United States Agency for International Development

Cambodia HIV/AIDS Strategic Plan 2002-2005

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Executive Summary

Cambodia has the highest measured national prevalence of HIV in Asia. The national 2002 HIV Sentinel Surveillance survey indicates an estimated HIV prevalence rate of 2.6 percent among general population adults aged 15-49 years. The HIV/AIDS epidemic can be categorized as one that is concentrated and in the early stages of becoming generalized due primarily to heterosexual transmission. In response, the United States Agency for International Development (USAID)/Washington designated Cambodia as a Rapid Scale-Up country for HIV/AIDS in 2002, a designation accompanied by increased financial and technical resources.

Since 1998, data suggests that HIV transmission in Cambodia has been declining, partly attributable to USAID's activities in HIV prevention since 1996. Reductions in risk-taking behavior among key target sub-populations have contributed to these declines, as has the increase in AIDS-related deaths. The national and international response to the AIDS epidemic has been pro-active and aggressive. Commitment at the highest levels of the government, a strong political will and evidence-based interventions have played a large role in the reduction of HIV transmissions among brothel-based female sex workers and uniformed personnel—two of Cambodia's most vulnerable populations.

Numerous challenges persist. Recent data suggest a general shift in HIV transmission from female sex workers and their male clients to transmission between husbands and their wives. This epidemiologic transition has resulted in the transmission of HIV to a greater number of infants. While the majority of people infected with HIV currently live in urban areas and in border provinces, especially those provinces bordering Thailand, this concentrated geographic pattern is expected to change in coming years due to a high degree of population mobility. Newly impacted populations and increasing demands for quality care services are among the issues donors and the government must address. Greater emphasis needs to be placed on improving the quality of, and access to, home-, community- and institutional-based care for people living with HIV/AIDS. Critical services include the diagnosis and treatment of tuberculosis and other opportunistic infections. All of these demands are placing an increasing burden on a relatively new and fragile health system.

In addressing the complexity of the epidemic, USAID/Cambodia is involved across the continuum from prevention to care and support to policy advocacy. In particular, the program aims to:

1. Concentrate geographically to provide a comprehensive package of prevention and care services in the most affected provinces;
2. Work nationwide on selected high-impact interventions such as condom

social marketing, training for uniformed personnel, and capacity-building for health facility staff;
3. Support programs that link prevention to care and support as a way to slow the spread of HIV into the general population, especially among women and infants, and care for the increasing number of HIV-infected Cambodians;
4. Promote effective models of home and community care for those infected and affected by the epidemic in order to bring care closer to home and to lessen the burden on the formal health system;
5. Continue to conduct research on best practices to effectively reach key populations and encourage behavior change;
6. Expand Cambodia's premier "second generation" surveillance system to monitor epidemiological and behavioral trends of the epidemic, followed by the use of the data to develop appropriate programs; and
7. Involve all segments of Cambodian society that can best deliver the message of self-protection and non-discrimination, including Buddhist monks and nuns, village leaders, elected officials, and pop culture celebrities.

The Cambodia HIV/AIDS strategy operates under the Public Health Interim Strategy 2002-2005: Increased Use of High Impact HIV/AIDS and Family Health Services and Appropriate Health Seeking Behaviors (pending approval for extension until 2006). It is in harmony with the Cambodian Ministry of Health's Comprehensive and Multisectoral Response to HIV/AIDS 2001-2005 as well as the Health Sector Strategic Plan 2003-2007.

The HIV/AIDS component is the most significant portion of the overall Population Health and Nutrition (PHN) portfolio for Cambodia, consisting of $13.8 out of $22.1 million of the annual PHN budget. The implementation modality for the Mission's PHN program includes working through eleven Cooperating Agencies, some of which provide sub-awards to over fifty local and international non-governmental organizations.

As a Rapid Scale-Up country, Cambodia is required to demonstrate results within the timeframe of the strategy. As a result, monitoring and evaluation are key components of the strategy. The Cambodia strategy follows the Agency's established comprehensive system on reporting results and involves close cooperation with USAID/Washington to develop benchmarks and report on progress.

While the epidemic seems to rage on unabated in other parts of the world, Cambodia—despite its human resource and financial limitations—is making progress by responding in a timely and evidence-based manner. The role of USAID, as the largest bilateral HIV donor, is to encourage local participation and nurture indigenous commitment and enthusiasm. This HIV/AIDS Strategy, 2002-2005, is the road map to achieve that goal.

Acronyms

ABC	Abstinence, Be Faithful, Condoms Use
ADB	Asia Development Bank
AEM	Asia Epidemic Model
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANE	Asia and Near East
API	AIDS Program Index
ARV	Antiretroviral
ART	Antiretroviral Therapy
AusAID	Australian Agency for International Development
AZT	Zidovudine
BSS	Behavioral Surveillance Survey
CA	Cooperating Agency
CBA	Use Condoms, Be Faithful, Abstinence
CAA	Children Affected by AIDS
CDC	Centers for Disease Control and Prevention
CDC-GAP	Centers for Disease Control and Prevention-Global AIDS Program
CDHS	Cambodia Demographic and Health Survey
CENAT	National Center for Tuberculosis and Leprosy
CIDA	Canadian International Development Agency
CUP	Condom Use Program
DfID	Department for International Development
DFSW	Direct Female Sex Worker
DOTS	Directly Observed Treatment (Short-Course)
EPP	Estimations Projections Program
EWC	East West Center
FHI	Family Health International
FSW	Female Sex Worker
FY	Fiscal Year
GDP	Gross Domestic Product
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with AIDS
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HBC	Home-Based Care
HCAR	HIV/AIDS Care and Support
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HIVA	HIV/AIDS Prevention
HKID	Children Afflicted by HIV/AIDS
HSS	HIV Sentinel Surveillance
ID	Infectious Disease
IEC	Information, Education and Communication
IFSW	Indirect Female Sex Worker
ILO	International Labor Organization
IPT	Isoniazid Prophylactic Therapy
IR	Intermediate Result
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau
KHANA	Khmer HIV/AIDS NGO Alliance
LS	Life Skills
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information System

MoH	Ministry of Health
MoI	Ministry of the Interior
MoND	National Ministry of Defense
MSM	Men Who Have Sex with Men
MTCT	Mother-to-Child Transmission
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology & Sexually Transmitted Diseases
NGO	Non-Governmental Organization
NMCHC	National Maternal and Child Health Center
NSP	National Strategic Plan
OD	Operational District
OI	Opportunistic Infection
OPH	Office of Public Health
OVC	Orphans and Vulnerable Children
PARH	Policy Analysis, Reform and Systems Strengthening/HIV
PHN	Population, Health and Nutrition
PLWHA	People Living with HIV/AIDS
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RCH	Reproductive and Child Health
RGC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
SO	Strategic Objective
SpO	Special Objective
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SURV	HIV/AIDS Surveillance
SW	Sex Worker
TB	Tuberculosis
TBA	Traditional Birth Attendant
TBD	To Be Determined
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UHN	United Health Network
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDOL	United States Department of Labor
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WRA	Women of Reproductive Age

I. The Country Situation

A. The Overall Development Situation

Three decades of civil war, including the brutal genocide and systematic destruction of infrastructure under the Khmer Rouge regime, created a deficit in Cambodia's economy and left its largely rural population severely deprived. The Paris Peace Accord in 1991 and the UN-brokered elections in the early 1990s signaled a new but tenuous beginning. Unfortunately, economic recovery was further crippled by domestic political upheaval in 1997 and the subsequent financial crisis in the region from 1997-1999.

In the past decade, the Cambodian people have made immense progress towards rebuilding their country, but challenges persist: eighty-five percent of the nation's population resides in rural areas with inadequate access to basic services. According to the United Nations Development Program (UNDP)'s 2003 Human Development Index, which measures a country's achievements in life expectancy, educational attainment and adjusted real income, Cambodia ranks 130th out of 173 countries.

Poverty, malnutrition and poor or non-existent health services have resulted in some of the worst health conditions in the world (see Table 1). Almost one in ten babies will die prior to his/her first birth-day. Diarrheal diseases, acute respiratory infections and low vaccination rates for preventable diseases are the primary causes for almost half of the extremely high under-five mortality rate. Chronic malnutrition among Cambodian children is common, with 45 percent of children moderately stunted and more than one in five severely stunted.

Additionally, levels of micro-nutrient deficiency for iron, vitamin A and iodine are high among children and women. A cycle of poverty, ill health and debt continues to cripple the country's development. Expenditures for health are a

major cause of debt, landlessness and poverty. Cambodians spend a significant portion of their scarce income paying for health care provided by traditional healers, drug sellers and unregistered or untrained pharmacists.

Table 1: Demographic and Health Indicators

Total Population[a]	12.3 million
Male:Female ratio[a]	93 : 100
TFR (women age 15-49)[b]	4.0
Annual Population Growth Rate[b]	1.8%
CPR (married women)[b]	18.5%
Unmet need for contraception[b]	32.6%
Population under age 15[a]	42.5%
Life expectancy at birth (male/female)[d]	54 / 58 years
Maternal Mortality Ratio[b]	437 / 100,000
Births attended by trained professionals[b]	31.8%
Women receiving antenatal care[b]	37.7%
Pregnant women receiving 2+ doses of TT[b]	30.0%
Neonatal Mortality Rate[b]	37.3 / 1,000
Infant Mortality Rate[b]	95.0 / 1,000
Under 5 Mortality Rate[b]	124.4 / 1,000
Adult population with HIV/AIDS[e]	2.6%

Sources: a US Census Bureau, 2002 International Database
b National Institue of Statistics, Directorate General for Health (Cambodia) and ORC Maccro, 2000 Cambodia Demographic and Health Survey
c World Bank, 2002 World Development Report
d Population Reference Bureau, 2003 World Population Wall Chart
e NCHADS, 2002 HIV Sentinel Surveillance (HSS) survey

The burden of communicable diseases is tremendous, especially HIV/AIDS, tuberculosis (TB) and malaria. The HIV/AIDS epidemic in Cambodia threatens to undermine successes that could be achieved through other development efforts in economic growth and the reduction of morbidity and mortality. For this reason, the United States government ranks health assistance to Cambodia as a priority and the United States Agency for International Development (USAID) has prioritized Cambodia as a Rapid Scale-up country for HIV/AIDS interventions (see Section I/D Rapid Scale-Up Designation).

B. The HIV/AIDS Situation

1. HIV/AIDS Epidemiology in Cambodia

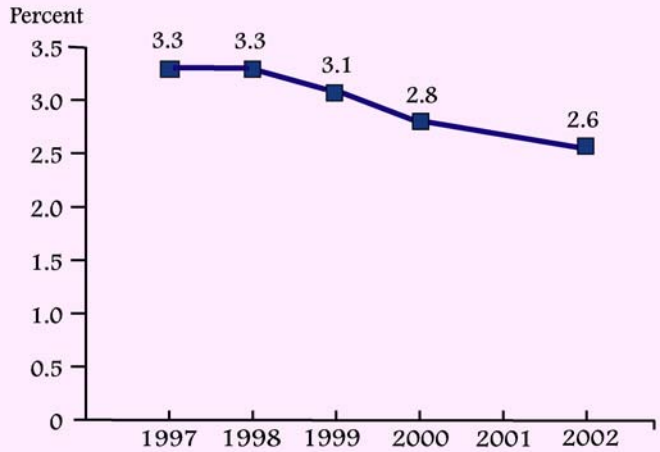
Cambodia has the highest national prevalence of HIV in Asia. Most experts feel that Cambodia is moving toward a generalized epidemic because the prevalence in the general population is greater than one percent. The national 2002 HIV Sentinel Surveillance (HSS) survey indicates an estimated HIV prevalence rate of 2.6 percent among general population adults aged 15-49

years.[1] Based on this prevalence rate, approximately 157,500 adults are estimated to be currently living with HIV/AIDS in Cambodia.

The first HIV positive test result was reported to the National Blood Transfusion Center in Phnom Penh in 1991. In late 1993 and early 1994, the first cases of AIDS were diagnosed. Between 1995 and 1998, HIV surveillance data from the national surveillance system managed by the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) showed rapid transmission of HIV in several key populations predominantly due to heterosexual transmission.

Results from Cambodia's surveillance system present evidence of HIV transmission declines among the general population since 1998 (see Figure 1). The reduction in risky behavior among key target sub-populations has contributed to these declines, as has the increase in AIDS-related deaths.

Figure 1: Estimated HIV Prevalence among Men and Women Aged 15-49



SOURCE: NCHADS, 2002 HSS.

Commitment at the highest levels of the Cambodian government, a strong political will and evidence-based interventions have together contributed to HIV prevalence declines among some of the sentinel surveillance populations. The decline in prevalence among sex workers since 1998 has been dramatic, especially among direct (e.g., brothel-based) female sex workers (DFSWs), while the decline among the police has seemingly plateaued since 2000. Prevalence rates among women who obtain antenatal care (ANC) services have remained fairly constant, approximately three percent, but as high as eight percent in some provinces, suggesting increasing transmission in the general population (see Table 2, below).

