2018

NATIONAL AIDS SPENDING ASSESSMENT FOR PERIOD 2016-2017 IN CAMBODIA

NATIONAL AIDS AUTHORITY (NAA)

MINISTRY OF HEALTH

10/6/2018

CAMBODIA'S SIXTH NATIONAL AIDS SPENDING ASSESSMENT (NASA VI), 2016-2017

ACKNOWLEDGMENT

The National AIDS Spending Assessment (NASA) for the years 2016 and 2017 in Cambodia was made under the leadership of the National AIDS Authority and with technical and financial assistance from UNAIDS and Health Policy Plus (HP+).

We would like to thank the members of the NASA Steering Committee - representatives from NAA, MoH, NCHADS, UNAIDS, HP+, PEPFAR and Civil Society representatives - for providing guidance in the overall process, validation of the draft results and providing valuable insights during the preparation of this report.

Special appreciation is due to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Health Policy Plus (HP+) for providing both financial and technical support in carrying out the study.

TABLE OF CONTENTS

LIST OF FIGURES

KEY INDICATORS OF HIV SPENDING IN CAMBODIA, 2016-2017

HIV spending and Key Macro indicators	2016	2017
HIV spending - US$	$ 31,507,719	$ 34,447,888
GDP - US$ (Current US$)[1]	$ 20,016,747,754	$ 22,177,200,512
Health Spending - US$[2]	$ 1,207,000,000	No data
Health spending as a share of GDP - %	6%	No data
HIV spending as a share of Health Spending[3] - %	0.03%	No data
HIV spending per capita – US$	$ 2.00	$ 2.15
HIV spending per PLHIV[4] - US$	$ 441	$ 487
HIV and AIDS Expenditure by Funding Sources	**2016**	**2017**
Public HIV Spending - US$	$ 7,913,080	$ 8,257,614
Private HIV Spending - US$	$ 54,694	$ 67,335
International HIV Spending - US$	$ 23,539,944	$ 26,122,939
Public HIV Spending - % over total HIV spending	25%	24%
Private HIV Spending - % over total HIV spending	0.17%	0.20%
International HIV Spending - % over total HIV spending	75%	76%
HIV and AIDS Expenditure by Programmatic Area %	**2016**	**2017**
ASC.01 Prevention	19%	15%
ASC.02 Care and treatment	43%	46%
ASC.03 Orphans and vulnerable children (OVC)	0.5%	0.5%
ASC.04 Programme management and administration	34%	33%
ASC.05 Incentives for Human resources	2%	3%
ASC.06 Social protection and social services	1%	1%
ASC.07 Enabling environment	0.3%	1.1%
ASC.08 HIV and AIDS-related research	0.1%	0.5%
HIV Expenditure by Beneficiary %	**2016**	**2017**
BP.01 People living with HIV	44%	47%
BP.02 Key populations	13%	7%
BP.03 Other key populations	6%	7%
BP.04 Specific “accessible” populations	0.3%	0.5%
BP.05 General population	1%	1%

[1] Source: https://databank.worldbank.org/indicator/NY.GDP.MKTP.CD/1ff4a498/Popular-Indicators

[2] Source: Cambodia National Health Accounts 2012-2016: Health expenditure report, April 2019. Available at: https://iris.wpro.who.int/bitstream/handle/10665.1/14362/9789290618690-eng.pdf

[3] NHA 2016 in Cambodia only captures Current Health Expenditure, while NASA 2016 tracked also capital expenditure. For the purpose of this report the total HIV spending in NASA was divided by the Current Health Spending.

[4] Source: AEM projections

BP.06 Non-targeted interventions	36%	37%

EXECUTIVE SUMMARY

HIV spending on HIV in Cambodia peaked at US$ 58.1 million in 2010 and has been in decline ever since. In 2016 it has reached its lowest value of US$ 31.5 million, while in 2017 an increase helped to bring the total HIV expenditures to US$ 34.4 million.

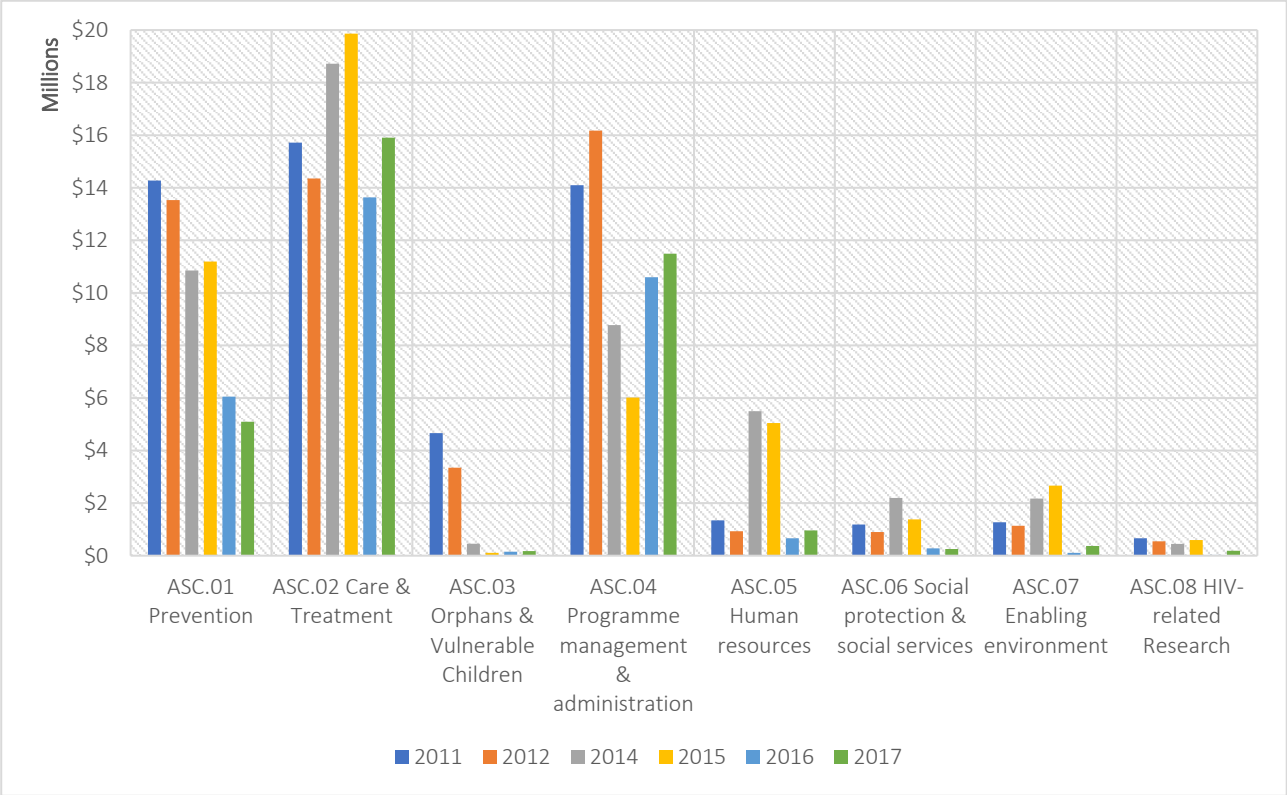
The share of Public spending on the HIV Response in Cambodia has increased steadily from 4% in 2010 to 24% in 2017, although in absolute figures it stays relatively static, varying from US$ 6 to 8 million annually in the last seven years.

The country depends largely on international funding to maintain its national AIDS response: international funds cover 75% of the national HIV spending in 2016, or US$ 23.5 million, and 76% in 2017, or US$ 26.1 million, and are the main funding source for all HIV programmatic areas. The Global Fund to Fight AIDS, Tuberculosis and Malaria remains the largest financing source, providing 50% and 54% of all funds for HIV in Cambodia in 2016 and 2017. Government of the United States was the third biggest donor in 2016-2017. Although its contribution declined over the last years – from US$ 13.9 million in 2011 to US$ 4.4 million in 2017, US Government is the main source of funding for the Prevention interventions, and specifically those targeting key affected populations.

Care and Treatment represents 43% in 2016 and 46% in 2017 of the total HIV expenditures, followed by Programme management and administration (34% for 2016 and 33% for 2017) and Prevention (19% for 2016 and 15% for 2017).

Spending on Prevention demonstrates a steady decrease since 2011 – from USD$ 14 million in 2011 to US$ 5 million in 2017. Similar trend shows for most of the other HIV programs (see Figure 1). The difference in the approach to classifying salaries of the staff engaged in service delivery (in NASA V these expenses were not assigned to the corresponding prevention and care and treatment interventions, like in NASA III, NASA IV or, partially, NASA VI but grouped separately under ASC.05 Human resources) led to high spending rates in ASC.05 Human resources in 2014-2015. Smaller spending compared to previous years was registered under ASC.03 Orphans and Vulnerable Children, ASC.06 Social Protection and Social Services, ASC.07 Enabling Environment and ASC.08 HIV-related research.

Figure 1 – Evolution of spending on key AIDS Spending Categories (programmatic areas), 2011-2017



People living with HIV benefit from 44% and 47% of total HIV spending in 2016 and 2017 respectively. Non-targeted interventions represented 36% of the HIV spending in 2016 and 37% in 2017. Key populations, altogether, represented 19% of total HIV spending in 2016 and 14% in 2017. Interventions targeting populations with the highest risk of HIV infection – people who inject drugs, sex workers, transgender, men who have sex with men – have gone down significantly: from US$ 9.5 million in 2011 to US$ 2.5 million in 2017.

Since 2012 majority of HIV spending is implemented by public sector providers. In 2016 their share reached 62% of the HIV Response in Cambodia, and 65% - in 2017. Private sector non-profit providers implemented 35% of total HIV spending in 2016 and 33% in 2017, remaining the largest service delivery force for Prevention interventions (81% of total Prevention spending in 2016 and 85% - in 2017).

Domestic public funding starts playing a more prominent role in the HIV response, although a significant part of the Government spending captured by NASA relates to the shared health system cost, hence is not HIV-earmarked. Considering a declining trend in the resource availability from the international sources, there is an evident need to expand and prioritize country's internal allocations.

1 INTRODUCTION

1.1 CONTEXT

Cambodia's HIV response over the past two decades has been highly successful and has led the country to be one of seven globally to achieve the 90-90-90 targets (that translates into 73% of all people living with HIV being virally suppressed)[5]. The number of new HIV infections has fallen for 62% between 2010 and 2018 in 2018; out of estimated 73,000 PLHIV, 82% know their HIV status, and 81% of estimated people living with HIV are receiving anti-retroviral therapy (ART) in Cambodia[6].

Cambodia's successful HIV program has emerged from a sound policy and strategic framework that dates back more than two decades. The national strategies and goals complement Cambodia's legal framework, which is, overall, conducive to creating an enabling environment for the HIV response. These achievements, while driven by the Cambodian government, have been heavily dependent on external financial and technical support. International investments amounted to 82% of financing for the HIV response in 2015[7].

Assessing AIDS spending, the source of the financing, and the distribution of the funds across different HIV services and beneficiaries is crucial to ensure that funds are used optimally and equitably. National AIDS Spending Assessment (NASA) provides a framework and tools for undertaking a comprehensive analysis of actual HIV expenditures (health and non- health). It provides decision makers with strategic information that allow countries to mobilize resources, have a stronger accountability and a more efficient and effective program implementation. Between 2009-2015, Cambodia has conducted five rounds of NASA. This report summarizes the HIV expenditures for the period 2016-2017.

1.2 OBJECTIVES

The overall goal of NASA is to monitor flow of funds used to finance the AIDS response. NASA VI objectives were to:

- Track HIV expenditures, for the period 2016-2017, from origin to the last point of service for different financial sources (public, private or external), providers, beneficiaries (target groups) and inputs (production factors);

[5] UNAIDS; Ending AIDS: Progress towards the 90-90-90 targets (July 2017)

[6] http://aidsinfo.unaids.org/

[7] NAA," Cambodia's Fifth National Aids Spending Assessment (NASA), 2014-15"

- Provide financial data that will inform the discussion around sustainability of the AIDS response in Cambodia.

NASA VI data collection included AIDS expenditures from a number of sources: domestic, international and private ones.

2 MEHTODOLOGY AND PROCESS

2.1 NASA FRAMEWORK

NASA measures spending for the final consumption of goods and services in the AIDS responses by tracking the flow of spending from its origin to the final beneficiary, through six classifications – Financing Sources, Financing Agents, Providers of Services, AIDS Spending Categories, Beneficiary Populations and Production Factors.

NASA monitors actual expenditures (public, private and international) and those in the health sector and in other sectors (social mitigation, education, labor and justice) that make up the National AIDS Response.

As part of this methodology, NASA employs tables and double-entry matrices to represent the origin and destination of resources, thus avoiding double counting of expenses through the reconstruction of resource flows for all HIV transactions.

2.2 NASA CLASSIFICATION

The NASA classifies HIV spending according to a standardized tool that is based on concepts and nomenclatures of sectoring, financing and production internationally agreed. Therefore, pertinent official statistics can be readily used, and specific estimates collated according to the international standards that are easily integrated into a comparative framework. In NASA, financial flows and expenses related to the AIDS are organized in three dimensions finance, service, and consumption with each dimension further divided into two categories. The framework for the NASA system thus has six categories in total:

- Funding
  - Financial Sources (FS) are entities that provide funds to financial agents;
  - Financial Agents (FA) are entities that collect financial resources to fund service provision programs and to make decisions related to the program.
- Service Provision
  - Providers of Services (PS) are entities that are engaged in the production, supply and provision of services related to HIV and AIDS;
  - Production factors (PF) are the inputs used to supply goods and services;
- Consumption

- The AIDS Spending Categories (ASC) are interventions and activities related to HIV and AIDS that are offered to the beneficiaries;
- The Benefiting Populations (BP) are direct beneficiaries of the interventions carried out.

2.3 DATA COLLECTION AND PROCESSING

2.3.1 NASA TASK FORCE

NASA VI exercise was led by the National AIDS Authority (NAA), with technical and financial assistance from UNAIDS and the USAID-financed Health Policy Plus Project (HP+). NAA established a NASA Steering Committee with the participation from NAA, MoH, NCHADS, UNAIDS, HP+, PEPFAR and Civil Society representatives. NASA Steering Committee guided the overall process and validated the draft results.

2.3.2 DATA COLLECTION

The standard NASA data collection questionnaire was used to obtain information from 33 public, private and international organizations and agencies. Data was collected between May – September 2018.

Most of the organizations were familiar with the data collection requirements, thus providing enough detail which allowed the NASA team to correctly assign codes to each of the provided amounts of expenditure. Whenever data provided required additional disaggregation, the team has contacted a respective institution/organization and discussed possible assumptions to achieve a necessary level of detail for NASA.

Another important task for the NASA team was to avoid double-counting of the same transaction flows. This was achieved by constantly reviewing all the entries and exclude possible duplication. NASA dataset contains an indicator which informs whether a certain amount of money is included or excluded from the total ("0" for excluded, "1" for included). At the stage of the data entry all transactions were marked as "1" – included. Whenever double-counting of the same resource flow has been discovered, the indicator for this transaction was switched to "0" – excluded.

Generic rule for the inclusion of a transaction amount is that this amount has been provided by the organization closest to the level of service provision / consumption. For example, when the NASA team receives a completed data collection form from FHI360 and Cambodian Women for Peace and Development (CWPD), it excludes from the dataset the amount that FHI360 has transferred to CWPD and includes the expenditure of CWPD that have been received from FHI360.

2.3.3 DATA PROCESSING

The data collected on expenditure were first launched in Excel® spreadsheets, checked and balanced. All information obtained or collected was checked in the greatest detail possible to ensure the validity of data sources and records. The data were then transferred to the NASA Resource Tracking Tool (RTT) (resource monitoring software), which is designed to facilitate data processing for NASA. The databases resulting from RTT were then exported to Excel® to produce tables and graphs for analysis.

