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**CAMBODIA
COUNTRY PROGRESS REPORT**

**Monitoring the Progress towards the
Implementation of the Declaration of Commitment
on HIV and AIDS**

**Reporting period:
January 2008-December 2009**

**Prepared and Submitted by:
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Foreword

It is with great pride that I present Cambodia's 2010 Progress Report, which is following up on the Implementation of the Declaration of Commitment on HIV/AIDS that was adopted by 189 countries during the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001.

This report has been prepared under the leadership and coordination of the National AIDS Authority (NAA) and with broad participation of all key stakeholders in Cambodia's response to HIV and AIDS. The consultative process involved key government ministries and departments, civil society, including representation of people living with HIV and of most-at-risk populations, and development partners.

I am especially pleased to say that this report demonstrates in more than one way the progress that has been made in the response to HIV and AIDS in Cambodia. The data reported for the 25 UNGASS indicators and additional information presented in the report demonstrates the significant progress that has been made in HIV prevention, care and treatment, and impact mitigation.

The report also demonstrates Cambodia's success in building one single comprehensive system to track the HIV epidemic and to monitor and evaluate the national response to it. Although new data has not yet become available for all the 25 UNGASS indicators, Cambodia is this year able to present data against several indicators that could not be reported in previous rounds.

Alongside these successes, we are aware that some of the achievements are still fragile and that efforts need to be continued and even stepped up. Prevention will have to continue to focus where the epidemic is concentrated, especially among entertainment workers, men who have sex with men, and injecting drug users. Further efforts in the area of treatment will need to be targeted at improving the quality of care for people living with HIV (PLHIV). More attention will need to be given to supporting them and their families as well as assisting orphans and vulnerable children.

A major challenge in maintaining and scaling up efforts in prevention, care and treatment, and impact mitigation is to guarantee that the necessary resources are available. This is especially a concern in times of global economic downturn. The last National AIDS Spending Assessment (NASA) shows a decrease in HIV spending in Cambodia in 2009. Renewed efforts and commitments are required from the Royal Government of Cambodia and from its development partners to make sure that the achievements to date will not be jeopardized by a shortage of financial resources.

Finally, I would like to thank all the members of the NAA and its partners for their participation and invaluable contributions in preparing this report. The close cooperation between all stakeholders including government, civil society, development partners and the private sector is recognised as a key factor in Cambodia's successful response to HIV and AIDS. The NAA is looking forward to continuing this productive and rewarding relationship.



Dr. NUTH SOKHOM
Senior Minister, Chairperson of NAA

Acknowledgements

The development of the 2010 UNGASS Country Progress Report was led by the National AIDS Authority (NAA) with support from HIV/AIDS Coordinating Committee (HACC) and the Cambodia UNAIDS Country Office. The report is the result of a participatory process involving extensive consultations with a wide range of stakeholders including Government, national and international NGOs, multilateral and bilateral agencies, faith-based organizations, and private sector institutions. The constructive participation of all partners is gratefully acknowledged.

Data included in the report were obtained from the Cambodia Demographic and Health Survey (CDHS), the Behavioural Surveillance Survey (BSS), HIV Sentinel Surveillance (HSS), STI Sentinel Survey (SSS) and the HIV Prevalence among Drug Users Survey as well as programme monitoring data from the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), the National Maternal and Child Health Centre (NMCHC), the National Centre for Tuberculosis and Leprosy Control (CENAT) and the National Blood Transfusion Centre (NBTC) at the Ministry of Health (MoH), as well as the Ministry of Education, Youth and Sports (MoEYS).

Data collection and entry as well as the preparation of national consultation and data vetting meetings were led by staff of NAA's Planning, Monitoring, Evaluation and Research (PMER) department, especially Dr. Ly Chanravuth and Ms. Sovann Vitou under the direction of H.E. Dr. Hor Bun Leng, Deputy Secretary General of the NAA.

The National AIDS Spending Assessment (NASA) was carried out under the leadership of NAA with supervision by H.E. Dr. Hor Bun Leng and day-to-day coordination of the process by Mr. Sok Serey. Dr. Savina Ammassari, Ms. Alexandra Illmer and Mr. John Keating (UNAIDS Country Office) together with Mr. Christian Aran (UNAIDS Geneva) provided technical support in the design and implementation of the NASA.

The team at HACC, under the guidance of Mr. Tim Vora, facilitated the collection of information from civil society organisations both at sub-national and national level. This has ensured that views of representatives from networks of people living with HIV (PLHIV) and most-at-risk populations (MARPs) are reflected in the report.

Dr. Savina Ammassari, Ms. Madelene Eichhorn and Ms. Barbara Donaldson (UNAIDS Country Office) provided technical, managerial, and coordination support in the UNGASS reporting process.

Mr. Jan de Jong, recruited through the Swiss Tropical and Public Health Institute (Swiss TPH), helped ensure data was reported in line with the UNGASS guidelines and assisted with the report writing. Sheryl Keller provided technical support to conduct secondary analysis of CDHS data. Technical assistance was also granted by Dr. Nicole Seguy and Dr. Rajendra-Prasad Yadav from the World Health Organization (WHO) in Cambodia.

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Dr Teng Kunthy
Secretary General of NAA

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Acronyms and Abbreviations

AEM	Asian Epidemic Model
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ASC	AIDS Spending Categories
BSS	Behavioural Surveillance Survey
CCC	Country Coordinating Committee
CDHS	Cambodia Demographic and Health Survey
CENAT	National Centre for Tuberculosis and Leprosy Control
CoC	Continuum of Care
CQI-ATR	Continued Quality Improvement for Anti-Retroviral Therapy
CRIS	Country Response Information System
CSO	Civil society organization
DFID	Department for International Development
FTA	Functional Task Analysis
GDJ-TWG	Government-Donor Joint Technical Working Group on HIV/AIDS
HACC	HIV/AIDS Coordination Committee
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IBSS	Integrated Biological and Behavioural Surveillance
IDU	Injecting drug users
MARP	Most-at-risk population
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MoH	Ministry of Health
MSM	Men who have sex with men
MoEYS	Ministry of Education, Youth and Sports
MoSVY	Ministry of Social Affairs, Veteran and Youth Rehabilitation
NAA	National AIDS Authority
NACD	National Authority for Combating Drugs
NASA	National AIDS Spending Assessment
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NCPI	National Composite Policy Index
NGO	Non-governmental organization
NMCHC	National Maternal and Child Health Centre
NOVCTF	National OVC Task Force
NSP II	National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS, 2006-2010
NSP III	National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS, 2011-2015
OD	Operational (Health) District
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PLHIV	People living with HIV
PMER	Planning, Monitoring, Evaluation and Research
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International

SOP	Standard Operating Procedure
STD	Sexually transmitted disease
SRA	Situation and response analysis
SSS	STI Sentinel Surveillance
TB	Tuberculosis
TRaC	Tracking Results Continuously
TWG	Technical Working Group
VCCT	Voluntary confidential counselling and testing
UA	Universal Access
UCO	UNAIDS Country Office
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	UN Development Assistance Framework
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UN JSP-OPB	Joint UN Support Programme Operational Plan and Budget
WHO	World Health Organization

I. Status at a glance

(A) The Inclusiveness of the Stakeholders in the Report Writing Process

The preparation of this report has involved participation from a broad range of stakeholders in the national response to HIV and AIDS in Cambodia¹. The process was led by the National AIDS Authority (NAA) with assistance from the HIV/AIDS Coordination Committee (HACC) and the UNAIDS Country Office (UCO) in Cambodia. It followed a similar approach to the one used in the previous round of UNGASS reporting two years ago and was guided by the 2010 UNGASS *Guidelines on Construction of Core Indicators*².

In order to inform all stakeholders about the aim of the UNGASS 2010 reporting process and the suggested method to develop the report, a concept note was circulated. The note also called for the involvement of all stakeholders in order to ensure the correct reflection of information presented.

Data for the measurement of the indicators were collected from various sources, including the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), the National Blood Transfusion Centre (NBTC), the National Maternal and Child Health Centre (NMCHC), the National Centre for Tuberculosis and Leprosy Control (CENAT) as well as the Ministry of Education, Youth and Sports (MoEYS). Data were also derived from various surveys such as the Cambodia Demographic and Health Survey (CDHS), the Behavioural Surveillance Survey (BSS), the HIV Sentinel Surveillance (HSS), the STI Sentinel Survey (SSS) and the HIV Prevalence among Drug Users Survey.

The data were entered and reported through the UNGASS 2010 online reporting tool³. All stakeholders were encouraged to review the data while data collection and data entry were going on over a number of months.

Several consultation meetings were held at sub-national and national level in order to complete the National Composite Policy Index (NCPI). During these meetings input was collected from government institutions, civil society organizations, representatives from people living with HIV (PLHIV) and most-at-risk populations (MARPs) networks, the private sector and development partners such as bi- and multilateral organizations including the United Nations (UN).

Part A of the NCPI was administered to officials from key ministries and other government departments during a national-level consultation meeting. Part B was completed through consultation meetings involving civil society organizations in two regions of Cambodia as well as meetings at the national level which aggregated the collected information to incorporate the voices from as many civil society stakeholders as possible.

¹ Special mentioning should be made of the fact that active participation from PLHIV and MARPS was sought and encouraged at all stages of the consultation and reporting preparation process. Representatives from civil society also gave opening remarks at the 2010 UNGASS Report National Consultation Meeting and Validation Meeting.

² UNAIDS (2009) UNGASS Guidelines on Construction of Core Indicators for 2010 reporting (see http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf).

³ See reporting tool at <http://ungass2010.unaids.org> with Country viewer username: cv_KH and Password: KHme1453C

Spending data for 2006, 2007, and 2008 included in this report were obtained from two National AIDS Spending Assessments (NASA) conducted in 2007 and in 2009.

A draft of this report was circulated to all stakeholders for their review and comments. The report was also presented and discussed during an inclusive national meeting involving all the stakeholders to vet the data and validate findings and recommendations before submitting the report to the UNAIDS Secretariat in Geneva.

(B) Status of the Epidemic

No new data on HIV prevalence have become available since the previous Country Progress Report. The latest estimates on HIV prevalence are based on data from the 2006 HIV Sentinel Surveillance (HSS) and the 2005 Cambodia Demographic and Health Survey (CDHS) and on calculations and modelling performed by a team of national and international experts at Cambodia's Consensus Workshop on HIV Estimates and Projections in June 2007⁴.

These estimates showed that HIV prevalence among adults aged 15 to 49 decreased to 0.9 percent in 2006 from 1.2% in 2003. HIV prevalence was estimated to have dropped to 0.7 percent in the current reporting period (2008-2009). The projections are based on the assumption that interventions are sustained at the same level.

Epidemiological data show that the epidemic in Cambodia is concentrated among sex workers and entertainment workers, men who have sex with men and injecting drug users. Although prevention programmes have had significant results, HIV prevalence among these most-at-risk populations continues to be high and there is a general consensus that there is a real risk of a second-wave of HIV infections within these groups.

(C) The Policy and Programmatic Response

Political commitment at the highest level in the Royal Government of Cambodia is recognized to be an important factor in Cambodia's success in creating a supportive legal and policy environment and in building a strong national response to HIV.

There has been significant progress in leadership and high level commitment through the work of the First Lady Lok Chumtiev Bun Rany Hun Sen, members of the National Assembly, the National AIDS Authority, business leaders, civil society leaders, positive women, and through faith-based leaders. The Prime Minister Samdech Hun Sen formally accepted and endorsed the recommendations of the AIDS in Asia Commission in May 2008.

In the past two years new policies for HIV interventions have been developed, and various existing policies have been revised in an attempt to better reflect the challenges that have been arising in the national response to HIV in Cambodia. For example the Law on Drug Control is under revision and a new Standard Operating Procedure (SOP) has been developed to further improve interventions with workers in

⁴ NCHADS (2007) Report of Consensus Workshop – HIV Estimates and Projection for Cambodia 2006-2012

entertainment establishments⁵. However, some new laws and policies that are not conducive to HIV prevention have seen the light in the reporting period and their implications will be discussed in this report.

Cambodia has made significant efforts to review the progress towards achieving the Universal Access (UA) targets set for 2008 and 2010. These review processes have resulted in clear documentation of the current status and challenges as well as recommendations to inform future strategic planning. In general, the findings indicate that Cambodia is seeing remarkable progress in the health sector response to HIV through the rapid scaling-up of the Continuum of Care (CoC), but additional efforts are needed to scale up HIV prevention interventions especially among high risk groups.

It is generally agreed that in order to sustain the achievements in the reduction of HIV prevalence among the general population, prevention interventions that target most-at-risk populations need to be scaled up. Progress has been made in responding to the quickly changing policy and institutional environment and in developing better targeted interventions. Considerable challenges remain, however, in particular the question of how to respond to current changes in female sex work as forced brothel closures have led to an increase in the number of women working in entertainment establishments such as karaoke bars, beer gardens, and massage parlours who sell sex.

Civil society organizations (CSOs) play a significant role in the national response to HIV. Recognition of their role has resulted in a good relationship between them and the government as well as in better coordination through the participation of CSOs in consultation meetings. However, the application of a tool to measure civil society participation in the planning and implementation of efforts to reach Universal Access found that civil society involvement in these processes cannot be seen as meaningful participation⁶. This view is also reflected in Part B of the NCPI enclosed in Annex 2 of this report.

Following the HIV prevalence estimates and projections that were published in 2007, NAA led the development of the Cambodia's Situation and Response Analysis (SRA) and the revision of the second costed National Strategic Plan for a Multisectoral Response to HIV/AIDS for 2006-2010 (NSP II) in 2007. The seven strategies of the NSP II and the estimated costs for each of these strategies are presented in Table 1.