Table 2: HIV prevalence among sentinel groups

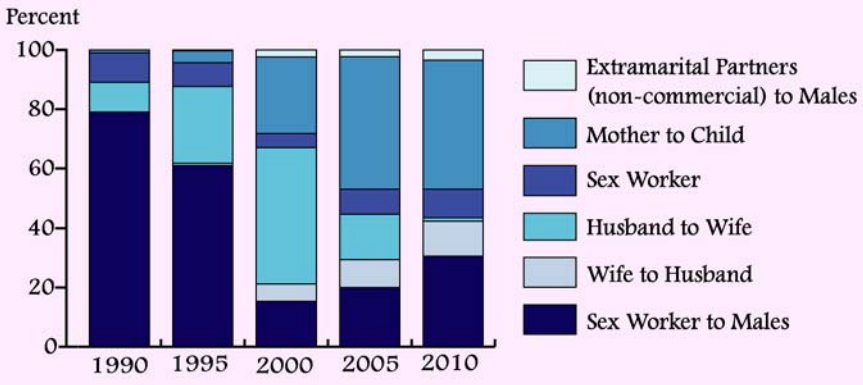
	1998	2000	2002
Adult Population aged 15-49 [a]	3.3%	2.8%	2.6%
Direct Female Sex Workers	42.6%	31.1%	28.8%
Indirect Female Sex Workers	19.2%	18.8%	14.8%
Urban Police	6.2%	3.8%	3.9%
Blood Donors	4.2%	2.7%	2.3%***
ANC Attendees (Crude)	3.2%*	2.3%	2.8%
TB patients	3.9%**	6.7%	8.4%

Source: NCHADS/HSS, 1997-2002; *1997 data; **1999 data; ***2001 data
[a] Estimate based on sentinel data.

2. The Shifting Epidemic

Despite these declining trends in overall HIV prevalence, HIV transmission is increasing among certain subpopulations. According to the 2002 Asia Epidemic Model (AEM), developed by the East West Center (EWC), University of Hawaii, and funded by USAID, the male to female HIV infection ratio has decreased from what was previously estimated to be 2.5:1.0 in 1995 to 1.4:1.0 in 2000. The AEM predicts that the ratio will be 1.0:1.0 by 2005, as many of the men infected in the early 1990s become ill and pass away. This indicates a general shift in HIV transmission between sex workers and their male clients, to transmission between husbands and their wives. (See Figure 2 on the changing modes of HIV transmission over time).

Figure 2: Primary Modes of HIV Transmission, 1990 to 2010



SOURCE: EWC, University of Hawaii, 2002 AEM.

This epidemiologic transition has resulted in the transmission of HIV to a greater number of infants. According to the 2002 AEM, one-third of all new HIV infections in 2000 can be attributed to mother-to-child transmission (MTCT). MTCT is projected to be responsible for nearly half (45%) of all new

infections in 2005. A further indication of the progression of the epidemic is the high number of HIV infected children from aged 0-15 years of age: 12,000 children 0-15 years of age are believed to be currently living with HIV/AIDS.

At the same time, the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) working group on Global HIV/AIDS and sexually transmitted infection (STI) surveillance estimated that by the end of 2001, there were 55,000 orphans in Cambodia—children who have lost one or both parents due to AIDS. This number is projected to increase significantly in the coming years as more AIDS-related deaths occur among men and women.

3. Geographic Patterns of the Epidemic

Although the HIV epidemic has spread to all provinces in Cambodia, the majority of people infected with HIV live in urban areas and in border provinces, especially those provinces bordering Thailand (see Map 1). This concentrated geographic pattern is expected to change in coming years due to migration to and from urban areas and from Cambodia to neighboring countries. As men and women leave their spouses and partners in search of economic stability, they often form new sexual networks that will inevitably increase the rate of HIV transmission.

4. Underlying Factors Leading to Risky Behavior

The HIV epidemic in Cambodia is driven primarily by the commercial sex industry. In Cambodia, this exchange can be found among direct (e.g., brothel-based) and indirect (e.g., based in karaoke lounges, massage houses, restaurants or casinos) sex workers. Commercial sex is fueled by poverty and lack of opportunities. With literacy levels among women in Cambodia persistently low and formal sector employment extremely competitive, many young women turn to work in brothels or entertainment facilities where they are at high-risk for HIV transmission and infection.

Map 1: HIV Prevalence by Geographic Location and High-Risk Populations, January 2003

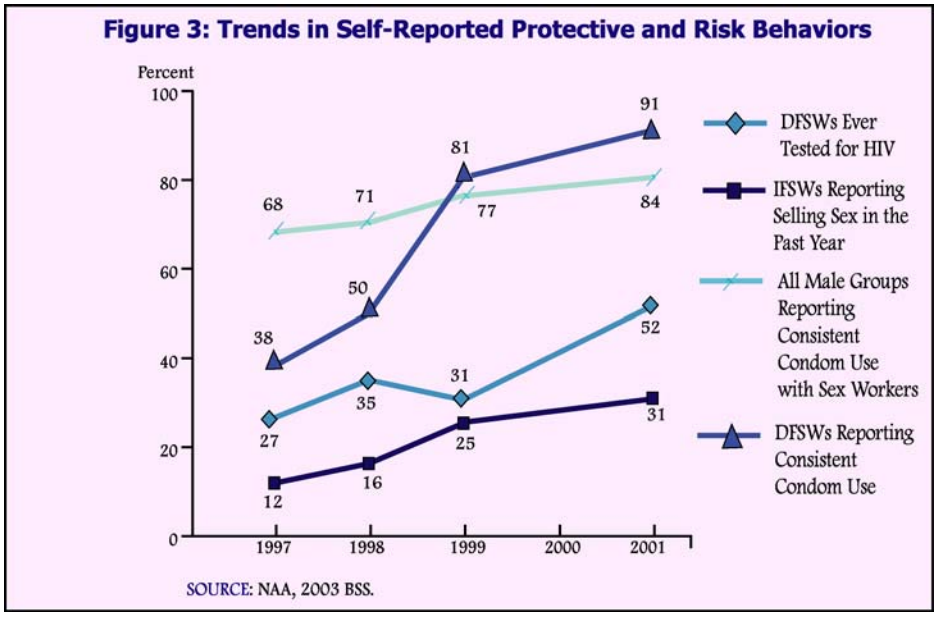
NOTE: Provinces were ranked by HIV prevalence and behavioral data using HSS and BSS data to determine high, medium, or low prevalence classification.

At the same time, tacit acceptance of male promiscuity and power imbalances between men and women in Cambodian society exacerbate the predominantly sexual transmission of HIV in the context of commercial sex. Social norms permit sexual relationships between married and un-married men and sex workers or “sweethearts” (non-commercial, regular sexual partners). Women typically do not engage in sexual activity until marriage (around age 20), but traditional gender roles often prevent them from talking about sex or negotiating condom use with their partners.

Cambodia’s dire economic situation also contributes to the spread of the virus. As men and women leave their spouses and partners in search of employment opportunities, they become detached from traditional familial and community support. New support networks may be difficult to establish, particularly for women entering the commercial sex industry. Female sex workers tend to change their venues of service frequently in order to maintain the allure of a “fresh face.” Male migrant workers, largely sanctioned by society to seek commercial sex, put their spouses and partners at risk when they return to their homes, often in rural villages.

While behavior change has been clearly demonstrated among sentinel groups in recent years (see Figure 3, below), evidence from other countries earlier in the epidemic readily illustrates that changes in high-risk sexual behavior are difficult to sustain over the medium- and long-term. Moreover, anecdotal reports from USAID implementing partners and NCHADS indicate that more commercial sex work is going “underground,” with greater numbers of women

moving from brothels into more clandestine, indirect forms of sex work. Results from the 2001 Behavioral Surveillance Survey (BSS), show an increasing proportion of beer promotion girls and other girls working in the recreation and entertainment industry reporting selling sex in the last year. The growing underground nature of commercial sex increases women's vulnerability to HIV and discourages them from seeking prevention information, counseling, testing and support services.



5. Increasing Need for Care, Support and Treatment

Although prevention programs have played an important role in reducing and stabilizing HIV prevalence among some important sub-population groups, Cambodia is experiencing increasing transmission in the general population. This shift is demonstrated by recent TB and HIV co-infection rates: HIV prevalence increased among TB patients from 3.9 percent in 1999 to 8.4 percent in 2002. The 2002 HSS also documented higher prevalence rates among TB patients in provinces bordering Thailand (Banteay Meanchey, 15.6% and Battambang, 21%) and in Phnom Penh (16%). These high and increasing rates indicate that greater numbers of HIV-infected individuals and children and families affected by HIV/AIDS require medical care and psycho-social and economic support (see Table 3).

Greater emphasis needs to be placed on improving quality and access to home-, community- and institutional-based care for people living with HIV/AIDS (PLWHA). Critical to care and support services are diagnosis and treatment of TB and other opportunistic infections (OIs) in order to prolong the lives and reduce the suffering of PLWHA. Moreover, as the price of

antiretrovirals (ARVs) decreases to affordable levels, it is imperative to prepare the health care system to deliver these drugs to patients in the future. Currently, there are five NGOs providing antiretroviral therapy (ART) at no or low cost in Cambodia. However, the programs are all considered pilot projects and cumulatively serve less than 1,000 Cambodians living with AIDS.

Table 3: Estimated HIV infection and AIDS data for Cambodia, 2002

Cumulative HIV Infections (aged 15-49) [a]	236,136
Number of New HIV Infection [a]	9,005
Cumulative AIDS Cases [a]	93,738
Cumulative AIDS Deaths [a]	78,653
Number of New AIDS Cases [a]	18,930
Number of New AIDS Deaths [a]	17,973
Number of People Living with HIV/AIDS (aged 15-49) [a]	157,500
Male to Female Ratio of HIV Infection [a]	1.1 : 1.0
Number of Children Living with HIV/AIDS (aged 0-15) [b]	12,000
Number of HIV/AIDS Orphans [b]	55,000
Source: a NCHADS, 2002 HSS b UNAIDS, Report on the Global AIDS Epidemic, 2002	

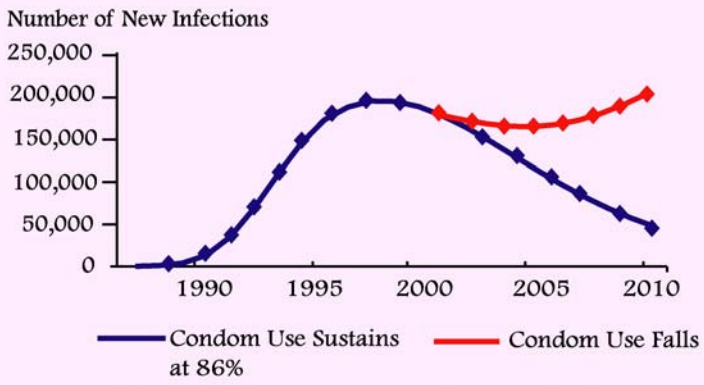
6. The Challenge

Although Cambodia can claim some credit in reducing HIV prevalence rates among concentrated sub-populations, the country must continue to strengthen its prevention efforts, even as care, support and treatment activities become equally important. High-risk sexual behavior remains a concern for certain sub-populations and bridging groups (groups that link sub-populations at high risk of HIV infection with the general population). Moreover, infection rates are still high despite the overall declines. A relaxation in HIV prevention efforts would have a detrimental effect on the epidemic, reversing declines and increasing the number of new infections. (See Figure 4 for projected epidemic trends with and without sustained condom use).

C. USAID Assistance and the Population, Health and Nutrition (PHN) Program

USAID began supporting health activities in Cambodia in 1994 with a focus on improving reproductive and child health (RCH) and reducing transmission of STIs and HIV among populations at high risk of infection and transmission. Strategic Objective Two (S02), “Improved Reproductive and Child Health” and Special Objective Two (Sp02), “Reduced transmission of STD/HIV among high-risk populations” were developed in 1996.

Figure 4: Projected Epidemiologic Trends with and without Sustained Prevention Efforts



SOURCE: University of Hawaii, EWC, 2002 AEM.

Political unrest in July 1997 resulted in the temporary suspension of almost all mission activities in Cambodia. In late 1997 USAID activities resumed in the form of a scaled-down health program with RCH and HIV/AIDS components. Congressional restrictions curtailed USAID's collaboration with the Royal Government of Cambodia (RGC) and restricted funding only to non-governmental organizations (NGOs). The immediate impact was a sizable reduction in mission funding, from $35.6 million in 1997 to as low as $15.7 million in 1999. Recognizing the need of Rapid Scale-up countries to work with the government, legislative and policy restrictions imposed in 1997 were lifted for HIV/AIDS programs for fiscal year (FY) 2002. Restrictions were lifted for the rest of the Population, Health and Nutrition (PHN) portfolio for FY 2003.

USAID's PHN portfolio at this time emphasized increasing supply, access and demand for high quality reproductive and child health services for Cambodians in targeted districts. The Special Objective for HIV/AIDS and STIs emphasized policy development and behavior change, with an emphasis on developing and testing model STI and HIV/AIDS service delivery programs for populations considered most at risk for HIV infection and transmission. The SO and SpO both ended in September 30, 2002 and official close-out procedures are in progress. However, the mandates of the two objectives are clearly visible in the new integrated SO for the Three Year PHN Interim Strategy, reflecting the conscious effort to sustain progress to date and to expand program models that have proven successful.

