Cambodia Country Progress Report

Monitoring Progress towards the Targets of the 2011 UN Political Declaration on HIV and AIDS

Reporting Period:
January 2012 – December 2013

Prepared and submitted by
The National AIDS Authority
on April 7, 2014

FOREWORD

In June 2011, Cambodia participated in the UN General Assembly High-Level Meeting on AIDS in New York. At this meeting, Cambodia renewed its commitment to the HIV response and adopted new targets by signing the 2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS.

On behalf of the National AIDS Authority, it is my pleasure to submit the 6th Country Report on Global AIDS Response Progress Reporting. The purpose of the report is to provide feedback with respect to the goals agreed upon and progress made in Cambodia's response on HIV and AIDS using global indicators for the period 1 January 2012 to 31 December 2013. The period under this review falls within the timeframe of implementation of the Third National Strategic Plan (NSPIII) for a Comprehensive and Multi-sectoral response to HIV and AIDS (2011-2015) and the Rectangular Strategy Phase II of the Royal Government of Cambodia.

On the road towards achieving the Millennium Development Goals, Cambodia has been sharpening its policy and programmatic response in the fight against HIV and AIDS to "getting to zero": zero new infections, zero AIDS-related deaths, and zero discrimination.

Over the past two years, Cambodia has undertaken innovative approaches to assist national leaders, policy makers, programme implementers, and CSO and MARPs representatives to gain more confidence and competence in contributing to a more strategic and sustainable HIV response. The efforts in the past two years have taken into account the changing HIV epidemic, global context of resource constraints and increasing domestic contribution along with the enhancement of country ownership.

In terms of political commitment, the First Lady **Samdach Kittipritbandit Bun Rany Hun Sen** has been engaging the health sector and local authorities to get involved in the implementation of the Action Plan for Women and Children's Health that Cambodia committed to at the United Nations' meeting in June 2011. Furthermore, the Council of Ministers' Order on the "Seven-Point Policy Directives" for the HIV and AIDS response was issued in late 2013 under the directive of **Samdach Akkak Moha Sena Padei Decho Hun Sen**, Prime Minister of Cambodia, to reactivate the collaboration of stakeholders for optimizing the use of all sources of funding to achieve tangible, effective, and efficient results and move forward with a sustainable response.

In addition to high level leaders, many more government agencies, civil society organisations and community networks have been collaborating with each other to develop and to implement a new conceptual framework called "Cambodia 3.0" for the elimination of new HIV infections by 2020.

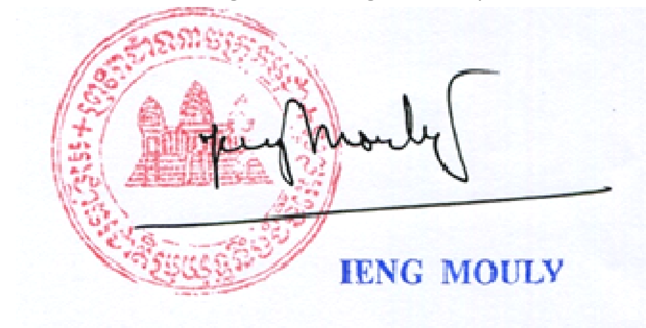
To support programmatic actions listed in Cambodia 3.0 of the health sector, the Investment Framework for an Effective and Efficient Response to HIV/AIDS in Cambodia has been endorsed by the Policy Board to serve as a program guiding tool for the national HIV and AIDS response in Cambodia. This tool was developed to assist key stakeholders to prioritize interventions and to increase effectiveness and efficiency in the HIV and AIDS response covering programmatic areas, enabling environment, and development synergy.

With respect to the human rights perspective, efforts have been made on strengthening partnerships between government, development partners, CSOs and representatives of PLHIV/MARPs from the

national to the local level to improve the policy and legal environment to support HIV and AIDS programmatic interventions.

The national HIV response is currently largely funded by international sources, although the share of funding from the Royal Government of Cambodia has been increasing. In 2012, only 11% of total spending on HIV/AIDS came from the Cambodian government. As this share increases in the face of declining external funding, it will be increasingly important that the government is able to manage domestic funds transparently, responsibly, and efficiently. In addressing the threats to the sustainability of the HIV and AIDS response, development partners need to shift their approach of support from aid effectiveness toward development effectiveness, and reframe their partnership with Cambodia by strengthening country systems and local institutional capacity to own the response.

Lastly, I would like to express my deep appreciation and thanks to many people, institutions and organizations involved in the development and editing of this report amidst their busy schedules of work supporting the national response. These include our ministries, UN agencies, development partners, civil society and representatives of KAPs and PLHIV. We strongly believe that the open dialogue between duty bearers and rights holders at various levels has enabled the marginalized, the disadvantaged and the excluded to regain their rights to equitable access to health and non-health services.



ACKNOWLEDGMENTS

The 2014 Country Progress Report was written by the National AIDS Authority (NAA) with supporting input from the national monitoring and evaluation system of the NAA and from the HIV/AIDS Coordinating Committee (HACC) and UNAIDS Country Office (UCO) of Cambodia. The development of this report would not be possible without the contributions of a broad array of stakeholders, including ministries and departments of the Royal Government of Cambodia; both national and international non-governmental organizations; bilateral and multilateral donor agencies; faith-based organizations, private sector representatives, civil society and representatives of Key Affected Populations and PLHIV.

The NAA's Planning, Monitoring, Evaluation and Research department (PMERD), under the leadership of H.E. Dr. Phalla Tia, Deputy Chair, and H.E. Dr. Teng Kunthy, Secretary General, was responsible for coordinating the data compilation and entry and for the reporting. Grateful acknowledgment is extended to H.E. Dr. Hor Bun Leng, Deputy Secretary General and Dr. Ngin Lina, Director of PMER Department, for their exceptional leadership in this important endeavour and to the members of the PMERD department.

Contributions from civil society were essential for accurate portrayal and understanding of the availability and effectiveness of service delivery to people living with HIV and members of groups recognized for their elevated susceptibility to HIV infection. The coordination of the many civil society organizations, networks, self-help groups, and other independent agencies at national (Phnom Penh) and sub-national levels (Sihanoukville and Siem Reap) was carried out by the team at the HACC, led by Mr. Tim Vora and Mr. Nhim Dalen.

Assistance with the preparation of this report was provided by Dr. Muhammad Saleem of the UNAIDS Country Office and a team of consultants: Dr. Phauly Tea, Ms. Serey PhalKien, Mr. Sok Serey, and Mr. David Ham.

The attendees at the national validation meeting held on March 21, 2014 provided valuable inputs and feedbacks to ensure that the information in this report is as accurate as possible and best reflects the current status of the HIV epidemic and response in the country.

The following individuals deserve special recognition for their direct support in compiling and validating data: H.E. Dr. Mean ChhiVun, Dr. Ly Penh Sun, Dr. Seng Sopheap, Dr. Fujita Masami, Ms. Emily Welle, Mr. Mam Sovatha, Mr. Path Veasna, Mr. Sun Sokleng, Dr. Toun Sovanna, Dr. Khun Kim Eam, and the staff of the Data Management Unit, Surveillance Unit, labs, and Logistics and Supply Management Unit at NCHADS.

ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
ART	Antiretroviral treatment
ARV	Antiretroviral (drugs)
ASC	AIDS spending category
BA	Baseline assessment (for the Cambodia 3.0 framework)
BK	BROS Khmer (a study published in 2010)
BSS	Behavioral Surveillance Survey
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CDC	Council of Development of Cambodia
CDHS	Cambodia Demographic and Health Survey
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CENAT	National Center for Tuberculosis and Leprosy Control
CoPCT	Continuum of Prevention to Care and Treatment
CPITC	Community peer-initiated testing and counseling
CQI	Continuous quality improvement
CRDB	Council of Rehabilitation and Development Board
CSO	Civil society organization
EC	European Commission
EW	Entertainment worker
FI	Friends International
FONPAMs	Forum of Networks of PLHIV and MARPs
GARPR	Global AIDS Response Progress Reporting
GBV	Gender-based violence
GDJ TWG	Government-Donor Joint Technical Working Group
GF/GFATM	Global Fund / Global Fund to fight AIDS, Tuberculosis and Malaria
HAARP	HIV/AIDS Asia Regional Program
HACC	HIV/AIDS Coordinating Committee
HIS	Health Information System
HSS	HIV Sentinel Survey
HSSP	Health Sector Support Project
IBBS	Integrated Biological and Behavioral Survey
INGO	International NGO
JMI	Joint monitoring indicator
JSP	Joint Support Programme
JUTH	Joint UN Team on HIV/AIDS
KAP	Key affected population
KHANA	Khmer HIV/AIDS NGO Alliance
M&E	Monitoring and evaluation
MARP	Most-at-risk population
MoEYS	Ministry of Education, Youth and Sports

MoH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
MoSVY	Ministry of Social Affairs, Veterans, and Youth Rehabilitation
MS	Mith Samlanh
MSM	Men who have sex with men
NAA	National AIDS Authority
NACD	National Authority for Combating Drugs
NAPVAW	National Action Plan on Violence Against Women
NASA	National AIDS Spending Assessment
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology and STD
NCPI	National Commitments and Policy Instrument
NGO	Non-governmental organisation
NMCHC	National Maternal and Child Health Center
NSP	Needle and syringe programme
NSP	National Strategic Plan for Comprehensive and Multisectoral Response to HIV/AIDS, 2011-2015
OD	Operational district
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PBA	Program Based Approach
PCPI	Police-Community Partnership Initiative
PLHIV	People living with HIV
PMERD	Planning, Monitoring, Evaluation and Research Department
PMTCT	Prevention of mother-to-child transmission
PSE	Population size estimates
PSK	Population Services Khmer
PWID	People who inject drugs
PWUD	People who use drugs
SOP	Standard operating procedure
SSF	Single stream funding
SSS	STI surveillance survey
TB	Tuberculosis
TG	Transgender
TWG	Technical working group
UIC	Unique identifier code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	UN Development Assistance Framework
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing
WHO	World Health Organisation

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STATUS AT A GLANCE

Inclusiveness of stakeholders in the report writing process

The 2014 Global AIDS Response Progress Reporting (GARPR) process was led by the National AIDS Authority (NAA) with support from the HIV/AIDS Coordinating Committee (HACC), UNAIDS, WHO, and UNICEF. Stakeholders working in all sectors of the HIV/AIDS response in Cambodia provided valuable contributions to the 2014 GARPR, including: government ministries and secretariats, national and international non-governmental organizations (NGOs), bilateral organizations, UN agencies, and civil society organizations (CSOs) including networks of people living with HIV (PLHIV) and members of most-at-risk populations (MARPs).

Data for this report were gathered from routine monitoring systems, earlier reviews (e.g. 2013 midterm review, WHO HIV health sector review), Spectrum software output, the National AIDS Spending Assessment (NASA) for 2011-2012, and various surveys, including HIV Sentinel Surveys (HSS), Behavioral Surveillance Surveys (BSS), and the Cambodia Demographic and Health Survey (CDHS).

Several government institutions provided the majority of the indicator data for this year's GARPR: the NAA, National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), National Maternal and Child Health Centre (NMCHC), and National Centre for Tuberculosis and Leprosy Control (CENAT).

This report also draws on data from the National Commitments and Policy Instrument (NCPI), which measures progress on the development and implementation of national HIV/AIDS policies, strategies, and laws. Part A of the NCPI was completed by government officials and Part B was completed by members of civil society in collaboration with the UN, development partners, and the private sector.

Data for the GARPR indicators and the NCPI were validated at a national workshop held in Phnom Penh on March 21, 2014, and feedback from the participants has been incorporated into this report. The report writing was led by the NAA with support from a team of external consultants.

Status of the epidemic

The prevalence of HIV in Cambodia has been steadily declining over the past decade and was estimated to be 0.7% in 2013 among the general population, ages 15-49.

The epidemic continues to be concentrated among certain groups of people at higher risk of infection: entertainment workers[1] (EWs), men who have sex with men (MSM), transgender people (TG), people who inject drugs (PWID), and prisoners. Current prevalence of HIV within these populations range from 2.1% for MSM to 24.8% among people who regularly inject drugs.

Further details on HIV prevalence, HIV incidence, and AIDS-related mortality are shown in the section of this report titled “Overview of the AIDS epidemic”.

Policy and programmatic response

On the road towards achieving the Millennium Development Goals, Cambodia has been sharpening its policy and programmatic response in the fight against HIV and AIDS to “getting to zero”: zero new infections, zero AIDS-related deaths, and zero discrimination. Over the past two years, Cambodia has undertaken innovative approaches to assist national leaders, policy makers, programme implementers, and CSO and MARPs representatives to gain more confidence and competence in contributing to a more strategic and sustainable HIV response. The efforts in the past two years have taken into account the changing HIV epidemic, global context of resource constraints and increasing domestic contribution along with the enhancement of country ownership.

In terms of political commitment, **the First Lady Samdach Kittipritbandit Bun Rany Hun Sen** has been engaging the health sector and local authorities to get involved in the implementation of the Action Plan for Women and Children's Health that Cambodia committed to at the United Nations’ meeting in June 2011. Furthermore, the Council of Ministers’ Order on the “Seven-Point Policy Directives” for the HIV and AIDS response was issued in late 2013 under the directive **of Samdach Akkak Moha Sena Padei Decho Hun Sen, Prime Minister** of Cambodia, to reactivate the collaboration of stakeholders for optimizing the use of all sources of funding to achieve tangible, effective, and efficient results and move forward with a sustainable response.

In addition to high level leaders, many more government agencies, civil society organisations and community networks have been collaborating with each other to develop and to implement a new conceptual framework called “Cambodia 3.0” for the elimination of new HIV infections by 2020. The main objective of the initiative is to reach remaining pockets of individuals who are at very high risk of acquiring HIV/STI and of transmitting infections to their partners.

To support programmatic actions listed in Cambodia 3.0 under the health sector, the Investment Framework for an Effective and Efficient Response to HIV/AIDS in Cambodia has been endorsed by the Policy Board to serve as a program guiding tool for the national HIV and AIDS response in Cambodia.

[1]The Law on Suppression of Human Trafficking and Sexual Exploitation, adopted in 2008, led to the closure of brothels. As a result, women who sold sex moved to entertainment establishments such as karaoke bars, beer gardens, casinos, bars, and night clubs, or sold sex on the street or in parks. “Entertainment worker” is the term used in the country to refer to these women who engage in sex work.

This tool was developed to assist key stakeholders to prioritize interventions and to increase effectiveness and efficiency in the HIV and AIDS response covering programmatic areas, enabling environment, and development synergy.

Efforts have been made on strengthening partnerships between government, development partners , CSOs and representatives of PLHIV/MARPs from the national to the local level to improve the policy and legal environment to support programmatic interventions on HIV prevention, treatment and care, and impact mitigation. These efforts include the following:

1. With the directive of the Council of Rehabilitation and Development Board (CRDB) of the Council of Development of Cambodia (CDC), HACC has been selected as the NGO representative to sit on the Government-Donor Joint Technical Working Group (GDJTWG) on HIV and AIDS.
2. With support from UN and Development Partners, the Forum of Networks of PLHIV and MARPs (FONPAMs) has been used to select the representation of CSOs/CBOs for the new membership of the Country Coordinating Mechanism (CCM) for the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), in response to eligibility criteria of the New Funding Model approach.
3. At the grassroots level, the Cambodia 3.0 initiative (with its associated standard operating procedures (SOPs)) has been guiding the selection of proportionate numbers of outreach workers and Self Help Groups to connect with MARPs in hot spot areas and PLHIV in affected communities, respectively.

The above mechanisms open an interface for duty bearers and rights holders at various levels to ensure that the marginalized, the disadvantaged and the excluded regain their rights with equitable access to health and non-health services.

Along with the institutional support for partnership collaboration, representatives of CSOs, PLHIV and MARPs have joined the National Legal and Policies Technical Working Group which constitutes a part of the coordination mechanism for the implementation of the National Strategic Plan III. Additionally, their involvement in the consultation meetings with government and development partners in the National Legal Review for the HIV and AIDS response in 2013 offered them another opportunity to influence government policy makers and program implementers to revisit the gap between policy development and policy implementation. Recommendations of the Global Commission on HIV and the Law were used as a key reference throughout the review process. Besides the recommendations on key affected population (KAPs), the National Legal Review suggested an update of the National Youth Policy to specifically address the HIV and sexual and reproductive health needs of young people living with HIV, young people who use drugs and young people who are MSM or transgender or those who sell sex.

A current problem is that duty bearers and rights holders have different perceptions on what an enabling environment approach entails for the response to HIV and AIDS. Some MARPs may expect a wider policy ‘space’ which can address the decriminalization of sex work and the legal identity of MSM and transgender persons. Duty bearers have another view which is focused on safety and universal access to health services for MARPs and PLHIV. The duty bearers, who are mainly government officials, must adhere to the national constitution. From this perspective, some MARPs may express their

dissatisfaction which goes beyond the responsibility areas of public health, public security and local authority officers.

The Health Sector review, which was undertaken in mid-2013, calls for concerted efforts between stakeholders to sharpen epidemiological targeting and expand more effective interventions at sufficient intensity and scale, in order to identify the few new HIV infections and introduce earlier treatment to harness the dual benefits of mortality reduction and prevention among those at highest risk. However, over the past two years, the transition from the previous approach to the development and roll-out of the Cambodia 3.0 initiative (along with revised SOPs on the Boosted Continuum of Prevention to Care and Treatment (CoPCT), Boosted Continuum of Care and Boosted Linked response) has required a lot of programmatic, financial and administrative preparation both at national and sub-national levels. Other challenges in recent years have included the shift from direct food support towards the adoption of HIV-sensitivity within social protection schemes at the end of 2012, and the lack of incentive support for health care workers in 2013 along with governance and fiduciary measures.

To better reach the unreached MARPs (including entertainment workers, female and male sex workers, men-having-sex-with-men, transsexual and transgender persons and drug users), a supportive legal and policy environment will need to be further strengthened in light of improved scientific understanding of the epidemiology of HIV in Cambodia, and technological advances. Over the past two years, the government sector (health, public security, local authority) and NGOs/CBOs have worked together in Phnom Penh and a few provinces to strengthen mechanisms between national and sub-national levels to provide an enabling environment supportive of MARPs working/living in hotspot areas. With the expansion of the Police Community Partnership Initiative (PCPI), the capacities of rights holders (particularly PLHIV and MARPs) and duty bearers (including the Ministry of Health (MoH), Ministry of Interior (MoI), Ministry of Labour and Vocational Training (MoLVT), National Authority for Combating Drugs (NACD) and other relevant ministries) have been upgraded through sensitization workshops that address misunderstanding on law and policies related to MARPs.

The decrease in international funding by 20% from 2010 to 2012 reported in the latest NASA, along with expensive AIDS spending per capita ($3.4 for Cambodia as compared to only $1.4 for regional median), requires rationalization of governance and program architecture. Attempts are being made to scale back architecture and make it more efficient. The common decision of the GDJTWG in choosing the "PBA (Program Based Approach) established and functional for Prevention, Treatment and Impact Mitigation" as an expected output of the Joint Monitoring Indicators (JMIs) for 2012-2013, is a critical step on the road for the implementation of Aid and Development Effectiveness at the country level. The Mid-Term Review of the High Level Meeting on the United Nations General Assembly 2011 Political Declaration on HIV and AIDS (held in June 2013) recommended support to the country system especially on governance and accountability, in order to influence key sectors/institutions which are running HIV/AIDS projects to "do more with less" and minimize as much as possible the waste, duplication and the incoherence among their projects.

Overview of GARP indicators

The table below shows the values for the GARPR indicators for the current reporting period, as well as from the GARPR 2012 reporting period for comparison. Note the following:

- The "Status" column indicates whether an indicator has decreased (↓), increased (↑), or remained roughly stable (—) between GARPR 2012 and GARPR 2014.
- The "Online data" columns show whether complete data were submitted online for a given indicator.
  "Completed" means data which adhere to the GARPR definitions were submitted online.
  "Partially" means data were submitted online, but the data did not exactly match the GARPR definitions. This includes cases where an indicator is based on multiple variables (e.g. multiple questions from a population-based survey) but not all of the variables had data available, or when disaggregated data were not available.
  "Incomplete" means no data were submitted online for that indicator.

Indicators	GARPR 2012			GARPR 2014			Status
	Value	Source	Online data	Value	Source	Online data	
Target 1: Reduce sexual transmission of HIV by 50% by 2015							
General population							
1.1 Young people: Knowledge about HIV prevention	45.1%	CDHS (2010)	Completed	45.1%	CDHS (2010)	Completed	—
1.2 Sex before the age of 15	0.4%	CDHS (2010)	Completed	0.4%	CDHS (2010)	Completed	—
1.3 Multiple sexual partners	0.8%	CDHS (2010)	Completed	0.8%	CDHS (2010)	Completed	—
1.4 Condom use at last sex among people with multiple sexual partnerships	40.9%	CDHS (2010)	Completed	40.9%	CDHS (2010)	Completed	—
1.5 HIV testing in the general population	7.1%	CDHS (2010)	Completed	7.1%	CDHS (2010)	Completed	—

1.6 HIV prevalence in young people	Not reported (0.2%)[2]	HSS (2010)	Incomplete	0.2%	HSS (2010)	Partially	—
Sex workers (entertainment workers)							
1.7 Sex Workers: prevention programmes			Incomplete			Incomplete	
1.7.1 Correct answer to question 1 "Do you know where you can go if you wish to receive an HIV test?"			Incomplete	75.7%	BSS (2013)	Partially	
1.7.2 Correct answer to question 2 "In the last twelve months, have you been given condoms?"			Incomplete	43.1%	BSS (2013)	Partially	
1.8 Sex workers: condom use	Not reported (94.8%)	BSS (2010)	Incomplete	94.3%	BSS (2013)	Partially	—
1.9 HIV testing in sex workers			Incomplete	68.3%	BSS (2013)	Partially	
1.10 HIV prevalence in sex workers	13.9%	HSS (2010)	Partially	13.9%	HSS (2010)	Partially	—
Men who have sex with men							
1.11 Men who have sex with men: prevention programmes	69.5%	BK[3] (2010)	Completed			Partially	
1.11.1 Correct answer to question 1 "Do you know where you can go if you wish to receive an HIV test?"	79.8%	BK (2010)	Completed	86.7%	BSS (2013)	Partially	↑
1.11.2 Correct answer to question 2 "In the last twelve months, have you been given condoms?"	81.4%	BK (2010)	Completed	49.2%	PSK (2012)	Partially	↓
1.12 Men who have sex with men: condom use	66.4%	BK (2010)	Completed	87%	PSK (2012)	Partially	↑
1.13 HIV testing in men who have sex with men	34.0%	BK (2010)	Completed	86.8%	BSS (2013)	Completed	↑
1.14 HIV prevalence in men who have sex with men	2.1%	BK (2010)	Completed	2.1%	BK (2010)	Completed	—
2 Reduce transmission of HIV among people who inject drugs by 50% by 2015							
People who inject drugs							

[2]No data were submitted online in GARPR 2012, but there were some relevant data from the HSS 2010 which were mentioned in the narrative report. The statistic is provided here for reference.

[3] BROS Khmer study (2010)

2.1 Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	120	MS[4] *et al.* (2012)	Completed	1,140	IBBS (2012)	Completed	↑
2.2People who inject drugs: condom use	81.3%	BSS (2007)	Partially	69.1%	IBBS (2012)	Partially	↓
2.3People who inject drugs: safe injecting practices	62.2%	BSS (2007)	Partially	34.0%	IBBS (2012)	Partially	↓
2.4HIV testing in people who inject drugs	35.3%	BSS (2007)	Partially		BSS (2010)	Incomplete	
2.5HIV prevalence in people who inject drugs	24.1%	BSS (2007)	Partially	24.8%	NACD (2012)	Partially	—
3 Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths							
3.1 Prevention of mother-to-child transmission	65.1%	NMCHC (2012)	Partially	72.3%	NMCHC (2013)	Partially	↑
3.1a Prevention of mother-to-child transmission during breastfeeding			Incomplete			Incomplete	
3.2 Early infant diagnosis	33.2%	NCHADS (2012)	Completed	45.4%	NCHADS (2013)	Completed	↑
3.3 Mother-to-child transmission of HIV (modelled)			Incomplete	7.1%	NCHADS (2013)	Completed	
4 Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015							
4.1 HIV treatment: antiretroviral therapy	81.5%	NCHADS (2012)	Partially	68.0%[5]	NCHADS (2013)	Partially	↓
4.2a 12 months retention on antiretroviral therapy	87.0%	NCHADS (2012)	Partially	84.5%	NCHADS (2013)	Partially	↓
5 Reduce tuberculosis deaths in people living with HIV by 50% by 2015							
5.1 Co-management of tuberculosis and HIV treatment	32.7%	CENAT (2012)	Partially	40.7%	CENAT (2013)	Partially	↑
6 Close the global AIDS resource gap by 2015							
6.1 AIDS spending	58M	NAA (2011)	Completed	51M	NAA (2013)	Completed	↓

[4] Mith Samlanh

[5] This is based on a different definition of the denominator than was used in GARPR 2012. Using the same definition for the denominator as in GARPR 2012, the percentage for GARPR 2014 would be 83%. Please see the section on Target 4 in this report for more details.

7 Eliminating gender inequalities							
7.1 Prevalence of recent intimate partner violence	9.0%	CDHS (2010)	Partially	9.0%	CDHS (2010)	Partially	—
8 Eliminating stigma and discrimination							
8.1 Discriminatory attitudes towards people living with HIV						Incomplete	
10 Strengthening HIV integration							
10.1.1 Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	69.7%	CDHS (2010)	Partially	69.7%	CDHS (2010)	Partially	—
10.1.2 Current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent	81.5%	CDHS (2010)	Partially	81.5%	CDHS (2010)	Partially	—
10.2External economic support to the poorest households	27.2%	CDHS (2010)	Completed			Incomplete	

NOTES ON DATA SOURCES

For the reporting of GARPR 2014, there are two sources of data which are being used for the narrative report and the online report: a) NCHADS new projections in 2012 and b) the combined version of NCHADS new projections 2012 and Spectrum 5.

