

Kingdom of Cambodia

Nation Religion King



Ministry of Health

Annual Report 2006



National Center for HIV/AIDS, Dermatology and STD

February 2007

Acknowledgement

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

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

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

Sincerely,



Dr. Mean Chhi Vun
Director of NCHADS

NCHADS Annual Report for 2006

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NCHADS Annual Report 2006

A. GENERAL REPORT

1. BACKGROUND

1.1 HIV/AIDS Epidemic Situation in Cambodia:

The HIV Serosurveillance survey (HSS) 2003 found a 1.9% HIV prevalence among adults aged 15-49 years. Using HSS 2003 figures, it was estimated that 123,000 adults were living with HIV/AIDS including 57,000 women and that an estimated 9,000 children were living with HIV in 2003. The HSS round IX was conducted from November 2006 to February 2007. HSS 2006-2007 HIV prevalence estimates will be calibrated with the CDHS 2005-2006 HIV prevalence estimates in a consensus workshop that will be held at NCHADS in April 2007. The output of this expert consultation will include updated official estimates of HIV prevalence among the general population of adults and children, and estimates of the number of adults and children in need of ART.

After reaching the 3 by 5 targets in 2005, Cambodia has committed to further strengthen its response to the HIV/AIDS epidemic and reach Universal Access by 2010.

1.2 Priorities for NCHADS in 2006: the Comprehensive Annual Operational Work Plan 2006: In April 2005, a Workshop was organized by NCHADS to prepare the Annual Comprehensive Work Plan 2006, based upon the updated Strategic Plan, with provinces and NGO partners. Three MoH departments (Planning, TB and NMCHC) also participated. At this meeting Annual national and provincial targets were set. The result was the Annual Operational Comprehensive Plan 2006, which incorporated, many of the inputs and expected outputs of partners working in coordination with PAOs in provinces. This Work plan was also firmly grounded within the Ministry of Health Annual Operational Plan 2006, prepared for the HSSP.

The 2006 Work Plan focused on the following priorities:

- Implement the reviewed Strategic Plan for HIV/AIDS and STD Prevention and Care 2004-2007
- Continuing integrating HIV/AIDS and STD plans within MoH Annual Operational Plan (AOP)
- Extending the Continuum of Care through health care system
- Expanding VCCT services
- Provision of ART
- Maintaining the proven Targeted Prevention programme
- Strengthening the M, R & E system

- Strengthening NCHADS capabilities
- Continuing capacity building for provincial and national levels

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

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

The Work Plan 2006, including PBSI, budgeted for a total of \$ 8,696,562, allocated 7% for prevention activities, 47% for the treatment and continuum of care (including ARV drugs), 14% for surveillance, research and data management, and 32% for programme planning, monitoring and reporting, and administration costs, incentives and contingency; from 17 sources.

This Report describes what was achieved in implementing this Plan during the year. Section B of this Report describes programme achievements against NCHADS targets, as set in the Strategic Plan for 2006. Section C describes financial disbursements against budgets. The remainder of this section describes some of the key activities of NCHADS as a management system.

2. NCHADS MANAGEMENT SYSTEM

2.1 Planning and Monitoring Cycle in NCHADS: In order to ensure the smooth implementation of the programme, the workshop on Review of Implementation of HIV/AIDS/STI Programme was held in March 2006, to review output of implementation the activities, provide feedback to the planners for next planning cycle, and to identify and solve problems in implementation of the programme activities. The GFATM-R2 Planning for year 2006 Workshop was held in January and for year 2007 was held in October. The Annual Coordination Workshop was held in October to review progress made during first 3 quarters, to inform update technical, strategies or guideline updates in the programme, and to review the work plan for 2007.

2.2 Signing of LoAs: during the year NCHADS signed the Letter of Agreement with:

1. *AIDS Health care Foundation of USA (AHF)* from 2006 to 2010, to provide technical support to increase and strengthen the ART roll out and scale up of ART delivery services in three provinces (Kampong Thom, Kampot, and Stung Treng).
2. *Catholic Relief Services (CRS)* to provide technical support to increase and strengthen the care and support for PLHA at the facility and community levels, STI treatment, education and coverage, BCC for prevention in 2 provinces (Sampov Loun, Bovel OD/Battambang, and Pailin city).
3. *Cambodia HIV/AIDS Education and Care (CHEC)* from 2006-2007, to implement the home based care services in 3 provinces (Saang/ Kandal, Preah Sdach/ Prey Veng and Kampong Trach/ Kampong Chnaing).
4. *Family Health International (FHI)* from 2006-2007, to support the Continuum of Care in 3 provinces (Pailin, Battambang) and also to support the STI/RTI prevention and care in 6 provinces (Kampong Cham, Battambang, Bantey Meanchey, Pursat, Pailin, and Siem Reap).
5. *Foundation Rodolphe Merieux and University of Sciences of Phnom Penh* for year 2006,
6. *Health Net International (HNI)* from 2006-2007 to implement the HIV/AIDS Community Home-Based Care Programme in Takeo and Pursat province.
7. *MAGNA Children at Risk-Cambodia* from 2006 - 2007 to implement prevention, care and support for the HIV/ AIDS programme in Phnom Penh, Takhmao/ Kandal province.
8. *Maryknoll* from 2006 to 2011 to implement the HIV/AIDS and STD Prevention and Care Programme in Phnom Penh and Kandal province.
9. *Pharmaciens Sans Frontiere-Comite International (PSF-CI)* from 2006 to 2007 for Strengthening NCHADS's logistics Management of ARVs and other HIV/AIDS related supplies at the OD level.
10. *World Vision Cambodia* from 2006-2007 to 2011 to implement the HIV/AIDS and STD Prevention and Care Programme in Phnom Penh, Kandal, Takeo, Kampong Speu, Kampong Chhnaing and Kampong Thom province.

2.3 Standard Operational Procedures (SOP): In this year NCHADS developed many SOP such as:

- 1 *SOP for implementation of NCHADS Programme activities:* to ensure that the programme can achieve its goals and objectives with full transparency and accountability. The purpose of these procedures is to

define the mechanisms for approval of programme activities, a financial management model, a set of procurement procedures for goods, services and civil works, monitoring and reporting schedules, permissible rates for payment of per-diem, incentives, allowances, and the mechanism and procedures for decentralisation to provinces.

- 2 *SOP for the Outreach/Peer Education and 100% Condom Use Programme to Sex Worker in Cambodia.* In 1999 the outreach strategy was assessed through an external evaluation conducted under the World Bank funding, and re-designed. At the same time the 100% Condom use Policy was officially approved and launched through - out the country. For the next 5 years both interventions were vigorously applied in almost all provinces. In late 2005 the Strategies and Guidelines for the Outreach/Peer Education Programme and the 100% CUP to sexual entertainment services were extensively reviewed. A workshop was held with participants from NCHADS, PAOs managers, and other involved partners. In addition, in early 2006, a Technical Working Group, Chaired by the Ministry of Women's Affairs was established. As a result of these reviews, the following Strategy and Guidelines was developed, [and endorsed by the NAA, the MoWA and the MoH].
- 3 *SOP for Implementation the Community Home Based Care activities in Cambodia.* The purpose of this SOP was to provide practical guidance on the programme implementation by all stakeholders of Community Home Based Care programme nationwide as part of the Operational Framework for CoC for PLHAs, approved by the MoH. It also to harmonize the implementation at national, provincial operational levels in a well coordinated.
- 4 *SOP for Implementation the MMM activities in Cambodia.* The purpose of this SOP is intended to use for guidance of public health care providers and other concerned stakeholders, especially CPN+, who are responsible for putting into practice the MMM concept laid down in the Operational Framework on CoC for PLHAs in Cambodia as part of the scaling-up towards universal access to prevention, care, treatment and support initiative. It lays out the practical steps to establish an MMM at the OD, and specifies the concrete package of activities that can provided by MMM.
- 5 *SOP for Quality Improvement (QI) for HIV Counselling and Quality Control (QC) for HIV Testing.* This SOP is prepared by VCCT technical sub-working group with technical supported from reference laboratories. It is very important to develop this SOP to improve the quality of counselling and testing services in Cambodia. It is divided into 2 main parts, Quality Improvement for counselling services such as counselling regular supervision and counselling network meeting; and

Quality Assurance for HIV testing such as regular supervision and quality control for HIV testing.

- 6 *SOP for Quality Improvement of OI/ART service in RH*
- 7 *SOP for Integration of Pediatric AIDS Care into the Comprehensive CoC*
- 8 *SOP for Provincial and Municipal Logistic Management:*
- 9 *SOP for NCHADS Logistic Management*
- 10 *Guideline for Rational use of Drug for Health Providers at STD clinics*

2.4 Policy and Strategy

1. *National Policy and Strategies for Prevention and Care of Sexually Transmitted and Reproductive Tract Infections (STI/RTIs) 2006-2010:*

“The national policy and strategies of sexually transmitted infections (STIs) prevention and control in Cambodia”, officially approved by the Ministry of Health in 1999, is the effective tool of prevention and control of HIV/AIDS in Cambodia since it is linked closely to the prevention and care of STI/RTI, especially among high risk population.

In 2006, STI/RTI Unit of NCHADS collaborate with TWG review this Policy. The main purpose and overview for the national policy and strategies of prevention & care for STI/RTI is to provide a framework of activities toward the acceleration of response on time in STI/RTI prevention and care in Cambodia in order to achieve the goal of World Health Organization (WHO) for Universal Access of HIV prevention and care and treatment for all people in 2010.

To attain the goal above, the Ministry of Health of Cambodia has revised and updated the national strategies and to encourage implementing them till 2010 focusing on essential objectives as below:

- To increase active participation of public institutions, civil society organizations, particularly non-governmental organizations (NGOs) and international organizations those are partnership in development of STI/RTI prevention & care.
- To promote financial contribution and resources mobilization, and to concentrate on the result of research that lead to identify priority interventions in order to assure that grant has been used effectively with ownership, harmonization, good result and accountability.
- To ensure that the national policy, guideline and other initiatives relevant to STI/RTI prevention & care are non-stigmatization and non-discrimination and without conflict of gender-sensitive in Cambodian socio-cultural environment.
- To gain experiences, especially the strength and capacity building of all partners and relevant institutions for expanding and keeping sustainability of interventions of STI/RTI prevention & care in Cambodia.

2.5 Recruitment of additional Contract Staff

To meet the demands of the expansion and acceleration of the NCHADS Programme, NCHADS hired a number of contract staff to meet specific demand created by the programme (see below): principal among these are:

- 2 Accounts Assistants, 1 M &E officer, 1 Project Assistant (funded by GFATM)
- 1 Admin Officers (funded by EUROPAID) to replace the previous staff who moved to work for other project,

Procurement of ARV drugs and CD4 Counting reagents:

ARV Drugs:

Procurement of ARV drugs by NCHADS in 2006 period totalled \$ 3,449,487.22. ARV procurement was supported by four major funding sources: The Global Fund to Fight AIDS, TB and Malaria, The World Bank, The European Union, and the Asian Development Bank. In addition, the Clinton Foundation provided a donation of pediatric ARV formulations to NCHADS.

