Scaling Up Towards Universal Access

to HIV Prevention, Treatment, Care, and Support




Cambodia Country Report

February 2006

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NATIONAL AIDS AUTHORITY

Cambodia Country Report on Scaling Up Towards Universal Access to HIV Prevention, Treatment, and Care & Support

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TABLE OF CONTENTS

LIST OF ANNEXES

Acronyms

100% CUP	:	100% Condom Use Programme
AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Ante-Natal Care
ART	:	Anti-Retroviral Therapy
ATS	:	Amphetamine-Type Substance
BCC	:	Behaviour Change Communication
BSS	:	Behavioural Surveillance Survey
CBO	:	Community-Based Organisation
CoC	:	Continuum of Care
DSW	:	Direct Sex Workers
FBO	:	Faith-Based Organisation
GFATM	:	Global Fund to Fight AIDS, Tuberculosis & Malaria
HBC	:	Home-Based Care
HIV	:	Human Immunodeficiency Virus
HSS	:	HIV Sentinel Surveillance
IDSW	:	Indirect Sex Workers
IDU	:	Injecting Drug User
IEC	:	Information, Education & Communication
M&E	:	Monitoring & Evaluation
MDG	:	Millennium Development Goals
MoCR	:	Ministry of Cults & Religions
MoEYS	:	Ministry of Education, Youth & Sports
MoH	:	Ministry of Health
MoLV	:	Ministry of Labour & Vocational Training
MoND	:	Ministry of National Defence
MoRD	:	Ministry of Rural Development
MoSVY	:	Ministry of Social Affairs, Veterans & Youth Rehabilitation
MoWA	:	Ministry of Women's Affairs
MSM	:	Males who have Sex with Males
NAA	:	National AIDS Authority
NCHADS	:	National Centre for HIV/AIDS, Dermatology & STI
NGO	:	Non-Government Organisation
NSP II	:	National Strategic Plan for a Comprehensive & Multisectoral Response to HIV/AIDS 2006-2010
OD	:	Operational District
OI	:	Opportunistic Infection
OVC	:	Orphaned & Vulnerable Children
PLHA	:	Person Living with HIV/AIDS
PMTCT	:	Prevention of Mother-to-Child Transmission
RGC	:	Royal Government of Cambodia
SSS	:	STI Surveillance Survey
STI	:	Sexually Transmitted Infection
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNGASS	:	United Nations General Assembly Special Session
VCCT	:	Voluntary & Confidential Counselling & Testing
WHO	:	World Health Organisation

Executive Summary

In Cambodia, a national consultation on universal access was held on February 7, 2006, with participation from representatives from government, civil society, the donor community, and other stakeholders. The results of this consultation were distilled into a country report that was presented at a regional consultation held in Pattaya, Thailand on February 14-16. This document refines the initial country report, in line with the recommendations that arose from the regional consultation.

The challenges facing Cambodia in scaling up towards universal access to prevention, treatment, care and support are two-fold: (1) increasing the coverage of prevention, treatment, care and support services; and (2) sustaining the financial and technical support necessary for large scale programmes and effective social services. Most of the elements that are critical to move from planning to concrete actions are in place: vigorous political and institutional commitment to respond to the epidemic; an effective prevention campaign that has reduced HIV prevalence; a strong health sector response based on the continuum-of-care model; access to financial resources from international and bilateral mechanisms; and the active involvement and participation of civil society.

To ensure prevention access, the coverage of evidence-based outreach programmes that have proven to be effective in reaching most-at-risk populations (DSW, Uniformed Services) must be scaled and expanded. The scaling of targeted interventions for other high-risk populations (IDSW, MSM, IDU/ATS users and mobile populations) will be facilitated by establishing national estimates of population size, prevalence, incidence, and patterns of risk behaviour among MSM, IDU and mobile populations through the collaboration of the government and civil society and the allocation sufficient resources by development partners. Increasing the coverage and access to VCCT and PMTCT services must be done concurrently with quality assurance efforts and continued attention to health systems strengthening, for example, strategies for cooperation between services (HIV/STI, TB, MCH, mental health). Maintaining a high level of quality and making these services 'friendly' and acceptable to various population groups will encourage uptake of these services.

Spousal transmission accounts for 43% of all new infections in Cambodia. Women need to have a range of choices and alternative strategies to protect themselves from HIV. This in part can be achieved by access to education for girls and expanding economic opportunities to women. Effective implementation of laws and policies that protect women's rights will help reduce women's vulnerability to HIV/AIDS. Addressing gender stereotypes and inequities with young people, through the education system will help ensure that future generations are gender-sensitive.

The strengthening, expansion and full integration of CoC into the health care delivery system is the clearest manifestation of a scaled up treatment and care access response. Achieving this, however, depends on continued efforts to rehabilitate public health infrastructure. There is a need to devise effective ways to recruit, train and retain health and social welfare workers in the public sector, including rectifying the inadequacy of civil service salaries through public administration reforms such as the MBPI, merit-based recruitment practices and performance management principles, all embraced under the Ministry of Health incentive reform scheme proposal.

To reduce stigma and discrimination, the greater involvement, representation and participation of PLHIV in advocacy, programme planning, implementation, monitoring and evaluation at all levels must be increased and strengthened. Advocating for scaled up introduction of workplace policies is one way of cultivating a supportive social and legal environment for PLHIV, which will also benefit other at-risk groups such as sex workers, IDU, MSM, and migrants, contributing in the fight against their social and legal exclusion. Care and support initiatives must strive to promote an environment where ethical, legislative and normative activities conform to the highest standards of civil and human rights and protect the privacy and dignity of individuals.

Scaled-up OVC/impact mitigation efforts must include adequate coverage of programmes that provide psycho-social and economic support to OVC, affected families and people living with HIV. Assessing the impact of HIV/AIDS on non-health

sectors such as education, labour and rural development is essential to provide a basis for the development of appropriate strategies to address the impact of HIV at the sectoral level. To take OVC and impact mitigation work to scale nationally, the following steps will be taken:

- Establish a National Steering Group on OVC/Impact Mitigation, with MoSAVY as the lead organisation, with concerned departments in MoE, MoWA, MoL, MoC&R, MoI formally appointed to the NSG. The NSG will be accountable for the following actions in 2006:
    a. Conduct national assessment for OVC/Impact Mitigation including mapping, review of existing policies, strategies and size estimation;
    b. Develop a National Operational Framework, taking account of policies, legal framework and guidelines including a minimum package for OVC with key accountabilities/responsibilities for each partner - NSG to organise meetings with key relevant partners to harmonize partner roles and responsibilities (INGOs, NGOs, and Development Partners) of each stakeholder;
    c. Develop and implement a joint work plan.

The operational framework must include advocacy to development partners to support integrated approaches for impact mitigation in local and national development programming.

Working towards universal access to HIV prevention, treatment, care and support requires not only a coordinated national response but also coordinated monitoring and evaluation. A national M&E framework has been built into the national strategic plan, setting clear 5-year targets and proposing a mechanism for monitoring progress against the national strategic plan. To accomplish this, the capacity of institutions to effectively monitor their programmes must be enhanced. The research agenda of the NSP II needs coordination from either NCHADS or NAA. Strategies that will help translate surveillance data into programmes and policies must be developed, including the dissemination of monitoring, evaluation and research findings to a wide audience. Systems for tracking resource flows (domestic and ODA) also need to be established as part of the national M&E system.

Looking into the future, strategies are required that will address HIV/AIDS as an endemic disease. This can be done initially by ensuring that HIV/AIDS and its concomitant issues are integrated into development documents, plans and programmes and in the health sector, to continue utilising the CoC model as a platform for strengthening health systems to addressing a range of chronic diseases. Ministries that have developed work plans related to HIV/AIDS are faced with a lack of financial resources to translate these plans into actions. To address this, standards could be developed for allotting a specific percentage of line ministries' budget for HIV/AIDS activities. The private sector must also be encouraged to invest in HIV/AIDS activities within companies, subsequent to the introduction of workplace policies.

Scaling up towards universal access, an introduction[1]

In the four years since UN Member States made a Declaration of Commitment on HIV/AIDS at the 2001 Special Session of the UN General Assembly, the global AIDS response has steadily grown and gained momentum. World leaders have now committed to "developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it".

This momentum has occurred within wider efforts to place countries more firmly in command of their own development programmes. The establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Bank's Multi-country AIDS Program, and the increased bilateral assistance from high-income countries are just some of the global responses to date. Civil society advocacy, special pricing by pharmaceutical companies for low-income countries, increased generic competition and local production, and negotiations facilitated by philanthropic foundations have slashed the prices of first-line antiretroviral medicines and increased their availability. The 3 by 5 initiative, launched by WHO and UNAIDS, has built on these developments to catalyze and mobilize support for national AIDS programmes to expand access to treatment. Increased funding has also been mobilized for research and trials of vaccines, microbicides and other new technologies. A renewed emphasis on the importance of HIV prevention has reinforced the clear imperative that scale up of the AIDS response must be comprehensive.

Based on the above, UNAIDS is facilitating a multi-partner effort, driven by the countries themselves, to scale up towards universal access. The process aims to identify solutions to the key obstacles that are blocking comprehensive and integrated scale up of prevention, treatment, care and support services and to develop nationally agreed, targeted plans or 'roadmaps' for building significantly greater coverage of services by 2010.