NCHADS is in the process of organizing an extensive consultation with the international and local experts to come up with new modeling of projection using combined version of NCHADS new projections 2012 and Spectrum 5.

Due to time constraint for this reporting exercise and the pending result of the upcoming consultation, it was decided that this 2014 GARPR reporting will use:

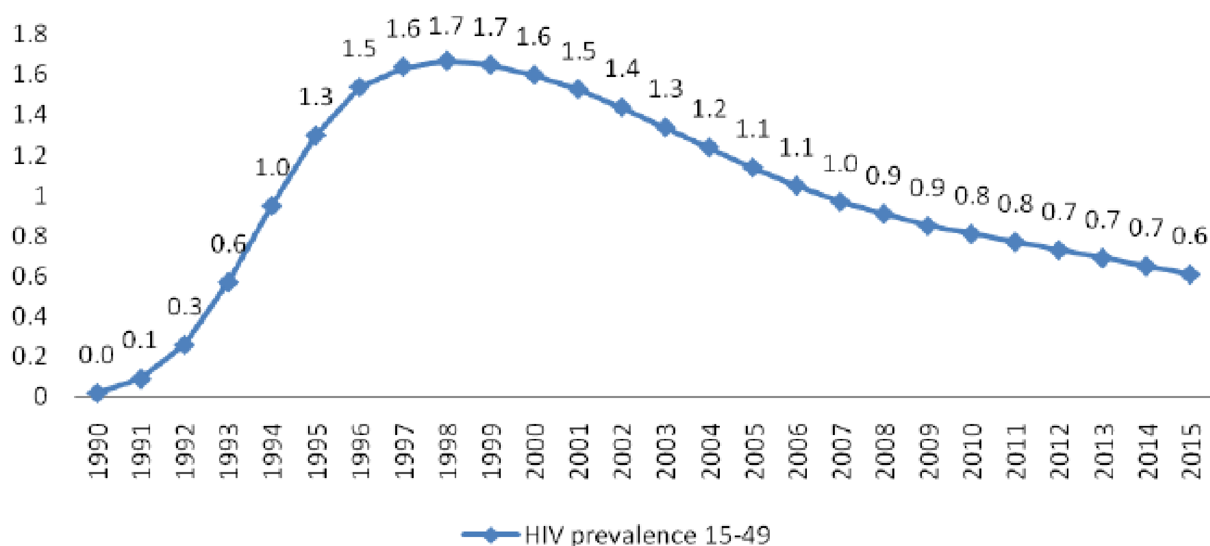
- The NCHADS new projection of 2012 for the overview of HIV and AIDS epidemic
- For the national response to HIV and AIDS epidemic, relevant targets which use the numerator and/or denominator relating to the projection, two data will be provided for each indicator (i.e. target 3, target 4 and target 5).
- For the online reporting, it was decided that the combined version of NCHADS new projection 2012 and Spectrum 5.03, will be used to update those data.

OVERVIEW OF THE AIDS EPIDEMIC

HIV prevalence

According to the NCHADS report "*Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015*", the prevalence of HIV among the general population aged 15-49 years old was estimated to be 0.7% in 2013. HIV prevalence in Cambodia has been steadily declining for over a decade which is due in part to targeted HIV prevention activities and widespread coverage of antiretroviral treatment (ART) which reduces the viral load of people on ART, decreasing their chances of transmitting the virus to others.

Figure 1: HIV prevalence among general population, aged 15-49
(source: NCHADS (2011) Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015)



HIV prevalence is substantially higher for certain MARPs, however. The most recent HIV prevalence among MARPs based on various studies are:

Most-at-risk population	Estimated HIV prevalence	Data source
Men who have sex with men	2.1%	BROS Khmer study (2010)
Female entertainment workers	13.9%	HSS 2010
People who inject drugs	24.8%	IBBS 2012
Transgender people	-	Not available
Prisoners	-	Not available

HIV incidence

The graphs below show that HIV incidence has also been decreasing, among both adults and children. In 2013, an estimated 1,093 adults aged 15+ and 46 children aged 0-14 was newly infected with HIV. HIV incidence is projected to decrease even further for both adults and children in the coming years.

Figure 2: Number of individuals and females aged 15+ newly infected with HIV
(source: NCHADS (2011) Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015)

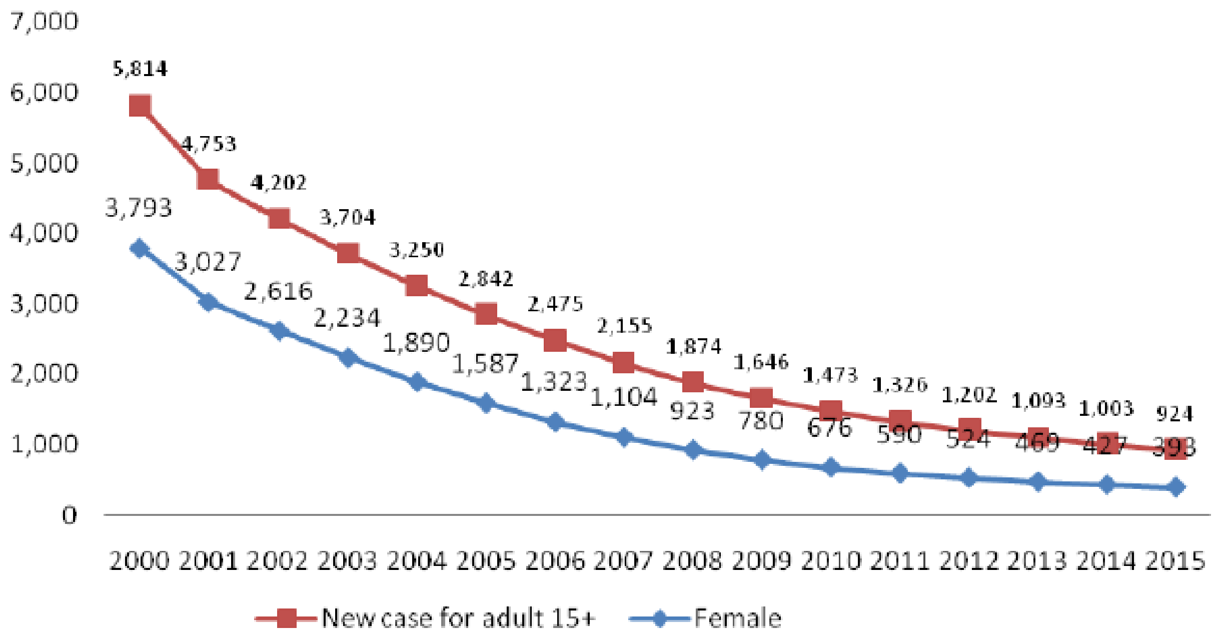
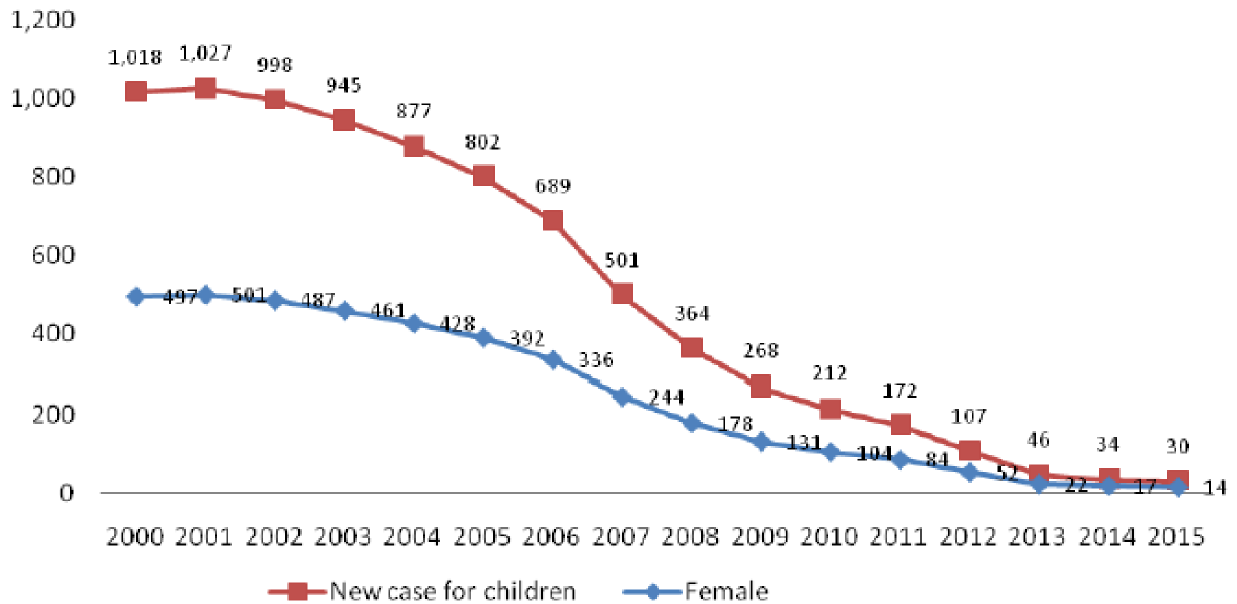
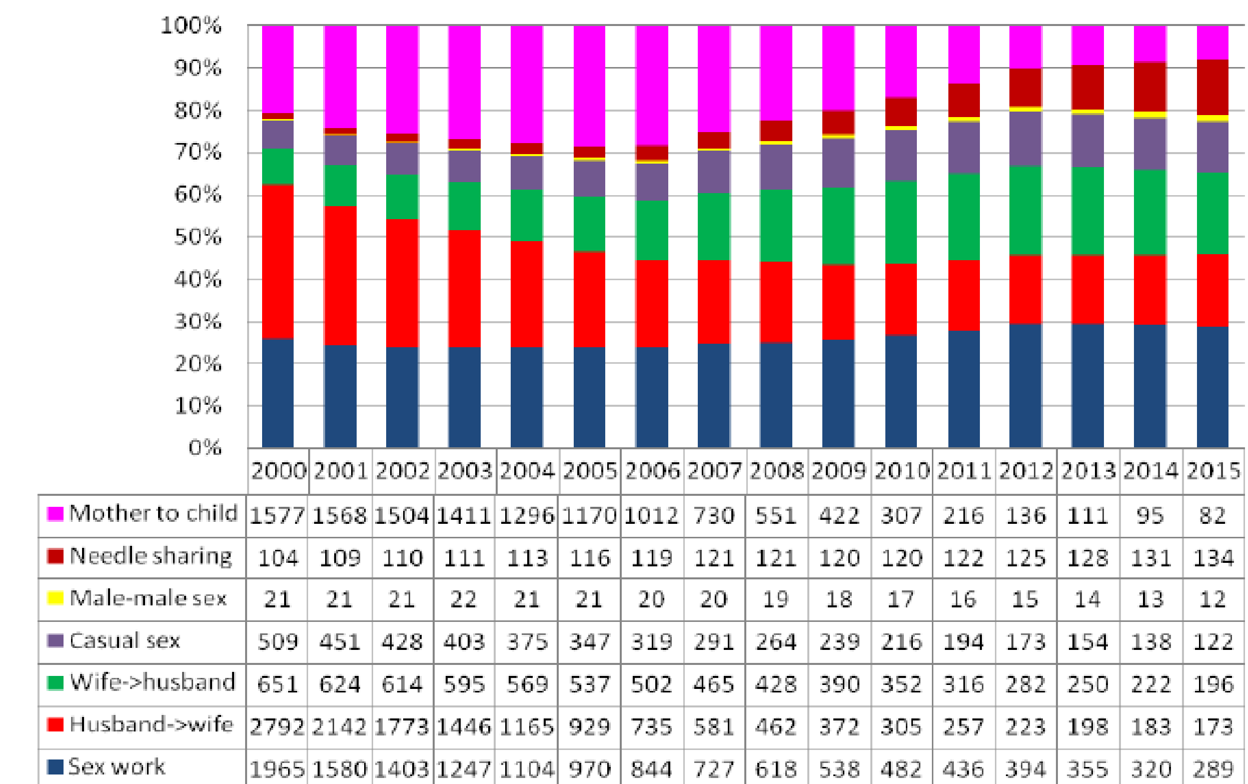


Figure 3: Number of new HIV cases among children aged 0-14 years, 2000-2015 (source: NCHADS (2011) Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015)



The graph below shows modes of transmission for new HIV cases. Roughly one-third of new cases are believed to result from spousal transmission. The graph also highlights the significant role of sex work in HIV transmission and the troubling increase in the proportion of new infections resulting from needle sharing.

Figure 4: Proportion of new HIV cases by different modes of transmission, 2000-2015 (source: NCHADS (2011) Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Mother to child	1577	1568	1504	1411	1296	1170	1012	730	551	422	307	216	136	111	95	82
Needle sharing	104	109	110	111	113	116	119	121	121	120	120	122	125	128	131	134
Male-male sex	21	21	21	22	21	21	20	20	19	18	17	16	15	14	13	12
Casual sex	509	451	428	403	375	347	319	291	264	239	216	194	173	154	138	122
Wife->husband	651	624	614	595	569	537	502	465	428	390	352	316	282	250	222	196
Husband->wife	2792	2142	1773	1446	1165	929	735	581	462	372	305	257	223	198	183	173
Sex work	1965	1580	1403	1247	1104	970	844	727	618	538	482	436	394	355	320	289

AIDS-related mortality

The trends for AIDS-related mortality differ for adults vs. children. AIDS deaths among children aged 0-14 years were projected to continue declining up to 2015 and perhaps beyond. However, AIDS-related deaths among adults were projected to increase slightly and plateau after the steep decline before 2010. The authors of the *Estimations and Projections* (NCHADS, 2011) report speculated that this may be a result of emerging resistance to ARVs.

Figure 5: Number of AIDS deaths among adults aged 15+, 2000-2015 (source: NCHADS (2011) Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015)

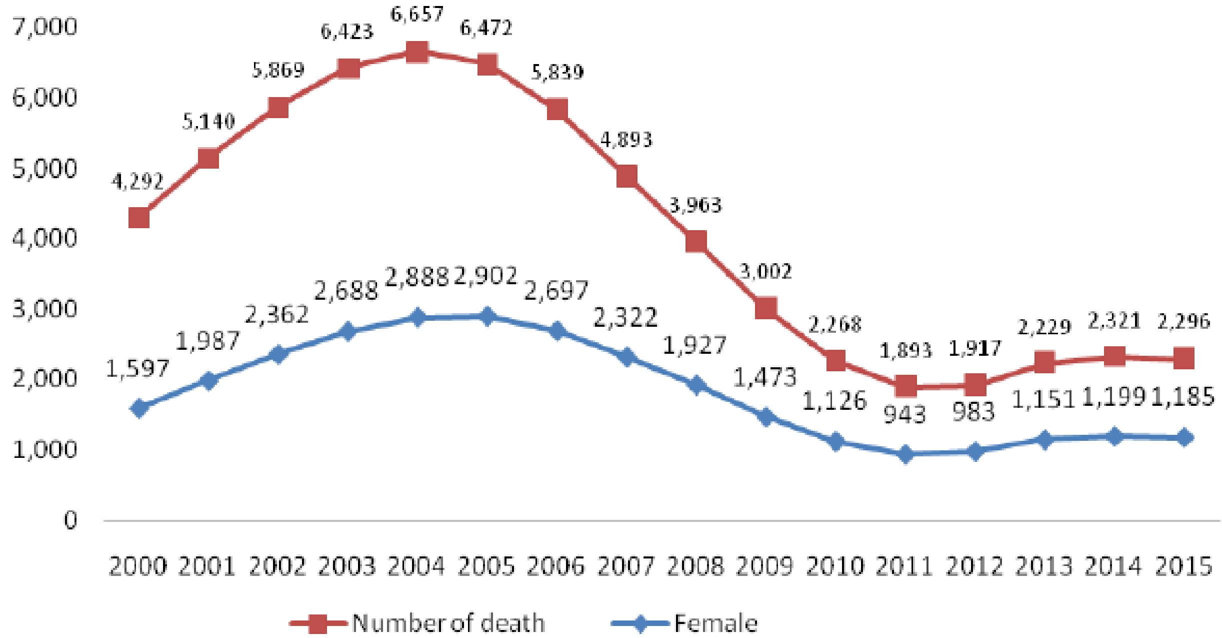
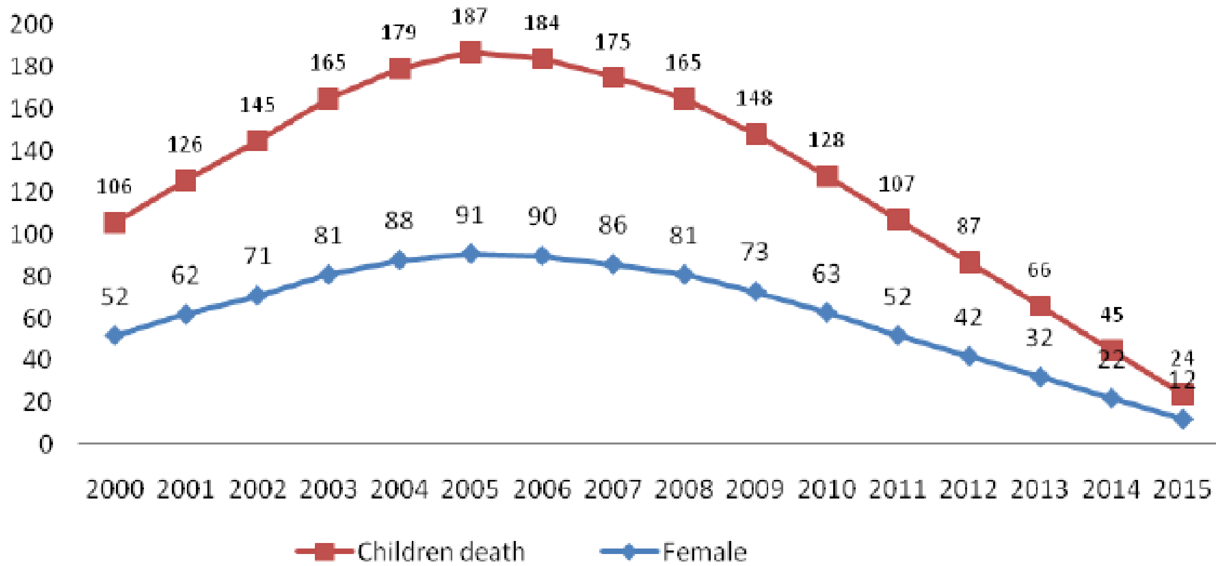


Figure 6: Number of AIDS deaths among children aged 0-14 years, 2000-2015 (source: NCHADS (2011) Estimations and Projections of HIV/AIDS in Cambodia, 2011-2015)



NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Target 1: Halve sexual transmission of HIV by 2015

GENERAL POPULATION

There were no new data for the general population indicators numbered 1.1 through 1.6. The most recent data for these indicators come from the 2010 CDHS. The next CDHS is scheduled to be conducted in the next few years, at which point progress against these indicators can be measured.

There have been a number of efforts in the past two years which could have a positive impact on these indicators. For example, HIV knowledge and prevention behaviors among youth will hopefully increase since the *Life Skill Curriculum on Sexuality and HIV Education* was finalized and rolled out, reaching over 100,000 students to date. Sexuality education has also been integrated in the new five-year *Education Strategic Plan (2014-2018)*.

ENTERTAINMENT WORKERS

As mentioned earlier in this report, the closure of brothels made it harder to identify and reach women engaged in sex work. Many women who previously sold sex directly moved to entertainment establishments such as karaoke bars, beer gardens, casinos, bars, and night clubs, and were therefore called “entertainment workers”. Since this change, some studies which sample entertainment workers have made a distinction between higher-risk entertainment workers, defined as those having more than 2 clients on average per day, from entertainment workers who have 2 or fewer clients on average per day.

The most recent relevant data for indicators related to entertainment workers come from the BSS 2013. In the BSS 2013, most of the women had 2 or fewer clients on average per day, and so the GARPR 2012 statistics in this section exclude entertainment workers with more than 2 clients on average per day.

Indicator 1.7 measures HIV prevention programme coverage for sex workers, defined as the percentage of sex workers who answered “yes” when asked (a) if they know where to go to receive an HIV test, and (b) whether they had been given condoms in the last 12 months. There is some evidence that HIV prevention programme coverage for sex workers has decreased since GARPR 2012 according to this definition. The BSS 2013 reported the percentage of sex workers who know where to go for an HIV test (76%) separately from the percentage of sex workers who had been given condoms in the last 12 months (43%). This means that the highest possible percentage of sex workers who answered yes to *both* questions is 43%. This is a decrease from GARPR 2012, where 69% of a comparable sample of entertainment workers answered “yes” to both questions.

Condom use among sex workers with their last paid client has remained stable. In GARPR 2012, the proportion of entertainment workers who used a condom with their last client was 95%. In GARPR 2014,

the proportion was similarly high at 94%. However, consistent condom use with clients was just above 80% in both GARPR reporting periods.

HIV testing among entertainment workers has steadily increased over the years. In 2007, 52% of indirect female sex workers had taken an HIV test in the previous 12 months and knew their results. This increased to 64% in the GARPR 2012 reporting period, and increased again to 68% in the BSS 2013.

Despite the decrease in the HIV prevention programme coverage indicator (1.7), condom use with clients appears stable and HIV testing has increased slightly since the last GARPR. Furthermore, new initiatives have been rolled out in recent years targeting entertainment workers. Among these is the national Cambodia 3.0 strategy which aims to eliminate new HIV infections by 2020, in part by improving and better targeting prevention services for MARPs through the implementation of the Boosted Continuum of Prevention to Care and Treatment SOP along with several initiatives such as finger prick testing, partners tracing, etc. In order to ensure that services can be provided well to MARPs (including EWs) a comprehensive GIS Mapping exercise of MARPs population was conducted in late 2013 by the Flagship Team covering Phnom Penh (all five operational districts) and five hotspot provinces. The recent preliminary exploration of unreached PWID in Phnom Penh (supported by WHO) has also contributed to improve in depth-knowledge of EW who also inject heroin.

While there is no new prevalence data for entertainment workers in this reporting period, these enhanced prevention activities will hopefully contribute to a decline in HIV prevalence among this population.

MEN WHO HAVE SEX WITH MEN

Much of the data for MSM are not directly comparable from GARPR 2012 to 2014 due to differences in research methodology and the way findings were reported. However, the evidence suggests that there have been improvements since the last GARPR reporting period.

The available data show an increase in the proportion of MSM who know where to get an HIV test, from80% in 2010 (BROS Khmer study) to *at least*87% in 2013 (BSS 2013): while the BSS 2013 study did not report the proportion of MSM who knew where to get an HIV test, the study showed that 87% of MSM in the sample had an HIV test in the previous 12 months, which means that at least this percentage of MSM knew where to get tested. The HIV testing rate of 87% is also a very large increase from GARPR 2012, when only 34% of the MSM surveyed had received an HIV test in the previous 12 months.

Further, condom use among MSM appears to have increased. In GARPR 2012, this indicator was reported as 66%, and in GARPR 2014, it was 87%. The definitions of condom use differed between the two reporting periods but it seems unlikely that this increase is purely an artefact of the different definitions: the 66% from GARPR 2012 refers to the proportion of MSM who used a condom the last time they had anal sex, whereas the Population Services Khmer (PSK) data used in GARPR 2014 refer to

the proportion of MSM who reported consistent condom use (i.e. not differentiating between types of sexual acts). Further, the PSK data come from a series of studies on MSM which have shown an increase in condom use compared to before.

There were no new estimates of HIV prevalence among MSM generated during the past two years.

For all MARPs, a priority area of action will be to empower communities to implement finger-prick testing to accelerate case detection. It will also be important to engage key implementers and introduce innovate monitoring systems to track and retain cases throughout the HIV cascade.

Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

Efforts to reduce HIV transmission amongst people who inject drug have been hampered by the current legal and policy environment (i.e. the Law on Human Trafficking and Sexual Exploitation, the Village Commune Safety Policy, and most recently, the new law on drug control) which have driven people underground, while at the same time disturbed current needle and syringe programme (NSP) service delivery.There are not many studies on PWID in the country. The 2012 IBBS suggests that there are around 1,300 PWID in the country, of whom more than 90% are believed to be opiate injectors. It is important to stress that after consistent attempts made by relevant NGOs, they could only reach 350 PWID (in total) so far because of the reason mentioned above. A recent preliminary exploration of unreached PWID in Phnom Penh conducted by WHO's consultant suggests that apart from EWs who inject heroin, there are also other PWID amongst other populations such as rubbish collectors, construction workers, etc., that have not been reached by any NSP.

Indicator 2.1 measures the number of needles and syringes distributed per PWID per year by needle and syringe programmes. The figure given here (1,140 per year) is based on the 2013 NACD/HAARP report which compiled data received from 2 NGOs working on this area (KHANA and Friends International). It was calculated by dividing the total number of needles and syringed distributed (399,000) by the total number of PWID reached (350).

Indicator 2.2 measures condom use amongst people who use drugs. The 2012 IBBS included two questions regarding condom use: a) "Used a condom last time had sex with non-regular partners" where 88.1% of respondents answered "Yes", and b) "Always used a condom with non-regular partners in the past 12 months" where 68.8% of respondents answered "Yes". After weighting, condom use amongst PWID was calculated as 69.1%. The poorer coverage as compared to the previous report is because of the reason mentioned above.

Indicator 2.3 measures safe injecting practices amongst PWID. The 2012 IBBS used the question: "Use only new needles and syringes in the past month" to which the response was 34%. The lower coverage as compared to the previous report is because of the reason mentioned above.