Supplier	ADB	Clinton Foundation *	E EUROPEAIDS	GFATM (Round IV Y1)	GFATM (Round IV Y2)	World Bank	Total
Abbott			\$ 2,638.46			\$347,526.15	\$ 350,164.61
Aurobindo	\$106,445.00				\$ 85,825.00	\$179,924.80	\$ 372,194.80
BMS			\$ 34,427.68	\$ 48,341.56		\$ 20,394.08	\$ 103,163.32
Cipla		\$ 150,026.00	\$ 66,525.00	\$ 523,925.04	\$ 914,640.48	\$223,797.98	\$ 1,655,116.52
Gilead			\$ 6,160.90			\$120,790.53	\$ 126,951.43
GSK			\$ 15,687.00				\$ 15,687.00
Hetero			\$ 77,440.00		\$ 47,395.80		\$ 124,835.80
Merck		\$ 38,919.30	\$ 1,824.84	\$ 209,788.50	\$ 355,893.00	\$ 15,800.01	\$ 622,225.65
Ranbaxy			\$ 24,000.00	\$ 48,337.80	\$ 88,842.48	\$ 27,000.00	\$ 188,180.28
Roche			\$ 8,261.41			\$ 10,387.00	\$ 18,648.41
Strides			\$ 4,414.22				\$ 4,414.22
Total	\$106,445.00	\$188,945.30	\$241,379.51	\$ 830,392.90	\$ 1,136,703.96	\$ 945,620.56	\$ 3,449,487.22

**Donation of pediatric ARV formulations by Clinton Foundation to NCHADS.*

CD4 Counting reagents:

In 2006, the four sites in possession of a BD FACSCOUNT CD 4 Counter - NIPH, Battambang, Kampong Cham and Takeo - performed a total of 42,809 CD 4 tests. Total expenditures for CD 4 reagents were \$225,235 (not including cost of shipping). Based on the strong performance in the first year of operating the rationalized CD 4 testing network developed in 2005, NCHADS was able to negotiate a reduction in price per kit from \$265 to \$225 for 2007.

DFID	EUROPEAID	GFATM	TOTAL
\$ 59,625.00	\$ 83,860.00	\$ 81,750.00	\$ 225,235.00

2.7 Procurement of Medical Equipment

In order to improve the quality of care and treatment services for PLHAs, NCHADS also supplied the Medical Equipment to VCCT, STD clinics and Referral Hospital.

Description	Quantity	Funded by
Spectrophotometer	9	GFATM
Hemato-Analyzers	13	10 by GFATM and 3 by US-CDC
RPR sharker	4	GFATM
Bench centrifuge	14	GFATM
Small Centrifuge Z200A	7	US-CDC
Refrigerators	8	7 by GFATM, 1 by US-CDC
Bed for Clinical Examination	16	GFATM
Radio surgery	1	US-CDC
CO2 Laser	1	US-CDC
Freezer	2	US-CDC, DFID

Equipment and Furniture:

Description	Quantity	Funded by
Desktop computers	46 sets	- 21 by GFATM, - 9 by DFID, - 16 by US-CDC
Laptop computers	9 sets	- 4 by DFID, - 2 by GFATM - 3 by US-CDC
Printer	35 sets	- 12 by US-CDC, 23 by GFATM
Colour printer	2 sets	- GFATM
LCD Projector	2 sets	- US-CDC & GFATM
Photocopy Machine	2 sets	- GFATM
Fax machine	1 set	- US-CDC
Furniture for VCCTs	6 sets	DFID
Furniture for MMM	9 sets	GFATM
Generator	1 set	EU, CDC and DFID

2.8 Civil Work:

- The construction of the MMM building in Kampong Speu, Kampong Chhnaing, and Sre Ambel Referral Hospital were completed with funded by GFATM Project.
- For the EUROPEAID Project, the renovation of the laboratory room and two counselling rooms in Ang Roka Referral Hospital were completed.
- The renovation of the VCCT room in Preah Kosmak RH, Cumkiry and Touk Meas /Kampot, Oddong/ Kampong Speu, Kampong Ro/ Svay Rieng were completed with funded by DFID.

- DFID Shared fund with Clinton Foundation for renovation of Laboratory room in Neak Loeung RH.

2.9 Data Management

Responding initially to the urgent need for accurate patient monitoring of ART, and quickly expanding to the whole area of data management, a new Provincial Data Management Unit was been established in 11 province-cities. The two contract Data Management Officers were recruited with 2 Government Officers to work in this Unit. The Provincial Data Management Unit will work with facilities and PAO home-based care (HBC) coordinator to ensure timely, reliable and complete reporting of HIV/AIDS prevention and care activities in the province.

2.10 PBSI

For PBSI in NCHADS the PAB decided to adjust the indicator relating to proportion of planned work achieved. Based on the presentation to the Steering Committee in June, provincial PBSI were extended. The expansion of PBSI raised issues concerning the management of provincial PBSIs, and consolidating the management of NCHADS and Provincial PBSI. The issues and the overall success of the PBSI scheme were presented to the DFID Steering Committee in December 2005. In early 2006 a contract staff to manage the provincial PBSI scheme for the PAB, with GFATM funding was recruited. In July 2006, NCHADS also organized the workshop on Review of PBSI Procedure for Provinces-cities. The objectives of this workshop were to introduce the PBSI Scheme for NCHADS Program and some new additional format and to re-orient the PBSI procedure for provinces-cities. Based on the result and suggestion of this workshop, NCHADS develop SOP for PBSI that will be finalized and disseminated in Q1, 2007. At the end of 2006, there are 761 officers who received the incentives (189p supported by DFID, 549p by GFATM, 11p by WHO and 12p by CHAI)

2.11 Retreat

NCHADS is the vital institutions responsible to coordinate, develop policy, guidelines, strategies and curriculum for the implementation of HIV and AIDS care and prevention within the health sector. The successes of NCHADS undoubtedly contribute by building good partnership, building the strong team spirits, information sharing, and partnering with local and international NGOs. In order to strengthen and to improve the culture of teamwork, and to take a forum for discussion any internal issues, information sharing, as well as to review the NCHADS 2007 work plan, and revise on the Functions and Task analysis of each unit, NCHADS conducted the Retreat for 4 days in Sihanouk Ville.

2.12 Surveillance

- The **SSS 2005** results were disseminated in a public forum.
- For **HSS 2006**, the Data collection has been finalized, and data entry, data analysis, dissemination and report writing will be completed by mid 2007.

2.13 Research

- AUSAID, UNSW and other donors presently support the Study/ Research Programme to support the optimal use of Antiretroviral Therapy such as Qualitative study of ARV adherence, Cohort Study of ARV adherence, Immune Restoration Disease (IDR) and treatment outcomes, and Intervention study.

- *The Study on HIV Treatment Beliefs and Practices and Adherence to ART in Cambodia:* in September the findings were disseminated of the first element of this long-term study (3years) being conducted by NCHADS (Social Health Clinic). Objectives of this study was to improve ARV adherence and treatment outcomes through:
 - o Understanding HIV treatment beliefs and practices,
 - o Understanding ARV related behaviour
 - o Contribution to design of tools to measure ARV adherence

- *The Study on Over treatment of Cervicitis and the High Prevalence of Reported Vaginal Discharge among Low Risk Women in Cambodia:* the report has been finalized and will be discussed in the Technical Working Group on STI/RTI before disseminating officially in early 2007.

- *The Study on Evaluation of the STI Management Protocol for Female SWs in Cambodia.* The Data collection has been finalized, and data entry, data analysis, dissemination and report writing will be completed by early 2007.

2.14 Symposium on HIV Medicine

In collaboration with the National Centre in HIV Epidemiology and Clinical Research, and University New South Wales, Australia, and sponsored by Roche Company, NCHADS organized the First Phnom Penh Symposium on HIV Medicine with 415 participants from RHs, NGOs and partners from 24 provinces. The objective of this Symposium was to share experience among people working in the field of care for PLHA, improve and increase the knowledge of health care providers, clinicians, counsellors, lab technicians.

2.15 Steering Committees

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

2.16 External Reviews

DFID MAT:

The MAT visited in April/May; and again in October for the DFID OPR (Output to Purpose Review). The recommendations of OPR will provide be taken into the consideration to ensure the project is smoothly implemented to reach the objectives. NCHADS is satisfied with the achievements and more likely to reach the objectives of the programs at the end of the project.

EUROPE AID Project Assessment:

This was conducted in November by an external consultant, recruited by the European Delegation in Bangkok.

2.17 External Audits

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

2.18 16th International AIDS Conference in Toronto, Canada

7 NCHADS staff attended the 16th International AIDS Conference in Toronto, Canada (1p supported by EUROPAID, 4p by GFATM, and 3 supported by other sources). Thus, this is the opportunity for Cambodia to:

1. To share the Cambodian experience on HIV/AIDS with other countries and learn from each other;
2. To gain knowledge and practical experience on the HIV/AIDS implementation.
3. To be exposed to and share with the Canadian culture, arts etc.

2.19 Challenges and Constraints

During the year NCHADS primary focus was clear:

- Rapid expanding access to treatment and care, within the capacity of the health system, while ensuring adequate quality, sustainability and long-term effectiveness;
- Ensure long-term commitments of service providers for HIV/AIDS care and treatments;
- Ensure long-term funding commitments to run the HIV/AIDS programs, and
- Strengthening NCHADS managerial and administrative systems to ensure that it can achieve this goal effectively and efficiently within the environment it has to work in.

B. OUTCOME OF SERVICES DELIVERIES

1. HIV/AIDS prevention activities for the general population and specific groups

In December 2006, there were a total of 32 specialized STI clinics covering 22 of the 24 Cambodian provinces and cities (except Mondulhiri province and Kep city). Of the 32 specialized STI clinics, 29 are upgraded with laboratory support to perform RPR testing and basic microscopy (Annex: STI indicator 1). Of those, 16 are functioning. This laboratory support enables specialized clinics to use refined algorithms for the management of STIs in high-risk populations especially those who are asymptomatic.

In Q4 2006 a total of 17,142 consultations were provided at the specialized STI clinics [2,235 consultations to male patients, 5,227 consultations to low-risk women and 9,680 STI consultations to sex workers (5,109 for DSW; 4,571

for IDSW), of which 5,870 were monthly follow-up visits]. The total number of consultations has increased compared to Q 3 2006 and the number of consultations of IDSW has increased drastically (>2,000 more consultations for IDSW than in Q3 2006) (figure 1).