Table 1: The Second National Strategic Plan for a Multisectoral Response to HIV and AIDS, 2006 to 2010 (NSP II)

NSP II Strategies	Unit: USD					
	2008		2009		2010	
	Amount	%	Amount	%	Amount	%
Prevention	51,988,444	65	64,902,548	64	75,659,438	66
Care and Treatment	11,696,942	15	13,774,308	14	14,195,742	12

⁵ NCHADS (2009) Standard Operating Procedure for a Continuum of Prevention to Care and Treatment for Female Entertainment Workers

⁶ A tool developed by the Seven Sisters, adapted to suit the Cambodian context. The tool was filled by representatives of CSOs through group discussions and plenary sessions organized by HACC in October 2009. This resulted in a score of level 2 (influence) on a scale of 0 to 4 where 4 represents the maximum level of influence.

Impact Mitigation	6,212,778	8	8,544,867	8	10,665,444	9
Coordination, Management and Administration	2,859,364	4	4,280,815	4	4,386,162	4
Legal and Policy Enabling Environment	1,039,769	1	1,444,072	1	756,594	1
M&E, Research and Surveillance	5,198,844	7	8,152,119	8	7,565,944	7
Resource Mobilization	519,884	1	659,208	1	756,594	1
Grand Total	79,516,026	100%	101,757,938	100%	113,985,918	100

Source: The Second National Strategic Plan for a Multisectoral Response to HIV and AIDS, 2006 – 2010 (NSP II).

In 2010, NAA will develop a costed NSP III for 2011-2015 with support from government institutions, civil society organisations, representatives from PLHIV and MARPs networks as well as technical agencies and development partners.




(D) Overview of UNGASS Indicator Data

Since the last reporting no new data have become available from regularly conducted surveys, with exception of the HIV Prevalence Survey among Drug Users, which was conducted by the National Center for HIV/AIDS, Dermatology and STIs (NCHADS) in 2007. Therefore, most of the same survey data sources have been used as for the 2008 Country Progress Report: the Cambodia and Demographic Health Survey (CDHS), 2005; the STI Sentinel Surveillance Survey (SSS), 2005; the HIV Sentinel Surveillance Survey (HSS), 2006; and the Behavioural Sentinel Surveillance Survey (BSS), 2007.

Following the first-ever survey on HIV and drug users (DU/IDU Survey), data is now available to measure several indicators dealing with drug users. The HIV Prevalence Survey among Drug Users surveyed 528 injecting and non-injecting drug users in 11 rehabilitation centers in four cities/provinces, and non-institutionalised drug user communities in Phnom Penh.

New HIV estimates for the general population are expected to become available after the HSS has been repeated later this year.

The status of the 25 UNGASS indicators is summarized below, and further in Table 2 which gives the details on the status of each indicator per 2008 and 2010 UNGASS reporting tool rounds:

-  NASA II (indicator 1) covered the years 2007 and 2008 and hence two National Funding Matrixes are included in the report as Annex 3. The data are presented in Section VI of this report, together with data on 2006 with a trend in spending in the last three years.
-  The completed NCPI (Part A and Part B) (indicator 2) is attached (Annex 2).
-  Thirteen indicators are reported in full (indicators 1,2,3,5,7,11,12, 13,15,16,17,19,22).

- ❗ Other indicators could only be reported partially, because not all required disaggregated data (e.g. by sex, age groups) are available (indicators 4,6,8,9,14,18,23,24).
- ❗ Three indicators cannot be reported at all because of a lack of data (indicator 20,21,25); and
- ❗ Indicator 10 is not reported because Cambodia is not a high prevalence country (i.e. prevalence less than 5 percent).

Table 2: UNGASS Indicators at a Glance⁷

UNGASS Indicator		Status		Value
	Description	2008	2010	
1	Domestic and international AIDS spending	Completed	Completed	
2	National Composite Policy Index	Completed	Completed	
3	Blood Safety - 2009	Completed	Completed	100%
4	HIV Treatment: Antiretroviral Therapy - 2008	Partially Completed (2006)	Partially Completed	94.9% (adults)
	HIV Treatment: Antiretroviral Therapy - 2009	Partially Completed (2007)	Partially Completed	100% (adults)
5	Prevention of Mother-to-Child Transmission - 2008	Completed (2006)	Completed	27.0%
	Prevention of Mother-to-Child Transmission - 2009	Completed (2007)	Completed	32.3%
6	Co-Management of Tuberculosis and HIV Treatment - 2009	No Data	Partially Completed	4.8%
7	HIV Testing in the General Population	Completed	Completed	4.1%
8	HIV Testing in most-at-risk populations - Sex Workers	Partially Completed	Partially Completed	68.1%
	HIV Testing in most-at-risk populations - Men Who have Sex with Men	Partially Completed	Partially Completed	58.0%
	HIV Testing in most-at-risk populations - Injecting Drug Users	No Data	Partially Completed	35.3%
9	Most-at-risk populations: Prevention Programmes - Sex Workers	No Data	No Data	-
	Most-at-risk populations: Prevention Programmes - Men Who have Sex with Men	No Data	No Data	-

⁷ *Partially Completed* indicates that not all the required disaggregated data (e.g. by sex, age groups) was available for entry in the online reporting tool. *No Data* indicates that the indicator could not be reported in line with the definition included in the *Guidelines on Construction of Core Indicators*. However, for most of these indicators related data are available, which are presented in the relevant sections of this narrative report.

	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users	No Data	Partially Completed	-
10	Support for Children Affected by HIV and AIDS	Not Relevant to Country	Not Relevant to Country	-
11	Life Skills-based HIV Education in Schools - 2009	Completed	Completed	34.1%
12	Orphans: School Attendance - Part A	Completed	Completed	76.1%
	Non-Orphans: School Attendance - Part B	Completed	Completed	91.6%
13	Young People: Knowledge about HIV Prevention	Completed	Completed	47.6%
14	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers	No Data	No Data	-
	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex with Men	No Data	No Data	-
	Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users	No Data	Partially Completed	-
15	Sex Before the Age of 15	Completed	Completed	0.6%
16	Higher-risk Sex	Completed	Completed	3%
17	Condom Use During Higher-risk Sex	Completed	Completed	40%
18	Sex Workers: Condom Use	Partially Completed	Partially Completed	99%
19	Men Who Have Sex with Men: Condom Use	Completed	Completed	86.5%
20	Injecting Drug Users: Condom Use	No Data	No Data	-
21	Injecting Drug Users: Safe Injecting Practices	No Data	No Data	-
22	Reduction in HIV Prevalence	Completed	Completed	0.4%
23	Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers	Partially Completed	Partially Completed	14.7%
	Most-at-risk Populations: Reduction in HIV Prevalence - Men Who have Sex with Men	Completed	Completed	4.5% ⁸
	Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users	No Data	Partially Completed	24.4%
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy – 2009	No Data	Partially Completed	86.7%
25	Reduction in Mother-to-Child Transmission - 2009	No Data	No Data	-

⁸ This is the HIV prevalence for non-transgenders in Phnom Penh, which was the largest sub-group included in the SSS 2005.

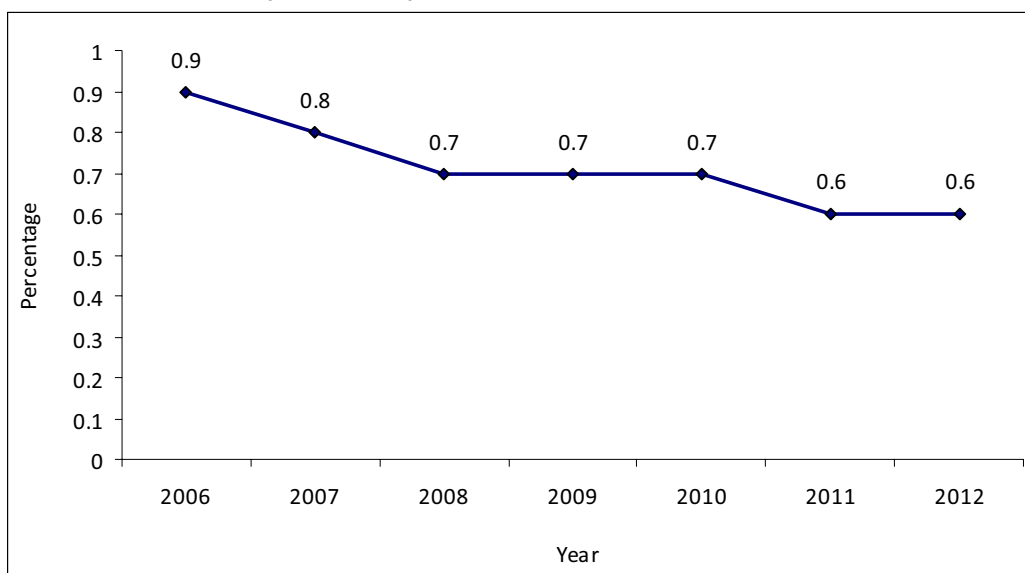
II. Overview of the AIDS Epidemic

HIV Prevalence in the General Population

Following the Consensus Workshop of HIV Estimates and Projections in June 2007, HIV prevalence in the general population (adults aged 15 to 45 years) was estimated to be 0.9 percent in 2006 and 0.7 percent in the 2008-2010 period (Figure 1). It was predicted that HIV prevalence in the general population would drop further to an estimated 0.6 percent of the adult population in 2011 and 2012.

This decrease in the proportion of persons living with HIV can be attributed to the decline in the number of new infections and the increasing number of deaths among persons who were infected in the early years of the epidemic.

Figure 1: Projected prevalence of HIV among the general population aged 15 – 49 years with ART available (2006 – 2012)

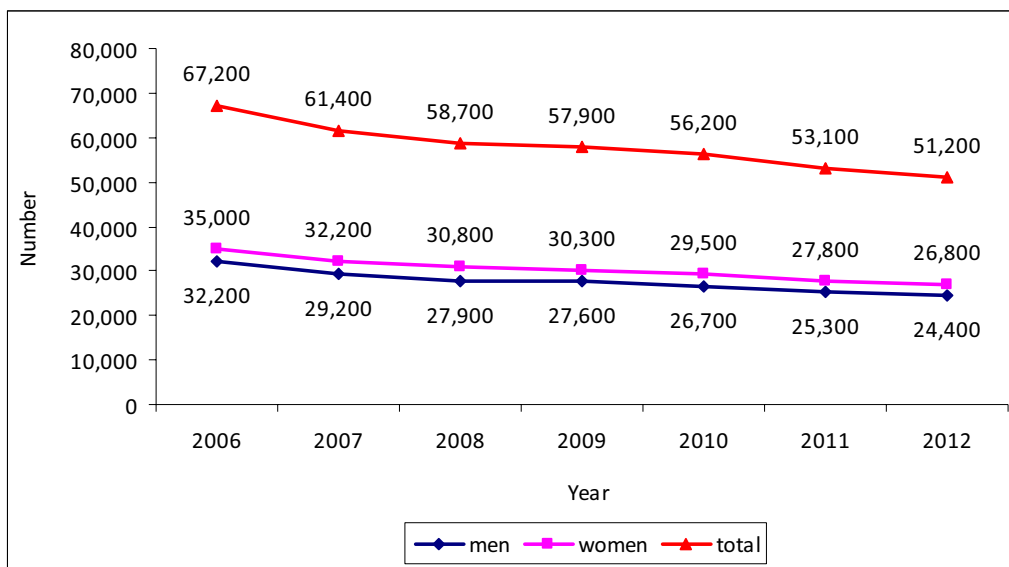


Source: Report on Consensus Workshop on HIV Estimates and Projections for Cambodia 2006-2012; Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs; 25-29 June 2007.

The number of adults living with HIV was forecasted to decline steadily (Figure 2). In 2008 and 2009 there were respectively an estimated 58,700 and 57,900 people aged 15-45 living with HIV. An estimated 52 percent of them were women.

Cambodia's epidemic has been attributed primarily to heterosexual transmission among high risk groups, particularly female sex workers, their clients, and the other sex partners of clients. As the epidemic has matured, the proportion of women among persons living with HIV/AIDS has increased.

Figure 2: Projected number of people aged 15-49 living with HIV in Cambodia (2006 – 2012)



Source: Report on Consensus Workshop on HIV Estimates and Projections for Cambodia 2006-2012; Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs; 25-29 June 2007.

UNGASS Indicator 22: HIV Prevalence in Young People

In line with the *Guidelines on Construction of Core Indicators*, HIV prevalence in young people is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites⁹.

The last HSS (2006) found an HIV prevalence of 0.41 percent among pregnant women aged 15 to 24 years attending antenatal clinics and of 1.1 percent among all pregnant women attending antenatal clinics.

The 2005 CDHS reported 0.2 percent HIV prevalence in young people aged 15 to 24. Prevalence in this group was found to be higher among women (0.3 percent) than among men (0.1 percent).

