Kingdom of Cambodia

Nation Religion King

Ministry of Health

Annual Report 2005

National Center for HIV/AIDS, Dermatology and STD

March 2006

Acknowledgement

It gives me great pleasure to review the past year achievements and see all that our teams of dedicated staffs working together with committed communities in the provinces have done to improve the quality of HIV/AIDS & STI Prevention and Care activities for the benefit of people of the Kingdom of Cambodia. I also want to thank our partner funding donors and the Government of the Kingdom of Cambodia for their strong support.

When we see what has been achievement we receive motivation to continue striving, to set higher overall goals and objectives, to continue meeting the various changing needs of people and their communities.

We hope that you come to understand us deeper as you read further here, but please keep the why questions coming, so we can continue striving higher.

Sincerely,

Dr. Mean Chhi Vun
Director of NCHADS

NCHADS Annual Report for 2005

Contents

2.1. Availability of services

2.1.1. VCCT

2.1.2 Health facility-based care (HFBC) services

Laboratory support

2.1.3. Community-based services

Home-based care (HBC)

PLHA support groups

2. 2. Patient coverage

2.2.1. VCCT

2.2.2. OI and ART

2.2.3. PMTCT

2.2.4. TB/HIV collaboration

3. Training

3.1 VCCT

3.2 OI/ART

3.3 PMTCT

4. Drug and logistic support

5. Normative tools and guidelines

C. FINANCIAL ACHIEVEMENTS

NCHADS Annual Report 2005

A. GENERAL REPORT

1. BACKGROUND

1.1 Overview of HIV/AIDS Situation in Cambodia:

The Cambodian HIV epidemic appears to have slightly decreased with a HIV prevalence among adults aged 15-49 that declined from 2.1% in 2002 to 1.9% in 2003. In 2003, 123,100 adults aged 15-49 years were estimated to be living with HIV/AIDS with women accounting for 47% of them. Of the total number of adult living with HIV/AIDS, 19,814 were estimated to have AIDS. These estimates, together with the rough estimates (NCHADS) of 12,000 children infected in 2003 with HIV will be updated.

1.2 Priorities for NCHADS in 2005: the Comprehensive Annual Operational Work Plan 2005: In April 2004, a Workshop was organized by NCHADS to prepare the Annual Comprehensive Work Plan 2005, based upon the up-dated Strategic Plan, with provinces and NGO partners. Three MoH departments (Planning, TB and NMCHC) also participated. At this meeting Annual national and provincial targets were set. The result was the Annual Operational Comprehensive Plan 2005, which incorporated, for the first time, many of the inputs and expected outputs of partners working in coordination with PAOs in provinces. This Work plan was also firmly grounded within the Ministry of Health Annual Operational Plan 2005, prepared for the HSSP.

The 2005 Work Plan focused on the following priorities:

- Implementing the reviewed and up-dated Strategic Plan for HIV/AIDS and STD Prevention and Care 2004-2007
- Continuing integrating HIV/AIDS and STD plans within MoH Annual Operational Plan (AOP)
- Extending the Continuum of Care through health care system
- Expanding VCCT services
- Provision of ART to reach '3x5' targets
- Maintaining the proven Targeted Prevention programme
- Strengthening the M, R & E system
- Strengthening NCHADS capabilities
- Continuing capacity building for provinces

There was thus no major change in programme emphasis for the year, rather continuing emphasis on implementation and strengthening management and systems. The focus of the Plan was on:

- Investment at NCHADS level – in expanding services through renovations of STI clinics and VCCTs, ensuring continuous and timely supplies of drugs, reagents and consumables, particularly with respect to ARV drugs, and training, with particular emphasis on expanding access to treatment and care.
- Vigorous implementation at provincial level of the Strategic Plan's prevention and care packages: IEC/BCC, 100% CUP, STI, CoC, VCCT, OI/ART
- Improved coordination, monitoring and supporting of implementation with continued emphasis on the comprehensive approach, involving all partners, continuing supervision and capacity building, strengthened monitoring and reporting, supported by the PBSI scheme.

The Work Plan 2005, including PBSI, budgeted for a total of **$18,164,702**, of which 60% was to be managed by NCHADS, and 40% by NGO partners.

This Report describes what was achieved in implementing this Plan during the year. Section B of this Report describes programme achievements against NCHADS targets, as set in the Strategic Plan for 2005. Section C describes financial disbursements against budgets. The remainder of this section describes some of the key activities of NCHADS as a management system.

2. NCHADS MANAGEMENT SYSTEM

2.1 Closing the ADB Project: Although the ADB/JFPR "Community Action for Preventing HIV/AIDS" Project formally closed on 31 December 2004, the following activities continued into 2005: finalizing the Report of the Final Survey, compiling the Project Completion Report (PCR); compiling and analysing the project cost data (Input-Output data) and Report; preparing the Project Impact Report, and hosting the **Regional Technical Meeting at Siem Reap** for the project, and the **Final Inter-country Meeting** held in Hanoi in June. Three primary lessons were taken away from this project:

- the technical packages developed are being adopted by all three countries, to a greater or lesser extent, as the framework for a comprehensive, decentralised HIV/AIDS prevention and care programme;
- the planning, reporting and fund flow mechanisms established are likewise proving to be useful models for the countries;
- the regional management, but country-level implementation approach established, appears to be appropriate.

The $1.7 million allocated to Cambodia was all disbursed, with clean audits; the lessons have been particularly learned and built upon in Cambodia.

2.2 Procurement of ARV drugs and CD4 Counting machines:

ARV Drugs:

Procurement of ARV drugs by NCHADS started in 2004, but took much longer than expected, since it was a new process and there was a lot of learning involved on all sides. A special extension from ADB was agreed; and various approvals from DFID, GFATM and other donors were necessary as the process developed. In addition, it was agreed that this procurement would be conducted in parallel with the HSSP/WB ARV drug procurement. The full supply of ARV drugs worth $508,960 was completed in mid-2005. This was a major achievement. Cambodia may well be the first country in Asia to demonstrate a model for the effective procurement of ARV drugs – and all locally managed. The role of the Clinton Foundation was crucial, and extremely helpful.

Supplier	ADB/DFID etc Consortium	World Bank (HSSP)	Total
GSK	$17,833		$17,833
CIPLA	$153,266	$48,589	$201,855
Hetero	$14,867	$7,265	$22,132
BMS	$31,425	$9,978	$41,403
Abbott/MEGA	$63,006	$64,493	$127,499
BI	$26,512	$8,820	$35,332
Merck		$45,028	$45,028
Strides		$17,878	$17,878
Total	**$306,909**	**$202,051**	**$508,960**

CD4 Counting machines:

The procurement of CD4 Counting machines was equally time-consuming, innovative, but ultimately successful. Again, the Clinton Foundation was extremely important and helpful, as it facilitated the breakthrough to switching from purchase (at $45,000 per machine) to leasing, for only the cost of the reagents, with the actual machines becoming available for $2000 at the end of three years. The whole deal was negotiated to cost $159,265 per year for machines and reagents – a very considerable saving. By mid-August 2005, four CD 4 FacsCount machines were strategically placed in 4 regional sites (Battambang, Takeo, Kampong Cham, and NIPH/Phnom Penh) providing free services to all CoC sites.