The year 2001 saw a significant milestone for USAID's PHN program with a planned shift from the uncertainties of year-to-year funding to a committed three-year interim strategy. The Public Health Interim Strategy 2002-2005 is the result of extensive consultation between USAID and the RGC, the Cambodian Ministry of Health (MoH), USAID's implementing partners, other

donors and representatives of Cambodian and international NGOs. USAID's major implementing partners agreed to work collaboratively throughout the planning process and during the implementation and evaluation of the integrated strategy. USAID-funded partners, under the guidance of the Office of Public Health collaborate to avoid overlap in the continuation of existing projects, in the scale-up of proven models and in the initiation of new activities. The USAID partners renewed their commitment to develop and operationalize their interventions in tandem with the MoH's National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2001-2005 and the Health Sector Strategic Plan, 2003-2007 (see Section I/E. The Royal Government of Cambodia (RGC)'s National Response to HIV/AIDS below).

The Public Health Interim Strategy 2002-2005 is currently pending USAID/ Washington approval for a one year extension to 2006. If approved, the HIV/AIDS Strategy - as a companion to the PHN Strategy - will also be extended until 2006.

D. Rapid Scale-Up Designation

In late 2001, USAID/Washington designed an expanded response strategy aimed at improving the ability of developing countries to prevent HIV transmission and to provide services to those infected and affected by the epidemic. As part of the strategy, four countries—Cambodia, Kenya, Uganda and Zambia—were designated as "Rapid Scale-Up" countries. These countries began receiving significantly increased technical and financial resources in 2001 in order to achieve measurable impacts. Both USAID and the Centers for Disease Control and Prevention (CDC) are substantially increasing HIV/AIDS assistance in Cambodia.

E. The Royal Government of Cambodia's (RGC) National Response to HIV/AIDS

The RGC works with bilateral donors, local and international NGOs, United Nations (UN) agencies and numerous other entities on a range of prevention and care activities. The government's current priorities include intra-ministerial cooperation; prevention of mother-to-child transmission (PMTCT) of HIV; school-based HIV and family health education; behavior change communication (BCC) programs to populations considered to be at high-risk of HIV infection and transmission; capacity-building at the provincial level to respond to the HIV epidemic; and community-based prevention and care programs.

The RGC recently completed its National Strategic Plan (NSP) for a Comprehensive and Multisectoral Response to HIV/AIDS 2001-2005. The

strategy adopts two complementary approaches to decrease vulnerabilities to HIV/AIDS at the individual, community and societal levels. The first approach concentrates on the determinants of behaviors at the individual level while the second approach focuses on changing aspects of the socio-economic, legal and political environment.

Within the context of the NSP, a number of provincial and ministerial strategic plans have been developed (see Box 1, opposite). These plans recognize that individual risk is compounded by realities that significantly limit individual choices and options for risk reduction including illiteracy; gender power imbalances; ignorance about HIV/AIDS; discrimination and the marginalization of population groups such as trafficked women and children, sex workers, and PLWHA; the legal environment; policy capacity; and government commitment and capacity to mount effective responses and to protect and promote political, economic and social human rights.

Box 1: Ministerial HIV/AIDS Strategic Plans

HIV/AIDS strategic plans have been developed by several of Cambodia's line ministries including:

- **The Ministry of Health (MoH):** The MoH's Strategic Plan for HIV/AIDS and STI Prevention and Care, 2001-2005, is aimed at reducing transmission in high-risk situations through condom promotion; STI treatment promotion; awareness-raising; improved access to voluntary counseling and testing (VCT) services; and through efforts designed to equip the health system to cope with an increased demand for health services related to HIV/AIDS. NCHADS plays a leading role in implementing and over-seeing the national health response to HIV/AIDS, as well as providing technical support to other governmental agencies and national partners.

- **The Ministry of National Defense (MoND):** The MoND's HIV/AIDS Strategic Plan, 2002-2006, calls for the implementation of an STI/HIV/AIDS prevention peer education project and is working with Family Health International (FHI)'s IMPACT project to develop BCC messages for HIV/AIDS prevention and care targeted toward military personnel and their families.

- **The Ministry of Social Affairs, Labor, Vocational Training and Youth Rehabilitation (MoSALVY):** The MoSALVY's Strategic Plan for a Comprehensive Response to HIV/AIDS, 2002-2006, includes multiple interventions designed to decrease the social vulnerabilities of children and youth to HIV/AIDS; developing workplace interventions to prevent transmission of HIV and increase access to services; and enhancing programs preventing human trafficking. The ministry also strives to protect those who are in illegal situations due to human trafficking, including sex workers, domestic helpers and illegal immigrant workers.

- **The Ministry of Rural Development (MRD):** The MRD's Strategic Plan for a Comprehensive Response to HIV/AIDS, 2002-2006, aims to integrate HIV/AIDS prevention in all rural infrastructure programs. Current funding from UNICEF enables project implementation in Kampong Chhnang and Kampong Speu, establishing youth volunteer groups and working with the Village Development Committees.

There are two major institutions within the RGC that have an explicit HIV/AIDS mandate. The National AIDS Authority (NAA) plays a coordinating role in the

implementation of the plan. Established in January 1999, the NAA leads a multi-sectoral response, including representation from 24 line ministries as well as all of Cambodia's 24 provinces. The NAA has the legal mandate to coordinate policy development; strengthen partnerships among all stakeholders; mobilize resources from national and international institutions and agencies; advocate for legislative support and coordinate research among all parties involved in Cambodia's HIV/AIDS effort. NCHADS complements the NAA as the MoH's technical and implementation arm for HIV/AIDS. In this role, NCHADS works closely with NGOs and donors to develop protocols and curricula for STI treatment, VCT and continuum of care; conduct surveillance; operate VCT and STI clinics based in referral hospitals; implement the 100% Condom Use Policy (CUP) and other programmatic efforts.

F. Other International Assistance and Donor Collaboration

Cambodia continues to be heavily dependent on foreign assistance and international assistance continues to play a vital role in national development. Although Cambodia's Gross Domestic Product (GDP) grew at an average of four percent per year over the period 1996-2000 and progress was made in mobilizing government revenue, external assistance was still equivalent to an average of 15 percent of GDP from 1998-2000 and 138 percent of the national budget. External assistance in the year 2000 was equivalent to approximately $40 per capita. Moreover, the overall deficit in this period was almost completely financed (96%) from foreign sources and 73 percent of capital expenditures were foreign-financed.

Bilateral assistance comes from a number of countries. Japan is by far the largest bilateral donor, providing nearly $90 million per year, however, this is likely to decline in the near future. Although unaccounted for in official statistics, Chinese assistance is reported to be some $30 million a year; China is also the source of substantial foreign direct investment. Australia and France have each contributed around $20 million per year over the past two years. The U.S. is the largest donor in the health sector, contributing $23 million in FY 2002 out of a total aid package of $40 million. Other important bilateral donors include Sweden, Germany, the United Kingdom (UK) and the Netherlands, who contribute between $8-16 million per year. Japan, Australia, France and Germany all implement projects directly with the government. Australia, Sweden, the UK and the Netherlands channel significant portions of their assistance through UN agencies. Nearly all of the major donors channel a portion of their assistance to donor-country NGOs and/or local NGOs.

Coordination mechanisms have been put into place in the health and education sectors. The Health Sector Reform Program came out of a collaborative process and the MoH is working with its partners to develop a

sector-wide approach for managing future assistance and articulate a MoH strategy for 2002-2007.

Other bilateral and multilateral donors are very interested in establishing close partnerships within the HIV/AIDS sector. USAID identified several prospects for collaboration through consultations with other donors in the development of this strategy. These include partnerships with:

a) UNICEF: UNICEF has taken the lead in supporting and promoting the PMTCT program implemented by the National Maternal and Child Health Center (NMCHC) in Phnom Penh. USAID has participated in the technical working group meetings that helped shape this program and to develop the national guidelines for scaling-up the program to larger areas of the country. USAID partners are beginning to establish PMTCT programs and will support the national program to also expand its efforts.

b) Asian Development Bank (ADB): ADB has launched a new three-year assistance effort designed to prevent HIV/AIDS transmission, especially among highly mobile populations, in four provinces along Cambodia's borders with Thailand and Vietnam (Battambang, Koh Kong, Prey Veng and Svay Rieng).

Some of these provinces have also been selected as focus areas for USAID interventions. USAID and the ADB will work together to structure their respective assistance investments to complement and reinforce their efforts.

c) Japanese International Cooperation Agency (JICA): The USAID Cambodia mission has a signed a US-Japan Partnership agreement with JICA. The agreement includes some, but not all, of the following elements of JICA in-country support related to HIV/AIDS. JICA is currently providing technical assistance to the PMTCT program through its mother and child health (MCH) project at the NMCHC. JICA also provides support to the Khmer HIV/AIDS NGO Alliance (KHANA), a national NGO also supported by USAID. Support from both donors to KHANA complement each other, enabling KHANA to reach greater numbers of the population affected by HIV/AIDS. Additionally, JICA provides support to the National Center for Tuberculosis and Leprosy (CENAT) which, together with NCHADS, has developed an HIV/TB co-infection strategy. USAID played a significant role in developing this strategy along with CDC and JICA and will co-finance the pilot phase of the strategy in four provinces in collaboration with the CDC and JICA (see Section II/2. Care and Support /d. Principal Interventions).

d) Department for International Development (DfID): In the spring of 2003, the UK development agency began a new three-year HIV/AIDS strategy in Cambodia which includes budgetary support for NCHADS; technical

assistance and capacity-building for the NAA and its constituent ministries; an ambitious, national-level media effort; and support for the development of HIV/AIDS education activities by the Ministry of Education, Youth and Sports. USAID and DfID will coordinate closely in the implementation of the media activities and support to NCHADS and NAA. Moreover, DfID officials have indicated that they might consider targeting a portion of their support for a small number of Operational Districts (ODs), and would welcome USAID's assistance in identifying the sites for complementary programs in the provinces. DfID also plans to continue providing condoms for the USAID-supported Number One condom social marketing program.

e) The Bill and Melinda Gates Foundation: The Gates Foundation is funding KHANA through the International HIV/AIDS Alliance. USAID also funds KHANA to provide HIV/AIDS prevention, care and support. The Gates- and USAID-funded programs will complement each other in the provinces where KHANA works, enabling the organization to provide more comprehensive coverage than it could with only one funding source.

f) The Global Fund for HIV/AIDS, TB and Malaria (GFATM): The GFATM has approved funding for Cambodia in two rounds, totaling $47.41 million, of which $30.77 million has been awarded for HIV/AIDS. The focus of the Global Fund's HIV/AIDS program in the first round will be to reduce the burden of HIV/AIDS by mitigating the impact of AIDS on specific population groups such as sex workers; the military, police and other commercial sex clients; youth; garment factory workers; PLWHA; and pregnant and vulnerable women and their children. The second round will emphasize care and support, including possibly ART and pharmaceutical management related to ARV. The program will be implemented by 11 sub-recipients, of which two, KHANA and Population Services International (PSI), are also USAID partners.

USAID is extremely active as the bilateral donor representative on the Cambodia Coordination Committee and member of Technical Review panels. Moreover, USAID has taken the lead in helping the Principal Recipient establish their structure, hire staff, and create policies and protocols through direct financial as well as technical assistance. It is foreseen that USAID will continue to be actively involved in providing similar assistance and remain flexible to meet the needs of the changing donor environment.

g) Pfizer Foundation: The Pfizer Foundation is providing funding through EngenderHealth to the Reproductive and Child Health Alliance (RACHA), a local NGO, to develop HIV education among rural populations. The support is for a one-year period and complements USAID-funding by providing the strategy and materials for HIV education through community-based education programs including Buddhist Wat (temple) communities, village volunteers, traditional birth attendants (TBAs) and sero-discordant couples.

Others: Other donors providing funds for HIV/AIDS in Cambodia include the Australian Agency for International Development (AusAID) which is focusing its investments in a few selected provinces/ODs, the Canadian International Development Agency (CIDA), the European Union, French Cooperation, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Kreditanstalt für Wiederaufbau (KfW), the UN Population Fund (UNFPA), UNAIDS, the UN Educational, Social and Cultural Organization (UNESCO), the WHO and the World Bank.

Collaboration with other US Government Agencies

USAID also collaborates with US government agencies involved in HIV/AIDS program including:

a) Centers for Disease Control and Prevention (CDC): The CDC implements the Global AIDS Program (CDC-GAP) in Cambodia. USAID works closely with CDC-GAP in the western province of Banteay Meanchey, where both USAID and CDC implement HIV prevention and care programs. CDC-GAP also works with the RGC to provide technical assistance with USAID funds to the HIV surveillance system. A joint USAID-CDC review of the NCHADS was conducted in July 2003.

b) US Department of Labor (USDOL) (with the International Labor Organization (ILO)): The USDOL is funding the ILO to undergo an initiative on “HIV in the Workplace”. This initiative will focus on workplace policy toward PLWHA and help to establish workplace standards for HIV prevention programs. The key implementing agency for the USDOL program is one of USAID’s implementing partners on HIV/AIDS activities, Family Health International (FHI). As such, the USDOL program is well-integrated and coordinated with USAID.

c) US Department of State (USDOS): The USDOS, directed from the US embassy, has taken important steps to reduce the trafficking of women and children in Cambodia. This effort can potentially play a significant role in reducing HIV transmission, as a high proportion of trafficked women and girls end up in the commercial sex industry. USAID maintains information flow to embassy staff in order to ensure good coordination and to complement the USDOS efforts. In addition, the USAID supports the USDOS Regional Science and Technology Officer on matters related to cross-border programs and other HIV/AIDS activities of regional significance.