The universal access process was not launched in a vacuum. The World Summit and G8 commitments provide an opportunity to leverage additional action to reach the Millennium Development Goal (MDG) on HIV/AIDS. The process thus builds on a continuum of efforts to better help countries as they scale up their AIDS responses in a sustainable manner integrated with wider development efforts. Countries drive the process of scaling up towards universal access. However, this effort is taking place simultaneously at several levels: national, regional and global. Breaking through the obstacles to universal access requires a multi-pronged approach, linking country-level realities to regional and global-level opportunities. UNAIDS has been requested by the UN General Assembly to present an assessment on the process at a comprehensive review and high-level meeting regarding progress achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS on June 2006.

In Cambodia, the national consultation was held on February 7, 2006, participated by representatives from government, civil society, the donor community, and other stakeholders. The results of the national consultation were distilled into a country report that was presented in the regional consultation held in Pattaya, Thailand on February 14-16. This document refines the country report, in line with the recommendations that arose from the regional consultation.

[1] Excerpted from The Road to Universal Access (UNAIDS, January 2006).

Overview of the Cambodian HIV/AIDS epidemic[2]

According to the 2003 HIV surveillance data released by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS) in December 2004, the estimate of the national prevalence of HIV stands at 1.9% of all people aged 15 to 49 years, down from 2.2% in 2001. In all sentinel groups that formed part of the HIV surveillance system, the decline in HIV prevalence is evident. Levels of awareness about HIV/AIDS have gone up, and behaviour has changed. The prevalence among ante-natal care (ANC) attendees declined from 3.2% in 1997 to 2.1% in 2003. Even among sex workers prevalence decreased from over 40% to 20.8%.

Cambodia's mature epidemic, however, continues to be the most serious in the region. Almost half of new infections are now among married women. One third of new infections occur from mothers to children. As long as the epidemic is generalised, the risk of a rapid resurgence as soon as risk behaviours increase remains. Relatively small but significant groups appear to be severely affected. Small scale surveys have shown that males who have sex with males (MSM) and heroin injectors have a high prevalence of HIV (14-15% and 37-45%, respectively), along with other sexually transmitted infections (STI). White-collar workers, amphetamine-type substance (ATS) users, park-based sex workers, truck drivers were also identified as emerging groups at risk to HIV.

Condom use in brothels is higher than ever before, and fewer men visit sex workers. A more conscientious use of condoms appears to be mounting, although recent evidence suggests low condom use among young people[3]. Ninety-six percent of brothel-based sexual transactions are protected. Forms of sexual networking, meanwhile, are changing. Men increasingly turn to indirect sex workers and sweethearts for sex, with whom they are less likely to use a condom. Indirect sex workers (including freelance and park-based sex workers) are more likely to deny involvement in sex work and are consequently difficult to reach. Decriminalisation of risk behaviours is mixed: although sex work remains illegal, special permission is granted to sex workers to participate in the 100% Condom Use Policy (CUP). Male-to-male sex is not illegal, but highly stigmatised.

Uptake of PMTCT is low, largely due a lack of access to basic health and social welfare services of most Cambodians. The rural poor, who live farthest from health centres and in areas with low service coverage, are significantly disadvantaged. Only one third of the population has access to the minimum package of health services, and only one in ten births takes place in a health facility. Of the estimated 500,000 pregnant Cambodian women per year, only 48.6% ever attend ANC at least once.

Every day, more people with HIV become sick and join the ranks of those needing care and support. The number of adults with HIV/AIDS was estimated at 123,000 in 2002, plus 21,000 young children. Of those infected, 19,814 AIDS patients need medical care, a serious burden for the Cambodian health care system whose capacity is only 8,500 in-patient beds. Family livelihood is severely affected as more families, spouses and children are left behind due to the death of a breadwinner. Each day, fifty Cambodians die due to the consequences and complications of AIDS. There may be as many as 77,000 orphans and vulnerable children (OVC) in Cambodia, and thousands of families whose main providers are either ill or dead.

Poverty continues to drive men to leave their families and wives, and women to sell sex in order to make ends meet. There is increasing rural to urban migration by people in search of economic opportunities, among them many young women who work in garment factories and young men who work in construction. Gender inequities persist to fuel the sexual transmission of HIV. Condom negotiation within marriage is not acceptable for women, and a culture of masculinity tolerates men who have multiple sexual partners. Cases of rape are often settled out of court while survivors themselves are often stigmatised. Violence or coercion is often used to force women into commercial sex work. For sex workers, violence is commonplace. Gang rape carried out by groups of men on park-based sex workers or those whom they perceive as 'easy women', is also a real danger.

[2] Excerpted from the 2005 Situation & Response Analysis of the HIV/AIDS Epidemic in Cambodia (NAA, August 2005).
[3] Cambodia National Youth (11-18 years) Risk Behaviour Survey, MoEYS, September 2004

National response to the epidemic[4]

Since the first HIV and AIDS cases in the country were identified in 1991 and 1994 respectively, steps to curb the spread of HIV/AIDS have been immediate. Government ministries, primarily the Ministry of Health (MoH) and several non-government organisations (NGOs), initiated programs and projects to raise awareness and educate various population groups. The National AIDS Program of the Ministry of Health was reconstituted and expanded into the National Centre for HIV/AIDS, Dermatology and STDs, and a National AIDS Authority was created with a mandate for ensuring that the response expanded beyond the health sector to a multi-sectoral approach. This approach is reflected in both national strategic plans on the HIV/AIDS response.

Nearly all ministries, international and local organisations, with the support of donors, have implemented HIV activities (e.g. MoH/NCHADS) or have begun to integrate HIV/AIDS-related interventions in their policies and work plans. Prevention interventions are common to almost all government agencies and organisations, followed by activities in treatment and care, and in impact mitigation. The development of policies and strategic plans has taken place as well, at the national and provincial levels, and in various ministries and non-government organisations.

To date, most interventions have tightly focused on prevention. This has resulted in a wide and creative array of approaches and activities that relate to increasing levels of knowledge about the epidemic in specific population sub-groups and in the general population. Present interventions include peer education and outreach, condom promotion and social marketing, employing IEC, and the 100% Condom Use Program among groups with known high-risk behaviour. For care and treatment, the Continuum of Care and a host of programs and projects addressing the health care needs of PLHA are already in place. What remains are strengthening and scaling up to expand coverage and facilitate greater access to these services and facilities. In impact mitigation, various types of support are provided by Home-Based Care teams run by NGOs, CBOs, and FBOs and by some government agencies to OVC and families affected by HIV/AIDS. The most prominent national needs for impact mitigation are assessing and reducing the impact of HIV/AIDS on economic development and designing and implementing interventions in key sectors.

At the national and provincial levels, policies and strategies have been developed, HIV/AIDS is gradually being integrated in national and sectoral development plans, and a National AIDS Law has been promulgated, together with a Code of Conduct to guide its implementation. However, translating these into everyday reality that will positively impact on the epidemic remains a challenge. It is widely recognised that tracking and understanding the epidemic is essential. However, programme monitoring is still largely done to meet donor needs, while research and evaluation efforts are poorly coordinated. The national strategic plan has identified indicators with which progress against the plan will be monitored. There remains a clear need for a system for collating, interpreting and effectively disseminating the data for these indicators. A national operational research agenda needs to be developed to ensure that evidence is available to inform new strategies that may be required to address current and future trends in the epidemic.

Rational decentralisation of the national response to improve and further build local management and coordination by provincial, district and commune authorities remains a challenge. Comprehensive integration of HIV/AIDS management and decision making into the provincial Rural Development Committees and structures like the provincial and district joint facilitation teams will assist this process.

[4] Excerpted from Mapping Cambodia's Response to HIV/AIDS (UNAIDS Cambodia, July 2005).

Obstacles and recommended actions for key thematic areas

Advocacy and political commitment

Obstacles:

At the national and provincial levels, policies and strategies have been developed, HIV/AIDS has been integrated in national development plans, and a National AIDS Law has been promulgated. Translating these policies and strategies, however, into tangible gains that will improve the lives of the infected and affected people remains a challenge. High level government officials' public support for HIV/AIDS must move beyond words into increased assistance to the national AIDS coordinating body and relevant government agencies at both national and local levels.

Recommended actions:

1. Scale up introduction of workplace policies.
2. Increase and strengthen the greater involvement, representation and participation of PLHA in advocacy, programme planning, implementation, monitoring and evaluation at all levels.
3. Espouse a supportive public policy environment that will reduce stigma and discrimination.
4. Assess HIV/AIDS-related policies and operational plans within line ministries and provide assistance where necessary.
5. Increase the capacity for effective leadership in HIV/AIDS response across all sectors of society (government, private & civil society).

5-year targets:

1. 25% of large employers have HIV/AIDS workplace policies and interventions
2. 70% of respondents say that an HIV (+) female teacher who is not sick should be allowed to continue teaching in 2010.
3. Evidence of supportive AIDS policies (UNGASS AIDS Composite Policy Index).
4. 100 Commune Council leaders, Vice Governors and Secretaries of State actively engaged in national and provincial planning and dialogue
5. 90% of ministries actively participating in at least 10 NAA Technical Board meetings each year.

Sustainable financing, harmonization, and programming

Obstacles:

Sustained financial resources for scaling up responses can be accessed through international sources but the absorptive capacity of institutions is limited by inadequate capacity to program resources. The past 5 years have seen a considerable increase, expansion and scaling up of community-based interventions that has not been matched with national-level efforts.

