Scaling Up Towards Universal Access to HIV Prevention, Treatment, Care, and Support




Report on the Consultation on Universal Access Indicators & Targets in Cambodia

December 2006

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Report on the Consultation on Universal Access Indicators and Targets

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Acronyms

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

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I. Executive Summary

The global AIDS response has steadily grown and gained momentum since UN Member States made a Declaration of Commitment on HIV/AIDS at the 2001 Special Session of the UN General Assembly. This momentum has occurred within wider efforts to place countries more firmly in command of their own development programmes. Based on these developments, UNAIDS is facilitating a multi-partner, country-driven effort to scale up towards Universal Access.

In Cambodia, the first national consultation meeting was held in February 2006 and co-chaired by National AIDS Authority and NCHADS with participation from government, civil society, UN and development partners. The outcome of this consultation was a report that was presented to a regional consultation meeting in Pattaya, Thailand in mid-February 2006. The second consultation was held on November 2006 in order to improve understanding of Universal access as a concept and its related indicators and targets and to refine and come up with common indicators and targets. The results of this consultation were reported in an international meeting in Lusaka, Zambia on December 2006. Preceding the consultation was a pre-consultation meeting on Universal Access with Civil Society.

The twenty-one (21) draft indicators and targets were presented for discussion and feedback. Participants were divided into three workgroups (prevention, treatment & care, and impact mitigation) wherein each indicator was discussed. They were encouraged to give suggestions as much as possible on how the indicators can be improved.

During the plenary, various issues were brought up, further discussed, and settled. First to come up was the ambitious nature of Universal Access targets. This sentiment has also been expressed in previous consultations and in the pre-consultation meeting, especially when referring to certain population groups like IDUs and MSM who either live in the fringes of society or 'invisible' and therefore difficult to reach. On the other hand, others said that aiming high allows more room to mobilise additional resources. This is why it was agreed to keep higher targets regarding IDUs. The second issue was about HIV transmission between husband and wife. There were recommendations to add an indicator that would show transmission between husbands and wives aside from indicator 8, which is about high risk men's condom use with commercial sex workers. It was explained that husbands tend to use condoms only when their sexual partners are not their wives. The plenary decided not to follow this recommendation and to reconsider the issue in the future.

Related to the first issue were the population size estimates of drug users and MSM. Establishing interim and final targets is difficult especially if there is no baseline data on specific population groups. For the 2 types of drug users, figures are expected to be obtained from the UNODC. For MSM, however, no national population size estimate is available. The fourth issue was on TB & HIV collaborative activities. A question was raised on what providing support to TB patients mean. The guideline could elaborate further on what type of service constituted providing support to TB patients because the relation of TB and HIV as co-infections cannot be ignored.

Discussions on some terminology and its varied meanings also occurred. A number of indicators contained terms that required clarification from the participants. Specific examples include *'large employers'* with 25 or more employees. It was suggested that this be re-defined as having 100 or more employees. Related to this is the phrase *'educational and nutritional support'*. It was suggested that the minimum package of services that comprise educational and nutritional support be included in the indicator instead. The last issue to be discussed was about the term CAA versus OVC. The merits of using one term over the other led to a discussion that started in the work-group and extended well into the plenary. Many participants felt and believed that the term *'OVC'* is accurate

and specific enough to describe children who are infected with and affected by HIV/AIDS. However, the plenary decided that the OVC task-force definition must be used and the OVC components specified.

The second consultation on Universal Access indicators and targets was able to achieve its objectives of improving understanding of Universal Access as a concept and its related indicators and targets; and coming up with a common set of indicators and targets. Consequently, these indicators and targets have been finalised by the M&E working group. A third consultation is being planned, one that will focus on addressing programmatic and financial gaps that affect the achievement of these targets, as well as ensuring that operational plans are harmonised and aligned. The M&E guideline for the indicators and targets will also be elaborated and expanded as necessary.

On the part of government, its future plans include: revisiting the NSP II and other sectoral plans to ensure that efforts are aligned towards achieving UA targets; revisiting a costing exercise to ensure that it clearly identifies the gaps and what is needed to achieve UA targets; undertaking a national IEC campaign to increase awareness and comprehension of UA in Cambodian society; utilising the national IEC campaign to further strengthen social mobilisation efforts to achieve UA targets and to ensure national and international accountability; and continuing to provide the strategic and technical leadership, as well as coordination, to ensure that Cambodia meets its UA commitments.

II. Background

1. The concept of Universal Access[1]

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

This momentum has occurred within wider efforts to place countries more firmly in command of their own development programmes. Global responses include the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and increased bilateral assistance. Civil society advocacy have helped slashing the price of first-line antiretroviral medicines and increased their availability. The 3 by 5 initiative, launched by WHO and UNAIDS, has built on these developments to catalyze and mobilize support for national AIDS programmes to expand access to treatment.

Based on these developments, UNAIDS is facilitating a multi-partner, country-driven effort to scale up towards Universal Access. The process intends to identify key obstacles that are impeding comprehensive and integrated scale up of prevention, care and treatment, and support services, to come up with solutions to overcome these, and to formulate and develop nationally agreed, targeted plans or 'roadmaps' for building significantly greater coverage of services by 2010.

2. The Cambodian HIV/AIDS epidemic[2]

Cambodia's mature HIV/AIDS epidemic continues to be one of the most serious in Asia. Although the national prevalence rate of HIV has gone down significantly from 2.5% in 2000 to 1.9% in 2003, this figure still remains high compared to other countries in the region.

Condom use in brothels is much higher than before; 96% of brothel-based sexual transactions are now protected. As few men visit sex workers, forms of sexual networking change. Men increasingly turn to indirect sex workers and sweethearts for sex, with whom they are less likely to use a condom. The epidemic radiates out from the high-risk population groups, evidenced by the fact that almost half of new HIV infections are now among married women. One third of new infections happen between infected mothers and their children. This situation can potentially be exacerbated by the low uptake of PMTCT services. Of the estimated 500,000 pregnant Cambodian women per year, less than half are able to attend ANC at least once while only 1 in 10 births happen in a health facility.

The generalised epidemic has shown that relatively small yet significant groups seem severely affected. Targeted, small-scale surveys have indicated that males-who-have-sex-with-males (MSM) and heroin injectors have an alarming prevalence rate of HIV, with 14-15% and 37-45%, respectively, along with the presence of other sexually transmitted infections (STI). White-collar workers, amphetamine-type substance (ATS) users, park-based sex workers, and truck drivers are emerging as groups that are at-risk for STI and HIV.

Each day, more HIV-infected people become sick and join the ranks of those needing care, treatment and support. Cambodia's health care system still has a long way to go to be able to adequately respond to the health needs of Cambodians, and the estimated 123,100 adults and 21,000 children with HIV have little time to wait. There may be as many as 77,000 orphans and vulnerable children (OVC) in Cambodia, and thousands of families whose main providers are either ill or dead.