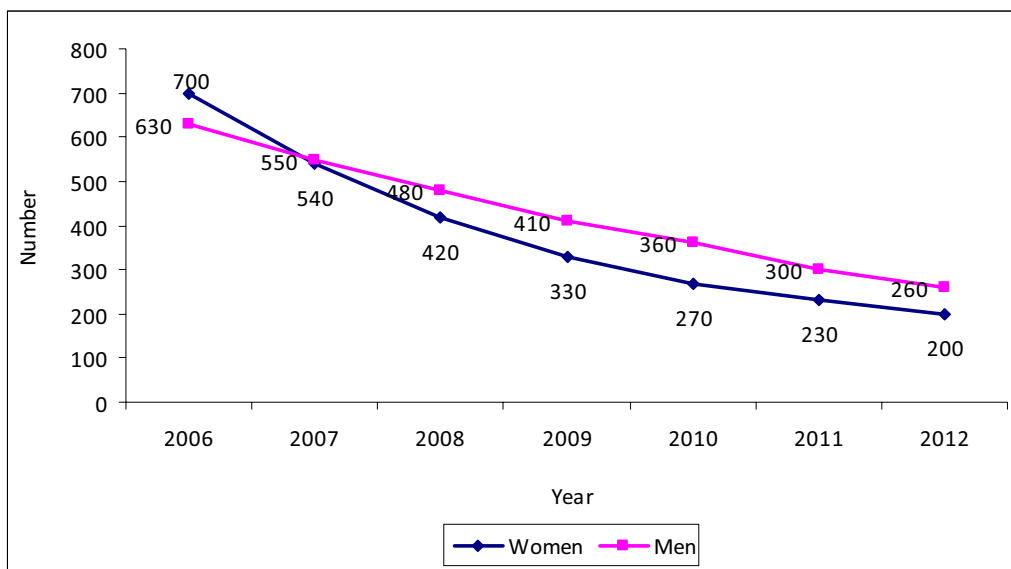
HIV Incidence in the General Population

Figure 3 shows that the falling prevalence is associated with a decreasing number of new HIV infections. The number of newly infected women was projected to have exceeded the number of newly infected men until 2007. Afterwards, HIV incidence was anticipated to be higher in the male population.

Figure 3 also shows that 900 people (480 men and 420 women) were estimated to have been infected in 2008. The number of newly infected people in 2009 was estimated to be 740; 410 men and 330 women.

⁹ UNAIDS (2009) Guidelines on Construction of Core Indicators: 2010 Reporting

Figure 3: Projected number of new HIV infections annually among the general population aged 15-49 years (2006-2012)



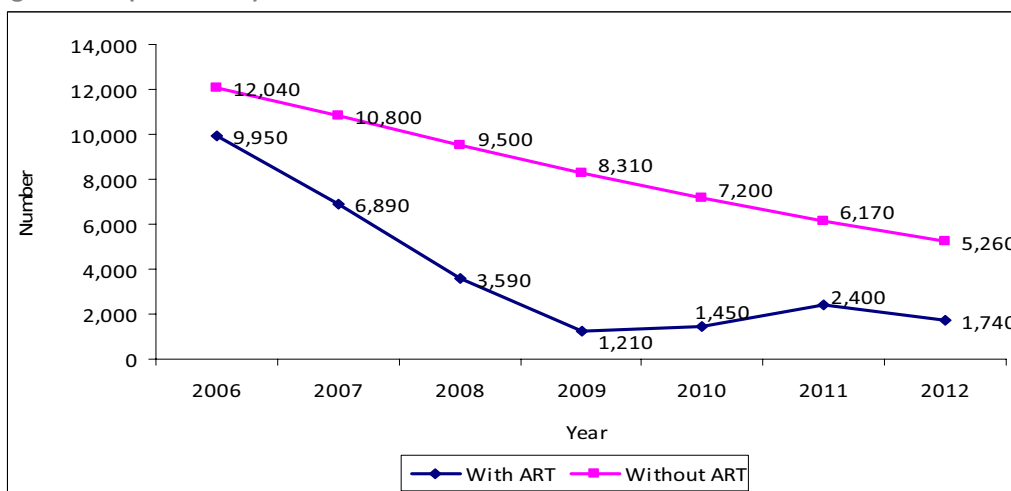
Source: Report on Consensus Workshop on HIV Estimates and Projections for Cambodia 2006-2012; Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs; 25-29 June 2007.

AIDS related Mortality in the General Population

The number of AIDS-related deaths in 2006 was estimated at approximately 10,000 people and is projected to have fallen sharply since then. Based on the projections, in the presence of antiretroviral therapy (ART), an estimated 4,800 people were predicted to have died of AIDS during the two years covered by this report.

Figure 4 shows that, despite the presence of ART, the number of AIDS-related deaths is expected to almost double between 2009 and 2011, before it will start decreasing again.

Figure 4: Projected number of AIDS related deaths annually among the general population aged 15-49 (2006-2012)



Source: Report on Consensus Workshop on HIV Estimates and Projections for Cambodia 2006-2012; Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs; 25-29 June 2007.

Projections of the number of AIDS-related deaths in the absence of ART provide an estimate of the number of lives saved owing to treatment. The difference between the two curves in Figure 4 represents the number of lives saved. It is estimated that approximately 13,000 lives were saved during the years 2008 and 2009.

UNGASS Indicator 23: HIV Prevalence among Most-at-risk Populations

(i) HIV Prevalence among Female Sex Workers

The most recent data comes from the 2006 HSS and shows that HIV prevalence among brothel-based female sex workers was 14.7 percent in 2006, down from 23.4 percent in 2003 (HSS 2003)¹⁰.

HSS 2006 found considerable differences in this indicator among the 22 provinces and municipalities covered by the survey. HIV prevalence among brothel-based female sex workers was over 20 percent in six provinces – Banteay Meanchey, Battambang, Kompong Speu, Koh Kong, Siem Reap, and Sihanoukville. In Banteay Meanchey province, the prevalence rate was found to be as high as 30 percent.

It should be noted that HIV surveillance surveys focused exclusively on female sex workers and hence, HIV prevalence data are not available for male sex workers.

(ii) HIV Prevalence among Men who have Sex with Men

Men who have sex with men (MSM) were for the first time included as a sentinel group in the 2005 STI Sentinel Surveillance (SSS), which covered Phnom Penh and two provincial towns (Battambang and Siem Reap)¹¹.

HIV prevalence was found to be highest among MSM in Phnom Penh (8.7 percent against 0.8 percent in the two provincial towns) and among transgender groups (7.9 percent compared to 2 percent for non-transgender MSM). HIV prevalence was highest among transgender groups in Phnom Penh (17 percent).

The largest sub-sample in the 2005 SSS was that of non-transgender MSM in Phnom Penh among whom HIV prevalence was 4.5 percent. It should be noted that the prevalence reported through the UNGASS online reporting tool concerns only this group which is at a lower risk of HIV infection compared to the transgender group.

(iii) HIV Prevalence among Injecting Drug Users

The results of the 2007 DU/IDU Survey showed that the HIV prevalence among injecting drug users is as high as 24.4 percent. HIV prevalence among non-injecting drug users is much lower and is estimated to be 1.1 percent.

¹⁰ The HIV prevalence reported here is after statistical corrections were made (EPP smoothed), while the Figure of 12.7 percent reported in the previous Country Progress Report is based on the raw data set of HSS 2006.

¹¹ The 2005 SSS provides data on HIV prevalence for certain sub-groups, such as MSM in Phnom Penh versus the two provincial towns and transgender versus non-transgender groups. However, the survey did not provide an overall estimate of HIV prevalence among MSM.

III. National Response to the AIDS Epidemic

New data on **prevention** show that progress has been made in blood safety, prevention of mother-to-child transmission and life-skills based education programmes in schools. For the first time, Cambodia is able to report on voluntary counselling and testing among injecting drug users. However, no new data has become available concerning voluntary counselling and testing among the general population, female sex workers and MSM or prevention programmes for most-at-risk populations¹².

Cambodia continues to show remarkable progress in coverage of **care and treatment** services. Data presented here show that the number of PLHIV with advanced HIV infection on ART increased by another 40 percent from 2007 to 2009. Moreover, the survival of PLHIV on ART after 12 months is currently estimated to be 86.7 percent for adults and 93.9 percent for children.

No new data has become available on **knowledge and behaviour change** with the exception of such data concerning drug users. The previous Country Progress Report stressed that increased efforts targeting young people is needed as the majority still lack comprehensive knowledge about HIV prevention as shown by the results of the 2005 CDHS.

Impact alleviation efforts continued to focus on orphans and vulnerable children. Again, reporting relies on data from CDHS, which is planned to be repeated later this year. However, a review of progress made with the implementation of the National Action Plan for Orphans and Vulnerable Children shows that growing numbers of orphans and vulnerable children are being reached by essential care and support services.

(A) Prevention

The considerable efforts led by Cambodia in the area of HIV prevention have helped to reverse the epidemic with steady declines in HIV prevalence and incidence rates. However, high HIV prevalence rates remain among people belonging to high risk groups including entertainment workers, men who have sex with men and injecting drug users.

It is recognised that progress in scaling up HIV prevention interventions has been insufficient. Interventions need to be more strategic and pragmatic in tackling some of the new challenges the national response is facing and require adequate financing. NASA II revealed that spending on prevention declined by 6 percent from 2006 to 2008, which exceeds the drop in overall AIDS spending (2.6 percent) in that period.

A source of particular concern is the changes that have occurred in the behaviour of sex workers, their clients and their sweethearts and more generally in the entertainment industry. Over the last years men have turned away from brothels and increasingly seek sex in non-brothel settings and through relationships with sweethearts where consistent condom use remains very low.

¹² These data are obtained from the CDHS and BSS which have yet to be repeated.

The 2008 Law on the Suppression of Human Trafficking and Sexual Exploitation has exacerbated this situation and has resulted in the closure of brothels and a growing number of women selling sex in entertainment establishments such as beer gardens, karaoke bars and massage parlours. These women are much more difficult to reach with HIV prevention interventions such as condoms, HIV and STI information as well as health service referral.

UNGASS Indicator 3: Blood Safety

All of the blood units that were donated in 2008 and in 2009 have been screened for HIV according to data from the National Blood Transfusion Centre (NBTC). The screening followed documented standard operating procedures and participated in an external quality assurance programme. This is a further improvement on the 97.3 percent reported by the NBTC in the previous Country Progress Report.

The number of blood units donated increased from 31,802 in 2007 to 39,733 units in 2008. This figure fell to 35,895 units in 2009, which still represents a 12 percent increase in comparison with the number of blood units collected in 2007. The NBTC reports that 0.81 percent of donated blood units tested HIV positive in 2009.

One concern, though, is the limited use of blood components in Cambodia, with 77 percent of all blood transfusions (2008) using whole blood rather than blood components. Moreover, the relatively small number of voluntary blood donors continues to be of concern, with less than one-third (31 percent) of all blood units donated by voluntary donors in 2009. However, voluntary blood donations are up from around 25 percent in 2007.

UNGASS Indicator 5: Prevention of Mother-to-Child Transmission

The number of HIV-infected pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission of HIV increased from 505 in 2007 to 777 in 2008 and 798 in 2009.

Figure 5, below, illustrates the expansion in coverage of prevention of mother-to-child transmission (PMTCT) interventions during the reporting period. The percentage of HIV-infected pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission increased to 32.3 percent in 2009 from 11.2 percent in 2007 and 1.2 percent in 2003.

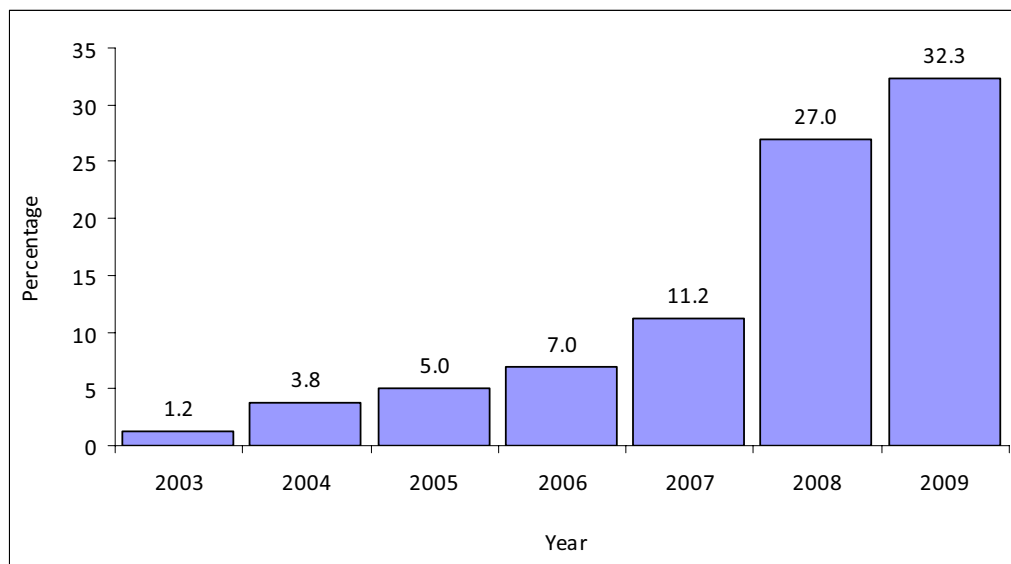
The number of HIV-infected pregnant women was estimated at 2,475 in 2009 by the National Mother and Child Health Centre (NMCHC) of the Ministry of Health. This denominator is based on new census data¹³ and an estimated HIV prevalence among pregnant women of 0.71 percent in 2009¹⁴ (HSS 2006).

¹³ The 2008 General Population Census of Cambodia, National Institute of Statistics, Ministry of Planning, September 2009.

¹⁴ HSS 2006 reported an HIV prevalence among pregnant women attending antenatal clinics of 1.1 percent. The estimated HIV prevalence in pregnant women in 2009, is based on projections using data from HSS 2006 and other sources.

The geographical coverage of PMTCT services further expanded during the reporting period. At the end of 2009, PMTCT services were available at 200 sites in 67 operational districts (ODs) up from 98 sites in 58 ODs in September 2007 and 27 sites in 16 ODs in December 2005¹⁵.