The impact of HIV/AIDS on non-health sectors like education, labour, and rural development has not been adequately assessed. Because of this, there is no joint sectoral operational framework covering key ministries that are clearly mandated to address OVC/impact mitigation, such as Ministry of Social Affairs Veterans and Youth Rehabilitation (MoSVY), Women's Affairs (MoWA), Education Youth and Sports (MoEYS), Rural Development (MoRD) and Labour and Vocational Training (MoLV).

Recommended actions:

1. Direct international and local funds to health and social service systems strengthening, e.g. human resource and relevant support structures.
2. Ensure a coordinated and comprehensive response in the health sector, which includes other MoH departments, provinces and NGOs.

3. Establish a National Steering Group on OVC/Impact Mitigation, with MoSAVY as the lead organisation, with concerned departments in MoE, MoWA, MoL, MoCR, MoI formally appointed to the NSG. The NSG will be accountable for the following actions in 2006:
    a. Conduct national assessment for OVC/Impact Mitigation including mapping, review of existing policies, strategies and size estimation;
    b. Develop a National Operational Framework, taking account of policies, legal framework and guidelines including a minimum package for OVC with key accountabilities/responsibilities for each partner; NSG to organise meetings with key relevant partners to harmonize partner roles and responsibilities (INGOs, NGOs, and Development Partners) of each stakeholder;
    c. Develop and implement a joint work plan.
4. Advocate to development partners to support integrated approaches for impact mitigation in local and national development programming.

5-year targets:

1. 8 ministries that are actively implementing an HIV/AIDS plan, as per their sectoral strategy
2. 30% of households with OVC are accessing livelihood opportunities
3. Assessment of OVC undertaken and used for policy formulation & programme planning
4. 70% of OD with at least 1 organization providing care & support to households with OVC
5. 5 sectoral impact assessments undertaken & disseminated
6. 50% of provincial & district development strategies address HIV/AIDS

Human resources, health systems, and infrastructure

Obstacles:

Human resource development and retention in the public sector is a challenge for the Ministry of Health. The health, education and social welfare sectors simply do not have enough trained and skilled staff to ensure 100% service coverage. Training programmes on several topics are available to health workers through the MoH or NGOs but there is little supervision and monitoring afterwards.

Low government salaries affect performance and promote high staff attrition rate. Majority of the health care in Cambodia occurs outside the government system. Only 18.5% of the population utilizes public systems. Rehabilitation of health infrastructure and systems remain key priorities of the MoH but this is hampered by a low national health budget.

Recommended actions:

1. Recruit, train, and retain health, education, and social welfare workers in the public sector.
2. Cultivate a supportive government policy. Increase access to quality training institutions and adequate placements within the health and social service sector.
3. Build on the lessons of the Continuum of Care model and its links to related health services to inform the social sector response.
4. Integrate responses into other current development programmes. Utilising and strengthening existing structures and systems is more productive and resource efficient than trying to set up new ones.
5. To ensure universal access in paediatric care:
    a. Integrate paediatric AIDS Care within the Continuum of Care as a priority;
    b. Rationalise procurement procedures for civil works development through outsourcing to credible private sector enterprises to expedite expansion of new sites. These would be especially supported by UNICEF, UNAIDS and WHO;
    c. Lessons learned in 2006 to inform scale up of paediatric HIV care in 2007.

5-year targets:

1. 100% of Operational Districts with Continuum of Care
2. 50% of provincial and district development plans address HIV/AIDS
3. Evidence of supportive AIDS policies (AIDS Composite Policy Index)

Human rights, gender equity, and enabling environment

Obstacles:

In 2002, 42% of new HIV infections were transmitted by husbands to wives. Though more men are currently infected than women, the latter are more vulnerable to HIV/AIDS because they have a low social status, resulting in lower levels of education, fewer economic opportunities, and increased risk for violence and abuse.

Condom negotiation within marriage is unacceptable for women while a culture of masculinity tolerates men to have multiple sexual partners. Consequently, there are very few programmes addressing condom use within relationships (married and otherwise). There is a need to expand programmes that will protect married women in discordant couples.

Recommended actions:

1. Empower women through providing education and expanding economic opportunities. Important topics of learning include reproductive health (HIV/AIDS, STI, and gender equality), condom negotiation skills, and life skills for girls.
2. Utilize other forms of communication (mass media, IEC materials & activities) to disseminate key messages (promoting gender equality, condom use, accessing VCCT, etc)
3. Increase number and coverage of interventions (education, service provision, etc) targeting at-risk men and their female partners.
4. Promote and advocate for the effective implementation of the AIDS Law and other laws & policies that protect/promote women's rights.
5. Work with men and boys to address gender stereotypes, including developing specific services to address male sexual and reproductive health.

5-year targets:

1. 5% of married women report consistent condom use
2. 25-30% of men with multiple sexual partners report consistent condom use

Commodities, services, and partnerships

Obstacles:

Access to some of the most-at-risk populations is limited. There are no national estimates of population size, prevalence, incidence, and patterns of risk behaviour among MSM, IDU and mobile populations. Addressing the needs of these population groups is vital in preventing a second wave of epidemic.

Access to basic health and social welfare services is difficult. Uptake to VCCT has been remarkably high, possibly indicating high levels of awareness of HIV risk and a diminishing of the stigma surrounding HIV. The continued strong uptake of VCCT services suggests that demand may not be being adequately met by current services. In contrast, the uptake of PMTCT remains low. Only 5% of HIV (+) pregnant women were covered by PMTCT. To date, PMTCT centres have covered 26.6% of the estimated annual 500,000 pregnant women. Of this percentage, 11.7% attend pre-test counselling although a slightly lower proportion actually takes the test, at 11.4%. The poor coverage of PMTCT is reflective of the limited availability of basic health care services. Only one-third of the population has access to the minimum package of health services. The rural poor, who live farthest from health centres and in areas with low service coverage, are disproportionately disadvantaged.

Recommended actions:

1. Establish national estimates of population size, prevalence, incidence, and patterns of risk behaviour among MSM, IDU and mobile populations.
2. Expand outreach programmes to those most-at-risk populations currently reached (DSW, Uniformed services) and initiate and take to scale targeted interventions to reach other high-risk populations (IDSW, MSM, IDU/ATS users).
3. Increase VCCT and PMTCT sites (as of 2005, there are 110 VCCT sites and 27 PMTCT sites), with particular attention given to reaching people living in rural areas. With particular regard to PMTCT, the following actions need to be taken:
    a. Lessons learned from Continuum of Care should be used for the expansion of the PMTCT programme and the integration of PMTCT services within the Continuum of Care should be further strengthened;
    b. Establish and pilot equity funds in a select number of CoC sites as a strategy to increase demand by HIV+ pregnant women for PMTCT services. Equity funds will subsidise transport costs and service/user fees. UNICEF and Clinton Foundation would lead efforts to set up pilots, together with the NCMCH and NCHADS. Lessons learned in 2006 to inform scale-up in 2007;
    c. Build capacity of midwives to support the delivery of PMTCT services, at the commune level. UNICEF and UNFPA to play a key role in supporting the Ministry of Health in this work;
    d. Expansion of the roles and responsibilities of the Community and home-Based Care teams and networks of People living with HIV at the CoC level to include to support access and awareness for PMTCT services in rural communities.
4. Promote these services, especially among people with low levels of education.
5. Develop and maintain the quality and availability of these services.
6. Make health services 'friendly' to various population groups, e.g. IDSW, transgendered persons, hidden MSM, etc. by training service providers and improving facilities.
7. The following actions need to be taken to scale up efforts with adolescents and young people:
    a. Interventions should focus on most-at-risk adolescents and children in particular, street children and out of school, including working children under the age of 15. Appropriate departments within the Ministry of Education, Youth and Sports, the Ministry of Social Affairs and Ministry of Labour would work as a sub-sectoral team, with Ministry of Education[5] in the lead role;
    b. Undertake a national assessment (biological/behavioural) of young people and drug use (with special attention on IDU) to inform scaling HIV prevention with young drug users/IDU;
    c. The National Authority against Crime and Drugs (NACD) should play an important role within the Technical Working Group on Drugs and HIV/AIDS led by MoSAVY;
    d. For the in-school youth population, continue to expand life-skills-based HIV and substance use education, including ensuring appropriate capacity development at all levels, with the Ministry of Education, Youth and Sports as the lead organisation.

5-year targets:

1. 98% of DSW and 90% of IDSW report consistent condom use
2. 80% of sex workers outside of 100% CUP
3. 50% of IDUs and ATS users are exposed to HIV prevention interventions
4. 75% of visible MSM are exposed to HIV prevention interventions
5. 50 PMTCT sites offering minimum package of PMTCT services
6. 50% of pregnant women attending ANC classes
7. 200 VCCT sites offering counselling & testing services
8. 45 CoC sites offering
9. 95% of PLHIV have access to CoC (19,000 AIDS patients on ART)
10. 750 HBC teams nationwide
11. 100% of OD (78) have a PLHIV

[5] *Participants to confirm discussions on lead role for this area.*

12. 300 health centres providing HIV testing among TB patients in 2006 with an expansion plan developed in 2007
13. Strengthen logistics and supply management, & monitoring and data management
14. Integrate ARV resistance into HIV/AIDS Surveillance System

The Cambodian road to universal access

The obstacles outlined in this report indicate clearly that the challenges facing Cambodia in scaling up towards universal access to prevention, treatment, care and support are three-fold: (1) increasing the coverage and quality of existing prevention, treatment, care and support services; (2) ensuring the sustained financial and technical support necessary to maintain the strong health sector response and strengthen social systems; and (3) the social exclusion and marginalisation which constrains access to services and support of vulnerable and most-at-risk populations is addressed through the application of the HIV Law , and other legislation like the Law on Domestic Violence to ensure that targeted and other prevention, treatment and care efforts go hand-in-hand with increased access to social and economic opportunities. Scaling up requires continued efforts to expand existing minimum packages of treatment, care and support (CoC) and ensure appropriate prevention packages adequately cover all most-at-risk populations, district-by-district and community-by-community. It is also necessary to measure progress and analyse barriers to implementation on a continuous basis in order to inform effective action. The national strategic plan for 2005-2010 was developed in this manner, building on the successes of the response to date while developing strategies to address with the changing nature of the Cambodian epidemic.