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[1] Excerpted from The Road to Universal Access; UNAIDS; January 2006.
[2] 2005 Situation & Response Analysis of the HIV/AIDS Epidemic in Cambodia; NAA; August 2005.

Societal attitudes and cultural realities continue to affect the vulnerabilities of certain population groups. Although sex work remains to be illegal, sex workers are mandated to participate in the 100% Condom Use Programme. Pre-marital sex and male-to-male sex are not illegal but highly stigmatised, making it difficult for programmes to reach these population groups (sexually active young people and MSM).

Poverty and gender inequities fuel the sexual transmission of HIV. When a parent becomes ill or dies, daughters are usually sent away to find jobs, making them susceptible to sexual exploitation and violence. Condom negotiation within marriage is not culturally acceptable for women, and a culture of masculinity tolerates men who have multiple sexual partners. Violence is experienced by women from varied social backgrounds: married women, women in relationships, women who are coerced into sex work, and rape survivors.

3. The national HIV/AIDS response[3]

The Cambodian government has been quick to respond in trying to curb the spread of HIV/AIDS since the first HIV and AIDS cases were detected in 1991 and 1994, respectively. Programmes and projects that aimed to raise awareness among and educate varied population groups were created primarily by the Ministry of Health and several non-government organisations (NGOs). The National AIDS Program of the MoH was reorganised to become the National Centre for HIV/AIDS, Dermatology and STDs (later STIs), or NCHADS, which was the focal point of the health sector response to the epidemic. The National AIDS Authority (NAA) was later created with a mandate of ensuring that the HIV/AIDS response extended beyond the health sector, reflective of a multi-sectoral approach that has since been adapted by both national strategic plans on HIV/AIDS.

As of this writing, most of the interventions have focused on prevention. This emphasis on prevention produced a wide and varied array of creative approaches that aimed to increase levels of knowledge about HIV/AIDS and related issues within specific population groups and among the general population. Current interventions among the most-at-risk populations include peer education and outreach, condom promotion and social marketing, IEC activities, and the 100% Condom Use Programme. For care and treatment, a host of programmes and interventions addressing the health care needs of PLHA, including the Continuum of Care (CoC), are already in place. What needs to be done is to strengthen these services, scale up to expand coverage, and facilitate greater access to the facilities.

In terms of impact mitigation, a number of Home-based Care Teams that are managed by NGOs, CBOs, FBOs, and by some government agencies provide a variety of support to OVC and families affected by HIV/AIDS. These types of support include daily care and hygiene, health and treatment education, psychological support, food ration, school materials, livelihood opportunities, among others. A critical national need relating to impact mitigation are assessing the impact of HIV/AIDS on other social sectors like economic development, and reducing its impact through the implementation of sectoral interventions.

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

HIV/AIDS has been integrated in national development plans, and a National HIV/AIDS Law has been promulgated. However, translating these into everyday reality that will positively impact on the epidemic remains a challenge. Tracking and understanding the epidemic is essential. Existing monitoring, evaluation

[3] *Mapping Cambodia's Response to HIV/AIDS; UNAIDS Cambodia; unpublished.*

and research activities are dictated by donors or ad hoc. The NSP II includes an M&E Framework that will guide the tracking of the national response to HIV for the next five years.

4. The first national consultation on Universal Access[4]

At the Gleneagles Summit in 2005, the leaders of the G8 nations committed to funding the universal access to HIV services. G8 leaders requested that a global road-map on scaling-up to Universal Access be presented to the UN General Assembly in 2006. At the subsequent High Level Meeting on AIDS held at the UN General Assembly, member States endorsed the Political Declaration which committed countries to setting ambitious targets for Universal Access for prevention and treatment and a road-map for achieving these targets by 2010, with interim targets to be reached in 2008.

In Cambodia, the first national consultation meeting was held in February 2006 and co-chaired by National AIDS Authority and NCHADS with participation from government, civil society, UN and development partners in order to: validate the existing NSP II indicators and targets and ensure that these were sufficiently ambitious; to fill gaps in target setting (especially MARPs); and to identify how Cambodia will achieve Universal Access, including identification of obstacles and opportunities, barriers to access and proposed solutions, and resource needs. The outcome of this consultation was a report that was presented to a regional consultation meeting in Pattaya, Thailand in mid-February 2006.

The findings in the first consultation are as follows. The challenges facing Cambodia in scaling up towards Universal Access to prevention, treatment, care and support are two-pronged: (1) increasing the coverage of prevention, treatment, care and support services; and (2) increasing the financial and technical support to sustain the health sector response and strengthen social systems. Most of the elements that are critical to move from planning to concrete actions are in place: vigorous political and institutional commitment, an effective prevention campaign, access to financial resources, and the active involvement and participation of civil society.

To scale up prevention, coverage of outreach programmes that have proven to be effective in reaching most-at-risk populations (DSW, Uniformed Services) must be expanded. Maintaining a high level of quality of services and making these services 'friendly' and acceptable to various population groups will ensure a continual attendance to these facilities, resulting in sustained service delivery. The strengthening, expansion and full integration of CoC into the health care delivery system is the clearest manifestation of a scaled up HIV/AIDS treatment and care response. Achieving this, however, depends on whether the rehabilitation of the public health infrastructure is completed and sustained.

Care and support initiatives must always strive to promote a legal environment where ethical, legislative and normative activities conform to the highest standards of civil and human rights and protect the privacy and dignity of individuals. To reduce stigma and discrimination, the greater involvement, representation and participation of PLHA in advocacy, programme planning, implementation, monitoring and evaluation at all levels must be increased and strengthened. Scaling impact mitigation efforts must look at expanding the coverage of programmes that provide socioeconomic support to OVC and affected families and strengthening PLHA networks. Being able to assess the impact of HIV/AIDS on non-health sectors like education, labour and rural development and developing strategies to reduce the impact are other aspects of scaled up impact mitigation.

Working towards Universal Access to HIV prevention, treatment, care and support requires not only a coordinated national response but also coordinated monitoring and evaluation. A national M&E framework

[4] Cambodia Country Report on Scaling Up Towards Universal Access to HIV Prevention, Treatment, and Care & Support; UNAIDS Cambodia; February 2006.

has been built into the NSP II, which will guide the tracking of the national response, setting clear 5-year targets and setting the mechanisms for measuring the coverage and effectiveness of the national response.

Looking into the future, strategies that will address HIV/AIDS as an endemic disease must be developed today. Broadly speaking, this can be done initially by ensuring that HIV/AIDS and its concomitant issues are integrated into development plans and programmes.