Figure 5: Percentage of HIV-infected pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission (2003-2009)



Source: PMTCT Program of the NMCHC, 2003-2009

UNGASS Indicator 7: HIV Testing in the General Population

Cambodia's 2005 Demographic and Health Survey (CDHS) included HIV testing. The results show that 4.1 percent of adults aged 15-49 had received an HIV test in the 12 months preceding the survey and knew their result.

Table 3 below illustrates that a higher percentage of males (5.1) than females (3.2) had received an HIV test and knew their results. Respondents aged 20 to 24 years were more likely to have tested and to know their results compared to those belonging to other age groups¹⁶.

¹⁵ See Cambodia's 2008 Country Progress Report.

¹⁶ Following the slightly modified disaggregation requirements for the 2010 UNGASS report, the figures provided in this reporting round somewhat differs from the figures presented in the 2008 UNGASS. Denominator figures and percentages for the male and female respondents and the age groups were accessed through MEASURE DHS website at <http://www.measuredhs.com/hivdata/data/start.cfm>. The numerator figures were calculated from this data. The data presented as "All" is weighted using the following male weight 1.66978375966686 and female weight 0.732150231949566

Table 3: Percentage of adults aged 15-49 who received an HIV test and know their result.

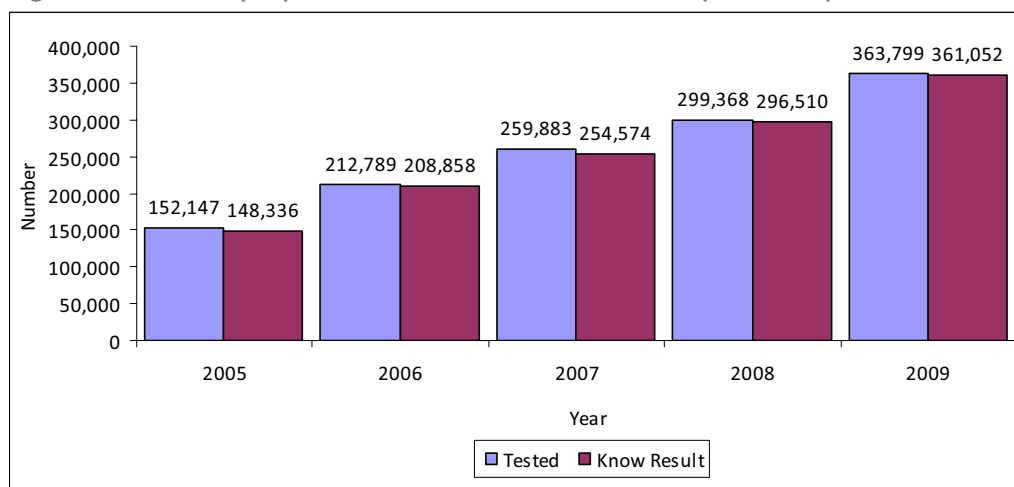
Indicator	All	Male				Female			
		All	15-19	20-24	25-49	All	15-19	20-24	25-49
Percentage tested and know their result	4.1%	5.1%	1.3%	7.8%	5.8%	3.2%	1.9%	5.4%	2.9%

Source: Cambodia Demographic and Health Survey, 2005

Data from routine monitoring by NCHADS cannot be compared with the 2005 CDHS, which are shown in Table 3 below, because the latter is a population-based survey, while NCHADS reports the number of people tested in VCCT sites. Still, the NCHADS data can provide a more up-to-date overview of the coverage and uptake of voluntary and confidential HIV counselling and testing (VCCT) in the country:

- The number of health facilities that provide VCCT further increased from 197 health facilities in September 2007 to 233 in December 2009.
- The number of people tested and who know their result continues to increase, as shown in Figure 6 below. It should be noted that the number of people tested reported by NCHADS includes people that may have been tested more than once in the same year. Therefore, it would be more correct to say that this number represents the number of HIV tests conducted for which test results were provided through post-test counselling.
- Data for 2009 show a further increase with 361,052 tests conducted for which test results were provided through post-test counselling. This represents an increase of 22 percent in comparison with 2008 and an increase of 42 percent since 2007.
- Figure 6 also shows that for most of the HIV tests conducted the result are provided through post-test counselling. For the period covered by the previous Country Progress Report, this was 98 percent. This percentage further increased to 99 percent for the years 2008 and 2009.

Figure 6: Number of people tested and who know their result (2005-2009)



Source: Annual Reports 2005 to 2009, National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

UNGASS Indicator 8: HIV Testing in Most-at-risk Populations

(i) HIV Testing among Female Sex Workers

The 2007 BSS found that 68.1 percent of brothel-based (direct) female sex workers had been tested for HIV and knew their result. Furthermore, the survey also showed that the percentage of non-brothel based (indirect) female sex workers that had been tested and knew their result was 51.8 percent. NCHADS will conduct the next BSS later this year.

Preliminary results of the last Tracking Results Continuously (TRaC) survey, conducted by Population Services International (PSI) during the second half of 2009, show that 64 percent of women working in entertainment establishment such as karaoke bars, beer gardens and massage parlours had been tested in the 12 months preceding the survey. The survey also found that 91 percent of those tested had received post-test counselling.

(ii) HIV Testing among Men Who Have Sex with Men

The 2007 BSS showed that more than half of MSM (58 percent) surveyed had been tested and knew their result. This BSS was the first that covered MSM and thus no comparison with earlier data is possible.

However, two years earlier, the 2005 STI Sentinel Surveillance Survey (2005 SSS) found that only 20 percent of MSM had been tested in the 12 months preceding the survey and knew their results.

(iii) HIV Testing among Injecting Drug Users

The 2007 DU/IDU Survey, which was the first of its kind in Cambodia, revealed that 35.3 percent of injecting drugs users had been tested in the 12 months preceding the survey and knew the result of their test.

UNGASS Indicator 9: Prevention Programmes for Most-at-risk Populations

The 2010 *Guidelines on Construction of Core Indicators* describe this indicator as measured based on the following questions:

- Do you know where you can go if you wish to receive an HIV test?
- In the last 12 months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

Injecting drug users should be asked the following additional question:

- In the last 12 months, have you been given sterile needles and syringes (e.g. by an outreach worker, peer educator or from a needle exchange program)?

Both the 2007 BSS and the DU/IDU Survey did not ask these specific questions.

Nonetheless, the 2007 BSS asked female sex workers and MSM whether they had received HIV/AIDS education in the past 6 months and the results are presented below.

(i) Prevention Programmes: Sex Workers

Table 4 below shows that 93.8 percent of brothel-based (direct) female sex workers had received HIV/AIDS education in the 6 months preceding the survey compared to 90.6 percent for non-brothel based (indirect) female sex workers.

Age was a determinant factor with younger female sex workers having been exposed to HIV/AIDS education to a lesser extent than older ones especially in non-brothel settings.

Table 4: Percentage of female sex workers and MSM that received HIV/AIDS education in the past six months

Education	All	< 25 Years	25+ Years
Brothel-based (direct) female sex workers	93.8%	92.0%	95.4%
Non-brothel based (indirect) female sex workers	90.6%	88.8%	93.5%
Men having Sex with Men (MSM)	96.2%	95.9%	96.8%

Source: Behavioural Sentinel Surveillance 2007

The 2007 BSS did not survey male sex workers and hence, their exposure to HIV/AIDS prevention programmes is not known.

The 2009 TRaC Survey found a much lower percentage of women working in entertainment establishments who had been exposed to HIV interventions in the six months preceding the survey (75 percent). HIV interventions included services such as peer education (27 percent of entertainment workers reached), family planning (26 percent), inter-personal communication campaign (1 percent), HIV testing and counselling (41 percent) and STI services (15 percent).

(ii) Prevention Programmes: Men Who Have Sex with Men

As shown in Table 4, 96.2 percent of MSM surveyed by the 2007 BSS reported to have received HIV education in the 6 months preceding the survey.

(iii) Prevention Programmes: Injecting Drug Users

This indicator cannot be reported in full, but the 2007 DU/IDU Survey among Drug Users did ask if respondents knew where VCCT services were available in their communities. 53.3 percent of injecting drug users interviewed gave a positive answer.

The two other questions concerning receipt in the last 12 months of condoms and of sterile needles and syringes were not asked in the drug user survey. However, the

survey asked whether respondent knew where to obtain condoms and sterile needles and syringes. The survey found that 93 percent of injecting drug users knew where to find condoms and 99.4 percent knew where to get clean needles and syringes.

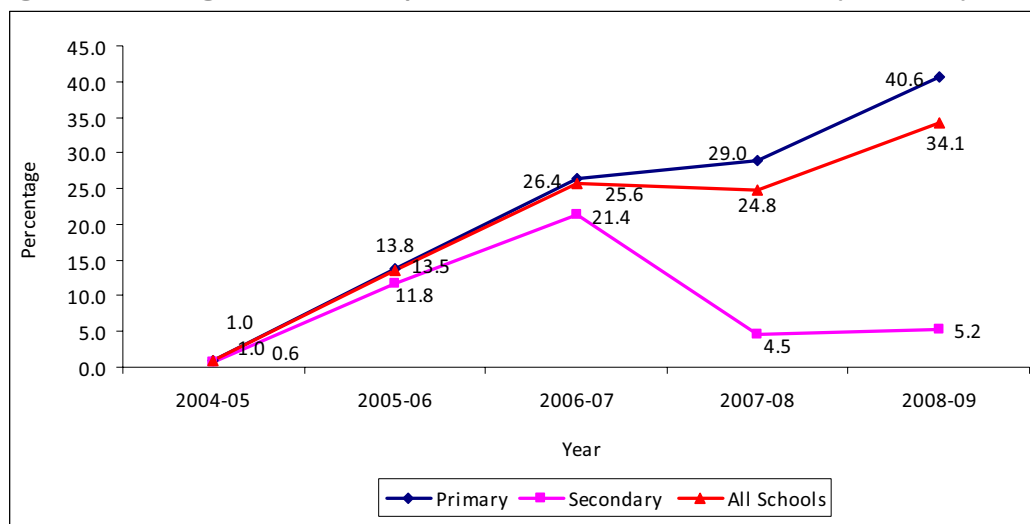
UNGASS Indicator 11: Life-Skills Based HIV Education in Schools

The School Health Department of the Ministry of Education, Youths and Sports (MoEYS) reported that 2,738 schools provided life-skills based HIV education during the school year lasting from September 2008 to June 2009. This represented 34.1 percent of all primary and secondary schools in the country which is a considerable increase from the 25.6 percent reported in the previous UNGASS Country Progress Report. It needs to be noticed that life-skills based HIV education is taught in selected schools in 14 out of 24 provinces and municipalities.

It is important to mention that in the school year 2008/9 only 5.2 percent of the secondary schools provided life-skills based education to their students compared to 40.6 percent of primary schools.

Figure 7 below shows data for both primary and secondary schools for the last five school years. The graph shows that in the school year 2007/8 there was a considerable drop in the percentage of secondary schools providing life-skills based HIV education. This was the result of an externally funded program coming to a close. The loss of funding did not have an impact on primary schools, because HIV education has been integrated in the primary school curriculum and is funded through the national education budget.

Figure 7: Percentage of schools that provide life-skills based HIV education (2004-2009)



Source: Data provided by the School Health Department of the Ministry of Education, Youth and Sports (MoEYS).

(B) Care, Treatment and Support

The rapid scale-up of care and treatment towards the achievement of Universal Access targets continues to be impressive, in particular the increase in the number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART).

With these outstanding results, attention in the past two years has shifted from coverage to the quality of ART services. The Continued Quality Improvement (CQI) initiative was launched by NCHADS in late 2007 with the aim to improve the quality of care and treatment services and to strengthen the communication among the different actors involved in the Continuum of Care (CoC). This initiative is now rapidly being taken to scale and is gathering promising results.

UNGASS Indicator 4: Antiretroviral Therapy

Access to ART continued to increase during the reporting period. By December 2009, ART was available at 52 health facilities, with more than half of these facilities also providing paediatric ART as shown in Table 5.

Table 5: Coverage of Antiretroviral Therapy, 2005-2007

Coverage	Dec. 05	Dec. 06	Dec. 07	Dec. 08	Dec. 09
Facilities with ART	30	44	47	51	52
Provinces covered (out of 24)	16	19	20	20	20
Operational Districts covered (out of 78)	22	30	39	39	39
Facilities with paediatric ART	11	19	22	27	29

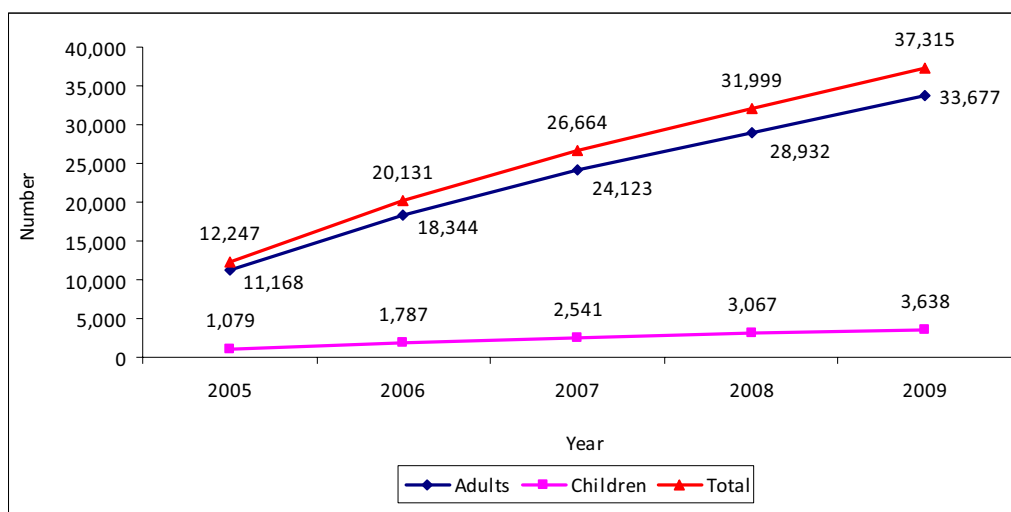
Source: Annual Reports 2005 to 2009, National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

The number of patients on ART increased by 40 percent during the reporting period, from 26,664 in December 2007 to 37,315 in December 2009. The number of children (younger than 15 years of age) on ART was 2,541 in December 2007 and increased by 43 percent to 3,638 in December 2009.