2.3 Signing of MoUs: during the year negotiations were conducted with the Clinton Foundation HIV/AIDS Initiative (CHAI) and a MoU signed between the MoH and CHAI. This had an immediate benefit in support from CHAI for the CD4 machine procurement. CHAI has established an official presence in-country,

based in NCHADS. Towards the end of the year a MoU was also signed between MoH and AHF (AIDS Healthcare Foundation) of USA, and the Letter of Agreement between NCHADS and AHF to support the Continuum of Care in three provinces (Kampong Thom, Kratie, and Ratanak Kiri).

2.4 Planning in NCHADS: NCHADS finalised the 2005 Work Plan and submitted it to MoH for inclusion in the HSSP AOP. NCHADS also conducted the Annual Planning Workshop 2006. In addition, NCHADS conducted an internal 3-day Planning Workshop at Sihanoukville for NCHADS staff to review the targets and indicators for the coming years. The Annual Coordination Workshop was held in September. The GFATM Planning Workshop was held in July.

2.5 Participating in the Review of the NAA Strategic Plan:
The NAA decided to review its national Strategic Plan. As an important member of the NAA, NCHADS was thus involved in various activities associated with this. NCHADS was given responsibility for reviewing Care activities.

2.6 Recruitment of additional Contract Staff
To meet the demands of the expansion and acceleration of the NCHADS Programme set out in the Road Map presented to the MAT and DFID, NCHADS hired a number of contract staff to meet specific demand created by the programme (see below): principal among these are 14 Accounts Assistants, 7 Data Management Officers, 5 Procurement Assistants, and 2 Logistics Officers.

2.7 Structure in NCHADS:
A number of institutional re-structuring exercises took place in NCHADS during the year:

- Responding initially to the urgent need for accurate patient monitoring of ART, but quickly expanding to the whole area of data management in NCHADS, a new **Data Management Unit** was been established. The two contract Data Management Officers were recruited and posted in the Unit. WHO has provided a long-term Technical Adviser to NCHADS to work with and support this Unit.
- Initially to ensure the consistent supply of ARV drugs, but also extending to the forecasting, procurement and supply of all NCHADS' programme consumables and drugs, with support from CHAI (Clinton Foundation), a new **Logistics Unit** was established. With support from CHAI, three contract Logistics Management Officers were recruited, and posted in the Unit. CHAI is providing Technical Advice and support to the Unit. Early in 2005 a team led by a short-term consultant recruited by WHO, with the Logistics Management Officer from NCHADS, CHAI, and a French

Adviser from the Dept of Pharmacy, with participation from the Essential Drugs Bureau of MoH and CMS, conducted an assessment of the logistics system required for OI/ARV drugs starting to arrive for the NCHADS Programme.

- To strengthen the overall planning and monitoring system, the M&E Unit was re-integrated with the Planning Unit to form a single Planning, Monitoring and Reporting Unit.

There were a number of implications arising from these changes, primarily, the need to adjust the NCHADS Planning format, and the NCHADS Chart of Accounts, to reflect them. This was also an opportunity to up-date the NCHADS Functional Task Analysis – a task that is on going.

In addition, NCHADS started to separate the primarily budgetary aspects of the Annual and Quarterly Work Plans from the activity aspects. This aimed to enable NCHADS Units to improve their time and task planning and management, and improve their overall operational efficiency. This was also linked to continuing efforts to identify standardized quantitative indicators of output which could be used for reporting against, linked to financial and time inputs. The Impact and Outcome Indicators of the Strategic Plan were reviewed, revised and almost finalised through the M&E TWG. Additionally, the Data Management unit took over the maintenance of existing data bases in NCHADS (eg STD service data and other Passive Surveillance data) which also feed into the overall Reporting system. Inclusion of Reports from specific activities (trainings and meetings), and minutes of various TWG meetings into Quarterly Reports was also started. The inclusion of these kinds of additional information has become standardized and routine, and is another positive contribution towards strengthening the 'performance management practice' of NCHADS.

2.8 PBSI

For PBSI in NCHADS the PAB decided to adjust the indicator relating to proportion of planned work achieved. Based on the presentation to the Steering Committee in June, provincial PBSI were extended. The expansion of PBSI raised issues concerning the management of provincial PBSIs, and consolidating the management of NCHADS and Provincial PBSI. The issues and the overall success of the PBSI scheme were presented to the DFID Steering Committee in December 2005. In early 2006 a contract staff to manage the provincial PBSI scheme for the PAB, with GFATM funding will be recruited.

2.9 Surveillance

- **The Cambodian Young Women Cohort study: i**n June the findings were disseminated of the first element of this long-term study being conducted by NCHADS in collaboration with UCLA and Brown universities in USA; this

element concerned female garment factor workers. The study concluded that 'There is low prevalence of HIV and HSVII among factory workers and little high risk behaviour……Female factory workers are not a high risk group'.

- The **SSS** preliminary results were circulated and discussed internally; though data cleaning and quality assurance continued, with the samples for QA sent to CDC Atlanta.The results appeared to ask some questions of the exiting STI strategy and programme which will need careful answering.
- The **BSS 2003 Report** was finalised and put on the NCHADS website; it was also available in hard copy in NCHADS.
- Preparation of the **HSS 2003 Report** continued, with FHI assistance.

2.10 Steering Committees

Steering Committee Meetings for DFID and EUROPAID was held as planned; for DFID in June and December; for EUROPAID in January and September. NCHADS was satisfied with the Meetings; as were the Steering Committees with NCHADS' presentations and performance.

2.11 External Reviews

DFID MAT:

The MAT visited in April/May; and again in October for the DFID OPR (Output to Purpose Review).

EUROPAID Mid-Term Evaluation:

This was conducted in December by an external team of consultants.

CDC-GAP/PEPFAR:

Cambodia has been selected as a PEPFAR country; a PEPFAR team visited Cambodia in October to review USAID and CDC-GAP activities.

2.12 External Audits

External audits for DFID, CDC and ADB funds were conducted during the year. No material issues arose in any of the audits

2.13 Kobe VIIth ICAAP

A number of NCHADS staff and TA attended the ICAAP at Kobe, and then at the Rio Conference.

2.14 Challenges and Constraints

During the year NCHADS primary focus was clear:

- Expanding access to treatment and care as fast as possible, within the capacity of the health system, while ensuring adequate quality, sustainability and long-term effectiveness; and
- Strengthening NCHADS managerial and administrative systems to ensure that it can achieve this goal effectively and efficiently within the environment it has to work in.

B. PROGRAMME ACHIEVEMENTS

1. HIV/AIDS prevention activities

HIV/AIDS prevention activities include services for the management of sexually transmitted infections (STI), and behavior change activities for high-risk populations.

Since 1999, the MoH has endorsed a "dual complementary approach for STI care", whereby targeted services for people in high-risk situations at specialized STI clinics coexist with integrated STI services at health center level for the general population. Integrated STI services are offered at 579 (60.0%) of the 966 primary health care centers. A total of 30 specialized STI clinics are spread over 22 of the 24 provinces. The specialized clinics provide services primarily to brothel-based direct female sex workers (DSWs) and to some of the indirect female sex workers (IDSWs), as part of the 100% condom use program strategy.

Of the 30 specialized STI clinics, 7 were upgraded with laboratory support to perform RPR testing and basic microscopy in 2004, and a total of 26 (86.7%) were upgraded in 2005 (Annex: STI indicator 1). This laboratory support enables specialized clinics to use refined algorithms for the syndromic management of STIs in high-risk populations. In 2005, a total of 28,656 STI consultations were provided to DSWs of which 6,366 were first visits and 22,290 were monthly follow-up visits. The annual number of consultations for DSWs at specialized STI clinics increased gradually between 2001 and 2004, when the 100% Condom Use Program was expanded nationally. The number of annual consultations for DSWs has been stable since then (Figure 1).