III. Highlights of the consultation

Introductory Activities

The consultation started at 8.30AM. Opening remarks were delivered by Mr. Tony Lisle (Country Coordinator, UNAIDS Cambodia). He welcomed and thanked the participants for attending the consultation, and expressed his optimism that this consultation will be as fruitful as the first. He also mentioned the pre-consultation meeting with civil society representatives that was done prior to this consultation to broaden civil society's engagement in the process[5].

Dr. Ly Penh Sun (Deputy Director, NCHADS), representing NCHADS Director Dr. Mean Chhi Vun, also thanked the participants for coming and recalled the process of the first consultation. He stated the importance of collaboration in coming up with the indicators and targets and that he expected the same process in providing feedback to the draft indicators and targets. H.E. Dr. Teng Kunthy (Secretary General, NAA) delivered the third opening remark. He said that he is hopeful that an agreement will be reached and a national buy-in will be gained on the Universal Access indicators and targets.

Dr. Hor Bun Leng (Deputy Secretary, NAA) provided the background and context of the second consultation. He started with the development of the National Strategic Plan for a Comprehensive & Multisectoral Response to HIV/AIDS 2006-2010 (NSP-II), which included a 5-year operational plan and a M&E framework. He then cited the High Level Meeting on AIDS, which called for ambitious targets to be set for Universal Access. Cambodia responded by holding the first consultation in February 2006. Since then, the M&E Advisory Group of the NAA had been busy developing the indicators and targets. He then proceeded to present the three objectives and expected outputs of the second consultation.

Objectives

The second consultation had the following objectives:

a. To gain national buy-in and consensus on Cambodia's Universal Access indicators and targets;
b. To understand and widely disseminate Cambodia's Universal Access indicators and targets; and
c. To establish a guide for national stakeholders on how to achieve Cambodia's Universal Access targets, through a road-map of key steps, which identifies and addresses the 'how's' of addressing obstacles, utilizing opportunities, and the methods of reporting and measurement of progress.

Expected outputs

The following outputs were expected from the second consultation:

a. All partners are working to one commonly agreed set of indicators and targets;
b. All partners understand the Universal Access indicators and targets and can measure progress; and
c. All partners have provided feedback and input into the Cambodian road-map and in developing the guide for implementation of the Universal Access targets.

[5] *See Proceedings of Civil Society Pre-Consultation on Universal Access in Annex 4.*

Workshop Proper

Dr. Ngin Lina (Chief, PPMER, NAA) presented the draft 21 Universal Access Indicators and Targets illustrated below:

	INDICATOR	Baseline 12/2005	Target 2008	Target 2010
1	Number of large employees that have workplace polices and interventions.	14	30	60
2	Percentage of respondents who say that an HIV+ teacher who is not sick should be allowed to continue teaching.	CDHS 2005	50%	70%
3	Number of ministries that are actively implementing an HIV/AIDS plan, as per their sectoral strategy.	6	9	18
4	Percentage of households with OVC that receive educational or nutritional support.	GFATM R5	30%	50%
5	Percentage of communes with at least 1 organisation providing care & support to households with OVC.	GFATM R5	50%	100%
6	Percentage of provincial and commune development strategies that address HIV/AIDS.	3%	25%	50%
7	Number & percentage of OD with CoC (Note that only OD with Referral Hospitals are counted, n=68).	20 (29%)	36 (53%)	40 (59%)
8	Percentage of high risk men who report consistent condom use with commercial sexual partners.	89%	95%	98%
9	Percentage of direct female sex workers who report consistent condom use.	96%	96%	98%
10	Percentage of indirect female sex workers who report consistent condom use.	84%	90%	98%
11	Percentage of IDUs who are exposed to HIV prevention interventions.	20%	60%	90%
12	Percentage of ATS users who are exposed to HIV prevention interventions.	n/a	40%	50%
13	Percentage of visible MSM who are exposed to HIV prevention interventions.	n/a	60%	90%
14	Number & percentage of OD with at least 1 PMTCT site offering the minimum package of PMTCT services.	18	30	50
15	Percentage of pregnant women attending ANC who are tested for HIV.	53.1%	75%	80%
16	Number of VCCT sites offering counselling & testing services.	104	230	300
17	Number of CoC sites operating with a minimum package of services.	30	46	50
18	Percentage of PLHA with access to CoC (OI & ART services) [Denominator = 25,000]	12,355 (49%)	19,000 (76%)	23,750 (95%)
19	Number of Home-based Care Teams	261	400	470
20	Number of Health centres providing support to TB patients for HIV testing.	150	350	470
21	Number of condoms sold.	21M	27.4M	29.4M

Table 1. Draft Universal Access Indicators and Targets – 2008 & 2010

After presenting the indicators and targets, she asked the participants to form three work groups. Using the Draft Universal Access Indicators and Targets as source document, she then asked the groups to discuss whether they agree on the indicators and targets or not, whether the purpose of each indicator is clear or not, and whether the definition is accurate and the method of measurement appropriate or not.

She proceeded with asking the first group to discuss the prevention indicators (8, 9, 10, 11, 12, 13, 14, 15, 16, and 17). The second group took on the care and treatment indicators (7, 18, 19, 20, and 21) while the third group tackled the impact mitigation indicators (1, 2, 3, 4, 5, and 6). The groups were given an hour to discuss the indicators and targets.

Work Group Discussions

Prevention

The following points were raised in this group's discussion:

a. In relation to indicator 8[6], it is important have an indicator that would show HIV transmission between husbands and wives, which currently represents the greatest share of new transmissions. This can be stated as, 'percentage of consistent condom use among husbands and wives'. This point was further discussed in the plenary;

b. The targets for indicator 11[7] are too high. It's difficult to come up with figures when you do not know the population size of your target group (in this case, IDU). The suggested targets are: 30% (2008) and 50% (2010);

c. Input from DHA-WG is needed to set targets for indicators 11 and 12[8];

d. For indicator 13[9], the purpose, method of measurement and interpretation can be stated in the same manner as indicator 11. One suggestion is to remove the word 'visible' from the phrase 'visible MSM';

e. For indicator 14[10] the only suggestion was to increase the 2008 target from 30 to 40; and

f. In measuring indicator 15[11], it was suggested that the numerator and denominator be revised into 'number of pregnant women who attend ANC at PMTCT sites receive counselling and testing', and 'total number of 1st ANC clients at PMTCT sites', respectively. It was also suggested that the 2008 target for this indicator be reduced from 75% to 70%.