Figure 8 below presents an overview of number of adults and children receiving ART from 2005 to 2009¹⁷.

¹⁷ Because a size estimate for children in need of ART is unknown, the proportion of children in need and receiving ART (i.e. coverage) is not available.

Figure 8: Number of adults and children (< 15 of age) on ART, 2005-2009



Source: Annual Reports 2005 to 2009, National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

NCHADS reports that by the end of the year 2009, 100.53% percent of the estimated number of adults with advanced HIV infection were receiving ART, up from 82.6 percent reported in the previous Country Progress Report for 2007¹⁸.

UNGASS Indicator 6: Co-management of Tuberculosis and HIV Treatment

This is the first time this indicator can be reported, owing to the significant improvements made in TB/HIV data collection. As a result, data on the number of adults with advanced HIV infection who are receiving antiretroviral therapy and who have started TB treatment (the numerator) are now available for all 24 provinces for the years from 2007 to 2009¹⁹.

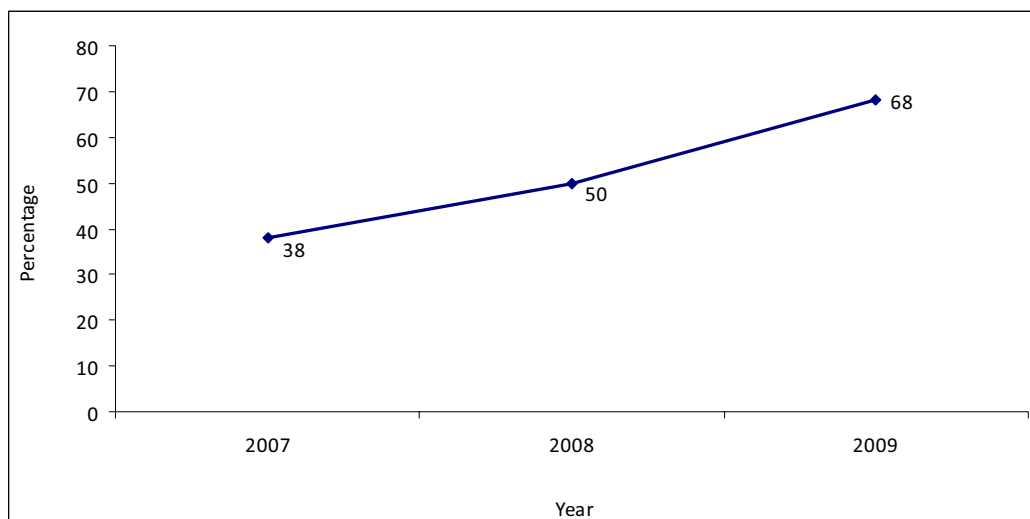
CENAT reports that there were 526 adults with advanced HIV infection who were receiving antiretroviral therapy and started TB treatment. WHO estimated the incident TB cases in the people living with HIV at 11,000, resulting in an indicator value of 4.8 percent for the year 2009.

HIV testing of TB patients has increased significantly as shown in Figure 9 below. The percentage of registered TB patients with unknown HIV status that were tested increased from 38 percent in 2007 to 68 percent in 2009.

¹⁸ The denominator is calculated using the Asia Epidemic Model and consensus was reached on the projections and estimates in June 2007. The model seems to underestimate the number of adults and children with advanced HIV infection. The estimates will be revised end of 2010 when new HSS data will have become available.

¹⁹ It should be noted that the denominator (estimated number of incident TB cases in people living with HIV) is calculated annually by WHO and is available at <http://www.who.int/tb/country/en>.

Figure 9: HIV testing of registered TB patients, 2007-2009



Source: TB Programme Routine Reporting System, CENAT

UNGASS Indicator 24: Survival after 12 months on Antiretroviral Therapy

Data on survival of adult patients after 12 months on ART are now available for 21 sites. Of the 3,296 patients who started ART at these sites in 2008 (2008 cohort) and were not transferred to another ART site, 2,858 or 86.7 percent were still on ART after 12 months.

The survival rate after 12 months on ART for all patients included in the 2008 cohort (adults and children) is 87.4 percent. Survival rates reported by individual facilities ranged from 76 to 99 percent.

The 2008 cohort for children under the age of 15 consists of 342 children with 321 of these children (93.9 percent) still being on ART after 12 months.

The National Program also reports on the survival of adult patients after 24, 36 and 48 months on ART, which are shown below in Table 6.

Table 6: Survival of adult patients after 12, 24, 36 and 48 months on ART

Indicator	12 months (2008 cohort)	24 months (2007 cohort)	36 months (2006 cohort)	48 months (2005 cohort)
Percentage of adult patients still on ART	87%	79%	72%	70%

Source: Data provided by the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

UNGASS Indicator 25: Reduction in Mother-to-Child Transmission

According to the *Guidelines on Construction of Core Indicators*, the percentage of infants born to HIV-infected mothers who are infected is measured through spectrum or other statistical modelling. This indicator cannot be reported, because this sort of modelling has not been done for Cambodia. Moreover, experts in Cambodia believe that, given the available data, this type of modelling would most likely result in an

under-estimation of the number of infants born to HIV-infected mothers who are infected.

Program data for the year 2008 show that out of 635 children born to HIV-positive mothers, 283 were tested after 18 months and 27 were found to be HIV-positive. Comprehensive data are not yet available for 2009. However, 2009 program data compiled so far shows that 750 children were born to HIV-positive women, of which 326 were tested and 51 of these tested HIV-positive.

(C) Knowledge and Behaviour Change

Data on HIV knowledge and behaviour come from surveys which have not been repeated since the last reporting. While the previous Country Progress Report could not report on knowledge and behaviour of injecting drug users, this now is possible based on data from the DU/IDU survey. It should be noted, however, that condom use and safe injecting practices among this high risk group could not be reported in conformity with the indicator guidelines.

Data on condom use among MSM and injecting drug users is limited while trends in condom use among female sex workers have been monitored for several years. Monitoring shows that condom use in commercial sex settings is generally very high. However, condom use with more regular partners, such as sweethearts, is much lower.

As was indicated in the previous UNGASS Country Progress Report, reaching women working in various types of entertainment establishments such as karaoke bars, beer gardens and massage parlours, is a considerable challenge. Prevention efforts with MARPs have further been complicated by the new Law on Suppression of Human Trafficking and Sexual Exploitation promulgated at the beginning of the current reporting period.

Key stakeholders in the national response to HIV and AIDS are currently engaged in addressing the changing HIV prevention environment. Efforts are underway to extend the 100% Condom Use Program (100% CUP) to all types of entertainment establishments in Cambodia.

UNGASS Indicator 13: Knowledge about HIV Prevention among Young People

The data reported here is based on the five questions regarding knowledge about HIV prevention which were included in CDHS 2005²⁰.

The results in Table 7 show that although the majority of young people aged 15 to 24 were able to give the correct answer to some of the individual questions, only 47.6 percent answered all five questions correctly.

²⁰ This data was obtained through a secondary analysis of the 2005 CDHS and varies slightly from the previous UNGASS report. Only a subset of households were selected for interviews with males, hence there are about twice as many female respondents as there are males. In order to compile an accurate total estimate (male + females), both numerator and denominator were weighted proportionate to the actual distribution of male and female respondents in the relevant age group as shown in the CDHS household member dataset. Male weight: 1.655523578; female weight: 0.71553867.

Most young people gave the correct answer to questions 1 and 2 concerning knowledge about ways to prevent sexual transmission of HIV and 89.7 percent knew that HIV is not transmitted through sharing food with someone who is infected. However, one-third did not know that a healthy looking person can have HIV and almost 30 percent believed that a person can get HIV from mosquito bites. Progress related to this indicator will be measured once the results of the next CDHS will become available next year.

Table 7: The percentage of young people aged 15-24 years who correctly identify ways to prevent sexual transmission and reject major misconceptions about HIV transmission

Questions	All	Male			Female		
		All	15-19	20-24	All	15-19	20-24
Question1: Can the risk of HIV transmission be reduced by having sex with only one uninfected and faithful partner?	88.1%	89.8%	87.7%	92.6%	86.4%	86.4%	86.5%
Question 2: Can a person reduce the risk of getting HIV by using a condom every time they have sex?	90.2%	92%	91.6%	92.6%	88.5%	88.3%	88.7%
Question 3: Can a healthy looking person have HIV?	66.1%	59.9%	56.3%	64.7%	72.3%	71.9%	72.8%
Question 4: Can a person get HIV from mosquito bites?	72.4%	75.6%	72.4%	79.9%	69.2%	70.2%	68%
Question 5: Can a person get HIV by sharing food with someone who is infected?	89.7%	89.2%	87.8%	91%	90.2%	89.7%	90.9%
Correct answer to all five question	47.6%	45.3%	41.4%	50.4%	50.1%	50.2%	49.8%

Source: Cambodia Demographic and Health Survey 2005

UNGASS Indicator 14: Knowledge about HIV Prevention among Most-at-risk Populations

The last BSS (2007) did not raise the above listed five questions and thus measurement of the level of knowledge about HIV prevention among female sex workers and men who have sex with men is not possible.

The DU/IDU Survey asked respondents whether people can protect themselves from HIV by using a condom correctly every time they have sex. The survey found that this question was correctly answered by 86.5 percent of the injecting drug users who were surveyed. It should be noted that the remaining four questions were not included in the survey questionnaire.

UNGASS Indicator 15: Sex before the Age of 15

Analysis of data from the CDHS 2005, show that only 0.6 percent of young people aged 15 to 24 reported to have had sexual intercourse before the age of 15. A comparison between men and women of this age group shows that women are more likely to engage in sexual intercourse before the age of 15 (0.9 percent of the women aged 15 to 24 interviewed) than men (0.3 percent of young men interviewed)²¹.

Moreover, CDHS 2005 reports that 19 percent of women aged 20-24 had engaged in sexual intercourse at the age of 18, against 8 percent for men aged 20 to 24.

The next CDHS is planned to be completed in 2010 and will generate new data to be used when reporting against this indicator in the future.

UNGASS Indicator 16: Higher-risk Sex

Similar to the previous indicator, the results reported for this indicator are based on data from CDHS 2005.

Of all adults aged 15 to 49 interviewed, 3 percent reported to have engaged in sexual intercourse with more than one partner in the 12 months preceding the survey. For adult men this percentage was 6, while only 0.2 percent of adult women reported to have engaged in higher-risk sex.

UNGASS Indicator 17: Condom Use during Higher-risk Sex

Approximately four out of ten of adults aged 15 to 49 who had sexual intercourse with more than one partner in the past 12 months preceding the survey reported the use of a condom.

Table 8 below shows the results of an analysis of CDHS data disaggregated by sex and age. Men aged 20 to 24 are engaged in higher-risk sex are more likely to use a condom in comparison to men aged 25-49.

Table 8: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months reporting the use of a condom

All	Male				Female			
	All	15-19	20-24	25-49	All	15-19	20-24	25-49
39.9%	40.9%	85.7%	72%	24%	8.6%	0%	100%	1.9%

Source: Cambodia Demographic and Health Survey 2005

A recent survey by PSI among high risk urban men with sweethearts found that consistent condom use with sweethearts increased from 57.7 percent in 2008 to 69.4

²¹ Following the slightly modified disaggregation requirements for the 2010 UNGASS report, the figures provided in this reporting round somewhat differs from the figures presented in the 2008 UNGASS. Denominator figures and percentages for the male and female respondents and the age groups were accessed through MEASURE DHS website at <http://www.measuredhs.com/hivdata/data/start.cfm>. The numerator figures were calculated from this data. The data presented as "All" is weighted using the following male weight 1.65552357836338 and female weight 0.715538669876618.

percent in 2009²². Consistent condom use with commercial partners increased from 84.7 percent in 2008 to 95.6 percent in 2009.

UNGASS Indicator 18: Condom Use among Sex Workers

According to the 2007 BSS, 99 percent of brothel-based (direct) female sex workers and 94 percent of non-brothel based (indirect) female sex workers reported the use of a condom with their most recent client.

Non-brothel based sex workers surveyed included karaoke girls, beer garden girls and beer promotion girls. Consistent condom use proved lower among beer promotion girls with 83 percent reporting consistent condom use during the three months preceding the survey, against 87 percent for karaoke girls and beer garden girls.

The TRaC survey found that condom use among women working in entertainment establishments (i.e., karaoke bars, beer gardens and massage parlours) varies depending on the type of partner. Condom use with clients is high, with 97 percent of the women surveyed reporting to have used a condom during last sex with commercial partner. However, only 63 percent of the women reported the use of a condom the last time they had sex with a sweetheart.

Data for male sex workers are not available because this group was not included in the 2007 BSS or in other surveys.

UNGASS Indicator 19: Condom Use among Men Who Have Sex with Men

The BSS 2007 found that 86.5% of MSM reported the use of a condom the last time they had anal sex.