Indicator 2.4 measures HIV testing in PWID. Neither the 2012 IBBS nor other studies capture this information.

Indicator 2.5 measures HIV prevalence in people who inject drugs. The 2012 IBBS shows that the HIV prevalence amongst this population was 24.8%. This percentage would have been much better if the country did not experience major legal and policy constraints.

Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

Indicator 3.1 measures prevention of mother-to-child transmission.

- The monitoring data of NMCHC (2013) indicates that there were 691 HIV+ pregnant women who received ARV in the past 12 months to reduce mother-to-child transmission. This excludes 108 women who received single dose Nevirapine at a private facility.
- Using NCHADS projection 2012 and Spectrum 5, the denominator is 956 in 2013 (i.e. the number of HIV-positive pregnant women who received ART medicines during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery). Using this denominator, the value for this indicator is 72.28%. (For reporting online this figure will be used).
- Using NCHADS projection 2012, the denominator (number of HIV-positive pregnant women who received ART medicines during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery) is 1,194 in 2013 and which gives the rate of 57.87%.
- With the implementation of the Boosted Linked Response, the adoption of Option B+, the adoption of streamlined HIV testing and counselling with finger prick and lay counsellors, linkage of longitudinal follow up by NCHADS and NMCHC along with the cascade of service provision for mother to child, the progress of this indicator has increased from 65.10% to 72.28%.

Indicator 3.2 measures early infant diagnosis.

- Using NCHADS projection 2012, the denominator would be 1,194 and the rate will be 36.3%.
- Using the combined NCHADS projection 2012 and the Spectrum 5.03, the denominator would 956 which gave the percentage of 45.40%. This rate is used for online reporting.
- The progress of this indicator from 33.2% in 2012 to 45.40% is the result of the implementation of the Boosted Linked Response, the paediatric coverage, the strengthening of family continuum approach that provides comprehensive services in HIV and AIDS testing and care for the family of any HIV infected individuals including children.

Indicator 3.3 measures mother-to-child transmission of HIV.

- Using NCHADS projection 2012 and Spectrum 5, the numerator (new HIV infection amongst infants 0-14 years old) is 68 in 2013 and the denominator (estimated number of HIV+ women who delivered the previous 12 months) is 956, which gives the rate of 7.11%. (For reporting online this figure will be used).
- Using NCHADS projection 2012, the numerator (new HIV infection amongst infants 0-14 years old) is 46 in 2013 and the denominator (estimated number of HIV+ women who delivered the previous 12 months) is 1194, which gives the rate of 3.85%.

- A national consultation for HIV projection for 2014-2020 will work on updating the data (numerator and denominator) and will provide more accurate data for these indicators.

Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

ART COVERAGE

ART coverage (indicator 4.1) has remained at over 80% for several years and was 83% in 2013, when calculated out of the number of people eligible for ART according to national guidelines (i.e. CD4 count below 350):

$$\frac{\text{Number of adults and children on ART}}{\text{Number of adults and children eligible for ART}} = \frac{50{,}659}{61{,}328} = 83\%$$

ART coverage according to the national eligibility guidelines did not differ much based on gender (82% of males vs. 83% of females) or age (85% of those aged 14 and under vs. 82% of those over 14 years old).

The relatively high coverage of ART among those eligible for treatment can be attributed to solid political commitment, as well as the strong collaboration between health facilities and the community which is built into national strategies. Such strategies include the Boosted Continuum of Care and Treatment, and Treatment as Prevention, both of which have begun to be rolled out in the past two years.

Note that for this reporting period, the denominator of indicator 4.1 was changed to *all* PLHIV, and not just those eligible for ART under global or national guidelines. This was done in order to facilitate comparisons across countries which may have different eligibility criteria for the initiation of ART. Based on this new definition, ART coverage in 2013 was calculated as 68%:

$$\frac{\text{Number of adults and children on ART}}{\text{Total number of PLHIV}} = \frac{50{,}659}{74{,}500} = 68\%$$

In order to maintain high coverage and quality of treatment services, Cambodia has been working in recent years to phase out d4t, increase the number of ART sites, and expand services to closed settings.

ART RETENTION

ART retention at 12 months decreased slightly from87% in GARPR 2012 to 85% in GARPR 2014. Of further concern is that retention at 60 months was only 75%. One possible factor that could be contributing to this reduction in ART retention may be the migration of Cambodians to neighboring countries.

The government has been collaborating with partners on activities which should increase retention in the near future. A unique identifier system has begun in the province of Battambang, which should decrease loss-to-follow-up by making it easier to track patients through the health system. Further,

active case management for PLHIV has been piloted, which should also decrease loss-to-follow-up and ensure timely access to ARVs.

EMERGING ISSUES

In 2013, WHO released new guidelines which set the eligibility for ART at a CD4 count of 500. When Cambodia adopts these guidelines, there will be an increase in the number of people who are eligible for ART. In the coming years, attention will need to be given to securing sufficient resources to ensure an adequate supply of ARVs, keeping treatment adherence high and drug resistance low, and introducing second and third line regimens. Potential actions to contribute to these include strengthening procurement and supply management capacity and performance, and utilizing public health-related TRIPS flexibilities to ensure continued access to affordable generic ARVs.

Guided by the global guidelines and the implementation of Cambodia 3.0, the 2013 Health Sector HIV Program Review helped identify priority actions to accelerate case detection, maximize retention, and prepare for sustainability. NCHADS came up with the following game changers to address the priorities action on continuum of prevention, care and treatment by a) empowering community for Finger-Prick Testing among KP to accelerate case detection, b) engaging key implementers across continuum of care to maximize retention and c) innovating monitoring system to track cases throughout HIV cascades.

Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

The numerator for this indicator was calculated from routine monitoring data of CENAT in 2013. The denominator is the estimated number of incident TB cases in PLHIV by CENAT using WHO guidelines for the high TB burden country (2012).

The percentage of referral cases for both sides (TB and HIV and AIDS) increased gradually from 40% in 2007, to 70% in 2009, and to over 80% in 2011-2012 (source: CENAT 2014). The proportion of HIV+ incident TB cases receiving treatment for both HIV and TB increased from 33% in GARPR 2012 to 41% in GARPR 2014. This may be an underestimate of the actual proportion of co-infected cases receiving treatment, since this percentage is based only on data from CENAT and not from NCHADS. Stratified data by age and gender are not available for this indicator.

Cambodia has made progress towards this target in recent years, through continued implementation of the three I's strategy (intensified case-finding, Isoniazid preventive therapy, infection control) and expansion of TB control activities to closed settings. The national clinical guidelines for HIV-TB management have also been revised.

However, there is still a need to strengthen reporting and coordination between the OI/ART clinics and TB clinics in order to provide more accurate data for future analyses and decisions. There are also challenges in terms of finding sufficient funding to provide incentives for staff and to implement the strategic plan for TB. Furthermore, TB detection and case management in closed settings should be

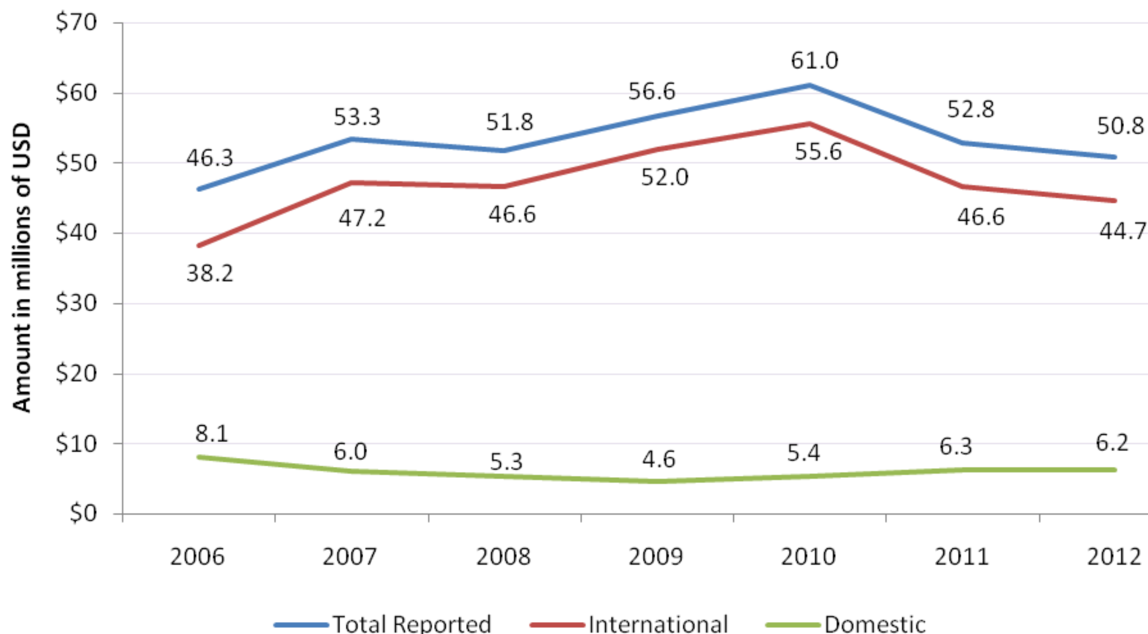
improved, as stated in the SOP for HIV, STI, and TB-HIV prevention, care, treatment, and support in prisons (and correctional centers) in Cambodia.

CENAT is in the process of formulating the 2014-2020 policy and strategic plan for TB control to reach MDG targets. These newly developed policies and strategies will address the identified shortcomings such as the lack of monitoring of TB deaths among PLHIV, as well as TB side effects and failures, including possible resistance to treatment.

Target 6: Close the global AIDS resource gap by 2015

HIV spending in Cambodia has been tracked since 2006 through the National AIDS Spending Assessments. The graph below shows a general trend of increasing funding for HIV/AIDS from 2006-2010, after which spending dropped significantly, primarily due to decreases in funding from international NGOs and the UN.

Figure 7: Total spending on HIV and AIDS, 2006-2012[6]



The Cambodian national HIV/AIDS response still relies for almost 90% of its funding from external sources, although the proportion of funding for the HIV/AIDS response coming from the government has increased.

Currently, it is proposed that Cambodia, as a low-income, high-burden country, will receive75.3 million USD for HIV/AIDS for 3.5 years (from January 2014 to June 2017) from the Global Fund. This works out

[6]Note that the NASA for 2009 and 2010 (NASA III) did not collect government salary data. However, the 2009 and 2010 totals in this graph include *estimates* of government salary expenditure in order to make them comparable to the other years. This is why the totals in this graph for 2009 and 2010 are higher than what is shown in the NASA III report.

to an average of 21.5 million USD per year for HIV/AIDS activities, which is roughly equivalent to the amount provided by GF in the past few years. However, negotiations are underway which may reallocate some of the GF HIV/AIDS funding to other GF areas (e.g. malaria, tuberculosis, health systems strengthening). Furthermore, funding from the US Government, one of the major contributors to the country's HIV/AIDS response, is expected to decline significantly starting in 2014. As a result, Cambodia may need to find other sources of funding and/or try to allocate funding more efficiently.

Further details about spending on HIV and AIDS are provided in the section of this report titled "Support from the country's development partners".

Target 7: Eliminating gender inequalities

PROGRESS MADE

Elimination of gender inequalities and gender-based abuse and violence is a priority target for the country. Significant achievements related to this target since the last GARPR report in 2012 include:

- Development of the HIV-sensitive National Action Plan on Violence Against Women (NAPVAW) and an internal guidance on the integration of gender produced by NGOs/CBOs
- Launch of the UNAIDS/UN Women Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV
- A detailed gender review conducted in 2013 which identified gaps and recommendations related to national laws and policies that impact on gender equality and HIV

At the programme level, key actions include:

- Comprehensive national prevention programmes offering education, referrals and counselling that target EWs, MSM/TG people and female drug users
- "Know Your Rights" training to women living with HIV and key affected women
- Comprehensive sexuality education programme covering sexual reproductive health & gender
- Nation-wide referral and counselling hotline service (Inthanou) for young people on sexual and reproductive health
- Programme that promotes safer workplaces, labour rights, gender empowerment and HIV education and awareness for beer promotion girls
- Mobilization of men and boys in prevention of GBV and HIV
- Create Connections programme which integrates gender equality into youth programmes
- Enhanced government, civil society and PLHIV and MARPs community leadership and action on HIV and Gender/GBV issues, on integrating gender equality into the HIV response, on gender-responsive budgeting, and the monitoring tool for the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) at the national and sub-national levels
- Development and dissemination of new tools, guidelines and training curricula targeting policy and implementation of gender-related programmes
- Programme on economic empowerment of women living with HIV, developing leadership and educating women on gender and leadership

- Working with police for reducing GBV against women and girls

Gender integration in HIV has also been improved. The capacities of local stakeholders on gender and HIV/AIDS, with support from Development Partners, have been strengthened. Gender equality advocates, including government and civil society representatives, were supported to participate in national and intergovernmental policy dialogue processes. Women living with HIV and key affected women gained knowledge and advocacy skills to access reproductive health services without discrimination.

There is also increased evidence on gender and GBV which can inform policies and programming. After the key studies conducted and launched in 2010 and 2011 (the PLHIV Stigma Index, the Most at-Risk Young Population study, and the Gender Audit), a number of studies have been conducted and launched: the Socioeconomic Impact of HIV at the Household Level (conducted in 2012, launched in 2013), the study on GBV (yet to be launched), the Young EW study 2013, and a study on the prevalence of GBV and on-going violence against children using a WHO standard tool.

However, none of these new studies provide data that match the GARPR indicator for Target 7 and so the reported data for the GARPR 2014 is the same as for GARPR 2012, from the CDHS 2010. Further, stakeholders in the national validation meeting held in March 2014 pointed out that the GARPR indicator itself has limitations which may reduce its usefulness in monitoring changes (e.g. it only focuses on physical and sexual abuse).

CHALLENGES

The relationship between HIV and gender/GBV remains a significant issue in Cambodia. It demands a concerted and collective effort to change attitudes, raise understanding of the criminality of violence and support community awareness and involvement in the promotion and protection of gender rights and equality. Gender stereotypes and discrimination are still strong, which leads to impunity and lack of reporting of GBV when it occurs.

The complexity and lack of adequate and consistent evidence and monitoring indicators related to HIV-gender and GBV at the global and national levels leads to limited understanding of issues, policy and programme targeting, and impact.

Another challenge is the lack of technical and financial resources and implementation capacity to expand some successful programs, which are informed by emerging evidence.

Lastly, there are insufficient partnerships between NGOs working on HIV and gender & human rights and the CEDAW committee, as well as insufficient linkages between established mechanisms on HIV and gender, especially at the decentralized level.

Special note was made by the participants in the national validation meeting that the indicator provided for this target at the global level is not adequate, given the importance of gender in the HIV response. Participants strongly recommended the review and inclusion of indicators that can measure GBV against KAPs, as well as the impact of gender inequality and discrimination at the global level.

REMEDIAL ACTIONS

Remedial actions to eliminate gender inequalities include:

- Expand successful programmes, including:
  - those on the social and economic empowerment of women and girls living with or affected by HIV
  - one stop services on GBV for key affected women and children, which address their social, legal and economic needs
- Invest in quality improvements of health services for women and girls, particularly in access to reproductive and sexual health services for PLHIV, women at most risk of HIV, MSM/TG and female IDUs. Make sure such health services are accessible and affordable
- Ensure adequate resources for effective implementation and monitoring of NAPVAW and linkages with the National Strategic Plan on HIV and the Three Zeros strategy. All relevant key stakeholders (community, law enforcement, local authorities, etc.) must be engaged in the implementation of the NAPVAW
- Develop the monitoring and evaluation indicators and monitoring tools, with clear and achievable benchmarks related to gender and HIV
- Allocate sufficient resources for monitoring and addressing gender and HIV issues
- Ensure all new funding proposals include a gender perspective
- Strengthen partnerships between HIV and gender and human rights stakeholders and improve collaboration between these organizations and key affected populations
- Further build evidence to inform advocacy and programming as well as mobilize sustainable resources for addressing gender and HIV issues and sustain high level political leadership of government, civil society and community leaders on gender and HIV issues and promote zero tolerance to GBV

Target 8: Eliminating stigma and discrimination

Although there are no new data for this indicator which is based on the CDHS, the following developments might have some positive impacts on the progress towards reducing discriminatory attitudes, and support for anti-discriminatory policies. The introduction of game changers in the continuum of prevention to care and treatment, and universal access to ART contributes a great deal to the reduction of stigma and discrimination against PLHIV and affected households.

Accelerated HIV case detection, efforts to maximize retention on ART, the introduction of the Cambodia 3.0 framework, and the application of new testing and counseling technology and approaches (e.g. Community Peer Initiated Testing and Counseling (CPITC) and finger prick testing) are contributing to

dramatic changes in the landscape of health care services for PLHIV and all 60,000 HIV-affected households in the country.

Systematic linkages between the community and health facilities through the involvement of 345 existing Home Based Care Teams and845 health centers contributes a great deal to the reduction of stigma and discrimination by increasing awareness that AIDS is no longer a death sentence. This new approach has been engaging PLHIV at national and sub-national levels in addressing aspects of the legal and policy environment which are hampering their access to health and non-health services. The large media coverage showing **Samdach Kittipritbandit Bun Rany Hun Sen** encouraging local people to make use of HIV and AIDS related services has also dramatically contributed to reduced stigma and discrimination on PLHIV and affected households.

On the reporting for Target 8, the disparity between the question asked on stigma and discrimination in the CDHS and the 2014 GARPR Guidelines[7] should be fixed in the next round of the CDHS.

Target 10: Strengthening HIV integration

Data for this indicator were extracted from CDHS 2010. For the 2014 GARPR, there is no updated information for current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age).

However, there are interesting findings comparing the schooling of HIV affected households (n=2,623) and non-affected households (n=1,349) in a study supported by UNDP in 2010 on the socio-economic impact of HIV at the household level in Cambodia:

- Overall, attendance levels between households were statistically equal (86% versus 85%). However, children In HIV-affected households still face many challenges which decrease school performance, and there are large disparities in repetition rates, especially for girls (22% versus 16%).
- Children from HIV-affected households also miss more school than their non-affected counterparts (15% against 12%).

It is also worth mentioning that household members (≥5 years of age) were found to be less educated in HIV-affected households as compared to non-affected households (30.5% against 37%).

Education level of household members (≥5 YOA)	HIV-affected HHs (n=2,623)	Non-affected HHs (n=1,349)
No school	9.3%	7.8%
At least some primary school	60.1%	55%
At least some secondary school	30.5%	37%

[7] In the 2014 GARPR guidelines, this indicator is composed of data from multiple questions, one of which is "Do you think children living with HIV should be able to attend school with children who are HIV negative?" The 2010 CDHS only included a question asking whether respondents thought a female teacher with the AIDS virus who is not sick should be allowed to continue teaching.

For indicator 10.2 (external economic support to the poorest households), it is hard to provide data for this indicator when external economic support is defined as free economic help (cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter) that comes from a source other than friends, family or neighbours unless they are working for a community-based group or organization. The CDHS 2010 does not have data which matches the GARPR definition for this indicator.

Regarding the phasing out of direct food support to HIV and AIDS-affected households in December 2012, a group of institutions and CSOs/CBOs convened with NAA (December 2013) to provide information about their respective contributions to this phase-out as part of the process of reprogramming and the development of Phase II of the SSF HIV Grant of GFATM. It was found that 20,693 out of 60,000 households did receive food support from different sources in 2012. Although new initiatives have been formulated in HIV-sensitive social protection schemes in 2013, there are concerns that the lack of food support would trigger adults of affected households to migrate far away from their hometowns to find jobs and subsequently adherence would be an issue. It is questionable whether those HIV-affected households can come out of poverty at the same pace as the rest of the population (1% moving out of poverty every year).

BEST PRACTICES

In response to the country context where the legal and policy environment has been hampering the national response on HIV and AIDS, PCPI stood out to be the first ever initiative which brings together institutions from different areas (i.e. Ministry of Interior, NAA, health system at the national and provincial level, NGOs and MARPs community and networks) to work together in securing safe spaces conducive to HIV responses targeting highest risk MARPs. Despite its slow start (since late 2010) when the managing authority was given to NAA, the current arrangement provides authority to the Ministry of Interior with close technical backup and monitoring by NAA. This initiative was created at a time when the country had been experiencing many obstacles (i.e. raids of entertainment establishments, frequent arrests of EW or MSM) while delivering services to MARPs. It aims to minimize such barriers, and thereby, allow good opportunities for service providers to do their jobs and serve MARPs.

Importantly, the PCPI structure was fully integrated into the coordination and management structure of the Boosted CoPCT SOP (of NCHADS), which implies that at all levels of the coordination and management of said SOP (from national to provincial level), there will be the presence of police (and other members as stated above) whose primary role will be to contribute to coordinate and facilitate any interventions aiming at MARPs as deemed necessary. This would mean that, for a particular hotspot province which has received PCPI training and once the coordination and management of the SOP is put in place, it is expected that service providers will have the freedom to fulfill their tasks in reaching and

serving MARPs. From the MARPs' point of view, they will no longer be fearful of police and local authority, and therefore, there will be more chance for them to come forward and seek services.

This initiative has proven to be critical as it was developed at a time when the country's effort was being intensified to reach the highest risk MARPs including those who also inject heroin; and this responds rightly to the global trend to move toward highly efficient and highly effective performance. Based on the experience and momentum gained so far, in 2014, it is likely that the PCPI will show more visible results in terms of fixing and transforming coordination complexity into a smooth and conducive environment in support of HIV responses targeting MARPs.

The second best practice which is also worth capturing was the whole process of development of the Boosted CoPCT SOP for MARPs, which involved a high level of enthusiasm and commitment from the leadership of NCHADS and all concerned partners (UN and NGOs). It should be said that this particular document has been the most thoughtful document in the history of drafting any SOPs or guidelines of NCHADS, with a very high level of participation of many partners including MARPs.

Linked to this interesting exercise some ten more key documents such as the Boosted Linked Response, the Boosted Continuum of Care, the Conceptual Framework on Cambodia 3.0, as well a number of related initiatives (e.g. finger prick testing, partner tracing, etc.) were also successfully developed in a very intensive manner over a period of one year and a half. A number of them have already been used for trainings at the national and provincial levels.

This remarkable achievement depicts the true commitment of the government institutions and development partners including MARPs and a good culture of open and constructive collaboration amongst different players in the field of HIV and AIDS. Should this momentum be well maintained, there will be a very good chance that the country would be able to be more productive and more effective in moving its HIV and AIDS response forwards.

MAJOR CHALLENGES AND REMEDIAL ACTIONS

Progress made on key challenges reported in 2012 Country Progress Report

Recognizing that the enabling environment continues to be one of key challenges for the country in terms of supporting HIV and AIDS related interventions, NAA, the Ministry of Interior and key partners have been working very hard to implement key activities of the PCPI during the reporting period using the GFATM money. Introduced since late 2010, this initiative greatly transformed the landscape for HIV and AIDS responses in the country. Specifically, there has been closer partnership of the Ministry of Interior, the MARPs community, relevant NGO partners, and health care workers at the operational district level through this first ever initiative where all members (of the PCPI mechanisms at the national and provincial levels) will equally play a core role in creating and sustaining safe spaces in support of HIV

and AIDS responses in the country. However, much effort is still needed to train PCPI implementers amongst hotspot provinces so as to ensure that it is well understood and effectively applied across the country.

Linked to the above topic of enabling environment, the legal environment of the country, and in particular the Law on the Suppression of Human Trafficking and Sexual Exploitation was perceived to have created much controversy and negative impact upon MARPs especially those involved in sex work; while at the same time, it has also greatly affected service delivery for these populations. Similarly, the village and commune safety policy constitutes another key challenge which has also contributed to not only disrupt HIV and AIDS interventions but also to drive the target populations underground making current efforts to reach and serve them even more complicated. Faced with these major legal and policy challenges, much energy was spent by focal points of NAA, Ministry of Interior and partners in using the PCPI as a mechanism to find way to cope with and address these challenges. Specifically, during each training session of the PCPI at the provincial level, specific topics outlining relevant articles of the said law and the true intention of the commune safety policy were discussed. More pushes are needed in order to ensure that law enforcement officers, the local authority and key partners are well acquainted with the true objectives and intents of the two legal documents and thereby, minimizing their negative impacts on the HIV and AIDS response in the country.

While efforts have been made during the reporting period to upgrade institutional and individual capacity, it is noted that this particular aspect **remains below the expected level for both the government and NGOs.** Coupled with this long term challenge, the phenomenon of brain drain, movement of capable staff as well as short turnover (of staff) have complicated this issue even further. Institutional memory is lost with the staff who leave an organization. With regard to community network capacity, the external technical assistance received by the network was noted; however, it is clear that improvement has not reached the expected level. A more focused strategy to address this challenge along with true and long term commitment of donors and partners are needed.

Salary supplementation for civil servants has been playing a key role in raising government staff's motivation and encouraging them to fulfill their assigned duties. **Progress in this aspect has been made but not yet at a satisfactory level; and usually, it is very time consuming and very bureaucratic, hence, frequent delay of payments**. The phase out of this scheme has been discussed, but it was not clear as to how this transition should be dealt with. This is of particular concern, as it will impact on HIV and AIDS work productivity as a whole, noting that some people have left their positions due to such uncertainty. Furthermore, with fewer outreach activities being conducted in the field (because of limited or lack of incentives and/or transport support),the situation may become even more critical.