II. Mission Strategy

USAID addresses the HIV/AIDS epidemic in Cambodia at multiple levels across the continuum from prevention to care and support to policy advocacy. Prevention interventions take place nationally and are targeted for population groups that are known to engage in high-risk behaviors and groups that are known to have a high prevalence of HIV infection compared to the general population. At the same time, generalized prevention, care and support interventions at the community level are implemented in focused geographic areas with high rates of HIV/AIDS and integrated into USAID's larger PHN portfolio. Included in care and support are home-based care (HBC); support for people living with HIV/AIDS (PLWHA) and children affected by AIDS (CAA); support for orphans and vulnerable children (OVC); technical support for, and promotion of, voluntary counseling and testing (VCT); and technical support for prevention of mother-to-child transmission (PMTCT) of HIV. Finally, USAID supports interventions at the policy level, both with national and local policy- and decision-makers, to create an enabling environment for the implementation of prevention, care and support activities.

A. Rationale and Major Elements

USAID's three-year interim strategy (now proposed to be extended until 2006) commenced in October 2002. The expanded response places primary emphasis on linking prevention to care and support. This focus supports the downward trend of HIV incidence among major high-risk groups and is aimed at helping to slow the spread of the epidemic into the general population, especially among women and infants. It also recognizes that as more HIV-infected Cambodians progress to symptomatic AIDS, effective linkages among the different program components are needed. Effective home-based treatment models are being developed, tested and replicated as appropriate for PLWHA who are unable to receive adequate treatment through the formal health system. USAID also helps to promote effective models for the support of children, adults (especially the elderly) and families affected by AIDS. Research on best practices to effectively reach key populations remains an important focus. Finally, USAID continues to support and expand Cambodia's premier "second generation" surveillance system to monitor the epidemiological and behavioral trends of the epidemic in Cambodia. These data are critical to help the RGC and other partners to appropriately balance prevention and care efforts; to develop optimal local prevention messages; and to target messages to multiple sectors of the population. In designing its assistance program for the HIV/AIDS sector, USAID followed the guidance of Cambodia's National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2001–2005 (see Section I/E The Royal Government of Cambodia's (RGC) National Response to HIV/AIDS). This plan reflects an important paradigm shift from an exclusively health-centered and top-down

approach to a more holistic development approach that is gender- and community- sensitive. In developing and implementing health sector-related interventions to address HIV/AIDS, USAID ensures consistency with NCHADS and NAA policies and guidelines.

USAID seeks to broaden this paradigm shift across its entire PHN strategy. In the past, by offering various health services through vertical structures, major opportunities have been missed to improve the technical quality of services; take full advantage of all available channels for HIV/AIDS prevention; and to improve cost-effectiveness. USAID will support the delivery of an integrated health package at the OD level, ensuring that links are made between HIV/AIDS and all other health programs. Integrated programming is expected to have a greater impact and to help in the identification of approaches which can be replicated by the RGC and other donors in other geographic areas.

Keeping the approved, integrated PHN strategy in mind, USAID/Cambodia's HIV/AIDS strategy is multidimensional with a national, a population and a geographic focus. The three foci are independent, but the overall program strategy is enhanced by the synergistic effect of all three working together simultaneously.

National Focus:

USAID continues to work with the RGC through the NAA, NCHADS, MoH, MoND, Ministry of the Interior (MoI) and other government entities to develop and implement policies, legislation, guidelines and frameworks. USAID and Cooperating Agencies (CAs) will continue to collaborate through technical working groups, such as those on Continuum of Care, VCT, TB/HIV, PMTCT and Monitoring and Evaluation to develop guidelines and frameworks, while at the same time support PLWHA networks to advocate for anti-discrimination legislation and policies as well as implementation guidelines for enacting and enforcing such legislation. For example, the Cambodian Parliament recently enacted the 2002 Law on the Prevention and Control of HIV/AIDS. USAID was instrumental in advocating for this law. Now, a USAID partner is working to help develop a complementary code of conduct to operationalize the law.

The USAID program plays an important role in turning national data and projections into action. USAID has been instrumental and essential to the national HSS and the BSS, which provide quality data to inform decision- and policy-makers as well asprogram managers and implementers at all levels. Similarly, the USAID-funded AEM projects the direction and magnitude of the epidemic based on existing serologic and other data and a certain set of rational assumptions.

Another national focus of USAID is to reduce stigma and discrimination against PLWHA. USAID provides support to government institutions and NGOs to incorporate a human rights framework as an underlying programmatic focus. This includes documenting cases of discrimination against PLWHA; addressing gender power imbalances; and recognizing the marginalization faced by groups—including sex workers and MSM—disproportionately impacted by the epidemic. USAID partners are also using the mass media innovatively to raise awareness about HIV/AIDS, condom use and protective behaviors. Mass media is expected to reach a wider audience than that covered by targeted outreach in the priority provinces.

Population Focus:

While the epidemic is becoming more generalized, the highest prevalence rates remain concentrated among populations engaged in risky behaviors including sex workers and select male client groups, especially those who are migrants or serve as uniformed personnel. Preliminary data have also shown that there are populations engaging in high risk behavior, including MSM, and others that are vulnerable to becoming at high-risk, including casino and garment factory workers. The strategy specifically focuses on prevention activities for these target populations.

In this strategy, population coverage is significantly greater than in USAID's prior HIV/AIDS prevention program. Interventions initiated under the former program are being taken to national-level scale including:

- Peer counseling programs for police and military personnel from their currently limited geographic focus in three provinces to a nationwide program (increasing coverage from 20 to 80 percent of Cambodia's military personnel);

- The condom social marketing campaign to reach all urban and peri-urban areas of the country (beyond its current focus in Phnom Penh and provincial capitals);

- HIV/AIDS counseling, STI and other reproductive health services for young women in garment and textile factories (from 15 to 25 factories, expanding coverage to over 40 percent of all garment and textile workers); and

- Peer counseling, STI and other reproductive health services to over 75 percent of all sex workers in the country (from the current program focus on seven NGO clinics and four private clinics in Phnom Penh and two provincial government STI clinics).

Geographic Focus:

The HIV/AIDS strategy also has a geographic focus. Fifteen ODs in seven focus provinces (Banteay Mean Chey, Battambang, Koh Kong, Kratie, Pursat, and Siem Reap) and Phnom Penh were selected based on specific criteria including epidemiological and demographic factors such as HIV prevalence, population density and potential synergies and overlaps with other donors. In the focus ODs, activities include HBC; support for OVC and CAA; technical assistance and capacity-building for health centers to provide treatment for OIs, especially TB; and the management of STIs, VCT and PMTCT. Additionally, community-based HIV education is implemented to increase awareness and promote condom use among the general population in these focus areas.

1. Prevention

Prevention remains the largest component of the HIV/AIDS strategy, even as USAID/Cambodia is approaching the epidemic through a continuum of prevention to care. Prevention is the most cost-effective way of mitigating the AIDS epidemic in Cambodia, given the HIV prevalence rate and the early stage of the generalized spread of the virus.

a. Long-term Goal

The overall objective is to reduce HIV incidence and prevalence and therefore the incidence and prevalence of AIDS, by changing behaviors and reducing transmission of HIV from HIV-infected to uninfected individuals.

b. Target Groups

Epidemiological and qualitative data indicate that the HIV/AIDS epidemic is still primarily driven by the commercial sex industry and the majority of existing cases are concentrated among sex workers and their male clients. Although HIV also spreads from male clients to their non-commercial sexual partners, this is a fairly recent phenomenon, signaling changes in the dynamic of the epidemic (see Section I/1 HIV/AIDS Epidemiology in Cambodia). Additionally, as the rate of partner change between non-commercial sex partners is relatively low, the impact of commercial sex on the overall epidemic remains the most important focus of the strategy. The strategy also includes the general population in its HIV prevention education efforts.

Female Sex Workers (FSWs) – Direct and Indirect

The HIV prevalence rate among direct (e.g., brothel-based) and indirect (e.g., based in karaoke lounges, massage houses, restaurants or casinos), though decreasing inrecent years, remains very high. Additionally, many women move in and out of the sex industry, leading to a high turn-over rate. New FSWs are continuously in need of HIV prevention counseling and education to protect themselves from HIV transmission from both commercial and non-commercial partners. USAID will continue to support activities to reduce the vulnerability of FSWs to STI/HIV transmission by promoting consistent condom use with all partners; providing technical support to the RGC's 100% CUP; and improving access to care of STI treatment for FSWs. Although the government's 100% CUP officially applies only to direct FSWs, various USAID CAs are bridging this gap by reaching out to indirect sex workers through various means. As experience working with FSWs grows, this strategy calls for further investigation into the dynamic state of commercial sex to identify new programs to meet the needs of these populations. While the strategy does not target male sex workers–who typically are not part of a readily-identified profession in Cambodia, but act more on an ad hoc sex-for-money basis–explicitly, it does include outreach to transgender sex workers (see Section II/F. Cross-Cutting Themes/1. Gender and Sexuality).

Male Clients of FSWs

Anecdotal evidence indicates that a very high proportion of men across all educational and occupational groups engage in commercial sex activities. Key male client sub-populations engaging in high-risk activities targeted in the strategy include the military and police, moto-taxi drivers and migrant workers. A common factor among all of these men is that they spend long periods of time away from their homes and families. Interventions with these men aim to

increase STI/HIV/AIDS awareness, increase condom use and decrease commercial sex activity.

Male clients targeted under the strategy include:

- **Military and Police (Uniformed Service Men)**

  Activities implemented include peer education and counseling; educational theater designed and performed by the men themselves; and active condom promotion and distribution. Peer educators focus on increasing skills needed for behavior change, such as communication and negotiation to deal with peer pressure and make decisions. In addition, the strategy emphasizes increasing access to STI services and promoting STI treatment and VCT among these men.

- **Moto-Taxi Drivers**

  Many moto-taxi drivers are independent men who are in the stage of life where experimentation and risk-taking, including sexual experimentation, are the norm. Additionally, many moto-taxi drivers double as recruiters for the commercial sex industry. The strategy focuses on implementing peer education, condom promotion and distribution and social marketing of condoms among these men.

- **Migrant Workers**

  Many men move from one part of the country to another, or to outside of the country, in search of employment and better living conditions. Migrant workers generally do not have the social support and companionship they are normally accustomed to in their home communities. Interventions for these men include HIV peer education and counseling; condom promotion and distribution; condom social marketing; and the promotion of couples counseling. These activities are conducted in both source and destination communities. In source communities, USAID partners are able to reach future and current migrants along with migrants' wives. When feasible, collaboration with agencies working in other countries' destination communities will also take place as part of the strategy.

- **Men who have Sex with Men (MSM)**

  Despite the intensive HIV research and surveillance that has been conducted in Cambodia, little is known about sexual behavior and HIV prevalence among men who have sex with men (MSM). Recent research conducted by USAID CAs found that risky sexual behaviors, such as unprotected anal sex, sex for money and multiple sexual

partners are common among MSM. This behavior puts them and their male and female sexual partners at high-risk for HIV infection: 14 percent of MSM tested in a recent study by FHI were HIV-infected. Additionally, a large proportion of MSM were found to have penetrative sex with both males and females: over 65 percent of MSM in the study self-reported having female sexual partners.[2] Rather than simply categorizing MSM as a "bridge group" of HIV transmission to the general population, more research is needed to understand gender identity, sexual fluidity and the role of bisexuality in the Cambodian context.

Among MSM, there are many self-identities and sexual orientations. Data suggest that sexual behavior among MSM in Cambodia may be more variable than in western countries, with bisexual behavior being more commonly reported. This necessitates a prevention approach different from that commonly used for men engaging in mono-gender sexual behaviors. Transgender individuals—those who self-identify with the gender different from his or her assigned biological sex—also have a long tradition in Southeast Asian societies. These individuals face very different challenges. They are more likely to sell sex as a means of survival as discrimination against them severely limits their access to other forms of income generation; they are, therefore, highly vulnerable to HIV transmission. Lastly, MSM may be less likely than others to accept HIV education messages as these are nearly always targeted for sex between a man and a woman.

The strategy recognizes MSM as a difficult target group. The program will build on limited knowledge by promoting advocacy and greater desensitization education with officials, program implementers and donors; supporting prevention efforts targeted at MSM; and establishing linkages to include this marginalized population into existing care and support services. For example, USAID supports a local NGO with branches in Phnom Penh and another in Siem Reap; in both sites, there are drop in centers with regular opening hours staffed by volunteers and at times, trained health professionals. Outreach workers in nearby social gathering areas pass out information on safer sex practices and encourage the men to come to the center, which serves as a referral hub for VCT and when needed, medical services.

- **Sweethearts**

While condom use has increased over the past few years among targeted male client groups during commercial sex activities and the frequency of commercial sex use among these groups has decreased, the most recent BSS indicates that "sweetheart" relationships (relationships with non-commercial, regular sexual partners) are

increasing. Evidence from the BSS and other qualitative research indicates that men use condoms much more infrequently with sweethearts than they do with sex workers. This may be due to a misconception that there is no or little risk of HIV transmission with sweethearts. In addition, condom sales, while continuing to increase in volume every year due to social marketing and condom promotion efforts, are now increasing at slower rates than in previous years. This may indicate market saturation. To address the problem of low condom use rates with sweethearts, the strategy calls for new ways of reaching this population with prevention messages that focus on behavior and not the types of relationships.