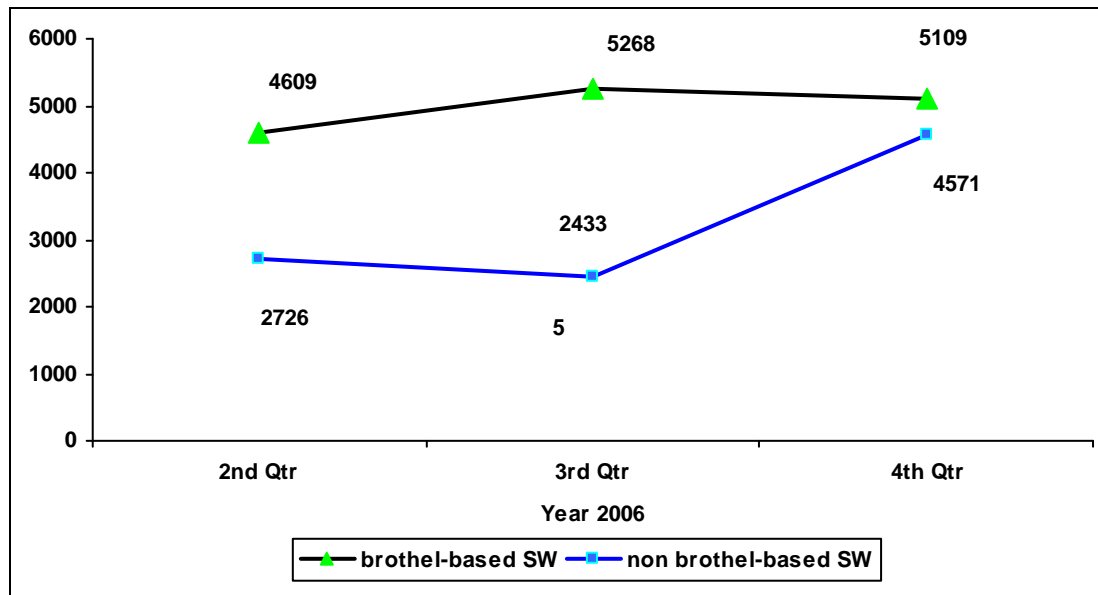


Figure 1: Trend in numbers of DSW and IDSW reported by PAO from 2002 to 2006

According to the November 2006 sex workers census reported by PAO, there were 2,977 DSWs (direct or brothel based sex workers) and 12,762 IDSWs (indirect or non brothel based sex workers including beer girls, and women working in Karaoke and massage parlors) in Cambodia.

Since 2002, it seems that the number of DSW is slowly decreasing and that the number of IDSW is increasing (figure 2).

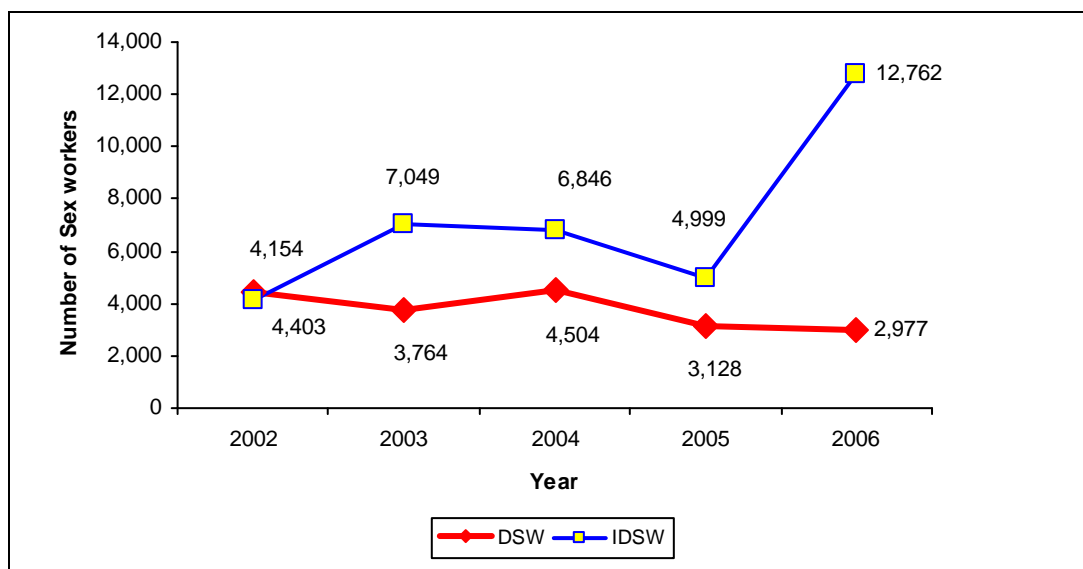


Figure 2: Trend in numbers of consultations for SW at specialized STI clinics in 2006

The strategy adopted in June 2006 to strengthen outreach/peer education for IDSW conducted by NGOs, include them in the 100% CUP and strengthen linkages between outreach /peer education for IDSW and STI clinics, has shown good results in Q4 2006 (Figure 1).

In Q4 06, of 639 male STI syndromes reported, 466 (72.9%) were urethral discharges and 147 (23.0%) were genital ulcers. Of 4,302 STI syndromes reported among low-risk women, 2,662 (61.9%) were cervicitis, 1,331 (30.9%) were vaginitis, 231 (5.4%) were PID and 65 (1.5%) were genital ulcers.

In Q4 06, of the 1,616 DSWs who attended specialized clinics for their first visit, 1,161 (70.7%) were diagnosed with a STI, including 565 (35.0%) with cervicitis. Of the 3,493 DSWs who attended specialized clinics for monthly follow-up visits, 1,356 (38.8%) were diagnosed with a STI, including 740 (21.2%) with cervicitis (Annex: STI indicator 2). In Q4 2006, of the 2,194 IDSWs who attended specialized clinics for their first visit, 1,145 (51.4%) were diagnosed with a STI, including 572 (26.1%) with cervicitis. Of the 2,377 IDSWs who attended the clinics for follow up visits, 571 (24.0%) were diagnosed with a STI, including 242(10.2%) with a cervicitis.

The proportion of sex workers diagnosed with cervicitis at follow up visits was significantly lower than that at first visits, both for DSWs and IDSWs. The results of the 2005 STI sentinel surveillance (SSS) showed a STI prevalence among DSW of 24.0% for any STI, 14.0% for Chlamydia, 13.0% for Gonorrhoea and 2.3% for syphilis. Prevalence of consistent condom use with clients was high (80%), but remained low with sweethearts (25%) and casual sex partners (34%). The SSS results showed that STI prevalence in 2005 was not significantly different from that observed in the 2000 STI Survey. FSW who had been selling sex for 12 months or fewer were significantly more likely to be carrying an STI than those who had been selling sex for >1 year. Comparing SSS 2005 results and routine data collected at STI clinics we found that STI clinic routine data on STI syndromes does not reflect and over estimates the real STI prevalence among the DSW population.

A big step has been achieved towards integration of STI/HIV/AIDS and PMTCT into RH, FP and ANC. A workplan for integration was discussed, a joint statement was signed between NCHADS and NMCHC on the implementation of PMTCT of HIV in January 2006, and a joint statement was signed between NCHADS and NMCHC on "strengthening the management of STI/RTI", to be approved by MoH. This joint statement defines the roles and responsibilities of NCHADS and NMCHC in ensuring linkages between STI prevention and care, RH, FP and maternal and new born health. Practical steps include the revision of health staff training curricula, common IEC material production, quality control of service delivery and linked response and monitoring of implementation of the linked response.

In 2007, NCHADS will expand STI services to MSM in 8 provinces (SHV, KHK, PLN, SRP, KCM, BTB, BMC and PST). MSM STI management will be included into existing specialized STI clinics.

2. Comprehensive care for PLHA

In December 2006, 34 operational districts (OD) in 19 provinces had established a Continuum of Care (Annex: CoC indicator). These CoC have been established in ODs that have OI/ART sites at the exception of Phnom Penh ODs.

VCCT

The number of VCCT services has increased drastically over the last 5 years, from 12 sites in 2000 to 140 sites by December 2006 (Figure 3).

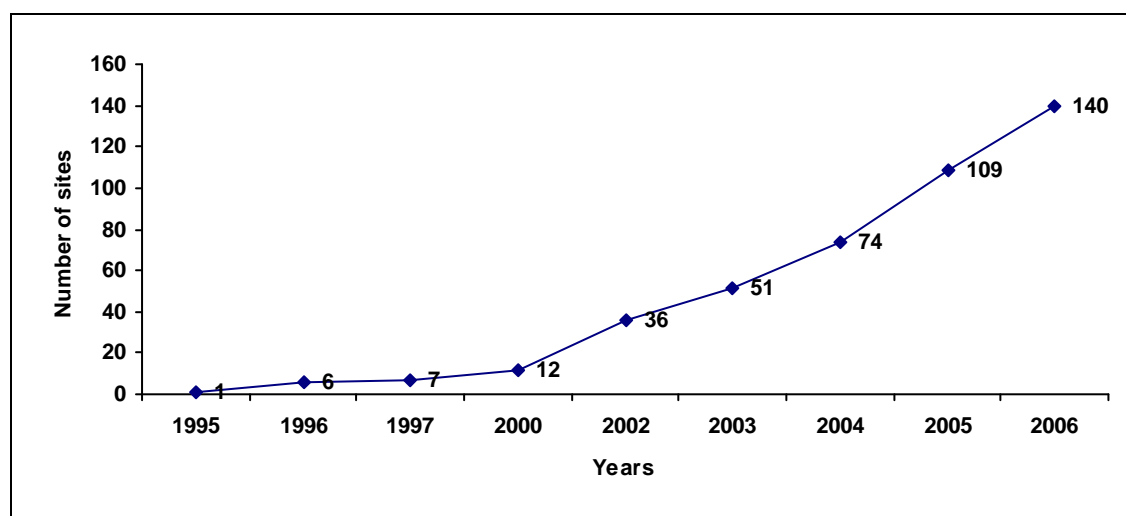


Figure 3: Trend in number of VCCT sites from 1997 to 2006

A total of 31 new VCCT sites have been opened during 2006. Of the current 140 VCCT sites, 114 are supported directly by the Government, 21 by NGOs (RHAC, PSI and Marie Stope) and 5 are private. Thus, a total of 135 VCCT sites operate in the public sector (Annex: VCCT indicator 1).

A total of 212,789 persons have been tested for HIV at VCCT sites in 2006 (Figure 4) including 59,477 persons in Q4 2006.