2.3.4 LIMITATIONS OF ASSESSMENT

- Absence of data:
    - Some organizations did not report data (e.g. UNDP) – therefore not included in NASA VI;
    - No data from National Health Accounts (NHA) on 2016 and 2017 (used 2015 estimates, which in its turn was based on 2013-2014 NHA data, adjusted for inflation) – data maybe outdated and may not reflect the actual health spending;
    - Out-of-pocket spending is not captured;
- Data quality and coverage of expenses:
    - Some data were reported aggregated (mainly for the AIDS Spending Categories, Beneficiary populations and Production factors) – NASA team discussed with the organization-respondent possible keys to distribute aggregated figures and applied them to obtain a more detailed result;
    - Expenses for communication and behavior change are not disaggregated by age and sex;
    - Using the data on procurement of test-kits does not always allow to correctly assign their value to a specific AIDS Spending Category that depends on the consumption of the test. In NASA, HIV testing appears in prevention programs (separately for each specific KAP) and in care and treatment – as provider-initiated testing and counselling;
    - It was not possible to disaggregate the consumption of ARV between first- and second-line treatment, data of the ARV procurements (top-down) was used in the place of consumption (bottom-up);
    - Similarly to the previous NASAs, it proved challenging to separate expenditure between social protection programs for orphans and vulnerable children (OVC) and social protection and social services for other populations. Whenever the details

on the beneficiary populations were not available, NASA team has divided the expenditure (e.g. on food relief for OVCs and PLHIV and their families) in equal shares between these two programs;

- There was no NASA conducted for the year 2013. This year is excluded from all the graphs and tables that provide time series of NASA results.
- Due to lack of costing data and detailed expenditure reports, some usage/procurement of medicines was difficult to properly account between OI or STI (e.g. Metronidazole, Ciprofloxacin, Clindamycin, etc.).
-

2.3.5 KEY ASSUMPTIONS

- ***Calendar years.*** The team analyzed 2016 and 2017 calendar years which corresponds to a fiscal year which begins on January 01 and ends on December 31. All the organizations provided data for the calendar years.
- **Exchange rates.** The results of the assessment are presented in US Dollars. When the data was reported in the local currency – Cambodian Riel – the following exchange rate has been applied to convert the amounts in to US Dollars:
  - In 2016 1 US Dollar = 4,050 KHR
  - In 2017 1 US Dollar = 4,050 KHR
- ***Using ASC.04.01 vs ASC.04.02.*** In NASA, AIDS Spending Category 04. includes various programme management and administration spending that usually captures the efforts on a national, regional or organizational level to strengthen coordination, policy and clinical guidelines, strategic information, monitoring and evaluation, drug supply systems etc. The majority of such expenditure is considered non-targeted (BP.06 Non-targeted interventions in the classification of Beneficiary populations), meaning that it benefits not just one specific population group. It also includes two sub-categories that are often lack consistency when applied – ASC.04.01 Planning, Coordination and Programme management and ASC.04.02. Administration and transaction costs. In NASA VI, as well as NASA III and NASA IV but unlike NASA V, the use of the ASC.04.02 was limited to transaction costs (bank charges for money transfer) and external audit. The use of the code ASC.04.01 was more common: it included many coordination activities at the national and sub-national level, development of policies, guidelines as well as a related printing and dissemination cost, public communication and advertising, office costs and staff salaries of the NAA, part of the NCHADS and costs of other

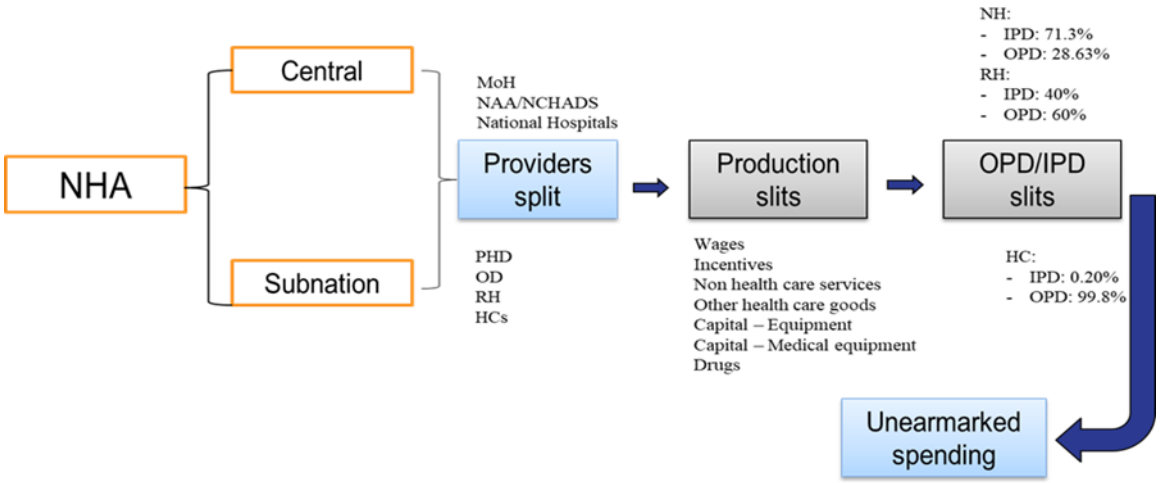
public or private organizations that do not provide services directly to the beneficiary populations (when such disaggregation was possible). The cost of running the service-providing facilities was assigned to an appropriate service-related ASC code, not to ASC.04.01. For example, cost of running drop-in centers, ART clinics etc has been coded depending on the functions such facility performs. So, the cost of running a drop-in center for PWID/PWUD was coded under ASC.01.10 Harm reduction programmes for PWID/PWUD, and the cost of the ART clinic maintenance was attributed to the ASC.02.01.03 ARV therapy.

- Coding of salaries. According to a NASA Classification and Definitions, the coding of salaries depends on the functions performed by the staff. This was not the case in the NASA V, when the decision has been made to classify all staff-related expenditure under the AIDS Spending Category 05.01 Monetary incentives for human resources. In NASA VI, after the data verification, the majority of the salaries have been re-assigned to the more specific function-related categories, keeping however the appropriate coding of these expenses as a Production factor PF.01.01 Labour income. E.g. expenditure on salaries for the NAA staff was classified as ASC.04.01 Planning coordination and programme management, laboratory staff of NCHADS – as ASC.02.01.05 HIV-related laboratory monitoring, staff working in the ART clinics – either as ASC.02.01.98 Outpatient care services not broken down by intervention or directly as ASC.02.01.03 Antiretroviral therapy.
- ART drugs: consumption vs procurement. General NASA rule prescribes the assessment team to estimate the cost of the consumed ART drugs by multiplying the cost of each regimen by a number of patients that received that particular scheme that year, adjusting the figure by a patient drop-out rate etc. This usually gives a necessary level of detail to assign a more detailed category to the expenditure, distinguishing, for instance, adult and pediatric, and first- and second-line regimes. While this was done in the NASA III and NASA IV, in the last two NASAs – NASA V and NASA VI - it was decided to use procurement data to reflect ART spending.
- Classification of Providers: NGOs working inside public hospitals and clinics were considered as providers of services during this and previous NASA studies. We maintained this classification in order to keep consistency with the way they were classified on previous NASAs. Nevertheless, it is important to mention that following the principles of the System of Health Accounts (SHA11), NGOs providing services inside public care setting would not necessarily be considered Provider of Services. The provider would be the public clinic or

hospital since the provision of services is their mainstay (the NGO would in this case be a Production Factor, providing services for the public hospitals and clinics).

- **NHA HIV sub-analysis and NASA-NHA crosswalk.** The data from the National Health Accounts was not available for the years 2016 and 2017. NASA team has used NHA results and the calculation paths (see Figure 2) from 2015[8]. The attribution to of the shared health systems cost to HIV has been discussed and agreed with the NHA team. Inflation rate of 3% was applied to obtain estimates for 2016 and 2017. For more explanation see Annex 1.

Figure 2 - NHA analysis path for NASA VI



[8] National AIDS Spending Assessment V for the years 2014-2015

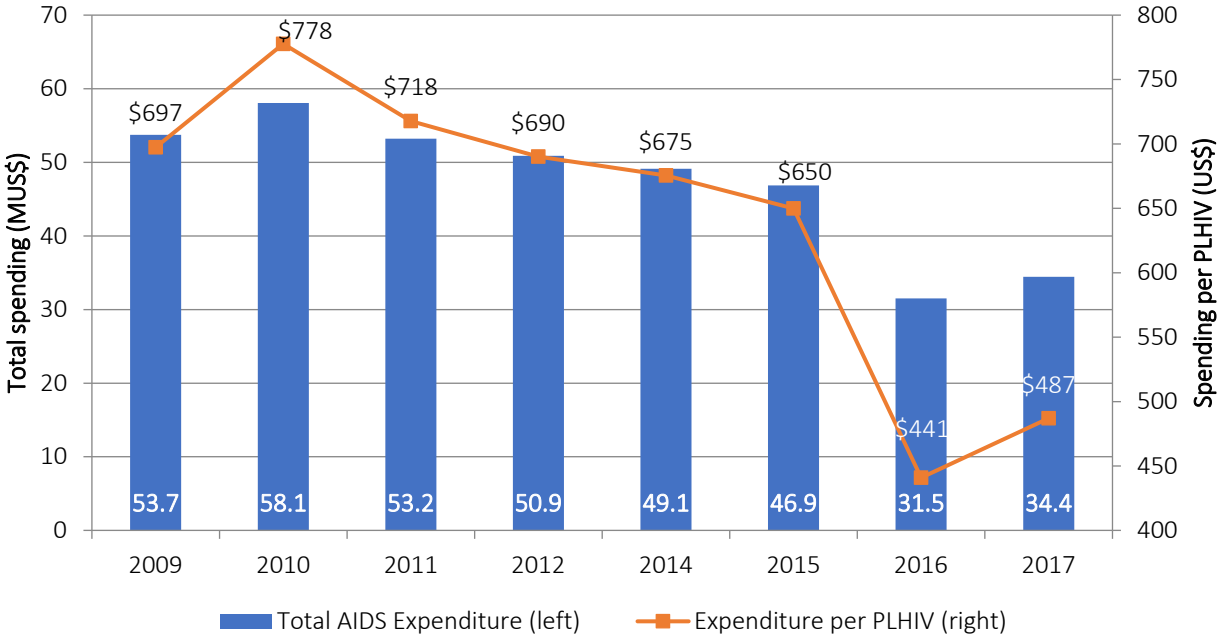
3 RESULTS OF NASA VI

3.1 TRENDS IN HIV EXPENDITURE

In 1991 the first case of HIV was reported in Cambodia, and by 1995 there were over 23,000 new infections [9]. The RGC worked closely with civil society and welcomed the assistance of NGOs, building a national program that has reduced the number of new infections to less than 1000 in 2018[10] and massively increased the number of people living with HIV who are on anti-retroviral therapy to around 59,500[11]. These impressive results have been reached with a more modest funding compared to the previous years.

The resources available from all sources for the implementation of the Cambodia AIDS response totaled US$ 31.5 million in 2016 and US$ 34.5 million in 2017, which was lower than in the period from 2009 to 2015 (Figure 3).

Figure 3 – Total HIV expenditure trends in 2009-2017



Over the last ten years a decreasing trend in international HIV investments has been noted at national, regional and global level. The global economic crisis, new global health priorities (e.g Non-communicable diseases) public health emergencies (e.g., Ebola outbreak in West Africa) as well as overall shift from vertical disease management to a health systems approach, has impacted

[9] Ending AIDS in Cambodia. December, 2016. https://kh.usembassy.gov/ending-aids-cambodia
[10] Cambodia Fact Sheet 2017, http://aidsinfo.unaids.org/
[11] Available at: http://aidsinfo.unaids.org/

negatively the international HIV financing. In many countries, like in Cambodia, less external funding is available now for the AIDS response.

In 2010 Cambodia spent a total of a US$ 58 million in support of the AIDS response[12]. The next five years reported relatively gradual decrease in AIDS spending: in 2015 almost US$ 47 million were used for the AIDS response[13]. Already in 2016 country has spent 15 million USD less than in the previous year, but recovered another US$ 3 million in 2017, finishing it with a total spending of US$ 34.4 million.

3.2 FINANCIAL FLOWS AND FUNDING MODALITIES

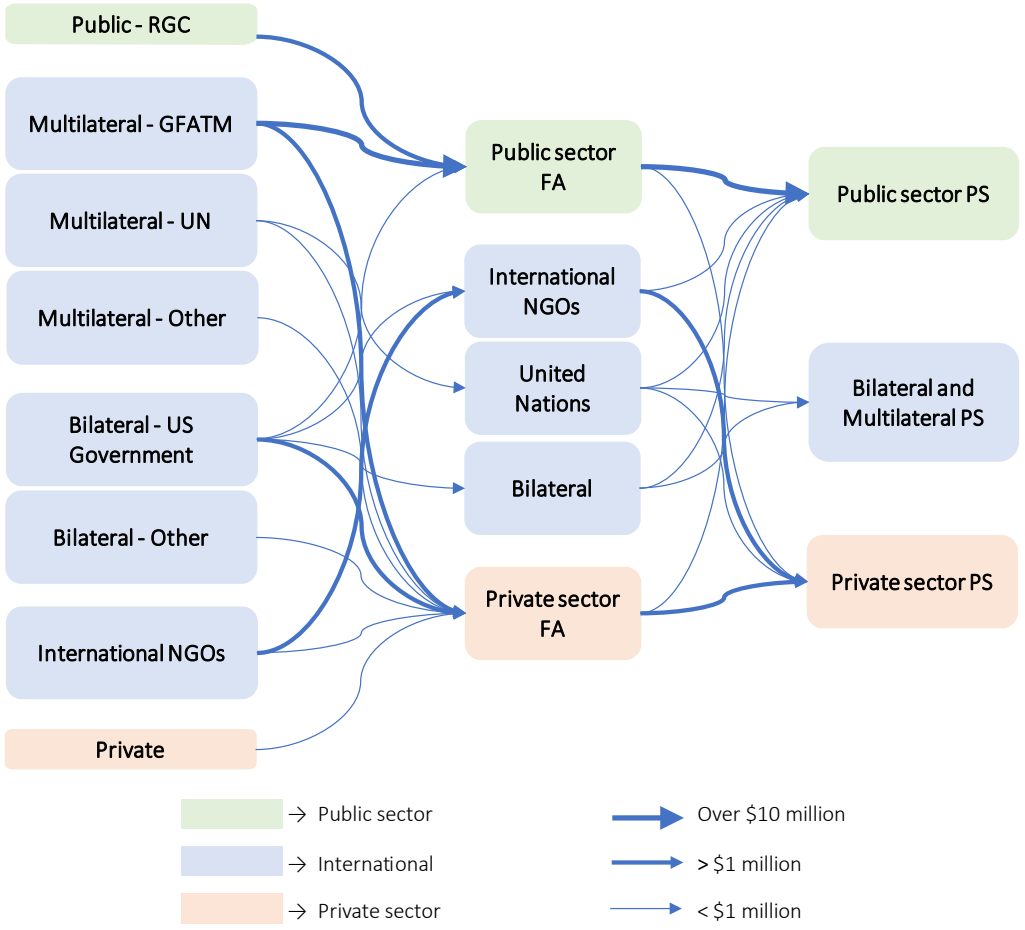
3.2.1 FUNDING FLOWS: FROM THE SOURCES TO SERVICE PROVIDERS

National AIDS Spending Assessment methodology distinguishes three main roles that organizations and entities of various types may play in the HIV response: Financing source, Financing agent and Provider of Services. One organization may be assigned with more than one role in a resource flow. Understanding the flow of funding helps the Government and the donors to adjust their allocations and to better focus their financing streams. Figure 4 graphically presents the map of the financial flows in Cambodia in 2016-2017.

In Cambodia, the biggest funder is The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Public sector Financing agents – Ministry of Health and its divisions (NCHADS, in particular, as one of the Principal Recipients of the GFATM grant), NAA – manage resources collected from various financing sources and transfer the money to providers to buy or pay for the goods or/and services to be delivered to beneficiary populations. Public sector providers dominate service delivery in this funding flow. Over US$ 10 million are being transferred annually in the recent years through this resource flow. The second largest funding flow also comes from The Global Fund, but is managed and executed in the private non-profit sector, mainly by national NGOs.

[12] National AIDS Spending Assessment III for the years 2009-2010
[13] National AIDS Spending Assessment V for the years 2014-2015

Figure 4 - Main Flows of Funding in Response to HIV, 2016-2017



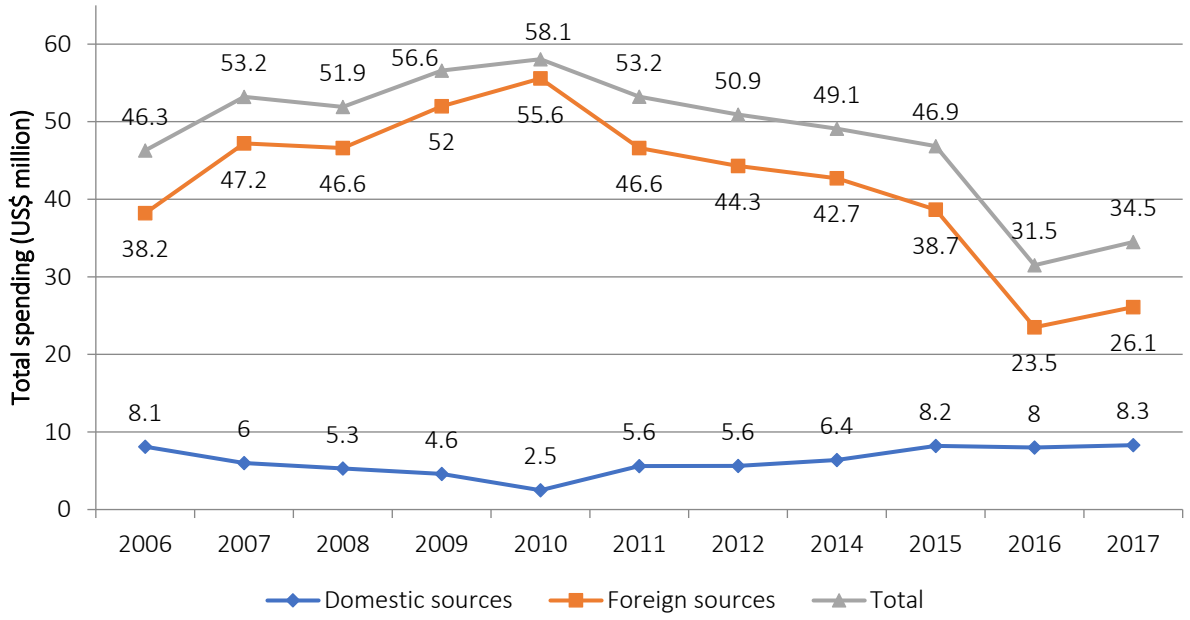
Even though US Government through PEPFAR has reduced significantly its contribution compared to the previous years, it still finances one of the largest transactions in the HIV Response in Cambodia, which is managed by US government agencies (CDC and USAID) and implemented by CDC, international and national NGOs and others.

3.2.2 FINANCING SOURCES

3.2.2.1 Financing Sources – overall trends

Financing sources are the organizations, governments, corporations or private individuals where the resources for implementing HIV interventions originate. Over the years, the composition of the funding mechanisms of the national AIDS response in Cambodia has evolved, but the key contributors remained.

Figure 5 - Total HIV Expenditure, 2006-2017[14] [15]



International funding remains the key funding source for the national AIDS response (Figure 5). Out of the US$ 52 million of the total AIDS spending in 2008, US$ 46.6 million were coming from the international financing sources. Figure 5 shows that the fluctuations in the total AIDS expenditures in Cambodia largely depends on the international donors. In 2017, for which the most recent results are available, HIV spending amounted to US$ 34.5 million – almost twice less than in 2010.