- **Youth**

  Cambodia has a large youth population—in 2000, 26 percent of the population was between the ages of 10 to 19, the highest proportion among Southeast Asian countries. Moreover, many more young people will soon enter into adolescence; another 31 percent of Cambodia's population was under ten in 2000.[3] While young people in general are more likely to be risk-loving and have greater exposure to HIV, data for Cambodian youth do not seem to support that claim. According to the 2000 Cambodia Demographic and Health Survey (CDHS), the age of first sexual debut and the age of first marriage are both essentially the same, 20 years. Accordingly, the strategy targeting youth emphasizes outreach to those at heightened risks and a message blend of abstinence and behavioral change.

  The youth addressed by USAID include urban youth; young women workers in garment factories; and youth in rural communities who are likely to become migrant workers. Activities focus on peer education and group education to enhance life skills; increase HIV awareness; promote abstinence among those who are not yet sexually active; and promote condom use and risk-reduction and avoidance among those who already are sexually active. While some youth currently engage in risky behavior, many more are at risk for engaging in risky behavior in the future. The strategy aims at reducing both types of risk.

- **Pregnant Women**

  Transmission of HIV from mother to child is increasingly becoming an important factor in the HIV epidemic in Cambodia (see Section I/1 HIV/AIDS Epidemiology in Cambodia). According to projections by the AEM, approximately 30 percent of all new HIV infections in Cambodia will result from mother-to-child transmission. In order to reduce vertical transmission, the strategy focuses on preventing HIV infection among women of reproductive age. Additionally, technical support is given to

health providers and counselors to help HIV-infected women make informed reproductive decisions; to provide the most appropriate care possible for HIV-infected pregnant women; and to provide information and counseling for HIV-infected breastfeeding women. VCT and proper referrals are also being promoted among pregnant women attending ANC with an attempt to reach HIV-infected pregnant women and to reduce transmission from mothers to their children.

- **General Women of Reproductive Age (WRA)**

  Besides young garment workers and expectant mothers, USAID reaches out to women facing risks in various settings. To complement prevention targeted at migrant men, new programs aimed at couples are being piloted, bringing in rural women who were previously neglected in HIV prevention. Other health programs in birth spacing and maternal health are also incorporating HIV prevention and anti-stigma messages for all women.

- **General Population**

  In addition to targeting populations at high risk of HIV transmission and infection, the strategy focuses on improving awareness and knowledge about HIV and reducing stigma among the general population. Activities implemented for the general population include social marketing of condoms; community-based HIV and STI education; STI treatment; and information, education and communication (IEC)/BCC efforts through mass media, community-based awareness-raising and faith-based institutions.

c. Principle Interventions

Turning the common ABC prevention framework around, the Cambodia strategy uses the CBA (Condom Use, Be Faithful, Abstinence) approach. This approach recognizes the reality that sex workers and their clients remain the critical links in HIV prevention in Cambodia and that condom use is the key intervention to stem the tides of HIV incidence.

HIV Education, Counseling and Behavior Change Communication (BCC)

The cornerstone of the HIV prevention strategy is education, counseling and BCC. These efforts are geared toward increasing awareness about HIV transmission and prevention; reducing negative attitudes about HIV/AIDS; promoting abstinence, monogamy, safer sex and condom use; reducing risky behaviors associated with HIV transmission; and increasing protective behaviors. The approaches employed in the strategy include:

- Mass Media: Mass media is defined broadly to include soap operas on television, radio shows, public service announcements, mobile shows and posters to reach a broad audience. It is well-documented that the use of mass media is particularly effective at reducing stigma regarding HIV/AIDS and encouraging preventive measures such as condom use. Mass media may also be effective at reaching MSM with HIV prevention information and reducing stigma and discrimination against MSM;
- Peer Education and Counseling: While mass media is effective for influencing changes at a societal level, peer education and counseling are effective at increasing awareness and skills that affect behavior change among individuals, families and groups. People who are from a given group usually understand the motives, pressures, obstacles and barriers of the members of that group and can therefore serve as effective educators and counselors. Peer education and counseling is being used in this strategy among the military and the police, garment factory workers, youth center attendees, moto-taxi drivers and sex workers;
- Life Skills (LS) Training: LS training helps individuals make health and behavior choices within the context of their life-goals and social environment. Through LS training, participants are empowered to protect themselves because not doing so hinders their future life-goals. LS training focuses not only on knowledge acquisition but on skills-building. Participants learn decision-making and negotiation skills needed to avoid peer pressure and are trained in problem-solving; and

- Theater Education: One of the more innovative and entertaining interventions used in HIV education and communication is theater. Target groups involved in theater education write their own stories and scenarios based on what they have learned in peer education and their own life experience. Participants are often motivated to think creatively as many contests are held to select the best plays. The plays are educational to the writers, performers and the audience.

Condom Promotion

Education must be accompanied with behavior change to prevent HIV infection and transmission. Through education, communication and counseling, population groups gain knowledge about what to do and the skills necessary to do it. Condom promotion provides the tools needed to take action.

The strategy has condom social marketing as its main method of condom promotion. USAID support to PSI for the social marketing of the Number One condom brand has led to national brand-name recognition and sales exceeding anticipated targets. Under the strategy, the program is being expanded to reach all urban and peri-urban areas of the country, with as much expansion into rural areas as possible. Additionally, a network of NGOs, the United Health Network (UHN), has been formed throughout the country, including in remote rural areas, to socially market condoms. In areas that have not yet been reached by social marketing of condoms, free condom distribution has been introduced as a temporary measure. Condoms are available in boxes in easily accessible locations for anyone to take when needed. The UHN is working to reduce the need for the free distribution of condoms in the future as the sale of condoms is a more sustainable approach and purchased condoms are more likely to be used than freely distributed condoms.

STI Treatment Promotion and Technical Support

The interaction between STIs and HIV infection is well known: treatment of STIs is known to greatly reduce the risk of HIV transmission upon exposure. Therefore, the strategy includes:

- Support of STI diagnosis and treatment in both the private and public sectors;
- Training for public-sector clinicians to improve diagnostic and treatment skills;
- Promotion of appropriate STI diagnosis and treatment among vulnerable populations most likely to have high STI-infection rates;
- Logistics support to ensure that necessary drugs are available when needed;
- Capacity-building of STI services for the purposes of the RGC's 100% CUP, including STI testing and treatment for sex workers on a monthly basis; and
- Support of Health Centers' physical infrastructure.

Voluntary Counseling and Testing (VCT) and the Prevention of Mother-to-Child Transmission (PMTCT)

VCT and PMTCT of HIV are essential components of the continuum of services from prevention to care and support for HIV/AIDS and integrated HIV/AIDS and family health interventions. It is through VCT that people transition from not knowing their HIV status to knowing their status. Knowing one's HIV status empowers individuals and couples to take action towards remaining uninfected or from infecting others. VCT is also at the center of efforts to integrate patient services including the prevention and treatment for OIs such as TB and other services to reduce the suffering of symptoms of AIDS and improve quality of life.

The strategy includes the provision of technical assistance to build capacity at VCT centers in USAID's focus provinces. USAID partners are working with NCHADS to improve the curriculum for counselor training and to expand coverage of VCT in rural areas. One such strategy is to train "satellite" counselors who can counsel and test in the rural communities, thereby saving clients from what can often be a very difficult trip to the VCT center.

A full program aimed at PMTCT has the potential to reduce transmission from HIV-infected mothers to their unborn and newly-born children by nearly half. In Cambodia, where 3,000 children are infected with HIV every year, this represents a substantial improvement in child survival. USAID is currently unable to provide ARVs in Cambodia for HIV-infected mothers in labor and

their neonates, although USAID CAs partner with UNICEF and the NMCHC, where nevirapine is available.

USAID partners are playing important roles in preventing vertical transmission in all other components of the MoH framework. These efforts include:

- Primary prevention of HIV among WRA;
- Promoting birth spacing, which will have an effect on reducing the number of pregnancies among HIV-infected WRA;
- Improving ANC services and coverage to reach women for VCT;
- Involving male partners (husbands) in ANC so that they can also receive counseling and be tested;
- Strengthening VCT services;
- Counseling women on appropriate infant feeding practices; and
- Prevention efforts aimed at preventing male partners of pregnant and lactating women from becoming infected with HIV.

Since individuals are highly infective immediately after becoming infected with HIV, newly infected husbands of pregnant and lactating women have a higher chance of infecting their wives. These newly infected pregnant women, in turn, have a higher chance of infecting their unborn and newly-born children. USAID partners continue to work with men to prevent new HIV infections, with special emphasis on husbands of pregnant and lactating women.

2. Care and Support

Prevention activities have played an important role in stabilizing and decreasing prevalence among some sub-population groups. At the same time, the epidemic is maturing with more people needing care and support services.

Although medical facilities in Cambodia have been rapidly improving, the health system still needs strengthening in order to respond to the increasing medical needs of PLWHA. Access to basic, quality health services in general is limited and AIDS medical care is in its infancy. Additionally, there is a serious shortage of hospital beds—according to UNAIDS, there were only 8,500 hospital beds in the entire country in 2000.[4]

The MoH has approved a Continuum of Care framework, which provides broad guidelines to the USAID program. Critical to care and support services are TB diagnosis and treatment for PLWHA. Cambodia is one of 22 nations with the highest TB burden in the world and evidence from the most recent HSS indicates an increase in the national HIV prevalence among newly diagnosed TB patients (see Section II/B. Country Situation/5. Increasing Need for Care, Support and Treatment). HIV is the greatest risk factor for the progression from latent TB infection to active disease. The annual risk of getting active TB for PLWHA is about seven to nine percent annually,

compared to the lifetime risk of ten percent for non-HIV-infected people who are infected with TB. This is the major reason for the large increase in active TB incidence in populations with a high prevalence of HIV infection. Isoniazid prophylactic therapy (IPT) is recommended for all HIV-infected people in countries like Cambodia. According to the WHO, giving IPT to all PLWHA can reduce the prevalence of TB among PLWHA to 60 percent of what it would be without IPT. USAID CAs are working with CENAT to help set up community Directly Observed Treatment (Short-Course) (DOTS) program in USAID priority areas.

Home-based care (HBC) is increasingly valued by the MoH and implementing partners. In a rural country with inadequate public health facilities, NGOs, along with community members and some MoH staff, have stepped in to provide the human touch needed for an effective care and support program. HBC teams provide psychological and some economic and medical support. As the reliance on these teams increase, it is hoped that team members will also become proficient in proper referrals and perhaps increase their medical support role to include monitoring of side effects and drug adherence.

Unique attention must be paid to children and families affected by AIDS who require medical care and psychosocial and economic support. While the exact number of AIDS orphans is not known, the general consensus is that the numbers are increasing dramatically. UN groups have estimated that by the end of 2001, there were 55,000 orphans in Cambodia and 12,000 children currently living with HIV/AIDS. USAID has initiated programs for children who are infected and affected by HIV/AIDS. A Pediatric AIDS initiative, partnering with faith-based organizations, will provide hospice care for children up to age 16 living with HIV/AIDS. Most of the children have been abandoned by families or are orphaned when their parents died.

a. Long-term Goal

To reduce the social and clinical impact of HIV and to increase the quality of life for PLWHA.

b. Target Groups:

People living with HIV/AIDS (PLWHA) and other chronic diseases such as TB

Voluntary counseling and testing (VCT) services can be an effective entry point for care and treatment for PLWHA. Unfortunately, many Cambodians do not have access to quality VCT—only 18 out of 24 provinces have public VCT services in provincial towns, although private sector testing, without counseling, seems to be readily available in most medium to large size towns.

Complementing the effort to train counselors and upgrade health centers' capacity to provide VCT, USAID also works to increase the demand for quality VCT services among its targeted population through community-based education, referrals and advocacy. The home-based networks build a solid relationship with community members to encourage individuals to use VCT services. Teams are trained to refer those infected with HIV to care and support services, such as TB preventive therapy and prophylaxis for other opportunistic infections; PMTCT services, where available; and other medical and supportive services that can help those living with HIV to live longer, healthier lives and prevent HIV transmission to others.

Orphans and Vulnerable Children (OVC), Children Affected by AIDS (CAA)

The HIV/AIDS strategy targets orphans and vulnerable children (OVC) and children affected by AIDS (CAA) between the ages of 0-18.[5] Childhood vulnerability for children infected and affected by AIDS begins early in Cambodia, long before parents fall ill or die. Stigma and discrimination in communities, at school and at workplaces against PLWHA means that children of families affected by HIV are often shunned, excluded from school and suffer the economic implications of loss of familial income.

Through community-based prevention, care and support interventions, the program identifies AIDS orphans; non-orphaned children who are affected by AIDS; and children who are HIV-infected. USAID partners work through multisector approaches to meet the needs of OVC and CAA.

In the long term, the children will require skills training, medication and life skills in adjusting to life without their primary support. But since so little is known about this development, USAID is funding a major two-year study

through the POLICY Project to understand the impact at the household level where there are affected and infected children present.