Care & Treatment

The following points were raised in this group's discussion:

a. The title of indicator 7[12] should be retained but its purpose should be taken from indicator 17[13], which the group felt was not needed and should be dropped. Another suggestion was to add 'paediatric care´ in the number of services;

b. Data collected to measure indicator 18[14] should be disaggregated by sex and age to identify the number and percentage of children living with HIV;

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[6] Percentage of high risk men who report consistent condom use with commercial sexual partners.
[7] Percentage of IDUs who are exposed to HIV prevention interventions. Baseline: 20%; 2008: 60%; 2010: 90%.
[8] Percentage of ATS users who are exposed to HIV prevention interventions.
[9] Percentage of visible MSM who are exposed to HIV prevention interventions.
[10] Number & percentage of OD with at least 1 PMTCT site offering the minimum package of PMTCT services.
[11] Percentage of pregnant women attending ANC who are tested for HIV.
[12] Number & percentage of OD with CoC (Note that only OD with Referral Hospitals are counted, n=68).
[13] Number of CoC sites operating with a minimum package of services.
[14] Percentage of PLHA with access to CoC (OI & ART services) [Denominator = 25,000]

c. In measuring indicator 19[15], the suggested numerator is 'number of PLHA who receive HBC' and the denominator is 'number of HBC teams'; and

d. For indicator 20[16], the group sought clarification on what providing support to TB patients means.

Impact Mitigation

The following points were raised in this group's discussion:

a. For indicator 1[17], the group suggested re-defining the term 'large employers' to mean 'with 100 or more employees' instead of just 25 or more employees. It was also suggested that the denominator be 'companies registered with the Ministry of Commerce'. As for setting targets, the group felt that it is important to know how many companies are indeed registered in the Ministry of Commerce. Only then can targets be set;

b. The targets of indicator 2[18] require validation from surveys like the CHDS 2005. Once these figures are updated, then the targets can be revised accordingly;

c. The group wanted to clarify the meaning of the phrase 'actively implementing' in indicator 3[19]. The group agreed that for a ministry to be considered actively implementing an HIV/AIDS plan, it must have an operational plan, allocated and disbursed resources, and progress and financial reports. In measuring this, the group suggested that the NAA Technical Board be added because they meet regularly and the Board is comprised by representatives from all ministries. In its interpretation, the group suggested that the word 'breadth' be replaced with the more comprehensible 'coverage'. For the denominator, the word 'correctly' should be replaced with 'currently';

d. For indicator 4[20] the group again wanted a clear and concise definition of educational and nutritional support. The group also discussed what the minimum package for educational and nutritional support includes. Another suggested that the contentious phrase be removed and be replaced with a 'minimum package of services and information';

e. As in the previous item, the group wanted to agree upon what is the minimum package of services being referred to in indicator 5[21]. It was further suggested that instead of working with Communes, we should try to work with Operational District; and

f. The first suggestion for indicator 6[22] is to separate the numbers of the provinces and from the number of the communes. Suggested numerators are the Provincial Development Strategies and Commune Plans. For interpretation, the group suggested that only provinces with HIV/AIDS-related strategies and include the commune therein.

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[15] Number of Home-based Care Teams
[16] Number of Health centres providing support to TB patients for HIV testing.
[17] Number of large employers that have workplace polices and interventions.
[18] Percentage of respondents who say that an HIV+ teacher who is not sick should be allowed to continue teaching.
[19] Number of ministries that are actively implementing an HIV/AIDS plan, as per their sectoral strategy.
[20] Percentage of households with OVC that receive educational or nutritional support.
[21] Percentage of communes with at least 1 organisation providing care & support to households with OVC.
[22] Percentage of communes with at least 1 organisation providing care & support to households with OVC.

Plenary

The three groups then presented their out puts during the plenary. The following issues were raised and discussed during the plenary:

a. Ambitious nature of Universal Access targets. Some participants felt the interim and final targets are overly ambitious. This sentiment has also been expressed in previous consultations and in the pre-consultation meeting, especially when referring to certain population groups like IDUs and MSM who either live in the fringes of society or 'invisible' and therefore difficult to reach. A number of stakeholders are apprehensive to commit to targets that they do no think they can achieve. On the other hand, this ambitious nature is what sets the Universal Access initiative apart from the other responses to the pandemic and enables it to drive the scaling up of efforts. There is nothing wrong in aiming high, because it also allows more room to mobilise additional resources. This is why it was agreed to keep higher targets regarding IDUs.

b. HIV transmission between husband and wife. There were recommendations to include an indicator that would show transmission between husbands and wives aside from indicator 8, which is about high risk men's condom use with commercial sex workers. It was explained that husbands tend to use condoms only when their sexual partners are not their wives The plenary decided not to follow this recommendation and to reconsider the issue in the future.

c. Population size estimates of drug users and MSM. Establishing interim and final targets is difficult especially if there is no baseline data on specific population groups (indicators 11, 12, and 13). For 2 types of drug users (IDU and ATS), figures are expected to be obtained from the UNODC. For MSM, however, no national population size estimate is available;

d. TB & HIV collaborative activities. A question was raised on what providing support to TB patients mean (indicator 20). The guideline could elaborate further on what type of service constitute providing support to TB patients because the relation of TB and HIV as co-infections cannot be ignored;

e. Some terminology and its varied meanings. A number of indicators contained terms that required clarification from the participants. Specific examples include *'large employers'* (indicator 1) with 25 or more employees. It was suggested that this be re-defined as having 100 or more employees. Another is *'actively implementing'* (indicator 3); clarification was sought on categorically defining what this phrase meant. Related to this is the phrase *'educational and nutritional support'* (indicator 4). It was suggested that the minimum package of services that comprise educational and nutritional support be included in the indicator instead; and

f. CAA versus OVC. The merits of using one term over the other led to a discussion that started in the work-group and extended well into the plenary. Many participants felt and believed that the term *'OVC'* is accurate and specific enough to describe children who are infected with and affected by HIV/AIDS. However, the plenary decided that the OVC task-force definition must be used and the OVC components specified, as was recommended by Dr Oum Sopheap.

Concluding Activities

Dr. Hor Bun Leng concluded the plenary discussions by focusing on the achievements of the day: highlighting the agreements made on some issues, underscoring the importance of further consultations regarding un-settled issues, and thanking the participants for their contributions. After this, H.E. Dr. Teng Kunthy delivered the closing remarks that officially ended the consultation.