Figure 6 - Evolution of the Financing Sources of the HIV Response in Cambodia, 2009-2017

Financing Sources	2009		2010		2011		2012		2014		2015		2016		2017	
	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%
The Global Fund	19,023,377	35%	22,711,245	39%	18,030,595	34%	20,027,132	39%	24,848,545	51%	19,276,367	41%	15,758,925	50%	18,732,595	54%
Bilateral Agencies	15,565,137	29%	15,662,525	27%	15,713,795	30%	15,872,474	31%	12,228,466	25%	14,047,855	30%	5,263,444	17%	4,641,631	13%
Royal Government of Cambodia	1,703,403	3%	2,436,832	4%	5,644,947	11%	5,671,862	11%	6,438,230	13%	8,188,161	17%	7,913,080	25%	8,257,614	24%
United Nations Agencies	7,547,437	14%	8,382,652	14%	7,128,857	13%	4,320,352	8%	2,309,481	5%	1,941,555	4%	925,220	3%	812,160	2%
International NGOs	9,119,295	17%	7,516,331	13%	3,736,224	7%	2,855,882	6%	2,409,038	5%	2,274,751	5%	1,543,413	5%	1,875,558	5%
Other Multilateral Organizations (excl. GF & UN)	612,307	1%	1,043,168	2%	1,745,621	3.3%	1,165,243	2.3%	860,173	2%	860,225	1.8%	48,941	0%	60,995	0.2%
Private Domestic	36,955	0.1%	51,540	0.1%	963,952	1.8%	956,837	1.9%	24,723	0.1%	262,750	0.6%	2,926	0.01%	2,709	0.01%
Private International	127,286	0.2%	255,175	0.4%	254,654	0.5%	57,619	0.1%	3,149	0.0%	12,745	0.0%	51,768	0.2%	64,626	0.2%
Total	**53,735,198**	**100%**	**58,059,469**	**100%**	**53,218,646**	**100%**	**50,927,401**	**100%**	**49,121,805**	**100%**	**46,864,409**	**100%**	**31,507,719**	**100%**	**34,447,888**	**100%**

[14] Results of every NASA exercise in Cambodia. 2013 is the only year for which NASA was not done.
[15] NASA II for 2007-2008 is available at https://www.unaids.org/sites/default/files/documents/cambodia_2007-2008_en.pdf
NASA III for 2009-2010 is available at: https://www.unaids.org/sites/default/files/documents/cambodia_2009-2010_en.pdf
NASA IV for 2011-2012 is available at: https://www.unaids.org/sites/default/files/documents/cambodia_2011-2012_en.pdf

Figure 6 above presents the findings of four last National AIDS Spending Assessments in Cambodia, covering the time period from 2009 to 2017, showing in a greater detail all main types of financing sources.

Figure 7 shows who were the largest donors of the HIV response in Cambodia in 2016 – 2017. Altogether they represent 99% of the overall country`s HIV resources.

Figure 7 – Top largest Financing Sources of HIV Response in Cambodia, 2016-2017

Top largest Financing Sources	2016	2017
The Global Fund to Fight AIDS, Tuberculosis and Malaria	15,758,925	18,732,595
Royal Government of Cambodia	7,913,080	8,257,614
US Government	5,144,851	4,407,615
AIDS Healthcare Foundation	1,031,634	1,175,482
UNAIDS Secretariat	813,001	770,406
Cambodian Red Cross	233,584	233,353
Government of France	26,321	137,451
Government of Sweden	83,488	96,088
European Commission	38,971	60,995
Caritas / Catholic Relief Services	33,577	43,145
UNFPA	88,442	25,498

3.2.2.2 Domestic Public Financing Sources[16]

Although the AIDS Response in Cambodia continues to be funded predominantly from international sources, The Royal Government of Cambodia (RGC) remains committed to maintain its share of funding. Domestic funding remains the only source of funding that is growing regularly in absolute terms, although relatively slowly (Figure 6). Such consistency is even more important considering the decreasing resource availability for HIV from the international donors (Global Fund and US Government in particular). In 2016-2017 domestic public spending amounted to US$ 7.9 and 8.3 million respectively, representing 25% and 24% of the total HIV expenditure in Cambodia (Figure 6)[17] Support from the Global Fund remained significant over the last 8 years, reaching its highest – US$ 24.9 million – in 2014 (Figure 6). The Global Fund remains the largest financing source of the AIDS response in Cambodia Global Fund remains the major financing source of the AIDS response in Cambodia: in 2016 – US$ 15.8 million (50% of total HIV spending), in 2017 – US$ 18.7 million (54% of total HIV spending) (Figure 6).

[16] More details on the composition and use of the domestic public resources can be found in **Error! Reference source not found. Error! Reference source not found.**

[17] More details on the composition and use of the GFATM resources can be found in 3.4.2 HIV Expenditure from the Global fund

3.2.2.3 Financing Source – Government of the United States of America [18]

Government of the United States of America remains the largest bilateral financer, and the third largest overall after The Global Fund and the Royal Government of Cambodia. In 2016 it represented 16% of the total HIV spending in Cambodia or US$ 5.1 million. In 2017 this amount was US$ 4.4 million, or 13% of the total spending on HIV in the country.

Traditionally, almost all US Government funding for HIV goes through either PEPFAR or The Global Fund. PEPFAR allocation[19] – total envelop available for Cambodia – has been declining over the years and is reported to be the following:

- Fiscal year[20] 2012: US$ 15 million,
- Fiscal year 2013: US$ 15 million,
- Fiscal year 2014: US$ 11.3 million,
- Fiscal year 2015: US$ 13 million,
- Fiscal year 2016: US$ 12 million,
- Fiscal year 2017: US$ 10 million.

For the Fiscal year 2019 US funding is estimated at the level of US$ 8.2 million[21].

In NASA, the US Government's expenditure on HIV has been tracked using a bottom-up approach – based on the reports of the final implementors: this explains a significant difference between the PEPFAR's allocation and NASA's actual spending.

NASA results from the previous years also show a decline in the funds originating from the US Government: in 2015 [22] a total of US$ 13.7 million spent for various HIV programmes and interventions in Cambodia, representing 29% of the total national HIV expenditure – almost US$ 9 million more than the expenditures recorded in 2017.

3.2.2.4 Financing Source – United Nations

In 2016, UN invested over US$ 0.9 million in the national AIDS response, and in 2017 – the amount was US$ 0.8 million, which represented 3% and 2% respectively, of the overall HIV spending.

NASA VI captured an HIV expenditure of International Labour Organization (ILO), United Nations HIV/AIDS Programme (UNAIDS), World Health Organization (WHO), United Nations Population Fund

[18] More details on the composition and use of the US Government resources can be found in 3.4.3 HIV Expenditure from the government of the united states
[19] Source for the PEPFAR allocation
[20] US Government Fiscal Year 2012 was between October 1, 2011 and September 30, 2012
[21] Source???
[22] National AIDS Spending Assessment V for the years 2014-2015

(UNFPA) and United Nations Development Fund for Women (UNIFEM). UNAID S remains the largest UN contributor in Cambodia, spending US$ 813,001 in 2016, and US$ 770,406 in 2017, followed by UNFPA, whose spending amounted to US$ 88 thousand in 2016, and US$ 25.5 thousand in 2017. Over the period 2009-2017, there is a steady decline in the in the United Nations financial investments in the national AIDS response (see Figure 5). In 2009 it totaled to US$ 7.6 million, representing 14% of the country's spending on HIV.

3.2.2.5 Other Financing Sources

In 2016-2017 AIDS Healthcare Foundation (AHF) contributed over US$ 1 million annually (Figure 7)[23].

3.2.3 FINANCING AGENTS

Financing agents are the organizations or institutions that decide how to spend the money allocated (made available) by Financing sources. Key functions of the Financing agents are: deciding what service or product to purchase, and selecting a service provider to deliver a service or a product to a beneficiary population[24]. In some cases, same organization may be both Financing source, Financing agent and a Provider of Services.

In 2016 and 2017 the largest Financing agent was the Royal Government of Cambodia, represented by various ministries and entities. Non-governmental and civil society organizations, representing Private sector Financing agents, were managing 22 and 20% of the overall HIV spending respectively, followed by international Financing agents which managed 10 and 9% of the spending in 2016 and 2017 (Figure 8).

Figure 8 - Financing agents in the HIV response in Cambodia, 2016 - 2017

FINANCING AGENTS		2016		2017	
		US Dollars	%	US Dollars	%
FA.01 Public sector	FA.01.01.01.01 Ministry of Health	19,894,222	63%	23,040,116	67%
	FA.01.01.01.06 Ministry of Labour (or equivalent sector entity)	11,260	0.04%	11,460	0.03%
	FA.01.01.01.08 Other ministries (or equivalent sector entities)	21,270	0.07%	62,891	0.18%
	FA.01.01.01.10 National AIDS Coordinating Authority	1,400,733	4%	1,281,543	4%
	FA.01 Public sector Total	21,327,486	68%	24,396,010	71%
FA.02 Private sector	FA.02.05 Not-for-profit institutions (other than social insurance)	7,079,310	22%	6,985,897	20%

[23] Further analysis of the transactions of the AIDS Healthcare Foundation may reveal that some proportion of its contribution (or even all of it) may originate from one or more bilateral or multilateral Financing Source.

[24] Also, the concept of a Financing Agent may vary depending on the perspective – e.g., for the US Government, financing agents for its PEPFAR funding is CDC or Department of Defense (DoD), while for the in-country HIV Response these organizations will be mainly considered as Financing Sources. In this case, a most likely Financing Agent for the majority of funds that directed to service delivery will be an organization, like FHI360, which facilitates the money flow to the actual service provision level.

	FA.02 Private sector Total	7,079,310	22%	6,985,897	20%
FA.03 International purchasing organizations	FA.03.01.22 Government of United States	210,667	1%	198,113	1%
	FA.03.02.04 International Labour Organization (ILO)	4,786	0.02%	1,450	0.00%
	FA.03.02.07 UNAIDS Secretariat	813,001	3%	770,406	2%
	FA.03.02.09 United Nations Development Fund for Women (UNIFEM)	9,183	0.03%	6,583	0.02%
	FA.03.02.16 United Nations Population Fund (UNFPA)	88,442	0.28%	25,498	0.07%
	FA.03.02.19 World Health Organization (WHO)	-	-	8,222	0.02%
	FA.03.03.01 International HIV/AIDS Alliance	1,031,634	3%	1,175,482	3%
	FA.03.03.09 Caritas Internationalis / Catholic Relief Services	33,577	0.11%	29,377	0.09%
	FA.03.03.14 Family Health International	467,701	1%	560,258	2%
	FA.03.03.18 National and International Red Cross Societies	233,584	1%	233,353	1%
	FA.03.03.23 Population Services International	208,348	1%	57,238	0.17%
	FA.03 International purchasing organizations Total	3,100,924	10%	3,065,980	9%
Financing Agents TOTAL		31,507,719	100%	34,447,888	100%

3.2.3.1 Public sector Financing agents

As presented in the Figure 8 above, a majority of resources in HIV response in Cambodia was managed in the public sector. In 2016, over US$ 21.3 million representing 68% of the total spending, been managed by various public sector entities: Ministry of Health, Ministry of Labour and Vocational Training (MoLVT), Ministry of Women's Affairs (MoWA), National Center for HIV/AIDS, Dermatology and STDs (NCHADS), National AIDS Authority (NAA), National Maternal and Child Health Center (NMCHC). In 2017, the amount of spending managed by public entities totaled US$ 24.4 million, representing 71% of the country's spending on HIV.

The results of the previous spending assessment (NASA V) confirm the increasingly strong role of the RGC in managing both domestic public and international resources. In 2014, the share of national HIV spending managed in the public sector comprised 60% (US$ 29 million), and 58% (US$ 27 million) – in 2015.

A large part of the funds managed by various RGC ministries and institutions comes from The Global Fund – in 2016 and 2017 country has been implementing an HIV (PR NCHADS) and an HSS (PR MoH) grant. In 2016, this Financing source (GFATM) comprised 63% of the total spending managed by the Government, or US$ 13.4 million. In 2017, GFATM grants amounted to 66% (or US$ 16.1 million) of the publicly managed HIV spending.

In 2016, the amount of the domestic public resources for HIV managed in the public sector was US$ 7.9 million (37% of the overall publicly managed funding), and US$ 8.3 million in 2017 (34% of the publicly managed HIV spending).

In the assessed years RGC managed a relatively small amount of money from a bilateral source - US Government. In 2016 that amount was US$ 14.5 thousand, in 2017 – US$ 41.5 thousand. In both years the HIV spending totals from the Financing source US Government channeled through the RGC comprised less than 1% of the overall funding managed in the public sector.

3.2.3.2 Private sector Financing agents

Private sector Financing agents are represented by various non-governmental and civil society organizations. They receive contributions from domestic private and international sources of funding.

In 2016, US$ 7.1 million (22% of the total HIV spending) was managed by the national and international NGOs in Cambodia; in 2017 it went down to US$ 7 million which represents 20% of the total HIV spending in the country. A majority of funds managed in the private sector - over 99% in both 2016 and 2017 - came from the international Financing sources, represented by the Governments of France, Japan, Sweden and The United States, The Global Fund, European Commission and others.

The largest share of the HIV expenditure managed in the private sector came from the US Government: US$ 4.2 million (60% of the total HIV funding managed by the private sector organizations) in 2016 and US$ 3.6 million (51% of the total HIV funding managed by the private sector organizations) in 2017. The next largest Financing source for the private sector Financing agents was The Global Fund. In 2016 and 2017 it channeled US$ 2.4 million and US$ 2.6 million through private sector FAs – national and international NGOs. This represents 33% and 38% of the total amount managed by private FAs in those years.

KHANA, one of the biggest non-governmental stakeholders in the HIV response in Cambodia, is the largest Private sector Financing agent for both US Government and the Global Fund money.

3.2.3.3 International sector Financing agents

International sector Financing agents are represented by various UN agencies, USAID / CDC and a number of international NGOs. All together they manage about US$ 3 million per annum (10% of the total HIV spending in 2016 and 9% in 2017).

Thirty-three in 2016 and thirty-eight per cent in 2017 of resources managed by the international organizations has been provided by the AIDS Healthcare Foundation followed by Government of the United States , supplying almost 30% annually of the total HIV spending managed by the international sector organizations. UNAIDS contributed and managed one quarter of the HIV spending in the international sector Financing agents putting US$ 0.8 million annually in 2016-2017.

3.2.4 PROVIDERS OF SERVICES

Most spending on HIV and AIDS in Cambodia are carried out by public sector providers, which absorbed 62% (US$ 19.7 million) in 2016 and 65% (US$ 22.3 million) in 2017 (Figure 9). Most of the remaining expenses were made by private providers who used 35% and 33% in 2016-2017 respectively, leaving 3% (in 2016) and 2% (in 2017) to bilateral and multilateral providers.

Figure 9 - Providers of Services of HIV Response in Cambodia, 2016-2017

PROVIDERS OF SERVICES		2016		2017	
		US Dollars	% of total	US Dollars	% of total
PUBLIC SECTOR	Hospitals (Governmental)	3,395,514	11%	3,469,525	10%
	Ambulatory care (Governmental)	6,353,502	20%	7,786,871	23%
	Mental health and substance abuse facilities (Governmental)	57,978	<1%	47,309	<1%
	Laboratory and imaging facilities	1,715,765	5%	1,809,092	5%
	Blood banks (Governmental)	320,667	<1%	1,878,643	5%
	Research institutions (Governmental)	148,757	<1%	125,347	<1%
	National AIDS commission (NACs)	1,460,979	5%	1,305,295	4%
	Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	6,116,876	19%	5,733,336	17%
	Departments inside the Ministry of Education or equivalent	28,128	<1%	25,498	<1%
	Departments inside the Ministry of Labour or equivalent	16,046	<1%	12,910	<1%
	Government entities n.e.c.	30,453	<1%	69,474	<1%
	PUBLIC SECTOR Providers TOTAL	**19,644,666**	**62%**	**22,263,300**	**65%**
PRIVATE SECTOR	Hospitals (Non-profit non faith-based)	256,823	1%	379,111	1%
	Civil society organizations (Non-profit non faith-based)	10,790,989	34%	10,995,278	32%
	PRIVATE SECTOR Providers TOTAL	**11,047,812**	**35%**	**11,374,389**	**33%**
Bilateral and multilateral agencies	**MULTILATERAL agencies TOTAL**	**815,241**	**3%**	**810,198**	**2%**
TOTAL HIV Spending		**31,507,719**	**100%**	**34,447,888**	**100%**

3.2.4.1 Public sector Service Providers

Public sector service providers are represented by a large number of public entities, namely hospitals, outpatient clinics (e.g. ART/VCCT sites), labs, blood banks, as well as such institutions like National

Centre for HIV/AIDS Dermatology and STDs (NCHADS) or National Maternal and Child Health Center (NMCHC) that not only manage HIV response and funding but also implement a wide range of services.

In 2017 public service providers implemented 65% of all in-country HIV interventions and programs (US$ 22.3 million). Out of this amount, 35% or US$ 7.9 million was RGC's own resources, and 65% or US$ 14.4 million came from various international financing sources, but predominantly The Global Fund.

This trend remains consistent across the last several years: in 2014-2015 public sector providers implemented almost 60% of the response, although in the absolute figures the amount was higher than in 2016-2017. In 2014 public sector providers of services carried out US$ 29.2 million, and US$ 27.1 million in 2015. RGC maintained and even increased its share in both funds availability and service delivery even considering overall decrease of funding available for the HIV response implementation.

3.2.4.2 Private sector Service Providers

Private sector service providers are represented by non-profit non-governmental and civil society organizations and private clinics[25]. Analysis of the collected data revealed that not for-profit HIV service providers have received or implemented any HIV funding.

A share of private sector providers in the HIV response provision although dropped compared to the previous years but remains relatively stable – one third of all activities and programs is provided in the private sector. For the comparison, in 2014 as well as in 2015 private non-profit HIV service provision amounted to US$ 18 million per annum, representing 37% and 38% of the overall HIV response correspondingly[26]. In 2016-2017 this amount went down to a little over US$ 11 million per annum (which represented 35% and 33% of the total HIV service delivery in Cambodia in 2016 and 2017).

Most of Private Providers of Services' spending (approximately 97% of it) originated from a variety of international financing sources: US$ 10.7 million in 2016 and US$ 11 million in 2017. The two largest and almost equal Financing sources for the private sector service providers were The Global Fund (with US$ 4.7 million representing 41% of all funding provided by private sector providers in 2017) and The Government of the United States (with US$ 4.1 million representing 36% of all funding

[25] Only Sihanouk Hospital Center of HOPE is included under this code

[26] National AIDS Spending Assessment V for the years 2014-2015, dataset. This data is not part of the NASA V report, but is calculated from the NASA V dataset for the purposes of this analysis.

provided by private sector providers in 2017). Funding coming from the international NGOs is managed and utilized in the private sector. In 2017, almost US$ 1.9 million originated from the international NGOs and was consecutively implemented by the private sector providers – it represented 16% of all private sector implementation.

3.2.4.3 Bilateral and Multilateral agencies - Service Providers

It is a relatively small share of the HIV spending that is usually being implemented directly by bilateral and multilateral partners, whose role instead is predominantly that of a Financing source or/and a Financing agent. The amount implemented directly by this type of Service providers was around US$ 0.8 million in both 2016 and 2017. A majority of their spending came from and was spent by UNAIDS.

3.3 PROGRAMMATIC DESCRIPTION OF HIV EXPENSES

Programmatic description of the spending on the HIV response in Cambodia consists of two dimensions: AIDS Spending Categories and Production Factors. AIDS Spending Categories are a classification of the activities, programs and interventions that make part of the HIV response in the country, while Production Factors are inputs to supply these activities, programs and interventions.