Challenges faced throughout the reporting period (2012-2013) that hindered the national response

Despite many years of effort geared towards addressing the enabling environment and legal barriers, it is commonly agreed that much more needs to be done so as to ensure that a truly safe space and

supportive environment conducive to the HIV and AIDS response amongst MARPs are put in place at each hotspot. The PCPI has greatly transformed the leadership, coordination and facilitation in support of the HIV and AIDS response, but such achievement was only observed in Phnom Penh and selected provinces; whereas, a number of provinces were still left uncovered. Although the Ministry of Interior was tasked to take the lead in moving this initiative forward, it was noted that donors seemed reluctant to provide direct financial support to this ministry; hence, the inconsistent commitment of the ministry in leading this initiative. Moreover, the ministry itself does not feel comfortable in making direct communication with NGOs and the MARPs community as it was felt that NGOs and MARPs community are *outside* of the ministry's responsibility. Lastly, it is important to stress that the PCPI concept requires behaviour change of police, local authority and relevant partners from repression to caring and support; and that is unique and will require a lot of time, commitment and a supportive environment.

The legal and policy climate is another challenging aspect which works in parallel with the enabling environment as described above. The presence of condoms is often used as evidence of sexual exploitation. As a result, a number of MARPs ended up in rehabilitation centres or in jails. Acknowledging the negative effect of the Law on the Suppression of Human Trafficking and Sexual Exploitation, on the HIV and AIDS response, visible effort has been made to address this issue. Specifically, Explanatory Notes were developed which aimed at guiding law enforcement officers to appropriately apply the law, and this document was shared officially with judges, prosecutors, lawyers, etc. in Phnom Penh and the provinces. However, it is still unknown to what extent this document has been used for in-depth training amongst relevant law enforcement officers and local authority. Given the complexity of the law, one cannot expect that the mere availability of the said document can resolve the problem. In short, its usefulness in terms of protecting MARPs from possible repression and arbitrary arrest is yet to be seen.

Also in the same field of legislation, the new drug law has been a subject for discussion amongst the civil society as it was felt that a number of articles were not in favour of drug users; in other words the law is *very tough* towards drug users. It appears that the law does not recognize the nature of addiction and its inevitable relapse; which means that those who relapse will face increased imprisonment, which is judged by NGOs as unfair, and the imprisonment is judged as being far too long. **It is very important to mention that prior to its approval, only very minimal suggestions from the UN family and NGOs were accepted by the drafting committee, despite repeated informal and formal requests**. The implementation of the Village and Commune Safety Policy has also contributed to disturb service provision, in particular amongst PWUD, PWID, EW and MSM, and this has resulted in poor NSP and related services coverage for the last few years. **The prison population has seen a significant increase approximately from the time when the Law on the Suppression of Human Trafficking and Sexual Exploitation was enacted. Many believe that this was the result of inconsistent implementation of the law followed by subsequent adoption of the Village and Commune Safety Policy and the new drug law.**

The next challenge has been the capacity of local staff, be it government or NGO, which does not appear to be over soon despite remedial action taken so far. Coupled with this issue, it was also observed that because of the limited governance and transparency, **staff recruitment and assignment in many public**

institutions has never been conducted in an open manner. Given such deficiency, one could imagine that it would be very difficult for the staff to have commitment to build themselves, as there is little certainty that their improved capacity will lead to a better position. Moreover, capable staff tend to move out looking for more generous payment, and therefore, the institutional memory will be lost. **Uneven sharing of workload, which is also common in public institutions, has also impacted on the institutions' performance as a whole.**

The capacity of community networks has also been an issue for many years despite technical backup and assistance from the UN family and NGOs. For all MARPs (with the exception of some MSM), it is very obvious that most of them have a very low level of education including steering committee's members; consequently, it is nearly impossible to raise their capacity fast enough to allow them to catch up with recent developments; noting that in many occasions the language used during the meeting was English – and the documents shared during the meeting were also in English - which leaves them outside the discussion. Technical capacity on advocacy and coordination are also lacking. Efforts to rectify the situation have been made through allowing them to study mainly English and computers; but progress has been very slow.

It was also observed that in addition to the capacity issue, the MARPs networks (i.e. Bandanh Chaktomouk for MSM and EW Coalition for entertainment workers) **sometime experienced internal conflicts at their management level** - despite concerted efforts by their partners to resolve these issues through institutional strengthening measures - which has had major implications on their profile and credibility. **The same applies to the community networks of PLHIV.**

When it comes to long term support for MARPs networks – especially the EW network and the MSM network, it is a little unclear as to which institutions or organization should play this role. They seem to run around from one agency to another looking for possible support but with very little result. Relying on GFATM is even trickier for them, unless they are connected to a strong NGO, to which they will play a role as sub-sub-recipient. In other words, given their limited capacity, a *small NGO* has very little chance to get financial support from the GFATM. In 2012, one NGO working with MSM and TG was closed down due to funding problems despite its hard work in serving MSM and TG in Phnom Penh and in Kean Svay (Kandal Province). In short, it is very challenging for them to develop a long term vision and planning when experiencing such financial uncertainty.

On a slightly different subject relating to the networks is another aspect worth stressing; and that is the idea of *leading the EW network by strictly using an EW (*and similarly, leading the MSM network by *strictly using an MSM)regardless of their capacity*. The rationale was that only a person who belongs to a given group can understand and know their people's concerns, and only that person should have the right to lead its network. However, in practice, testimony of slow and inefficient performance due to the limited capacity of the leader has been very obvious – and that has to change.

In terms of prevention, despite the fact that the country was recognized as a successful country in bringing down the HIV prevalence amongst the adult population, it seems that up to now there has not

been any clear leadership on this matter. Most of the activities in this area were conducted by NGOs which have their own systems for recording and reporting which is much more complicated especially when referring to PWID. Faced with this challenge and under the leadership of NCHADS, tremendous effort was made to re-strategize the prevention (and related care) approaches by way of a) focusing on those at highest risk, b) ensuring maximum intervention for those having greatest risk, c) building trust, promoting and facilitating HIV testing and d) maintaining PLHIV within the cascade of services. To this end a Boosted CoPCT SOP was developed aiming at bringing together various policy documents to create a cohesive guide for a coordinated continuum of HIV prevention, care (and treatment) for all most vulnerable MARPs in Cambodia. A series of trainings using this Boosted CoPCT SOP were organized in all hotspot provinces; however, the actual knowledge gained by relevant staff (government and NGOs) necessary for effective implementation of this SOP requires close monitoring and constant coaching. Standardized reporting using the same approach and reporting forms will need to be constantly monitored as well.

As for the NSP intervention for PWID, despite the high level of agreement between NACD and the Ministry of Health to shift the management of the NSP to be within the Ministry of Health, there is still a lot of work to be done in order to ensure that there is common understanding on this subject and also that the health system will be well equipped and ready to take this responsibility. Prevention work amongst garment factory workers relies on the Prakas 086 of MoLVT; but a more effective approach will need to be put in place in order to ensure that key HIV messages are reaching the target populations instead of focusing on the establishment of HIV and AIDS committees and delivery of awards and certificates to them.

With regard to care and treatment, Cambodia is known to be a country which has a high level of coverage; however it was noted that retention and adherence appear to be the primary concern which was due mainly to poverty and mobility. Currently, the country relies completely on the GF for buying antiretroviral medicines which constitutes a major risk should this financing source reduces**. It appears that the country might not be ready on time to allocate its own budget to cover this high cost**. New treatment eligibility criteria and challenges in getting people to test and enrol in early treatment are other factors which require further attention.

In terms of social support to HIV-affected households, there was a fragmentation of social protection programmes with delayed roll out of new programmes under the national strategic plan for social protection. **Faced with such limitations, concerned government entities do not seem to be ready for putting in place alternative options, which implies that a great proportion of affected and infected families will continue to experience hardship for many years to come;** and clearly this will have direct implication on treatment outcomes.

The M&E system and its data have seen a big improvement in terms of quality and usage for programming and policy making purposes. However, routine monitoring data to assess the coverage and quality of HIV prevention interventions among key populations, OVC support and impact mitigation activities, are still lacking. A unique identifier code (UIC) system has been tested and trialed by the

Flagship Team but it needs to be sped up for final adoption and nationwide application. It has also been a concern that this UIC system only covers EW and MSM, leaving PWUD and PWID outside of its scope. Ideally, it should cover all MARPs. Such limitations have apparently happened because of the lack of close coordination amongst key players. The lack of firm data of different MARPs especially PWID, MSM and TG has also been a concern as this has had implications on the calculation of coverage which needs to be reported regularly.

HIV is an important issue for youth, but HIV and AIDS aren't addressed in the national youth policy. So far there have only been a few studies on HIV and AIDS among youth, but there has been no follow-up on the recommendations from these studies. The use of reproductive clinics has also proven to be very limited and no clear mechanism has been set up to address this.

Concrete remedial actions that are planned to ensure achievement of agreed targets

The country has been working hard and is very committed to achieving the Three Zeros – zero new HIV infections, zero AIDS related deaths and zero stigma and discrimination, by adopting the Political Declaration on HIV/AIDS in June 2011 at the UN General Assembly. Strategies and activities that will be implemented from 2011 to 2015, to achieve HIV/AIDS targets, are included in the costed NSP III (2011-2015). Additionally, a number of SOPs and concept papers (e.g. a) Boosted CoPCT SOP, b) Boosted Linked Response which seeks to integrate PMTCT with maternal and newborn health and with sexual and reproductive and family planning services, c) Treatment as Prevention, d) Cambodia 3.0 conceptual framework, etc.), were developed; and trainings organized in most hotspot provinces. It is also worth mentioning that linked to the above mentioned SOPs and concept papers, a number of challenging initiatives were explored and introduced; namely, finger prick testing, partner tracing, etc.

To be able to achieve these ambitious goals, the PCPI will remain the core mechanism to address the complex issues of enabling environment and the legal system. Under the leadership of NAA and Ministry of Interior, more focused trainings and workshops will be deployed in remaining hotspot provinces. Much effort will be concentrated on making sure that the provincial mechanisms supporting PCPI operation will be in place, and in particular, the set-up of the rapid response teams at the grassroots level where MARPs are concentrated. Challenges faced vis-à-vis the legal issues will be also brought to the discussion at the PCPI training sessions. This will allow effective discussion amongst the members of the PCPI teams -- which include primarily police, health care workers, NGO representatives, and MARPs representatives – on the very issues they are facing during their day-to-day activities. Key legal documents such as the new drug law, the explanatory note of the Law on the Suppression of Human Trafficking and Sexual Exploitation could also be easily distributed (and also discussed) at these sessions.

Playing the role as the sole technical authority leading the PCPI, **NAA is planning to revise the PCPI document in 2014 to** ensure that a more focused approach will be applied and that experiences from the recent implementation of this initiative will be well captured and well reflected in the new document. **Planned annual meetings at the end of each year** will also provide more opportunities for all

partners to discuss issues of major concern relating to the implementation of the PCPI. In close partnership with HACC, NAA will also **re-programme the current budget available (from GFATM) to ensure that sufficient funds** (and appropriate activities) will be allocated first to priority provinces for 2014 and 2015.

The capacity of community networks will remain a long term challenge. More proactive leadership of relevant technical agencies is very much needed; specifically, a fairly clear path forwards (outlining how these networks can be strengthened) should be made. This should also include suggestions for a) resource mobilization needed for their operations, and b) short and long term capacity building of key staff and members of the networks of MSM and EW. KHANA has been playing an active role in forming a PWUD/PWID self-help group instead of a drug user network which is sensitive to the local authority. Such momentum will soon be expanded to other communities where and when applicable. Social mobilization will also play an important role in encouraging MARPs and PLHIV to better access relevant services. Careful selection of any new members of the board or executive committee and close monitoring of the performance of the board and or its secretariat will minimize the chance of mismanagement and internal conflicts.

Acknowledging that the current Boosted CoPCT SOP presents some level of complexity (from the operation point of view), it is foreseen that the document will be revised in 2014 so as to reflect the experiences learned in the field based on the past year's implementation and to re-direct in such a way that it will be more practical, more cost efficient, and more cost effective. As one of the core elements of this document, the roles of outreach worker for each population will also be reviewed in depth. Recent findings on the *Preliminary Exploration amongst Unreached PWIDs in Phnom Penh* (supported by WHO) will be carefully considered in this connection as this will have direct implications on how the outreach workers could carry out their work especially with those who inject heroin. The reporting mechanism, including different report forms, will also be revised. Linked to this SOP, a number of related documents such as the partner tracing document, the finger prick testing document, etc. would also be revised.

Of critical importance, the adoption of early HIV testing, counseling and immediate treatment among groups at highest risk of infection has been and will be one of the main focuses for NCHADS and key partners in the next few years. In this regard, two documents were developed for guiding the implementation of these initiatives: a) the SOP on Boosted COPCT (for MARPs and partners), and b) the SOP on Boosted Linked Response for PMTCT (for pregnant women and partners). As for the partners of PLHIV found in VCT and pre-ART and ART care, key approaches and operations will be defined in the Implementation Research Protocol on ART as Prevention.

In relation to the size estimation of all MARPs, it is foreseen that the outcome of the recent GIS mapping conducted by the Flagship team in 2013 will soon be launched. Additionally, the results of the IBBS (2012) have been approved. While all these recent papers will provide data and information on MARPs, it will be more helpful should all these data be systematically loaded in a specific host agency's website so that it is constantly available for all partners at all times. When and where applicable, regular updates

(annually) would help to ensure accuracy as mobility of these people is very certain. A national exercise to triangulate key data will help to improve data quality as well as reporting accuracy on coverage to donors including the GFATM. On a similar note, the most recent findings of a *Preliminary Exploration amongst Unreached PWIDs in Phnom Penh* along with recommendations to reach them will soon be presented to all relevant partners. The UIC system - using both Khmer and English languages - which is being led by the Flagship team will soon be shared with all partners, and it is hoped that this will give the opportunity to ensure the report's accuracy. The country should be encouraged to have and use only one UIC system which must be applied and utilized across the board including PWUD and PWID.

Linked to PWID and PWUD, noting that possession of small amounts of drugs for personal use does not cause serious social harm, the NACD should clarify the intent of the new law on drugs that possession of small amounts of illicit drugs for personal consumption should not be penalized. To achieve this, NACD should issue an explanatory note and conduct training especially with law enforcement and local authorities. On the issue of harm reduction including NSP, the Mental Health Programme is now in the process of finalizing the NSP policy and NSP SOP. More talks are being conducted at higher levels of the Ministry of Health to see how the commitment between NACD and the Ministry of Health (to incorporate harm reduction into the health system) should be effectively translated into a concrete action plan including capacity building needs and staff recruitment.

To be able to maintain and consolidate the results achieved so far, and in a context of declining financial resources for HIV and AIDS, a major challenge ahead which is being discussed amongst donors and relevant government institutions is to find ways to locally secure long term and sustainable funding for the national response. This would imply better prioritization while at the same time becoming more cost-effective in delivering key services to those in need.

There also should be efforts to better allocate the available funding. According to the most recent NASA, the category of "Programme Management & Administration" was tied with "Prevention" as the largest category of spending. In comparison to other countries, this is relatively high. Given the concentrated nature of the HIV epidemic in Cambodia, a greater proportion of funding could be spent on prevention efforts. Further, more funding could be allocated to social protection and enabling environment interventions.

As previously outlined, the national HIV response is currently largely funded by international sources, although the share of funding from the Royal Government of Cambodia has been increasing. In 2012, only 11% of total spending on HIV/AIDS came from the Cambodian government. As this share increases in the face of declining external funding, it will be increasingly important that the government is able to manage domestic funds transparently, responsibly, and efficiently.

In terms of challenges faced on social support to HIV affected household, the NAA and more specifically, the OVC working group has the role to convey strong messages to relevant government institutions and urge them to revisit this issue before it is too late; noting that this will also have significant implications on treatment outcomes.

With respect to HIV among youth, young people need to be involved in decision-making to enable them to advocate for the inclusion of HIV/AIDS in the national youth policy and advocate for youth-friendly services for reproductive health and HIV prevention and care. The recommendations of the MARYP study should also be implemented, and specific interventions need to be targeted to young people among key affected populations. Finally, the needs of adolescents living with HIV need to be better addressed.

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Key support received from development partners

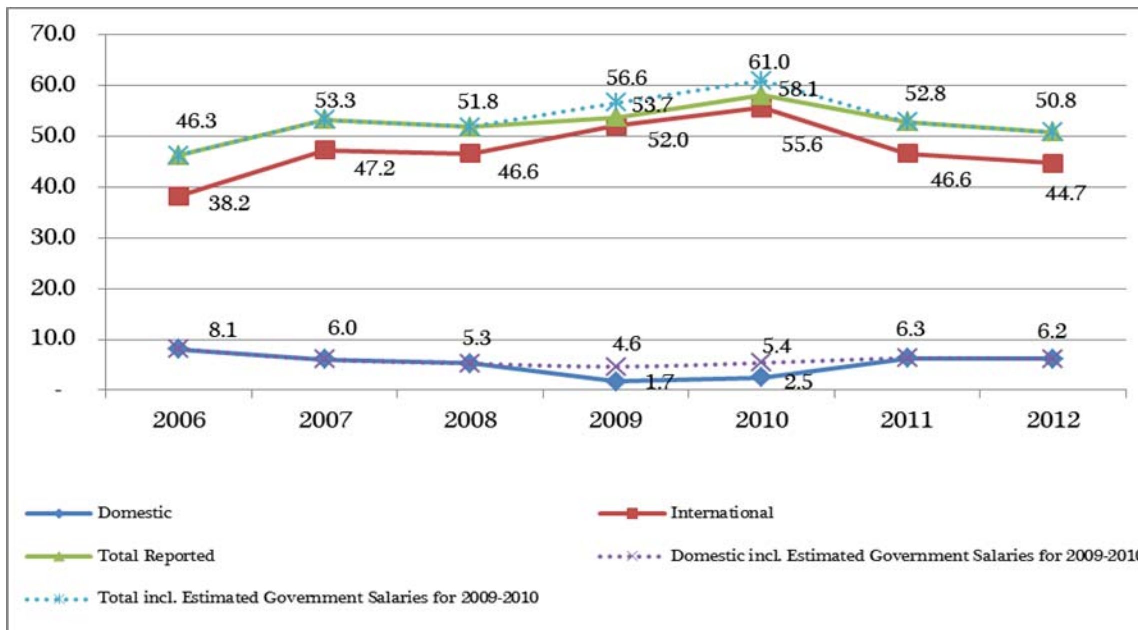
This section describes spending and funding on HIV and AIDS in the country, based on the NASA IV report. The main sub-sections are: a) total domestic and external spending, b) total spending by types of financing sources, c) total spending by types of financing agent, and d) total spending by AIDS spending categories.

Total domestic and external spending

Total reported HIV spending in Cambodia peaked at $58.1 million in 2010 and has since then decreased to $52.8 million in 2011 and almost $50.9 million in 2012, i.e. a decrease of over 12% over two years.

Figure 8 shows a more than doubling of domestic expenditure in 2011/2012 since 2009/2010. It must however be noted no government salaries were reported in NASA III, which has led to an underestimation of total and domestic expenditure in 2009/2010. The dotted lines in the graph show hypothetical domestic and total expenditure for 2009/2010 as adjusted with $2.9 million of estimated missing government salary expenditure (based on the average government salary data for 2011/2012). The resulting adjusted graph shows a more modest though still real increase in domestic expenditure of13.5% between 2010 and 2012. It also means that the estimated decrease in overall spending is probably even more important, at 17% between 2010 and 2012.

Figure 8: Total domestic and external spending



Total spending by types of financing sources

Figures 9 and 10 display the trends in levels and shares of funding per financing source.

The GF HIV grant has remained the most important source of funding of the AIDS response with around $20 million or 40% of total expenditure since 2010. This is followed by bilateral funding at almost $16 million or about 30%, of which on average 82% from the US Government over 2011/2012.

The Royal Government of Cambodia was the third most important contributor with a reported 10% of total funding. As explained, this is the current best estimate based on data available. This translates to $0.35 per capita of domestic funding for AIDS in 2012, compared to $0.10 per capita as the regional median (range: $0-19), and 0.03$ per capita among low-income countries in the region.

The data further show that the decrease in overall HIV spending in Cambodia since 2010 was largely due todecreasing contributions from the UN system (roughly halved since 2010 to 8% of the total) and from international NGOs (down by more than half to 6% of the total).

Minor, but increasing, contributions have come from non-Global Fund, non-UN multilateral sources (ADB, EC, HSSP-2 donors) as well as from private domestic sources (in the form of client co-payment for condom social marketing, which increased almost twenty-fold since NASA III).

Looking forward, an informal assessment of expected contributions from international sources done in parallel with the NASA IV data collection, showed a further declining trend in all but GF funding in 2013-

2015. If confirmed, this will further increase the share of, and hence dependence on, GF funding in the national response.

Figure 9: Total spending by types of spending sources (millions of USD)

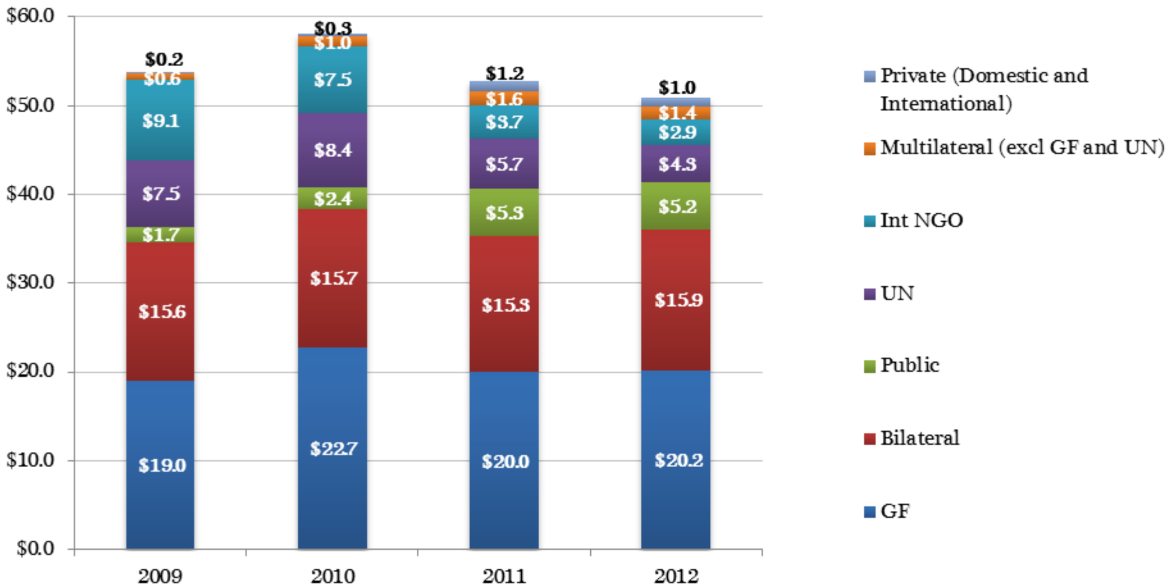
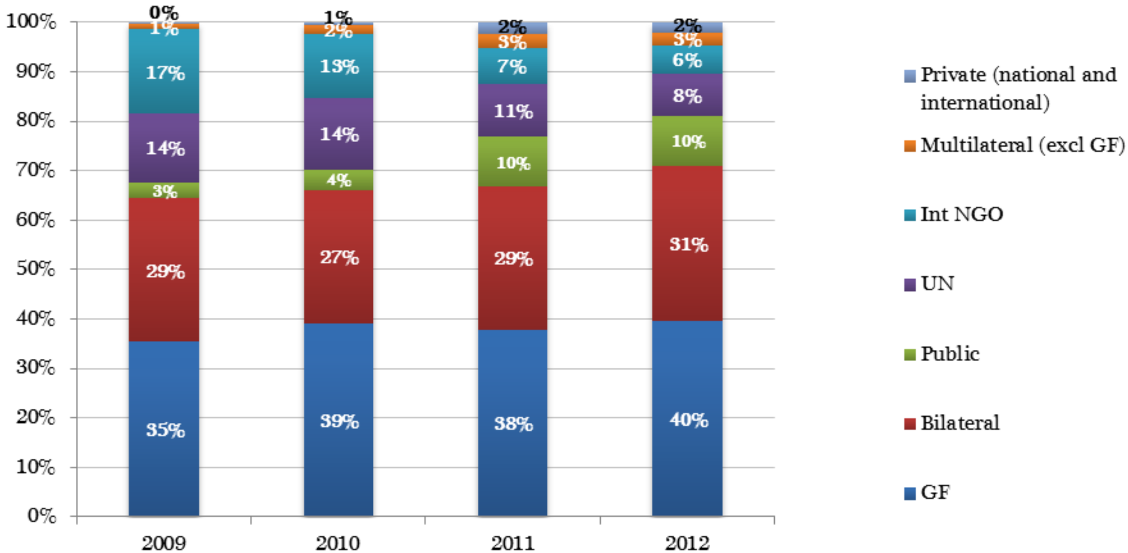


Figure 10: Total spending by types of spending sources (% of total)



Total spending by types of financing agents

Figures 11 and 12 show that the share of funding managed by public entities have steadily increased since 2009 to reach 53% in 2012. Over the same period, the share managed by INGOs has slightly decreased from 29% to 25% and that of national NGOs from 12% to 10%. The UN share decreased

alongside declining UN funding from 14% to below 10%. A small percentage of funds continued to be managed directly by bilateral donor agencies (Agence Française de Développement, USAID, and AusAID).