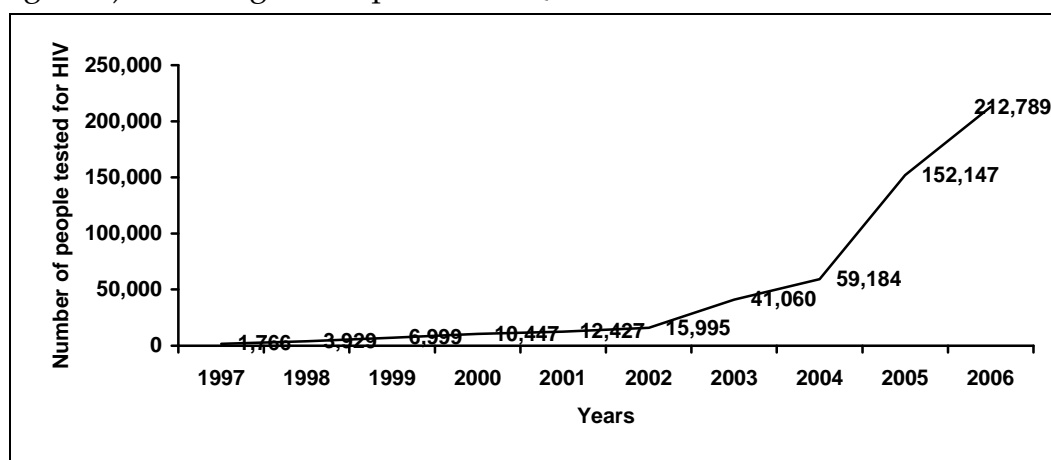


Figure 4: Trend in numbers of people tested for HIV at VCCT services from 1997 to 2006

Of the total number of people tested in 2006, 116,454 (54.7%) were female and 191,523 (90.0%) were aged 15-49 years (VCCT indicator 2) (Table 1).

	People tested for HIV N= 212,789 No. (%)	People tested HIV positive N=16,915 No. (%)
Age		
≤14 years	10,457 (4.9)	1,448 (8.6)
15-49 years	191,523 (90.0)	14,456 (85.5)
> 49 years	10,809 (5.1)	1,011 (5.9)
Sex		
Male	96,335 (45.3)	7,711 (45.6)
Female	116,454 (54.7)	9,204 (54.4)

Table 1: Characteristics of clients tested at VCCT sites, year 2006

Quality control of HIV testing was conducted in 2006 in collaboration with Pasteur Institute (IPC).

Provider initiated HIV testing and counseling (PITC) was approved in a policy document signed by MoH in September 2006 at health facilities that have VCCT services. Health care workers can propose HIV testing to any person who access health facilities, give pre-test information and provide a referral card to access VCCT services. The HIV test is conducted at VCCT sites as well as post-test counseling.

Koh Thom and Takmao in Kandal province have started PITC in Q3 2006. At both sites, the number of people tested for HIV has increased significantly after the introduction of PITC. In 2007, PITC will be expanded nationwide.

In Q4 2006, 99.4% (range: 78.8%-100% across sites) of VCCT clients who had a pre-test counseling were effectively tested for HIV and 98.6% (range: 82.4%-100 % across sites) of those tested received their result through post-test counseling (Figure 5). The target of 98% of people tested receiving post-test counseling is achieved (Annex: VCCT indicator 3).

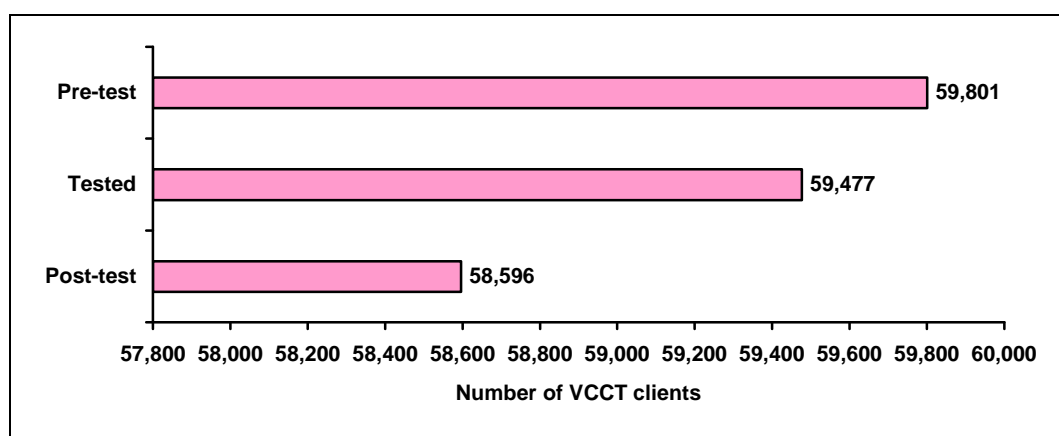


Figure 5: VCCT cascade in Q 4 2006

In Q4 06, of 59,801 VCCT clients, 2,946 (4.9%) were referred from the TB program (Figure 6). Thanks to joint TB/HIV collaborative activities, a total of 11,424 VCCT clients have been referred from the TB program in 2006, which is above the target of 9,000 for 2006 (VCCT indicator 4).

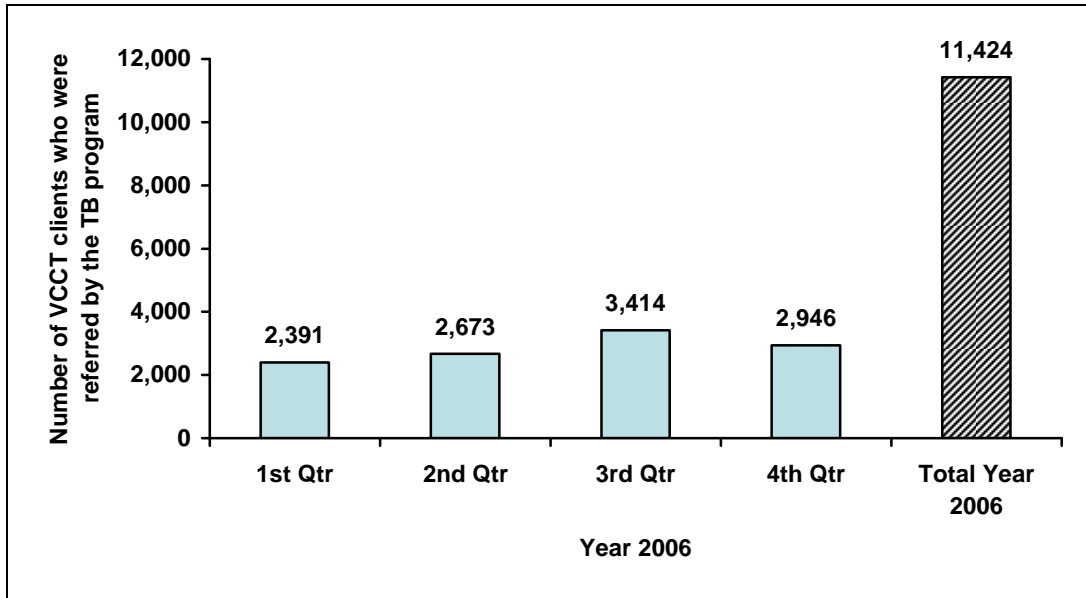


Figure 6: Trend in number of VCCT clients referred from TB program in 2006

In 2006, a total of 16,915 persons nationwide were detected HIV-positive at VCCT sites.

The HIV-infection rate among VCCT clients is still decreasing with 6.6% of VCCT clients found HIV-infected in Q4 2006 (Figure 7).

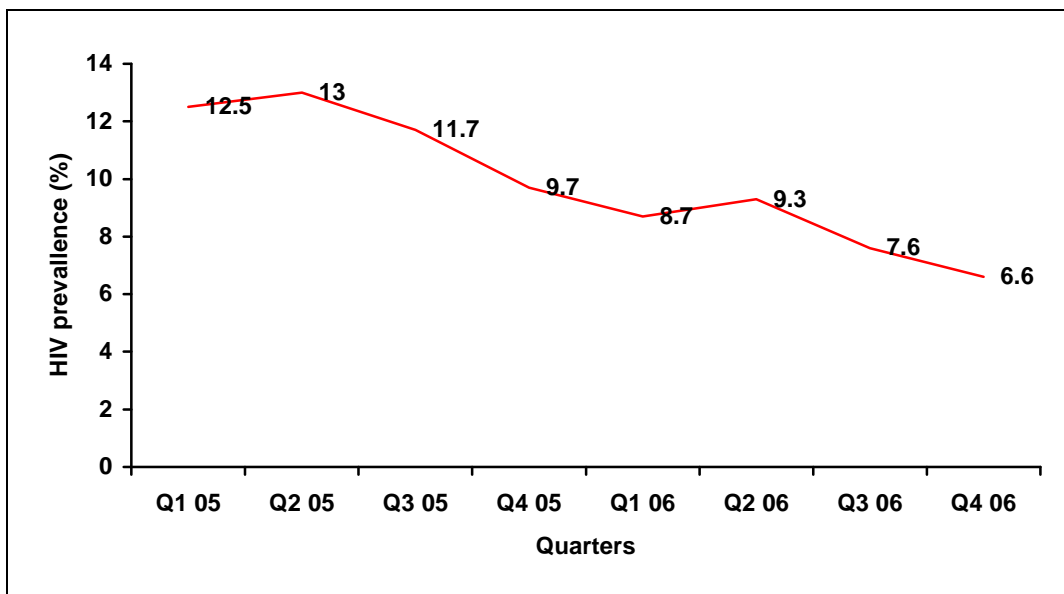


Figure 7: Trend in HIV-infection rate among VCCT clients from Q1 2005 to Q4 2006

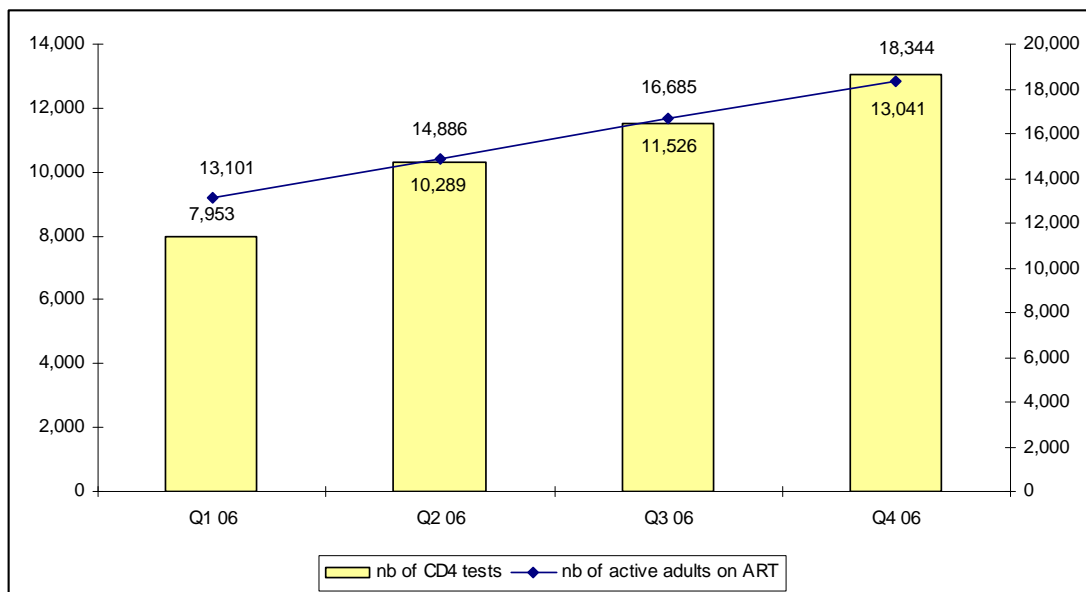


Figure 9: Trend in the total number of CD4 tests conducted at the 4 sites with leased FACScouts compared to the number of active adults on ART from Q1 to Q4 2006

Viral load testing is available at IPC. NIPH laboratory has been equipped for viral load testing and DNA PCR in 2006. Capacity will be strengthened at NIPH in 2007 to perform both testing in 2007.