3.3.1 EXPENDITURE PER AIDS SPENDING CATEGORY

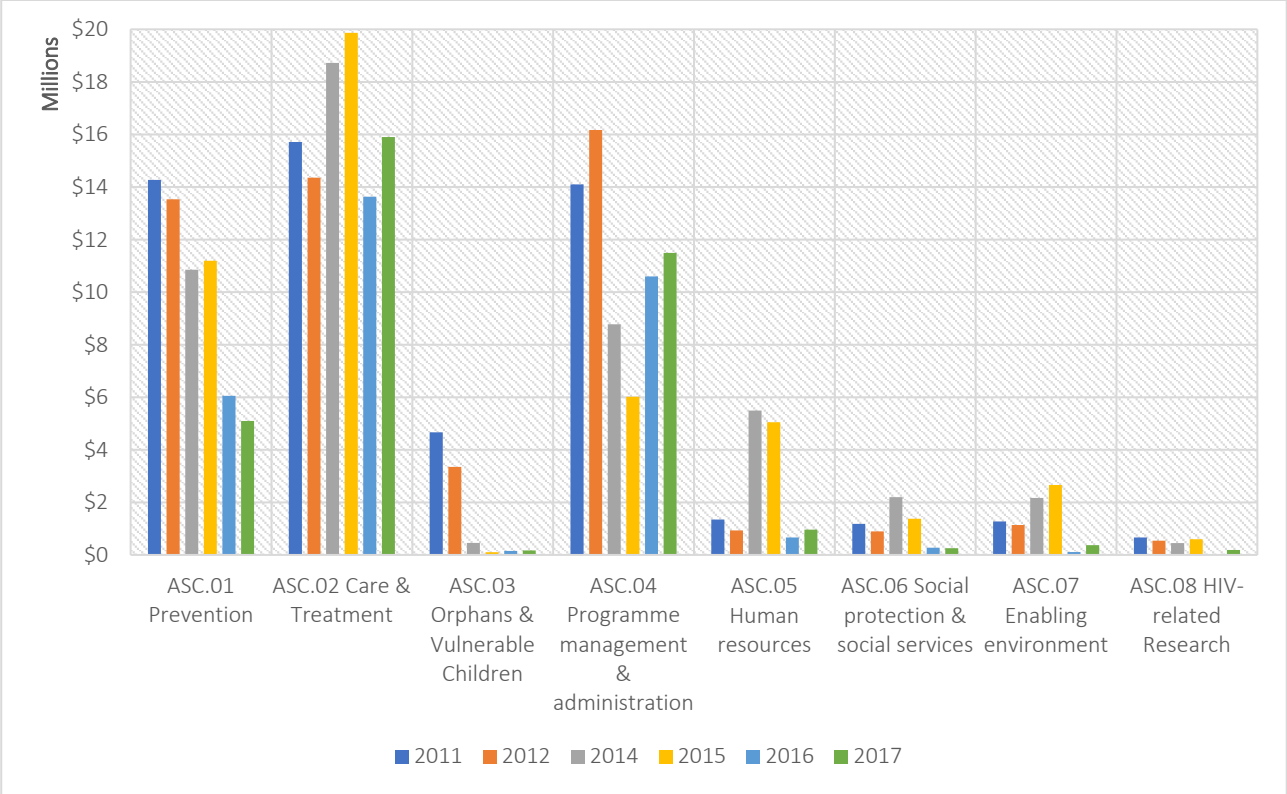
Classification of the AIDS Spending Categories includes health and non-health interventions and programs of the HIV response for the years 2011-2017 (except for 2013), consolidated in eight broader groups (see Figure 10).

Figure 10 – AIDS Spending Categories of the HIV Response in Cambodia, 2011-2017

AIDS SPENDING CATEGORIES	2011		2012		2014		2015		2016		2017	
	US Dollars	%	US Dollars	%	US Dollars	%	US Dollars	%	US Dollars	%	US Dollars	%
ASC.01 Prevention	14,272,159	27%	13,533,253	27%	10,850,297	22%	11,193,994	24%	6,051,378	19%	5,098,459	15%
ASC.02 Care and Treatment	15,716,094	30%	14,355,571	28%	18,722,478	38%	19,865,127	42%	13,631,573	43%	15,904,335	46%
ASC.03 Orphans and Vulnerable Children	4,666,336	9%	3,350,943	7%	455,887	0.9%	105,820	0.2%	152,277	0.5%	173,851	0.5%
ASC.04 Programme management and administration	14,100,083	26%	16,172,444	32%	8,776,940	19%	6,015,364	14%	10,596,276	34%	11,493,171	33%
ASC.05 Human resources	1,345,227	2.5%	932,088	2%	5,495,629	11.2%	5,047,118	10.8%	664,013	2.1%	960,853	2.8%
ASC.06 Social protection and social services	1,183,583	2.2%	898,745	2%	2,198,637	4.5%	1,378,475	2.9%	276,345	0.9%	255,068	0.7%
ASC.07 Enabling environment	1,273,239	2.4%	1,140,106	2%	2,170,532	4.4%	2,663,839	5.7%	107,435	0.3%	372,799	1.1%
ASC.08 HIV-related Research	661,926	1.2%	544,250	1%	451,405	0.9%	594,672	1.3%	28,422	0.1%	189,351	0.5%
TOTAL HIV Spending	**53,218,646**	**100%**	**50,927,401**	**100%**	**49,121,805**	**100%**	**46,864,409**	**100%**	**31,507,719**	**100%**	**34,447,888**	**100%**

Figure 11 visually presents similar information on annual trends of expenditure within each broader AIDS Spending Category.

Figure 11 – Trends of HIV expenditure across AIDS Spending Categories, 2011-2017



3.3.1.1 Expenditure on ASC.01 Prevention

In 2016 Prevention activities absorbed 19% of the total HIV spending, or US$ 6.1 million, however, already in 2017 it dropped by almost US$ 1 million, representing 15% of the HIV response expenditure with US$ 5.1 million. Since 2011, when prevention spending amounted to US$ 14.3 million, it has lost an unprecedented US$ 10 million, more than any other programmatic area of the HIV response in Cambodia. However, it may be the case, that the overall efficiency improved significantly, and with "more for less" approach Cambodia managed to maintain and increase HIV screening coverage as well as that of the prevention programs for the populations at-risk.

A detailed breakdown of the Prevention interventions (see Figure 12) shows that the largest expenditure is directed to programs aiming at stopping HIV transmission among PLHIV and prevention among various key populations at-risk.

Figure 12 - Detailed breakdown of ASC.01 Prevention, 2016-2017

ASC.01 PREVENTION AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of Prevention	US Dollars	% of Prevention
ASC.01.01 Communication for Social and behavioural change	19,401	0.3%	10,845	0.2%
ASC.01.02 Community mobilization	47,130	0.8%	49,422	1.0%
ASC.01.03 Voluntary counselling and testing	80,714	1.3%	99,783	2.0%

ASC.01.04 Prevention programmes for vulnerable and accessible populations	110,174	1.8%	180,659	3.5%
ASC.01.05 Youth in-school	22,057	0.4%	26,615	0.5%
ASC.01.07 Prevention of HIV transmission aimed at PLHIV	541,968	9%	1,472,081	29%
ASC.01.08 Prevention programmes for sex workers and their clients	1,503,854	25%	970,497	19%
ASC.01.09 Prevention programmes for MSM	813,749	13%	858,988	17%
ASC.01.10 Harm reduction programmes for IDUs	719,538	12%	534,865	10%
ASC.01.11 Prevention programmes in the workplace	23,312	0.4%	47,826	0.9%
ASC.01.12 Condom social marketing	147,399	2.4%	57,238	1.1%
ASC.01.13 Male condom provision	65,536	1.1%	-	-
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	65,536	1.1%	-	-
ASC.01.17 Prevention of mother-to-child transmission	724,256	12%	299,709	6%
ASC.01.19 Blood safety	324,804	5%	450,003	9%
ASC.01.98 Prevention activities not broken down by type	841,953	14%	39,929	1%
TOTAL SPENDING on PREVENTION	6,051,378	100%	5,098,459	100%

In 2017 almost US$ 1.5 million has been spent for prevention among PLHIV (aiming at partners of PLHIV), which represented 29% of the total spending for Prevention. Second largest spending occurred in the programs for sex workers and their clients with almost US$ 1 million (19% of Prevention), followed by prevention programs for men who have sex with men where US$ 0.9 million was spent in 2017, representing 17% of the total Prevention expenditure that year.

Harm reduction programs for the people who inject drugs absorbed US$ 720 thousand in 2016 – 12% of spending on Prevention, and US$ 535 thousand in 2017 – 10% of spending on HIV Prevention that year.

Over US$ 325 thousand in 2016 and over US$ 450 thousand in 2017 was spent on Blood safety programs, benefiting the recipients of blood and blood components.

Expenditure on PMTCT activities has declined for more than 50% in just one year – from US$ 724,256 in 2016 to just under US$ 300,000 in 2017. It should be noted that due to the decision to analyze ARV spending based on the procurement data, the expenditure on the PMTCT-related ARVs for mothers in labor and their newborn children is tracked under ASC.02.01.03 Antiretroviral therapy as part of Care and Treatment.

An outlier in 2016 was ASC.01.98 Prevention not broken down by type where almost US$ 842 thousand was registered under this category, more precisely – prevention among most-at-risk populations not disaggregated by type. This data came mainly from KHANA and PSI who did not provide enough details to break it down into more specific programs for KAP. In the classification of

the Beneficiary Populations, this amount is coded as BP.02.98 Key affected populations not disaggregated by type.

Majority of Prevention spending – 94% in 2016 and 97% in 2017 - came from the international sources of funding (see Figure 13). The largest share was provided by bilateral organizations, where the biggest donor is the US Government, supplying US$ 3.5 million in 2016 and US$ 2.5 million in 2017 for prevention interventions. The second largest prevention contributor is The Global Fund, which provided US$ 1.6 million or 27% of Prevention funds in 2016 and almost US$ 1.9 million or 37% of Prevention in 2017. Out of the GFATM-originated spending on Prevention, 48% (US$ 775,717) in 2016 and 57% (US$ 1,052,274) in 2017 was spent on the prevention among PWID, sex workers and their clients and men who have sex with men. Additionally, the money on Prevention from The Global Fund were spent for PMTCT activities, blood safety, workplace prevention and programs targeting prisoners, partners of PLHIV, health workers etc.

Figure 13 – Financing Sources of ASC.01 Prevention, 2016-2017

FINANCING SOURCES for ASC.01 PREVENTION		2016		2017	
		US Dollars	% of ASC.01	US Dollars	% of ASC.01
International	Bilateral	3,603,871	60%	2,626,465	52%
	GFATM	1,613,261	27%	1,861,111	37%
	UN	56,758	0.94%	955	0.02%
	Other multilaterals (exc. GF & UN)	48,941	0.81%	60,995	1.20%
	International NGOs	379,001	6%	409,899	8%
	International TOTAL	**5,701,833**	**94%**	**4,959,426**	**97%**
Private TOTAL		**51,768**	**0.86%**	**64,626**	**1.27%**
Public TOTAL		**297,777**	**5%**	**74,407**	**1%**
TOTAL Prevention		**6,051,378**	**100%**	**5,098,459**	**100%**

Analysis of the service provision modalities of Prevention component of the HIV response in Cambodia reveals that 81% of spending in 2016 and 85% in 2017 is carried out by the private sector providers - non-governmental and civil society organizations, both national and international, followed by public sector providers which absorbed 19% in 2017 and 15% in 2017 (see Figure 14).

Figure 14 – Providers of Services for ASC.01 Prevention, 2016-2017

PROVIDERS OF SERVICES FOR ASC.01 PREVENTION		2016		2017	
		US Dollars	% of ASC.01	US Dollars	% of ASC.01
Public	PS.01.01.01 Hospitals	231,209	4%	151,874	3%
	PS.01.01.02 Ambulatory care	258,033	4%	320	0.01%
	PS.01.01.04 Mental health and substance abuse facilities	57,978	0.96%	47,309	1%

	PS.01.01.05 Laboratory and imaging facilities	256,313	4%	-	-
	PS.01.01.06 Blood banks	314,834	5%	449,683	9%
	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	30,170	0.50%	126,733	2%
	PS.01.01.14.99 Government entities n.e.c.	-	-	580	0.01%
	Public TOTAL	**1,148,536**	**19%**	**776,498**	**15%**
Private	**PS.02.01.01.15 Civil society organizations (Non-profit non faith-based) TOTAL**	**4,902,222**	**81%**	**4,321,586**	**85%**
Bilateral and multilateral agencies	**PS.03.02 Multilateral agencies TOTAL**	**620**	**0.01%**	**375**	**0.01%**
TOTAL Prevention		**6,051,378**	**100%**	**5,098,459**	**100%**

3.3.1.2 Expenditure on ASC.02 Care and Treatment

Care and Treatment takes the largest share of the HIV response expenditure (Figure 10): in 2016 it amounted to US$ 13.6 million and represented 43% of the overall spending. In 2017 the expenditure increased by almost US$ 1.5 million and totaled US$ 15.9 million, representing 46% of the HIV spending in Cambodia. According to the results from the previous NASAs, spending on Care and Treatment peaked in 2015, when US$ 19.9 million have been directed to this program.

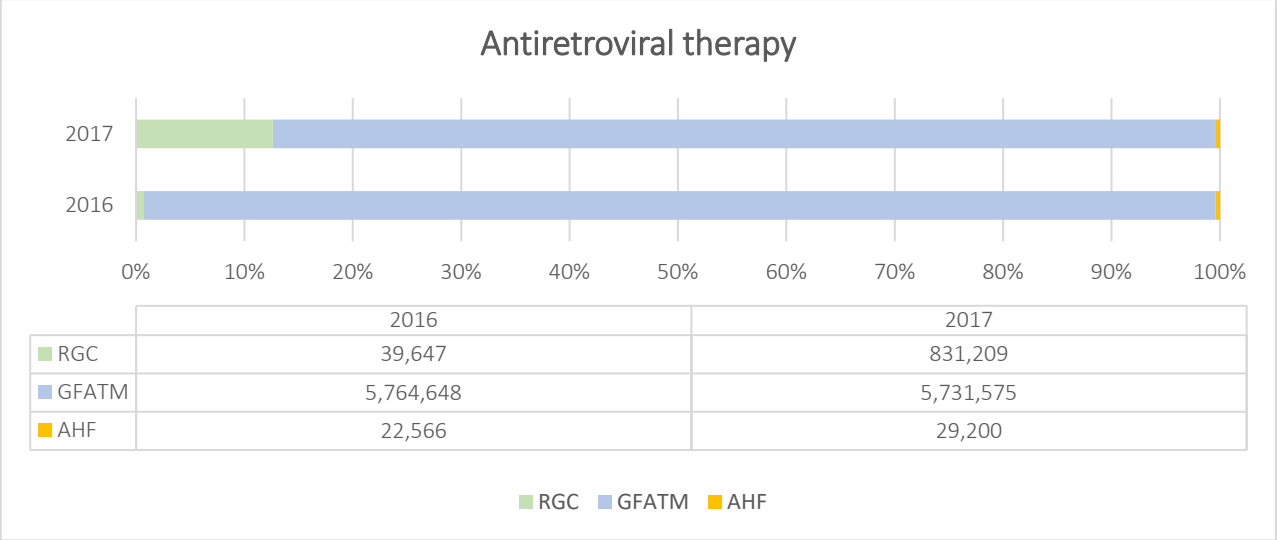
Figure 15 – Detailed breakdown of ASC.02 Care and Treatment, 2016-2017

CARE and TREATMENT AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.02	US Dollars	% of ASC.02
ASC.02.01.01 Provider-initiated testing and counselling	10,392	0.1%	733,777	5%
ASC.02.01.02 OI outpatient prophylaxis and treatment	97,854	0.7%	371,870	2%
ASC.02.01.03 Antiretroviral therapy	5,826,861	43%	6,591,985	41%
ASC.02.01.05 Specific HIV-related laboratory monitoring	2,522,154	19%	2,505,789	16%
ASC.02.01.07 Psychological treatment and support services	15,806	0.1%	77,450	0.5%
ASC.02.01.09 Home-based care	658,201	5%	957,228	6%
ASC.02.01.98 Other Outpatient care services	1,894,187	14%	1,789,979	11%
ASC.02.02.01 Inpatient treatment of OIs	12,515	0.1%	31,641	0.2%
ASC.02.03 Patient transport and emergency rescue	31,727	0.2%	47,916	0.3%
ASC.02.98 Care and treatment services not broken down by type	2,561,877	19%	2,796,701	18%
CARE and TREATMENT TOTAL	**13,631,573**	**100%**	**15,904,335**	**100%**

As described in the Figure 15 above, Antiretroviral therapy remain largest AIDS Spending Category of Treatment and Care with a spending of over US$ 5.8 million in 2016 and US$ 6.6 million in 2017. It represents 41% of the spending on Care and Treatment or 19% of the total HIV spending in Cambodia in 2017, the most recent assessment years. Majority of ARV cost – 99% in 2016 and 87% in 2017 - is

paid by The Global Fund, followed by the Royal Government of Cambodia that supplied <1% in 2016 and 13% in 2017. The rest of the ARV expenditure was covered by the AIDS Healthcare Foundation (see Figure 16).