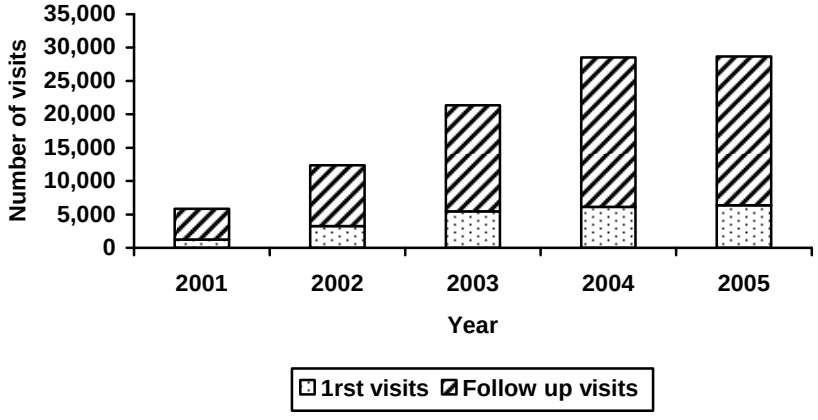


Figure 1: Trend in number of consultations for DSWs at specialized STI clinics from 2001 to 2005

In 2005, of the 6,266 DSWs who attended specialized clinics for their first visit, 4,454 (71.1%) were diagnosed with a STI, including 1,736 (27.3%) with cervicitis. Of 22,290 DSWs who attended specialized clinics for monthly follow-up visits, 6,875 (30.8%) were diagnosed with a STI, including 2,436 (10.9%) with cervicitis (Annex: STI indicator 2). As a consequence of the misinterpretation of the STI management protocol for sex workers by health care providers, the rates of cervicitis reported in 2005 are probably lower than they would normally be. In October 2005, instructions were given to correct this misinterpretation. It is therefore anticipated that in 2006, rates of diagnosis of cervicitis among sex workers will be higher than in 2005. It is important to note that the rate of cervicitis in sex workers presenting at the clinic is based on a presumptive diagnosis, combining risk factors and clinical signs. The protocol for STI management in sex workers will be validated by the end of 2006. These figures will be compared with the STI prevalence estimates among DSWs obtained from the STI sentinel surveillance (SSS) conducted in 2005 (results expected early 2006).

The table 1 below shows that the vast majority of new cases of STIs among DSWs presenting for their first or follow-up visit are vaginitis and cervicitis. Of the DSWs diagnosed with a STI, 35.4% had a cervicitis at follow-up visits compared with 39.0% at first visit ($p<0.001$).

Syndrome	New STI cases during first visit N= 4,454 No. (%)	New STI cases during follow-up visits N= 6,875 No. (%)	
Vaginal discharge			
Vaginitis	2,580 (58.0)	4,109 (59.8)	
Cervicitis	1,736 (39.0)	2,436 (35.4)	p<0.001
Lower abdominal pain (PID)	33 (0.7)	58 (0.8)	
Genital ulcer	28 (0.6)	53 (0.8)	
Genital warts	27 (0.6)	106 (1.5)	
Other	50 (1.1)	113 (1.6)	

Table 1: Reported new cases of STI among DSWs at specialized STI clinics in 2005

2. Comprehensive care for people living with HIV/AIDS (PLHA)

2.1. Availability of services

The framework for providing comprehensive care to PLHA in Cambodia is the Continuum of Care that include: (1) VCCT services, entry point for HIV prevention and care; (2) Health facility-based care (OI/ART services for adults and children, laboratory support, TB/HIV care and treatment and PMTCT); (3) Community services (HBC and PLHA support groups); and (4) MMM.

To date, 20 Operational Districts (OD) in 16 provinces have established a Continuum of Care (Annex: CoC indicator). These CoC have been established in ODs that have OI/ART sites at the exception of Phnom Penh ODs. Some CoCs still lack PMTCT services and will have to be selected with high priority for the scaling up of PMTCT services in 2006 by NMCHC.

3.1.1. VCCT

The number of VCCT services in Cambodia has increased drastically over the last 4 years, from 12 sites 2000 to109 sites by December 2005 (Figure 2).

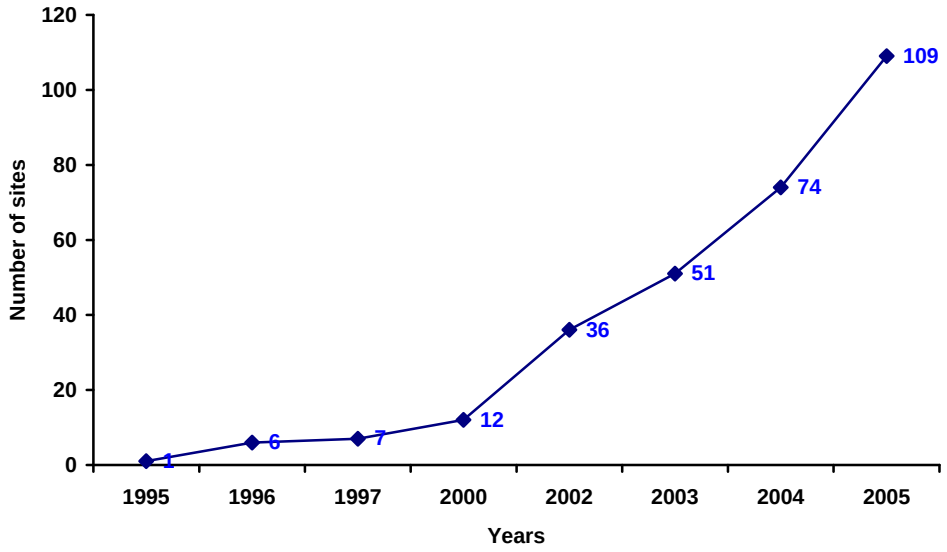


Figure 2: Trend in number of VCCT sites from 1997 to 2005

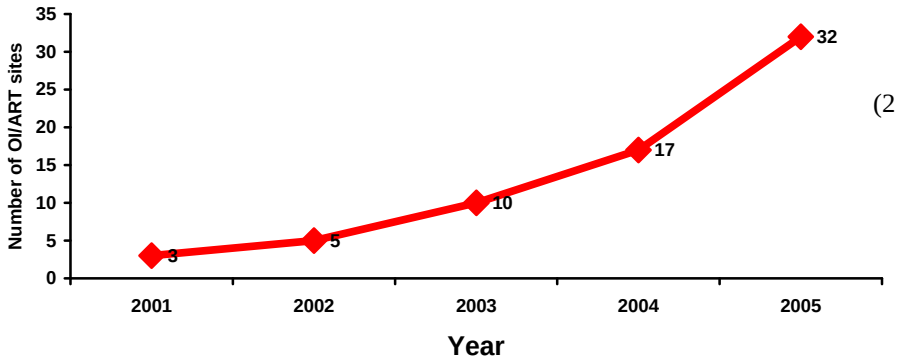
Of the current 109 VCCT sites, 86 are supported directly by the Government, 18 by NGOs and 5 are private. Thus, a total of 104 VCCT sites operate in the public sector (Annex: VCCT indicator 1). The target of having a VCCT site linked to each of the 67 referral hospitals and some former district hospitals in the 24 Cambodian provinces, up to a total of 107 VCCT sites operational by the end of 2005 is achieved.