In December 2006 a total of **20,131** active patients, including **18,344** adults and **1,787** children were receiving ART (Figures 10, 11, 12) (Annex: HFBC indicator 3).

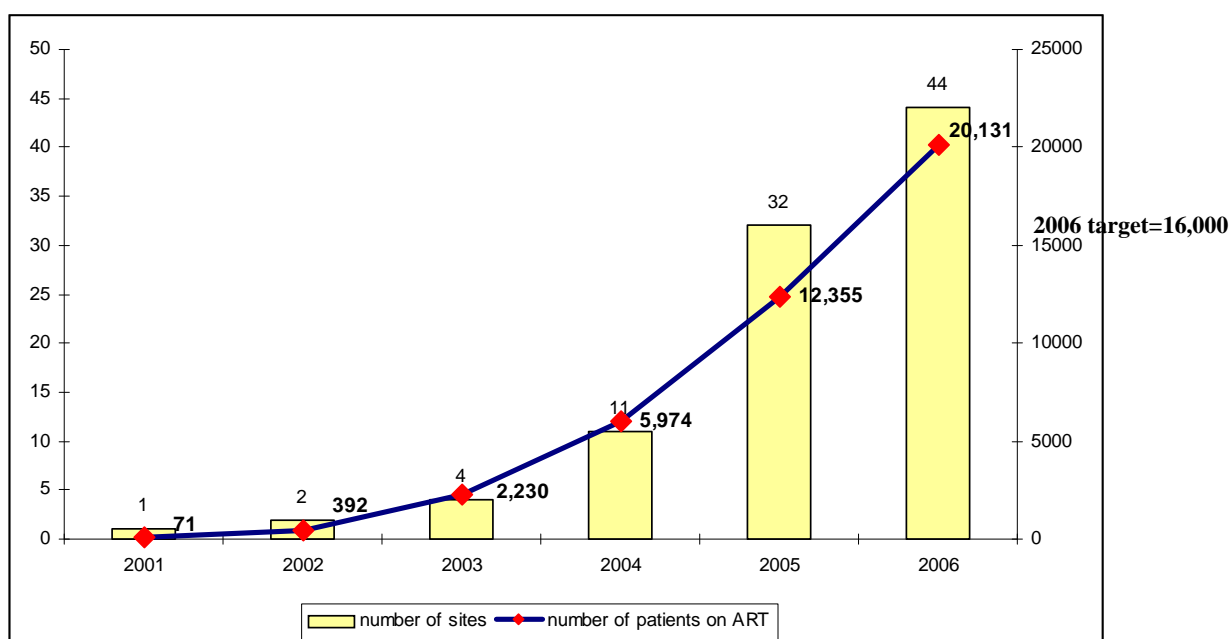


Figure 10: Trend in number of OI/ART sites and active patients on ART from 2001 to 2006

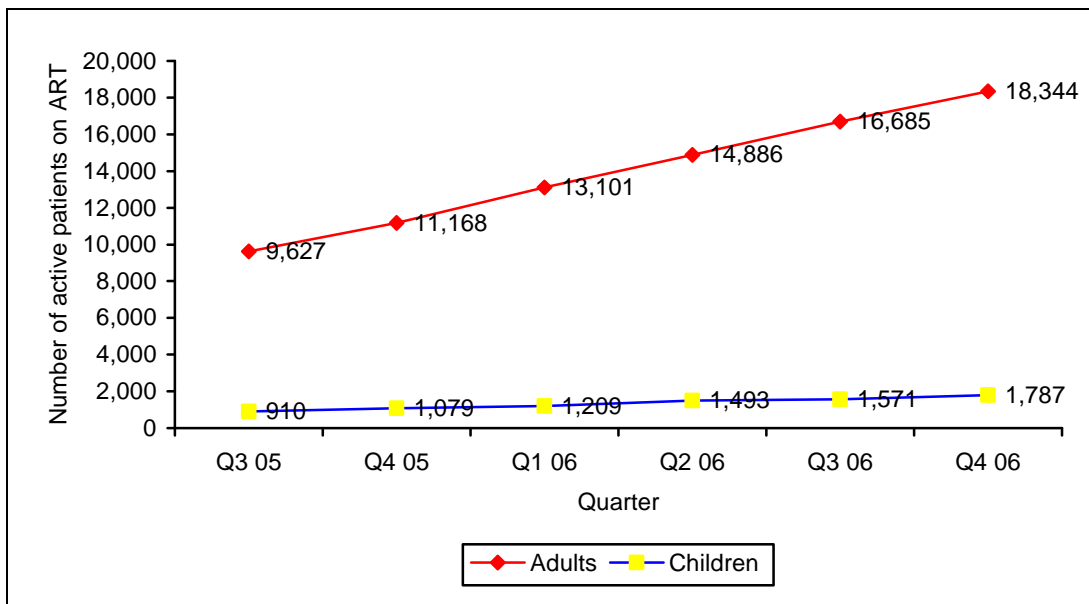


Figure 11: Trend in number of active adult and child patients from Q3 2005 to Q4 2006

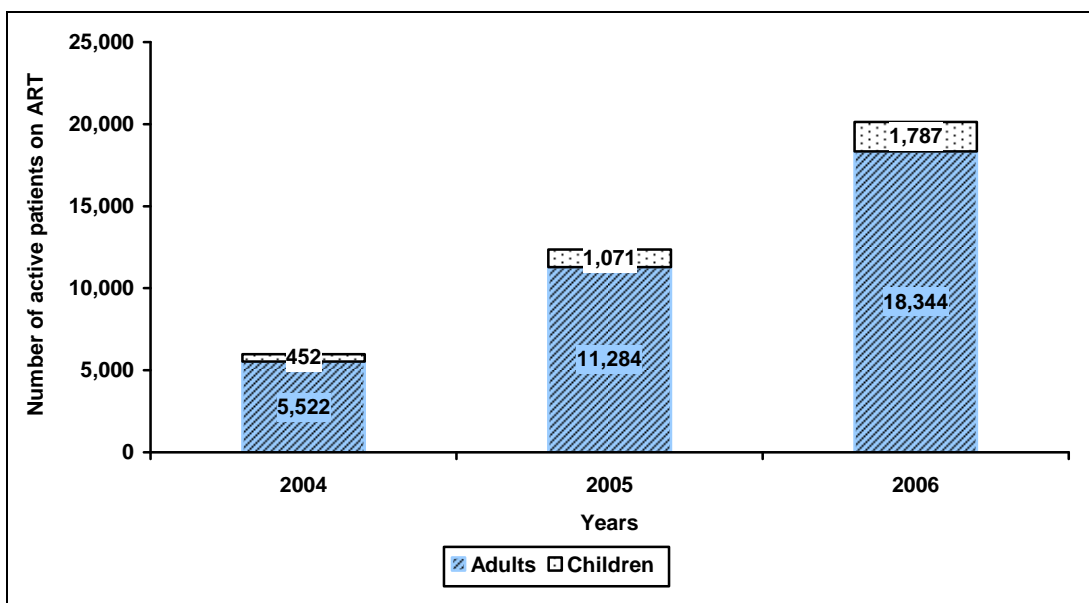


Figure 12: Trend in number of active adults and children on ART from 2005 to 2006

In 2006, female patients accounted for 49.6% of all active patients on ART and 49.9% of adult patients on ART.

At OI/ART sites, a total of 3,140 new patients started OI prophylaxis and management and 1,944 new patients (including 159 children) started on ART in Q4 2006 (Figure 13). The number of new OI patients has been declining slowly since the beginning of 2006.

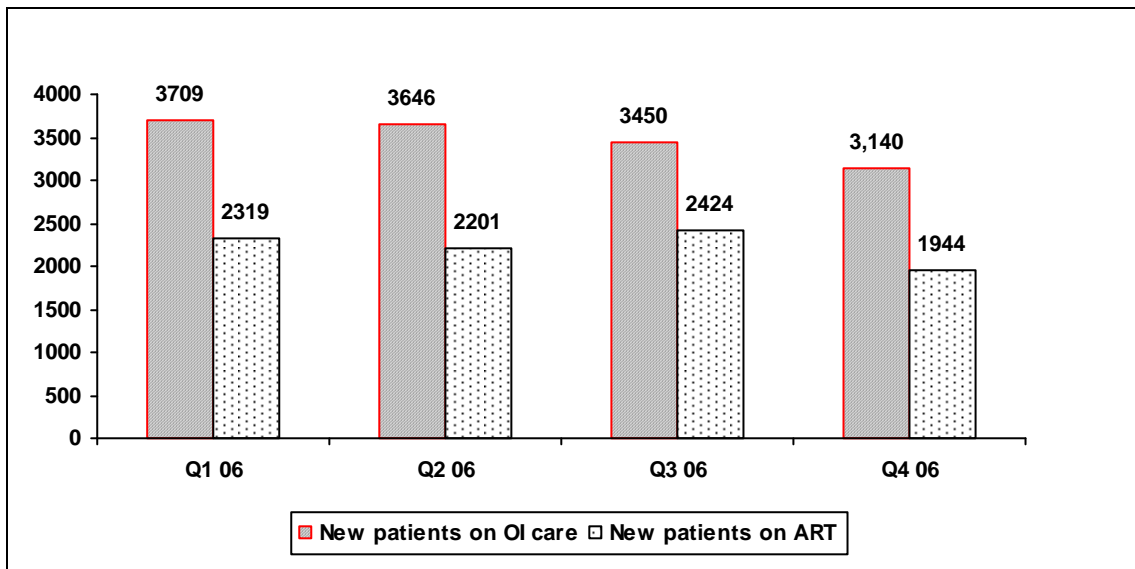


Figure 13: Trend in number of new patients on OI and ART from Q1 to Q4 2006

There were a total of 8,427 active OI adult patients not yet eligible for ART at the end of Q4 06. Of those, 5,559 (60.0%) were female, representing mostly spouses of male patients started on OI/ART care some years ago. Nation wide, 2,219 adult patients and 280 child patients enrolled in OI care were eligible for ART but not yet on ART at the end of December 06.