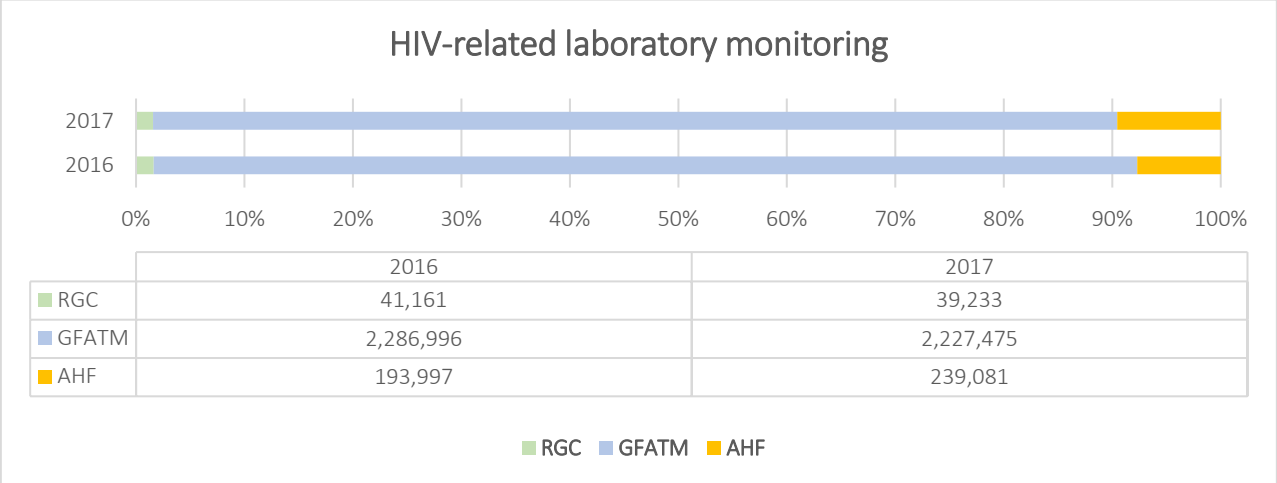
Figure 16 – Financing sources of the ASC.02.01.03 Antiretroviral therapy



	2016	2017
RGC	39,647	831,209
GFATM	5,764,648	5,731,575
AHF	22,566	29,200

Expenditure on HIV-related laboratory monitoring is closely linked to that of Antiretroviral therapy, as it depends on the number of patients that start and continue the lifelong treatment. Expenditure for this intervention amounted to US$ 2.5 million on an annual basis in 2016 and in 2017. It included the cost of the tests, reagents, materials, transportation of samples, wages of the lab specialists and the cost of the lab itself. Similarly to the ART provision, The Global Fund covered most of its cost – 91% in 2016 and 89% in 2017 (mainly reagents and materials, lab equipment and wages). AIDS Healthcare Foundation provided 8% and 10% of it in 2016 (mostly wages and transportation cost) (see Figure 17).

Figure 17 – Financing Sources of the ASC.02.01.05 Specific HIV-related laboratory monitoring



	2016	2017
RGC	41,161	39,233
GFATM	2,286,996	2,227,475
AHF	193,997	239,081

Care and Treatment expenditure assessment continues to suffer from a lack of details that allow further disaggregation: in 2017 almost US$ 1.8 million is coded under ASC.02.01.98 Outpatient care services not broken down by intervention and US$ 2.8 million is coded with even less details under ASC.02.98 Care and Treatment services not broken down by intervention, representing 29% of the Care and Treatment spending that year. A large part of this expenditure is a shared health systems cost attributed to HIV and calculated based on the data supplied by the National Health Accounts.

It has been proven challenging to correctly assign NASA codes to the cost of the procured test-kits. NASA recognizes several types of HIV testing, depending on the intention of this intervention. For example, voluntary HIV screening for general population, for various populations at-risk has its own respective code under ASC.01 Prevention, and so does testing of the donated blood and blood products. In its turn, testing of the patient in the clinic after he developed symptoms of the opportunistic diseases falls under ASC.02 Care and Treatment. Estimating the expenditure on these various kinds of testing based on the procurement data does not allow to disaggregate it correctly. In the case of Care and Treatment, if the data collection form indicated that, for instance, the procurement of tests falls under this component, the expenditure on HIV tests were assigned to ASC.02.01.01 Provider-initiated testing. The discrepancies between the assessed years in the expenditure in this code appear if the procurement happens once in two years.

Figure 18 – Financing Sources for ASC.02 Care and Treatment, 2016-2017

FINANCING SOURCES for CARE and TREATMENT	2016		2017	
	US Dollars	% of ASC.02	US Dollars	% of ASC.02
Royal Government of Cambodia	2,761,990	20%	3,968,153	25%
The Global Fund	10,374,691	76%	11,338,075	71%
Bilateral agencies	64,842	0.5%	119,835	0.8%
International NGOs	430,051	3%	478,272	3%
TOTAL Care and Treatment	**13,631,573**	**100%**	**15,904,335**	**100%**

Analysis of the Financing sources of the Care and Treatment programs (see Figure 18) demonstrates that the majority of spending comes from the Global Fund – 76% in 2016 (US$ 10,374,691) and 71% in 2017 (US$ 11,338,075). Half of this amount – US$ 5,764,648 in 2016 and US$ 5,731,575 in 2017 - has been utilized for the provision of the antiretroviral therapy for HIV patients in need. A large portion of Global Fund-originated spending for Care and Treatment goes to HIV laboratory monitoring – US$ 2,286,996 in 2016 and US$ 2,227,475 in 2017. The other US$ 2.3 million in 2016 and US$ 3.4 million in 2017 is divided among such activities as home-based care, provider-initiated

counselling and testing, patient transport, and other outpatient care services (case management, ART/VCCT clinics etc.).

A breakdown down of the Providers of Services for ASC.02 Care and Treatment shows that public sector ambulatory care providers (mainly ART/VCCT clinics) carried out the largest share of expenditure – US$ 6.1 million in 2016 and US$ 7.8 million in 2017. That represents almost half of all spending under this ASC (see Figure 19). Domination of the public sector service provision of treatment and care services remains stable also in the previous years: in 2014 and 2015 almost 80% of the services under ASC.02 Care and Treatment (US$ 14.9 and US$ 15.4 million correspondingly) were provided in the public sector[27].

Figure 19 – Providers of Services of ASC.02 Care and Treatment, 2016-2017

PROVIDERS OF SERVICES FOR ASC.02 CARE and TREATMENT		2016		2017	
		US Dollars	% of ASC.02	US Dollars	% of ASC.02
Public	PS.01.01.01 Hospitals	2,518,686	18%	2,589,516	16%
	PS.01.01.02 Ambulatory care	6,095,468	45%	7,786,551	49%
	PS.01.01.05 Laboratory and imaging facilities	1,459,453	11%	1,808,742	11%
	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	181,481	1.3%	142,794	0.9%
	Public Total	**10,255,088**	**75%**	**12,327,603**	**78%**
Private	PS.02.01.01.01 Hospitals (Non-profit non faith-based)	256,823	2%	379,111	2%
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	3,119,662	23%	3,197,621	20%
	Private Total	**3,376,485**	**25%**	**3,576,733**	**22%**
TOTAL ASC.02 Care and Treatment		**13,631,573**	**100%**	**15,904,335**	**100%**

In NASA VI, private sector service provision is represented by Sihanouk Hospital, Center of Hope and 19 NGOs that reported having provided care and treatment services in the assessed years. Their engagement in service provision is spread across a number of services: provision or ART, laboratory monitoring of ART, OI diagnostics and treatment, providing case management for PLHIV, home-based care and others. In 2016 private sector organizations provided services that amounted to US$ 3.4 million in 2016 and US$ 3.6 million in 2017, representing 25% and 22% of the total service provision under ASC.02 Care and Treatment correspondingly.

[27] National AIDS Spending Assessment V for the years 2014-2015

3.3.1.3 Expenditure on ASC.03 Orphans and Vulnerable Children

Spending on Orphans and Vulnerable Children has been on the decrease in the last 6 years. It hit its high in 2011 with US$ 4.7 million that represented 9% of the overall HIV spending that year, but was continuously decreasing ever since. In 2017 the NASA team was able to trace US$ 173,851 directed to OVC programs, which represents 0.5% of the total country's spending on HIV. The largest spending on OVC has been registered in ASC.03.03 OVC family/home support, which refers to in-kind support such as bed nets, clothes and shoes, blankets and bedding, food (not an ART-related nutritional support), and other support (Figure 20).

The lack of data in the OVC-specific AIDS Spending Category may also be related to the fact that most of the incoming data for the spending assessment does not provide a detailed disaggregation of expenditure into PLHIV and OVC. Thus, the interventions targeting OVC may be accounted for in ASC.02 Care and Treatment or ASC.06 Social Protection and Social Services.

Figure 20 – ASC.03 Orphans and Vulnerable Children by detailed AIDS Spending Category, 2016-2017

ASC.03 ORPHANS and VULNERABLE CHILDREN AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.03	US Dollars	% of ASC.03
ASC.03.01 OVC education	-	-	5,413	3%
ASC.03.02 OVC basic healthcare	-	-	1,550	0.9%
ASC.03.03 OVC family/home support	120,103	79%	121,054	70%
ASC.03.04 OVC community support	1,104	1%	1,191	0.7%
ASC.03.05 OVC Social services and administrative cost	4,039	3%	2,108	1.2%
ASC.03.98 Services for OVC not disaggregated by type	27,031	18%	42,535	24%
TOTAL ASC.03 Orphans and Vulnerable Children	**152,277**	**100%**	**173,851**	**100%**

Data collection revealed that international NGOs provided 100% of funding under ASC.03 Orphans and Vulnerable Children. The largest Financing Sources for this category is The Red Cross. Similarly, all the services were provided by the non-governmental organizations.

Further analysis of the expenditure trends in the past NASAs reveals that OVC programs suffered a major shift in resource availability and resource allocation modalities. Some Financing sources discontinued from 2012 to 2017, namely UNICEF and WFP, which together provided up to US$ 1.6 million (or 64% of the OVC expenditure) in 2011[28]. In the NASA VI, neither of them has submitted data for the analysis.

[28] National AIDS Spending Assessment IV for the years 2011-2012

Once a significant contributor of finances for OVC programs, The Global Fund shrank from US$ 1.3 million (28% of the OVC spending). GFATM data from 2016 and 2017 did not contain OVC-specific budget execution lines, so it was not possible to allocate any amount specifically to ASC.03. Orphans and Vulnerable Children.

3.3.1.4 Expenditure on ASC.04 Programme Management and Administration Strengthening

The assessment team was able to assign spending on ASC.04 to various categories (see Figure 21). All together they account for 33% of the HIV spending in Cambodia, totaling US$ 11.5 million in 2017. This trend – representing one-third of the HIV response – remains relatively consistent with the previous NASAs except for NASA V (years 2014 and 2015) when the allocation approach has been modified[29].

Figure 21 – ASC.04 Programme Management and administration Strengthening by detailed ASC, 2016-2017

ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION STRENGTHENING AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.04	US Dollars	% of ASC.04
ASC.04.01 Planning, coordination and programme management	6,968,679	66%	6,938,118	60%
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	2,646,702	25%	2,164,576	19%
ASC.04.03 Monitoring and evaluation	187,714	2%	309,319	3%
ASC.04.04 Operations research	68,356	0.6%	780	0.01%
ASC.04.07 Drug supply systems	258,445	2%	337,561	3%
ASC.04.08 Information technology	171,683	2%	80,837	0.7%
ASC.04.10 Upgrading and construction of infrastructure	294,696	3%	1,661,978	14%
TOTAL ASC.04 Programme Management & Administration Strengthening	**10,596,276**	**100%**	**11,493,171**	**100%**

Traditionally, the largest spending occurs within ASC.04.01 Planning, coordination and programme management, which includes a broad range of activities such as development of policies, laws, guidelines (including clinical protocols), standard operational procedures, coordination efforts of the HIV response at the national (e.g. by the MoH, NCHADS or NAA), provincial and organizational (e.g. KHANA as an umbrella organization arranges and coordinates implementation of the GF grant by their partner NGOs) levels. In 2016 spending under ASC.04.01 amounted to almost US$ 7 million which represented 66% of an entire Programme Management ASC. In 2017 the expenditure decreased by US$ 30,000 and represented 60% of the all Programme management efforts.

[29] See explanation in Key assumptions

ASC.04.02 is dedicated to transaction costs, bank charges and expenditure on outsourcing the external audit. However, by the decision of the steering committee in 2016 and 2017 it also includes a part of the shared health system's cost. Administration and transaction spending represents 25% of the total ASC.04 in 2016 or US$ 2.7 million, but in 2017, this amount dropped by US$ 0.5 million – US$ 2.2 million or 19% of the Programme Management spending.

In 2017, differently from 2016, a significant spending occurred under AIDS Spending Category dedicated to upgrading and construction of the infrastructure – almost US$ 1.7 million (14% of the ASC.04) was spent on procurement of the laboratory and office equipment, construction and renovations.

A majority of spending on Programme management and administration strengthening comes from The Royal Government of Cambodia and The Global Fund (see Figure 22).

In 2016 RGC spent US$ 4.3 million and in 2017 US$ 3.6 million under this category. It included, completely or partially, salaries of staff and office maintenance cost of NAA, NCHADS, NMCHC as well as Provincial Health Departments etc. It also includes an HIV-specific part of the coordination within the shared health system's cost, provided by the National Health Accounts.

As for The Global Fund – its contribution to ASC.04 totaled US$ 3.5 million in 2016 and US$ 4.8 million in 2017. In the past few years GFATM's share in the country's Programme management and administration has been inconsistent, peaking in 2012 with US$ 8.2 million which represented 50% of the total spending on ASC.04[30], while in 2015 it was estimated as low as US$ 0.8 million, representing 14% of the total ASC.04 expenditure[31].

Figure 22 – Financing Sources of ASC.04 Programme Management and Administration Strengthening, 2016-2017

FINANCING SOURCES for ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION STRENGTHENING		2016		2017	
		US Dollars	% of ASC.04	US Dollars	% of ASC.04
Public - Royal Government of Cambodia		4,319,290	41%	3,623,590	32%
International	Bilateral agencies	1,576,216	15%	1,786,154	16%
	The Global Fund	3,461,534	33%	4,813,680	42%
	UN	843,144	8%	800,588	7%
	International NGOs	393,166	4%	466,450	4%
Private		2,926	0.03%	2,709	0.02%
TOTAL ASC.04 Programme management		**10,596,276**	**100%**	**11,493,171**	**100%**

[30] National AIDS Spending Assessment IV for the years 2011-2012
[31] National AIDS Spending Assessment V for the years 2014-2015

A breakdown of ASC.04 Programme Management and Administration Strengthening by Providers of Services (see Figure 23) shows that 71% in 2016 and 69% in 2017 has been spent by various Government entities (MoH, NCHADS, NAA, NMCHC, as well as other ministries, Government entities and public hospitals), which play an important role as coordinating authorities carrying forward the HIV response in Cambodia. Private sector HIV response coordination effort accounts for 21% of the ASC.04 spending in 2016 and 24% – in 2017. Multilateral agencies absorb 8% and 7% in the 2016 and 2017 correspondingly.

Figure 23 – Providers of Services of ASC.04 Programme Management and administration Strengthening, 2016-2017

PROVIDERS OF SERVICES FOR ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION STRENGTHENING		2016		2017	
		US Dollars	% of ASC.04	US Dollars	% of ASC.04
Public	PS.01.01.01 Hospitals	246,165	2%	228,328	2%
	PS.01.01.05 Laboratory and imaging facilities	-	-	350	0%
	PS.01.01.06 Blood banks	5,833	0%	1,428,960	12%
	PS.01.01.13 Research institutions	148,757	1%	88,372	1%
	PS.01.01.14.01 National AIDS commission (NACs)	1,460,979	14%	1,305,295	11%
	PS.01.01.14.02 Departments inside the Ministry of Health	5,632,959	53%	4,875,403	42%
	PS.01.01.14.03 Departments inside the Ministry of Education	28,128	0.3%	25,498	0.2%
	PS.01.01.14.07 Departments inside the Ministry of Labour	10,186	0.1%	7,050	0.1%
	PS.01.01.14.99 Government entities n.e.c.	21,270	0.2%	23,187	0.2%
	Public TOTAL	7,554,277	71%	7,982,443	69%
Bilateral/multilateral agencies	**PS.03.02 Multilateral agencies TOTAL**	807,315	8%	796,858	7%
Private	**PS.02.01.01.15 Civil society organizations TOTAL**	2,234,684	21%	2,713,869	24%
TOTAL ASC.04 Programme management and Administartion Strengthening		10,596,276	100%	11,493,171	100%

3.3.1.5 Expenditure on ASC.05 Human Resources

In 2016 spending on ASC.05 Human Resources accounted for US$ 664,013 that represented 2.1% of the total HIV spending in the country. In 2017 this amount increased to US$ 960,853, or 2.8% of the HIV response in Cambodia (Figure 10).

Similar to other AIDS Spending Categories, due to inconsistency of data processing and coding, in 2014 and 2015 this category appears to be much larger due to the fact that a lot of salaries of the staff that implement HIV response were attributed to Human resources[32], which should have been

[32] National AIDS Spending Assessment V for the years 2014-2015

correctly coded under respective services (ASCs) the staff was providing. In NASA III, NASA IV and NASA VI (except for the part of the non-earmarked shared health systems cost provided by the NHA team) salaries of the staff that implement certain services are included under the relevant categories – e.g. salaries of staff providing Care and Treatment is coded under respective Care and Treatment category, staff of the NAA or NCHADS (or other relevant Government entities) coordinating HIV response is coded under ASC.04.01 Planning, coordination and programme management, staff working directly with MARPs – under a respective ASC inside Prevention. According to the decision of the NASA Steering Committee under ASC.05 in the NASA VI still falls part of the shared health systems cost, derived from the National Health Accounts. It incorporated into the ASC.05.01 Monetary incentives for human resources (see Figure 24 below).

Figure 24 – ASC.05 Human Resources by detailed AIDS Spending Category, 2016-2017

ASC.05 HUMAN RESOURCES AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.05	US Dollars	% of ASC.05
ASC.05.01 Monetary incentives for human resources	528,164	80%	543,533	57%
ASC.05.03 Training	135,849	20%	417,320	43%
TOTAL ASC.05 Human Resources	**664,013**	**100%**	**960,853**	**100%**

Royal Government of Cambodia bore most of the resources under ASC.05 – 80% in 2016 and 57% in 2017 (salaries of health care staff as a part of a shared health systems cost), followed by The Global Fund with a share of 16% in 2016 and 35% in 2017 that was supporting various training activities (see Figure 25). Bilateral agencies are represented by the US Government, which invested almost US$ 70 thousand in Training in 2017.

Figure 25 – Financing Sources of ASC.05 Human resources, 2016-2017

FINANCING SOURCES for ASC.05 Human Resources	2016		2017	
	US Dollars	% of ASC.05	US Dollars	% of ASC.05
Public - Royal Government of Cambodia	528,164	80%	543,533	57%
Bilateral agencies	15,781	2%	69,855	7%
The Global Fund	106,795	16%	333,110	35%
UN	11,070	2%	-	-
International NGOs	2,204	0.3%	14,354	1.5%
TOTAL ASC.05 Human Resources	**664,013**	**100%**	**960,853**	**100%**

Public sector providers were the main recipients and implementors of the activities under ASC.05 Human resources, 97% of all related funding in both 2016 and 2017, followed by civil society organizations, who delivered 3% and 2% of the activities correspondingly (see Figure 26).