2.1.2 Health facility-based care (HFBC) services

OI and ART services

Cambodia has rapidly scaled up health facility-based OI and ART services in the Public Sector in the last 4 years. At the end of 2005, 30 health facilities offer OI and ART services and 2 facilities offer OI services only in 16 provinces (Figure 3).

These OI and ART services are supported by the government and by partner NGOs. Of the total 30 sites with ART services, 11 provide paediatric care.



(2 sites OI only)

Figure 1: Trend in number of facility-based OI/ART sites from 2001 to 2005

NB: errors in number of OI/ART sites from 2001- 2003 from quarter 4 2005 report were corrected

Twenty two operational districts (ODs) have at least one facility that provides ART services (Annex: HFBC indicator 1). Two additional ODs have facilities that provide OI services and will start ART soon (Figure 4).

Laboratory support

Four leased CD4 FACScounts supported by NCHADS/GFATM /ADB /DFID/ EU were installed in 2005 in 4 provinces (Takeo, Kompong Cham, Battambang and at NIPH in Phnom Penh). CD4 count is also available at Pasteur Institute in Phnom Penh and in Sisophon Banteay Manchey (US CDC) (Figure 4). A total of 8,142 CD4 counts have been conducted in 2005 in the 4 provinces with the leased FACScounts.

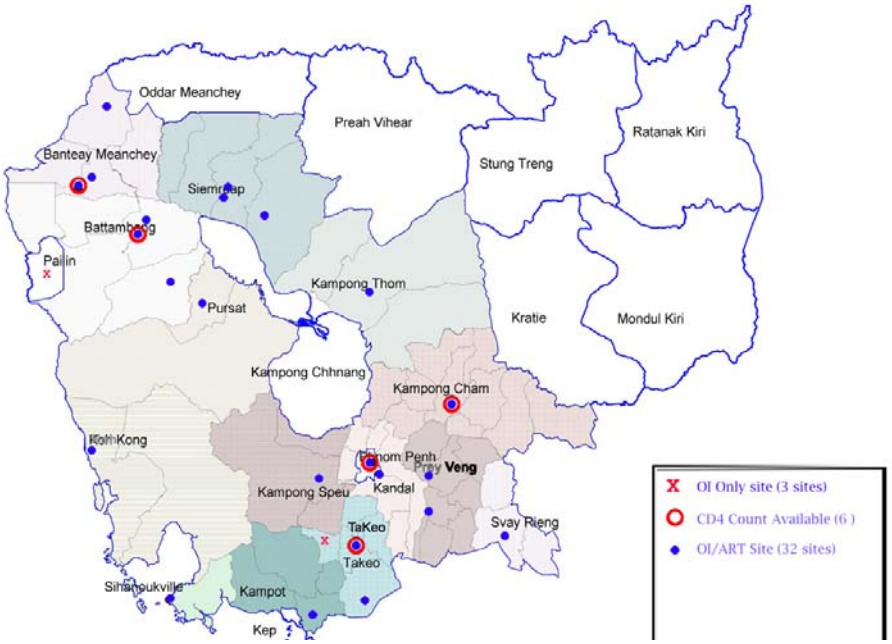


Figure 4: Location of facility-based OI/ART sites and CD4 count services as of 31/12/05

PMTCT services

In December 2005, Cambodia has 28 facilities that provide prevention of mother-to-child transmission (PMTCT) services. A total of 18 ODs have at least one health facility providing PMTCT services (Annex: HFBC indicator 2 and PMTCT indicator 1).

2.1.3. Community-based services

Home-based care (HBC)

The number of HBC teams providing services to people living with HIV/AIDS (PLHA) has been scaled up from 52 teams in 2001 to 261 teams in December 2005 (Annex: HBC indicator 1) (Figure 5). A total of 366 (about 30%) health centers are linked to HBC teams (Annex: HBC indicator 3) within the CoC. These HBC teams are supporting a total of 15,230 PLHAs at the end of 2005 (Annex: HBC indicator 2). HBC networks are established in 56 operational districts located in 17 provinces.

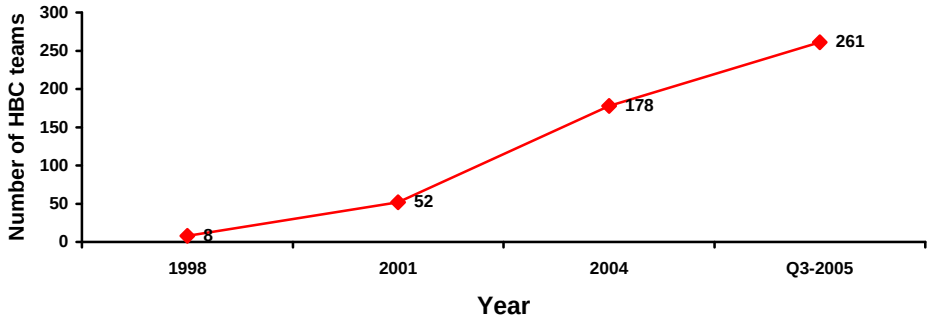


Figure 5: Trend in number of home-based care teams from 1998 to December 2005

PLHA support groups

The number of PLHA support groups has increased from 24 in 2002 to 466 in December 2005. These PLHA support groups are established in 14 (58.3%) provinces; 38 are in Phnom Penh and 428 in the provinces. The number of active PLHA supported by these support groups increased from 4,000 in 2002 to 15,533 by December 2005 (Figure 6).

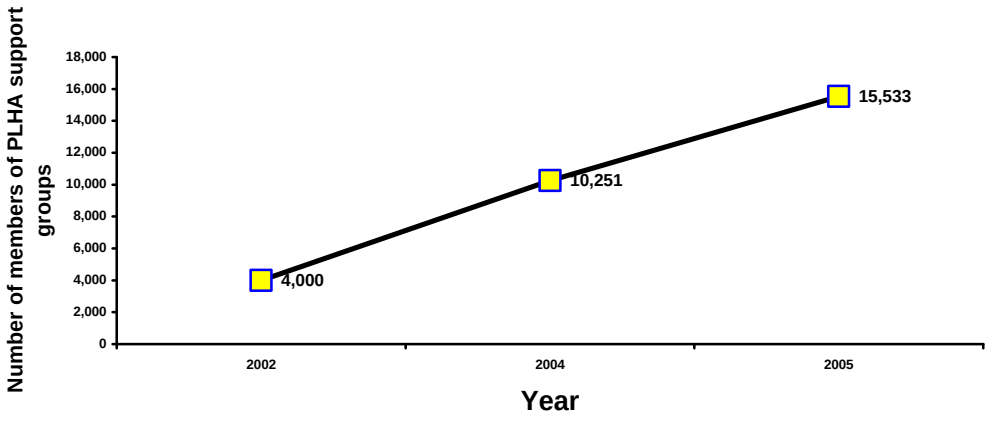


Figure 6: Trend in number of people supported by PLHA support groups from 2002 to 2005

2. 2. Patient coverage

2.2.1. VCCT

The number of people tested annually for HIV has increased from 1,766 in 1997 to 152,147 in 2005 (Figure 7). Assuming that 90% of all VCCT clients are 15-49 years, about 136,932 (2.2%) people aged 15-49 years were tested for HIV in 2005 (Annex: VCCT indicator 2). In 2005, gender equity in HIV testing is achieved with 82,172 (54.0%) women tested compared with 69,975 (46.0%) men.