Condom use was found to be highest among younger MSM (below 25) with 88.7% reporting condom use during most recent anal sex, against 81.7% for the age group 25 and older.

UNGASS Indicator 20: Condom Use among Injecting Drug Users

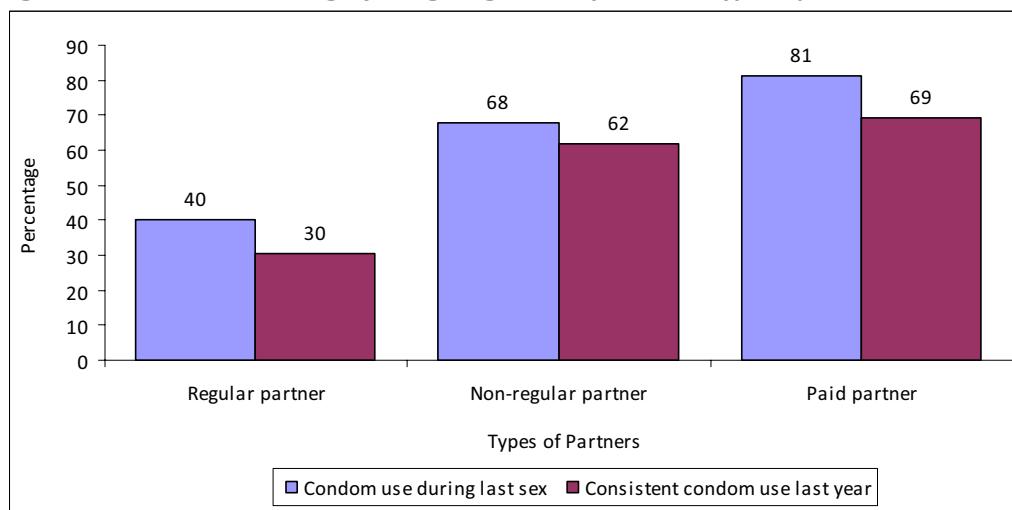
This indicator cannot be reported as defined by the *Guidelines on Construction of Core Indicators* as it requires reporting on the use of a condom during last sexual intercourse with any type of partner, including regular and non-regular partners and paid and unpaid sex.

The 2007 DU/IDU Survey measured condom use during last sexual intercourse by different types of partners. Figure 10 below shows that 40.2 percent of injecting drug user surveyed reported the use of a condom the last time they had sex with a regular partner. For sex with non-regular partners this percentage increases to 68 percent, while 81.4 percent of injecting drug users reported the use of a condom the last time they had sex with a paid partner.

²² The PSI Tracing Results Continuously (TRaC) survey among high risk urban men was repeated in November 2009 and included 1,100 men in Phnom Penh, Battambang, Siem Reap and Sihanoukville.

The survey also reports on consistent condom use during the last year with different types of partners. Consistent condom use ranges from 30.3 percent for sex with regular partners to 69.3 percent for sex with paid partners.

Figure 10: Condom use among injecting drug users, by different type of partners



Source: The HIV Prevalence Survey among Drug Users, 2007

UNGASS Indicator 21: Safe Injecting Practices among Injecting Drug Users

This indicator cannot be reported as defined in the *Guidelines on Construction of Core Indicators*. These require reporting on the use of sterile injecting equipment, while the HIV Prevalence Survey among Drug Users reports on the use of new needles and syringes, which includes new as well as cleaned needles and syringes.

This survey found that 62 percent of injecting drugs users reported the use of new needles and syringes (as per above mentioned definition). It also found that 35.5 percent of injecting drug users shared needles and syringes the last time they injected drugs and that 74 percent of injecting drug users never injected drugs that had been dissolved in the blood of someone else.

The relatively high levels of sharing needles and syringes is in contrast with the fact that almost all injecting drug users (99.4 percent) know at least one place where clean needles and syringes are available.

That almost all members of this high risk group know where to obtain clean syringes and needles is a good starting point for expanding community-based drug treatment/needle syringe programmes, while promoting an enabling environment and close collaborative relationships with communities and local authorities.

(D) Impact alleviation

Data concerning the coverage and outcomes of impact mitigation efforts remain limited, although various initiatives will start in the near future under the leadership of the Ministry of Social Affairs, Veteran and Youth Rehabilitation (MoSVY), such as the forthcoming OVC monitoring and evaluation (M&E) system strengthening initiative.

Nonetheless, there is evidence that progress has been made since the start of the implementation of the National Action Plan for Orphans and Vulnerable Children in 2007. A rapid review of progress in 2008 revealed that 38,855 orphans and vulnerable children received educational support, 41,229 households with OVC received food support, and more than 40 percent of communes in the country had at least one organization providing HIV-related care and support to families with OVC.

The progress made is recognised in Part B of the NCPI, with increasing numbers of OVC having access to care and treatment, support services, health services and livelihood activities. As indicated earlier, 3,638 children with advanced HIV infection were receiving ART at the end of 2009 (UNGASS indicator 4).




The establishment of the National OVC Taskforce (NOVCTF) and sub-national working groups under the leadership of MoSVY are recognised as important steps forward.

UNGASS Indicator 10: Support for Children Affected by HIV and AIDS

Given the fact that Cambodia is not a high HIV prevalence country (prevalence < 5%), this indicator does not need to be reported.

In any case, only fragmentary information is available concerning children aged 0-17 years who have lost one or both parents and on the medical, educational, emotional/psychological and social support they receive from different sources.

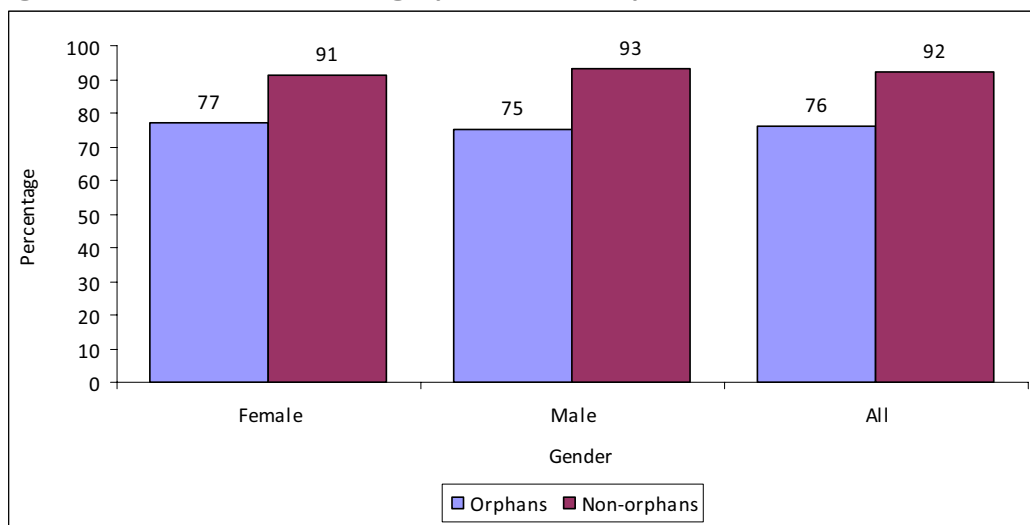
Secondary analysis of 2005 CDHS data provided the following estimates concerning orphans and more generally vulnerable children in Cambodia:

-  8.8% of children aged 0-17 years are orphans (one or both parents dead);
-  6.1% of children aged 0-17 years have a chronically ill parent; and
-  14.4% of children aged 0-17 years are orphaned and/or have a chronically ill parent.

UNGASS Indicator 12: Current school attendance among orphans and non-orphans aged 10-14

Secondary analysis of CDHS 2005 found that school attendance among orphans was much lower (76 percent) than among non-orphans (92 percent). Female orphans were somewhat more likely to attend school than male orphans as presented below in Figure 11.

Figure 11: School attendance among orphans and non-orphans, 2005



Source: Cambodia Demographic and Health Survey, 2005

The results of a secondary analysis of the CDHS 2000 and 2005 for the Cambodia OVC Situational Analysis are presented below in Table 9 and lead to the following conclusions:

- 🧑 School attendance is lowest among double orphans in 2000 and in 2005.
- 🧑 School attendance is considerably higher in 2005 compared to 2000 for all types of orphans and for male as well as for female orphans.
- 🧑 The gap between male and female orphans decreased between 2000 and 2005 for all types of orphans.
- 🧑 The gap between orphans and non-orphans decreased between 2000 and 2005.

Table 9: School attendance among children aged 10-14 years, by orphan status and gender (non-weighted values), 2000 and 2005

Orphan	Maternal	Paternal	Double	Non-Orphans
CDHS 2000 - Females	52.7%	61.4%	45.0%	74.0%
CDHS 2000 - Males	67.6%	74.9%	65.4%	84.0%
CDHS 2005 - Females	82.3%	80.4%	71.2%	87.9%
CDHS 2005 - Males	85.1%	83.8%	77.0%	89.9%

Source: Quantitative Secondary Data Analysis of DHS 2000 and DHS 2005 for Cambodia OVC Situational Analysis; UNICEF; September 6/7, 2007

IV. Best Practices

The key to the success of Cambodia's HIV response has been high level political commitment. This, together with strong leadership and effective coordination, strategic planning and successful resource mobilization, has allowed the Royal Government of Cambodia and its partners to halt and reverse the epidemic. Cambodia is one of the few countries in the world that has already achieved its Millennium Development Goals (MDGs) related to HIV.

Investments made in the Three Ones are paying off. The NAA plays a crucial role in organizing and convening key technical working groups and coordination forums and in building fruitful partnerships between government institutions, civil society organizations, development partners and the private sector. Numerous costed strategic plans have been developed, which are effectively guiding the national multisectoral response as well as responses in different sectors and with regard to specific most-at-risk populations among whom the epidemic is concentrated.

Regular reviews of progress involving all the stakeholders in the national response are another best practice in Cambodia. These have helped in detecting what works and what does not work so well, and subsequently in adjusting interventions to ensure that targets are met.

Multi-stakeholder reviews in the past two years have mostly focused on progress made towards the achievement of Universal Access (UA). The last review was conducted at the end of 2009 in preparation for a high-level mission on UA. Its aim was to review progress and identify the main constraints in scaling up the response to attain UA by the end of 2010.

In general, Cambodia has been successful in generating strategic information to inform programme planning and decision making. The national HIV monitoring and evaluation (M&E) system, including surveillance and research, has been strengthened considerably in recent years. The publication of the National HIV/AIDS Monitoring and Evaluation Guidelines in 2008 was an important step in building a single, well integrated multisectoral M&E system, concerning both health and non-health interventions.

The very rich information that has been assembled over the years has allowed for changes in the epidemic to be detected, and has thus facilitated the adjustment of existing interventions, and the development of new responses, in a timely manner.

V. Major Challenges and Remedial Actions

(A) Progress Made on Key Challenges Reported in the 2008 UNGASS Country Progress Report

A major challenge identified in the 2008 UNGASS Country Progress Report was the scale-up and more strategic targeting of HIV prevention at MARPs to avoid a resurgence of the epidemic. While the 100% Condom Use Program (CUP) in brothels has proven very successful in the past, with the closure of brothels it has become more difficult to reach out to women and girls at risk of HIV infection.

The 100% CUP is now being extended to entertainment establishments like karaoke bars, beer gardens and massage parlours based on a revised strategy and new standard operating procedures. There are also interventions targeting men who buy sex. The number of women and girls working in entertainment establishments has grown due to the closure of brothels and the lay-off of garment factory workers because of the global economic downturn.

Better targeted operational guidelines are under development for men who have sex with men and for drug users. Similar to those devised for entertainment workers, these guidelines aim to create a better enabling environment and to promote access to prevention and care by strengthening links and referral between community-based prevention services, HIV testing and STI services, and facilities providing ART.

These guidelines include M&E frameworks that encompass key indicators including standardized output indicators to monitor for prevention interventions. Currently data to monitor MARPs prevention interventions are obtained from regular surveys (i.e., BSS) that are conducted only every 2-4 years. Systematic and well aligned monitoring of MARPs prevention interventions by all service providers will help obtain data needed to track coverage much more frequently than before.

Another challenge identified in the last round of reporting relates to treatment and care. Cambodia is doing very well in providing access to treatment and care to all those in need. However, as emphasised by civil society, many poor PLHIV continue to have problems reaching health services, due to high transportation costs. For this reason they may interrupt treatment, which in turn may enhance drug resistance. Cases of stock-outs of drugs and expired drugs have also been reported. These concerns have been addressed in a recent assessment of procurement systems initiated by Global Fund. Clearly, the quality of services has received greater attention in recent times to ensure adherence to treatment and good treatment outcomes. Good progress has been made in this sense through the Continuous Quality Improvement (CQI).

Very promising results have also been achieved in the area of PMTCT by means of the Linked Response initiative. This has helped addressing in an effective way the low coverage of PMTCT services by linking HIV services with maternal and newborn health and reproductive health services. The Linked Response started in 2008 in five operational districts (ODs) and is being taken to nationwide scale with resources from Global Fund. Furthermore, a comprehensive national strategic plan for PMTCT was launched in 2008 to guide the interventions within this area.

Stigma and discrimination have been identified as main barriers in providing prevention, care and treatment services to PLHIV and MARPs. An assessment of stigma and discrimination is currently being conducted to get a better understanding of the situation and of whether it is improving.

Positive prevention has been given more attention during the last two years. The implementation of a comprehensive positive prevention package is expected to start in 2010.