Families and Community Members Affected by HIV/AIDS

Families of PLWHA and communities affected by HIV/AIDS play an important role in caring for, and providing support to, PLWHA and are essential to a sustained response for mitigating the impact of the epidemic. Fear of PLWHA caused by misinformation about HIV transmission and moralistic interpretations of individual behaviors can lead to stigma and discrimination against PLWHA. Stigma and discrimination further compound already difficult circumstances for providing care and support to PLWHA. This strategy targets family members of PLWHA and members and leaders of communities such as religious leaders to reduce misinformation and fear and replace the inclination to moralize with appropriate knowledge, attitudes and skills useful to provide care and support to PLWHA. Recognizing the importance of religion in Cambodian society, several of USAID's partners work on faith-based initiatives to train and support Buddhist monks in Wats (Buddhist temples) in this effort.

c. Target Areas

In line with USAID's integrated HIV/AIDS and family health strategy, care and support will be prioritized in the focus provinces and ODs. However, flexibility will be maintained in order to be able to respond in other geographic areas, given additional resources and unmet need.

d. Principal Interventions

Home-Based Care (HBC)

In 1998, responding to increasing number of people living with AIDS, the MoH and NGOs developed and implemented a pilot HBC program in Phnom Penh supported by WHO and DfID. Subsequently, USAID, JICA and other donors have supported the expansion of HBC in other provinces through implementing partners.

HBC aims to provide counseling; palliative care; medical care for selected OIs; referrals to other medical services when available such as DOTS and ART; and psycho-social and economic support to PLWHA, while reducing the demand on increasingly overburdened public health facilities. The current model of HBC is implemented jointly between health center staff, NGO staff and NGO-supported community volunteers. An important emphasis in HBC is

to train PLWHA as well as family and community members to take care and manage their own situation.

A recent evaluation of HBC conducted by KHANA[6] indicated that it has reduced the suffering of PLWHA and improved the quality of their lives and the lives of their families and care-givers by:

- Helping PLWHA to manage their OI and palliative care at an early stage. By helping to maintain and improve PLWHA'S general well-being and physical health, PLWHA are able to continue to work to generate needed income to support their families;

- Making information and services available, which helps to reduce overall household expenditures for inappropriate care provided by unregulated private services. Excess payments often lead to a loss of income, property and other family assets, which ultimately has serious consequences for children who become AIDS orphans; and

- Providing counseling and education to grandparents whose adult children are sick from AIDS so that they have the knowledge and skills to plan for their grandchildren's lives when they become primary care-givers.

In addition, the HBC has established good partnerships among public health providers, NGO staff, communities and family members and increased the understanding of HIV/AIDS by linking care and prevention and reducing discrimination against PLWHA in their communities.

It is important to continue to ensure the improvement of quality HBC services and to significantly increase coverage. USAID continues to support the expansion of the HBC program, linking it with integrated health care in public health centers in the focus ODs. The program promotes the development and utilization of referral systems among integrated health services at different levels, including linking HBC with VCT, PMTCT, birth spacing and TB diagnosis and treatment.

Support to Orphans and Vulnerable Children (OVC), Children Affected by AIDS (CAA)

USAID partners work through their HBC networks to identify children orphaned by AIDS and children who still live in families with one or more members infected with HIV. Although not yet orphans, these children face many of the same difficulties as OVC including stigma and discrimination; exclusion from community activities and school; and in the case of older children, risk of exploitation, including trafficking into commercial sex.

USAID's partners are working with AIDS orphans and vulnerable children (OVC) and children affected by HIV/AIDS (CAA) by testing different models to improve community cohesion; reduce stigma and discrimination against HIV/AIDS; and develop more social incentives to support these children.

To care for OVC, the strategy supports NGOs and faith-based organizations to:

- Engage community members and community and religious leaders to build sustainable responses to the needs of OVC and CAA;
- Place OVC with surviving extended families or, in situations in which extended family cannot provide support, arrange for foster or adoptive care;
- Support foster or extended families that provide care for OVC by helping the children gain attendance at schools or providing informal education and food supplements for families in need (implemented in partnership with the UN World Food Program);
- Provide older children with opportunities to learn a trade skill; and
- Work with communities to reduce stigma and discrimination against OVC and foster and extended families caring for OVC.

Buddhist monks supported by USAID and other donors play a key role in care and support activities as well as efforts to reduce stigma and discrimination at the community level (see Section on Faith-Based Response).

HBC teams working with families affected by AIDS extend efforts to improve the living situation for CAA including:

- Providing psycho-social counseling to CAA;
- Helping families plan for the eventuality of their children becoming orphans, including, whenever possible, making pre-arrangements for care once CAA become orphans; and
- Working with communities to reduce stigma and discrimination so that CAA can be included rather than excluded from school and other community activities.

HIV/TB Co-Infection

USAID recently supported, through the STOP TB partnership between USAID, CDC, JICA, and WHO, in collaboration with CENAT and NCHADS, a national workshop on the development of operational protocols and guidelines to pilot a HIV/TB co-infection program in four provinces in Cambodia. The focus of the program will be to support and strengthen the referral systems among VCT, HBC and TB diagnosis and treatment.

The strategy calls for continued provision of technical support to the HIV/TB technical working group to monitor and supervise the implementation of the pilot program. In one of the four pilot sites, Battambang province, USAID is providing support in focus ODs to ensure that the program's implementation is in accordance with the MoH DOTS expansion plan. TB diagnosis and treatment will be available to PLWHA who are supported by the HBC program.

USAID, through its partners, will also implement a pilot program for IPT among PLWHA in one focus OD in Battambang province, following the national guidelines for the HIV/TB co-infection program. This program will be implemented in close collaboration with the National HIV/TB working group of the MoH, JICA, CDC, WHO, USAID and other stakeholders.

Antiretroviral (ARV) Therapy

Currently, USAID/Cambodia is unable to procure or supply ARV. However, USAID partners are providing technical and operational support to other NGOs and the government health system for ARV therapy. USAID funding is supporting NGOs in Phnom Penh and Siem Reap that work with HIV-infected children, including providing ARV therapy. In Battambang and Maung Russey ODs, USAID partners are training medical providers and giving technical assistance at the referral hospitals to ready the staff to provide ARV therapy when ARVs hopefully become available there in the next few months. USAID staff and partners sit on committees and technical working groups to support government efforts to provide a continuum of care to PLWHA, including ARV therapy, and to assist in the writing of proposals to the Global Fund for ARVs and other resources for improving the continuum of care.

Faith-Based Response

Faith-based organizations have been actively involved in responding to HIV/AIDS prevention and mitigation activities since the early stage of the national response. UNICEF has supported the Ministry of Cult and Religion to develop the national guidelines for Buddhist monks' involvement in the HIV/AIDS response. In the past few years, USAID has joined this effort. USAID and partners support Buddhist monks and local Catholic charities in HIV care and support interventions including:

- Advocating at the national and village levels for increased quality and access to home- and community-based care and decreased stigma and discrimination against PLWHA;
- Providing HIV/AIDS care and support activities for OVC, CAA and families affected by AIDS including paying for funerals to

preserve the dignity of the deceased and providing counseling to minimize the emotional pain; and

- Promoting compassion by caring for OVC in USAID-supported orphanages, where necessary.

With USAID support, Buddhist monks have also been playing an important role at addressing gender issues related to HIV/AIDS. Traditional Cambodia has what is known as the "Women's Code." The Code dictates that Cambodian women should generally behave in a subservient fashion toward men and allows for double standards with regard to male and female sexual behavior and familial responsibilities. The traditional interpretation of the Code creates a context in which women are at increased risk of HIV infection without the control required to mitigate that risk. The monks have been working to reinterpret the Women's Code to emphasize gender equity and male and female social responsibility in a manner that is consistent with the original intent of the Code. The reinterpretation attempts to put some control back into the hands of women to help reduce women's risk of HIV infection.

Support for People Living with HIV/AIDS (PLWHA) Networks

USAID has supported the establishment of the two largest PLWHA networks in Cambodia. PLWHA networks encourage the active participation of PLWHA in all aspects of HIV/AIDS prevention, care and support. Many PLWHA have become actively involved in HBC for other HIV-infected persons. PLWHA involvement in HBC has recently been formally accepted by the Cambodian government and included in the government's continuum of care strategy for

HIV. USAID and partners are working to build the capacity of these PLWHA organizations to improve management and advocacy skills so they can effectively advocate for their own needs. USAID also facilitates the linkage of these groups to regional and global PLWHA networks. Continued support of these networks is core to USAID/Cambodia's HIV/AIDS strategy.

B. Strategic Objective #9 and Results Framework

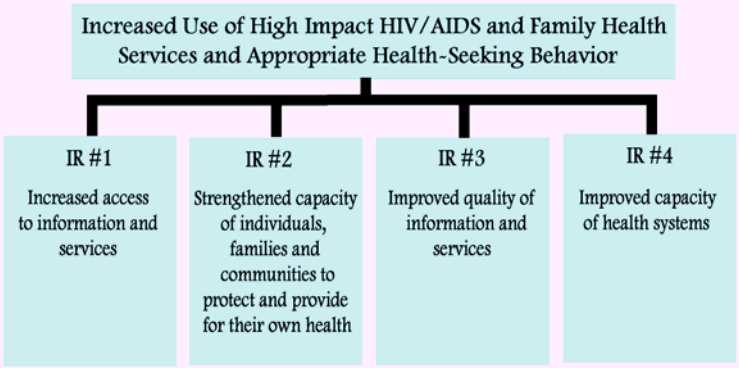
The results framework adopted during the development of the three year Public Health Interim Strategy 2002-2005 (pending approval for extension to 2006) incorporates the strengths of the former RCH and special STI/HIV/AIDS objectives which have recently been closed out (see Section I/C. USAID's Assistance and the Population, Health and Nutrition (PHN) Program). The new HIV/AIDS strategy is an important focus of this results framework.

Although the Office of Public Health (OPH) is functioning under a Strategic Objective that integrates family health and HIV/AIDS (see Figure 5), this strategy concentrates on reducing HIV transmission among high-prevalence groups and on stabilizing transmission rates in the general population. The HIV epidemic in Cambodia is now more mature and increasing numbers of PLWHA are progressing to the latter stages of HIV-related illness and AIDS.

Thus, the strategy also emphasizes the need to focus on care, support and treatment of PLWHA. Ironically, when ARVs become available at affordable prices in Cambodia, an increase in the HIV prevalence rate is likely to occur since HIV-infected people who are being treated are expected to live longer. On the other hand, early treatment of HIV infections can delay the onset of AIDS, thereby reducing prevalence.

The specific activities of this strategy are already underway and have been described in previous sections. Since USAID/Cambodia is already well into the implementation of this strategy, actual activities are described rather than illustrative activities. Below are the specific intermediate results of SO9 with brief summaries of activities that address them:

Figure 5: PHN Strategic Results Framework



IR 9.1: Increased access to information and services

This intermediate result (IR) focuses on increasing the number of accessible services, educators, condoms, HBC teams and health providers that are accessible to Cambodians. Examples of activities being implemented toward achieving this IR include:

- Training peer educators;
- Training STI, VCT and PMTCT service providers;
- Increasing the number of STI, VCT and PMTCT services available;
- Condom social marketing and distribution;
- Training HBC teams; and
- Training health care providers to treat OIs.

IR 9.2: Strengthened capacity of individuals, families and communities to protect and provide for their own health

This IR focuses on the creation of demand for services and information by clients. It requires that individuals, families and communities develop knowledge and skills necessary to change their behavior. It also calls for changes in social and environmental contexts that support behavior change. Examples of activities being implemented toward achieving this IR include:

- Providing peer education and other forms of education to targeted sub-populations;
- Training individuals in negotiation skills;
- Increasing awareness about HIV and HIV services (e.g., STI, VCT
- and PMTCT);
- Training in Life Skills (LS);
- Teaching PLWHA advocacy skills;

- Engaging in activities to reduce stigma and discrimination against PLWHA; and
- Motivating communities to take care of OVC.

IR 9.3: Improved quality of information and services

This IR focuses on increasing the ability of educators, service providers, HBC teams and health care providers to provide appropriate, quality services and information. The activities for this IR look similar to the activities for IR 9.2 as some activities work toward the achievement of more than one result.

Examples of activities being implemented toward achieving this IR include:

- Training peer educators;
- Training STI, VCT and PMTCT service providers;
- Training HBC teams; and
- Training health care providers to identify and treat OIs.

IR 9.4: Improved capacity of health systems

This IR focuses on improving systems that facilitate appropriate, accessible and quality care. Examples of activities being implemented toward achieving this IR include:

- Developing referral systems between HIV and TB diagnostic and treatment services;
- Developing information systems that track utilization rates of services and allow for follow-up with clients;
- Integrating services to make it easier for clients to access multiple services e.g., PMTCT services within ANC and delivery care and VCT within ANC; and
- Providing technical assistance for surveillance systems to ensure that accurate data are available for planning at all levels of the health system.

C. Implementation Modality

USAID/Cambodia implements the HIV/AIDS strategy in partnership with a series of international and local NGOs. Some of these NGOs are direct implementers, some operate via sub-contracts with other local NGOs and some do both direct implementation and sub-contracts. Implementing partners are also a mixture of non-sectarian and faith-based organizations. The common factor among all is the driving commitment to reduce HIV prevalence and mitigate the effects of the epidemic in Cambodia. USAID additionally provides technical assistance to various government ministries at national and

provincial levels, but direct financial assistance is not currently provided to government organizations.

