identified PLHIV for whom index testing is conducted in 4 PEPFAR provinces				$174,000
Other: specify in activity description	Complete and use findings from case control study to accelerate finding undiagnosed cases and risk elicitation	Completion and dissemination of case control study; Targeted approaches updated	Risk of HIV infection identified in 75% of newly identified PLHIV.				$75,000
Other: specify in activity description	Development of a system for rapid recency testing into routine clinical practice for more effective index case based testing	SOP developed. Rapid recency testing of newly identified PLHIV being used routinely in 2 PEPFAR-supported provinces	Rapid recency testing of newly identified PLHIV being used routinely in 4 PEPFAR-supported provinces				$70,000
Service delivery and quality improvement: general population	Adapt continuous quality improvement (CQI) systems to optimize case finding and identify programmatic gaps across the cascade	streamlined CQI approach conducted in 2 PEPFAR-supported provinces	streamlined CQI approach conducted in all 4 PEPFAR-supported provinces				$100,000
Service delivery and quality improvement: general population	Assist NCHADS to finalize and scale-up the Consolidated Community Action Approach for B-IACM (CAA) framework building in a system of data driven adaptive management that allows flexibility in refining SOPs to accelerate case detection, links to enrollment, and retention outcomes.	National CAA SOPs, guidelines, provincial training package, including job aids, data analysis and assessment tools developed; Training conducted in 4 PEPFAR provinces.	NCHADS and PEPFAR Provinces analyze community-based HTC data and identify challenges. Findings used to refine CAA SOP to increase HTC volume and yield. Nationwide scale up of revised CAA SOP.				$575,000
Service delivery and quality improvement: key populations	Support NCHADS to improve targeting and profiling and accelerate new case detection through the rapid scaling up of cost-effective interventions such as social networking (PDI, snowballing), HIV self testing, and use of social media	Cost-effective models for case detection developed and phased implemention in 4 PEPFAR provinces	Operational challenges from initial scale up of case detection identified and used to refine models and inform policy SOPs for nationwide implementation.				$500,000

Focused Outcome and Input Table (FOIT)
Cambodia

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Other: specify in activity description	TA for contact tracing and partner notification at the community level, based on identified case indexes from the facility, in order to identify undiagnosed and link them to HIV treatment	Cost-effective models for case detection among PPs developed and phased implemention in 4 PEPFAR provinces; National case detection increased by 20%	Operational challenges from initial scale up of case detection identified and used to refine models and inform policy SOPs for nationwide implementation; National case detection increased by 50%.				$600,364
Service delivery and quality improvement: key populations	Adapt guidelines for stigma and discrimination free services, including GBV and KP-competent services, develop training material and conduct TOT for public HIV services to increase case detection and retention	Stigma and discrimination-free skills, including KP-competency, checklist adapted and curriculum completed and approved; Training of HIV health providers implemented in 2 high burden provinces with participants representing all HIV service sites in the province; Quality of training assessed	Skill building curriculum adjusted based on initial training experience and training scaled up in 4 additional provinces, ensuring coverage of the 4 PEPFAR-supported provinces. Competency of participants from year 1 and client satisfaction assessed.				$400,000
Systems: Laboratory	Technical staff to strengthen national/provincial laboratory capacity and case finding						$0
Service delivery and quality improvement: general population	Technical staff working to strengthen HIV case finding and program gap analysis						$0