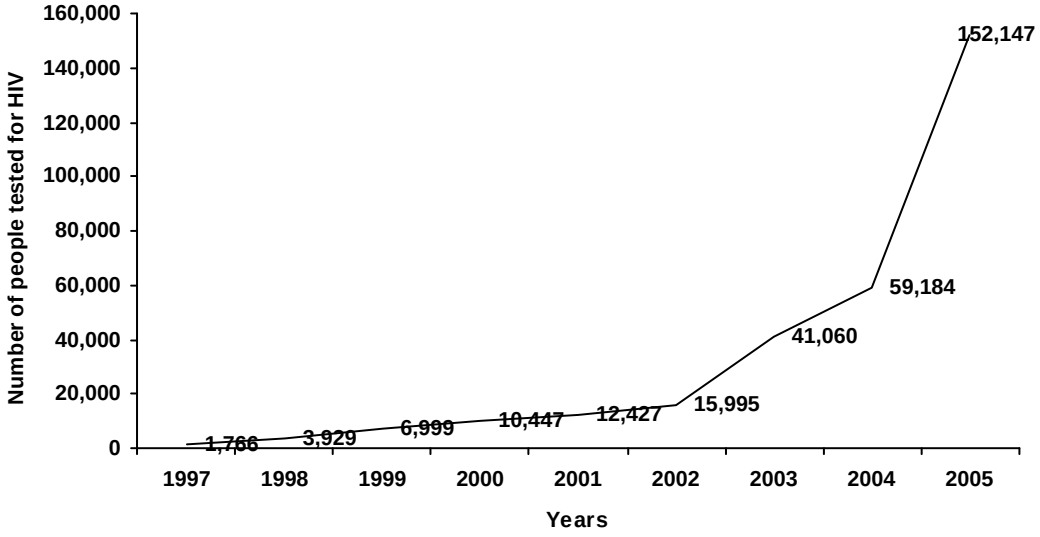


Figure 7. Trend in number of people tested for HIV from 1997 to 2005

In 2005, 99.6% (range: 68.2%-100% across sites) of VCCT clients who had a pre-test counseling were effectively tested for HIV and 97.5 % (range: 69.2%-100% across sites) of those tested received their result through post-test counseling (Figure 8). This cascade reflects the efficiency of VCCT services, and the ambitious target of 98% of people tested receiving post-test counseling is nearly achieved (Annex: VCCT indicator 3).

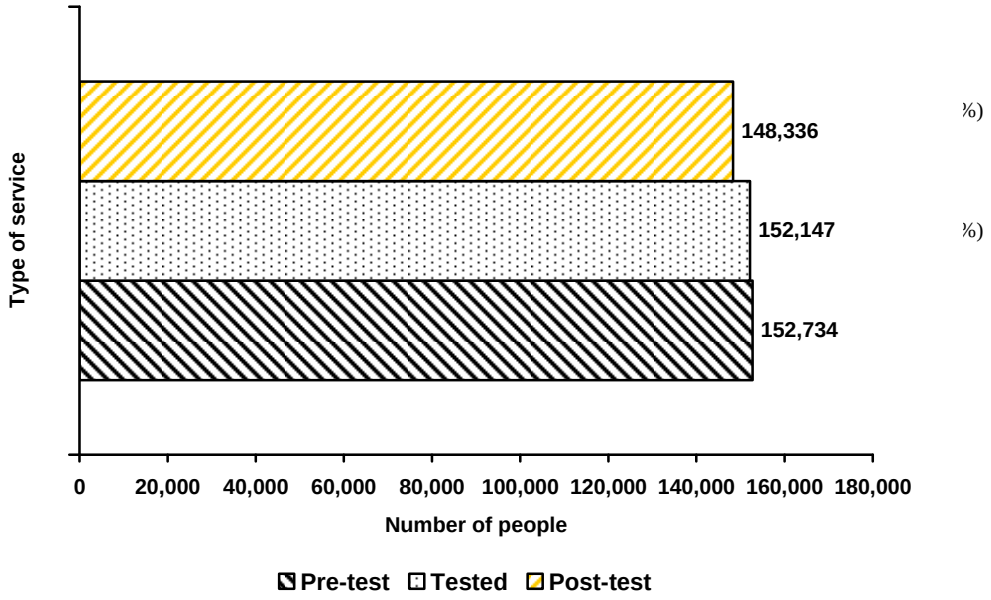


Figure 8. VCCT cascade in 2005

The trend in HIV prevalence among VCCT clients has decreased in the last 3 years from 24.0 % in 2002 to 12.5% in 2005 (figure 9). An in-depth analysis is being conducted to assess the changes over time in groups of population attending VCCT services and the variation of HIV prevalence across VCCT sites.

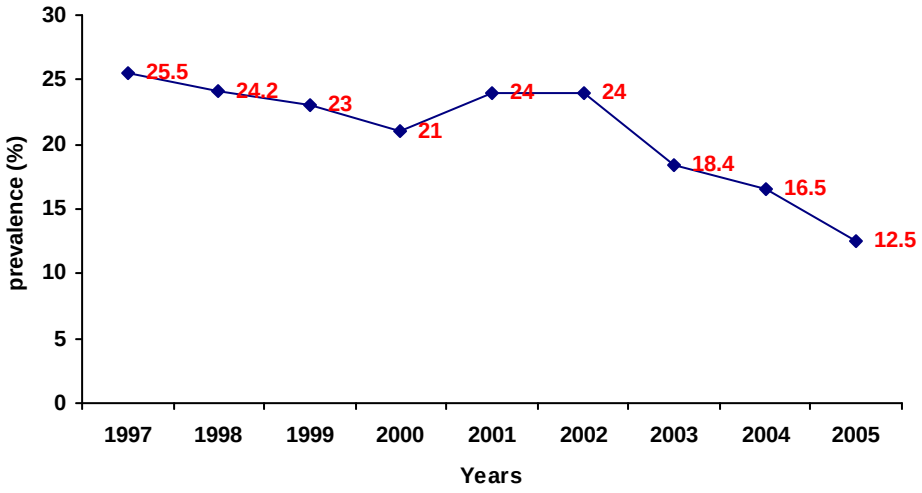


Figure 9. Trend in HIV prevalence among VCCT clients, 1997-2005

2.2.2. OI and ART

The number of active patients on ART has increased drastically over the last 4 years (Figure 10). As of 31 December 2005, 12,355 active patients were receiving ART, of which 11,284 were adults and 1,071 were children (Figure 11). More than 50% of the total number of adults with AIDS is on ART (Annex: HFBC indicator 3). The national and 3 by 5 target of a total 10,000 PLHA on ART by the end of 2005 is already achieved. Gender equity in ARV treatment was achieved in 2005, as female patients accounted for 48% of all patients.