Patient mobility across services

During Q4 2006, a total of 173 ART patients were transferred out to new ART sites located closer to their home residence. The number of patients transferred out is still insufficient. At the end of 2006, 8 ART sites have cohorts of more than 1,000 active patients on ART, including KSF hospital/Phnom Penh that has 2,745 active patients on ART.

Impact

Survival at 12 months

In 2006, some ART sites, namely Takeo, Siem Reap, Sotnikum, SH Center of Hope, Smach Manchey and Sisophon have been able to provide information on the status of their patients at the start of ART and on survival at 12 months. Most adult patients who started ART before January 2006 were WHO clinical stage III and IV at the start of ART (Table 2). At ART initiation the median CD4 count was < 60/mm³ at all sites. The proportion of patients diagnosed with tuberculosis (TB) at baseline varied from 29% to 54% across sites. The proportion of patients with ART experience at baseline varied from 1.4% to 8.1% across sites. All patients were started on first line regimen.

	Takeo N=1,296 No. (%)	Siem Reap N=1,201 No. (%)	Sotnikum N=285 No. (%)	SH Center of Hope N=867 No. (%)	Smach Meanchey (Koh Kong) N=70 No. (%)	Sisophon (BMC) N=289 No. (%)
WHO clinical stage						
I	55 (4.2)	52 (4.3)	12 (4.2)	0	1 (1.4)	-
II	121 (9.3)	181 (15.1)	17 (6.0)	42 (4.7)	2 (2.9)	-
III	629 (48.5)	618 (51.5)	102 (25.8)	273 (30.6)	28 (40.0)	-
IV	491 (38.0)	350 (29.1)	154 (54.0)	578 (64.7)	39 (55.7)	-
Median CD4 count (IQR)	50 (14-137)	58 (17- 137)	55 (18 - 121)	55 (14-161)	21 (7-59)	57
TB diagnosed at baseline	645 (49.8)	524 (43.6)	118 (41.4)	281 (31.3)	20 (28.6)	155 (53.6)
ART experienced	41 (3.2)	97 (8.1)	22 (7.7)	69 (7.7)	1 (1.4)	-
Started on first line regimen	1,296 (100)	1,201 (100)	285 (100)	-	57 (100)	289 (100)

Table 2: Baseline characteristics of adult patients started on ART before January 2006

At pediatric care services, the median CD4 % ranged from 7.6 to 9.2% across sites (Table 3). The proportion of children with ART experience at baseline varied was 1.5% at Takeo. All children were started on first line regimen.

	Takeo N= 132 No. (%)	Siem Reap N=265 No. (%)
Median CD4 % (IQR)	7.6% (4-13.7)	9.2% (4.3-14.9)
ART experienced	2 (1.5)	-
Started on first line regimen	132 (100)	265 (100)

Table 3: Baseline characteristics of children patients started on ART before January 2006.

At adult care services, the proportion of adult patients still alive and on ART after 12 months varies from 80.4% to 90.1% across sites (Tables 4, 5). Adult

patient survival at 12 months is good and similar to that found in other countries¹. At the four sites with > 100 adult patients on ART, at least 80% of patients were still on first line regimen after 12 months. In the absence of viral load monitoring, this can be used as a proxy to estimate that the proportion of patients with HIV drug resistance (DR) suppression after 12 months on ART is probably $\geq 80\%$, meaning that the level of DR at these sites is low.

	Takeo N=714 No. (%)	Siem Reap N=726 No. (%)	Sotnikum N=191 No. (%)	SH Center of Hope N=335 No. (%)
Transferred out ²	64 (n=650)	17 (n=709)	2 (n=189)	0 (n=335)
Died	67 (10.3)	62 (8.7)	20 (10.6)	20 (5.9)
Lost to follow up	22 (3.4)	30 (4.2)	17 (9.0)	13 (3.9)
Still alive and on ART at same site	561 (86.3)	617 (87.0)	152 (80.4)	302 (90.1)
Still on first line regimen	561 (86.3)	612 (86.3)	151 (79.9)	288 (86.0)

Table 4: Outcome of adult patients who initiated ART before January 2005, at 12 months after ART start

	Smach Manchev (Koh Kong) N=70 No. (%)	Sisophon N= 57 No. (%)
Transferred out	2 (n=68)	0 (n=57)
Died	15	8
Lost to follow up	4	1
Still alive and on ART at same site	49 (72.1) ³	48 (84.2)
Still on first line regimen	48 (70.6)	47 (82.5)

Table 5: Outcome of adult ART patients for whom 12 months follow up data is available to date

¹ Ferradini L, Jeannin A et al. Scaling up of highly active antiretroviral therapy in a rural district of Malawi: an effectiveness assessment. *Lancet* 2006; **367**:1335-42.

Coetzee D, Hildebrand K, et al. Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa. *AIDS* 2004;**18**:887-95.

Severe P, Leger P, et al. Antiretroviral therapy in a thousand patients with AIDS in Haiti. *N Engl J Med*. 2005 ;**353**:2392-4.

² The patients transferred out to other sites were removed from the denominator since follow up and outcome data were not available at the same site

³ For patients who were started on ART in 2005 for whom we have 12 months follow up (n= 35), the survival rate at 12 months was 85.7%.

At sites that provide pediatric care, the proportion of children still alive and on ART after 12 months was 93.2%, similar to that found in other countries⁴ (Tables 6).

	Takeo N=134 No. (%)	Siem Reap N=265 No. (%)
Transferred out	1 (n=133)	1 (n=264)
Died	9 (6.8)	8 (3.0)
Lost to follow up	0	10 (3.8)
Still alive and on ART at same site	124 (93.2)	246 (93.2)
Still on first line regimen	123 (91.8)	245 (92.8)

Table 6: Outcome of child ART patients for whom 12 months follow up data is available to date

Early warning indicators (EWI) for HIV Drug Resistance

EWI were measured at 6 ART sites with electronic database in 2006 (Table 7).

- NCHADS logistic Unit reported no ARV stock out at OI/ART sites in 2006 (HFBC indicator 5)
- 100% of patients were started on ART with the recommended first line regimen
- The proportion of patients lost to follow up at 12 months after ART initiation (HFBC indicator 7) ranged from 1.9% to 9.0% across sites. Only Sotnikum ART site was above the target of <5%.
- The proportion of patients still on first line regimen at 12 months after ART initiation (HFBC indicator 8) ranged from 70.6% to 86.3%. Only Smach Manchey was below the target of 80%
- Appointment keeping was not yet available in 2006

EWI should be monitored at all ART sites once the ART electronic database is rolled out at all sites in 2007.

Provinces/Cities	ART Services	drug stock outs	% started on standard first line	% lost to FU at 12 months	% still on first line at 12 months	appointment keeping
Banteay Meanchey						
	Serei Sophon HC	0%	100%	1.80%	82.50%	not available
Koh Kong						
	Smach Meanchey RH	0%	100%	5.90%	70.60%	not available

⁴ Chearskul S, Chotpitayasunondh T, et al . Survival, disease manifestations, and early predictors of disease progression among children with perinatal human immunodeficiency virus infection in Thailand. *Pediatrics*.2002 Aug;**110**:e25

Phnom Penh						
	CHSH	0%	100%	3.90%	86.0%	not available
Siem Reap						
	SRP Hospital (MFS/B)	0%	100%	4.20%	86.3%	not available
	SRP- Sothnikum	0%	100%	9%	79.90%	not available
Takeo						
	Takeo Hospital	0%	100%	3.40%	86.30%	not available
TARGET		0%	100%	<5%	>80%	>80%

Table 7: Early warning indicators performance at 6 ART sites in 2006.

TB/HIV collaborative activities

At the end of 2006, 222 health centers in 8 provinces, namely Svay Rieng (36 HC/37), Prey Veng (60 HC/90), Takeo (46 HC/70), Kampot (15 HC/47), Sihanoukville (2 HC/11), Kandal (16 HC/88), Siem Reap (16 HC/53) and Pursat (31 HC/31) have intensified TB/HIV collaborative activities. In particular, health centers with HBC teams facilitate the transportation of TB patients from the community to the nearest VCCT site for HIV testing.

At the 222 HCs, during Q4 2006, of the 4,644 newly diagnosed and old TB cases still on treatment but not yet HIV tested, 1,218 (26.2%) were reported by HBC teams as having attended VCCT services for HIV testing (Table 8). TB/HIV co-infected patients were referred to OI/ART sites.

	Total N*=4,644 No. (%)	Kampot N=491 No. (%)	Kandal N=308 No. (%)	Prey Veng N=1,532 No. (%)	Siem Reap N=254 No. (%)	SHV N=95 No. (%)	Svay Rieng N=1,573 No. (%)	Takeo N=391 No. (%)	Pursat N=240 No. (%)
Reported by HBC teams as HIV tested at VCCT	1,218 (26.2)	143 (29.1)	31 (10.1)	449 (29.3)	45 (17.7)	5 (5.0)	402 (25.6)	143 (36.6)	93 (38.8)
Reported by HBC teams as HIV positive	114 (9.4)	21 (14.7)	9 (29.1)	49 (10.9)	2	1	7 (1.7)	25 (17.2)	2 (2.2)

Table 8: Referral of TB patients to VCCT for HIV testing in 222 HC in 8 provinces with specific TB/HIV collaborative activities during Q4 2006 (reports from HBC teams)

*N= number of new TB patients in Q4 2006 + number of old TB patients still on treatment but not yet HIV tested at the 191 HC.

From January to December 2006 a total of 3,746 TB patients were actually transported to VCCT for HIV testing by HBC teams from their community (HBC indicator 3). This represents 32.8% of the 11,424 total VCCT clients that were referred from the TB program in 2006. Despite the limited number of

HBC teams with TB/HIV referral activities, they already contributed to about 1/3 of the total number of VCCT clients referred from TB nationwide.

The 2006 target of 5,000 TB patients transported to VCCT by HBC teams in the 8 targeted provinces has not been achieved but the proportion of TB patients referred to VCCT by HBC teams has increased since January 2006 (Figure 14).