IV. Key outcomes

1. Final UA indicators and targets – 2008 & 2010

After consulting with various stakeholders, a set of Universal Access Indicators and Targets has been finalised as follows:

	INDICATOR	Baseline 12/2005	Target 2008	Target 2010
1	Number of large employees that have workplace polices and interventions.	14	30	60
2	Percentage of respondents who say that an HIV+ teacher who is not sick should be allowed to continue teaching.	CDHS 2005	50%	70%
3	Number of ministries that are actively implementing an HIV/AIDS plan, as per their sectoral strategy.	6	9	18
4	Percentage of households with OVC that receive 1 of 6 components support.	GFATM R5	30%	50%
5	Percentage of communes with at least 1 organisation providing care & support to households with OVC.	GFATM R5	50%	100%
6	Percentage of provincial and commune development strategies that address HIV/AIDS.	3%	25%	50%
7	Percentage of high risk men who report consistent condom use with commercial sexual partners.	89%	95%	98%
8	Percentage of direct female sex workers who report consistent condom use.	96%	96%	98%
9	Percentage of indirect female sex workers who report consistent condom use.	84%	90%	98%
10	Percentage of IDUs who are exposed to HIV prevention interventions.	15%	40%	80%
11	Percentage of ATS users who are exposed to HIV prevention interventions.	n/a	40%	50%
12	Percentage of MSM who are exposed to HIV prevention interventions.	n/a	60%	90%
13	Number & percentage of OD with at least 1 PMTCT site offering the minimum package of PMTCT services.	18	40	50
14	Percentage of pregnant women attending ANC at PMTCT who received counselling and testing for HIV.	53.1%	70%	80%
15	Number of VCCT sites offering counselling & testing services.	109	230	300
16	Number and percentage of CoC sites operating with a minimum package of services.	30	46	50
17	Percentage of PLHA with access to CoC (OI & ART services)	12,355 (49%)	19,000 (76%)	23,750 (95%)
18	Number of Home-based Care Teams	261	400	470
19	Number of Health centres providing support to TB patients for HIV testing.	150	350	470
20	Number of condoms sold & distributed.	21M	27.4M	29.4M

Table 2. Final Universal Access Indicators and Targets – 2008 & 2010

2. The next steps

The second consultation on Universal Access indicators and targets was able to achieve its objectives of improving understanding of Universal Access as a concept and its related indicators and targets; and coming up with a common set of indicators and targets. Consequently, these indicators and targets have been finalised by the M&E working group. The next thing to be done is to elaborate and expand as necessary the M&E guideline for the indicators and targets.

Many participants, however, felt that there was not enough time to discuss and settle a number of issues. A third consultation is being planned, one that will focus on addressing programmatic and financial gaps that affect the achievement of these targets, as well as ensuring that operational plans are harmonised and aligned.

On the part of government, its future plans include:

a. Revisiting the NSP II and other sectoral plans to ensure that efforts are aligned towards achieving UA targets;

b. Revisiting a costing exercise to ensure that it clearly identifies the gaps and what is needed to achieve UA targets;

c. Undertaking a national IEC campaign to increase awareness and comprehension of UA in Cambodian society;

d. Utilising the national IEC campaign to further strengthen social mobilisation efforts to achieve UA targets and to ensure national and international accountability; and

e. Continuing to provide the strategic and technical leadership, as well as coordination, to ensure that Cambodia meets its UA commitments.

These plans were presented by Cambodia's delegation involving Dr. Teng Kunthy (Secretary General, NAA), Dr. Ngin Lina (Chief PPMER, NAA) and Dr. Oum Sopheap (Executive Director, KHANA) at the UNAIDS Programme Coordinating Board (PCB) meeting held in Lusaka, Zambia from 6 to 8 December 2006.

Annexes

Annex 1. List of Participants for the Universal Access Workshop

28 November 2006, HIMAWARI HOTEL

No.	Name	Agency	Remarks
1	Vong Sathiarany	NMCHC	
2	Savina Ammassari	UNAIDS	
3	Jane Batte	UNAIDS	
4	Sok Pun	NAA/UNDP	
5	Yi Sokha	NAA/UNDP	
6	Anthony Vaulier	PSF-CI	
7	Irene Moraa	PSF-CI	
8	Michael P. De Guzman	UNAIDS	
9	Long Dianna	PSI	
10	Tony Lisle	UNAIDS	
11	Kate Oganell	PSI	
12	Eve Buneau	IRD	
13	Oum Sopheap	KHANA	
14	Huy Chhong Darapheak	NAA	
15	Taing Phoeuk	Korsang	
16	Om Chhorvan	BSC	
17	Koy Phallany	Khemera	
18	Tan Yung Sear	BC	
19	Por Cheang	ILO	
20	Ly Penh Sun	NCHADS	
21	Im Sarun	CSEARHAP	
22	Tep Navuth	NAA	
23	Wagari Christine	MSF. France	
24	Sok Bunthoeun	MoCR	
25	Katy Pullen	UNIFEM	
26	Nicole Seguy	WHO	
27	Julie David	UNESCO	
28	David Harding	Friend International	
29	Ros Vanna	Friend International	
30	Touch Sophal	MoPW	
31	Seng Sut Wantha	UNDP	
32	Abupakar Sales	CIYA	
33	John Tucker	NHCC	
34	Sim Kimsen	NAA	
35	Chawalit Natpratan	FHI	
36	Heng Mory	WFP	
37	Van Than	MPWT	
38	Lyn Mayson	SCA	

39	Kim Sokhim	CRC	
40	Chea Bunthou	NAA	
41	Simeth Ouksophea	PR-MoH	
42	Veth Valda	MoSVY	
43	Tuy Amrith	NAA	
44	Ath Thorn	CLC	
45	Inga Olega	PR-MoH	
46	Heng Sok Rithy	CPN+	
47	Seng Sopheap	HACC	
48	Pen Mony	KHANA	
49	Ly Chanravuth	NAA	
50	Dr. Teng Kunthy	NAA	
51	Dr. Hor Bun Leng	NAA	
52	Dr. Lim Kalay	NAA	
53	Dr. Sou Sophy	NAA	

Annex 2. Workshop Outputs

Prevention Group

- To keep indicator "% of consistent condom use among husband and wife" or other indicators that shows transmission between husband & wife

- To reduce target of indicator 11

Baseline	2008	2010
15%	30%	50%

- To get input from DHA-WG for indicators 11 and 12

- Indicator 13:
  a. Purpose: the same with IDU indicator
  b. Measurement: the same with indicator 11
  c. Interpretation: the same with IDU indicator
  d. Remove "visible" from "visible MSM"

- Indicator 14: 2008 target: 40

- Indicator 15:
  a. Numerator: # of pregnant women who attend ANC at PMTCT sites receive counselling & testing and test result.
  b. Denominator: total number of 1st ANC clients at PMTCT sites

Baseline	2008	2010
53.1%	70%	80%

Care Group

- Indicator 7
  a. Retain the title but use the definition on indicator 7 instead
  b. Suggestion: please add paediatric care
  c. We don't need indicator 17

- Indicator 18 service for children
  a. Total number
  b. No. of adults (M&F)
  c. No. of children

- Indicator 19
  a. No. of PLHAs who receive HBC
  b. No. of HBC (teams?)

- Indicator 20
  a. What does providing support to TB patients mean?