Figure 26 – Providers of Services of ASC.05 Human Resources, 2016-2017

PROVIDERS OF SERVICES FOR ASC.05 HUMAN RESOURCES		2016		2017	
		US Dollars	% of ASC.05	US Dollars	% of ASC.05
Public	PS.01.01.01 Hospitals	399,454	60%	499,807	52%
	PS.01.01.13 Research institutions	-	-	36,975	4%
	PS.01.01.14.01 National AIDS commission (NACs)	-	-	-	-
	PS.01.01.14.02 Departments inside the Ministry of Health	243,845	37%	399,035	42%
	Public TOTAL	**643,299**	**97%**	**935,818**	**97%**
Bilateral and multilateral agencies	**PS.03.02 Multilateral agencies TOTAL**	**2,240**	**0.3%**	**5,985**	**1%**
Private	**PS.02.01.01.15 Civil society organizations TOTAL**	**18,473**	**3%**	**19,050**	**2%**
TOTAL ASC.05 HUMAN RESOURCES		**664,013**	**100%**	**960,853**	**100%**

3.3.1.6 Expenditure on ASC.06 Social Protection and Social Services

Spending on Social Protection and Social Services totaled less than US$ 0.3 million in 2016 and 2017. This money was spent on the activities to integrate PLHIV into the Health Equity Fund Target Benefit Contract in several provinces and on providing food relief and social welfare support to PLHIV families to safeguard their basic needs (see Figure 27).

Figure 27 – ASC.06 Social Protection and Social Services by detailed ASC, 2016-2017

ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.06	US Dollars	% of ASC.06
ASC.06.01 Social protection through monetary benefits	1,633	1%	-	-
ASC.06.02 Social protection through in-kind benefits	274,713	99%	255,068	100%
TOTAL ASC.06 Social Protection and Social Services	**276,345**	**100%**	**255,068**	**100%**

In the recent years funding for social programs were in decline: in 2014 they amounted to US$ 2.2 million which represented 4.5% of total HIV spending (see Figure 10), while in the last year of assessment – 2017 - dropped both in absolute terms (US$ 255,068 in 2017) and as a share (0.7%) of the total spending.

Most of the resources for the ASC.06 Social Protection and Social Services were mobilized through the Global Fund – 59% in 2016 and 56% in 2017. The rest 41% and 44% came from the Red Cross (see Figure 28).

Figure 28 – Financing Sources of ASC.06 Social Protection and Social Services, 2016-2017

FINANCING SOURCES for ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES	2016		2017	
	US Dollars	% of ASC.06	US Dollars	% of ASC.06
The Global Fund	162,817	59%	141,801	56%
International NGOs	113,528	41%	113,268	44%
TOTAL ASC.06 Social Protection and Social Services	**276,345**	**100%**	**255,068**	**100%**

All the activities under ASC.06 were implemented by the non-governmental civil society organizations grouped into PS.02.01.01.15 Civil society organizations (Non-profit non faith-based).

3.3.1.7 Expenditure on ASC.07 Enabling Environment

Of the overall HIV spending in Cambodia expenditure to improve the enabling environment comprise 0.7% in 2016 and 1.1% in 2017 (see Figure 10). In the course of the last few years it faced a dramatic decline in the resource availability: in 2014 spending on various enabling environment interventions and programs was registered at the level of US$ 2.2 million[33].

The most funded ASC.07 activities in 2016 and 2017 were those aimed at reducing gender-based violence (ASC.07.05) (see Figure 29), which was considerably higher than in 2014 and 2015 when less than US$ 5,000 has been assigned to this AIDS Spending Category in NASA V[34].

Figure 29 – ASC.07 Enabling Environment by detailed ASC, 2016-2017

ASC.07 ENABLING ENVIRONMENT AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.08	US Dollars	% of ASC.08
ASC.07.01 Advocacy	**11,646**	**11%**	**25,531**	**7%**
ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment	**2,734**	**3%**	**24,378**	**7%**
ASC.07.03 AIDS-specific institutional development			**21**	**0.01%**
ASC.07.04 AIDS-specific programmes focused on women	**9,183**	**9%**	**45,707**	**12%**
ASC.07.05 Programmes to reduce gender-based violence	**73,186**	**68%**	**219,463**	**59%**
ASC.07.98 Enabling environment activities ndt	**10,685**	**10%**	**57,698**	**15%**
Enabling Environment TOTAL	**107,435**	**100%**	**372,799**	**100%**

[33] National AIDS Spending Assessment V for 2014-2015
[34] National AIDS Spending Assessment V for 2014-2015

Enabling environment programs were financed mostly from the international sources (87% in 2016 and 95% in 2017), mainly from the international NGOs, The Global Fund and The Government of the United States. Royal Government of Cambodia provided the remaining 13% for these activities in 2016 and 5% in 2017.

Eighty-one and eighty-four per cent of the projects in 2016 and 2017 related to enabling environment are provided in the private sector by various civil society organizations (see Figure 30). Ministry of Women Affairs is another active player in the service provision, implementing 9% and 12% correspondingly of the total ASC.07 Enabling Environment in 2016 and 2017, although its part has decreased since the NASA V assessment. UNAIDS, coded under PS.03.02 Multilateral agencies, executed 5% and 2% of the Enabling environment projects in 2016 and 2017.

Figure 30 – Providers of Services of ASC.07 Enabling Environment, 2016-2017

PROVIDERS OF SERVICES FOR ASC.07 ENABLING ENVIRONMENT		2016		2017	
		US Dollars	% of ASC.07	US Dollars	% of ASC.07
Public	PS.01.01.14.02 Departments inside the Ministry of Health	-	-	21	0.01%
	PS.01.01.14.07 Departments inside the Ministry of Labour	5,860	5%	5,860	2%
	PS.01.01.14.99 Government entities n.e.c.	9,183	9%	45,707	12%
	Public TOTAL	**15,043**	**14%**	**51,588**	**14%**
Private	**PS.02.01.01.15 Civil society organizations TOTAL**	**87,325**	**81%**	**314,231**	**84%**
Bilateral and multilateral agencies	**PS.03.02 Multilateral agencies TOTAL**	**5,066**	**5%**	**6,980**	**2%**
ASC.07 ENABLING ENVIRONMENT TOTAL		**107,435**	**100%**	**372,799**	**100%**

3.3.1.8 Expenditure on ASC.08 HIV-related Research

HIV-related research comprises less than 1% of the HIV response in Cambodia. In absolute figures in the past it peaked in 2011 with US$ 662 thousand spent on this activity[35] (see Figure 10). In 2016-2017 it represents spending on the Integrated Biological and Behavioral Surveillance Survey (IBBS) among PWID/PWUD and Entertainment workers (Figure 31).

Figure 31 – ASC.08 HIV-related Research by detailed ASC, 2016-2017

ASC.08 HIV-RELATED RESEARCH AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.08	US Dollars	% of ASC.08
ASC.08.01 Biomedical research	28,422	100%	22,060	12%

[35] National AIDS Spending Assessment IV for the years 2011-2012

ASC.08.04 Social science research	-	-	167,291	88%
Grand Total	**28,422**	**100%**	**189,351**	**100%**

Financing source for the spending on HIV research is the Global Fund, both in 2016 and 2017. This activity was implemented in public sector, by NCHADS.

3.3.2 EXPENDITURE PER PRODUCTION FACTORS

A categorization of Production Factors in NASA provides a particular angle on the expenditure analysis – what budgetary/economic items were used to produce certain services, interventions and programs. Similarly to those used for accounting purposes, Production Factors classification in NASA contains a breakdown into Current and Capital expenditure with further specification of the particular code.

Figure 32 – Production Factors of the HIV Response in Cambodia, 2016-2017

PRODUCTION FACTORS		2016		2017	
		US Dollars	%	US Dollars	%
PF.01 Current expenditure	PF.01.01 Labour income	8,194,092	26%	7,384,228	21%
	PF.01.02 Supplies and services	20,929,792	66%	24,923,291	72%
	PF.01.98 Current expenditures not broken down by type	64,842	0.2%	119,835	0.3%
	PF.01 Current expenditure Total	**29,188,726**	**93%**	**32,427,354**	**94%**
PF.02 Capital expenditure	PF.02.01 Buildings	65,579	0.2%	54,530	0.2%
	PF.02.02 Equipment	2,253,414	7%	1,966,004	6%
	PF.02 Capital expenditure Total	**2,318,993**	**7%**	**2,020,534**	6%
Production Factors TOTAL		31,507,719	**100%**	34,447,888	**100%**

As shown in the Figure 32, the majority of HIV-related activities in 2016-2017 are produced with current expenditure, a part of which belongs to wages (26% and 21%), the rest goes to procure services and supplies (66% and 72%).

Capital expenditure implies spending money on construction, renovation and purchasing of equipment and vehicles. NASA VI registered such spending at 7% in 2016 and 6% in 2017, which mainly was used for various equipment, particularly for laboratories.

Closer look into the PF composition across programmatic areas shows similarity in the cost drivers. In Prevention, the production of services consists of 15% and 17% correspondingly of Labour income, 79% and 81% of Materials and Supplies (in particular, Reagents and Materials – 6% and 8% - and Consulting services – 23% and 45%), and Capital expenditure – 5% and 2% in 2016 and 2017. Care and Treatment in 2016-2017 is composed of 17% and 14% of Labour income, ARVs - 42% and 40%,

Reagents – 0%[36] and 15%, Travel and Transportation – 11% in both years, Capital expenditure – 11% and 0% correspondingly.

3.3.3 EXPENDITURE PER BENEFICIARY POPULATION

3.3.3.1 Total expenses per beneficiary population 2016-2017

NASA VI revealed that 44% in 2016, and 47% of the overall spending on HIV in Cambodia in 2017 reached people living with HIV (BP.01). A much smaller proportion of resources – 13% and 7% in the assessed years – benefited key affected populations (BP.02), and around 6% and 8% correspondingly was spent on programs targeting other key and "accessible" populations (BP.03 + BP.04) (see Figure 33).

Figure 33 - HIV Spending by Beneficiary Population, 2016-2017

BENEFICIARY POPULATIONS		2016		2017	
		US Dollars	% of Total	US Dollars	% of Total
BP.01 People living with HIV	BP.01.02 Children living with HIV	13,520	0.04%	11,449	0.03%
	BP.01.98 People living with HIV not disaggregated by age or gender	13,907,818	44%	16,191,145	47%
	BP.01 People living with HIV Total	**13,921,338**	**44%**	**16,202,594**	**47%**
BP.02 Key affected populations	BP.02.01 Injecting drug users (IDU) and their sexual partners	719,538	2%	560,248	2%
	BP.02.02.01 Female sex workers and their clients	1,503,854	5%	970,497	3%
	BP.02.03 Men who have sex with men (MSM)	559,075	2%	517,355	2%
	BP.02.04 Transgenders (TG)	254,674	0.8%	356,576	1%
	BP.02.98 "Key affected populations" not disaggregated by type	1,120,423	4%	97,167	0.3%
	BP.02 Key affected populations Total	**4,157,565**	**13%**	**2,501,843**	**7%**
BP.03 Other key populations	BP.03.01 Orphans and vulnerable children	152,277	0.5%	173,851	0.5%
	BP.03.02 Children born or to be born of HIV+ women	724,256	2%	299,709	0.9%
	BP.03.07 Prisoners	33,577	0.1%	97,135	0.3%
	BP.03.13 Partners of PLHIV	566,054	2%	1,472,081	4%
	BP.03.14 Recipients of blood and blood products	324,804	1.0%	450,003	1.3%
	BP.03 Other key populations Total	**1,800,967**	**6%**	**2,492,780**	**7%**
BP.04 Key "accessible" populations	BP.04.01 People attending STI clinics	51,483	0.2%	23,181	0.1%
	BP.04.03 High school students	22,057	0.1%	26,615	0.1%
	BP.04.04 University students	1,028	0.0%	768	0.002%
	BP.04.05 Health care workers	-	-	57,797	0.2%
	BP.04.10 Factory employees	23,312	0.1%	49,604	0.1%
	BP.04 Key "accessible" populations Total	**97,879**	**0.3%**	**157,965**	**0.5%**
	BP.05.01.02 Female adult population	9,183	0.03%	48,120	0.1%

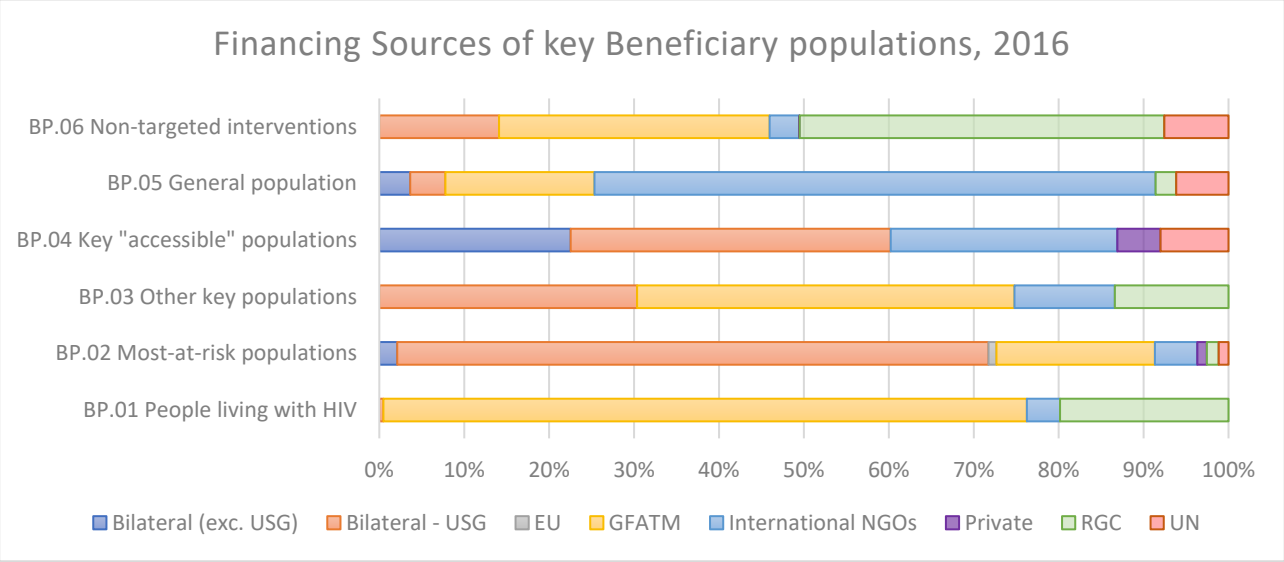
[36] No expenditure on Reagents and Materials in 2016 may be explained in two ways. First – NASA VI is using cash accounting approach for tracking the spending on the items procured centrally. If there was no procurement that year, NASA will capture zero expenditure. Second explanation – when NASA team obtains the data from the bulk procurement of various supplies and there is little detail to disaggregate it into more specific categories, such expenditure goes to PF.01.02.01.98 Material supplies not disaggregated by type.

BP.05 General population	BP.05.03.02 Young females	73,186	0.2%	219,463	0.6%
	BP.05.98 General population not broken down	158,890	0.5%	181,748	0.5%
	BP.05 General population Total	**241,260**	**0.8%**	**449,331**	**1.3%**
BP.06 Non-targeted interventions	BP.06 Non-targeted interventions	11,288,710	36%	12,643,375	37%
	BP.06 Non-targeted interventions Total	**11,288,710**	**36%**	**12,643,375**	**37%**
Beneficiary Populations TOTAL		**31,507,719**	**100%**	**34,447,888**	**100%**

Compared to previous NASAs, estimates of the programs targeting PLHIV have been going up and down in the absolute values: in 2011 its proportion totaled US$ 17 million representing 32% of the total spending, and in 2012 this amount shrank to US$ 15.4 million[37]. In the next years of assessment[38] – 2014 and 2015 – it amounted to US$ 36.6 and US$ 32.4 million correspondingly. This may have been caused by a different approach toward spending allocation in NASA V.

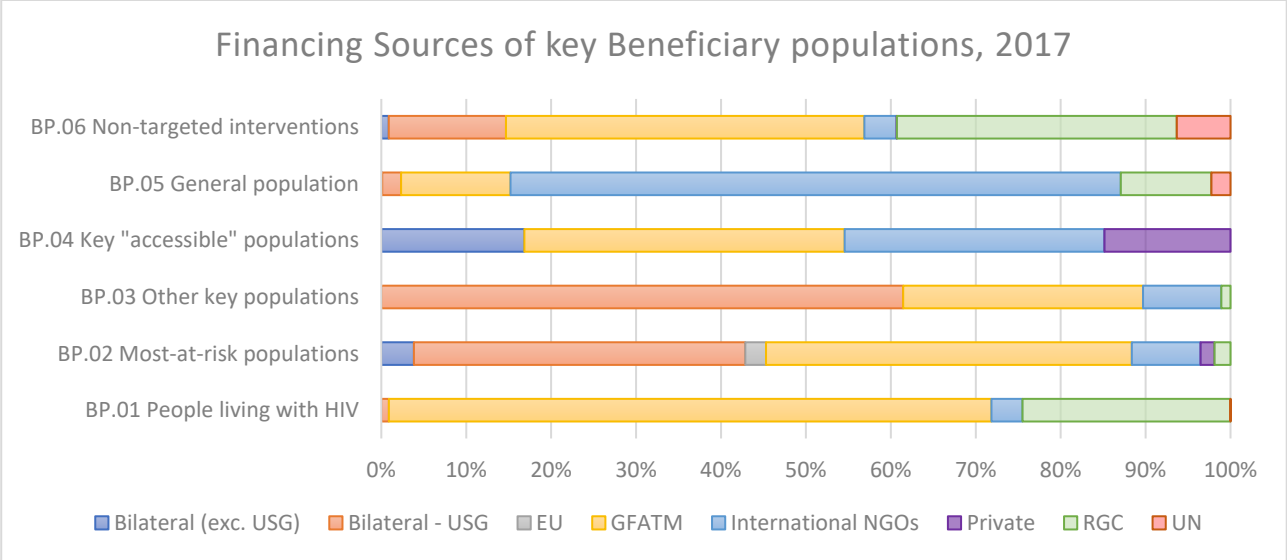
Financing sources participate differently in providing funds for various Beneficiary populations (see Figure 34, Figure 35).

Figure 34 – Financing Sources of key Beneficiary Populations, 2016



[37] National AIDS Spending Assessment IV for 2011-2012
[38] National AIDS Spending Assessment V for the years 2014-2015

Figure 35 - Financing Sources of key Beneficiary Populations, 2017



The Global Fund remains the largest financer for BP.01 People living with HIV, providing 76% of the category in 2016 and 71% in 2017, followed by the Royal Government of Cambodia with 24% in 2016 and 20% in 2017.