D. Tracking the Epidemic and Strengthening the Health Systems

The strategy includes three surveillance components: 1) HIV Sentinel Surveillance (HSS); 2) Behavioral Surveillance Survey (BSS); and 3) STI surveillance. The HSS has been conducted annually since 1995 among core sentinel groups (direct and indirect sex workers and police) considered to be at increased risk of HIV infection and transmission. Prevalence estimates for the general population must be based on sentinel populations that are more representative of the population as a whole. For women, ANC attendees provide the closest approximation available to the prevalence of HIV among women of reproductive age. A significant sample of ANC attendees is surveyed each year as proxies for women of reproductive age in the general population.[7] Finally, in order to understand how the epidemic is progressing in the population, TB patients are included in the HSS. Since TB is the primary opportunistic infection among PLWHA, this measure gives an indication of the increasing progression in the general population from HIV infection to AIDS.

For a number of years, the MoH has invited external advisors, in addition to those providing on-going technical support from USAID through FHI/IMPACT and the WHO, to work with NCHADS on the analysis and interpretation of the annual sentinel surveillance. Since at least 1999, the HSS and BSS methodology for the selection of study sites, the members of the sentinel groups and the data collection and blood specimen procedures (for the HSS) were all carried out in the same manner. The analysis indicates that the prevalence of HIV infection has either declined or remained virtually the same across all but one of the sentinel groups surveyed each year and that methodological biases are unlikely to be responsible. The declines are likely due to a combination of increased deaths in people with HIV infection and a slowing of the HIV incidence rate, probably attributed at least in part to increases in protective behaviors and reductions in risk behaviors.

Following the 2000 HSS, a careful examination of the available HIV and behavioral surveillance data was undertaken by the advisory group to determine a consistent approach for estimating the numbers of people living with HIV in Cambodia. The group estimated that 72,000 adult women and 97,000 adult men were living with HIV in 2000. Based on such estimates, the number of adults aged 15-49 living with HIV in Cambodia has fallen steadily from 210,000 in 1997 to 157,500 in 2002. This decline is most likely explained by a more rapid increase in the numbers of people dying of AIDS each year, than in decreased numbers of newly-infected individuals.

Periodic serological and behavioral surveys are also undertaken by NCHADS as part of the national HIV surveillance system. Two STI prevalence studies were conducted in 1996 and in 2000 and a male household BSS survey was conducted in 2000 in five provinces. The next round of these two surveys is planned for 2004.

The national surveillance system will undergo a critical but constructive review over the next three years as increasing epidemiological and laboratory resources and expertise become available through two key partners, CDC-GAP and the ADB. These new partnerships offer access to increase and on-going technical resources that will result in significant capacity-building at NCHADS. With this increased capacity and the projected epidemiological trends towards a more generalized epidemic, targeted assessments of marginalized groups who may be increasingly vulnerable to HIV infection are a priority for this strategy, including border laborers, migrants, fishermen and unsuspecting wives. MSM are currently not included in the surveillance system, although two USAID-funded CAs–KHANA and FHI–have begun conducting small scale surveys of this sub-population.

In Cambodia, STI and HIV surveillance findings are being used to evaluate programs; advocate for financial and political support at local, national and international levels; track epidemiological trends and changes over time; monitor the relationships between health service interventions, behavior changes and transmission and infection patterns; and to identify the need for special targets and strengthened efforts among certain sub-segments of the population.

Surveillance activity will be broadened throughout the implementation of this strategy to respond to the prevention and care concerns raised by the challenge of TB and HIV co-infection. TB is the primary opportunistic infection and cause of death for PLWHAs in Cambodia. The MoH has already taken the lead to adopt the WHO's guidelines to a Cambodia-specific framework that will be piloted in four sites located in both rural and urban areas. This effort is being carried out through a collaborative partnership between NCHADS and CENAT with support and technical assistance from WHO, USAID, JICA and CDC-GAP. USAID's contribution to this important partnership includes active leadership and participation in one of the four peri-urban pilot sites (see Section II/2. Care and Support/d. Principal Interventions). Technical assistance will also be provided to enhance the local use of information for management across all of the four provincial pilot sites in order to strengthen: the bi-directional referral systems; the utilization and management of VCT services; and the appropriate involvement of NGOs and community-based support groups. The technical approach to each of these areas will potentially take account of how they can be integrated into the national Health Information System (HIS). Lessons learned and tools and mechanisms

developed with regards to information use are expected to have immediate applicability in the Asia and Near East (ANE) region.

E. Research

USAID works with the RGC and its partners to develop a focused and coordinated research agenda, concentrating on practical issues and topics relevant to program operations and decision-making. USAID will continue to work with its partners and the MoH to see that the key lessons from the research results appropriately influence program planning and policy development. The following are examples of potential research activities USAID will either support or for which it will encourage other agency/donor support, during the strategy period:

- Testing mechanisms for increasing community care and support for AIDS-related OVC;
- Profiling clients of sex workers through qualitative assessments of direct and indirect sex workers;
- Conducting size estimations of sex workers and the extent of same sex sexual behavior in order to better understand the relative contributions of these sub-populations to the HIV epidemic in Cambodia and to more accurately estimate prevalence rates and proportions among these sub-populations;
- Monitoring the drug use situation to be able to identify early if there is a potential for increased HIV transmission due to injecting drug use;
- Supporting a qualitative assessment of what happens to sex workers after they leave sex work;
- Conducting an economic and social impact assessment of HIV epidemic in Cambodia; and
- Assessing the extent and effects of HIV/AIDS-related stigma and discrimination within the family and community on health-seeking behaviors.

USAID is also considering supporting research on the proposed introduction of ART in the management of HIV-infected persons, including HIV-infected pregnant women.

This would support the MoH's commitment to develop the most appropriate continuum of care models for PLWHAs for all levels and environments of care, including home-, community- and institutional-based care.

F. Cross-Cutting Themes

1. Gender and Sexuality

Gender-related factors shape the extent to which men and women and boys and girls are vulnerable to HIV infection. Poverty and other negative social factors such as trafficking, rape and violence against women force many women and some children and men into direct or indirect sex work. The common practice of men engaging in sex outside of marriage with sex workers and with "sweethearts" heightens the risk of infection for married women. While wives may know that their husbands have sex outside marriage, traditional gender roles often prevent women from talking about sex or negotiating condom use.

Societal expectations of men and women also have an impact on their care and support needs. For example, the burden of AIDS-related care often falls disproportionately on women. Already more vulnerable than boys to HIV infection, girls are also more vulnerable to dropping out of school to care for sick relatives or assume other domestic duties. For women of reproductive age infected with HIV, steps should be taken to reduce the likelihood of vertical transmission of HIV.

Another dimension of gender is the role of the transgender sex worker population in Cambodia. Srey Sros, or Pretty Girls as they self-identify, are a small but significant part of the sex worker subculture. They are often used as madams or gatekeepers in many brothels to lure clients and to keep a watch over the other sex workers. Gender misconception and public fear have contributed to violence and isolation experienced by this group, leading to increased exposure to HIV infection.

Recent research conducted by FHI, a USAID implementing partner, documented the fluidity of sexual practices in Cambodia. Over 60 percent of the male respondents in the study who reported engaging in same sex sexual behaviors also reported having sexual relations with women, particularly FSWs.[8] The reality suggests an alternate paradigm in conceptualizing prevention programs and challenges the easy assumption of a "heterosexual epidemic."

2. Youth

Cambodia has a very young population structure, resulting in a potentially high number of young people at risk of contracting HIV/AIDS. The HSS shows that young adults between 20-24, especially married women, police and direct FSWs, have the highest HIV prevalence rate of any age group. These data are

consistent with what we know of the dichotomous needs for youth in Cambodia: there are select sub-groups of sexually active young people that require prevention education and care services, and many more who are not sexually active but in need of relevant prevention messages. USAID's implementing partners target youth with messages promoting abstinence and the delay of sexual debut, along with consistent condom use (see Section II/A. Rationale and Major Elements/1. Prevention/b. Target Groups/Youth). Programs for groups exhibiting high-risk behaviors are already reaching substantial numbers of youth at risk and are described in greater detail under the subheadings for FSWs, garment factory workers, MSM, and mobile populations. However, there are fewer projects meeting the general needs of youth-at-large. The youth-friendly clinics run by the Reproductive Health Association of Cambodia (RHAC) and an associated program on sexual health education in the formal school system are two key interventions in the USAID strategy. USAID will monitor the shifting of the epidemic closely to meet the changing needs of populations impacted.

3. Capacity-Building

The majority of Cambodia's public health system staff was recruited and trained very rapidly during the Vietnamese occupation of 1979-89. Many of the skills acquired by these personnel were, and continue to remain, inadequate to respond to the country's burden of disease. Moreover, the planning, management and supervisory systems and skills needed to support the health care delivery system are similarly weak. Local and international NGOs are helping to fill this gap in many important ways, but such heavy reliance on external assistance should not delay the strengthening of the public health system's own capacity to meet citizens' basic health care needs.

4. Human Rights and Stigma Reduction

Key among the contextual factors that impact effective HIV prevention and care activities are the human rights environment in the country and the level of stigma about HIV/AIDS at the community level. The Law on the Prevention and Control of HIV/AIDS passed recently by the Cambodian legislature includes provisions against discrimination of PLWHA, but the implementation and enforcement of this law still need to be ensured. Meanwhile, at the community level, stigma forces those most vulnerable to HIV infection underground, thereby strengthening the chain of transmission between those individuals and groups and the rest of the community.

Programs for HIV prevention and care can be delivered more efficiently by service providers and will be received more readily by vulnerable groups, when the rights of those who are marginalized, including PLWHAs, are recognized and respected. That is, respect for rights translates into more effective prevention and care. For example, individuals at high risk of HIV transmission and infection (e.g., SWs, MSM, military and police, migrant workers, etc.) are more likely to receive and internalize prevention information when a local community works to lessen stigma against these groups. In the same way, when a local community works to eliminate stigma directed at PLWHAs, such individuals will not only be more likely to access appropriate care services, but will more likely be empowered to participate in the community's HIV prevention response.

Successful interventions to reduce stigma require a sound policy environment, intensive community behavior change interventions and the creation of an enabling environment to openly discuss the epidemic. The RGC has made significant strides over the past few years with the support of USAID, implementing partners and other donors to create such an environment. Milestones such as the national 2002 Law on the Prevention and Control of HIV/AIDS; the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2001-2005; the five year strategic plans developed by the MoH, MoND, MoSALVY and the MRD; and the involvement of the Ministry of Women's and Veteran's Affairs in putting gender issues at the fore all give testimony to the willingness and motivation of the RGC to halt the epidemic. USAID will continue to support the RGC's efforts, including in its strategy the Greater Involvement of People with AIDS (GIPA) principle.

III. Results and Reporting

A. Magnitude and Nature of Expected Results (USAID and Partners)

USAID/Cambodia alone cannot be expected to bring about targeted reductions in HIV/AIDS incidence and prevalence. These changes will require the combined efforts and contributions of many organizations and partners (e.g., MoH, NCHADS, NAA and other line ministries, NGOs, other donors) working together.

While USAID/Cambodia cannot be solely held accountable for achieving national targets, it will report on joint progress on several standard indicators, especially HIV prevalence rates, changes in sexual risk-reduction behavior and program coverage.

By 2005, USAID/Cambodia expects to achieve significant results in behavioral indicators and coverage area, as well as a solid foundation in health systems to deliver appropriate care for the populations. By 2008, the Mission will focus on higher level results such as sustained behavioral change over time, women using comprehensive MTCT services, and persons receiving home-based care and proper medical treatments, including ARV.

B. Country Reporting and Performance Indicators and Targets

As part of USAID's "Expanded Response to HIV/AIDS," the Agency has established an improved, comprehensive system to routinely monitor its HIV/AIDS program worldwide; manage its resources; and periodically report on the Agency's progress toward achieving its stated results. All Rapid Scale-Up and Intensive Focus Country missions, including USAID/Cambodia, will need to work closely with USAID/Washington to establish this program monitoring and reporting system and issue annual reports on progress at the country level. The mission intends, to the extent possible, to comply with these guidelines to track progress and to monitor trends over time.

Under these guidelines, USAID/Cambodia will report on the following three indicator levels as the data become available:

1) HIV sero-prevalence levels;
2) Changes in sexual risk-reduction behavior; and
3) Progress on implementing all five USAID program areas and populations covered (e.g., condom social marketing, STI services, OVC, PMTCT, and care, support and treatment, including VCT and ARV).

USAID will collect data and report on progress for these levels using these indicators:

1) HIV sero-prevalence rates for 15-24 year olds;
2) HIV prevalence for ANC women;
3) Number of condoms sold in the last twelve months (**NOT a performance indicator**, but reported as a required UNGASS indicator);
4) Percent of men age 15-49 who have had commercial sex in the last 12 months;
5) Percent of men age 15-49 who reported consistently using a condom with all commercial sex partners in the last 3 months;
6) Percent of men age 15-49 who reported consistently using a condom during the last 3 months with regular sweethearts;
7) Number of clients who were HIV-tested, including pre- and post-test counseling at USAID-supported VCT centers in the last 12 months;
8) Number of ODs that have at least 1 facility offering full package of PMTCT services;
9) Number of HIV-infected pregnant women who took full course of ARV prophylaxis during labor in the last 12 months;
10) Number of orphans and other vulnerable children receiving care and support in the last 12 months;
11) Number of individuals reached by community- and home-based care program in the last 12 months;
12) Number of individuals receiving ARV in the last 12 months; and
13) Level of program effort measured by the AIDS Program Effort Index

USAID will collaborate closely with the RGC and other donors, especially CDC-GAP, to ensure that the monitoring and reporting system meets the reporting requirements, to the extent possible, of all participating agencies.