Impact Mitigation Group

Indicator 1

- Revise:
  a. No. of employees: 100 or more
  b. Private sector includes business companies and other for-profit organisations
- Denominator: companies registered with the Ministry of Commerce
- Info Need: Check actual 2006 figures then set targets

Baseline	2008	2010
14?	2 x Y	2 x 2Y

Indicator 2

Update figures from CDHS 2000 and 2005 and based on those, revise the targets

Indicator 3

- Definition of 'actively implementing': with operational plan, allocated and disbursed resources, and progress (and financial) reports.
- Revise:
  a. Interpretation: replace 'breadth' with 'coverage'
  b. Add: method of measurement e.g. NAA Technical Board Meeting (because they meet regularly & includes all government ministries & secretariats)
  c. Denominator: replace 'correctly' with 'currently'

Indicator 4

- Define educational and nutritional support clearly
- What is the nationally agreed minimum package for educational and nutritional support? (Ref. USAID 3 of 6 areas; NCHADS)
- Eliminate 'or' i.e. "…educational and nutritional support"

Indicator 5

- Clearly define:
  a. 'Organisation' - NGOs, pagodas, CBOs, etc.
  b. Care & support minimum package of services
  c. Suggestion: work with Operational Districts rather than with Communes

Indicator 6

- Revise:
  a. Separate numbers for provinces & communes
  b. Numerator: Provincial Development Strategies & Commune plans
  c. Denominator: # of Communes / # of Provinces
  d. Interpretation: Incorporate only provinces with HIV/AIDS-related strategies and include the communes therein

PROCEEDINGS

Civil Society Pre-Consultation on Universal Access

23 November 2006
Cambodiana Hotel

Organized by
HIV/AIDS Coordinating Committee
on HIV/AIDS (HACC)

Sponsored by
: United Nation working (UNAIDS)

Prepared by: AM Vichet, Reporter
Reviewed and Edited by: Mr. Andrew Rankin, HACC Management Advisor
Prepared for: Mr. Seng Sopheap, HACC Coordinator
November 26, 2006

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Introduction

The purpose of this report is to present national level feedback and recommendations from civil society on Universal Access, *Cambodia's road map to scale up the National Response to HIV/AIDS*. All resulting recommendations quoted were compiled from a consultation workshop of key civil society stakeholders that was conducted at the Cambodiana Hotel on November 23 2006.

This report mainly focuses on group work consultation feedback, presentations and conclusions from facilitators. Four questions were put into discussion with three different groups. Details on the presentations, targets and indicators, however, can be found in the appendices.

The workshop was organized by HACC with financial support from UNAIDS.

Summary

This report shows that civil society has already taken many steps in monitoring and evaluation of HIV/AIDS interventions, and that civil society has a vital role to continue and scale-up monitoring and reporting on Universal Access (UA) indicators.

Moreover, it is recommended that UA targets in the context of the national response could not have been reached without the strong cooperation of civil society and national level agencies. In addition, civil society should continue to contribute to the promotion of UA in the future for strengthening of a comprehensive National Response to HIV/AIDS. Concurrently NGOs recommend that agencies working at a national level should develop a standard format of reporting to be disseminated to all NGOs and GOs for collecting appropriate data. The format should incorporate both qualitative and quantitative methodologies.

Finally, it was noted that HACC, as a national umbrella organization, should play an important role to coordinate or disseminate information from national level to their members and relevant NGOs working on HIV/AIDS.

Process of the workshop

The workshop was opened by the facilitator of the event, Mr. Saman Dimara, HACC M&E program officer, introducing the workshop agenda.

Official Opening by Dr. Ngin Lina, NAA and Mr. Tony Lisle, UNAIDS

Dr. Ngin Lina, Chief of PPMER at the National AIDS Authority (NAA), commenced proceedings by introducing the Regional Universal Access workshop, which was conducted in Pattaya, Thailand on February this year. Dr Lina's presentation for the day's workshop, on the 28 UA indicators drafted by the NAA was also outlined.

Mr. Tony Lisle, Country Coordinator of UNAIDS, followed and described a brief history of Universal Access, the concept of which was first introduced in the July 2006 UNGASS meeting in New York. He added that one of the most important parts of this process is to set national targets for HIV/AIDS prevention, treatment, and care support and that this cannot be achieved without the engagement of civil society. Without civil society playing a role in this process it is not possible to undertake an effective response. This, however, does not mean that working towards universal access has not started yet. In February this year, the first national consultation on UA took place to review the National HIV/AIDS Strategic Plan which provided an opportunity for civil society to identify and fill gaps of government responses.

The key processes UA were also stressed, focusing on the concept that it is a basic human right of all people to receive HIV/AIDS prevention, treatment and care support and that NGOs and GOs are accountable for ensuring this. Consequently, relating to UA, NGOs and CBOs have a role in responding to the needs of the community. While all are determined to reach the national UA targets, all stakeholders have to keep in mind that nationally, 123,000 people need services including quality long term treatment. More over, the importance of very strong partnerships between NGO and GO being built and maintained in the long-term to respond to these needs was stressed.

The current situation of prevention coverage situation in Asia Pacific and other regions of the world was also discussed. It was identified that current prevention coverage is around 3-5% for all population groups. If there is only coverage of 3-5% of those at-risk target groups such as; CSW and clients, MSM, IDU, there clearly not the coverage of at least 80% needed to provide a complete prevention service package, meaning that the cause of HIV transmission cannot be stopped. Consequently the importance of coverage and defining ambitious targets was stressed, as was the defining of roles for NGOs and CBOs on M&E processes to keep all accountable for effectively reaching target groups. At the end of his speech, he added that he feels confident about partnerships, and the work in the community of the organization's represented by participants at the workshop, in Cambodia and his strong belief that Cambodia will achieve the success.

Presentation on History and objectives of Universal Access by Dr. Leng Kuoy, Team Leader, M&E, Research and Training, KHANA

Dr. Leng Kuoy presented the history and key objectives of UA (Details in attachment 3). Key point in the presentation included the following:

1. Scaling up towards Universal Access to Prevention, Treatment, Care and Support
2. Toward Universal Access…
3. Process so far…
4. High level Meeting 2006
5. Key discussion points and recommendation
    - The process of moving towards meaningful participation of civil society at the country level
    - Key targets for 2010
    - Accountability – both NGO and government sector
    - UNAIDS role in promoting civil society engagement

Overview on Universal Access indicators and targets by Dr. Ngin Lina, Chief of PPMER, NAA

Dr. Ngin Lina, NAA presented the Cambodia Universal Access indicators and Targets 2008 & 2010[23], which were drafted by NAA, through the National M&E Advisory Group. Twenty-two (22) indicators were presented and discussed. Those important to discuss with participants focused on how to measure indicators, evaluation processes and responses.

Some comments were raised that the indicators were set too high. Thus, it is difficult for civil society to accept as realistic. It was noted by Dr. Lina that all the indicators were set very high according to UA concepts. However, the indicators will be revised at future consultations.