Programs aiming at Key affected populations (BP.02) – PWID and their sexual partners, SWs and their clients, MSM, transgender – were getting their funding predominantly from the US Government through PEPFAR, especially in 2016 when it funded 70% of all KAP programs (or US$ 2.9 million). Already in 2017, share of USG funding to support prevention programs for KAP dropped significantly and represented only 39% of the total spending on "BP.02 Most-at-risk populations" (just under US$ 1 million). The Global Fund's investment into KAP programs increased both in absolute figures and as a share of total: in 2016 – US$ 0.8 million, in 2017 – US$ 1.1 million, which, however, did not cover the gap, created with the withdrawal of the USG support.

BP.03 Other key populations includes OVCs, children born or to be born from HIV+ mothers (beneficiary of all PMTCT interventions), partners in the discordant couples, prisoners and recipients of blood and blood products, and is financed mainly by the US Government (US$ 0.5 million in 2016 and US$ 1.5 million in 2017) and GFATM (US$ 0.8 million in 2016 and US$ 0.7 million in 2017). A contribution of iNGOs (such as Caritas/CRS, Red Cross, International Planned Parenthood Federation) and The Royal Government of Cambodia totaled US$ 0.2 million each in 2016, although in 2017 only US$ 27 thousand came from RGC, while iNGOs support for programs for BP.03 Other key populations have slightly increased (approximately by US$ 15 thousand) compared to 2016.

Programs benefiting so called "accessible" populations, that are relatively easy to reach for an HIV Program – through schools, universities, clinics, workplace - in 2016 were funded by various bilateral

sources, (including US Government) – US$ 60 thousand, iNGOs – appr. US$ 26 thousand, UN – US$ 7 thousand. No such expenditure has been tracked under the GFATM contribution in 2016, although in 2017, it provided almost US$ 60 thousand for prevention programs aimed at people who attend STI clinics. In 2017, appr. US$ 50,000 from various iNGOs benefited BP.04 Key "accessible" populations, and another US$ 23,500 was spent by private companies and organisations on workplace prevention.

Majority of funding aiming at BP.05 General population in 2016 came from iNGOs – appr. US$ 160,000, GFATM – appr. US$ 42,000, UN – appr. US$ 15,000, USG – appr. US$ 10,000, other bilateral donors – Governments of France, Japan and Sweden – appr. US$ 9,000, and RGC – appr. US$ 6,000. In 2017, HIV-related programs for general population were funded by iNGOs – US$ 323,000, GFATM – almost US$ 58,000, RGC – appr. US$ 48,000, UN and USG – appr. US$ 10,000 each.

Non-targeted interventions – those in the area of coordination, policy development, programme management, capacity strengthening etc. – were funded by the RGC (US$ 4.9 million in 2016 and US$ 4.2 million in 2017), GFATM (US$ 3.6 million in 2016 and US$ 5.3 million in 2017), USG (US$ 1.6 million in 2016 and US$ 1.8 million in 2017). International NGOs provided US$ 0.4 and US$ 0.5 million in 2016 and 2017, while contribution from the UN agencies for the non-targeted interventions was registered at the level of appr. US$ 0.9 million in 2016 and US$ 0.8 million in 2017. Additional US$ 110,000 for this BP category came from the French Government in 2017.

Most of the programs across various BPs was implemented either by public or private non-profit providers (see Figure 36 and Figure 37).

Figure 36 – Service Providers for key Beneficiary Populations, 2016

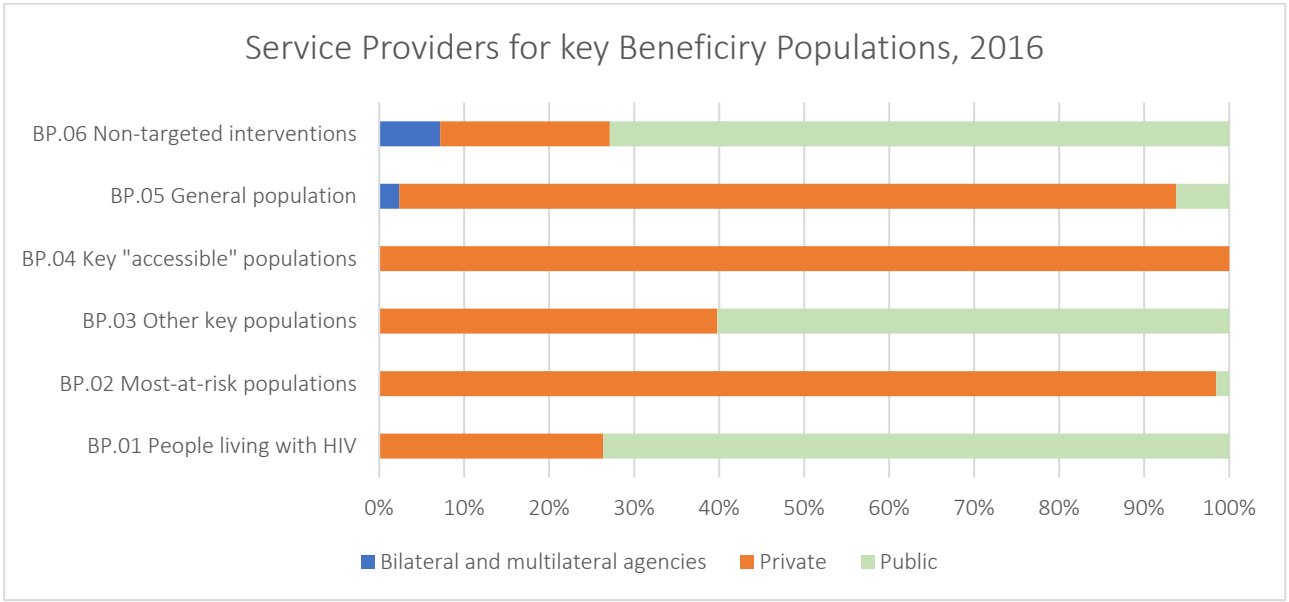
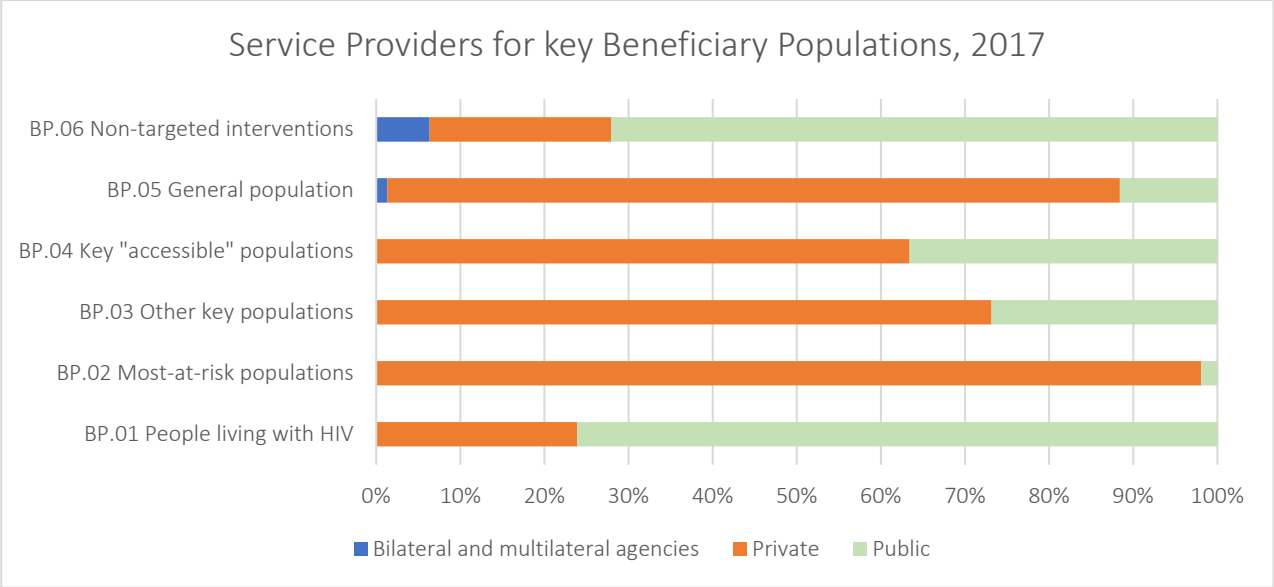


Figure 37 – Service Providers for key Beneficiary Populations, 2017



Public sector providers were key in the implementation of programs aiming at PLHIV, representing 74% of the PLHIV-targeting service provision (or US$ 10.3 million) in 2016, and 76% (or US$ 12.3 million) - in 2017. Correspondingly, 26% and 24% of services for PLHIV have been delivered by private non-profit providers.

Services for key affected populations (BP.02 Most-at-risk populations) were provided mainly (98% in both years) in the private sector, by NGOs. Only 2% of these crucial services was provided in the public sector.

Key providers for BP.03 “Other key populations” in 2016 were public, whose share was at 60%, while already in 2017 the situation has changed, so that 73% of the services for these populations were delivered by private non-profit providers, leaving only 27% for public service provision.

In 2016, all service provision for BP.04 Key “accessible” populations happened in the private sector, but already in 2017 public providers started implementing 27% of these services and programs.

Ninety-one per cent of services for general population in 2016 and eighty-seven percent in 2017 was provided by private sector providers, 6% in 2016 and 12% in 2017 – by public sector providers, 2% in 2016 and 1% in 2017 – by bilateral and multilateral organizations.

Public sector providers dominated implementation of the non-targeted interventions – 73% in 2016 and 72% in 2017, followed by private providers, whose share of the non-targeted, policy level, interventions has been 20% in 2016 and 22% in 2017. Bilateral and multilateral organizations provided 7% and 6% of BP.06 Non-targeted intervention in 2016 and 2017 respectively.

3.4 ANALYSIS OF HIV SPENDING BY KEY FINANCERS IN 2016-2017

3.4.1 DESCRIPTION OF THE DOMESTIC PUBLIC SPENDING IN CAMBODIA

Royal Government of Cambodia mobilized US$ 7.9 million in 2016 and US$ 8.3 million in 2017. As a Financing Source, RGC has two types of funding: first – resources earmarked for HIV within the National HIV Strategic Plan, and second – a non-earmarked funding that goes to the overall health system functioning in Cambodia. To track an HIV earmarked spending NASA team obtained budget execution reports from MoH, NAA, NCHADS etc. To calculate the HIV share in the overall health systems spending NASA team used various assumptions and proxies applied to the figures in the consolidated health expenditure reports available to the National Health Accounts. Based on the NHA data, a non-HIV-earmarked shared health systems spending in Cambodia represented 17% and 16% of the total estimated HIV spending in Cambodia in 2016-2017. Inside the domestic public allocation for HIV it represented a share of 66% each year.

Figure 34 breaks down domestic public spending into the AIDS Spending Categories, financed by the Government, across last six years of assessment – 2011-2012, 2014-2015 and 2016-2017.

Coordination and Programme management function receives the most of the Government resources, as all spending to maintain this function within key public institutions, such as National AIDS Authority, NCHADS, provincial programs etc., falls under ASC.04 Programme Management and Administration Strengthening. Domestic public resources include both earmarked and non-earmarked HIV expenditure data. In 2016 and 2017 it represented 55% and 44% of the total RGC HIV spending.

Figure 38 – Domestic public spending on HIV by AIDS Spending Categories

	ASC.01 Prevention	ASC.02 Care and Treatment	ASC.04 Programme management	ASC.05 Human resources	ASC.07 Enabling Environment
2017	74,407	3,968,153	3,623,590	543,533	47,931
2016	297,777	2,761,990	4,319,290	528,164	5,860
2015	511,700	3,508,973	3,411,791	724,634	31,063
2014	715,679	2,437,681	2,733,904	520,366	30,600
2012	2,384,270	2,542,984	737,049		7,560
2011	2,042,206	2,676,809	918,372		7,560

ASC.02 Care and Treatment is the second largest program in the RGC funding portfolio with US$ 2.76 million in 2016 and almost US$ 4 million in 2017 (35% and 48% of RGC HIV spending). Prevention allocation in the Government funds for HIV is much smaller – US$ 300 thousand in 2016 (4% of total RGC share) and US$ 75 thousand (1% of total RGC share) in 2017 were captured under this ASC in the assessment.

Since the beneficiary populations coding depends largely on a particular AIDS Spending Category, it comes as no surprise that the biggest allocation goes to BP.06 Non-targeted interventions[39] - 61% of the total domestic public spending in 2016, and 50% - in 2017. The second largest beneficiary group for the RGC funding is People living with HIV, a beneficiary population for all Treatment and Care programs. In 2016 the share of domestic public expenditure that benefited PLHIV was at the level of 35%, and 48% in 2017. In 2016 3% of the public funding availed by the RGC was directed to PMTCT programs, benefiting children born or to be born from HIV+ mothers (in NASA – BP.03.02), although

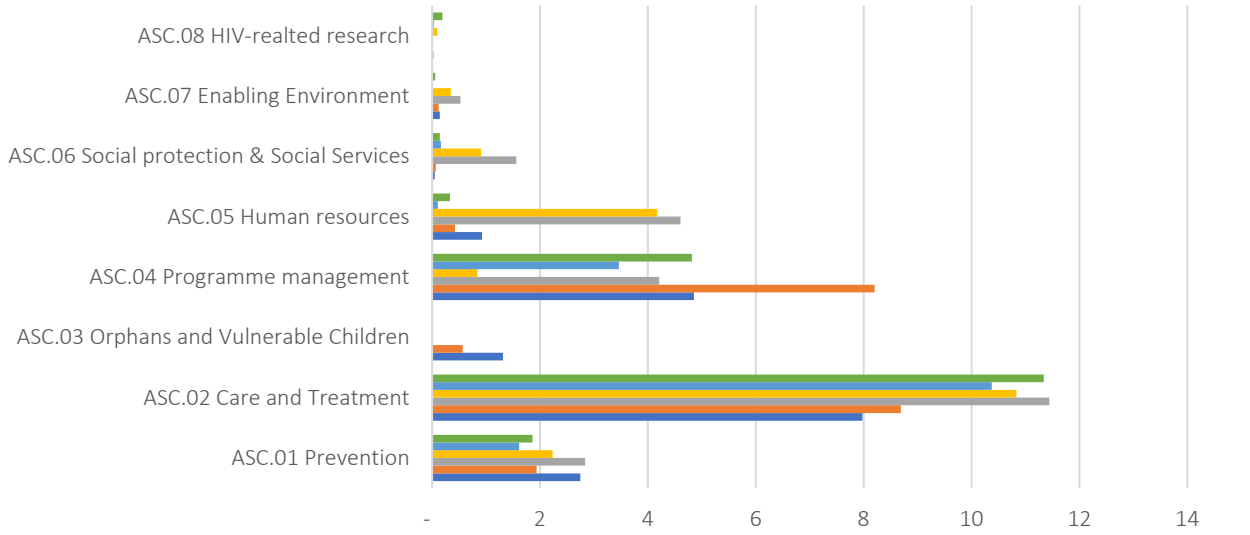
[39] This BP code is used, among others, for all policy and coordination level activities, where all population groups of the HIV Response benefit from its implementation.

no such funding was reported in 2017[40]. Additionally, 1% of domestic public funds annually target Key affected populations (BP.02 Most-at-risk populations includes PWID and their sexual partners, SWs and their clients, MSM, transgender) – US$ 57 thousand in 2016 and US$ 47 thousand in 2017, which is considerably lower than in the previous years. In NASA V Government's spending benefiting KAP totaled US$ 716 thousand in 2014 and US$ 512 thousand in 2015 This also demonstrates an alarming trend of shifting the focus of the Government resources away from the populations that need them the most.

3.4.2 HIV EXPENDITURE FROM THE GLOBAL FUND

The Global Fund accounts for 50% and 54% of the total HIV expenditure in Cambodia in 2016 and 2017 with a contribution of US$ 15.8 and US$ 18.7 million correspondingly.

Figure 39 – GFATM-originated spending on HIV by AIDS Spending Categories



	ASC.01 Prevention	ASC.02 Care and Treatment	ASC.03 Orphans and Vulnerable Children	ASC.04 Programme management	ASC.05 Human resources	ASC.06 Social protection & Social Services	ASC.07 Enabling Environment	ASC.08 HIV-realted research
2017	1,861,111	11,338,075		4,813,680	333,110	141,801	55,467	189,351
2016	1,613,261	10,374,691		3,461,534	106,795	162,817	11,405	28,422
2015	2,235,156	10,829,254	5,100	839,887	4,174,003	908,240	346,499	96,889
2014	2,834,832	11,440,132	12,646	4,210,842	4,604,467	1,561,978	525,525	12,106
2012	1,937,565	8,689,154	565,872	8,201,023	425,399	69,604	122,476	16,038
2011	2,746,968	7,976,430	1,314,067	4,851,966	926,328	48,287	143,481	23,069

[40] However, as mentioned in the previous sections of this report, it was impossible to separate cost of PMTCT-related ARVs from the rest of the ARV drugs, so 100% of ARVs, including those purchased with public funding is captured under ASC.02.01.03 Antiretroviral therapy, and not under ASC.01.17.98 PMTCT

Figure 39 demonstrates the priorities of the GFATM resource allocation – these predominantly are Care and Treatment services (66% and 61% of the total GF allocation), Prevention (10% of the total GF allocation annually) and Programme Management (22% and 26% of the total GF allocation).

The highest spending in Care and Treatment was registered in ASC.02.01.03 Antiretroviral therapy (accounts for 37% and 31% of the total GF allocation) and ASC.02.01.05 HIV Laboratory monitoring (15% and 12% correspondingly).

Prevention expenditure from The Global Fund is directed to focused prevention (among PWID/PWUD, FSW and MSM and their partners/clients), which amounts to US$ 776 thousand in 2016 and US$ 1.05 million in 2017 (5% and 6% of the total GFATM spending on HIV), followed by programs to prevent mother-to-child transmission (US$ 441 thousand and US$ 254 thousand in 2016 and 2017, 3% and 1% of the total GFATM spending on HIV) and blood safety programs (US$ 277 thousand and US$ 381 thousand or 2% of the GFATM spending on HIV annually).

In 2016-2017 ASC.04.01 Programme management and coordination (US$ 1.5 million and US$ 2 million, or 10 and 11% of the total GF allocation) and ASC.04.02 Administration and transaction costs associated with managing and disbursing funds (US$ 1.6 million and US$ 1 million, 10% and 6% of the total GFATM HIV allocation) are top two Management activities supported with the GFATM money.