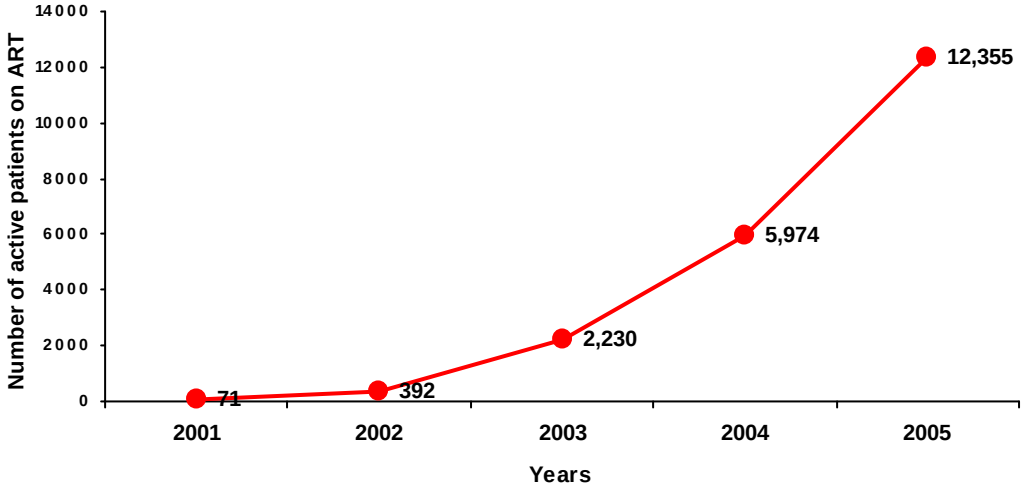


Figure 10: Trend in number of active patients on ART from 2001 to 2005

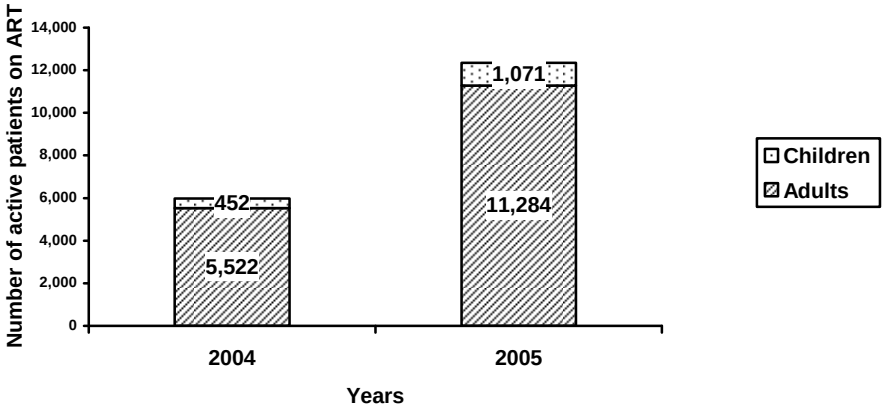


Figure 11: Trend in number of adults and children on ART from 2004 to 2005

At OI/ART sites, a cumulative 13,775 new patients started OI prophylaxis and a cumulative 7,666 new patients started on ART in 2005 (Figure 12). An average of 1,152 new patients were enrolled for OI prophylaxis and management each month and since July 2005 an average of 765 OI patients were enrolled on ART each month. The proportion of patients eligible for ART (WHO stage 4 or CD4 <200/mm3) who were started on ART over time is not yet available. These data will be available in 2006.

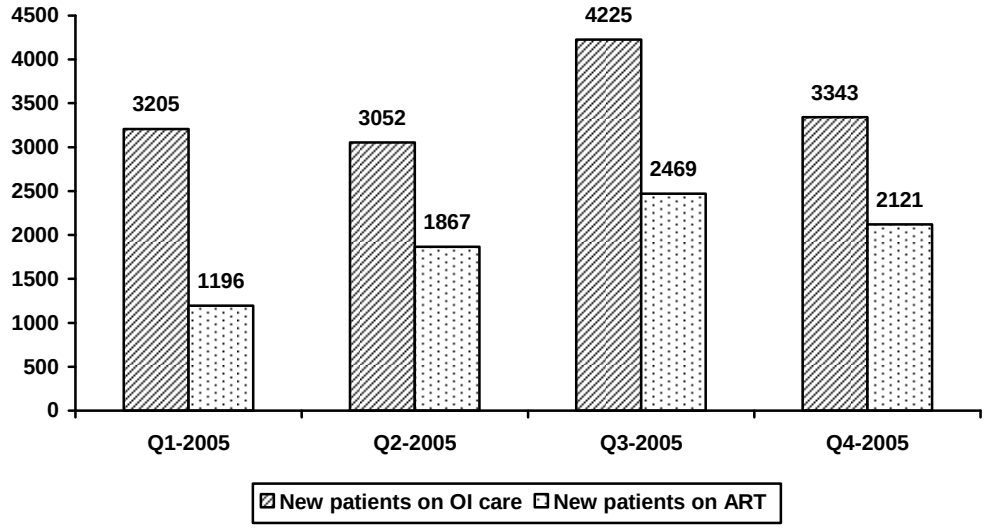


Figure 12: Trend in number of new patients on OI and ART from 2001 to 2005

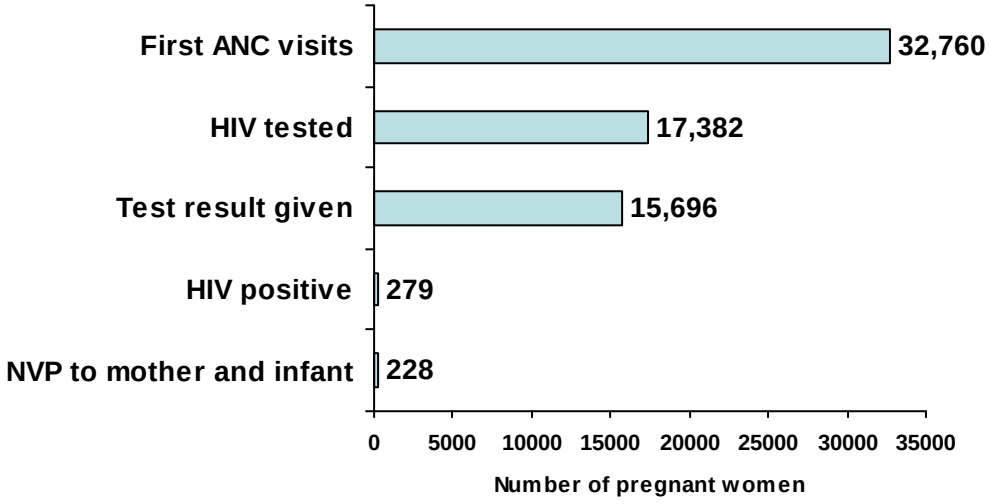
Of the cumulative number of new patients who started on ART in 2005, 233 (3.0%) were lost or had died as of December 2005.

Patient outcome data such as the percentage of patients still alive and on ART 12 months after initiation (HFBC indicator 6) are not yet available. These cohort data will be collected and analyzed in 2006.

2.2.3. PMTCT

In Cambodia only 46.1% of pregnant women have at least one prenatal consultation (National Health statistics, MoH, 2003). In 2005, of 32,760 first ANC attendees at ANC clinics with PMTCT services, 17,382 (53.1%) were tested for HIV (Annex: PMTCT indicator 2). Among women who came for their first ANC visit at PMTCT sites, 15,696 (47.9%) received their test result through post- test

counseling (Annex: PMTCT indicator 3). Of the total number of couples in which the woman attended ANC clinics with PMTCT services for their first ANC visit, 4,160 (12.7%) husbands/partners also received post-test counselling (Annex: PMTCT indicator 4). Among women tested for HIV, 279 (1.6%) were HIV positive. Of those tested positive, 228 (81.7%) mothers and 237 (85.0%) infants received ARV prophylaxis (Annex: PMTCT indicator 5) (Figure 13).



In Cambodia, it is estimated that 64% of the population is infected with Mycobacterium tuberculosis. The number of detected active TB cases has increased from 19,007 in 2000 to 31,814 in 2004. A national survey conducted in January 2005 among TB patients found an overall HIV prevalence of 10.0%. TB/HIV co-infection rates were 5.5% among SS (+) PTB, 15% among SS (-) PTB and 22% among EP-TB. OI/ART services reported that TB is a common opportunistic infection, observed in up to 40% of PLHA enrolled in OI/ART cohorts. Likewise, high mortality rates among TB-HIV co-infected patients are being observed. In August 2005, CENAT reported a mortality rate of 37% (within 2 months of TB treatment) among TB/HIV co-infected patients with CD4 <200/mm3 not yet receiving ART.