Introduction to Group work by Miss Long Dianna, M&E Coordinator, PSI

Miss Dianna introduced the group work section of the day's program by distributing four questions relating to UA to each of the three working groups (all groups received the same questions). Each group participated in a half-hour discussion, with a presentation of group results to all participants following.

Each group had 9-10 members from different NGOs. Each group had one presenter and writer. Recommendations from each groups work were then presented and explained to all participants. Key recommendations were outlined in the conclusions by Miss Dianna Long

At the end of the workshop, Miss Dianna concluded the results from all groups. This was followed by Dr. Leng Kuoy adding a few recommendations and his appreciation of the participants actively participating in the workshop. Finally, Mr. Sopheap raised recommendations for the next steps for the promotion of UA.

[23] Draft by NAA, detail table in appendix 2

Conclusions and Recommendations

What are NGO's already doing in monitoring & evaluation of HIV/AIDS interventions?

- NGOs have their own M&E system by conducting meetings with NGO staff and network to collect quarterly and annually report;
- NGOs have developed target indicators for their own institution to monitor implementation activities for measuring the Outcomes;
- NGOs focus on case study and collect photos that relevant to Maternal and child health, Risky behavior, discrimination and condom use;
- NGOs have monitoring and evaluation in the field to collect information for example, incidence (new case), Death rate, migration, etc;
- Many NGOs are involved in initiative such as NGO mapping, working on HIV/AIDS, in order to provide information; and
- Beside, civil society attend meetings such as COC, MMM, PROCOCOM, Network with NGOs and GO for technical improving and reporting of data collection. Civil society contributes to establish NGO comprehensive.

What is civil society's role in monitoring and reporting on UA indicators?

- Civil society should provide education and training to all implementers and target group;
- Civil society should follow the National guidelines and to collect/compile M&E information relating to UA on a standard format; and
- Civil society should strengthen existing networks and report referral system and provide regularly system and encourage to NGOs to having regularly meeting and cooperation among all stakeholders.

Can UA targets be reached in the context of the national response?

- UA target indicator cannot be reached unless there is strong involvement from all agencies to develop a core plan for implementation;
- A standard M&E system is necessary; and
- The target maybe cannot be reached because the UA target is very high.

How can civil society's contribution to the promotion of UA be strengthened in the future?

- To strengthen its contribution for the promotion of UA in the future, Civil society can contribute such as developing a Letter for Agreement between CBO and PHD for M&E system;
- National planning should have contributions on implementation from both civil society and government;
- Civil society should be involved in the annual evaluation of National M&E system because civil society could fill the gaps and provide recommendations to government institutions for improving UA implementation;
- Civil society should incorporate UA into their programs and increase knowledge of UA for comfortable implementation;
- Civil society should provide clear and regular report with qualitative and quantitative to each other, particularly in areas relating to UA;
- In addition, NAA/NCHADS should develop a standard of M&E system for all implementing agencies;
- NAA/NCHADS must have a clear understanding on UA then transfer knowledge to civil society;
- When civil society contributes reports, NAA/NCHADS should have the role to combine these reports with others and share this information back to NGOs/civil society; and
- Civil society/NGO should continue to be members of network organizations such as HACC in order to share information through this channel.

Dr. Leng Kuoy raised additional comments and recommendations. Firstly, through the discussion in the group work, key outputs and good recommendations were raised from the workshop. Some of these were:

- This good result could not have been reached, or continue to be achieved in the future without good processes and recognition from national level;
- Civil Society may not be interested in continuing to participate in UA and other civil consultation processes if recommendations such as those identified today to support the reaching of national goals are not recognized at a national policy level; and
- Finally, even if we set reliable target UA indicators and participate actively we still have to think carefully about what exactly will we do, and how?

It was noted that if all this can be achieved ultimately at-risk target groups will get positive impact from these actions, and that all stakeholders should be ambitious with both target numbers of beneficiaries and with the quality of services/ activities offered.

At the end of the workshop, Mr. Seng Sopheap, HACC Coordinator noted that Universal Access is a new concept for Cambodia. However, that the process has already began to support UA within civil society by activities such as this workshop and the development of UA indicators and targets. He added that all the results and recommendations from this workshop would be presented and discussed as part of the second national consultation workshop on UA indicators and targets on 28th November, with national level and donor agencies. Finally, the results of these national consultation, feedback and progress will be presented at the UNAIDS Programme Coordination Board meeting to be held in Lusaka, Zambia on December 6-8th 2006.

Mr. Sopheap also noted that the concept of UA, and in developing indicators and responses based around this concept, is not only a national level initiative in Cambodia but is an international initiative throughout the world. It should guarantee that by 2010, PLWHA has the right and ability to access all services. This goal is has been set by government as well as civil society. Some major efforts have already been achieved as a starting point to provide necessary services for PLWHA, for instance the government system has COC, MMM, Home based Care that provide opportunity for PLWHA to access the services.

In terms of civil society the importance of setting indicators and improving monitoring systems etc was identified, as donors are placing an increased importance on this when NGO's submit proposal. Also, that until this time it has been hard to find formal indicators for groups such as OVC, MSM, etc. It is therefore appropriate to follow a response led by NAA guidelines including 3 in 1 actions; including one for planning, one for coordination and one for M&E. HACC would continue to support these activities through advocacy, information sharing and representing civil society.

It was concluded the UA will play an important role with civil society in the future and that therefore it has been an important exercise at this workshop to get critical recommendations from participants. This information should continue to be used to provide input to discussion and future program actions at national and international level.

Appendices

A. List of Participants

N	ឈ្មោះជាអក្សរខ្មែរ	English Name	តួនាទី Position	អង្គការ Agency	ទូរស័ព្ទ Tel.
1	គីម ឡាយ	Kim Lay	Counselor + Care	MARYKNOLL	012 998794
2	សុខ ប៊ុនធឿន	Sok Bunthoeun	Core Trainer	Mo Rch	012 83 44 29
3	មាស ចន្ថី	Meas Chanthy	Field Supervisor	RHAC	012 87 21 18
4	សោម យេន	Soam yan	ប្រធានការិ	Mo Religiou	012 75 80 45
5	តាំង ភឿក	Taing Phoeuk	Manager	KorSang	012 25 80 74
6	សុខ សុភនាថ	Sok SopheakNeath	Team Leader	NAS	012 64 14 22
7	នាដ ភូមិន្ទ	Nead Phoumen	Coordinator	LCM HCN	012 85 54 05
8	ព្រំ យីម	Prom Yim	P.O	SEADO	092 79 62 88
9	សុប អ៊ូស្មាន	Sop Usman	Director	IL DO	012 83 02 23
10	សុខ សុត្ថាវី	Sok Sothavy	Director	KIVKS	012 500028
11	ស៊ូ សានិត	Sou Sanith	Coordinator	BTB HCN	012 93 53 01
12	លាភ ស្រីលុច្ស	Leap SreyLuch	Networking PLO	CPN+	016 86 50 32
13	អ៊ុង គីមសួរ	Ung KimSour	P . O	SCC- SR	092 27 64 99
14	ឡេង គួយ	Leng Kuoy	TL M&E	KHANA	012 28 08 18
15	រស់ រក្សា	Rous ReakSa	Interpreter	Pyramid	016 45 53 69
16	អ៊ាន គីមឆាយ	Ean Kim Chhay	E _ Director	ACCY	012 76 91 64
17	ឱ អ៊ី	Or EE	Coordinator	TASK	012 37 09 65
18	សេង មិចរ៉ាមី	Seng MichRamy	Office Manager	CChouk Sar	012 79 28 86
19	Anu Riikonen	Anu RiiKonen	TA	SCA	092 28 94 00
20	តាន់ យង់ស៊ា	Tang YungSea	Coordinator	បណ្តាញចតុមុខ	016 95 52 91
21	ឱម វុឌ្ឍរ៉ូ	Om Vuthuro	Acting PM	CRC	012 9314 34
22	Jane Batte	Jane Batte	SMO	UNAIDS	092 8683 50
23	Tony Lisle	Tony Lisle	VCC	UNAIDS	012 99 06 95