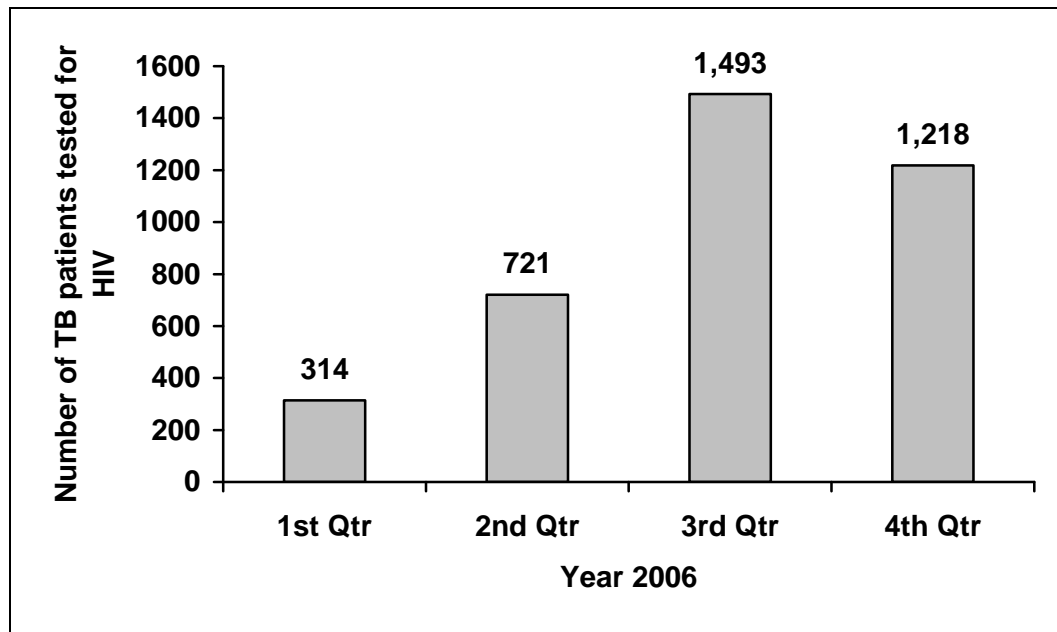


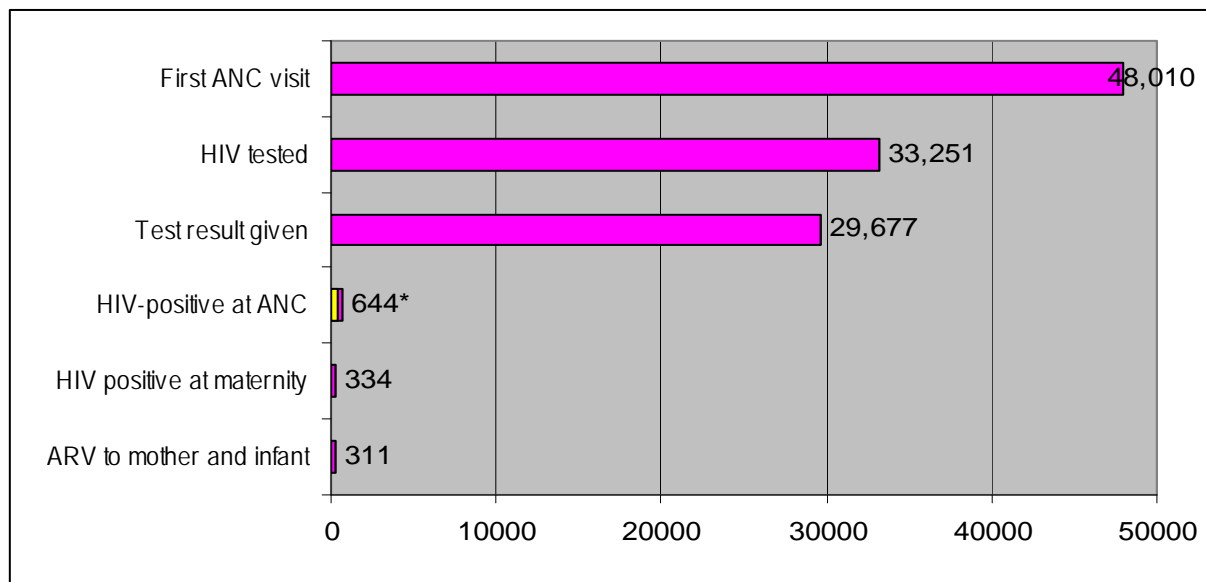
Figure 14: Trend in number of TB patients referred by HBC teams from 8 provinces who attended VCCT for HIV testing in 2006

PMTCT services

In December 2006 Cambodia had 60 facilities in 21 provinces that provided PMTCT services, including 39 at referral hospital level (Annex: PMTCT indicator 1). A total of 39 ODs had at least one health facility providing PMTCT services (Annex: HFBC indicator 2 and PMTCT indicator 2).

From January to December 2006, of a total of 48,010 first ANC attendees at ANC clinics with PMTCT services, 33,251 (69.3%) were tested for HIV (Annex: PMTCT indicator 3) (Figure 15). Of the total of women who came for their first ANC visit at PMTCT sites, 29,677 (61.8%) received their test result through post-test counseling (Annex: PMTCT indicator 4). Of women who attended ANC clinics with PMTCT services for their first ANC visit, 7,720 (16.1%) had husbands/partners who accepted testing and 7,045 (14.7%) also received their test result through post-test counselling (Annex: PMTCT indicator 5). Among women tested for HIV at PMTCT services, 383 (1.2%) were HIV positive on their first test and an additional 9 on their second. In addition, from Jan-Dec 2006, 252 known HIV-positive pregnant women were referred to PMTCT from CoC services. A total of 334 HIV-infected pregnant women delivered at PMTCT services between Jan and Dec 06. Of those, 103 (30.8%) were eligible for ART and had started HAART and 208 (62.3%)

received ARV prophylaxis. Of 337 infants of HIV-infected mothers identified through PMTCT services who delivered between Jan and Dec 06, 323 (95.8%) received ARV prophylaxis (Annex: PMTCT indicator 7). Of those, 110 (34.1%) received single dose NVP only, and 213 (65.9%) received NVP and ZDV. The proportion of children receiving NVP and ZDV continued to increase in Q 4 2006 as recommended in the PMTCT guidelines. Of the children born to HIV-infected mothers, 3 were detected HIV-infected at 18 months.



(* includes 392 tested HIV positive at ANC and 252 referred to PMTCT services)

Figure 15: PMTCT cascade in 2006

In 2003 it was estimated that 2.1% of pregnant women were infected with HIV, with provincial differences ranging from 0.6 to 3.5 %. With 461,000 estimated live births per year, it is estimated that about 9,700 pregnant women are HIV-infected, that 20-30% of them are eligible for HAART and that without any intervention, annually about 3,000 babies may be infected with HIV from their mothers.

Despite government efforts to scale up the services, in 2006 only 29,677 (6.4%) of the total annual number of pregnant women got an HIV test result (Annex: PMTCT indicator 9) and only 323 (3.3%) of HIV-infected pregnant women received a complete course of ARV prophylaxis to reduce MTCT. Although the coverage of PMTCT services has increased from 24 sites (32,760 women seen for a first visit at ANC) in 2005 to 60 sites (48,010 women seen for a first visit at ANC) by the end of 2006, it is still insufficient.

HBC services

At the end of 2006 there were 292 HBC teams in Cambodia (Annex: HBC indicator 1) (Figure 16). The 2006 target of 270 HBC teams is already achieved. A total of 516 (54.8%) health centers were linked to HBC teams (Annex: HBC indicator 4) in 17 provinces within the CoC.

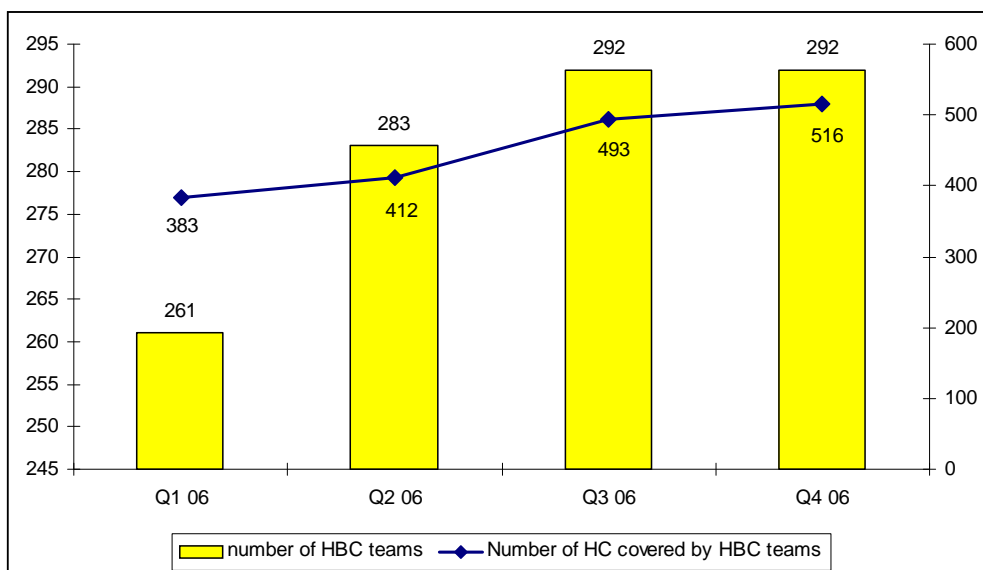


Figure 16: Trend in number of HBC teams and HC covered by HBC teams from Q1 to Q4 2006

At the end of 2006 HBC teams were supporting a total of 22,634 active PLHA (Annex: HBC indicator 2). The 2006 target of 16,000 PLHA supported by HBC teams was achieved.

In 2006, HBC teams strengthened their role for patients referral from the community to health facility-based services of the CoC, including referral to VCCT, OI/ART, ANC services and TB screening. In Neak Loeng/Prey Veng, HBC teams achieved good results in transferring pregnant women to ANC services.

PLHA support group (PLHA SG)

In December 2006 there were 640 active PLHA SG in Cambodia. These PLHA SG are currently established in 14 provinces (*source: CPN+ report*). A total of 29,064 active PLHA were supported by these support groups at the end of 2006 (Figure 17).