Most of the elements that are critical to move from planning to concrete actions are in place: vigorous political and institutional commitment to respond to the epidemic; an effective prevention response that has reduced HIV prevalence; access to financial resources from international and bilateral mechanisms; and the active involvement and participation of civil society. These will all contribute to the successful implementation of the national strategic plan and help ensure that the response to HIV is sensitive to the changing needs and priorities of the evolving epidemic, in spite of the mentioned challenges.

To ensure a sustained financing of the response, government could consider allotting a specific percentage of line ministries' budgets for HIV/AIDS activities. Ministries that have developed work plans related to HIV/AIDS are faced with a lack of financial resources to translate these plans into actions. The private business sector must also be encouraged to invest in carrying out HIV/AIDS activities within companies, which is a step up from the introduction of workplace policies.

Universal Access for Prevention

To scale up prevention, coverage of outreach programmes that have proven to be effective in reaching most-at-risk populations (DSW, Uniformed Services) must be expanded. The scaling of targeted interventions for other high-risk populations (IDSW, MSM, IDU/ATS users and mobile populations) needs to be informed through work to establish national estimates of population size, prevalence, incidence, and patterns of risk behaviour among MSM, IDU and mobile populations through the collaboration of government and civil society. This work will benefit programme planning and implementation with these populations. Other prevention interventions that urgently require scaling are the blood safety programme, coverage and quality of universal precautions, and prevention in institutional settings such as prisons and orphanages.

Increasing access to VCCT and PMTCT services by expanding service provision will be essential to reach populations; especially HIV+ pregnant women living in rural and remote areas must be done concurrently steps to assure quality of services. As vital elements of the continuum of care model, increasing access to VCCT and PMTCT services is critical in achieving and maintaining the comprehensiveness of services. Maintaining a high level of quality of services and making these services 'friendly' and acceptable to various population groups will encourage uptake of these services. The application of equity funds to subsidise user fees and transportation costs, two major barriers to access for pregnant women (especially rural women) seeking PMTCT services, will be a critical strategy for national scaling of services.

There is a clear need to empower women to control and decide on matters related to their sexuality, so they can protect themselves from HIV infection. This can be achieved by designing a range of alternative prevention strategies to targeted interventions, providing and increasing access to education for girls and expanding economic opportunities to women. There

is a need to develop and implement a range of strategies which reduce women's vulnerability to HIV/AIDS by eliminating all forms of gender-based discrimination and violence. A key strategy is the effective implementation and monitoring of laws and policies that protect women's rights, including the HIV Law and the Law on Domestic Violence. Working with young people through the education system to help them address gender stereotypes and inequities will help ensure that future generations are gender-sensitive and empowered.

Universal Access for Treatment and Care

The strengthening, expansion and full integration of CoC into the health care delivery system is the clearest manifestation of a scaled up HIV/AIDS treatment and care response. Achieving this, however, depends on continuing efforts to rehabilitate public health infrastructure. Continuing efforts (through, for example, public administration reform initiatives like the MBPI) to improve ways to recruit, train and retain health and social welfare workers in the public sector is a priority. There are currently no Nursing and Social Work colleges in Cambodia. Nurses and social workers are important service providers and the lack of institutions and resources to build human resources impedes the effectiveness of the public health system. The salary scale of government service providers needs to be reviewed and revised. These changes are an essential prerequisite for strengthening the health care delivery system to improve the delivery, quality and coverage of its services.

To reduce stigma and discrimination, the greater involvement, representation and participation of PLHIV in advocacy, programme planning, implementation, monitoring and evaluation at all levels must be increased and strengthened. Representation and participation must be given increased attention to prevent tokenism. Advocating for scaled up introduction of workplace policies is one way of cultivating a supportive social and legal environment for PLHIV, which will also benefit other at-risk population groups such as sex workers, injecting drug users, men having sex with men, and migrants, contributing in the fight against their social and legal exclusion. Care and support initiatives must always strive to promote a legal environment where ethical, legislative and normative activities conform to the highest standards of civil and human rights and protect the privacy and dignity of individuals.

OVC/Impact Mitigation

Scaling OVC/impact mitigation efforts must address expansion and coverage of programmes that provide socioeconomic support to OVC and affected families and the strengthening PLHIV networks to engage fully in impact mitigation efforts. Assessing the situation and numbers of OVC and the impact of HIV/AIDS on non-health sectors like education, labour and rural development is an essential requirement for informing national scaling of IOVC/impact mitigation work. This work needs to be carried out under the aegis of a national steering group of key ministries (lead by MoSAVY) on OVC/impact mitigation that will coordinate assessments, guide the development of a national operational framework outlining key accountabilities for all partners and implement and monitor a comprehensive work plan. The operational framework must include advocacy to development partners to support integrated approaches for OVC/impact mitigation in local and national development programming.

Monitoring and Evaluation

Working towards universal access to HIV prevention, treatment, care and support requires not only a coordinated national response but also coordinated monitoring and evaluation. The national strategic plan has identified indicators with which progress against the plan will be monitored. There remains a clear need for a system for collating, interpreting and effectively disseminating the data for these indicators. To accomplish this, the data collection, analysis and utilisation capacity of institutions must be enhanced. Continued support is needed for surveys that monitor the trends of the epidemic, including the demographic and health surveys, regular BSS, HSS, SSS studies, and the passive surveillance system. There is a need to agree to a national research agenda, which requires coordination from either NCHADS or NAA. Strategies that will help translate surveillance data into programmes and policies must be developed along with strategies that will disseminate M&E and research findings to a wider audience.

Looking to the future, strategies that will address HIV/AIDS as an endemic disease must be developed. This can be done by ensuring that HIV/AIDS and its concomitant issues are integrated into development documents, plans and programmes, and through strengthening the capacity of the health sector to treat chronic relapsing conditions.

Resource Requirements

RESOURCE ESTIMATES TO REACH TARGETS BY 2010

Per population groups:

CSW + Clients	:	$5 million
IDU	:	$1.5 million
MSM	:	$140,000
OVC	:	$4 million

Per NSP II Strategy:

Strategy 1 (Prevention)	:	$144 million
Strategy 2 (Care, support & treatment)	:	$143 million
Strategy 3 (Impact mitigation)	:	$18 million
Strategies 4-7	:	$27 million

4. Coordination & implementation
5. Legal & Policy Environment
6. M&E, Research
7. Resource Mobilisation

ANNEXES

NATIONAL CONSULTATION ON UNIVERSAL ACCESS

ANNEX 1. WORKSHOP AGENDA

SCALING UP TOWARDS UNIVERSAL ACCESS
TO PREVENTION, TREATMENT, CARE AND SUPPORT

COUNTRY CONSULTATION
KINGDOM OF CAMBODIA

7th FEBRUARY 2006
CAMBODIANA HOTEL

AGENDA		
Country Consultation Hosted by NAA and NCHADS Overall Goal & Objectives *Goal: To* build consensus on national scaling up towards Universal Access on Prevention, Treatment and Care and Support by 2010. *Objectives*: a) To present the status of the national HIV response, based on the UNGASS review and the National Strategic Plan b) To identify obstacles to universal access in Cambodia, requiring local, regional and global actions c) To determine aspired country outcomes for Cambodia by 2010, utilizing key targets d) To develop a broadly-defined country roadmap for Cambodia		
Co-Chairs of the Consultation: *Dr Teng Kunthy, Director-General (Acting), National AIDS Authority and Dr Mean Chhi Vun, Director, National Centre for HIV/AIDS, Dermatology and STIs*		
Time	Session Detail	Objectives/Outcomes
08.30	Welcome by Co-Chairs Dr Teng Kunthy & Dr Mean Chhi Vun	
08.40	Introduction to Universal Access	This session will provide a broad outline of the concept of Universal Access *Presentation by UNAIDS Secretariat*
08.50	Taking Treatment and Care to Scale Presentation of the national plan for scaling treatment and care to 2010.	This session will provide: 1. An overview of progress and lessons learned in taking treatment and care to scale to date 2. An overview of treatment and care (COC) targets as outlined in the MOH/NCHADS Plan 2004-2007 and reflected in the NSP 2006 – 2010 3. An overview of the scale-up plan for treatment and care (including major milestones, resources required and actions planned to overcome obstacles) *Presentation: Dr Mean Chhi Vun, Director, National Centre for HIV/AIDS, Dermatology and STIs*
09.50	Break	
10.15	Universal Access – Taking Key Prevention Interventions and Impact Mitigation to Scale Overview of current efforts to take prevention to scale: *Most-at-Risk Populations (sex workers, MSM, IDU/drug use)* *PMTCT* *Spousal Transmission* *Impact Mitigation* Sheila, Matt, Tony to provide support to Dr Kunthy for the development of the presentation	This session will provide: 1. An overview of current progress and lessons learned to date, in taking key prevention and impact mitigation interventions to scale 2. An overview of existing prevention and impact mitigation targets outlined in the 2006-2010 NSP *Presentation: Dr.Teng Kunthy, Director-General (Acting), NAA and Dr Mean Chhi Vun, Director, National Centre for HIV/AIDS, Dermatology and*