24	កង សេរី	Kang Serei	Coordinator	CHRAN	012 58 82 93
25	ង៊ិន លីណា	Ngin Linna	Chief of PPNAR	NAA	
26	Eksalan	Ek Sacan	Proj. Coordinator	CARAM	012 78 21 93
27	Omaly Hap		Vice – President	CIYC	012 43 06 33
28	អ៊ុំ សុភាព	Oum Sopheap	ED	KHANA	012 34 96 35
29	Roeun Cheattheri		Educator	ELC	012 52 66 34
30	អំ វិចិត្រ	Am Vichet	Consultant	Freelance	012 77 27 97
31	អ៊ីវ កុសល	Iv Kosal	Project Manager	CVD	012 773989
32	ឡុង ឌីអាន់ណា	Lang Dianna	M&E Coordinat	PSI	016 53 11 35
33	នីម សុគុន្ធារី	Nim Sokuntheary	ED	CHEMS	016 96 69 69
34	សាវីនា អាមាសាន	Savina Ammassan	M & E Advisor	UNAIDS	092 67 70 33
35	Jim Noonan	Jim Noonan	Co Director	MARYKNOLL	023 21 17 30
36	មាស លីវី	Meas Livy	TL Assistant	RACHA	012 86 05 56
37	ប៉ែន លក្ខិណា	Pen Leakhena	Trainer	CHEC	092 29 51 29

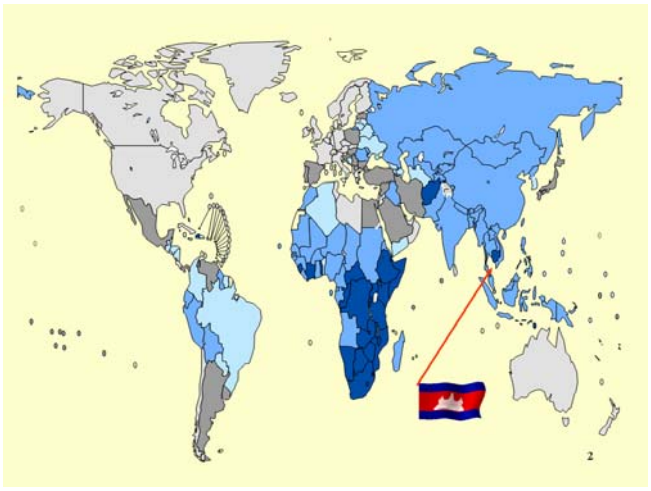
Annex 4. Lusaka presentation

Cambodia's Steps Towards Universal Access

Lusaka, Zambia
6-8 December 2006

H.E. Teng Kunthy, M.D.
Secretary General, National AIDS Authority, Cambodia
Dr. Oum Sopheap
Executive Director, Khmer AIDS Alliance, Cambodia

1



2

Overview of the Cambodia Epidemic

- End of 2003 PLHIV: 123,100*
- Prevalence among 15-49 age group: 1.9%*
- Primarily heterosexual epidemics
- Concentrated epidemics among IDU and MSM (MSM prevalence rate 5.1%)
- Pregnant women LHIV: 2.2%*
- Children LHIV: 7,300[1]
- Number of HIV/AIDS-related OVC: 70,000

*HSS in 2003-NCHADS
[1] UNAIDS-2004 Update

Steps Towards Universal Access (UA)

1. National Strategic Plan II (2006-2010)
2. 1st National Consultation on UA (Feb 2006)
3. M&E Advisory Group meetings on UA (Feb-Dec 2006)
4. Civil Society Pre-Consultation on UA (Nov 2006)
5. 2nd National Consultation on UA Indicators and Targets (Nov 2006)

➢ Next steps towards Universal Access (2007 onwards)

National Strategic Plan II 2006-2010

- Builds on lessons learned in the past (NSP I 2001-2005)
- Developed with active involvement of government, civil society, donors and other stakeholders
- Outlines a comprehensive and multisectoral national response to HIV/AIDS
- Includes operational plan and M&E framework
- Costed to establish gaps in funding

1st National Consultation Meeting on Universal Access (February 2006)

- Broad representation from Government, civil society, private sector and the donor community
- Results distilled into a national report presented in a regional consultation on UA (Thailand, Feb 2006)
- Challenges in scaling up towards UA identified:
  - Increasing coverage of services
  - Sustaining financial and technical support

National M&E Advisory Group Meetings on UA (Feb-Dec 2006)

- Group including Government, NGO, CS and donors
- Refinement and definition of 21 UA indicators
- Consultation on UA indicators and targets
- Choice of ambitious UA targets

Achieving Universal Access: What Will It Take?

Indicator	2010 Target	Resources available	Resources required	Gap in resources
% IDU are exposed to HIV prevention interventions	80%	$ 500,000	$ 2,500,000	$ 2,000,000

8

Civil Society Pre-Consultation on UA (Nov 2006)

- Broader engagement of CS in consultation process on UA
- Stronger collaboration of civil society with Government and other partners
- Wider consensus on UA indicators and targets
- Improved understanding of UA and civil society's role in achieving targets

2nd National Consultation on UA Indicators and Targets (Nov 2006)

- Improved understanding of indicators and targets and methods of measurement
- Adoption of a common set of UA indicators and targets
- Guidelines to monitor and evaluate UA-related interventions

Next Steps Towards UA

- Revisiting strategic plan and refine costing to identify gaps and address priority needs
- Conducting national UA campaign
- Strengthening social mobilization
- Enhancing coordination and harmonization

Thank you

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