Another major challenge is that impact mitigation measures have been largely focused on support to orphans and vulnerable children, with inadequate assistance being channelled through their families to ensure a family-centred approach that ensures the survival, health and development of children as well as the adults that care for them. Moreover, still too little has been done to address OVC as part of national social protection initiatives and social safety nets. HIV impact mitigation interventions are yet to be fully integrated with other pro-poor initiatives such as health equity funds and cash transfers to households to keep children in school.

The growing need for resources associated with commitments made to achievement of Universal Access was seen as another important challenge in Cambodia's UNGASS Country Progress Report of 2008. The last National AIDS Spending Assessment (NASA) confirmed that Cambodia's national response continues to rely heavily on external funding. Clearly, the country has been doing well in attracting financial resources from Global Fund including through the recent successful Round 9 application.

With increasing uncertainties in global AIDS financing, the Royal Government of Cambodia has started to think of financing scenarios and 'hard choices' to aid improved prioritization of interventions. An exercise called aids2031 was undertaken with the aim to forecast trends in the epidemic and to evaluate the costs over the next twenty years. Aids2031 has represented a first step in this direction which will be followed by a more cost-effectiveness oriented strategic planning envisaged for the development of the National Strategic Plan 2001-2015 (NSP III).

(B) Challenges Faced Throughout the Reporting Period (2008-2009) that Hindered the National Response

Although the national response in Cambodia has had a great deal of success, there is no room for complacency. A lot of challenges and barriers remain, which will need to be addressed with greater vigour and consistency. The lack of individual and institutional capacity, for example, continues to represent an overarching constraint in the process of scaling up the response to achieve UA to prevention, care, treatment and support.

Another major challenge faced in 2008 and 2009 has been the weak enforcement of certain policies and laws, something that needs to be tackled with increased efforts. This includes reports about cases where people seeking treatment have been asked to pay for services which should be free of charge.

There were also new challenges emerging during the reporting period, especially with regard to high risk groups. The 2008 Law on the Suppression of Human Trafficking and

Sexual Exploitation has led to fundamental changes in the entertainment establishment environment with brothel closures and sex workers enduring more harassment and arrests than in the past. The legislation has had negative effects on HIV prevention efforts as it has made it more difficult to reach out to women and girls who sell sex. Since the removal of brothels it has become more difficult distinguishing between those who for the most part sell sex and those who sell sex only occasionally. This will further complicate the task of conducting surveys such as the HSS and BSS in a rigorous manner.

In 2009 there were also considerable challenges in reaching out to people who use drugs and in particular injecting drug users. There still is insufficient understanding of the importance of harm reduction programmes including methadone as well as needle and syringe programmes. Some progress has been made with the revision of the Drug Law which among other decriminalizes voluntary access to HIV services and drug treatment by drug users. Approaches to reach out to this group at high risk of HIV infection as well as to provide adequate prevention, care and treatment services in prisons and drug rehabilitation centres need further improvement.

Another major concern has been related to the eviction and relocation of HIV affected families and to ensuring that people living with HIV (PLHIV) continue to have access to vital services for treatment and support. The case of families resettled from Borei Keila, a central area in the capital city, to the rural outskirts in Toul Sambo was instructive in raising attention to the special needs of PLHIV in these kinds of situations which involve considerable distress.

During 2008 and 2009 there were several challenges in terms of civil society's role in the national response. The only human rights-based organization working in HIV ceased to exist and left a gap yet to be filled. A number of networks and organizations faced internal management and governance problems which resulted in a loss of leadership and credibility, and subsequently curtailed their contributions to the response. Meanwhile, a positive achievement was the restructuring of Cambodia's Country Coordinating Committee (CCC) to include a larger number of representatives from civil society.

The abrupt cessation of salary supplementation at the end of 2009 also deserves mentioning. It is anticipated that the lack of incentives will result in a reduction in working hours and a rise in absenteeism together with increases in situations where patients are charged for services that should be for free. The state of affairs at this point remains unclear, but the detrimental effects of this measure have already appeared. These could be irreversible in some instances. The main anticipated effect is the loss of health centre staff to the private sector. This may contribute to increases in unregulated private practice and diversion of patients from the public to the private sector, enhancing the increased burden on the poor and most vulnerable.

(C) Concrete Remedial Actions that are Planned to Ensure Achievement of UNGASS

It is of critical importance that laws, policies, strategies and other guiding documents are properly enforced and implemented. Cambodia has a wealth of well-informed

strategic plans and other documents which were developed following robust reviews and assessments of progress. These are instrumental in guiding the work that remains to be done to achieve commitments made at the time of the UNGASS Declaration.

The main remedial actions that are planned will be included in the costed NSPIII (2011-2015), which will be developed in 2010 and will inform the preparation of the Global Fund Round 10 proposal. The NSPIII will incorporate the recommendations of the recent Functional Task Analysis (FTA) of the national response. The aim of the FTA was to examine the role, mandate and functions of relevant government institutions and civil society responsible for HIV and AIDS interventions and their relationships and performance in the context of the national multisectoral response.

A number of initiatives are also planned to further strengthen the collection and use of data needed for proper reporting on progress to attain UNGASS commitments. In the next round of surveillance surveys additional questions in the questionnaires will be included in order to obtain data that still is missing or cannot yet be properly disaggregated. The next BSS, HSS and CDHS are all planned to take place in 2010. Work has already started to amend the questionnaires for these next survey rounds. Concrete steps have also been taken toward the establishment of an integrated biological and behavioural survey (IBBS) in the subsequent surveillance rounds. This will help improving data obtained for UNGASS and other kind of reporting.

For the third time the National AIDS Spending Assessment (NASA) will also be conducted at the beginning of 2011 and cover the fiscal years 2009 and 2010. This will help Cambodia obtaining up-to-date spending information and will facilitate financial resource tracking as well as costing of strategic plans to address HIV and AIDS in a more cost-effective manner.

VI. Support from the Country's Development Partners

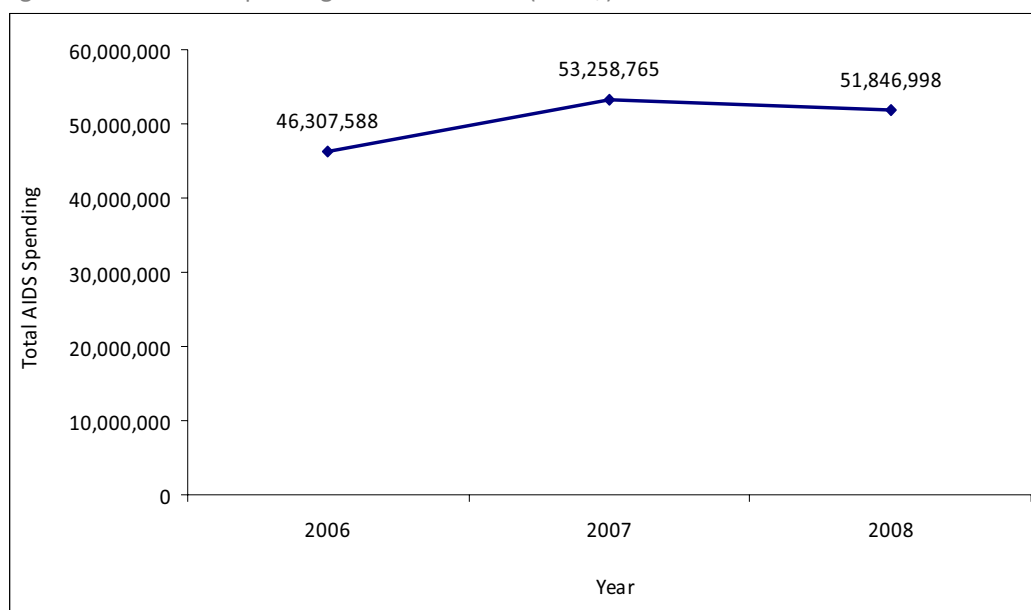
(A) Key Support Received from Development Partners to Ensure Achievement of UNGASS Targets

Data on domestic and international AIDS spending (UNGASS Indicator 1) are collected by the NAA through regularly repeated National AIDS Spending Assessments (NASA). This kind of assessment was conducted for the first time in preparation of the 2008 Country Progress Report and provided data for 2006.

The second NASA covered the years 2007 and 2008. The results for these latter two years are presented in the National Funding Matrixes included in Annex 3.

The results of NASA I and NASA II show that an estimated US\$ 46,307,588 was spent on HIV-related interventions in 2006 in Cambodia. Total spending increased by 15 percent to US\$ 53,258,765 in 2007 and then dropped by 2.6% to US\$ 51,846,997 in 2008 (Figure 12).

Figure 12: Total AIDS spending trend 2006-2008 (in US\$)



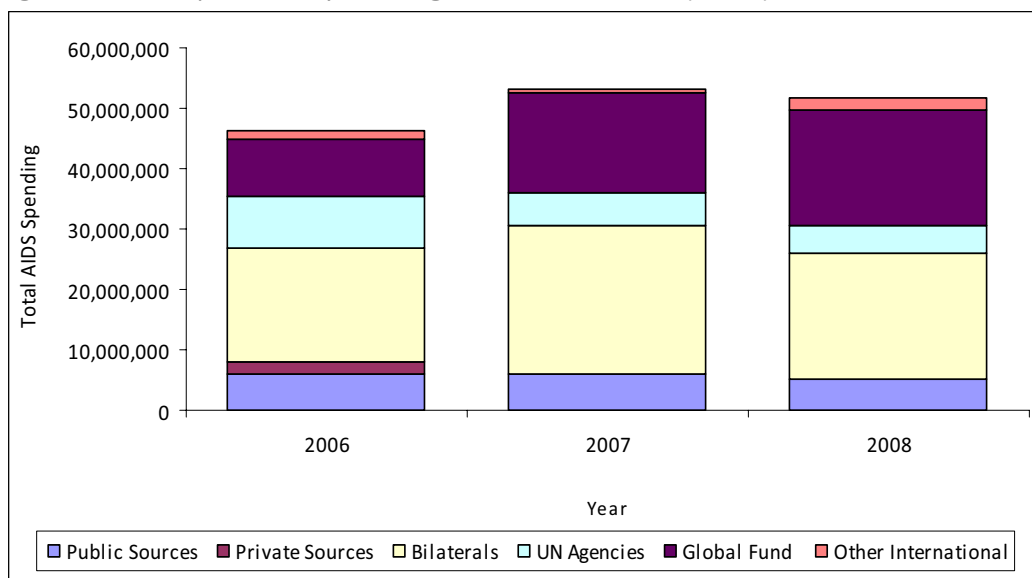
Source: National AIDS Spending Assessments I (2006) and II (2007 - 2008)

The main financiers of the national response to HIV in Cambodia were bilateral agencies and the Global Fund. Both contributed 62 percent of total AIDS spending in 2006 and 78 percent in 2007 and 77 percent 2008.

Figure 13 illustrates the growing importance of the Global Fund as a source of funding for HIV-related programmes in Cambodia.

The national budget of the Royal Government of Cambodia contributed 13 percent of HIV spending in Cambodia in 2006²³. This percentage dropped to 11 percent in 2007 and 10 percent in 2008.

Figure 13: AIDS expenditure by financing sources, 2006 – 2008 (in US\$)

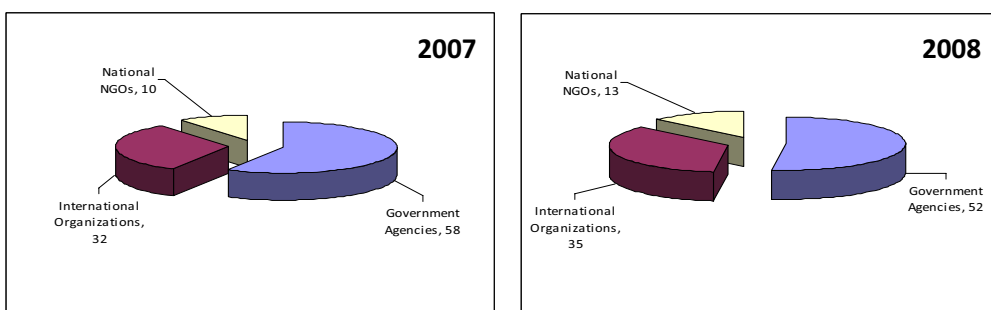


Source: National AIDS Spending Assessments I (2006) and II (2007 - 2008)

Financing agents are the institutional entities that receive funds from the funding sources, manage these funds and make programmatic decisions on their use. The funding agents act at an intermediary level between the funding sources and the service providers.

Figure 14 shows that government agencies managed more than 50 percent of all HIV spending in 2007 and 2008, while international organizations made programmatic decision concerning approximately one-third of the expenditures. The role of national NGOs as financing agents is more modest, with management control over 10 percent of HIV spending in 2007 and 13 percent in 2008.