		STIs
10.45	Taking Key Prevention Interventions and Impact Mitigation to Scale – Identifying Main Obstacles, Critical Actions, Targets *Group work* to develop a "roadmap" which confirms targets and outlines how to reach these targets for: *Most-at-Risk Populations (sex workers, MSM, IDU/drug use)* Facilitators: Ly Penh Sun & Matthew Warner Smith *PMTCT* Facilitators: Chin Sedtha & Gabriella Hok *Spousal Transmission* Facilitators: Bun Eng & Michael De Guzman *Impact Mitigation* Facilitators: Sheila Robinson & Sop heap (Khana)	The objective of the group work session is to develop a road map which: 1. Confirm key prevention[6] and impact mitigation targets for scaling 2. Develop a roadmap showing how these will be achieved, taking into account actions to overcome obstacles, major milestones, taking into account the following areas: • Resources required for scaling • Partnerships • Advocacy • Public Policy • Planning, coordination and harmonization • Sustainable Financing • Organization and Systems • Infrastructure/services
12.00	Lunch	
13.00	Taking Key Prevention Interventions and Impact Mitigation to Scale – Identifying Main Obstacles, Critical Actions, Targets *Group work* session continued	
14.15	Taking Key Prevention Interventions and Impact Mitigation to Scale *Presentation* of Group Work in Plenary for each key prevention area *Most-at-Risk Populations (sex workers, MSM, IDU/drug use)* *PMTCT* *Spousal Transmission* *Impact Mitigation* Note: During the presentations, facilitators (Matthew, Gabriella, Michael and Sheila) to listen for and summarise key points/issues that can be used in the General Conclusions & Recommendations session (Michael to summarise on powerpoint) Presentation Session to be facilitated by: Tony & Sheila	Objective of session: Presentation and discussion of road maps for scaling each key prevention area which include: 1. Targets 2. Obstacles identified 3. Actions to overcome obstacles 4. Major milestones 5. Resources required for scaling based on the 2006-2010 NSP
15.15	Break	
15.45	Taking Prevention and Impact Mitigation to Scale Presentation of Group Work in Plenary continued	
16.15	General Conclusions & Recommendations for Scaling –Up Prevention, Impact Mitigation, Treatment and Care Summary of key recommendations and actions to be taken to achieve Universal Access in Cambodia – facilitated plenary discussion Session to be facilitated by: Tony & Sheila	The outcomes will be a set of recommendations/key actions to be taken to support national scaling up of prevention, treatment, care and impact mitigation. *Dr.Teng Kunthy, Director-General (Acting), NAA and Dr Mean Chhi Vun, Director, National Centre for HIV/AIDS, Dermatology and STIs*
17.00	Wrap Up/Close	

[6] *VCT to be addressed as a cross-cutting intervention*

ANNEX 2. WORKSHOP SESSION GUIDE

SCALING UP TOWARDS UNIVERSAL ACCESS
TO PREVENTION, TREATMENT, CARE AND SUPPORT

COUNTRY CONSULTATION
KINGDOM OF CAMBODIA

7th FEBRUARY 2006
CAMBODIANA HOTEL

GUIDANCE FOR GROUP WORK DISCUSSIONS

Introduction:

The goal of the Cambodia consultation is to build consensus on national scaling up towards Universal Access on Prevention, Treatment and Care and Support by 2010. The objectives of the consultation are as follows:

e) To present the status of the national HIV response, based on the UNGASS review and national strategic planning frameworks
f) To identify obstacles to universal access, requiring local, regional and global actions
g) To determine aspired country outcomes by 2010, utilizing key targets
h) To develop a broadly-defined country roadmap, highlighting key milestones and major interventions required to reach 2010 targets

The outcome of the country consultation[7] will be a country report or "roadmap" that specifically addresses: (i) the status of the national HIV response, (ii) specific obstacles and proposed solutions to scaling up HIV prevention, treatment, care and support, (iii) determination of country targets on prevention, treatment and care and support that they want to reach by 2010, and (iv) outline key milestones and major interventions required to reach 2010 targets.

1. Select a group facilitator and a rapporteur to record and present the outcomes of the group's discussions
2. Use the points listed below to guide the group's discussion and to provide a framework for reporting back to the plenary session

- Review and where necessary revise existing targets for taking the intervention to scale
- Identify obstacles and propose key solutions to mitigate obstacles
- Review resources required and available to 2010 for taking the intervention to scale
- Review partnership requirements to take the interventions to scale (adequate/inadequate; what is required)
- Practical coordination and harmonisation requirements to take the intervention to scale (what is in place, what is not in place and needs to be developed)
- Organisation and systems requirements to take the intervention to scale (what is in place; what is not in place and needs to be developed)
- Infrastructure requirements to take the intervention to scale
- Advocacy and policy requirements to take the intervention to scale (what is in place; what is not in place and needs to be developed)

[7] *The outcomes of the country consultations will be presented at the regional consultations for discussion, and subsequently compiled into a regional report, for use by the Global Steering Committee on scaling up towards universal access. An assessment of this process will be prepared by UNAIDS and shared at the UN General Assembly Review and High-Level Meeting on implementation of the Declaration of Commitment on HIV/AIDS, scheduled for 31 May-2 June 2006.*

ANNEX 3. SUMMARY OF WORKSHOP OUTPUTS

Summary of Workshop Outputs

	Targets	Obstacles	Solutions	Resources	Organizational	Advocacy and policy
MARP	80% of hidden populations	Access Technical capacity of NGOs	Outreach programmes Redefine "indirect" sex work Workplace programme in settings of vulnerability	As identified in costing '05-10: CSW = $9 million IDU = $2 million (excluding substitution) MSM = $30 million	Develop operational framework	Harm reduction exception from article 5 of drug law Advocacy for harm reduction with policy makers and implementers
PMTCT	50 PMTCT sites by 2010 80% of pregnant women will attend ANC in ODs with a PMTCT site	Low coverage of ANC: transport costs; user fees VCCT: weak counseling skills; confidentiality	Subsidize transportation costs Home visits by ANC Strengthen home based care for referral of pregnant women to VCCT Equity funds Mobile VCCT		Integration of PMTCT into health system Strengthen referral systems Strengthen logistics systems Expand salary supplementat'n	Advocacy for equity funds
Spousal Transmis-sion	25-30% condom use by men with sweethearts and couples at-risk	Gender Poverty Low levels of risk perception	Empowerment of women Mass media campaigns Interventions targeting at-risk men		Integration into health promotion and MoWA	Promote ANC Promote HIV Law & other policies and legislation
Impact mitigation	30% of families with OVC access livelihood options		Situation assessment (incl coverage survey and socio-economic impact study) Expanded package of support for OVC and caregivers	7 million '05-10	Integration into rural development and other plans	

Comments:

Operational frameworks needed

Coordination by relevant sectors (implementation issues) and at provincial level

Definition of "at-risk" married couples

Youth and young people- prevention interventions and youth-friendly health services (adolescent services lacking)

MARP Working Group Outputs

<table>
<tr><td>Review and/or revise existing targets</td><td colspan="2">CSW – target defined as condom use rates (outcome) 98% and 90% direct and indirect respectively; 80% coverage of sex workers outside of the 100% CUP (new target); target for % of establishments covered by 100% CUP?

Drug users, with particular emphasis on IDU – 80% coverage of IDU; 80% coverage of problematic ATS users

MSM – 80% of visible MSM</td></tr>
<tr><td>Identify <u>obstacles</u> and propose <u>key solutions</u></td><td>CSW
• Move to “indirect” sex work.
• 100% CUP cannot work with mobile sex workers (i.e. sex outside of sex establishments)
• Hidden population - measurement of population size is difficult; mobility of the population; stigma and discrimination.
• Bong-thoms (pimps) resistant to interventions with indirect CSW (condom possession as evidence of commercial sex)
• Availability of condoms
IDU
• Hidden population (access)
• Technical capacity of local organizations
• Legal environment (article 5 of the drug law- incitement)
• Drug use in institutions (prisons)
MSM
• Access
• Technical capacity
• Stigma- political and social resistance/sensitivity
• Barriers to access sexual health services</td><td>Solutions:
• Revise the case definition for the 100% CUP to include non-brothel sex establishments
• Targeted peer-based outreach programmes
- build trust with CSW and pimps
- work with police
• PSI working with street vendors to increase condom availability (e.g. ice-cream sellers, fruit sellers)
• Workplace interventions for vulnerable settings (e.g. beer gardens and karaoke bars that aren’t established sex venues)

• Peer-based outreach programmes
• Pharmacotherapies
• Increase access to VCCT and ART- remove barriers for drug users

• Peer-based outreach
• Hotline- Inthanou training to deal with MSM queries
• Prevention messages in general prevention interventions (focus on behaviours, not identity)
• Increase accessibility of sexual health services</td></tr>
<tr><td>Review resources required and available to 2010</td><td colspan="2">Human resources: capacity building in use of outreach as a modality to reach hidden populations

CSW
• Resources needs to maintain 100% CUP
• Outreach interventions need to be funded- extension of 100% CUP? NGOs?