Four provinces have had TB/HIV collaborative activities, namely Phnom Penh, Battambang, Banteay Manchey and Sihanoukville. In three of these four provinces, during the first semester 2005, of 1,483 persons who tested HIV positive at VCCT sites, 1286 (86.7%; provincial range: 82%-89%) were referred for TB screening. The proportion of HIV-infected patients for whom active TB was

identified ranged from 19.1% to 32.4% across provinces. In the same three provinces, of 1,148 registered TB patients during the first semester 2005, 414 (36.1%; provincial range: 8.4%-87%) were referred to VCCT sites for HIV testing.

More recently, 300 health centers have been selected in 12 ODs to intensify TB/HIV collaborative activities. Among those, 100 health centers with HBC teams will facilitate the transportation of TB patients from the community to the nearest VCCT site for HIV testing.

3. Training

3.1 VCCT
The 2005 expansion of VCCT services has been supported by the initial training of 45 new counselors, refresher training of 77 counselors as well as initial training of 55 laboratory technicians and refresher training of 48 laboratory technicians. Initial data management training was conducted for 19 VCCT staff and refresher data management training was conducted for 37 VCCT staff.

3.2 OI/ART
The initial training for OI/ART teams include a five month initial in-service course for clinicians, a 3 week course for counselor nurses, a 3 week course for drug and logistic managers, and short training activities for auxiliary staff. OI/ART teams also receive "secondment" training which consists in an extensive visit of an existing and running OI/ART before they actually start their new site. Since 2004, 96 clinicians (Annex: HFBC indicator 4), 57 nurse counselors and 30 drug and logistic managers have been trained.

3.3 PMTCT
In 2005, 114 health care workers (midwives and nurses) were trained on counseling for PMTCT (Annex: PMTCT indicator 7).

4. Drug and logistic support

To date, none of the OI/ ART sites had stock-outs of essential ARVs (Annex: HFBC indicator 5)

In 2005, most ART sites were able to report the number of patients on each ART regimen. Most prescribed regimens were d4t+3TC+NVP, d4t+3TC+EFVand AZT+3TC+NVP, whereas 1.6% of adults were already on PI-based regimens (Table 2).

ARV drug regimen	Adults N= 9,958 No. (%)	Children N= 970 No. (%)
d4t+3TC+NVP	5,903 (59.3%)	744 (76.7%)
d4t+3TC+EFV	1,739 (17.5%)	187 (19.3%)
AZT+3TC+NVP	1,511 (15.1%)	28 (2.9%)
AZT+3TC+EFV	630 (6.3%)	10 (1.0%)
PI-based regimens	157 (1.6%)	1 (0.1%)
Other regimens	18 (0.2%)	0

Table 2: Distribution of antiretroviral drug regimens prescribed for HIV infected patients in Cambodia, Dec 2005

6. Normative tools and guidelines

PMTCT guidelines have been revised by the National Maternal and Child Health Center (NMCHC) in October 2005. In these guidelines, the use of Nevirapine alone is not anymore recommended for pregnant women and infants.
OI and ART guidelines for adult and children are in revision process.

A joint statement has been signed in March 2005 by the National Centre for TB and Leprosy Control (CENAT) and NCHADS on strengthening care and treatment strategies for HIV/AIDS and TB. This joint statement defined roles and responsibilities of both programs to effectively implement the operational frameworks for TB/HIV and CoC, endorsed by the MOH respectively in 2002 and 2003.

ANNEX: Monitoring and Evaluation indicators

	STI Indicators (NCHADS)	**2005 target**	**2005 score**
1	Number and percent of specialized STI clinics with laboratory support to perform RPR and basic microscopy	19 (63%)	26 (86.7%)
2	Proportion of DSWs diagnosed with cervicitis during monthly follow up consultations at specialized STI clinics	< 25%	10.9%
3	STI prevalence among DSWs (N Gonorrhea and/or Chlamydiae trachomatis)	<25%	Results not yet disseminated

	VCCT indicators (NCHADS)	2005 target # (%)	2005 score
1	Number of licensed VCCT sites operating in the public and non-profit sectors	100	104
2	Number and percentage of adults (aged 15-49) who received HIV counseling and testing ++	103,976 (1.64%)	132,932 (2.2%)
3	Percentage of those tested who received their result through post-test counseling	98%	97.5%

	Health Facility Based Care Indicators (NCHADS)	2005 target	2005 score
1	Number (%) OD[1] with at least one center that provides ART services	22	22
2	Number (%) OD with at least one center that provides PMTCT services	15	18
3	Number (%) AIDS Cases on HAART	9,814 adults (49.4%)	11,284 adults (57.0%) including 5,423 (48%) female + 1,071 children 12,355 total
4	Number clinicians trained to provide ARVs	60	96
5	Number (%) OI/ ART sites with one or more stock-outs of essential ARVs	0%	0%
6	% people on ART alive 12 months after initiation	>80%	Not available

	Home Based Care Indicators (NCHADS)	2005 target	2005 score
1	Total number of HBC teams actively providing home-based care and support services to PLHA	185	261

[1] Cambodia has 24 provinces, 76 ODs, including 68 ODs with referral hospitals.

2	Number of PLHA supported by HBC teams	15,000	15,230
3	Number (percent) of HCs with HBC teams	30%	366

	Continuum of Care Indicators (NCHADS)	**2005 target**	**2005 score**
1	Total number of Operational Districts with a Continuum of Care	22	20

	PMTCT Indicators (NMCHC)	**2005 target**	**2005 score**
1	# (%) ODs with at least one facility offering the minimum package of PMTCT services		18
2	% ANC 1 women who received HIV testing at PMTCT sites		53.1%
3	% ANC 1 women who receive post-test counselling	30%	47.9%
4	% husbands and/or partners that receive post-test counselling through PMTCT program		12.7%
5	# (%) children born to HIV positive mothers, identified through PMTCT program that received a complete course of antiretroviral prophylaxis		237 (85.0%)
6	# (%) children born to HIV infected mothers who received ARV prophylaxis at birth and are HIV infected at 18 months		Not available for 2005
7	number of health care workers, counselors and PLHA trained in PMTCT in the past 12 months		114 midwives and nurses

C. Financial Report

This Report presents both expenditures (and the proportion of planned budget disbursed) and achievement of planned activities, as the major indicators of achievement. It includes the eight main sources of NCHADS programme funding: DFID, GFATM, CDC, EUROPAID, CHAI, CTAP, WB and FHI.

In the expenditures columns only expenditures recorded in the NCHADS accounts system as allowable reconciled expenditure against advances are shown. These include both actual expenditures incurred and recorded during the year. But for the FHI, the expenditures received from FHI.