Figure 11: Total spending by types of financing agent (millions of USD)

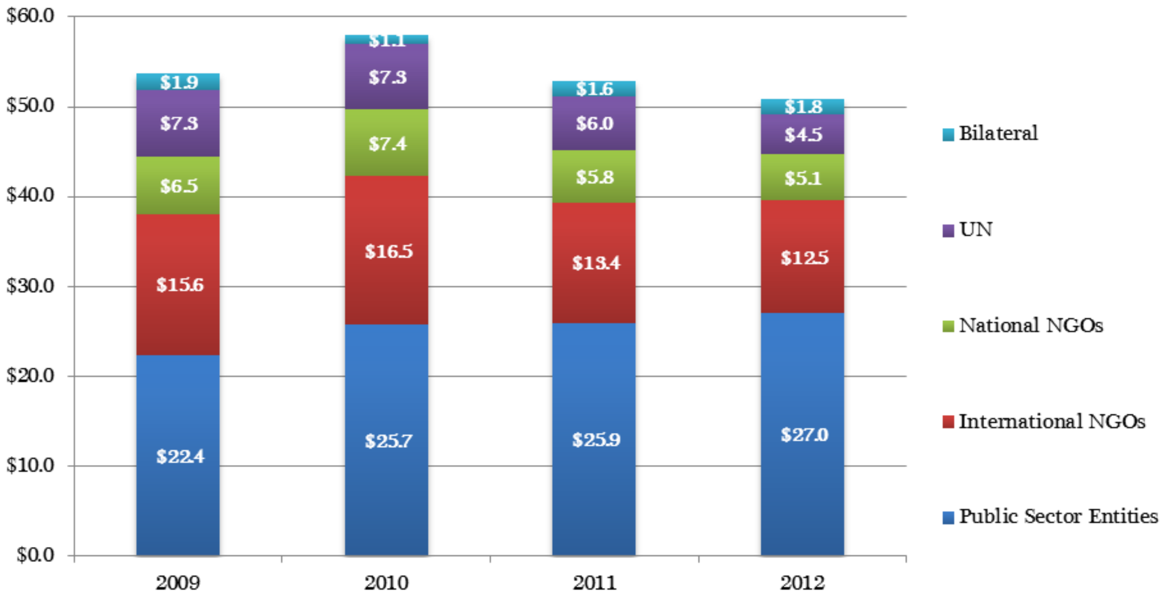
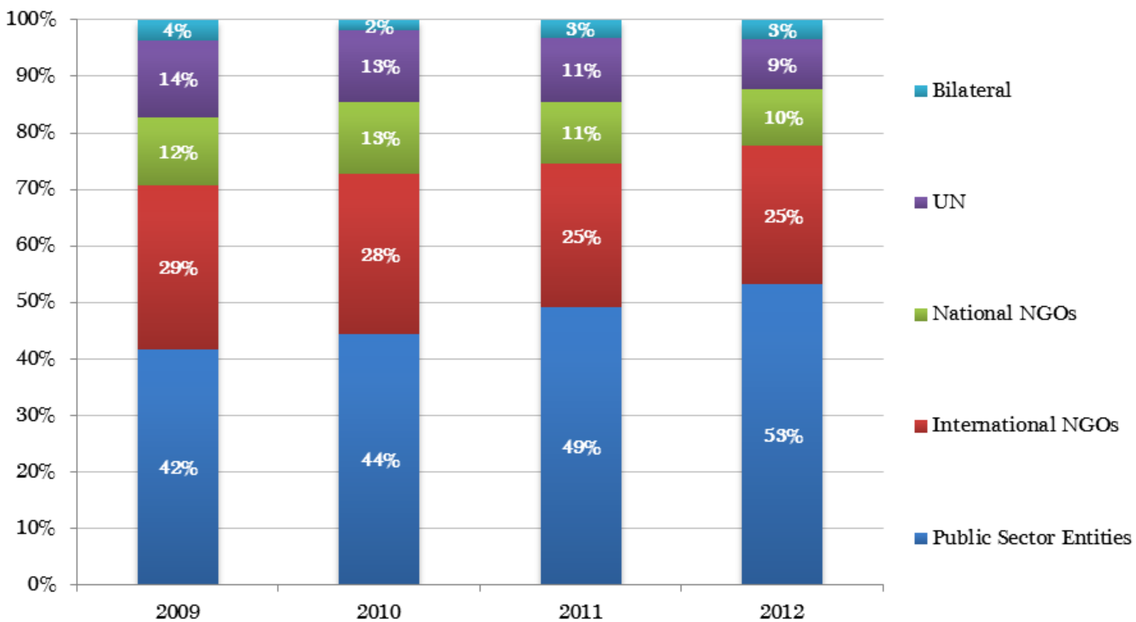


Figure 12: Total spending by types of financing agent (% of total)



Total spending by AIDS spending categories

Figures 13 and 14 show overall trends for AIDS spending categories since 2009.

Spending on Prevention increased in absolute and relative terms (by one third) to represent the largest expenditure post since 2011 at over $14.5 million or almost 30% of the total. Programme Management and Administration (PM&A) decreased by some $6 million or 28% between 2010 and 2012, to become the second largest expenditure post, just below Prevention. The reported amount and share for Care and Treatment have decreased from $15 million or 28% in 2009 to $11 million or 22% in 2012.

Social Protection and OVCs have started to decline slowly since 2011 and represented just over $6 million or 12% of total expenditure in 2012, down from 15% in 2009/2010.

We also observe a three-fold decline in expenditure on Enabling Environment (EE) since NASA III, to only 2% of the total. While Enabling Environment cannot easily be captured in 'packages of essential services' such as Prevention, Care and Treatment or even Social Protection, it is likely that this low share does represent an underinvestment in the area of EE. It certainly does in comparison with the recommendations of the 2008 report of the Commission on AIDS in Asia, which advised to spend 10% on Enabling Environment.

Training and Incentives are a separate ASC in NASA. It has increased four-fold to 7% of the total since NASA III because Incentives were recorded for the first time in NASA IV.

Figure 13: Total spending by AIDS spending categories (millions of USD)

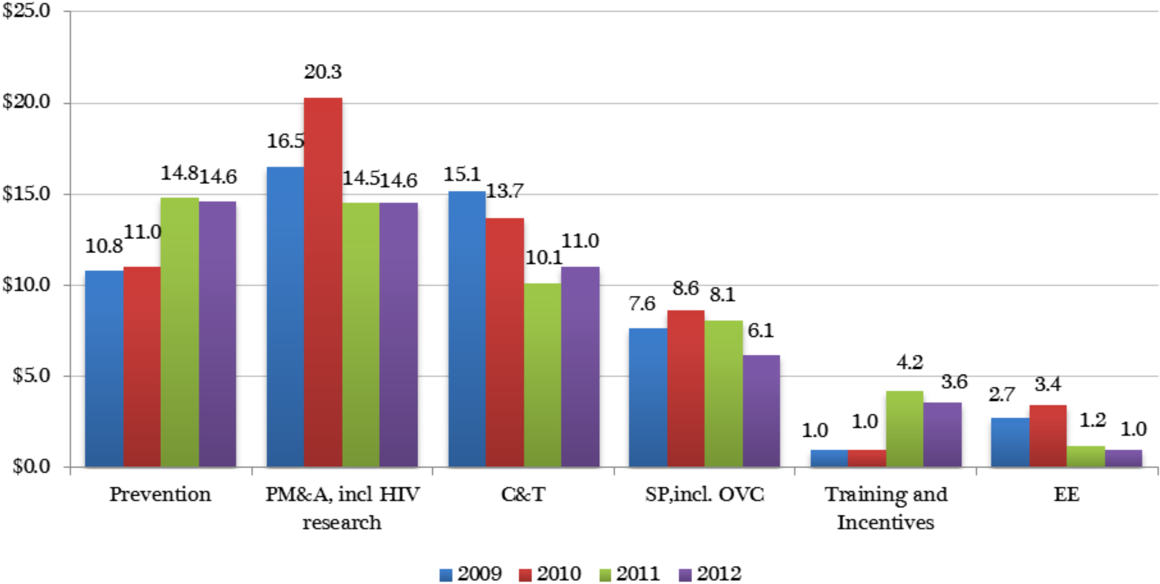
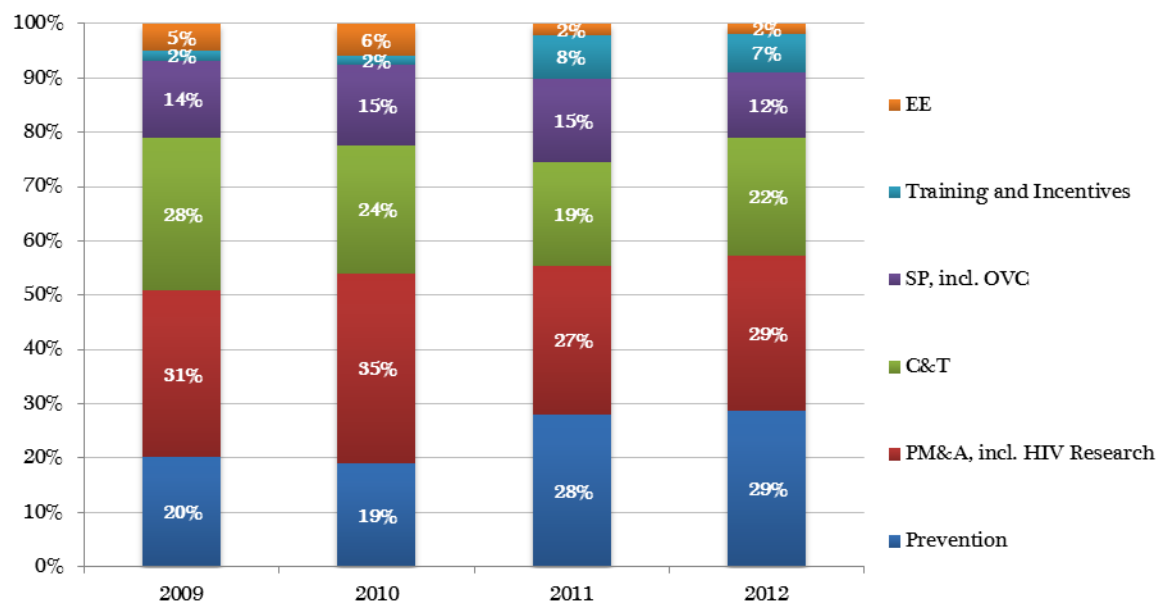


Figure 14: Total spending by AIDS spending categories (% of total)



Key Points:

- Three positive trends were observed in 2011/2012: prevention spending increased to become the first programme area in terms of spending (29%); spending on programme management and administration decreased to become the second largest post (29%); and treatment spending decreased while serving a steadily growing number of beneficiaries. Part of these trends was due to better data quality and recording.
- Social Protection and OVC decreased to some 12% of total spending. It is not clear if this decrease is justified by decreasing needs (e.g. decrease in the size of the target population, gradual integration of service delivery in this area) or is in fact leading to a loss of coverage in essential services.
- Incentives have been recorded for the first time and represent around 5% of total spending.
- The threefold decrease of already quite low spending on Enabling Environment is likely to eventually affect the effectiveness and quality of the delivery of certain services.

Actions that need to be taken by Development Partners to ensure achievement of targets

Critical consideration has been given to re-focusing the HIV response to ensure cost efficiency and cost effectiveness. This has translated into exploring new approaches and initiatives to reach and serve those who have multiple risks (e.g. PWID, EW who inject heroin, etc.). More work is being conducted by WHO and key partners aiming at ensuring effective implementation of new initiatives (such as partners tracing) and finding/reaching unreached PWID.

A major event which highlighted development partners' interventions was the review of the national health sector response to HIV and sexually transmitted infections in Cambodia which was conducted

from 30 April to 10 May 2013 by a team of national and external members. The purpose of the review was to assess the progress made under the Strategic Plan for HIV/AIDS and STI Prevention and Care in the Health Sector, 2011–2015. The review focused on the period from 2011 to 2012, and took place at a time when Cambodia 3.0 was being finalized. The review team was invited by the leadership of NCHADS to examine and comment on the contents and feasibility of the new framework. As part of the review process, visits also took place in the Health Department of Phnom Penh municipality and in the provinces of Battambang, Banteay Mean Chey and Svay Rieng.

The review concluded that the national health sector response to HIV in Cambodia was strong, efficiently directed and managed, and appropriately structured. It recognized opportunities for and obstacles to further progress, as well as how to make more efficient use of available resources. The review concluded that the current work and achievements place Cambodia's response to HIV as being among the most effective in the world; and it was progressing well towards its 2011–2015 strategic objectives. A series of specific recommendations were made; and if they are well implemented with a sustained sense of urgency and bolstered by the needed human and financial resources, it is believed that Cambodia should be able to achieve the elimination of new HIV infections by 2020.

With regard to the UN family, and in order to maximize its contribution to the results of the National Strategic Plan for a Multi-Sectoral Response to HIV/AIDS 2011-2015 (NSP III), an annual work plan was developed (and implemented) by the Joint United Nations Team on HIV and AIDS (JUTH).The JUTH's contributions have been consistent with the United Nations Development Assistance Framework (UNDAF 2011-2015).Strategic areas have been identified and Seven Joint Outcomes and relevant Primary Conveners as well as partner agencies have been agreed in the Joint Support Programme2011-15 (JSP 2011-2015). Each joint outcome area is convened by the primary convenor(s) which play a role of brokering for technical assistance and partnership; convening, initiating, planning and ensuring results; mobilizing resources including leveraging financial and human resources; and ensuring timely reporting of progress on targets of the JSP.

The Joint UN Support Programme Operational Plan and Budget for 2011-2015 - developed with the active involvement of representatives of Government and of other stakeholders – will continue to be an important tool for guiding the UN alignment with the NSP III. Annual planning and reporting exercises continue to be conducted systematically.

In addition, the Government Donor Joint Technical Working Group – which meets quarterly and on an extraordinary basis when the need arises - has provided the opportunity for NAA and development partners to jointly identify national HIV/AIDS programme priorities and promote effective coordination and monitoring of the implementation of Cambodia's response to HIV/AIDS in a consultative and cooperative manner. To ensure its effective functioning, a Secretariat, chaired by the Secretary General of the NAA, was formed at the NAA.

Its key focus areas are primarily to: 1) promote policy and strategy coherence across sectors, 2) facilitate harmonisation and alignment of Official Development Assistance agreements on existing, emerging and

planned goals and priorities, in line with the NSP III, 3) promote consistent approaches and strategies of government and development partner support to the national response, 4) oversee progress and impact of the HIV Law and National Strategic Plan, and 5) develop and promote shared accountability amongst GDJ TWG and relevant partners. Annually, key tasks and responsibilities of the GDJ TWG will be agreed upon and summarised in an annual action plan with agreed Joint Monitoring Indicators (JMIs). Quarterly progress against the JMIs will be reported to the Cambodia Development Council.

As part of the UN's joint effort to contribute to the development of the country, the UNDAF for 2011-2015 incorporates HIV aspect as a cross-cutting element that has been addressed in all of the outcome areas including social protection, economic growth and sustainable development, health and education, gender and governance. This document will continue to play an important role to ensure that contribution from each UN agency will be well harmonized across all sectors including HIV and AIDS.

MONITORING AND EVALUATION ENVIRONMENT

Overview of the current monitoring and evaluation (M&E) system

Significant progress has been made in the past few years with the development of one single, coherent M&E system to obtain strategic information from different sources (i.e., surveillance, routine monitoring, research, evaluation, modelling) to track progress made through the national response to HIV and AIDS in Cambodia. The importance of M&E is now better recognised by stakeholders as demonstrated by their reference to M&E and SI issues in meetings and in documents. Considerable resources for M&E system strengthening were obtained through Round 9 which now are employed under Single Stream Funding (SSF) and used to improve M&E capacity, and equipment of a large number of organizations.

Efforts to strengthen the national M&E system have been guided by Strategy 6 of the NSP III whose aim is to "ensure availability and use of strategic information for decision-making through monitoring, evaluation and research". This strategy is articulated around the 12 elements of a functional HIV/AIDS M&E system.

The NAA is responsible for overall coordination of the national multi-sectoral M&E system. It also has a central data storage function and the role to produce and disseminate information on progress made by the national response as a whole, across different sectors. The Planning, Monitoring, Evaluation and Research Department (PMERD) of the NAA deals with strategic planning and M&E/research issues.

NCHADS/MoH collects health sector data regarding prevention, treatment and care and together with NMCHC/MoH gathers PMTCT data and with CENAT/MoH TB/HIV related data. Data regarding blood safety is obtained by NAA from the National Blood Transfusion Centre (NBTC). The MoH is also responsible for operating the Health Information System (HIS) and implements CDHS which is an important source of HIV related data. In the non-health sectors, the Ministry of Education, Youth and Sports (MoEYS) collects data on teaching of life skills in schools whose focus includes HIV and from NGOs

who are involved with the Life Skills for HIV/AIDS Education Programme targeting youth and children out of school. The Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) compiles data from different sources to track support to OVC and households of PLHIV. NGOs and other civil society organizations report a variety of data to line ministries and to different donors.

Data collection roles and responsibilities are clearly defined in national guidelines. NCHADS and NMCHC have the strongest structures and systems and the longest experience and strongest capacity. However, there has been progress too at MoEYS, MoSVY and across smaller NGOs who are benefitting through Khana, HACC from GFATM and other investments and assistance to upgrade their capacity, infrastructure and equipment so that they can properly perform their M&E functions.

The Boosted CoPCT, PMTCT and the surveillance TWG are forums where constructive discussions on M&E take place. It is here that concrete work is accomplished to advance the national M&E systems and its various sub-systems. The aim is to align and harmonise routine monitoring systems and practices across all service providers operating under the Boosted CoPCT. UNAIDS has been a driving force in these meetings and is looked upon as an expert advisor.

Routine programme monitoring

Routine monitoring indicators are mainly described in the M&E frameworks of sector-and population-specific strategic plans. The indicators used in the health sector response are the most numerous and important ones. They are listed in several programme documents including in the Boosted CoPCT SOP, the Boosted Linked Response SOP and the National PMTCT Strategic Plan and the Boosted Continuum of Care SOP. The M&E frameworks included in SOPs developed by NCHADS constitute the strongest foundation for standardised reporting of data as well as the set of indicators used by GFATM and PEPFAR recipients. Todayall of them are close to being fully aligned and harmonised due to NCHADS's leadership and efforts together with service providers to develop common service delivery package. Apart from the health sector indicators there are several important indicators used to monitor the outputs and outcomes of impact mitigation measures and of OVC support.

Surveys and surveillance

Cambodia has a relatively good surveillance system. Surveillance has been conducted regularly since the first cases of HIV were detected in the early 1990s including BSS, HSS and SSS and other prevalence studies. A decision has recently been taken to combine BSS and HSS into IBBS in order to save resources. UNAIDS has worked with partners to improve surveillance methods and tools and to ensure the data obtained can be used for national and international reporting.

Population size estimates (PSE) have improved. Different methods have been utilised such as capture-recapture and mapping methodologies. New size estimates have been recently produced for PWID/PWUD by NCHADS, KHANA and other partners and for TG by FHI360. Clearly, size estimates remain a major area requiring further investment for regularly updating methodologies and estimates. A GIS based mapping conducted in 2013 by the Flagship team will be launched soon and expanded.

HIV evaluation and research

More will need to be done to assess the relevance and efficacy of new intervention models and approaches under the Cambodia 3.0 initiative. A new evaluation and research agenda will have to be developed by NAA and NCHADS and UNAIDS shall be supporting this effort.

A number of specific surveys and studies have been carried out in the past years including the Socio-Economic Study of HIV/AIDS at the Household level (supervised by UNAIDS M&E Unit), the Most At Risk Young People Survey, TraC studies etc. UNAIDS has been involved with the design and the quality control of many of these studies. In the future more discussions need to take place to prioritise research in order to fill critical gaps.

UNAIDS has made a major contribution by supporting National AIDS Spending Assessments (NASA) since 2007. By now four NASAs have already been conducted which have made valuable spending data available for 2006-2013.

Data dissemination and use

Data is used much more than in the past both for national and international reporting and for planning and resource mobilization purposes. Cambodia submitted on time Country Progress Reports (UNGASS and GARP) in 2003, 2004 (interim report), 2006, 2008, 2011 and 2012. An increasing number of indicators were reported upon and civil society involvement in the reporting process grew.

Importantly, the use of data to analyse the situation and to inform strategic plans has much increased. People have also gained a better understanding of the strengths and weaknesses of data from different sources such as routine monitoring, surveillance, studies and assessments. Access to data and information on national websites has improved. Still more effort is needed to make up-to-date HIV/AIDS data and relevant M&E documents and materials available, including in Khmer language, on the website of the NAA and on the websites of other organizations.

Challenges faced in the implementation of the comprehensive M&E system

The main challenges faced during the implementation of the comprehensive M&E system include:

- Insufficient coordination efforts and limited cooperation from a number of key players
- Insufficient understanding of partners on the definition and importance of indicators which have led to low quality data; while at the same time it was also felt that a number of GARPR indicators are also not straight forward;
- Timeline difference between surveys, surveillances (locally conducted) with reporting period of GARPR making the reporting complex and not effective;
- Inadequate capacity of staff to deal with their daily work;
- A number of data is not available at relevant ministries, meaning the information that we are seeking are not something that those ministries possess;
- Structural obstacles and institutional disagreement;

- Insufficient resources support for the data management system and the function of the current national database (i.e. human resources, equipment, and software);
- The second edition of the National M&E Guidelines was developed since 2011, but it is not yet fully implemented due to insufficient local capacity to apply the document in their day to day activity; and
- The long delay of approval of the GFATM on the re-programmed budget has led to inability of the M&E Unit to conduct a number of planned activities, such as OVC size estimation, joint annual review, Mid-term Review of NSP III, and M&E Training.

Remedial actions planned to overcome the challenges

Remedial actions planned to overcome the challenges are:

- Ensure that the management of NAA will officially communicate with relevant institutions and partners to ensure that they fully understand the importance of the M&E system and its use in policy and programmatic activities;
- Official communication will be made with relevant partners to ensure that additional questions will be added into their annual reporting system (or survey), so that relevant data and information can be made available at the next reporting period;
- Discuss internally to find way to improve and strengthen the M&E system and make sure that the management of PMERD will work in a more focused way and avoid possible waste of resource;
- Officially communicate with relevant partners to see whether the timeline for different surveys, surveillances, studies, etc. can be reframed so as to minimize time gap (which results in the lack of data); and
- Update the M&E System Strengthening Plan so that it is more focused and fits well into the actual need

A number of key M&E activities are planned for the next two year to obtain quality Strategic information. These include activities to address gaps identified data gaps as well as those meant to reach objectives under the Cambodia 3.0. The most significant activities are summarized below:

More Regular Surveillance and Surveys – Since the Cambodia epidemic currently is concentrated among key populations it has been recognized that Cambodia does not conduct surveillance on key populations [MARPS] on regular basis to understand and effectively address these high risk and high burden groups. In light of the fact that the most high risk of EWs and IDUs have not reduced in HIV prevalence in the past 5 years, suggest more frequent monitoring is needed. For this reason 3 populations will be surveyed during the next two years. Two Integrated Biological and Behavioral Surveillance Surveys are planned. One will combine MSMs and IDU/DU (2015) as they share geographical hotspots which provide economies of scale. The second will include IBBS among EWs (2014).Both these IBBS's will includes both HIV and STI testing.

Baseline Assessment [BA] for Cambodia 3.0 initiative – As part of Cambodia's commitment to the global Three Zeros' Initiative, NCHADS and development partners, have developed the Conceptual

Framework for Elimination of New HIV Infections in Cambodia by 2020, known as Cambodia 3.0 Initiative. The baseline assessment will be conducted in early 2014 to serve as baseline to track progress made against the Cambodia 3.0 initiative over the coming years. GFTAM funding will cover 7 ODs, USAID Flagship Project will cover 4 ODs and United Nations partners will support 3 ODs and US CDC will cover 4 ODs for the Baseline assessment. This BA will produce a comprehensive set of strategic information on the HIV situation and response.

Strengthening community based monitoring – In order to assess progress of Cambodia 3.0 towards its objectives, surveys alone are not enough. More routine monitoring is needed, particularly at the field level and from the demand side. For this reasons, investments are being made to develop a community based monitoring system which can record, analyze and report issues of access and quality to services including stock outs, expired drugs, responsiveness of health staff, incidents of stigma and discrimination or human rights violations, and need for legal services.

Continuous Quality Improvement scale up – Despite an electronic database system, electronic data quality is not checked regularly yet, and the use of data by ART site team (clinician, data management, nurses, ART site manager etc.) to monitor quality of patients' management at their own facility is still limited. The CQI is meant to improve the quality and use of data related to standard criteria at pre-ART/ART sites, improve communication between clinician team, community support teams and data management team at pre-ART/ART sites to work together in improving the quality of patient care, and to develop a continuous quality improvement system at pre-ART/ART sites. This protocol will be expanded to more sites and will include assessment for new sites and evaluate old sites.

Community based training for Boosted CoPCT– in response to the new SOP for Boosted CoPCT, it is critical that the main implementers (NGOs/CSOs) are well trained in the data collection, collation and reporting of the "boosted" and comprehensive service package indicators. A two-pronged approach is planned with 1) intense and periodic training to NGO/CSO staff on the M&E framework, and 2) training of government counterparts who will provide oversight, verification and final reporting of the data.

Costing of Cambodia 3.0: Building on NASA-IV accomplished in 2013, costing of the Cambodia 3.0 initiative is planned to be conducted in 2014. The aim of the costing is to estimate the resource needs as well as identify and select the most cost-effective mix of interventions to achieve the goals of Cambodia 3.0 by 2020. This will also help build local capacity in costing techniques

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

The national consultation meetings were led by the NAA in cooperation with HACC and UNAIDS, with financial support from The Global Fund. There were two types of consultation meeting: (i) pre-consultation meetings to pre-fill the NCPI and (ii) a national validation meeting. For civil society, pre-consultation meetings were organized by HACC at national and sub-national levels to pre-fill the NCPI part B. These meetings were attended by participants from NGOs, the UN family, the private sector, and communities. The government meetings to pre-fill the NCPI part A were led by the NAA and were attended by participants from government ministries at the national level.

The national validation meeting was held at the Cambodiana Hotel in Phnom Penh on 21 March 2014. There were over 77 participants including representatives from the government, development partners, multi- and bi-lateral agencies, private sector, and civil society including communities of PLHIV and MARPs whom are leading managing, implementing and contributing to the national HIV/AIDS response. The objectives of the national validation meeting were to review and validate the collected data for the core indicators, and to provide additional inputs regarding emerging issues, challenges, and remedial actions.