Drug use
• Funding needs identified in NSP costing. Potential donors: GFATM round 6 (proposal for comprehensive programme for drug users); AusAID; USAID

MSM
• Funding needs identified in NSP costing for scale-up of existing NGO programmes</td></tr>
</table>

Review partnership requirements	CSW • NCHADS and NGOS • Civilian and military police • ILO • Employers (bar owners) and trade unions (e.g. Hospitality Union) and Ministry of Labour & Vocational Training • Local clinics (RH services) • CSW associations (CPU quite stigmatised- excludes indirect workers) • Local authorities • CPN+ • Mobile and migrant associations Drug users: • NAA and NACD (policy level) • MOH mental health program • Civil society (Khana, Friends etc) • Law enforcement • Link to CoC MSM • NAA (advocacy) • Civil society (FHI, Khana, Care…) • NCHADS - link sexual health services to outreach programmes
Practical coordination and harmonisation requirements Organisation and systems requirements	CSW • Effective communication – use of working groups and other mechanisms, especially donor level coordination • Better information flow from thematic TWGs (e.g. condom use working group, drugs and HIV, UN TG) to JGD-TWG • Coordination at provincial level Drug use • DHA • JGD-TWG
Infrastructure / service requirements	Outreach element of 100% CUP? Reaches indirect & freelance CSW? MoH mental health: treatment and rehab facilities through which to deliver pharmacotherapies Sexual health services- remove barriers for access by MSM VCCT and ART clinics- remove barriers for access by MSM and drug users
Advocacy and policy requirements	Legal clarification of harm reduction and associated practises- HIV Law; drug legislation (“treatment subdegree”) Targeted advocacy of the need for and benefits of harm reduction- policy and operational stakeholders

PMTCT Working Group Outputs

Long term goal: elimination of paediatric HIV infection

With CoC roadmap, what would it take to get universal access to PMTCT services by 2010?

Given target to Increase to 45 sites offering full package CoC/OI/ART (as approved by MOH, PMTCT is included within CoC package)

Review and/or revise existing targets	Existing Targets for 2010 from Nat'l Strategic Plan: - 50 health facilities offering minimum package of PMTCT to be fully linked to CoC services Additional target: - 80 % of pregnant women accessing ANC in districts with availability of CoC/PMTC services
Identify obstacles and propose key solutions	Obstacles: - Low coverage of ANC - Due to distance & transportation costs, user fees, quality not acceptable, understaffing (provider high work load) - Low attendance at facilities for Labor & Delivery - User fees, distance, transport - Women lost to follow up at every stage pre- & post-delivery - VCCT services not routinely offered to pregnant women at service delivery points - Provider counselling skills in VCCT weak - RGOC Policy: yes-Primary training in Midwifery; No-investment not approved for TBAs - Confidentiality concerns of patients - primary prevention for PMTCT: - spouses of high risk men - Other services can be strengthened to serve PMTCT goals - PMTCT Plus (partners, other children, families of HIV+ women) Key Solutions: - Subsidize transportation costs to ANC services - Equity funds - Capacity building and training of caregivers to strengthen skills in counselling & PMTCT service provision - *HIV teams mobile to remote areas—do group counselling & HIV testing- suggested by Dr Vun. Some controversy- no consensus* - Policy considerations by MoH (in shorter term): - to invest in service provider cadres like midwives and TBAs, - to expand where these cadres can work - To encourage/subsidize service providers who go to homes to assist deliveries - Pilot project to assess feasibility of opt-out/routine VCCT at ANC - Support existing networks like Self Help Groups; encourage HIV prevention education at village & commune level - Prior to delivery, HIV+ women receive drugs at ANC site or OI care site to have at home (will need education re: how to take the drugs, need HBC team to follow up with her & prevent loss to follow up)

Review resources required and available to 2010	NSP main resource for establishment of 50 sites is within CoC integrated package—SOP will be finalized soon Gaps in resources relate most to ANC coverage and Labor & Delivery - Equity fund resources can support User fees - Home Based Care resources could be used for transportation subsidies - Exemption fees could help subsidize L&D fees (problem: fees motivate providers to provide services; some donors cannot support fee payments, but would support equity fund at selected sites) - NGO and FBO partners support counsellors at ANC sites & contract to pay user fees for delivery services; further NGO/FBO support for transportation costs under discussion - GFATM awards - Allow options to be selected at the provincial, OD level - HBC to take on additional responsibilities, including management of funds with support of some of existing partners, such as District PLWHA networks
Review partnership requirements	Existing mechanisms: Existing Partnerships are strong and with continued communication and cooperation should be adequate in the near future. Links with care, treatment and support need to be institutionalized in the future to ensure sustainability. Attention needs to be given to urban settings (in particular Phnom Penh)
Practical coordination and harmonisation requirements Organisation and systems requirements	In place: PMTCT Secretariat Requirements: Increased human resources in the Secretariat Dissemination of PMTCT Guidelines renewed coordination and harmonization. Stronger referral systems between PMTCT and CoC sites which are far away from each other. Strengthen laboratory systems and organization. Expansion of performance based incentive schemes. Logistics management needs to be strengthened.
Infrastructure / service requirements	Laboratory infrastructure needs to be strengthened. Develop sustainable sources of water and electricity.
Advocacy and policy requirements	Increased advocacy for equity funds and subsidized user fees by donors. Existing policies are adequate.

Spousal Transmission Working Group Outputs

Review and/or revise existing targets	NSP: 5% of married women report consistent condom use; 69% of married men with casual partners use condoms in marital sex 25-30% of married couples who are at risk report consistent condom use 25-30% of married men with casual partners use condoms in marital sex
Identify obstacles and propose key solutions	Obstacles: CULTURE & GENDER ISSUES; POVERTY; LOW LEVEL OF KNOWLEDGE/PERCEPTION OF RISK; LIMITED ACCESS TO INFORMATION & SERVICES; LIMITED COVERAGE OF SERVICES Solutions: 1. Empowerment of women through education on reproductive health (HIV/AIDS, STI, gender equality); condom negotiation skills, life skills (for young people also). 2. Utilize other forms of communication (mass media, IEC materials & activities) to disseminate key messages (promoting gender equality, condom use, accessing VCCT, etc) 3. Increase number and coverage of interventions (education, service provision, etc) targeting female partners of at-risk men. 4. Increase number and coverage of interventions (education, service provision, etc) targeting at-risk men.
Review resources required and available to 2010	Female partners of at-risk men are not identified as a vulnerable group Recommendation: Female partners of t-risk men should be singled out as a vulnerable group.
Review partnership requirements	Donor Community/ NCHADS/ NAA/ NGOs/Civil Society Line Ministries (MoH; MoND; MoSVY; MoWA; MoI; MoCR; MoEYS, MoPWT; MoInf; Local Authorities Recommendation: Existing partnerships should be strengthened.
Practical coordination and harmonisation requirements	No proper coordination mechanism in place. Spousal transmission is not frequently discussed in the present TWG (prevention, mobility, etc). Recommendation: Set up a proper coordination mechanism (form a TWG on spousal transmission); or Increase focus on spousal transmission in the discussions of the present TWGs (prevention, mobility, etc).
Organisation and systems requirements	Recommendation: Integrate prevention messages/services into existing health services packages being provided by government & NGOs (e.g. integrating prevention messages for married couples in HBC; including positive prevention for discordant couples through SHG of PLHAs)
Infrastructure / service requirements	Recommendation: Utilize existing government & NGO structures (national networks, provincial, OD, NGOP networks) in integrating health services for married couples.
Advocacy and policy requirements	Recommendations: Promote and strengthen ANC services. Promote and advocate for the effective implementation of the AIDS Law and other laws & policies that protect/promote women's rights. Utilize mass media in doing advocacy work.

Impact Mitigation Working Group Outputs

1. Issues to consider
   - definition of impact mitigation
   - populations covered under impact mitigation: vulnerable children, abandoned children, PLHA, household (family members), foster parents and communities
   - social and psychosocial support
   - lack of coordination
   - how PLHA families on ART cope in the long term: look at sustainable livelihoods; how do destitute families (breadwinners who died, those who are very sick and getting into ART) put lives back together?

3. Review NSP targets (Strategy 3)- largely endorse the targets
   - 30% families accessing livelihood options

Package of interventions	WHEN	Obstacles	Solutions	Outputs
Situation assessment of OVC	2006 to 2007	Who's going to do it – partners? Funds?	Steering group: MOEYS, MOSVY, MOWA (?),MOH, NCHADS, UNICEF (provide funds), WFP, NGOs, etc.	▪ System recommendations ▪ Policies ▪ Plans with costs ▪ Resource allocation framework
Coverage survey			Now taking place	
Socio-economic assessment			Now taking place	
Expanded package of home and community based care and support for PLHA, including OVC (PLHA, families with members on long term ART or those with chronically ill members). Coordinated provincial and managed at OD level	2007 onwards	▪ Clarify definitions (e.g. home care versus community care) ▪ Lack of agreement on definition of packages/ coordination ▪ How implemented in the ground depends on resources and capacity of NGOs even if there are national guidelines ▪ Lack of linkages between other development efforts and implementers ▪ Insufficient/inconsistent budgetary incentives for health centre staff ▪ Lack of standard cooperation agreements at local level ▪ Development NGOs not sufficiently	▪ Start a technical working group on impact mitigation (national and provincial) ▪ Expand provincial level coordination of HBC activities; organized by KHANA and PAO staff hired in 6-7 provinces (BTB, SR, etc) which meet monthly ▪ Complementary/ supplemental budget for health staff ▪ Guidance from situation assessment ▪ Use COC or PRDC as entry point for coordination among key sectors (?)	▪ Local plans including coordinating mechanisms ▪ Additional cooperation/ agreements between NGOs and ministries (MOH, MRD, MOEYS, MOSVY, MOWA, MoCR) ▪ Coordination mechanisms ▪ Delivery systems

		engaged in impact mitigation ▪ Guidelines (now revised) in place but not consistently applied	▪ Including impact mitigation in provincial development plans ▪ Advocate to development partners for integrated approaches (to impact mitigation) in development programming	
Expanded package of support and services to OVC, caregivers and social support networks (pagoda, MMM, CPN+, widows etc)	2007	▪ Players not working together	▪ Start a technical working group on impact mitigation (national and provincial)	▪ National coordination
▪ $6.567 million needed by 2010 to cover school support, nutritional support, child care and skills training				