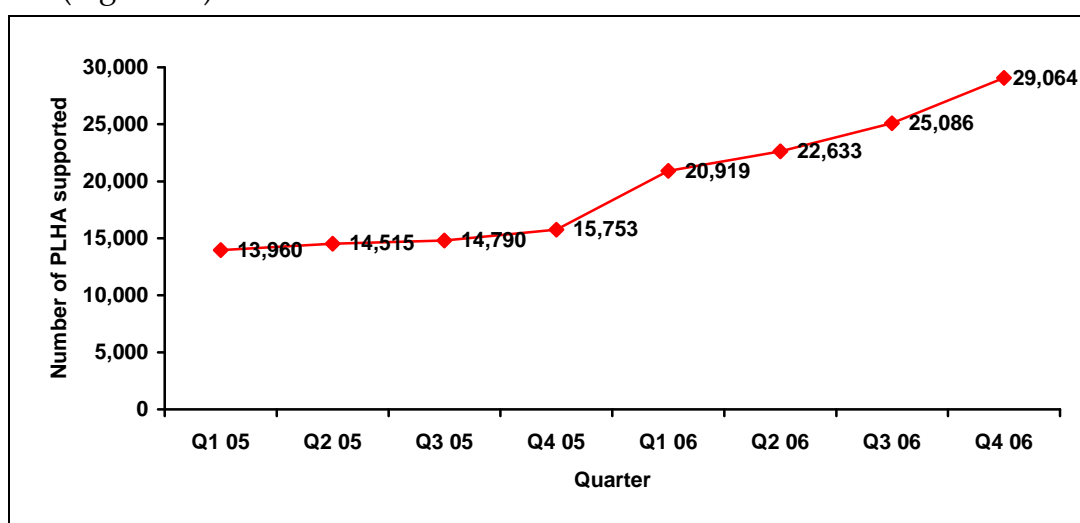


Figure 17: Trend in number of people supported by PLHA support groups from Q1 05 to Q4 06 (*source: CPN+*)

C. Financial Report

This Report presented both expenditures, the proportion of planned budget disbursed and achievement of planned activities, as the major indicators of achievement. It includes the ten main funding sources of NCHADS programme: DFID, GFATM, CDC, EUROPAID, CHAI, CTAP, WB, AHF, TREAT Asia, USAID-HSSC and FHI.

In the expenditures columns shown only expenditures recorded in the NCHADS accounting system to reconcile expenditure against the budget plan. These include both actual expenditures incurred and recorded during the year. But for the FHI and USAID-HSSC, the expenditures were compiled according to the figures provided by two organizations to NCHADS.

Achievement

During this year, for the proportion of expenditures against the work plan calculated by funding sources for both NCHADS and provincial levels were shown below:

- 84 % of planned DFID funds
 - 82 % of planned EUROPAID funds.
 - 67 % of planned funds from the GFATM, (included all: R1, R2 and R4)
 - 93 % of CDC funds.
 - 49% of CTAP funds.
 - 24% of WB.
 - 100 % of FHI.
 - 44% of CHAI.
 - 51% of AHF.
 - 32% of TREAT Asia
-
- Expenditure was significantly better NCHADS HQ than at Provincial levels, because some activities at the provincial level were postponed and adjusted by new updated technical SOP such as SOP on Outreach and 100% CUP.
 - For CTAP funding expenditures only for running clinic at Social Health Clinic,
 - WB, Treat Asia, and CHAI expenditures were achieved by NCHADS HQ.
 - FHI expenditures only achieved by NCHADS HQ, and expenditures for ODs not included in this table.
 - And USAID-HSSC expenditure was spent at 7 provinces where the supported were provided: PNP, BTB, BMC, SRP, KRT, SHV and PST
 - In some cases the sum of Annual Plans of NCHADS Units are different to the Annual Plan (especially for DFID): these are because some units get reallocated and approved by Steering Committee.

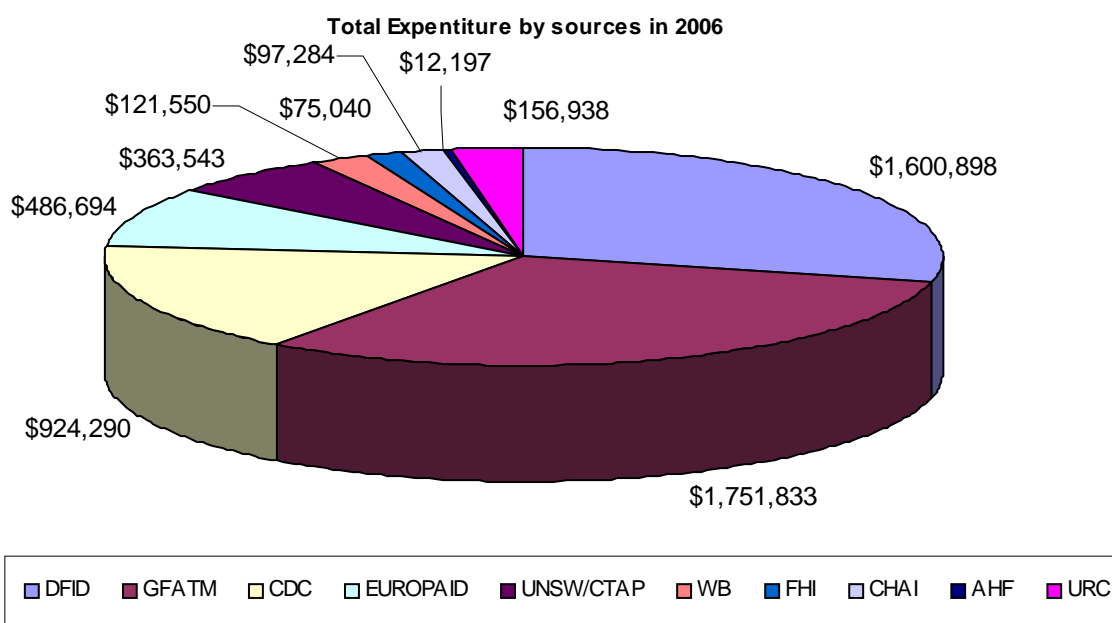


Table 1: Summary Expenditure by Sources in 2006

Sources	Year Plan	Total Exp	%
DFID	\$ 1,909,883	\$ 1,600,898	84%
GFATM	\$ 2,608,922	\$ 1,751,833	67%
CDC	\$ 988,678	\$ 924,290	93%
EUROPAID	\$ 592,302	\$ 486,694	82%
UNSW/CTAP	\$ 744,377	\$ 363,543	49%
WB	\$ 500,000	\$ 121,550	24%
FHI	\$ 75,000	\$ 75,040	100%
CHAI	\$ 221,600	\$ 97,284	44%
AHF	\$ 24,138	\$ 12,197	51%
TREAT Asia	\$ 98,478	\$ 31,465	32%
Grand Total	\$ 7,763,378	\$ 5,621,732	72%

Table 2: Summary Expenditure by Components and Sources in 2006

Project Components	DFID	GFATM	CDC	EUROPE AID	CTAP	WB	FHI	CHAI	AHF	URC	TREAT Asia	Grand Total
VAT Exp	1,819	352	505	-		-	-	-	-	-		
IEC	206,072	23,240	13,305						1,500			244,117
Outreach	50,120	14,456	3,434				13,929					81,939
100% CUP	19,422	20,410	5,532			41,263						86,627
STD Management	45,306	127,851	122,703				14,326					310,186
Universal Precaution			2,760									2,760
Health Facility Based care	1,849	265,481	35,108	5,775				6,868	1,810	31,053	31,465	379,409
Home Based Care /Support Group	196,272	46,198	22,201						1,683	15,304		281,658
VCCT	47,991	232,216	196,435	7,634				7,363		95,866		587,505
CoC Referral Network	7,120	53,849	6,658	4,745					1,099			73,471
PMTCT		10,181	6,005									16,186
Surveillance and Research	48,314		89,787		363,543		46,785					548,429
Planning, Management & Monitoring	277,921	437,495	355,784	47,668				23,289	35	14,715		1,156,907
Data Management	14,982	9,507										24,489
Logistic Management	218,938	477,769		298,281		80,287		23,694				1,098,969
Admin & Finance	464,772	32,828	64,073	122,591		121,550		36,070	6,070			847,954
Total Expenditure	1,600,898	1,751,833	924,290	486,694	363,543	121,550	75,040	97,284	12,197	156,938	31,465	5,621,732

Table 3: NCHADS Expenditures by Components, funded by DFID in 2006

	Components	Year Plan	Expenditure	%
1	BCC	\$ 165,670	\$ 137,071	83%
2	STD	\$ 16,945	\$ 14,755	87%
3	AIDS Care	\$ 253,990	\$ 189,718	75%
4	VCCT/LS	\$ 66,576	\$ 41,669	63%
5	Research	\$ 88,000	\$ 48,314	55%
7	PMR	\$ 145,065	\$ 118,444	82%
8	Data Management	\$ 21,000	\$ 14,982	71%
9	Logistic	\$ 250,793	\$ 210,664	84%
10	Admin & Finance	\$ 398,833	\$ 432,824	109%
	Total	\$ 1,406,872	\$ 1,208,441	86%

Table 4: NCHADS Expenditures by CDC funded in 2006

	Unit	Year Plan	Expenditure	%
1	BCC		\$ 1,000	#DIV/0!?
2	STD Unit & NSTD clinic	\$ 202,520	\$ 122,438	60%
3	AIDS Care		\$ 5,340	#DIV/0!?
4	VCCT/LS	\$ 14,400	\$ 20,939	145%
5	Surveillance	\$ 162,000	\$ 85,644	53%
6	Research	\$ 12,000	\$ 4,143	35%
7	PMR	\$ 50,450	\$ 60,094	119%
8	Data Management	\$ 2,500	\$ -	0%
9	Logistic	\$ 65,565	\$ 114,414	175%
10	Admin & Finance	\$ 210,300	\$ 228,789	109%
	Total	\$ 719,735	\$ 642,801	89%

Table 5: NCHADS Expenditures by GFATM (R1, R2 &R4) funded in 2006

	Components	Year Plan	Expenditure	%
1	BCC	\$ 46,200	\$ 43,135	93%
2	STD	\$ 22,200	\$ 34,233	154%
3	AIDS Care	\$ 343,021	\$ 285,349	83%
4	VCCT/LS	\$ 56,700	\$ 12,228	22%
5	PMR	\$ 121,000	\$ 104,455	86%
6	Data Management	\$ 15,000	\$ 9,507	63%
7	Logistic	\$ 1,342,922	\$ 693,156	52%
8	Admin & Finance	\$ 434,660	\$ 425,295	98%
	Total	\$ 2,381,703	\$ 1,607,358	67%

Table 6: NCHADS Expenditures by EUROPAID funded in 2006

	Component	Year Plan	Expenditure	%
1	AIDS Care	\$ 1,500	\$ 617	41%
2	PMR	\$ 56,160	\$ 38,235	68%
3	Logistic	\$ 357,900	\$ 298,281	83%
4	Admin & Finance	\$ 141,040	\$ 120,009	85%
	Total	\$ 556,600	\$ 457,142	82%

Table 7: NCHADS Expenditures by CHAI, 2006

	Components	Year Plan	Expenditure	%
1	AIDS Care	\$ 30,000	\$ 6,868	23%
2	VCCT/LS	\$ 10,000	\$ 7,362	74%
3	PMR	\$ 80,000	\$ 23,289	29%
4	Logistic	\$ 68,000	\$ 23,694	35%
5	Admin & Finance	\$ 33,600	\$ 36,070	107%
	Total	\$ 221,600	\$ 97,283	44%