The consultation meeting was presided by **Excellency Ieng Mouly, Senior Minister and Chairman of the National AIDS Authority**. Welcome remarks were provided by H.E. Hor Bunleng, Deputy Secretary General of the NAA, who outlined the objectives and process for the GARPR. Additional remarks were provided by Dr. Ly Penh Sun, Deputy Director of NCHADS, who affirmed NCHADS' support for the report preparation process as a key institution providing much of the data for GARPR 2014. Supporting remarks were also provided by Ms. Marie-Odile Emond, Country Director of UNAIDS. UNAIDS has supported the preparation of the country report especially in terms of conducting the new Spectrum modeling version 5 that is a source of data for this year's GARPR.

Mr. Tim Vora, Executive Director of HACC, expressed his thanks to the NAA and spoke about HACC's role in leading the consultation meetings for civil society to pre-fill the NCPI part B. There were three separate meetings organized with CSOs, NGOs and other development partners, held in Preah Shihanouk province, Siem Reap province and Phnom Penh. He noted that the process of completing the NCPI part B for this year were more fruitful than the previous two years and had more active participation. Moreover, the results showed that CSOs had more activities than previous years in terms of development and coordination. However, the results also showed there was limited financial support

and some challenges related to the implementation of programs targeting hard-to-reach MARPs and a lack of IEC materials.

Opening remarks were delivered by **Excellency Ieng Mouly,** Senior Minister and Chairman of the NAA. He welcomed and thanked the participants and stressed the Royal Government of Cambodia's strong commitment and continued support to achieving the Three Zeros strategy which has been reiterated by **Cambodia Prime Minister Hun Sen and Samdach Kittiprit Bandit Bun Rany Hun Sen**. He requested all members of the meeting to fully participate, and to engage in open discussion about the validity of the data/information and any new emerging issues in the national response to HIV/AIDS in Cambodia. He also emphasized that there is a need to strengthen good governance with mutual accountability for donors, policy makers, program implementers, and especially beneficiaries.

The participation from attendees at these national consultation meetings was excellent, ensuring that the expertise of the various stakeholders has been reflected in a balanced way, and incorporated into the GARPR 2014 reporting.

The table below shows the planned process for preparing the GARPR 2014 report.

Activities	Jan-14				February 2014																								
	w 1	w 2	w 3	w 4	1	2	3	4	5	6	7	13	14	15	16	17	18	20	21	22	23	24	25	26	27	28	3	4	5
Receive letter from UNAIDS																													
Prepare action plan for report preparation and budget																													
Discuss and prepare timeline with OSG																													
Submit action plan and budget to NAA leader																													
Search documents related to GARPR and reporting tools																													
Online training on how to use online tools																													
Extract tools and guideline from website																													
Generate online tools to Excel sheet																													
Group indicators and data sources																													
Secure technical assistance for report writing																													
Organize NME-TWG																													
Prepare invitation and communication to data sources																													
Prepare national funding matrix extract from NASA IV																													
National launch GARPR and reporting tools																													
Data collection																													
Start writing narrative report by indicators																													
Action plan and invitation letter for Civil Society Pre-Consultative Meeting on GARPR																													
Filling NCPI Part A																													
Filling NCPI Part B																													
Field visit to civil society regional workshop																													
Consolidate reports																													
Finalize CSOs' report and submit to NAA																													
National Consultative Meeting on GARPR validation																													
Finalize GARPR																													
GARPRtranslation																													
Submit GARPR to Policy Board																													
Submit GARPR to Royal Government																													
Submit GARPR to UNAIDS Geneva																													

ANNEX 2: National Commitments and Policy Instrument (NCPI) 2014

COUNTRY:

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: The National AIDS Authority

Postal address: # 16, Coroner Street 270 and 150, Sangkat Toeuk La-ak II, Khanna Tuol Kork, Phnom Penh, Cambodia

Tel: 855-23 883 540

Fax: 855-23 885 279
E-mail: info@naa.org.kh
Date of submission: 07 April 2014

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
NAA	H.E Dr Tia Phalla	Yes	Yes	Yes	Yes	Yes	Yes
NAA	H.E Dr Teng Kunthy	Yes	Yes	Yes	Yes	Yes	Yes
NAA	H,E Dr Hor Bun Leng	Yes	Yes	Yes	Yes	Yes	Yes
MoLVT	HE Dr Huy Han Song		Yes	Yes			
NACD	Dr Thong Sokunthea	Yes		Yes	Yes		
MoLVT	Chuor Eangly	Yes	Yes	Yes			
NCHADS	Dr Ly Penh Sun	Yes	Yes	Yes	Yes	Yes	Yes
DRHC/MoRD	Chhim Chansovanna	Yes	Yes	Yes			
NACD	Lut. Meas Vyrith		Yes	Yes	Yes		
CENAT	Mr Chea Manith	Yes	Yes	Yes	Yes	Yes	Yes
CENAT	Dr Khun Kim Eam	Yes	Yes	Yes	Yes	Yes	Yes
NAA	Dr Huot Serey Roth	Yes	Yes	Yes			
NAA	Dr Ngin Lina			Yes	Yes	Yes	Yes
NAA	Ms Khet Saly						Yes
NAA	Mr Chea Punleu						Yes
MoEYS	Mr KimSanh	Yes	Yes	Yes	Yes	Yes	Yes
NAA	Dr Voeung Yanath	Yes	Yes	Yes			
CENAT	Dr Khun Kim Eam	Yes	Yes	Yes	Yes	Yes	Yes
MoWA	Dr Hou Nirmita	Yes	Yes		Yes		Yes
MoWA	Dr Seng Phaldavine	Yes	Yes		Yes		Yes
MoLVT	HE Dr Huy Han Song		Yes	Yes			
NCWC	Ms Chan Sotheavy			Yes	Yes	Yes	
MoSVY	MR Khlong Vichetr	Yes	Yes	Yes	Yes	Yes	Yes
CRC	Mrs Dy Dara	Yes	Yes	Yes			
NMCH	Dr Tuon Sovanna	Yes	Yes	Yes	Yes	Yes	Yes

CARD	Dr Say Ung	Yes	Yes	Yes			
NMCH	Dr Tuon Sovanna	Yes	Yes	Yes	Yes	Yes	Yes
NMCH	Mr Keo Sothy	Yes	Yes	Yes	Yes	Yes	Yes
PAS/ BMC	Dr Che Pichet	Yes	Yes	Yes	Yes		
PAS/ BTB	Thann Chroy	Yes	Yes	Yes	Yes		
PAS/KRT	Khau Banly	Yes	Yes	Yes	Yes		
PAC/Pursat	H.E Chhun Song	Yes	Yes	Yes	Yes		
PAS/SRP	Mr Moung Narin	Yes	Yes	Yes	Yes		
PAS/Pursat	Mr Tek Sopheap	Yes	Yes	Yes	Yes	Yes	
MoJ	Phan Chanly	Yes	Yes	Yes	Yes	Yes	
NCHADS	Mom Chandara				Yes	Yes	
NCHADS	Samrith Sovannarith				Yes	Yes	
NCAHDS	Lon Say Heng				Yes	Yes	
NCHADS	Dr Kim Bunna				Yes	Yes	
NAA	Ly Chanravuth	Yes	Yes	Yes	Yes	Yes	Yes
NAA	Sou Sophy	Yes	Yes	Yes	Yes	Yes	Yes
NAA	Thong Dalina	Yes	Yes	Yes	Yes	Yes	Yes
NAA	Tan Sokkey	Yes	Yes	Yes	Yes	Yes	Yes
NAA	Keo Chamnan	Yes	Yes	Yes	Yes	Yes	Yes
MoNASRI	Mr Un Sopheap	Yes	Yes	Yes	Yes	Yes	Yes

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
HACC	Mr. Tim Vora, ED	Yes	Yes	Yes	Yes	Yes
HACC	Mr. Nhim Dalen, M&E Advier	Yes	Yes	Yes	Yes	Yes
HACC	Mr. Heng Koy, PM	Yes	Yes	Yes	Yes	Yes
HACC	Mr. CheavSamphy, M&E	Yes	Yes	Yes	Yes	Yes
HACC	Mr. Hoy Leangseng, RSO	Yes	Yes	Yes	Yes	Yes
UNAIDS	Mrs. Marie OdilleEmond					
UNAIDS	Mrs. NamadaAcharyaDakal	Yes	Yes	Yes	Yes	Yes
UNAIDS	Ms. Holly Norrie, M&E Fellow	Yes	Yes	Yes	Yes	Yes
MHC	PhertSoriya/PC	Yes	Yes	Yes	Yes	Yes
WVC	Ho Daravuth/PM	Yes	Yes	Yes	Yes	Yes
WOSO	Sot Vanarith/Staff	Yes	Yes	Yes	Yes	Yes
WOSO	KhatSokha/PC	Yes	Yes	Yes	Yes	Yes
WOMEN	Chum Nak/PO	Yes	Yes	Yes	Yes	Yes
WNU	PechSokchea/Staff	Yes	Yes	Yes	Yes	Yes
WHO	EngPary/Officer	Yes	Yes	Yes	Yes	Yes
WDA	CheaSovanny/PM	Yes	Yes	Yes	Yes	Yes
VC	Hout Totem/ED	Yes	Yes	Yes	Yes	Yes
URC	LengKuoy/M&E Team Leader	Yes	Yes	Yes	Yes	Yes
UNODC	Aaron Waton/CBT officer	Yes	Yes	Yes	Yes	Yes
TASK	YauMalosya/PO	Yes	Yes	Yes	Yes	Yes
TASK	DoeunVuthea/PM	Yes	Yes	Yes	Yes	Yes
SHCH	Chhavalith/Coordinator	Yes	Yes	Yes	Yes	Yes
SEADO	VaKimyan/S/W	Yes	Yes	Yes	Yes	Yes
SEADO	Kong Chanphana/CSO	Yes	Yes	Yes	Yes	Yes
SCC	SomPiseth/PC	Yes	Yes	Yes	Yes	Yes
SCC	San Bon/BM	Yes	Yes	Yes	Yes	Yes
SCC	CheaPhal/PLHA	Yes	Yes	Yes	Yes	Yes
SCC	Vorn Van/PLHA	Yes	Yes	Yes	Yes	Yes
SCC	ChhaySoheang/DU	Yes	Yes	Yes	Yes	Yes
SCC	Ling Khun/DU	Yes	Yes	Yes	Yes	Yes
SCC	Lay Kimsorn/DU	Yes	Yes	Yes	Yes	Yes
SCC	Cheng Sovanratha/DU	Yes	Yes	Yes	Yes	Yes
SCC	Touch Dara/DU	Yes	Yes	Yes	Yes	Yes
SCC	Heab Sin/PPC	Yes	Yes	Yes	Yes	Yes
RHAK	Hun Rady/ES	Yes	Yes	Yes	Yes	Yes
RHAK	Min Samart/EO	Yes	Yes	Yes	Yes	Yes
RHAC	VounCharithy/PL	Yes	Yes	Yes	Yes	Yes
RHAC	Ty Sotheavy/EO	Yes	Yes	Yes	Yes	Yes
RHAC	EK Sreyneang/EO	Yes	Yes	Yes	Yes	Yes
RHAC	MoeunMeng/MSM	Yes	Yes	Yes	Yes	Yes
RHAC	MoeunVithy/MSM	Yes	Yes	Yes	Yes	Yes
RHAC	HeangSamoeun/PLWHA	Yes	Yes	Yes	Yes	Yes

RHAC	Cheng Sinuon/PLWHA	Yes	Yes	Yes	Yes	Yes
RHAC	HengTha/PLWHA	Yes	Yes	Yes	Yes	Yes
PWHO	KhengSophal/ED	Yes	Yes	Yes	Yes	Yes
PSI	Chum Bunly/IPC Coordinator	Yes	Yes	Yes	Yes	Yes
PPN+	NhemSaran/CO	Yes	Yes	Yes	Yes	Yes
PPN+	Ngounsreymom/CO	Yes	Yes	Yes	Yes	Yes
PPN+	Van Chanthou/CO	Yes	Yes	Yes	Yes	Yes
PFD	NhemNaryroth/PM	Yes	Yes	Yes	Yes	Yes
PFD	YertNeroth/PC	Yes	Yes	Yes	Yes	Yes
PFD	NhemNarith/PC	Yes	Yes	Yes	Yes	Yes
PC	Hem Kim Eng/PO	Yes	Yes	Yes	Yes	Yes
PC	Sao Veng/CSO	Yes	Yes	Yes	Yes	Yes
PC	Pen Savy/PC	Yes	Yes	Yes	Yes	Yes
PC	VuthSokhom/PM	Yes	Yes	Yes	Yes	Yes
NAA	Ly Chanravuth/PMEAO	Yes	Yes	Yes	Yes	Yes
MSPC	PhornSotheavuth/CM	Yes	Yes	Yes	Yes	Yes
MS	Kem Soleil/	Yes	Yes	Yes	Yes	Yes
MHSS	PhelSophy/ED	Yes	Yes	Yes	Yes	Yes
MHSS	ChhornSona/PC	Yes	Yes	Yes	Yes	Yes
MHSS	Bo Putreatrey/PC	Yes	Yes	Yes	Yes	Yes
MHSS	So Sovan/Program Staff	Yes	Yes	Yes	Yes	Yes
MHSS	Mean Makara/PC	Yes	Yes	Yes	Yes	Yes
MHSS	DeabVeasna/MSM	Yes	Yes	Yes	Yes	Yes
MHSS	PhumPhearun/CSO	Yes	Yes	Yes	Yes	Yes
MHSS	San Say/MSM	Yes	Yes	Yes	Yes	Yes
MHSS	HortVireak/MSM	Yes	Yes	Yes	Yes	Yes
MHSS	Leam La/MSM	Yes	Yes	Yes	Yes	Yes
MHSS	Sao Ratha/Ad	Yes	Yes	Yes	Yes	Yes
LWD	KhimVichit/Assitant PM	Yes	Yes	Yes	Yes	Yes
KYA	MithNak/Director	Yes	Yes	Yes	Yes	Yes
KWCD	Say Nara/Coordinator	Yes	Yes	Yes	Yes	Yes
KWCD	Torn Sreychin/TG	Yes	Yes	Yes	Yes	Yes
KOSHER	Nguon San/ED	Yes	Yes	Yes	Yes	Yes
Korsang	TaingPhoeuk/ED	Yes	Yes	Yes	Yes	Yes
KHANA	ChuobSokchamrouen	Yes	Yes	Yes	Yes	Yes
KHANA	TithKimuy/Deputy Director	Yes	Yes	Yes	Yes	Yes
KBA	Mrs. Yan Somaly/PC	Yes	Yes	Yes	Yes	Yes
KBA	Yan Somally/PC	Yes	Yes	Yes	Yes	Yes
ILO	ChhungPor/ HIV FP	Yes	Yes	Yes	Yes	Yes
IDA	Pan Sopheap/Coordinator	Yes	Yes	Yes	Yes	Yes
HoF	ChormVichit/Project Officer	Yes	Yes	Yes	Yes	Yes
HOF	VenSavath/Staff	Yes	Yes	Yes	Yes	Yes
HI-F	Hou Navy/Staff	Yes	Yes	Yes	Yes	Yes
HAI	KloutPhally/CO	Yes	Yes	Yes	Yes	Yes
GENEROUS	ChhonSokhoeun/ED	Yes	Yes	Yes	Yes	Yes
FRC	Mr. NengVannak,	Yes	Yes	Yes	Yes	Yes
FRC	NengVannak/HOD&LO	Yes	Yes	Yes	Yes	Yes
FHD	SimRattana/QHS	Yes	Yes	Yes	Yes	Yes
Esther	NhimSovanvuty/Coordinator	Yes	Yes	Yes	Yes	Yes

EOS	PhanSovann/CHEFM	Yes	Yes	Yes	Yes	Yes
EOS	Dy Na/PM	Yes	Yes	Yes	Yes	Yes
EOS	PhinBunly/PC	Yes	Yes	Yes	Yes	Yes
DYMB	NhemSopheap	Yes	Yes	Yes	Yes	Yes
DCWO	SomSophat/Program	Yes	Yes	Yes	Yes	Yes
CWPP	MeasChakriya/OW	Yes	Yes	Yes	Yes	Yes
CWPP	KronSarith/OW	Yes	Yes	Yes	Yes	Yes
CWPP	Chhorn Ann/ PM	Yes	Yes	Yes	Yes	Yes
CWPP	KrySoNornn/PC	Yes	Yes	Yes	Yes	Yes
CWPP	Kong Sopheap/EW	Yes	Yes	Yes	Yes	Yes
CWPP	SomSoyim/EW	Yes	Yes	Yes	Yes	Yes
CWPP	SleasRiya/OW	Yes	Yes	Yes	Yes	Yes
CWPP	EangSreyvan/OW	Yes	Yes	Yes	Yes	Yes
CWPP	MeasSokhum/OW	Yes	Yes	Yes	Yes	Yes
CWPP	KronSarith/OW	Yes	Yes	Yes	Yes	Yes
CWPP	Sun Sopheak/OW	Yes	Yes	Yes	Yes	Yes
CWPP	KeoSavin/PC	Yes	Yes	Yes	Yes	Yes
CWPP	KeoSichan/Coordinator	Yes	Yes	Yes	Yes	Yes
CWPP	OukPhalla/Staff	Yes	Yes	Yes	Yes	Yes
CWPP	KeoSichan/PC	Yes	Yes	Yes	Yes	Yes
CSSD	So Sophany/ED	Yes	Yes	Yes	Yes	Yes
CSO	So Sophany/CSO	Yes	Yes	Yes	Yes	Yes
CSDA	ChorgPhat/Staff	Yes	Yes	Yes	Yes	Yes
CSCN	NgetSobarak/ED	Yes	Yes	Yes	Yes	Yes
CRC	ThaingKimrin/Staff	Yes	Yes	Yes	Yes	Yes
CRC	Sao Sitou/PPC	Yes	Yes	Yes	Yes	Yes
CPR	Seng Tack/PM	Yes	Yes	Yes	Yes	Yes
CPR	SengTak/PM	Yes	Yes	Yes	Yes	Yes
CPR	Sin Sophun/CSo	Yes	Yes	Yes	Yes	Yes
CPR	Seng Tack/PM	Yes	Yes	Yes	Yes	Yes
CPR	MokKarona/CSO	Yes	Yes	Yes	Yes	Yes
CPN+	SornSotheariddh	Yes	Yes	Yes	Yes	Yes
CPN+	Sang Sopha/MMM	Yes	Yes	Yes	Yes	Yes
CPN+	Kim Kong/MMM	Yes	Yes	Yes	Yes	Yes
CNMWD	SouSotheavy/ED	Yes	Yes	Yes	Yes	Yes
Chhouksor	Sos Mary/Director	Yes	Yes	Yes	Yes	Yes
CHETRIG	Chan Vuthea/ED	Yes	Yes	Yes	Yes	Yes
CHETRIG	EaltSakphear/ED	Yes	Yes	Yes	Yes	Yes
CHETRIG	Mean Ben/CSV	Yes	Yes	Yes	Yes	Yes
CHETRIG	Kim Socheata/CSV	Yes	Yes	Yes	Yes	Yes
CHEC	KasemKolnary/ED	Yes	Yes	Yes	Yes	Yes
CHC	UngChoun/Staff	Yes	Yes	Yes	Yes	Yes
CHC	Meas Bora/Manager	Yes	Yes	Yes	Yes	Yes
CDRCP	LengSothea/ED	Yes	Yes	Yes	Yes	Yes
CCW	PrumDalish/PO	Yes	Yes	Yes	Yes	Yes
CARITAS	Song Bunthan/Admin and IT	Yes	Yes	Yes	Yes	Yes
CARITAS	Liv Sharon/PM	Yes	Yes	Yes	Yes	Yes
CARITAS	Kim Sokha/HBC	Yes	Yes	Yes	Yes	Yes
CARAM	Yin Sokunmah/PO	Yes	Yes	Yes	Yes	Yes

BFD	An Reoun/CSO	Yes	Yes	Yes	Yes	Yes
BFD	NhoekSophy/PM	Yes	Yes	Yes	Yes	Yes
BC	Bunthan/National Coordinator	Yes	Yes	Yes	Yes	Yes
Austria Aid	ChhunBunmeng/PM	Yes	Yes	Yes	Yes	Yes
AUA	HengChheang Kim/PM	Yes	Yes	Yes	Yes	Yes
AUA	Han Sienghorn/ED	Yes	Yes	Yes	Yes	Yes
ARM	SokSerm/Staff	Yes	Yes	Yes	Yes	Yes
ARM	SerngSopin/Consular	Yes	Yes	Yes	Yes	Yes
APHEDA	Ly Kimsong/PC	Yes	Yes	Yes	Yes	Yes
APCASO	RD Marte/PM	Yes	Yes	Yes	Yes	Yes
ANKO	Kong Samnang/staff	Yes	Yes	Yes	Yes	Yes
AHF	Than Meak/PFD	Yes	Yes	Yes	Yes	Yes
AHF	GneapSina/MSM	Yes	Yes	Yes	Yes	Yes
AHF	DyChenda/MSM	Yes	Yes	Yes	Yes	Yes
AHF	Tem Seyha/PA	Yes	Yes	Yes	Yes	Yes
AHF	ChoeunSinoeun/PC	Yes	Yes	Yes	Yes	Yes
AHEAD	HengBunseth/ED	Yes	Yes	Yes	Yes	Yes
AFESIP	So Sopkeak/Social Worker	Yes	Yes	Yes	Yes	Yes
AFESIP	Sopyrun/ORC	Yes	Yes	Yes	Yes	Yes
AFESIP	So Sopheak/OU	Yes	Yes	Yes	Yes	Yes
AFD	Chan Sophan/CHEFM	Yes	Yes	Yes	Yes	Yes

A.I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV? (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed less than 1.2)

Yes	No

IF YES, **what is the period covered** *[write in]*:

2011-2015

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.

The current National Strategic Plan for Multi-sectoral and Comprehensive response to HIV and AIDS (NSP III) is covering the period 2011-2015

The National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS 2011-2015 is built on the key guiding principles and apply to all its strategies, objectives and activities. Moreover, this strategic plan has built on the findings of the Functional Task Analysis (FTA) commissioned by NAA at the end of 2009 which provides comprehensive recommendations for organizational, management and leadership strengthening.

To maintain the declining incidence prevalence of HIV, prevention efforts need to prioritized to achieve the Three Zero targets i.e. 1) high coverage of quality of continuum of preventions and care services for most-at-risk population (MARPs), 2) Provision of quality care services for PLHIV 3) reduce stigma and discrimination on KAPs (Key Affected Populations)

Other key areas of focus are to increase technical and organizational of the National AIDS Authority and CBOs networks to effectively apply the recommendations of Cost-effectiveness of HIV prevention and impact mitigation for prioritizing interventions of the NSP III and making the best use of limited resources for concentrated HIV and AIDS epidemic.

The National AIDS Authority needs to engage key stakeholders to contribute to the development effectiveness innovations. More support is needed to support country system to act as the country accountability mechanism for HIV and AIDS response in Cambodia with the application of Program Based Approach (PBA).

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies

There are 29 ministries and secretariat involve for the development and implement of the National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS. They are: MoWA, MoND, MoInt, MoInf, MoT, MoEYS, MoLVT, MoH, MoNASRI, MoSVY, MoRC, MoCFA, MoP, MoPTC, MoIME, MoRD, MoLUMUC, Office of Council Minister, MoPWT, MoEF, MoAFF, MoEnv, MoFAIC, SoPC, MoCA and CRC.

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Social Welfare	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No

Young People	Yes	No	Yes	No
Other:	Yes	No	Yes	No
CRC, and other members of NAA	Yes	No	Yes	No
Infrastructure development	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

With the concentrated epidemic, it was hard to mobilize the funding support for Uniformed Services especially for young military recruits who have been deployed to border areas.

Not enough support to implement the recommendations of the survey on Most At Risk Young People

Not adequate attention to workers (both Khmer and Chinese) involved Infrastructure development such as road and bridge or hydropower dam on HIV prevention. The contribution of private companies for HIV response as corporate policy has been not been reactivated for a long time.

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	Yes	No
Elderly persons (not specific age)	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers (Entertainment Workers)	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations	Yes	No
SETTINGS		
Prisons (close setting)	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

Migrants/mobile populations especially cross-border to Thailand in remarkably increased over the past two years causing a difficulty to reach them on continuum of prevention , treatment , care and support. Retention rate of ART is only 83% in 24 Month and 76% at 60Months (data in 2012).

Sex Workers: The term sex worker is no longer use in current Cambodia context. The favorite word is entertainment worker (EW) instead of sex work worker. EWs are including both direct and indirect people who sell sex. This target group is among Most-at Risk Population and is a focus group that needs to be prioritized with highly attention on high quality of effective prevention intervention alike MSM and IDU groups. Come up with that MARPs Community Partnership Initiative (MCPI) provides a framework and operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach) to access to quality of service for PLHIV and integration of HIV impact mitigation into broader and national protection strategy of Royal Government of Cambodia.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/ young men	Yes	No
Other specific key populations/vulnerable subpopulations	Yes	No

1.5. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	No

1.6. Does the multisectoral strategy include an operational plan?

Yes	No

1.7. Does the multisectoral strategy or operational plan include?

a) Formal programme goals?	Yes	No	N/A
b) Clear targets or milestones?	Yes	No	N/A
c) Detailed costs for each programmatic area?	Yes	No	N/A

d) An indication of funding sources to support programme implementation?	Yes	No	N/A
e) A monitoring and evaluation framework?	Yes	No	N/A

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organized.