ANNEX 4. LIST OF PARTICIPANTS

List of Participants

Ministries

NCHADS	:	Mean Cchi Vun
NCHADS	:	Ly Penh Sun
NCHADS	:	Lan Van Seng
NAA	:	Teng Kunthy
NAA	:	Sheila Robinson
MoEYS	:	Kim Sanh
MoEYS	:	Im Sethy
MoSVY	:	Em Sophon
MoND	:	Tan Sokhay
MoWA	:	Chou Bun Eng
MoLV	:	Lay Meng Ly

TWG Chairs

PMTCT	:	Kum Kanal
PMTCT Coordinator	:	Sathiarany Vong
CDC PMTCT Advisor	:	Nicole Davis
Mobility	:	Tep Navuth
OVC	:	Oum Somavatey
CoC (Paediatric)	:	Alex Hurd

Civil Society

FHI	:	Chawalit Natpratan
FHI	:	Tess Prombuth
PSI	:	Andrew Boner
KHANA	:	Oum Sopheap
CPN+	:	Heng Sokrithy
HACC	:	Seng Sopheap

Bilaterals

DFID	:	Nicolet Hutter
USAID	:	Sok Bunna
SIDA	:	Pia Bergman
US-CDC	:	Hor Bun Leng
GFATM PR	:	Or Vandin

Multilaterals

UNDP	:	Renato Pinto
UNDP	:	Seng Sutwantha
UNODC	:	Tea Phauly
UNESCO	:	Julie David
UNFPA	:	Chong Vandara

WHO	:	Massimo Ghidinelli
WHO	:	Nicole Seguy
WFP	:	Mory Heng
UNICEF	:	Haritiana Rakotomamonjy
UNICEF	:	Chin Sedtha
ILO	:	Chun Bora
WB	:	Simeth Beng
UNAIDS	:	Tony Lisle
UNAIDS	:	Matthew Warner-Smith
UNAIDS	:	Gabriella Hok
UNAIDS	:	TAP Catalla
UNAIDS	:	Michael P. De Guzman

Private sector

CAMFEBA	:	Van Sou Leng
CCTU	:	Choun Mom Thol
CFDTUC	:	Rong Chhun

REGIONAL CONSULTATION ON UNIVERSAL ACCESS

ANNEX 5. COUNTRY PRESENTATION TEXT

COUNTRY PRESENTATION

HIV prevalence among vulnerable & high-risk populations:

The following figures are from the HIV surveillance data released by NCHADS in December 2004

- 1.9% of all people aged 15 to 49 years
- DSW: 20.8%
- IDSW: 11.7%
- Uniformed Services: 2.7%
- Married Women: 2.1%

Figures for IDU and MSM are from small scale studies done by NGOs, covering Phnom Penh only

- IDU: 37.5%
- MSM: 14.4%

- Mobile Populations: has not been established yet

Key Trends:

- HIV prevalence among adults continues to decline, but Cambodia's mature epidemic remains to be one of the most serious in the region.
- Almost half of new infections are now among married women.
- One third of new infections occur from mothers to children.
- Men increasingly turn to indirect sex workers and sweethearts for sex, with whom they are less likely to use a condom.
- Increased need for care, support and impact mitigation as more people with HIV become sick and join the ranks of those needing medical treatment, care and support
- By 2010, it is projected that HIV/AIDS will account for more than 1 in 4 orphans in Cambodia (142,000), comprising 28% of the projected total orphans.

KEY CHALLLENGE 1

Obstacle: ACCESS

a. Access to some vulnerable populations is limited. There are no national estimates of population size, prevalence, incidence, and patterns of risk behaviour among MSM, IDU and mobile populations. Addressing the needs of these population groups is vital in preventing a second wave of epidemic.

b. Access to basic health and social welfare services is difficult. The uptake of PMTCT remains low. In contrast, uptake to VCCT is high but is not adequately met by current services. Only one-third of the population has access to the minimum package of health services. The rural poor, who live farthest from health centres and in areas with low service coverage, are disadvantaged. Only 5% of HIV (+) pregnant women were covered by PMTCT. To date, PMTCT centres have covered 26.6% of the estimated annual 500,000 pregnant women. Of this percentage, 11.7% attend pre-test counselling although a slightly lower proportion actually takes the test, at 11.4%.

Solutions:

a. Expand outreach programmes to high-risk populations currently reached (DSW, Uniformed services) and scale targeted interventions to reach other high-risk populations (IDSW, MSM, IDU/ATS users). For example, adapting the 100% Condum Use Programme to reach IDSW. To guide programme planning and scaling efforts, nationwide assessments should be carried out among MSM, drug users and mobile populations.

b. Increase VCCT and PMTCT sites (as of 2005, there are 110 VCCT sites and 27 PMTCT sites) to reach people living in the rural areas. Promote acceptability of these services, especially among people with low levels of education. Develop and maintain availability and high quality of these services. Make services 'friendly' to various population groups e.g. IDSW, transgendered persons, hidden MSM, etc. by training service providers and improving facilities.

5-year targets:

- 98% of DSW and 90% of IDSW report consistent condom use
- 80% of sex workers outside of 100% CUP
- 80% of IDUs and ATS users are exposed to HIV prevention interventions
- 80% of visible MSM are exposed to HIV prevention interventions
- 50 PMTCT sites offering minimum package of PMTCT services
- 50% of pregnant women attending ANC classes
- 200 VCCT sites

KEY CHALLENGE 2

Obstacle: GENDER INEQUITES CONTINUE TO FUEL THE SEXUAL TRANSMISSION OF HIV

In 2002, 42% of new HIV infections were transmitted by husbands to wives. Though more men are currently infected than women, the latter are more vulnerable to HIV/AIDS because they have a low social status, resulting in lower levels of education, fewer economic opportunities, and increased risk for violence and abuse. Condom negotiation within marriage is unacceptable for women while a culture of masculinity tolerates men to have multiple sexual partners. Consequently, there are very few programmes addressing condom use within relationships (married and otherwise). There is a need to expand programmes that will protect married women in discordant couples.

Solutions:

1. Empower women through providing education and expanding economic opportunities. Important topics of learning include reproductive health (HIV/AIDS, STI, gender equality), condom negotiation skills, and life skills for girls.
2. Utilize other forms of communication (mass media, IEC materials & activities) to disseminate key messages (promoting gender equality, condom use, accessing VCCT, etc)
3. Increase number and coverage of interventions (education, service provision, etc) targeting at-risk men and their female partners.
4. Promote and advocate for the effective implementation of the AIDS Law and other laws & policies that protect/promote women's rights.
5. Work with men and boys to address gender stereotypes, including developing specific services to address male sexual and reproductive health.

5-year targets:

- 5% of married women report consistent condom use
- 25-30% of men with multiple sexual partners report consistent condom use

KEY CHALLENGE 3

Obstacle: HEALTH AND SOCIAL SERVICE SYSTEMS ARE UNABLE TO COPE WITH AN INCREASING NEED FOR TREATMENT, CARE AND SUPPORT

a. Human resource development and retention in the public sector is a challenge for the Ministry of Health. The health, education and social welfare sectors simply do not have enough trained and skilled staff to ensure 100% service coverage. Training programmes on several topics are available to health workers through the MoH or NGOs but there is little supervision and monitoring afterwards. Low government salaries affect performance and promote high staff attrition rate.

b. Majority of the health care in Cambodia occurs outside the government system. Only 18.5% of the population utilizes public systems. Rehabilitation of health infrastructure and systems remain key priorities of the MoH but this is hampered by a low national health budget.

c. Sustained financial resources for scaling up responses can be accessed through international sources but the absorptive capacity of institutions is limited by inadequate capacity to programme resources.

Solutions:

a. Recruitment, training, and retention of health, education, and social welfare workers in the public sector.
b. Cultivate a supportive government policy. Increase access to quality training institutions and adequate placements within the health and social service sector.
c. Build on the lessons of the Continuum of Care model and its links to related health services to inform the social sector response.
d. Directing international and local funds to health and social service systems strengthening, e.g. human resource and relevant support structures.

5-year targets:

- 100% of Operational Districts with Continuum of Care
- Evidence of supportive AIDS policies (AIDS Composite Policy Index)

KEY CHALLENGE 4

Obstacle: LACK OF ADEQUATE ASSESSMENT OF THE IMPACT OF HIV/AIDS IN NON-HEALTH SECTORS

The past 5 years have seen a considerable increase, expansion and scaling up of community-based interventions that has not been matched with national-level efforts. The impact of HIV/AIDS on non-health sectors like education, agriculture, and rural development has not been adequately assessed. Because of this, there is no joint sectoral operational framework covering key ministries with clear accountabilities to address impact mitigation.