Slight modifications of these standard indicators that more accurately reflect the situation in Cambodia were reviewed and approved by the Office of HIV/AIDS. The rationale for the modifications appears in the Performance Indicator Reference Sheets.

Although Cambodia is described as experiencing a generalized epidemic, the highest infection levels continue to be found among specific populations who engage in sexual behaviors that increase their risk of exposure to and transmission of HIV. Although the global indicators identified in USAID's Guidance on the new Monitoring and Evaluation Reporting System Requirements for HIV/AIDS Programs are population-based, in Cambodia it will be important to continue to monitor prevalence (and ideally incidence) of populations engaging in high-risk behaviors.

The Performance Data Table (see Table 4) is for the three year integrated Public Health Interim Strategy, 2002-2005, with additional targets projected for 2008.

1. General Explanation of the Performance Data Table:

The Performance Data Table presents the HIV/AIDS indicators selected by the Office of Public Health for the duration of the Three-Year Public Health Strategy 2002-2005. Targeted HIV prevention activities and social marketing of condoms are implemented nationally. Treatment, care, support, and general population prevention activities are implemented in geographic focus areas. Where possible, data will be collected and reported nationally and for the geographic focus areas. Geographic focus area data will be reported in the aggregate. The MoH launched its first five-year National Health Sector Strategic Plan 2003-2007 in November 2002. National targets for 2007 for key health indicators have been determined by MoH, including several HIV/AIDS indicators. USAID targets for 2008 are similar to and/or extrapolated from the MoH 2007 targets.

2. Explanation by Indicator (See Table 4 for indicators):

1. The National HIV prevalence among adults aged 15-49 in Cambodia has declined from 3.3 percent in 1998 to 3.1 percent in 1999, 2.8 percent in 2000 and to 2.6 percent in 2002. A WHO/UNAIDS/NCHADS Consensus Team re-analyzed the HSS data for these years in September 2002 using an Estimations Projections Program (EPP) to take multiple factors into account in adjusting the data. The HIV prevalence decline among sex workers is even more dramatic, from 42.6 percent in 1998 to 28.8 percent in 2002 and among urban police from 6.2 percent in 1999 to 3.9 percent in 2002.

2. HIV prevalence rates among women attending ANC services have remained fairly constant, at just under three percent. Despite this trend, the Asia Epidemic Model projects that the number (and proportion) of new HIV infections among women and their children is increasing.

3. **This indicator is reported as required, but is not considered an indicator of performance.**

4., 5., and 6. These behavioral indicators are included in the national Behavioral Surveillance Survey. Indicator number 4 is a measure for partner reduction. Indicator numbers 5 and 6 are measures of consistent condom use.

7. The MoH had six VCT centers in 2002 operating at the provincial level. By the end of 2003, the MoH expects to have at least 20 centers. USAID-supported services recently began in October 2002 with the new country strategy. Data for this indicator come from RHAC clinic reports. Other partners will also be supporting this indicator over the next three years.

8. The baseline from 2003 is 2 ODs, Battambang and Phnom Penh, that have full package PMTCT services. Currently, the MoH has 6 ODs with at least 1 full package PMTCT service. (Phnom Penh has two sites). Full package PMTCT services include VCCT for ANC clients, delivery services for HIV-infected pregnant women with ARV prophylaxis for the mother and the infant, and counseling on best infant feeding options. Five of these ODs are within the USAID focus geographic areas. Of these, 3 are directly supported by USAID partners. Another is supported by CDC-GAP. All 5 in the geographic focus areas, and all six nationally, receive important inputs from USAID and its partners through participation in the national level Technical Working Group on PMTCT, technical assistance in writing proposals for the Global Fund, organizing of workshops for training provincial health staff, as well as other inputs when requested from the MoH. USAID is restricted from providing the ARV prophylaxis drugs, but UNICEF is currently supporting this aspect of the program. JICA and the French Corporation are also involved in supporting the NMCHC. PMTCT is an area with tremendous donor and government collaboration.

9. The 2003 baseline for ARV prophylaxis among HIV-infected pregnant women is less than 100. This number is expected to increase as more PMTCT sites open in various parts of the country. One challenge is that ANC attendance is very low. This means the number of pregnant women who get tested is small and the number of women who test positive is very small. However, of those that test positive within the PMTCT program, a very high proportion receives ARV prophylaxis. Although USAID does not supply or procure the ARVs, USAID partner efforts are key to getting women into the services where they can access the life saving medicines for their children.

10. The indicator for OVC and CAA is supported by three USAID implementing partners. The national projected total for OVC for 2007 is 508,000. The USAID OVC care and support target set for 2008 is 25 percent of the total projected number of OVC for the 7-province USAID focus area (164,587), or 41,147 children.

11. According to the 2002 HSS, the estimated number of adults aged 15-49 living with HIV/AIDS in Cambodia in 2002 is 157,500. The number of PLWHA nationally is projected to be 114,141 in 2005, of whom 42,383 are

expected to require care and support. For the USAID 7-province focus area, the number expected to require care and support in 2005 is 15,123, according to estimations developed by FHI/Cambodia.

12. ARV Treatment is slowly becoming available in Cambodia. A number of organizations are providing ARVs to clients in Phnom Penh and in Siem Reap. Both of these ODs are within the USAID geographic focus areas. Although USAID does not provide or procure ARVs, USAID partners are actively involved in supporting the existing programs through technical support, referral of patients, participation on the Technical Working Group for Continuum of Care, technical assistance to write the proposals to the Global Fund, as well as other requested areas of support. In addition, two additional ODs, Maung Russey and Battambang, with direct technical support from USAID partners and ARVs from UNICEF will begin ARV treatment as a part of the continuum of care. CDC-GAP will also soon begin providing ARV treatment in its geographic target area. The baseline number of individuals receiving ARV treatment in Cambodia is under 1,200.

13. The Future's Group conducted the API survey in early 2003. Baseline data are available from both the 2000 and 2003 surveys. Overall, Cambodia has improved its total API score by 11 points in the past two years, from 57 to 68. Increased program effort was reported in every category except monitoring and evaluation.

Table 4: Performance Data Table 2003: USAID/Cambodia OPH Rapid Scale-Up Targets

	Indicator	Level, Baseline date, Source		Baseline	2003 target	2004 target	2005 target	2008 target
1.	**HIV sero-prevalence rates for 15-24 year old. (e.g. SWs, men at risk and general adult population)**	National 2000 HSS	7-province USAID Priority Area HSS	**Ntl** 31.1%(DSW) 16.1% (IDSW) 3.1% (Police) 2.8% (Adult)	29% (CDSW) 15% (IDSW) 3.0% (Police) 2.7% (Adult)	27% (CDSW) 14% (IDSW) 2.9% (Police) 2.6% (Adult)	25% (CDSW) 12% (IDSW) 2.8% (Police) 2.4% (Adult)	17% (CDSW) 10% (IDSW) 2.6 (Police) 2.2 (Adult)
2.	**HIV prevalence for ANC women**	National 2000 HSS	Focus area HSS	**Ntl** 2.80%	2.80%	2.80%	2.80%	2.80%
3.	**Number of condoms sold in the last twelve months.**	National 2002 PSI	Focus area PSI United Health Network MIS(P)	**Ntl** 16.5 million	18 million (actual: 21,498,217)	20 million	22 million	25 million
4.	**Percent of men age 15-49 who have had commercial sex in the last 12 months**	National 2001 BSS	Focus area 2003 BSS (P)	**Ntl** 32%(Military) 33%(Police) 18%(Mototaxi)	30% 30% 15%	28% 28% 15%	25% 25% 15%	20% 20% 15%
5.	**Percent of men age 15-49 who reported consistently using a condom with all commercial sex partners in the last 3 months**	National 2001 BSS	Focus area 2003 BSS (P)	**Ntl** 87%(Military) 85%(Police) 79%(Motor driver)	90% 90% 85%	90% 90% 90%	90% 90% 90%	90% 90% 90%

Indicator		Level, Baseline date, Source		Baseline	2003 target	2004 target	2005 target	2008 target
6.	**Percent of men age 15-49 who reported consistently using a condom during the last 3 months with regular sweetheart**	National 2001 BSS	Focus area 2003 BSS (P)	**Ntl** 26% military 31% police 33% mototaxi	28% 33% 35%	30% 35% 38%	35% 40% 40%	50% 50% 50%
7.	**Number of clients who were HIV-tested, including pre- and post-test counseling at USAID-supported VCT centers in the last 12 months;**	National MoH and Private clinic records	Focus area HFA (P&OD) Private clinic records	**Prov** 2,679 (MoH) 3,264(USAID)	11,000	11,550	13,000	20,000
8.	**Number of ODs that have at least 1 facility offering full package of PMTCT services**	NA	Focus area HFS (P&OD) Program reports and NMCHC. 2003 baseline from NMCHC	Prov 2	2	5	7	15
9.	**Number of HIV-infected pregnant women who took full course of ARV prophylaxis during labor in the last 12 months**	Program records	Focus area Program reports and NMCHC 2003 baseline from NMCHC	**Ntl** <100	<100	150	210	500
10.	**Number of orphans and other vulnerable children receiving care and support in the last 12 months.**	Provincial 2002 baseline from program reports	Focus area KAPC (OD) Program reports	**Prov** **5,855**	7,000 (actual: 11,070)	10,000	15,000	25% of the 164,587 OVC projected, or 41,147 OVC

Indicator		Level, Baseline date, Source		Baseline	2003 target	2004 target	2005 target	2008 target
11.	**Number of individuals reached by community- and home-based care programs in the last 12 months**	Program records	Focus area KAPC (OD) program reports	**Prov 6,266**	7,000	8,500	10,000	14,000
12.	**Number of individuals receiving ARV in the last 12 months**	National MoH and Program records		**Ntl <1,200**	1,200	1,500	2,000	3,000
13.	**Level of program effort measured by the AIDS Program Effort Index (API)**	National 2003 Future's Group	NA	API Score 58.2	65	70	75	85

Ntl= National level, Prov= Provincial level, aggregated across USAID geographic focus area

Sources: 1) USAID Global Health Objectives (Feb. and Dec. 2002)
2) Expanded Response for Monitoring and Reporting on HIV/AIDS (April and September, 2002) and Guidance on M&E Reporting (April and June, 2002)
3) Handbook of Indicators for HIV/AIDS/STI Programs (March 2002)
4) UNGASS (August 2002)

C. Contribution to International and Expanded Response Goals

By adopting the USAID/Washington guidelines, USAID/Cambodia will also contribute to the measurement of progress with respect to National, United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and USAID Expanded Response Targets. To the extent possible, USAID/Cambodia has adopted the UNAIDS and UNGASS standards for the Agency reporting system so that most data are compatible with all three systems.

D. Planned Surveillance, Surveys and other Monitoring and Evaluation Activities

USAID will continue to provide technical assistance through partners to strengthen national HIV surveillance (see Section II/D. Tracking the Epidemic and Strengthening the Health System). CDC-GAP will be an integral partner in these efforts. Additionally, USAID will continue to provide technical assistance through its implementing partners to strengthen the BSS to collect relevant data on risk behaviors among key target populations.

In addition to these large national level surveys, USAID will implement facility assessments to evaluate the quality and coverage of key HIV/AIDS services such as VCT and PMTCT. Facility records will also be monitored by implementing partners to establish coverage rates of these services.

Endnotes

1) Trend data are derived from an analysis of HSS data collected from sentinel surveillance groups, antenatal care (ANC) attendees and from the 1999 Cambodian Male Household Survey, BSS IV, conducted in five provinces (Battambang, Sihanoukville, Kampong Cham, Phnom Penh, and Siem Reap).

2) M.Rodolph and S. Hersey, *Sexual Behavior, STIs and HIV among Men who have Sex with Men in Phnom Penh*, *Cambodia* (Cambodia: Family Health International 2000)

3) United Nations Population Fund, *World Population Prospect* (NY, NY: UN, 2002)

4) UNAIDS, Cambodia Country Profile, 2000

5) USAID uses UNICEF's definition of childhood, between the ages of 0-18

6) D. Wilkinson, *An Evaluation of the Ministry of Health's Home Care Programme for People with HIV/AIDS in Cambodia* (Cambodia: KHANA 2000)

7) In Vonthanoak et al. (2002), "How Well Do Antenatal Clinic Attendees Represent the General Population?" *International Journal of Epidemiology* (31:344-354), researchers reported that HIV prevalence among ANC attendees is a relatively good indicator of prevalence among women in the general population.

8) M.Rodolph and S. Hersey. FHI 2000.

9) The implementation of the portfolio would occur through: a) OPH managing the initiative; b) OPH contracting out the initiative to an existing CA; or c) OPH partnering with a centrally-managed CA.

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