CSO had significantly contributed to support the government to put it commitment toward the United Nations Political Declaration on HIV and AIDS

In the NSPIII development and the implementation of The National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS 2011-2015.

In the establishment and implementation of Conceptual Framework of health sector for eliminating new HIV infection in Cambodia by 2020 aiming at eliminating HIV and AIDS.

In joining important platform for program design, policies and guidelines development and decision making process at country level such as CCC/GFATM and GDJ TWG

1.9. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No	N/A

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

Over the past two years, there was uneven engagement of key stakeholders to contribute to the development effectiveness innovations which has been guided through the Joint Government and Donors platforms of coordination.

Based on the exercise in the development of Investment Framework for an Effective and Efficient response to HIV/AIDS, it is found that it was no easy to move stakeholders from HIV specificity toward HIV sensitivity. In this regard, not enough support for moving needed HIV affected households from dependency to resilience with appropriate livelihood and microfinance support.

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS

Common Country Assessment/UN Development Assistance	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
National Social Protection Strategic Plan	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other *[write in]*:	Yes	No	N/A
Program Based Approach (PBA) has been applied mostly in health sector (not effective)	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	Yes	No	N/A
HIV impact alleviation (including palliative care for adults and children)	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support (including social protection or other schemes)	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other *[write in]*:	Yes	No	N/A

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes? (2010)

Yes	No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a plan to strengthen health systems?

HIV and AIDS program has remarkably contributed in strengthening health system (from national to sub-national level through the use of 100 M USD over the past two years.

The Cambodia 3.0 framework encapsulates the key steps to be taken in eliminating of new HIV infections through (1) early diagnosis of HIV infection and early access to ART as prevention and a boosted continuum of care, (2) boosted prevention of mother-to-child HIV transmission, (3) boosted access to -- and utilization of -- prevention, care and treatment services by most-at-risk populations, (4) strengthening of community-based health services, and (5) enhanced monitoring and evaluation of impacts.

5. Are health facilities providing HIV services integrated with other health services?

Area	Many	Few	None
a) HIV counselling & testing with sexual & reproductive			
b) HIV counselling & testing and tuberculosis			
c) HIV counselling & testing and general outpatient care			
d) HIV counselling & testing and chronic non-communicable			
e) ART and tuberculosis			
f) ART and general outpatient care			
g) ART and chronic non-communicable diseases			
h) PMTCT with antenatal care/ maternal & child health			
i) Other comments on HIV integration:			

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, health sector has been implementing a new conceptual framework for elimination of new HIV infections in Cambodia by 2020 ("Cambodia 3.0").

There was a continued overall decline of national HIV prevalence in the population at large from a peak of 2% in 1998 to 0.7% in 2012, according to estimation and projection models.

Associated with a considerable scale-up of HIV counselling, testing, care and treatment, the estimated number of new HIV infections plummeted from almost 15 000 to 20 000 annually in the early 1990s to around 1300 in 2012.

To bring the mother-to-child transmission rate of HIV to below 5%,"boosting strategy" has been implemented to successfully scale up routine voluntary testing and counselling at point-of-care and provide, simultaneously, antiretroviral therapy to all eligible women.

The treatment coverage rate among PLHIV was higher in 2009 than in 2012. This seeming decline has to be interpreted against the background of changing criteria for starting ART, from CD4<200-250 in 2009 to CD4<350 in 2012.

What challenges remain in this area:

Structures, capacities and services dedicated to HIV and STI prevention, care and treatment and the early diagnosis and treatment of HIV/tuberculosis co-infection

Access to services by the MARPs should be expanded, and in some cases revitalized, in a supportive legal and policy environment.

Follow-up along the cascade of services, from creation of and demand VCCT to sustained

and efficiently-monitored use of care and treatment should be strengthened through effective and more strategic information management, linkage of data bases and tighter communication and collaboration among service providers.

Sharper epidemiological targeting and more effective interventions introduced at sufficient intensity and scale geared to identifying new HIV infections and introducing early treatment

Access to, and voluntary use of, VCCT by pregnant women attending ANC expanded with full and timely provision of ART for life during pregnancy and/or shortly before delivery to protect their offspring from HIV infection.

Stronger synergy fostered within the health sector and across other sectors of development.

Greater support to health personnel provided through improved salary, skills upgrading and incentives to ensure staff retention.

External financing sustained and a growing financial share secured from national sources.

A.II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers

Yes	No

B. Other high officials at sub-national level

Yes	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

Samdach Akak Moha Sena Padei Techo Hun Sen, Prime Minister orders the Council of Cabinets to issue the Seven Points Policy directives to guide actions toward key areas for the response to HIV and AIDS in Cambodia.

Cambodia's successes in its fight against HIV and AIDS can largely be identified as the result of political commitment at the highest level of government, supported by the leadership, dedication and mobilization of the First Lady Samdach Kittiprit Bandit Bun Rany Hun Sen. First Lady does a critical role model with her empathy, passion to marginalized people in both national and sub-national level. For example, she always support to vulnerable children, pregnant women and disable people.

2. **Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?**

Yes	No

2.1. IF YES, does the national multisectoral HIV coordination body:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, what is his/her name and position title?		
Have a defined membership?	Yes	No
IF YES, how many members? *29 Ministries and 24 Provinces and Municipalities*		
Include civil society representatives?	Yes	No
IF YES, how many? Currently there are 120 NGO working on HIV and AIDS		
Include people living with HIV?	Yes	No
IF YES, how many?		
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and	Yes	No

3. **Does the country have a mechanism to promote coordination between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?**

Yes	No	N/A

IF YES, briefly describe the main achievements:

CSO representative sits in important coordination forum such as the GDJTWG on HIV and AIDS, in CCM/GFATM and Technical Advisory Board. CSO had joined in the meetings and workshops as well as joining in developing some policies and guidelines such as NSP review among CSO, Technical Support Plan, Boosted CoPCT, and other nation standard and guideline for better response to HIV and AIDS. CSOs member and representative had contributed to strengthen commitment of the government through being a full member of other national TWGs.

The CBCA (Cambodian Business Coalition on AIDS) has been able to engage employers of private companies to apply non stigma and discrimination against PLHIV and install enabling environment in the workplace. GMAC and CAMFEBA has been stronger supporter of the integration of HIV and AIDS in the workplace issue by the Ministry of Labor

Vocational Training.

What challenges remain in this area:

The connection between grass root Out Reach workers, Self Help Groups with upper level is somehow not well coordinated. In this regard, evident based findings for decision making among CSOs especially at the sub-national level is somehow not well reported to national level.

Participation of Key affected populations (KAP) in M/E process is limited.

4. **What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?**

0%

5. **What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?**

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]:	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies? (review only policy but not law)

Yes	No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	No

IF YES, name and describe how the policies / laws were amended

Ministry of Justice Explanatory Notes on the Law on the Suppression of Human Trafficking and Sexual Exploitation particularly in relation to prohibition on use of condoms as evidence, the legality of selling sex in private (which is legal between consenting adults), and the restrictive meaning of 'soliciting'.

The 7 points Policy Directives suggests added the fight against AIDS and mother health-care as additional points in the Village-Commune Safety policy of the Ministry of Interior.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

As far as the law and policies is concerned, there was no major inconsistency between HIV

and AIDS policies and other ministerial order or other sector law or policies instrument. The joint efforts between NAA, NACD, Ministry of Interior and local with support of UNAIDS, MOH, WHO, UNODC, FHI, HARP in the Police Community Partnership has been addressing remaining negative attitudes to a harm reduction approach, 100% Condom use Program in 34 hot spots in the country.

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

***Since 2011*, what have been key achievements in this area:**

Outstanding national leadership, commitment and progress towards the achievement of MDG 6, particularly in working towards halting and reversing the spread of HIV. By averting large numbers of 'downstream' infections, the early Cambodian response curbed the transmission that was driving the epidemic, later enabling the programme to reach universal access to antiretroviral treatment.

Strong political support from the Royal Government of Cambodia, 7-points policy directives has been issued by the Council of Ministers in December 2013 to guide focus interventions and to strengthen coordination with key stakeholders: (1) support for country mechanism to mobilize resource for HIV and AIDS response in the country : and (2) Mobilization at least 100 MUSD in 2012 and 2013 for HIV and AIDS response in Cambodia (referring to NASA IV (50.9 MUSD for 2012 where 11% was generated from government)

Joint efforts in securing 71 MUSD for Phase II of SSF / GFATM for 2014-2015

New Conceptual Framework for the elimination of new HIV infections in Cambodia by 2020 ("Cambodia 3.0") developed by NCHADS/Ministry of Health and apply in 2012 and 2013 with different sources of funding.

Some thematic reviews of NSPIII have been undertaken (Health sector, gender assessment, HIV sensitivity and social protection, Legal and policies review…)

Key stakeholders have been working to formulate the contribution of HIV and AIDS in the NSDP 2014-2018

What challenges remain in this area:

Not enough cross-border collaboration to address the need of migrant and mobile populations (continuum of prevention, treatment, care and support) as well as social and legal services to reduce their vulnerability.

There were poor health seeking behavior among MSM/TG and poorer networking of MSM/TG compared to EWs.

Room for improvement of engaging private sector as social corporate responsibility for the response to HIV and AIDS is still limited.

More engagement of young people in contributing to policy and program design and resource mobilization for HIV and AIDS response is still a challenge.

A.III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS AND VULNERABLE GROUPS

People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers (EW)	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:

The Law on the Prevention and Control of HIV/AIDS was enacted by the National Assembly since 2002. In chapter VIII it is clear state on non-discrimination to people living with HIV/AIDS such as they should have equal rights to access public services, testing working and other involvement of the preparation any strategy and policy. This Law also has its implementing guidelines (2005) outlines measures to combat discrimination. Prohibit discrimination against people living with HIV by law enforcement officers and in prisons and detention / rehabilitation centers.

Moreover, the national Law does not have a specific law on non-discrimination. However, Article 31 of the Constitution states all citizens shall be equal before the law and have the same freedoms and obligations. Protection is afforded to PLHIV and key affected populations through a number of policies and other legislation.

Briefly explain what mechanisms are in place to ensure these laws are implemented:

The enforcement of HIV/AIDS Laws and policies use the mechanism consist various commissions of the National Assembly such as Human Rights, Health & Women & Social Welfare; and oversight mechanisms at the national (ministry) and local (sub-national democratic development institutions) levels. The Legal and policy technical working group is a committee to oversight and monitor the implement of HIV/AIDS Laws. The member of technical working group include, Ministry of Justice, Ministry of Interior and other respect institution

To inform efforts to develop new legal service options to address HIV-related legal problems, a Toolkit for Scaling up Comprehensive Legal Services in the context of HIV is being developed by CPN+ with support from UNAIDS and KHANA.

Visit to National Assembly and Senate has been planned as results of the implementation of PCPI and especially the recommendations of Legal and Policies review related to HIV and AIDS.

Briefly comment on the degree to which they are currently implemented:

Although, there are clear structures and mechanism for implementing and monitoring

HIV/AIDS Laws and its policy, there are still remain challenges with limited capacity and no enough financial support to the implementation of Laws and policies.

2. Does the country have laws, regulations or policies that present obstacles6 to effective HIV prevention, treatment, care and support for key populations and vulnerable groups

Yes	No

***IF YES,* for which key populations and vulnerable groups?**		
People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations [write in below]:	Yes	No

Briefly describe the content of these laws, regulations or policies:

Actually the application of Harm Reduction has not cause direct obstacles for PWID. However, the lack of resources to support a large range of services (health and non-health) causes the difficulty for PWID to show up to enroll in the program.

Briefly comment on how they pose barriers:

PCPI creates partnerships through capacity building and facilitates dialogue and problem solving during coordination meetings at community level. The process entails a series of sensitization workshops and trainings, co-facilitated by government and implementing NGO partners. Police then conduct coordination meetings every two months at post level and quarterly meetings at sub-district and municipal levels to address barriers to HIV efforts.

A.IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No

IF YES, **what key messages are explicitly promoted?**		
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes	No

Is HIV education part of the curriculum in:		
Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?

Yes	No

b) gender-sensitive sexual and reproductive health elements?

Yes	No

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

Yes	No

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

	IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations *[write in]*
Condom promotion						
Drug substitution therapy						
HIV testing and counseling						
Needle & syringe exchange						
Reproductive health, including sexually transmitted infections						
Stigma and discrimination						
Targeted information on risk reduction and HIV						
Vulnerability reduction (e.g. income generation)						

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

***Since 2011*, what have been key achievements in this area:**

Cambodia 3.0 Framework with Boosted CoCPCT through accelerating HIV Case Detection and Maximizing Retention towards Zero AIDS Deaths in Cambodia. New innovative approach has been applied in the streamlined HTC Model to Accelerate HIV Case Detection where every Health Center and Hospitals and meeting point such as (Karaoke, sauna, massage...) or CBO send to HTC.
Policy change to streamline testing procedures (Finger-Prick, Task Shifting) for community testing targeting Key Affected Population (KAP) has been advocated
HTC for partners and adolescent has been established along with TAsP
Introduce maintenance of ART for Key population at the community level
Positive prevention

Harm Reduction PCPI

What challenges remain in this area:

Logistic support for reagent in the new innovative the streamlined HTC Model with appropriate supply chain starting from forecast. Policy change to streamline testing procedures using Finger-Prick requires task shifting and appropriate training for community testing targeting KAP The coordination between gate keeper of the enabling environment, establishment owners, health Care providers and Village health volunteers at Health centers level, especially in the hot spot areas Involvement of partners in the positive prevention

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No

***IF YES*, how were these specific needs determined?**

Sharper epidemiological targeting to optimize Boosted CoPCT: The objective should be to reach remaining pockets of individuals at very high risk of acquiring HIV/STI and of transmitting infections to new partners.

***IF YES*, what are these specific needs?**

See 3.2 (above) Better coordination between Public Security officials working as Community Enablers and health care providers, local authority and entertainment establishment owners To reach the unreached population (PWID, street based EWs, high class EWs, TG/MSM…)

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Economic support e.g. cash transfers	1	2	3	4	N/A
Harm reduction for people who inject	1	2	3	4	N/A
HIV prevention for out-of-school young	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A

HIV testing and counseling	1	2	3	4	N/A
IEC on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
Reduction of Gender based violence	1	2	3	4	N/A
School-based HIV education for young	1	2	3	4	N/A
Treatment as prevention	1	2	3	4	N/A
Universal precautions in health care	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

A.V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

***If YES*, Briefly identify the elements and what has been prioritized:**

Boosted COC, LR, TAsP

Briefly identify how HIV treatment, care and support services are being scaled-up?

Increase the level of CD4 Count up to 350 since mid 2010

TAsP to cover MARPS, serodiscordant couple (CD4 Up to 500), Option B+ (pregnant women), TB patients (regardless), Partner tracing

Increase uptake of HTC among MARPs by CPITC (including lay counselor by using finger prick)
D4T Phase out; Increase ART sites; expand services to close setting

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
Economic support	1	2	3	4	N/A
Family based care and support	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working	1	2	3	4	N/A
HIV testing and counselling for people with	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Palliative care for children and adults	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related	1	2	3	4	N/A
Other*[write in]*:	1	2	3		N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	No

The HIV Sensitive social Protection : A review of Cambodia's social protection schemes for incorporating HIV sensitivity , Council for Agriculture and Rural Development (CARD) mentions about Health Equity Fund, education scholarship, school meals, health vouchers, microfinance

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

Yes	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

Yes	No	N/A

IF YES, for which commodities?

Condoms, test kids, OI/ARV drugs and other lab equipment's

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

***Since 2011*, what have been key achievements in this area:**

If the denominator is the eligible PLHIV for ART. Currently, the current rate of ART users is as high as 82.6%)

Good collaboration between Health facilities and community

See above

What challenges remain in this area:

- Retention and adherence due to poverty and migration

-Quality of care limited and incentive support/ motivation

- Staff turnover in big scale

-Logistic supply management is limited

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No	N/A

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No	N/A

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

***Since 2011*, what have been key achievements in this area:**

School attendance of OVC through Community Based Health Care

Access to School feeding program

AIDS care on Children infected by HIV/AIDS (CIA)

Succession plan for OVC

Social Protection

Network of Women and Child focal point at commune level

What challenges remain in this area:

WFP support ends since the end of 2012 … leave to 50% cut off as compared to before 2012

HIV and AIDS donors put less priority of food support

More disaster (flood and drought) climate change; Land certificate were used by HIV affected households to borrow the money from the bank or microfinance institution.

A.VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes	In Progress	No

Briefly describe any challenges in development or implementation:

As part of Three-Ones Principle and under leadership of the National AIDS Authority, The National HIV/AIDS Monitoring and Evaluation System Strengthening Plan (NM&E SSP) has been developed since 2010 for 5-year period (2010-2015) to provide the setting for a coordinated monitoring and evaluation (M&E) of Cambodia's multi-sectoral response to the HIV/AIDS. The National HIV and AIDS M&E Guidelines has updated to the second edition in 2011 to ensure a coherent and integrated framework for Monitoring progress and evaluating the outcomes of Cambodia's multi-sectoral response to the HIV/AIDS epidemic as outlined in NSP III. National Monitoring and Evaluation Working Group has been created, which composed by government sectors, development partners, bilateral and multi-lateral donors. This national working group has clear ToRs and specific tasks to ensure the sound of the strategic information response to HIV/AIDS in Cambodia. Several challenges have been faced during implementation of the comprehensive plan and mechanism, however. The main challenges of the implantation are:

-Lack of common understanding at different levels of implements the M&E plan;

-Harmonization and alignment of understanding indicators 'definition and lead to law data quality;

-Insufficient partnership between national stakeholders and development partners;

-Lack of adequate and consistent evidence –based data and monitoring indicators related to gender and HIV, gender and Gender-based Violence (GBV) and social welfare for orphan and vulnerable children (OVC) ;

-Timeline for most population-based surveys, for example CDHS are not aligned to the reporting period of GARPR;

-Translating commitment from the M&E plan into action remains challenging because of limited capacity, structural complication and institutional disagreement;

-Limited discussion on the protocol, questionnaire and methodologies of conducting survey, surveillance and any studies;

-Insufficient resources to support the function of M&E components

1.1. IF YES, years covered [write in]:

2010-2015

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, some partners	No	No

Briefly describe what the issues are:

Since the NSP III has been developed, the M&E Framework is available for implementation. Under leadership of NAA, we have subsequent meetings and consultation process to harmonize national indicators and update the National Monitoring and Evaluation Guidelines to the second edition with clear definition. There were 56 harmonized indicators for both UA

health and multi-sectoral indicators to track the progress of the national response to HIV/AIDS in Cambodia. In the process of developing these indicators; all key partners such as UNAIDS, CSOs, Ministries, PLHA network and MARPR groups have been involved.

However, there was likely fairly involvement from bilateral partners and private sectors.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardised set of indicators that	Yes	No
Guidelines on tools for data collection	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In Progress	No

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

11% and above

Briefly describe any obstacles:

There is an M&E Unit under the Department of Planning Monitoring Evaluation and Research at NAA. In this Unit, there are five government staffs working for. The unit functioning somehow remains challenges. The most obstacles are: (1) inadequate capacity of staffs to deal with their daily work; and, (2) lack of equipment to support the M&E function, especially at sub-national level.

Moreover, the M&E system is still not properly functioning. Moreover, M&E system of various organizations are not parallel.

The second edition of the National M&E Guidelines has been developed since 2011, but it is not yet fully implemented due to insufficient capacity to translate the commitment into action.

4. Is there a budget for implementation of the M&E plan?

In the Ministry of Health?	Yes	No

In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere *[write in]*?	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces	Fulltime	Part time	Since
Permanent Staff [Add as many as needed]			
Director Department of Planning Monitoring			2001
Deputy Director of Department in charge of M&E			2001
Deputy Director of Department in charge of Database			2002
M& E chief unit			2010
Junior researcher			2001
	Fulltime	**Part time**	**Since**
Temporary Staff [Add as many as needed]			
M&E Specialist			2007
M&E officer			2013
Database and reporting			2013
M&E Coordinator			2007

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

Briefly describe the data-sharing mechanisms:

The 2nd edition of the National M&E Guidelines has clearly stated; the mechanism of data flow at national and sub-national level is shared by vertical and horizontal flows (ranging from the provincial to national levels and ministerial levels). The National M&E Technical Working Group is another mechanism to reinforce the flow data to verity sources. Moreover, data collection and reporting mechanisms have been developed, piloted, disseminated and documented. Also, after the GFATM approval grant on M&E sub-component, training to officers in data collection and reporting specific data has been started.

Civil society organizations and development partners have also their own M&E systems in place to capture data and generate reliable and useful information. These systems are mostly initiative supported by PEPFAR and GFATM.

What are the major challenges in this area:

The National M&E System aims to track input and output indicators as well as outcome and impact indicators. However, these data is not frequently found by direct relevant ministries, neither the National Monitoring and Evaluation system, particularly routine monitoring data.
Some challenges have faced during implementation:
-Staff have limited capacity to fully function M&E system
-Structural obstacles and institutional disagreement
-Lack of coordination efforts from key players

-Lack of routine monitoring data and report from key partners and ministries even though the
-Data collecting roles are clearly defined

-Insufficient resources support to the function of the current national database (Human resources, equipments, and software)

-Lack of Staff motivation for both national and sub-national level

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No

6. Is there a central national database with HIV- related data?

Yes	No

With support from UNAIDS, a new network server was installed at the NAA to improve the management and storage of data in the national multi-sectoral HIV/AIDS database. Many progresses has been achieved in collecting data and promoting the use of data from different sources. However, the effort is needed to strengthen and fix up the current database and make compatible with other major database in the health sector and CamInfo for easy integration of HIVV/AIDS data from other sectors

NCHADS has also data management in place and data collect from partners is quarterly basis. Data collect and store at NCHAD Database are mostly related to health services.

6.1. *IF YES*, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above	Yes, but only some of the above	No, non of the above

***IF YES*, but only some of the above, which aspects does it include?**

Several studies among key population have been conducted recently. Such as MSM size estimation and evaluation; IBBS for DU/IDU, Bros Khmer Survey for MSM, TraC by PSK for young population.

6.2. Is there a functional Health Information System

At national level	Yes	No
At sub-national level	Yes	No
IF YES, at what level(s)? *[write in]*		

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs	Estimate of current need only	No

7.2. Is HIV programme coverage being monitored?

Yes	No

(a) IF YES, is coverage monitored by sex (male, female)?

Yes	No

(b) IF YES, is coverage monitored by population groups?

Yes	No

IF YES, for which population groups?

EWs, MSM, DUs/IDUs, young peoples, Gender, OVC etc

Briefly explain how this information is used:

The information have been use in annual workshop, the national congress; publication through quarterly and annually report, newsletters; upload into website and storage into national database

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?

-At national level

-At provincial level

-At district level

Briefly explain how this information is used:

Through coordination Meetings and disseminate as hard copies

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Yes	No

9. How are M&E data used?

For programme improvement?	Yes	No

In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other *[write in]*:		

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

The M&E data has been used for preparing quarterly and annually report regularly. Moreover, the M&E data has been used as information for the global AIDS response report. However, the availability and quality data remains challenges:
-Some data are missing for particular group such as DU/IDU, OVC, and sex workers.
-Quality of data is still limited
-Some questions are not integrated into the routine monitoring plan in term of genders, young people...

10. In the last year, was training in M&E conducted

At national level?	Yes	No
IF YES, what was the number trained: 3 (NMCH, MoSVY, NAA)		
At subnational level?	Yes	No
IF YES, what was the number trained: 3 trainings (Provincial PMTCT Staff)		
At service delivery level including civil society?	Yes	No
IF YES, how many? 4 trainings		

10.1. Were other M&E capacity-building activities conducted other than training?

Yes	No

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

M&E Capacity trainings
TraC 2012

BSS 2013
IBBS 2013
National AIDS Spending Assessment (NASA) IV
HLM Mid Term Review
Health Sector Review

What challenges remain in this area:

Since the establishment of the GFATM reprogramming in 2013, the approval was delayed approval until Jun 2013. Many important activities regarding the M&E could not conduct timely, such as OVC size estimation, joint annual review, Mid-term Review of NSP III, and M&E Training

B.I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policyformulations?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
• CSOs feel that they have significantly contributed to supporting the government in their efforts in honoring the United Nation Political Declaration on HIV and AIDS on preventing new HIV infections through developing a conceptual Framework for Elimination of New HIV infection in Cambodia by 2020. • CSO have contributed to the development of the Cambodia three - zero(zero new infection, zero AIDS related death and zero discrimination) by helping to formulate the strategy and plan activities to implement the strategy. • CSO have participated in meetings and workshops as well as contributing to the developing of policies and guidelines such as NSP review among CSO, Technical Support Plan, Boosted CoPCT, and other national standards and guidelines for a better response to HIV and AIDS. CSOs members and representatives have contributed as members of various national TWGs. • Yet, in recent years, some NGOs working on HIV and AIDS, particularly local NGOs and CBOs, are facing resource shortages that decreases their ability to represent and participation.

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representativesbeen involved in the planning and budgeting process for the National Strategic Planon HIV or for the most current activity plan (e.g. attending planning meetings and reviewingdrafts)?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
• Civil Society Organization (CSO) representatives, men who have sex with men (MSM) networks, entertainment worker (EW) networks, transgender (TG) representatives and people living with HIV (PLHIV) networks were systematically engaged in the planning process of the National Strategic Plan review, (this was not developed during the reporting period!, national operational procedures (SOP) and annual operational plans for both technical and financial planning. HACC play an important role in gathering input and concerns of its network members and CSOs to contribute to these strategic plans. • CSO increased its participation in the development of national strategy and policies. For example, provincial level CSO were invited to contribute to the investment plan and integrated HIV/AIDS plan. At the national level, the policy board engaged representatives of CSOs to participate in its meetings.

- Due to reduced financial support in recent years, regional CSO had to cut travel to attend national level meetings and workshops. This led to limited CSO participation in planning and budgeting processes.

3. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:**

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The national HIV budget (national budget refer to the total budget of Cambodia response to HIV and AIDS activities including Global Fund, private sector and government budget)?

LOW					HIGH
0	1	2	3	4	5

c. ***The national HIV reports?***

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

- The activities of CSO were planned to contribute to the nationally agreed programme and formulated in the National Strategic Plan (NSP), annual operational plan, and national standard operating procedures and guidelines.
- CSO are systematically engaged as an integral part of the national HIV response in terms of implementation and reporting the progress. The achievements of CSO, especially the prevention intervention among most at risk population (MARPs), care and treatment, impact mitigation and strategic information were highlighted in national reports where applicable.
- CSO members such as Cambodia People Living with HIV Network (CPN+) and NGO working with EW and MSM engaged in the development process of GARPR at the sub-national level mentioned that they have never got any financial support from the government budget to implement their activities related HIV and AIDS.
- Specific target groups such as male partners of high risk EW were not included in the NSP III.

4. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society includedin the monitoring and evaluation (M&E) of the HIV response?**

a. Developing the national M&E plan?

LOW					HIGH

0	1	2	3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
• CSO play a crucial role in contributing both technical expertise and financial support to the government in M&E planning, M&E implementing and using M&E and research results. There were several CSO representatives include HIV/AIDS Coordinating Committee (HACC), FHI 360, KHANA, Population Service Khmer (PSK), Marie Stopes International Cambodia (MSIC), Reproductive Health Association of Cambodia (RHAC), Cambodia People Living with HIV Network (CPN+) and MARPs' networks in the national level technical working group (TWG) such as National M&E TWG and other related M&E and research committees. • There was less involvement of CSO at the sub-national level in the monitoring and evaluation of HIV and AIDS. The PASP budget is limited, therefore not all provinces can be represented; of all CSO who were invited not all accepted. All NGOs working at the sub-national level need to send quarterly report to Provincial AIDS and STI Program (PASP) on the progress of HIV related activities using PAPS format. • Participation and representation of Key affected populations (KAP)in M/E process is limited. There is a big gap to be filled in this area.

5. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, and faith-based organizations)?**

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
• The government acknowledges the significant contribution of CSO in the Cambodia and their achievements in response to HIV and AIDS, particularly organizations such as EW networks, MSM networks, TG networks, CPN+, AUA, WNU, CCW, HACC, International NGOs, local NGOs, CBO and faith-based organizations. However we still do not have a meaningful level of participation from KAP overall.

6. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:**

a. Adequate financial support to implement its HIV activities?

LOW					HIGH

0	1	2	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
• Through the financial support from the Global Fund, Australian Aid Program and USAID – Flagship project as well as other development partners, CSO in Cambodia have sufficient funding for program activities on HIV, particularly for targeted programs for only MARPs and PLHIV. However, there is no any access for CSO to the government budget for HIV and AIDS. • The technical assistance in implementing HIV activities provides stability and continuity in services in Cambodia and tends to build local capacity and MARPs network in response to HIV and making a resilient community. However, there is insufficient technical support from the government. • To ensure services can be provided longer term the government must increase its contribution in funding and technical supports for implementing HIV activities. • The CSO are aware that the national budget allocated to HIV and AIDS contributed 11% of the total funding and this does not cover development or implementation of activities (NASA IV – 2013).

7. ***What percentage* of *the following HIV programmes/services is estimated to be provided by civil society?***

Prevention for key populations				
People living with HIV	<25%	25-50%	51-75%	>75%
Men who have sex with men	<25%	25-50%	51-75%	>75%
People who inject drug	<25%	25-50%	51-75%	>75%
Sex workers	<25%	25-50%	51-75%	>75%
Transgendered people	<25%	25-50%	51-75%	>75%
Palliative care	<25%	25-50%	51-75%	>75%
Testing and counseling	<25%	25-50%	51-75%	>75%
Know your rights/legal service	<25%	25-50%	51-75%	>75%
Reduction of stigma and discrimination	<25%	25-50%	51-75%	>75%
Clinical services (ART/OI)	<25%	25-50%	51-75%	>75%
Home based-care	<25%	25-50%	51-75%	>75%
Programme for OVC	<25%	25-50%	51-75%	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

Very poor		Excellence

0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• The government is a crucial partner of the CSO in the fight against HIV, however almost all of the activated and service are provided by CSO. • Based on NASA-IV 2011-2012, around 90% of the total budget spent on HIV and AIDS in Cambodia came from CSO and development partners. CSO through its representation of vulnerable group, MARPs, PLHIV, and NGOs working on HIV have significantly contributed to the NSP review, technical support plan, national standard operation procedure (boosted SoP), and other new initiative of the government at both national and sub-national level. • For example: the Flagship consortium in close collaboration with NCHADS conducted the comprehensive GIS mapping of MARPs in 11 ODs in 5 provinces and municipality include Phnom Penh, Kampong Cham, Siem Reap, Banteay Meanchey, and Preah Sihanuk to provide strategic information of MARPs' hotspot to guide the national response to the right targeted area (high risk hotspots) for HIV intervention. • CSOs play an important role in supporting both technical and financial support the government to ensure its effective implementation of NSP and nation standard operation procedure especially on the prevention intervention, strategic planning, and monitoring and evaluation of HIV and AIDS program in the Country. • CSO worked to support and strengthening the implementation of M&E systems among their own organizations in response to changes in the national M&E systems. For example, HACC has provided the capacity building to NGOs working with MARPs and OVC on M&E through 5-day training including basic M&E technique, data collection, data compilation, data cleaning, data analysis and data use.
What challenges remain in this area:
• CSO are involved in the planning, implementing, monitoring and evaluation of the HIV and AIDS response still face limited financial support. This limits their ability to deliver and monitor activities and services. • It can be difficult to create the environment where MARPs feel comfortable accessing and engaging with services, activities and supports. For example; CSO reported that many MARPs do not feel comfortable leaving their homes or are constantly on the move. • MHC, CPWD and SCC report that it is still difficult to reach MARPs especially PWID, MSM and TG as they do not engage in society (often they remain at home for long periods of time) and are worried about being arrested by police • There is less implementation from the government concerning the prevention intervention activities of the HIV response. • Clinical services for MARPs (Pre-ART/ART) are rare among CSO as there is only Chhouck-Sar clinic that provide HIV/AIDS services specifically to MARPs.

- The HIV testing and counseling at community level has not been sufficiently implemented by NGOs. For example, the finger-prick testing was only implemented in semester of 2013.

II. Political Support and Leadership

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No

IF YES, describe some examples of when and how this has happened:

- Key populations and vulnerable group's networks became members of the national Joint Government Donor TWG, were included as voting member in the Global Fund country coordinating committee and were members of working groups of Boosted Continuum of Prevention to Care and Treatment (CoPCT) TWG of NCHADS and other national strategies and national technical working groups.

III. Human Rights

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations *[write in]*	Yes	No
• Domestic Violence Law		

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

- Constitutional Law that protect all general people in Cambodia
- Law on the prevention and control of HIV/AIDS in Cambodia

• The Convention on the Elimination of All Form of Discrimination against Women (CEDAW) • Law on the Protection and the Promotion of the Rights of Persons with Disability • Child protection policy
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
• Establishment of Provincial Orphan and Vulnerable Children Task Force (POVCTF), Commune Council of Women and Children (CCWC), District AIDS Committee (DAC), Commune AIDS Committee (CAC), Commune Council (CC), TCC, MAC, Provincial AIDS Committee (PAS), Provincial AIDS and STI Program (PASP), and Village Health Support Group (VHSG).CSO report that there is significant overlap in the area that these committees are working. Consolidation of these committees could make them more effective. • The establishment of the monitoring and evaluation of HIV and AIDS programs and care and support services for OVC and victims of gender base violence has been positive, however there is still significant challenges in implementing and enforcing the law and regulation in this area.
Briefly comment on the degree to which they are currently implemented:
• There are documentation available concerns the legal framework related to non-discrimination of PLHIV and other vulnerable groups. However the implementation of these laws and policy is still a challenge because some may conflict with other recent law and policy formulated by the government. For example, the 100% condom use program which was endorsed by the government through Prakas 066 to be implemented for HIV intervention in Cambodia since 1999 is contradicting with the commune and village safety policy and Law on the suppression of anti-human trafficking and sexual exploitation. • The report of national review of legal and policy frameworks 2013 has identified that implementation of the protective Laws is very limited in particular to those which are related to PLHIV and key affected population (KAPs).

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No

Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations *[write in]*	Yes	No

Briefly describe the contents of these laws, regulations or policies:
• There is a conflict in the laws of Cambodia between HIV intervention and the enforcement of anti-drug and anti- prostitution laws including: • Law on Drug Control • Commune/village safety policy, on the "no drugs use and circulation"; "no children and women trafficking"; "all sex workers are considered as trafficked women"; • Law on Suppression of Anti-Human Trafficking and Sexual Exploitation

Briefly comments on how they pose barriers:
• There have been several discussion has been made since 2011 among key players such as Ministry of Interior, Ministry of Health, NAA, NCHADS, NACD, and CSO on the contradictions between the implementation of these policies and HIV program implementation, those parties had clarify and remove the barrier of misunderstanding and interpretation of law by agreeing that possession of a condom is not evidence of sexual trafficking anymore (until the 2013 explanatory note endorse by the Ministry of Justice. • However the implementation of these explanatory note by some local authority is still a big problem that leads MARPs especially EW not carry condom because they fear arrest. • NGO report that there is still the perception within the Cambodia society that sex workers, PWID, MSM, and TG are considered as anti-social elements. This makes it difficult to work with MARPs freely. • Sex workers are arrested in public parks for soliciting sex, disturbing the peace and social security, etc. Condoms are still used as evidence for soliciting sex (All NGOs reported this is still the case). The baseline survey on the enabling environment for MARPs (PCPI) in Phnom Penh in 2012 by FHI 360 mentioned that 15.5% of EW participants reported having been arrested in the past 12 months. • The same situation has been raised by PWUD and PWID as the police still arrest people who use drugs but do not sell or circulate drugs even though the law has clarified that use of drugs is not illegal. In the 2012 PCPI baseline survey mentioned that 40.7% of PWUD were arrested in the past 12 months; of these, more than half (54%) were arrested due to using drug.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.
• Domestic Violence Law • The Convention on the Elimination of All Form of Discrimination against Women (CEDAW) • Law on Suppression of Human Trafficking and Sexual Exploitation • Law and Drug Control • Marriage Law • Polygamy Law

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
• National Strategic Plan III; in the guidance principal of the NSP had clearly states that "Human Right Based" and "Gender based" approaches are to be respected. • National Guideline on Client Rights and Provider Rights (MoH); this guideline mentions clearly the equality of people in accessing care and treatment services, privacy, confidentiality and the right to make informed choices. • Boosted CoPCT SOP has a section that mentions human rights, legal service and gender based violence • The seven-point policy which is recently endorsed by the government in late 2013 is great effort of government and civil society in HIV and AIDS response especially on the reinforcement of the 10o% condom use policy, enable in accessing to care and treatment among MARPs and integrate HIV response into the commune and village safety policy.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	No

IF YES, briefly describe this mechanism:
• Despite the existence of laws on the prevention and control of HIV/AIDS, which clearly prohibits discrimination on the perceived or actual status of HIV, there is a lack of functioning mechanisms for recording, documenting or addressing discrimination faced by

PLHIV.

- Stigma Index 2010 provides evidence that discrimination based on the HIV status exists in communities, health institutions, education sector and for employment. In the same study, 67% of PLHIV who had their rights violated had attempted to access legal assistance but only 6% knew about any legal service NGOs to approach for help. 39% of all physical harassment/threats experienced by WLHIV had been due to their HIV status.

- 89% of all physical assaults on WLHIV had been perpetrated by those living in the same household and they were also discriminated by their neighbors (23%).

- WLHIV were about twice as likely to suffer from psychological pressure from their spouse/partner (45%) or be subjected to gossip (31%).

- In the absence of a functioning mechanism, not a single case has been reported. National review of Legal framework (2013) has strongly recommended the establishment of a functioning mechanism for reporting HR violations and providing legal services.

- There are few cases of HIV related discrimination that have been recorded separately by NGOs and their networks for case study or success stories to be included in their own report, yet there is no clear mechanism for tracking and advocating in these areas of discrimination.

- CSO through HACC should create complaint mechanism and track all cases of discrimination. CSO and HACC should advocate to the government and development better solutions and outcomes for the victims of discrimination.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-of charge to all people in the country		Provided free-of charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
• PLHIV, EW, MSM, TG, PWID, PWUD, OVC, Pregnant women, pregnant positive women.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIVprevention, treatment, care and support?

Yes	No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
• Boosted Continuum of Prevention to Care and Treatment SOP for MARPs • Boosted Link Response • Boosted continuum of care (CoC) • Treatment As Prevention • National Strategic Plan (NSP) III • 100% Condom Use Program (CUP)

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
• Boosted Continuum of Prevention to Care and Treatment SOP for MARPs • Boosted Link Response • Boosted continuum of care (CoC) • Treatment As Prevention

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

IF YE,S briefly describe the content of the policy or law:
Law on the prevention and control of HIV/AIDS in Cambodia

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

IF YES on any of the above questions, describe some examples:
• National AIDS Authority and CPN+ play important role in ensuring non-discrimination and human rights protection for PLHIV, OVC and key populations. Legal Service such as LICADO, ADHOC, and CCHR generally focusing on human rights for general people not PLHIV. The institutions rein place, but the implementation of a commitment towards human rights protection is weak. Cambodia has only one human rights mechanism (Human Rights Committee). • The benchmark indicators for human rights are considered: • % of PLHIV reported human right violation in the past 12 month • % of PLHIV reported they experience discriminated in the past 12 month • % of OVC drop out of school due to their HIV status (their parent) *These indicators were included in the Stigma Index survey among PLHIV and Socio-economic impact of HIV at household level in Cambodia by UNDP in 2010.*

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?

Yes	No

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?

Yes	No

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

Yes	No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No

Other *[write in]*:	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

Very poor									Excellence
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• There is some documentation concerning the legal framework related to non-discrimination of PLHIV and other vulnerable group in Cambodia such as Law on the Protection and the Promotion of the Rights of Persons with Disability, The Convention on the Elimination of All Form of Discrimination against Women (CEDAW), Polygamy Law, Domestic Violence Law, Law on the prevention and control of HIV/AIDS in Cambodia, Marriage Law, National Policy On Cambodia Youth Development, Child protection policy, and Prison law that is still valid and implemented. • The Police Partnership Community Initiative (PCPI) was implemented in recent year which was considered as the community dialogue among local authority, HIV program implementer and key affected population as well health actors to discuss on the real issue happened in community and find out the solution and ways forward.
What challenges remain in this area:
• There is one legal framework exist in the country to protect people living with HIV and related discrimination issue, yet there is no specific law or regulation to protect the rights of specific population at risk such as EW, MSM, TG, PWID and PWUD. • There are 21.8% of EW, 6.9% of MSM, and 10.4% of TG who carry condom in the past 6 months reported fear of arrest by police for carrying condom (2012 PCPI baseline survey, FHI 360). • The prevention program for HIV among MARPs including harm reduction program, needle and syringe program (NSP)and methadone maintenance therapy (MMT) for PWID and PWUD exist in the Country, but there is still low awareness and even heard that program among police official is limited. In 2012 PCPI baseline survey mentioned that there is only 57% of police participants reported ever heard of harm reduction programs, 63% ever heard of NSP and only 11% ever heard of MMT service. • Those legal frameworks on rights related HIV should be applied for all sector including the private companies, but some companies do not fully respect the law. There is no monitoring of the implementation of this law in the private sector.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would yourate the effort to implement human rights related policies, laws and regulations in 2013?

Very poor										Excellence
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• Even there are some legal framework exist in the country, yet the implementation of those mentioned law and policy are still a challenge while some of those policy may conflict to the recent law and policy formulated by the government. • NAA, NCHADS, NCMH, and CSO play an important role in advocating to build better enabling environments for HIV and AIDS program implementation. For example, working to resolve the conflict in the laws relating to HIV and AIDS. • The implementation of the PCPI has starting to build better working environment at the community level by bringing all relevant key players including the local authority, police, health care worker, PLHIV and MARP to discuss on any obstacle and find out the solution. • CSO has also put significant effort into improving non-discrimination of HIV and AIDS at grass roots level. For example, CPN+ and AUA are working with the health sector to create environments for treatment and services that are free from discrimination.
What challenges remain in this area:
• Most of law enforcers are still not clear on few articles of law relating to the suppression of anti-human trafficking and sexual exploitation (SAHTSE) and commune/village safety policy that lead to miss interpretation and implementation which resulting contradicting with the HIV program implementation. For example; there are only 26% of EEs and hotspots where MARPs gather have condom available on site (GIS mapping of MARPs in 2013), this is because EE owner fear arrest or fine. • The dissemination of law is not widely conducted in national and sub-national levels. This means that the laws are implemented and interpreted by police and local authority only. • In the 2012 PCPI baseline survey conducted by FHI 360 mentioned that nearly 94% of police participants believed arresting and detaining MARPs was an appropriate solution for reducing HIV and AIDS as well as drug use. Additionally, a high proportion of police participants believed that MARPs should be arrested for using drugs (97%), selling sex (88%) and carrying needles and syringes (55%). • Human rights related HIV violation still a huge concern among MARPs in recent year. In the 2012 PCPI baseline survey conducted by FHI 360 shown that nearly one-fifth (17%) of MARP participants reported having been arrested and 70% of police participants reported having arrested a most-at-risk individual in the past year. PWUD participants had significantly higher rates of self-reported arrests than the other population of interest. • Some private sector company especially bank and micro-finance institution do not fully respect or implement the law related HIV and they not allow PLHIV to be employed in their firm (CPN+ and PLHIV)

IV. Prevention

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
• Conceptual Framework for Elimination of New HIV infections in Cambodia by 2020 • Boosted CoPCT SoP; • Sharpening the Boosted response for population at highest risk • Treatment As Prevention • 100% Condom Use Program (CUP100%) • Branded programs for MSM, EW and TG (Named SMART Girl, M Style, TG package of intervention) • NSPIII 2011-2015

IF YES, what are the specific needs?
• Foster the implementation of Police Community Partnership Initiative (PCPI) to remove the barrier of contradicting of the implementation of law/policy/regulation and the HIV program. • Community based treatment for PWID and PWUD – Methadone Maintenance Therapy (MMT) service • HIV prevention for young at risk people (in school and out of school) who are currently sexual active as well as positive prevention • Financial support

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Agree Strongly	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A

HIV prevention in the workplace	1	2	**3**	4	N/A
HIV testing and counseling	1	2	3	**4**	N/A
IEC on risk reduction	1	**2**	3	4	N/A
IEC on stigma and discrimination	**1**	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	**4**	N/A
Prevention for people living with HIV	1	2	3	**4**	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	**3**	4	N/A
Risk reduction for intimate partners of key populations	1	**2**	3	4	N/A
Risk reduction for men who have sex with men	1	2	**3**	4	N/A
Risk reduction for sex workers	1	2	**3**	4	N/A
School-based HIV education for young people	1	2	**3**	4	N/A
Universal precautions in health care settings	1	2	**3**	4	N/A
Other *write in*:	1	2	3	4	**N/A**

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

Very poor										Excellence
0	1	2	3	4	5	6	**7**	8	9	10

Since 2011, what have been key achievements in this area:

- Conceptual Framework for Elimination of New HIV infections in Cambodia by 2020
- Boosted CoPCT SoP
- Finger prick testing has been implemented by lay counselors (outreach workers) of MARPs
- Comprehensive GIS mapping of most at risk population hotspot
- Sharpening the Boosted response for population at highest risk
- Treatment As Prevention
- The unique identifier code (UIC) among most at risk population (MARPs) is being designed in late 2013 and will implement in early 2014 to avoid double counting and track all information service delivery with protecting the confidentiality
- 100% Condom Use Program (CUP100%) has been reactivated and reinforced in 2013

- Brand program (smart girl, Mstyle, TG package) – TG package launching on March 2014 at Siem Reap province

- Garment Manufacturers Association in Cambodia (GMAC) and Cambodia Federation Employers and Business Association (CAMFEBA) in the response to HIV AIDS in the workplace that help not only to reduce stigma and discrimination toward workers LWH in the workplace, but also to promote behavior change in preventing HIV in the workplace.

What challenges remain in this area:

- The financial support is decreasing for HIV and AIDS programs in Cambodia and as a result there are some NGOs(KWCD, KDFO, CUD and others) working on HIV that are close to, or beginning to, change their target areas to those other than HIV and AIDS.

- Misinterpretation and enforcement of HIV related law and policy is still a challenge for HIV program; as in the GIS mapping of MARPs finding shown that there is only 26% of entertainment establishment (EE) where condom is available on-site and there is 5% of EW hotspot were not cover by NGOs.

- There is an increasing duplication risk of MARPs while most of them are mobile

- Lack of IEC materials and condom distribution

- Difficult to reach MARP for prevention program because they often move from place to place and hidden as well,

- Most of beneficiaries are mobilized from place to place for income generating

- Behavior changes of MARPs are slightly increased for accessing to health care services. They still rely heavy on NGO support

V. Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:

- Clear national standard and guideline such as Boosted Link Response, Boosted CoC, and Treatment as Prevention

- Pre ART/ART

- Clear linkage from community to health facility (Referral System)

- MMM and home and community based care

- Social and child protection

- Continues Quality Control (CQI)
- TB – HIV and HIV – TB program

Briefly identify how HIV treatment, care and support services are being scaled-up?

- Increased number of Pre ART/ART site enables PLHIV to access those services.
- More than 90% of eligible PLHIV received ART
- Clear linkage and referral system from community to health facility (HBC, MMM, CoC, Health Facility)

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Agree Strongly	N/A
Antiretroviral therapy	1	2	**3**	4	N/A
ART for TB patients	1	2	**3**	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	**3**	4	N/A
Early infant diagnosis	1	2	3	**4**	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	**2**	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	**4**	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	**1**	2	3	4	N/A
Nutritional care	1	2	**3**	4	N/A
Paediatric AIDS treatment	1	2	**3**	4	N/A
Post-delivery ART provision to women	1	2	3	**4**	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assaut)	**1**	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	**3**	4	N/A
Psychosocial support for people living with HIV and their families	1	2	**3**	4	N/A
Sexually transmitted infection management	1	2	3	**4**	N/A
TB infection control in HIV treatment and care facilities	1	2	**3**	4	N/A
TB preventive therapy for people living with HIV	1	2	3	**4**	N/A
TB screening for people living with HIV	1	2	3	**4**	N/A
Treatment of common HIV-related infections	1	2	3	**4**	N/A
Other *write in*:	1	2	3	4	**N/A**

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very poor										Excellence
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• More than 90% of eligible PLHIV accesses to ART, • Clear national standard and guideline such as Boosted Link Response, Boosted CoC, and Treatment as Prevention • Home based care nationwide • Impact mitigation program has been carried out by the Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY).MoSVY has developed the national standard and guideline on package of support need to be provided to OVC including, education, health, economic, food & nutrition, psychosocial support, and other support (legal, shelter…) and has rolled out its implementation across nationwide. In addition, several NGOs such as World Vision, ICC, Save the Children, Plan International, and others, implement livelihoods, care and support programmes for PLHIV, MARPS and OVC households. • The treatment service for PLHIV is considered high both in terms of coverage and quality, but care and support services are still limited.
What challenges remain in this area:
• Stigma Index 2010 shows that even though most PLHIV currently are on treatment 23% do not have free and available access to ART (this relates to transportation cost). • Some specific HIV food and nutrition programmes (WFP) have stopped. PLHIV and OVC are in principle covered under broader social protection, livelihoods and school feeding programmes but this is not systematically monitored. • A review of HIV-sensitivity of social protection was conducted in 2013 but key recommendations to further improve HIV integration into existing or emerging social protection schemes and access to key services need to be implemented. • The WFP food support service is provided through a broader social protection mechanism since its project on food supply to PLHIV and OVC was over in late 2012. • The finding of the Expired ARV drug survey among 257 PLHIV in three different provinces of Cambodia include Battambang, BanteayMeanchey and Siem Reapin early 2013 shown that there is 13.3% of PLHIV on ART participants received expired ARV drug in the last quarter; and 8.5% received nearly expired ARV drugs – this is an anecdotal record reviewed by HACC not representative of the whole population living with HIV.

- There is limited support in providing transportation to access ARV treatment, in particular to poor PLHIV.
- Patients are required to receive ARV for a short time, frequently, and this leads them to spend more money to access ARV treatment.
- Lack of equipment to check viral-load leads to lost follow-up.
- Quality care and treatment training needed to improve skills of health care service providers.
- There are some problem with planning and procurement of ARV and OI drugs. We must ensure that all those drugs are well planned prepared and procured to avoid any delay or expiry.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in2013?

Very poor										Excellence
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Over 90% of infected children received ARV treatment;
- Impact mitigation program has been carried out MoSVY. MoSVY has developed the national standard and guideline on package of support need to be provided to OVC including, education, health, economic, food & nutrition, psychosocial support, and other support (legal, shelter…) and roll out its implementation across nation wide
- The treatment service for PLHIV is considered high both coverage and its quality yet care and support service still limited.

What challenges remain in this area:

- There is no longer a full package of food and nutrition support to OVC by the World Food Program since its end in2012;but the WFP had integrate this support into the social protection component – the same support still in place but they change supporting model and most of NGO working on PLHIV and OVC had not familiar to the new supporting model

that make them hard to access that support. This is due to the lack of information from national to province level NGOs.

- There is limited support of transportation to access ARV treatment among infected OVC.

- The economic support for those households with OVC needs to be scaled up by merging requirements for both financial and vocational skill.

- Positive prevention among young adolescent on ART needed to be strengthened because they are at high risk.