The remaining 2% (US$ 0.3 million) in 2016 and 4% (US$ 0.7 million) in 2017 of the total GFATM-originated spending is distributed between ASC.05.03 Training, ASC.06 Social protection and Social service, ASC.07. Enabling Environment and ASC.08 HIV-related research.

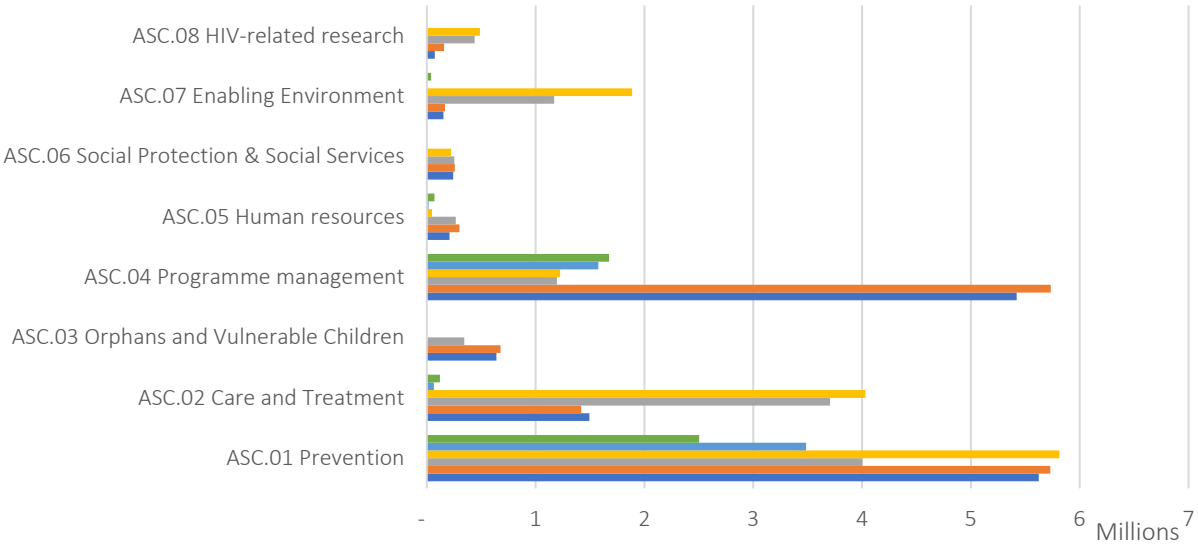
If broken down by Beneficiary population, 67% and 61% of GFATM resources in 2016-2017 are spent on programs benefiting PLHIV, 23% and 28% - on the non-targeted interventions (such as Trainings, policy development, coordination and administration of funds), 5% and 6% - on Key affected populations. The remaining share (5% in 2016 and 4% in 2017) of GFATM funds is distributed between other key populations such as Prisoners, Partners of PLHIV, Recipients of blood and blood products, children born or to be born from HIV+ mothers etc.

3.4.3 HIV EXPENDITURE FROM THE GOVERNMENT OF THE UNITED STATES

US Government represented 16% and 13% (US$ 5.2 million and US$ 4.4 million) of the total HIV spending in Cambodia in 2016-2017. Figure 40 shows how it is distributed across main AIDS Spending Categories of NASA.

Among the biggest donors of the HIV response in Cambodia, only USG funding portfolio is concentrated mainly on Prevention which amounted to US$ 3.5 million in 2016 and US$ 2.5 million in 2017, which represented 68% and 57% of the total USG expenditure on HIV in the years of assessment. The main emphasis in Prevention programs funded by the USG was made on focused prevention among PWID/PWUD, FSWs, MSM.

Figure 40 – Spending on HIV from the US Government by AIDS Spending Categories



	ASC.01 Prevention	ASC.02 Care and Treatment	ASC.03 Orphans and Vulnerable Children	ASC.04 Programme management	ASC.05 Human resources	ASC.06 Social Protection & Social Services	ASC.07 Enabling Environment	ASC.08 HIV-related research
2017	2,503,358	119,835		1,675,245	69,855		39,321	
2016	3,485,279	64,842		1,576,216	15,781		2,734	
2015	5,813,152	4,030,416		1,225,588	47,879	223,964	1,886,502	487,748
2014	4,002,887	3,705,647	344,581	1,194,816	266,003	253,233	1,170,294	439,299
2012	5,729,948	1,418,817	677,470	5,734,561	299,473	257,020	167,301	158,929
2011	5,623,741	1,493,444	639,162	5,420,465	208,046	242,650	153,164	73,903

Second largest USG-funded activity lies in the area of ASC.04 Programme management and Administration Strengthening – 31% and 38% of USG spending went to this ASC in 2016 and 2017. Almost all of it was spent within ASC.04.01 Policy, coordination and programme management. A remaining share went to support Care and Treatment, Human resources and Enabling environment programs.

Analysis of the populations which benefited from USG contribution to HIV response in Cambodia reveals that in 2016 and 2017 56% and 22% of it focused on Key affected populations. Additional 31%

and 40% of HIV spending of the USG went to perform non-targeted policy-level interventions, and another 10% and 33% correspondingly was used to implement programs specifically benefiting partners of PLHIV.

Considering that USG resources are reducing, it leaves HIV response managers with an urgent need to find a way to continue supporting focused prevention programs either by shifting the funding from other existing programs or finding a new source of funding for these important interventions.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

1. The results of the National AIDS Spending Assessment demonstrate a continuous decrease of the HIV expenditure in Cambodia over the years, peaking in 2010 with US$58.1 million and reaching its lowest point in 2016 - US$ 31.5 million. While in 2017 the overall estimated country's spending on HIV has increased amounting to US$ 34.5 million, it is unlikely that this trend continues in the following years. RGC, The Global Fund and US Government are the biggest funding sources of the HIV Response in Cambodia.

2. Cambodia relies heavily on the international funding that comprises 75% in 2016 and 76% in 2017 of the total expenditure on HIV. According to NASA findings, funding from external donors has suffered the most significant reduction in the recent years, particularly that coming from the US Government.

3. Cambodia is well publicized as one of the achievers of 90-90-90 treatment targets in global scale[41]. . To understand whether the spending levels are sufficient for ensuring an impact towards eliminating the AIDS epidemic, a comparison with the resource needs estimates is of the key importance. A global exercise to estimate resource requirements to successfully implement a Fast-Track approach, conducted in 2016[42], produced such forecast until 2030. Projections of the resources required to stay on the Fast-Track for 2016 and 2017 amounted to US$ 56.2 million and US$ 60.4 million correspondingly. A simple comparison with the actual expenditure obtained in NASA VI unveils the uncovered financial gap of US$ 24.7 million in 2016 and US$ 26 million in 2017, or 43% and 44% of the total HIV resource requirements. Naturally, a closer look is needed to how the resource needs were calculated and if the calculation strategy is compatible with the NASA results.

4. RGC has been consistently increasing its contribution in the past years, from US$ 2.5 million in 2010 to US$ 8.3 million in 2017. Considering the diminishing resources from the international community of donors, domestic spending has increased also as a share of the total HIV expenditure: in 2016 and 2017 it represented 25% and 24% correspondingly.

5. NASA proves essential in understanding the map of various funding sources and their roles in the HIV response, especially in the light of the anticipated gradual decline in donor support. While

[41] https://www.aidsdatahub.org/sites/default/files/UNAIDS-2019-global-AIDS-update_2019.pdf
[42] Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, et al. (2019) Correction: What Is Required to End the AIDS Epidemic as a Public Health Threat by 2030? The Cost and Impact of the Fast-Track Approach. PLOS ONE 14(3): e0213970.

the majority of RGC spending is channeled to HIV care and treatment programs (35% in 2016 and 48% in 2017) as well as HIV Response coordination and programme management (55% in 2016 and 44% in 2017), support from the US Government (68% and 57% in 2016 and 2017) was concentrated on prevention programs, especially the focused prevention among key affected populations. USG share in focused prevention alone was 70% in 2016, declining to 40% in 2017. GFATM remains stably the largest funder of the care and treatment program in Cambodia: 66% and 61% of it's spending in 2016 and 2017 has benefited various medical interventions for PLHIV. Global Fund's support remains crucial for scaling-up ART program in Cambodia: in 2016 it provided 100% of funding for ART drugs procurement, while in 2017 the RGC stepped in providing a 13% share of the resources for ARV drugs. As per country's commitments in bringing in the Global Fund grant in the future, the RGC needs to scale-up its ARVs-related contributions to US$ 1.7 million annually till 2020[43].

6. Spending on key affected populations is of the crucial importance to bring down a number of new HIV infections in Cambodia. However, due to a re-focusing or withdrawal of funding from some international donors these particular programs suffered the most. In NASA V the expenditure on prevention programmes benefiting PWID, FEW, MSM and transgender amounted to US$ 4.6 million in 2014 and US$4.9 million in 2015. In 2016 NASA VI has registered this expenditure at US$ 4.2 million, dropping down to US$ 2.5 million in 2017. As per the findings of the Transition Readiness Assessment, PEPFAR discontinued funding for the direct HIV services implemented by CSOs in 2018[44], which will mean even less resources available in the future.

7. Over the years Cambodia demonstrated a significant progress in enrolling and maintaining people on ART, which may have led to decreasing in a number of PLHIV requiring social services because of their HIV status. NASA shows a steep decline in resources available for social protection and social services: in 2016 it amounted to US$ 276 thousand and in 2017 – US$ 255 thousand, representing less than 1% of the overall country's spending on HIV. Funding from two largest sources – WFP and UNICEF - has been either withdrawn or significantly decreased. NASA VI does not contain data on the use of Health Equity Fund by PLHIV, although such analysis should be part of the spending assessment. It must be noted though that a 2017 URC study found that 49% of people living with HIV surveyed had IDPoor cards and thus were eligible for the fund[45].

[43] Preparing for Transition: Financing Cambodia's HIV Response. HP+ Policy brief, June 2018. Available at: http://www.healthpolicyplus.com/ns/pubs/8221-8389_CambodiaHIVbrief.pdf
[44] Towards Ending AIDS in Cambodia: Transition Readiness Assessment. UNAIDS, NAA, December 2018. Available at: https://aidsdatahub.org/sites/default/files/publication/UNAIDS_Towards_Ending_AIDS_in_Cambodia_Transition_Readiness_Assessment_2018.pdf
[45] Preparing for Transition: Financing Cambodia's HIV Response. HP+ Policy brief, June 2018. Available at: http://www.healthpolicyplus.com/ns/pubs/8221-8389_CambodiaHIVbrief.pdf

8. Another layer of analysis that is missing in NASA VI (as well as in previous exercises) is the out-of-pocket spending related to HIV. Recent studies demonstrate that a significant portion of health expenditure is out of pocket and the poor in particular are exposed to the risk of catastrophic health expenditure. In many countries, HIV status is considered to be one of the vulnerability factors. Unfortunately, it was not possible to collect the data on OOPS mainly due to the lack of sources of data. Similar challenge exists also for the National Health Accounts exercise.

9. Lastly, there is a number of methodological and data interpretation issues in NASA VI that require further attention and possible modification or alignment. Differences in interpretation and coding of the data, such as salaries, program management and transaction costs etc., may have a significant impact on the NASA results, affecting its compatibility across years. One of the examples of such differences and their impact on the NASA VI and NASA V results is expenditure on key affected populations. NASA Notebook[46] – a set of rules and classifications – instructs to assign Beneficiary population code according to the function – AIDS Spending Category. Thus, expenditure that fall under ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men and ASC.01.10 Harm-reduction programmes for injecting drug users should be assigned one of the corresponding codes of Beneficiary Population classification – BP.02.01 Injecting drug users and their sexual partners, BP.02.02 Sex workers and their clients, BP.02.03 Men who have sex with men or BP.02.98 Most-at-risk populations not broken down by type (or corresponding more detailed sub-codes). In NASA V, not all of the expenditure classified as one of the abovementioned ASCs has been assigned with a BP code correctly, thus making it difficult to compare with all other NASAs. As a result, a sum of ASCs related to services for key affected populations – PWID, sex workers and their clients, MSM, transgender – is larger than a sum of the corresponding BPs (which shouldn't be the case). To prepare this report we conducted additional analysis to ensure compatibility of the HIV spending time series for 2010-2017. Another example is assigning ASC codes to the salaries of staff implementing various HIV services. As per NASA Notebook, salaries fall under the specific ASC code according to the function performed by the staff. For instance, salaries of outreach workers of harm-reduction programmes for PWID should be coded under one of the codes inside ASC.01.10 Harm-reduction programmes for injecting drug users and their sexual partners (thus, keeping the cost part of the focused prevention), instead of ASC.05.01 Monetary incentives for human resources (the case of NASA V). in this case, making the NASA results compatible requires re-classifying the entries in the dataset of NASA V. Such additional effort can be

[46] NASA Notebook, UNAIDS. Available at: https://www.unaids.org/en/dataanalysis/datatools/nasapublicationsandtools

easily avoided in the future once the NASA Steering Committee agrees on the NASA methodology application for the next exercises.

10. Shared health system cost associated with HIV represents a significant part of NASA, representing 17% (or US$ 5.3 million) of the total estimated HIV expenditure in 2016 and 16% (or US$ 5.4 million) - in 2017. This includes a share of health care budgets executed at OD and PHD levels, referral hospitals, health centers etc. Further effort is required to harmonize NASA and NHA approach to the data collection, interpretation and application.

4.2 RECOMMENDATIONS.

1. In the face of continuously diminishing international resource availability for Cambodian HIV Response, an adequate domestic funding boost is most urgently required. A rapid pace of the economic development resulted in higher GDP and more resources available for health and social sectors. National and international partners in Cambodia have collected and developed a good evidence basis for considering an investment into health in general and HIV Response in particular a national priority.

2. Besides committing to scaling-up ART programme, Cambodian Government needs to boost its support for prevention programmes, specifically those targeting key affected populations. It is both a political- and an operational-level quest. It requires high-level negotiations to form a political will to use budget revenues for HIV, a topic that despite being an internationally recognized public health threat, is still considered sensitive by many politicians and public sector executives. On the other side, operational challenges, such as developing contracting mechanisms between Government and CSOs or building the capacity of public service providers to implement new services, have to be addressed too.

3. Efforts to scale-up and maintain antiretroviral program – a high-impact and resource-consuming intervention - have to be continuously monitored and evaluated. This goes also for expenditure tracking. High-quality and detailed expenditure data will help to understand the cost drivers and support strategic and operational planning of the HIV Response. Additionally, monitoring of drugs cost supports the analysis of whether the chosen procurement scheme manages to maintain procurement prices at their lowest or most optimal levels. Collecting a more detailed data on running the ART sites informs policy makers on the challenges as well as optimization options (decisions on staffing, office maintenance options, equipment requirements, lab services etc), especially during scale-up.

4. Resource tracking efforts should continue and the NASA team should seek for a greater level of expenditure detail that will allow for a more in-depth analysis, especially for the high-impact interventions such as those aiming at key affected populations, as well as care and treatment. It is recommended that service providers keep their records on the expenditure for these programs as detailed as possible, so that a more rigorous and comprehensive analysis by beneficiaries and services provided may be possible.

5. Synergies with NHA should be explored, and NASA and NHA teams should unite their efforts to produce a better HIV sub-account and to improve the quality of NASA. It is recommended to align the schedules for data collection between the teams, agree on the data collection and interpretation beforehand to complement both exercises in the future.

6. Utilization of the National AIDS Spending Assessment classifications should be unified for the future exercises to ensure time series compatibility. NASA Steering Committee, with the technical advice from UNAIDS, should agree on the application of the NASA classification for the future exercises and prepare an explanatory/guidance note for the NASA team.

ANNEX 1.

Calculation path for HIV/AIDS sub-account in the National Health Accounts is based on a disease split introduced in the NHA. It then uses the account codes and service provision splits to extract health-related HIV spending for NASA:

- NHA account code was retrieved from the main expenditure subaccount numbers: 6000, 6100, 6200, 6300, 6400, 6500 and 2100:
    - 6000: for all types of purchases and supplies at/to health facilities (PHD, OD, RH and HCs as well as at the national level);
    - 6100 and 6200: for all kinds of services provided by health facilities;
    - 6300 for tax payment;
    - 6400 to 6500 for staff salary and allowances;
    - 2100 for kinds of tangible purchases and procurements at all facilities setting.
- HIV/AIDS Disease split by providers and Outpatient (OPD) and Inpatient (IPD) services:
    - National hospitals: IPD: 71.3% and OPD 28.63%;
    - Referral and provincial hospitals: IPD 40% and OPD 60%;
    - Health centers or former district hospitals: IPD: 0.2% and 99.8%.
- Economic categories used for splitting:
    - All cost related to employees;
    - Incentive, wages and salaries;
    - Non health care services;
    - Health care goods and commodities;
    - Drugs;
    - Capital investment such as equipment and infrastructure.
- HIV/AIDS split by categories from health information system:
    - Inpatient section:
        - Urethral discharge;
        - Vaginal discharge;
        - Genital ulcer;
        - Genital warts;
        - AIDS Symptoms.
    - Outpatient section:
        - Urethral discharge;

- Vaginal discharge;
- Genital ulcer;
- Genital warts;
- VCCT;
- Pre-ART and ART;
- STI consultation.

These are the step undertaken to calculate HIV/AIDS sub-account in the NHA for NASA:

Step 1: Total expenditure by all providers from NHA

Step 2: Classify the expenditure by cost category

Step 3: Classify expenditure by services (OPD or IPD) and proportion

Step 4: Calculation formula: A x C or B x C (where A = B in case of detail expenditure)

Step 5: Get the proxy estimation of expenditure for 2016 and 2017:

- Using 2015 expenditure by each expenditure;
- Multiply by the Inflation rate of 3%.

Summary table of Cross-Walk NASA/NHA:

Expenditure in NHA group by Production factors, in US$	2014	2015	2016	2017
Wages	2,352,297	2,403,261	2,475,358	2,549,619
Non-wage labour income	501,809	512,681	528,061	543,903
Other drugs and pharmaceuticals (excl. ARV)	303,979	310,565	319,882	329,478
Material supplies not disaggregated by type	209,705	214,249	220,676	227,296
Services not disaggregated by type	1,629,696	1,665,005	1,714,955	1,766,403
Laboratory and other medical equipment	172,142	175,872	181,148	186,582
Grand Total	**5,169,628**	**5,281,631**	**5,440,080**	**5,603,282**