Solutions:

- Establish a national steering group on impact mitigation that will coordinate the assessment of sectoral impacts of HIV/AIDS and will guide the development of a national operational framework with key accountabilities.
- Advocate to development partners to support integrated approaches for impact mitigation in local and national development programming.

5-year targets:

- 30% of households with OVC are accessing livelihood opportunities
- Assessment of OVC undertaken and used for policy formulation & programme planning

- 70% of OD with at least 1 organization providing care & support to households with OVC
- 5 sectoral impact assessments undertaken & disseminated
- 50% of provincial & district development strategies address HIV/AIDS

CROSS-CUTTING ISSUES IN SCALING-UP FOR UNIVERSAL ACCESS

- In the future, the challenge is adapting strategies to address HIV as an endemic disease, rather than an epidemic.
- Need to build robust systems and support structures to sustain the responses, e.g. the potentials and implications for broader systems strengthening brought on by the Continuum of care model.

RESOURCE ESTIMATES TO REACH TARGETS BY 2010

Per population groups:

CSW + Clients	:	$5 million
IDU	:	$1.5 million
MSM	:	$140,000
OVC	:	$4 million

Per NSP II Strategy:

Strategy 1 (Prevention)	:	$144 million
Strategy 2 (Care, support & treatment)	:	$143 million
Strategy 3 (Impact mitigation)	:	$18 million
Strategies 4-7	:	$27 million

4. Coordination & implementation
5. Legal & Policy Environment
6. M&E, Research
7. Resource Mobilisation

Challenges Of Scaling Up Towards Universal Access To Prevention, Treatment, Care And Support

CAMBODIA

Regional Consultation "Universal Access"
14 February 2006
Pattaya, Thailand

Key Characteristics of the HIV/AIDS Epidemic

HIV/AIDS Prevalence data *(from HIV Sentinel Surveillance, 2003)*

- 1.9% of adults (aged 15 to 49 years)
- Estimated # PLHA in 2003: 123,100 (47% women)
- Estimated # AIDS patients: 20,000
- Estimated # children living with HIV/AIDS: 15,000
- Direct Sex Workers: 20.8%
- Indirect Sex Workers : 11.7%
- Uniformed Services: 2.7%
- ANC clients: 2.1%

No accurate information available for other vulnerable groups (IDU,MSM, mobile populations)

Key Characteristics of the HIV/AIDS Epidemic and Response

Key trends:

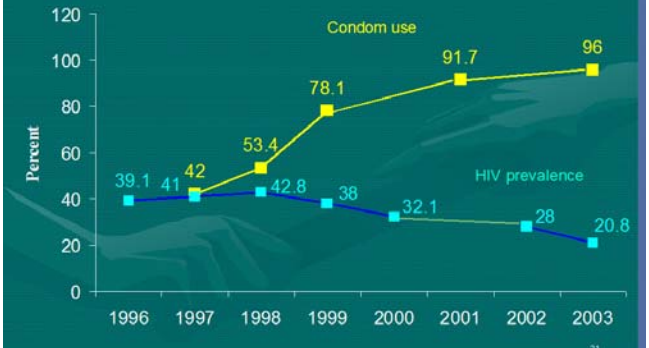
- Declining HIV prevalence, but Cambodia's mature epidemic remains one of the most serious in the region
- Main route of HIV transmission through unprotected heterosexual intercourse
- HIV epidemic has moved from high-risk groups into the general population, resulting in majority of new infections among married women and their newborns
- Current condom use rates high among brothel-based SW, lower amongst indirect sex workers and their clients, but very low with their sweethearts

Estimated National HIV Prevalence* among Adults Aged 15-49, 1995-2003, Cambodia

* From the modeled numbers of PLHA

18

Condom use, HIV prevalence, Brothel-based SWs, 1996-2003, Cambodia



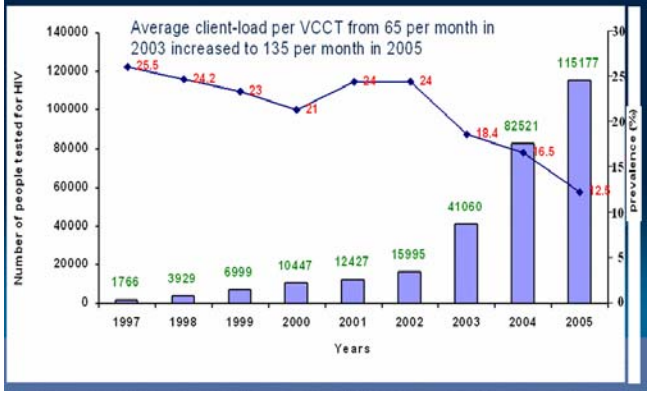
21

Key Characteristics of the HIV/AIDS Epidemic and Response

Key trends:

- VCCT from 1 site in 1995, to 7 in 2001, up to 110 by 2005
- Average uptake per VCCT site: 65 clients/month (2003) →135 (2005)
- HBC teams from 8 in 1998 → 261 in 2005 (15,600 PLHA supported)
- PLHA Peer Support Network: initiated in 2001, up to 439 groups with 14,790 members in 12 Provinces (CPN+)
- OI/ART services from 1 site in 2001 → 32 sites by 2005
- 12,355 PLHA on ART by end 2005 (64% of those in need- including 1,071 children)
- PMTCT services from 1 site in 2002 → 27 in 2005
- Limited availability of impact mitigation interventions, including those for OVC

Number of people attending VCCT services and HIV prevalence from 1997 to September 2005



Key Challenge (1)

SCALING UP ACCESS

- Expansion of prevention, care and treatment services and social welfare services is limited. Uptake of VCCT, OI/ART increasing but not yet adequate. Limited coverage of ANC and PMTCT services: 5% of HIV (+) pregnant women reached by PMTCT in 2005
- Access to some vulnerable populations is limited. There are no national estimates of population size, prevalence, incidence, and patterns of risk behaviour among MSM, IDU, OVC and mobile populations

Key Challenge (1)

Solutions:

- Increase Continuum of Care sites, including VCCT, OI/ART & PMTCT to reach people living in the rural areas. Promote awareness of these services
- Continue outreach services to high-risk populations (DSW, Uniformed services) and expand them to reach other high-risk populations (IDSW, MSM, IDU/ATS users and mobile populations)

Key Challenge (1)

5-year targets:

- 200 VCCT sites offering services
- 45 COC sites, coverage up to 95% PLHA
- Expand nationwide HBC network: 750 teams
- Expand PLHA network to all 78 health operational districts (DPN+)
- 50 PMTCT sites and 50% of pregnant women attending ANC classes
- 98% brothel-based SW and 90% IDSW report consistent condom use
- At least 50% IDUs and ATS users reached by HIV prevention interventions
- 75% MSM reached by HIV prevention interventions

Key Challenge (2)

REDUCE SPOUSAL TRANSMISSION OF HIV

- Gender inequities continue to fuel the sexual transmission
- Condom negotiation within marriage is uncommon and difficult for women

Key Challenge (2)

Solutions:

- Empower women through education and expanding economic opportunities
- Utilize other forms of communication to disseminate key messages
- Increase number and coverage of interventions targeting at-risk men and their female partners
- Promote and advocate for the effective implementation of the AIDS Law and other laws that protect/promote women's rights
- Educate men and address male sexual and reproductive health specific needs

Key Challenge (2)

5-year targets (tentative):

- 5% of married women report consistent condom use
- 25-30% of men with multiple sexual partners report consistent condom use

Key Challenge (3)

STRENGTHEN CAPACITY FOR MULTISECTORAL RESPONSE TO THE DEMAND FOR PREVENTION, TREATMENT, CARE AND SUPPORT, AND IMPACT MITIGATION

- Limited capacity to deliver quality health and social welfare services
- Weak capacity to mobilize resources and/or absorb available resources
- Scarce capacity to coordinate broad partnerships

Key Challenge (3)

Solutions:

- Build on the lessons learned from the Continuum of Care model of NCHADS and its integration with related health services to inform the social sector response
- Increase access to quality training institutions and adequate placements within the health and social service sectors
- Direct international and local funds to health and social service systems strengthening

Key Challenge (3)

5-year targets:

- *Evidence of supportive AIDS policies (AIDS Composite Policy Index)*
- *8 Ministries actively implementing HIV/AIDS sectorial plans*
- *Capacity building targets to be determined*

Key Challenge (4)

EXPAND IMPACT MITIGATION TO NATIONAL SCALE

Limited knowledge and data on the overall impact of HIV/AIDS on families and communities and on non-health sectors like social welfare, education, agriculture, and rural development.

Lack of clear strategy and joint sectoral operational framework to guide impact mitigation interventions.

Key Challenge (4)

Solutions:

- Establish a technical working group on impact mitigation to coordinate the assessment of sectoral impacts of HIV/AIDS and develop a national operational framework with key accountabilities.
- Advocate to partners to support integrated approaches for impact mitigation at national and local levels

Key Challenge (4)

5-year targets:

- *50% of provincial development strategies include impact mitigation*
- *30% of households with OVC are accessing livelihood opportunities*
- *70% of OD with at least 1 organization providing care & support to households with OVC*

Long term Issues In Scaling-up For Universal Access

- Addressing gender inequality
- Empowering youth in making informed decisions through life skills education
- Adapting strategies to address HIV as an endemic disease, rather than an epidemic.
- Building robust systems to sustain the responses and ensuring continued availability of financial resources

Total estimated resource requirements to reach targets by 2010

Per population groups:

CSW + clients	$5 million
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