Figure 14: AIDS financing agents, 2007 and 2008

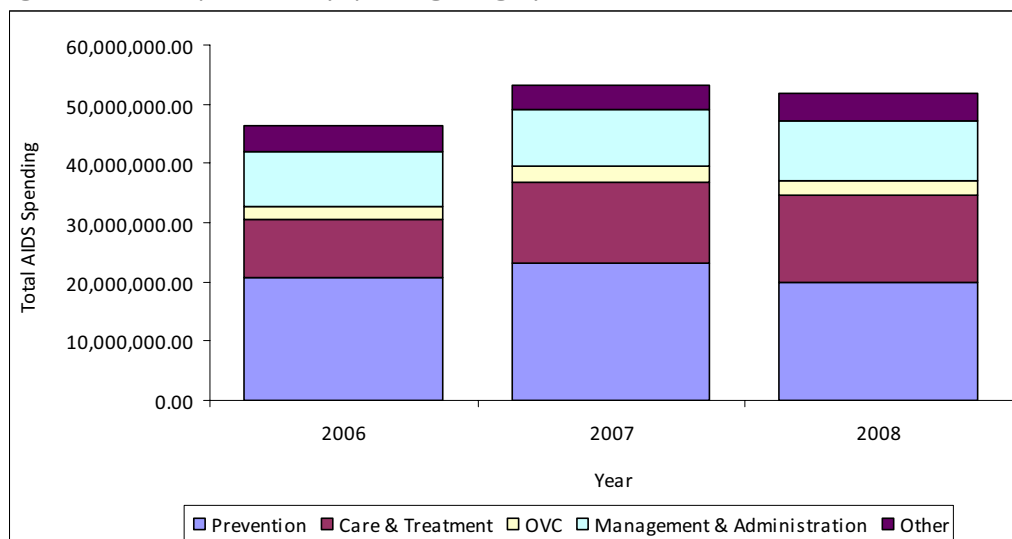


Source: National AIDS Spending Assessment II (2007-2008)

²³ It needs to be mentioned that national funds were mostly used for blood screening concerning HIV as well as other diseases. This means that the public share of total AIDS spending in reality is much lower.

Figure 15 gives a breakdown of expenditures by for the main spending categories and shows that *Prevention* and *Care and Treatment* account for approximately two-thirds of total AIDS spending in the years 2006 to 2008.

Figure 15: AIDS expenditure by spending category, 2006-2008



Source: National AIDS Spending Assessments I (2006) and II (2007/2008)

While *Prevention* continues to be the largest spending category, its share of total AIDS spending decreased by 6 percent from 2006 to 2008.

Meanwhile, spending on *Care and Treatment* increased steadily from 21 percent in 2006 to 25 percent in 2007 to 29 percent in 2008 and this despite the drop in total AIDS spending registered at the end of that period.

Programme Management and Administration constituted 20 percent of total AIDS spending in 2008 and in 2006 and 18 percent in 2007. The main spending categories included in *Other* are *Incentives for Human Resources, Social Protection and Social Services, Enabling Environment and Community Development, and HIV Related Research* (see Annex 3).

(B) Actions that Need to be Taken by Development Partners to Ensure Achievement of UNGASS

The good and long-established cooperation between the Government and the development partners has been one of the key factors contributing to the success of Cambodia's response to HIV. The continued commitment from the development partners is of utter importance and as mentioned earlier there is no room for complacency from any partner in the national response to HIV and AIDS in Cambodia.

The United Nations has aligned its support to the Government of Cambodia through the Joint UN Support Programme Operational Plan and Budget (UN JSP-OPB) with annual planning and reporting exercises. The next UN JSP-OPB will be developed in 2010 and will cover the period from 2011 to 2015 in alignment with the NSP III.

The 2011-2015 UN Development Assistance Framework (UNDAF) for the first time mainstreams HIV across all outcome areas including social protection, economic growth and sustainable development, health and education, gender and governance. The indicators included in the UNDAF are fully aligned with the national core indicators included in the National HIV/AIDS M&E Guidelines.

The Development Partners Forum, with representatives from bi-lateral agencies, UN organizations and selected international NGOs, conducts regular meetings to coordinate its activities. In addition, the Government Donor Joint Technical Working Group is a mechanism to exchange information on progress and on how to address challenges. Whenever possible and requested, the development partners should continue providing technical assistance and advisory services.

Development partners also have a responsibility to advocate for and contribute to a more effective and efficient national response. Development partners need to promote low cost and high impact interventions whenever possible and appropriate. Efforts are already underway, but still more needs to be done to maximize benefits from investments in the health sector response to HIV and AIDS in terms of overall health systems strengthening. Moreover, development partners need to advocate for increased financial contributions to the national response from the national budget.

It is crucial that the financial and technical support from development partners will be aligned to the national priorities as stipulated in the forthcoming NSP III.

VII. Monitoring and Evaluation Environment






Monitoring and evaluation (M&E) are an integral part of Cambodia's response to HIV and the subject of Strategy 6 of the NSP II. The National HIV/AIDS M&E Guidelines were issued in 2008 and describe in detail how the national multisectoral system for tracking the epidemic and the national response functions. Their purpose is to provide a coherent and well integrated framework for monitoring the progress and evaluating the results of Cambodia's multisectoral response to the HIV epidemic as outlined in costed national strategic plans.

The National M&E Guidelines illustrate Cambodia's 54 core HIV/AIDS indicators which include, Universal Access, UNGASS and MDG indicators, and are aligned with the NSPII strategies. The M&E Guidelines describe each one of the core indicators in detail including indicator definitions, sources of data and methods of measurement.

(A) Overview of the Current Monitoring and Evaluation (M&E) System

The national multisectoral M&E system is managed by the NAA with technical guidance from the national M&E Technical Working Group (M&E TWG). This TWG is made up of M&E specialists from the NAA and its member organizations including government agencies, civil society organizations, private sector institutions and development partners. It has made valuable contributions and has assisted the NAA in making progress with the strengthening of the national multisectoral M&E system.

Several important results have been achieved in the area of M&E during the reporting period (2008-2009), these are:

-  An extensive assessment of the national M&E system and of selected sub-systems was conducted in 2008. To identify gaps and remedial actions to overcome the gaps the assessment used the Global Fund's M&E System Strengthening Tool.
-  The results of the M&E system strengthening assessment were used to formulate the USD 7-million M&E sub-component of the Round 9 Proposal which was approved for funding by the Global Fund in November 2009.
-  The results of the assessment have also constituted the basis for the development of the National HIV/AIDS M&E System Strengthening Plan 2010 – 2015. The plan addresses all of the 12 components of a functional national HIV M&E system²⁴.
-  The national multisectoral HIV database using the Country Response Information System (CRIS) was further expanded and strengthened.
-  An M&E capacity building curriculum in Khmer language was developed and the implementation of a comprehensive training strategy has started in 2008.

²⁴ The 12 components include (1) Organizational structures with M&E; (2) Human capacity for M&E; (3) M&E partnerships; (4) M&E plan; (5) Costed M&E work plan; (6) M&E advocacy, communications and culture; (7) Routine programme monitoring; (8) Surveys and surveillance; (9) M&E databases; (10) Supervision and data auditing; (11) Evaluation and research; and (12) Data dissemination and use.

- 🧑 Standard Operating Procedures (SOP) for the Continuum of Prevention to Care and Treatment for female entertainment workers were devised. The SOP includes an M&E framework that aligns indicators, definitions, measurement methods, data sources, frequency and tools of data collection and reporting. Both government and non-governmental service providers were trained in data collection and management.
- 🧑 SOPs and detailed M&E frameworks are currently under development for tracking prevention, care and treatment interventions targeting men who have sex with men and drug users as well as for monitoring different kinds of support that is provided to OVC and to families affected by HIV.
- 🧑 New population size estimations were produced for the three major most-at-risk populations including men who have sex with men, drug users and entertainment workers.
- 🧑 Cambodia's surveillance system, through the implementation of the DU/IDU Survey, was further expanded and data on all three MARPs are now available. BSS and HSS as well as the Behavioural Risks On-site Serosurvey among At-risk Urban Men in Cambodia are scheduled to be conducted in 2010.
- 🧑 Strengthening of the routine information system for the health sector has resulted in additional, reliable and timely programme level data including on survival of people on treatment and on HIV resistance.
- 🧑 The second National AIDS Spending Assessment (NASA) was conducted for the years 2007 and 2008. A third round of NASA will start at the end of 2010 with a focus on the years 2009 and 2010.
- 🧑 The national HIV/AIDS research agenda was developed and several specific surveys were completed or are currently ongoing, including the Aids2031, Knowledge, Attitudes and Practices Study, Socio-Economic Study, Adolescent and Young People's Sexual and Drug Use Behaviour Survey/Most-at-Risk-Adolescence and the Stigma Index.

(B) Challenges Faced in the Implementation of a Comprehensive M&E System

The National M&E System Strengthening Plan identifies gaps and recommends remedial actions to enhance the implementation of one single, well integrated multisectoral M&E system in Cambodia. A number of challenges remain including:

- 🧑 Although M&E functions are clearly defined not all institutions have equally well functioning M&E systems and structures in place.
- 🧑 Institutional and individual capacity for M&E, including for surveillance and research, remains limited especially in the non-health sector. Protracted M&E capacity development as well as additional M&E staff is required.
- 🧑 In many institutions basic infrastructure and equipment for M&E are still lacking (e.g., computers, software, internet access) and in particular in those operating at the sub-national levels.

- ✘ Further strengthen partnerships and mechanisms is required to enhance the coordination all stakeholders involved in the implementation of the national M&E system and to facilitate their exchange of information.
- ✘ Collection of standardized routine programme monitoring data from a large number of actors at national and sub-national levels, including the avoidance double reporting through parallel reporting channels.
- ✘ A particular challenge for monitoring the non-health sector response is the weak data auditing and supportive supervision, this challenge extend to civil society, where data are often not systematically checked for completeness and/or accuracy.
- ✘ The need to align questionnaires for sentinel surveillance surveys with international guidelines for the construction of indicators in order to ensure that data can be compared globally, including that used for UNGASS reporting.
- ✘ Much greater efforts are needed to ensure an adequate dissemination and utilization of data for policy making and programme planning.

(C) Remedial Actions Planned to Overcome the Challenges

The National M&E System Strengthening Plan proposes detailed activities to address the identified challenges. The activities will be carried out over several years from 2009 to 2015. They aim to enhance government and non-government cooperation as well as collaboration between these and other stakeholders to further strengthen the collection of data needed for monitoring and evaluation and subsequently to promote an effective management and use of data.

Remedial actions focus on the strengthening of all 12 components of a functional HIV/AIDS M&E system with particular emphasis on: organizational structures with HIV M&E functions; human and institutional capacity for M&E; partnerships to plan,, coordinate and manage the M&E system; routine HIV programme monitoring (especially MARPs prevention interventions); national and sub-national databases; supportive supervision and data auditing; surveys and surveillance; HIV evaluation and research; and data dissemination and use.

Special efforts will be made in the coming years to adopt Integrated Biological and Behavioural Surveillance (IBBS) for all the key populations at high risk of HIV infection.

The need to develop annual costed national HIV M&E workplans is also being addressed through exemplary leadership by the NAA and assistance of the national M&E TWG whose role is to support and monitor the implementation of the National M&E System Strengthening Plan. The multi-year plan has been costed and most activities will be funded by the Global Fund Round 9 Grant.

(D) The need for M&E Technical Assistance and Capacity Building

The strengthening of human and institutional capacity through formal and on-the-job M&E training is critically needed to bring about a more effective and efficient

implementation of the national HIV/AIDS M&E system. Technical assistance working with the NAA and with some of its key members has contributed to the considerable progress made in the area of M&E system strengthening during the reporting period. It has provided support in producing results and has also proven helpful for building capacity of staff on the job and during training workshops.

Vigorous individual and institutional capacity development is foreseen under the M&E sub-component of the Global Fund Round 9 whose implementation is expected to start at the beginning of 2011. Additional national and international technical assistants to help with the strengthening of M&E will be recruited under this round.

The M&E sub-component is designed as a comprehensive M&E capacity building process that is sufficiently protracted over time to make a real impact. It pays attention to the need of a multisectoral response to HIV, and to a meaningful participation in the response and in its monitoring and evaluation by civil society and stakeholders other than government. The planned activities will build on lessons learned in the past and will capitalise on existing systems, structures and experience by following a pragmatic methodology that aims to tackle fundamental structural and human resource constraints. The idea is to encourage 'learning by doing'.

Institutional and individual capacity will be built over five years and with significant financial resources to make a real difference in how strategic information and other kind of evidence is collected, processed, analysed and used to improve the national response to HIV in Cambodia. Capacity will be developed across sectors to ensure comprehensive data of good quality are obtained and used much more effectively than in the past to inform policy design and programme planning.

Under Round 9 noteworthy investments will be made not only in capacity development but also in upgrading infrastructure and equipment to ensure the national M&E system can function properly and produce the expected results. The combination of these efforts will help bolster the efficiency and effectiveness of Cambodia's multisectoral response, and lead to more evidence-based HIV/AIDS programming and planning as well as policy development.

Annex 1: Consultation/preparation process for the Country Progress Report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator form?

a) NAC or equivalent	Yes ✓	No
b) NAP	Yes	No ✓
c) Others (please specify)	Yes	No ✓

2) With inputs from

Ministries:

Education	Yes ✓	No
Health	Yes ✓	No
Labour	Yes ✓	No
Foreign Affairs	Yes	No ✓
Others	Yes ✓	No

(Please specify)

- Ministry of Planning
- Ministry of Rural Development
- Ministry of Interior
- Ministry of Public Works and Transport
- Ministry of Justice

Civil society organizations	Yes ✓	No
People living with HIV	Yes ✓	No
Private sector	Yes ✓	No
United National organizations	Yes ✓	No
Bilaterals	Yes ✓	No
International NGOs	Yes ✓	No
Others	Yes ✓	No

(Please specify)

- Organizations/networks representing MARPs, in particular sex workers, MSM and injecting drug users
- Cambodian Red Cross
- Faith Based Organizations

- 3) Was the report discussed in a large forum? Yes ✓ No
- 4) Are the survey results stored centrally? Yes ✓ No
- 5) Are data available for public consultation? Yes ✓ No
- 6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name/Title : **Dr. Hor Bun Leng**
Deputy Secretary General of the National AIDS Authority

Date : 30 March 2010

Signature : 

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Annex 2: National Composite Policy Index Questionnaire

Annex 3: National Funding Matrix for 2008 and 2009

Annex 4: Data Sheets for 25 Core Indicators