Achievement
During this year:

- 56 % of planned **DFID** funds were spent
- 66 % of planned **EUROPAID** funds

- 35 % of planned funds from the **GFATM**, and
- 84 % of **CDC** funds.
- 54% of CTAP funds
- 43% of WB
- 129 % of FHI
- 61% of CHAI

Expenditure was significantly better at Provincial level than at NCHADS HQ:

- of **DFID** funding, 90% of planned provincial expenditures was achieved, while only 53% of planned expenditures was achieved by NCHADS HQ: this primarily reflects a slow progress in NCHADS in making procurements;
- of **GFATM** funding, 81 of planned provincial expenditures was achieved, while only 32% of planned expenditures was achieved by NCHADS: almost all this planned central expenditure was procurements, and NCHADS planed included GFATM R1, R2, and R4; but GFATM-R4 just started in January 2006.
- for **CDC** funding, 71% of planned provincial expenditures was achieved; the 70% of planned expenditures achieved by NCHADS.
- of **EUROPAID** funding, , 77% of planned provincial expenditures was achieved, and 65% of planned expenditures was achieved by NCHADS HQ – again, largely due to slow procurement;
- CTAP funding expenditures only for running clinic at Social Health Clinic, and WB, CHAI expenditures were achieved by NCHADS HQ.

Table 1: Summary Expenditure by Sources in 2005

Sources	Year Plan	Total Exp	%
DFID	$ 2,429,141	$ 1,364,120	56%
GFATM	$ 4,550,682	$ 1,597,623	35%

CDC	$ 1,087,349	$ 913,557	84%
EUROPAID	$ 520,557	$ 342,355	66%
CTAP	$ 360,000	$ 193,751	54%
WB	$ 500,000	$ 212,884	43%
FHI	$ 325,450	$ 419,342	129%
CHAI	$ 45,661	$ 27,802	61%
Grand Total	**$ 9,818,840**	**$ 5,071,434**	**52%**

Table 2: Summary Expenditure of NCHADS and Provincial by Sources in 2005

Project Components	*DFID*	GFATM	CDC	EUROPAID	CTAP	WB	FHI	CHAI	Grand Tot
VAT Exp	$ 2,264	$ 184	$ 604						$ 3,052
IEC	$ 182,805	$ 2,014	$ 18,312				5286		$ 208,417
Outreach	$ 86,021	$ 36,104	$ 7,205	$ 997			100173		$ 230,500
100% CUP	$ 57,896	$ 39,661	$ 6,368			$ 7,273			$ 111,198

STD Management	$ 87,437	$ 268,196	$ 106,418				31121		$ 493,172
Universal Precaution	$ 15,426		$ 2,760	$ 1,679					$ 19,865
Support Group and MMM	$ 3,564	$ 16,676							$ 20,240
Institutional Care	$ 177,713	$ 561,521	$ 42,100	$ 132,696		$ 48,966	12530	$ 7,913	$ 983,439
Home Based Care	$ 73,758	$ 2,825	$ 17,959			$ 156,645			$ 251,187
VCCT	$ 67,554	$ 351,387	$ 232,823	$ 14,450			12860		$ 679,074
CoC	$ 59,520	$ 36,731	$ 5,440	$ 5,407			207152		$ 314,250
PMTCT			$ 2,187						$ 2,187
Surveillance and Research	$ 3,886		$ 19,943		$ 193,751		50220		$ 267,800
Project Coordination and Managemenent	$ 546,276	$ 282,324	$ 451,438	$ 187,126				19889	$1,487,053
Total Expenditure	**$ 1,364,120**	**$ 1,597,623**	**$ 913,557**	**$ 342,355**	**$ 193,751**	**$ 212,884**	**$ 419,342**	**$ 27,802**	**$5,071,434**

NB: For GFATM Plan (included R1, R2 and R4), but the expenditure has only R1 and R2, for R4 just started since Janaury 2006

Table 3: NCHADS DFID Expenditures in 2005

	Components	Year Plan	Expenditure	%
1	BCC	$ 95,960	$ 87,065	91%
2	STD	$ 92,130	$ 31,162	34%
3	AIDS Care	$ 578,980	$ 233,599	40%
4	Surveillance	$ 6,000	$ -	0%
5	Research	$ 40,000	$ 3,886	10%
6	PCM	$ 596,983	$ 396,083	66%
	Total	**$ 1,410,053**	**$ 751,795**	**53%**

Table 4: NCHADS Expenditures by GFATM funded in 2005

	Components	Year Plan	Expenditure	%
1	BCC	$ 21,090	$ 9,911	47%
2	STD	$ 425,557	$ 249,165	59%
3	AIDS Care	$ 3,538,101	$ 934,858	26%
4	PCM	$ 424,945	$ 214,194	50%
	Total	**$ 4,409,693**	**$ 1,408,128**	**32%**

Table 5: NCHADS Expenditures by EUROPAID funded in 2005

	Components	Year Plan	Expenditure	%
1	BCC	$ 10,638	$ 997	9%
2	AIDS Care	$ 298,491	$ 145,547	49%
3	PCM	$ 191,236	$ 180,310	94%
	Total	**$ 500,365**	**$ 326,854**	**65%**

Table 6: NCHADS Expenditures by CDC funded in 2005

	Components	Year Plan	Expenditure	%
1	BCC	$ -	$ 2,060	#DIV/0!
2	STD	$ 60,000	$ 28,730	48%
3	AIDS Care	$ 58,840	$ 115,733	197%
4	Surveillance	$ 86,600	$ 4,303	5%
5	Research	$ 49,000	$ 9,780	20%
6	PCM	$ 192,500	$ 151,352	79%
	Total	**$ 446,940**	**$ 311,958**	**70%**

Table 7: Provincial Expenditures by DFID in 2005

	Province	Year Plan	Expenditure	%
1	BTB	$ 45,649	$ 30,737	67%
2	KCM	$ 24,288	$ 23,953	99%
3	KCN	$ 40,209	$ 37,652	94%
4	KDL	$ 39,036	$ 35,967	92%
5	KEP	$ 17,223	$ 14,535	84%
6	KPT	$ 39,228	$ 35,745	91%
7	KTM	$ 38,605	$ 36,225	94%
8	KRT	$ 25,998	$ 25,033	96%
9	KSP	$ 39,910	$ 35,140	88%
10	KHK	$ 34,640	$ 34,260	99%
11	OMC	$ 19,740	$ 19,650	100%
12	MDK	$ 12,168	$ 11,546	95%
13	PLN	$ 11,194	$ 10,644	95%
14	PNP	$ 12,010	$ 9,941	83%
15	PST	$ 14,318	$ 11,953	83%
16	PVG	$ 72,307	$ 70,238	97%
17	PVH	$ 19,663	$ 19,011	97%
18	RTK	$ 19,736	$ 17,424	88%
19	SRP	$ 43,712	$ 38,820	89%
20	SHV	$ 17,821	$ 16,024	90%
21	STG	$ 20,747	$ 17,469	84%
22	SVR	$ 56,321	$ 44,270	79%
23	TKV	$ 14,048	$ 13,918	99%
	TOTAL	**$ 678,571**	**$ 610,155**	**90%**

Table 8: Provincial Expenditure funded by GFATM 2005

Province	Year Plan	Expend	%
KCM	$ 38,159	$ 32,047	84%
PLN	$ 13,771	$ 12,949	94%
PNP	$ 27,086	$ 20,114	74%
PST	$ 24,286	$ 18,179	75%
SHV	$ 24,615	$ 16,564	67%
TKV	$ 22,159	$ 22,274	101%
Total	**$ 150,076**	**$ 122,127**	**81%**

Table 9: Provincial Expenditures by CDC funded in 2005

Province	Year Plan	Expenditure	%
BMC	$ 274,964	$ 193,975	**71%**

Table 10: Provincial Expenditures by EUROPAID funded in 2005

Province	Year Plan	Expend	%
PST	2,205	1705	77%
TKV	17,987	13796	77%
Total	**20,192**	**15,501**	**77%**