Cambodia Report NCPI

NCPI **Header**

is indicator/topic relevant?: Yes
is data available?: Yes
Data measurement tool / source: NCPI
Other measurement tool / source:
From date: 01/01/2013
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Additional information related to entered data. e.g. reference to primary data source, methodological concerns::
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::
Data measurement tool / source: GARPR

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

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Describe the process used for NCPI data gathering and validation: The National Consultation meeting was led by the National AIDS Authority (NAA) and processed by jointly by HIV/AIDS Coordinating Committee (HACC) and UNAIDS under financial support of The Global Fund. The objectives of the meeting were to employ to review, validate and elaborate key inputs regarding to new emerging issues, challenges and remedial action along the core indicators and targets. This national validation meeting was organized at Cambodianna Hotel, Phnom Penh on 21 March 2014. There were over 77 participants, i.e.; representatives from the government, development partners, multi and bi-lateral agencies, private sectors, civil society (i.e., PLHIV and MARPs whom are leading managing, implementing and contributing to the National HIV/AIDS).

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions: The meeting was used to discuss with all the key involved agencies to get consensus on some data which were initially collected by the consultant team. The inputs from the meeting were important to improve the quality of data.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like): There were some issues of time and human resource constraints.

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

Organization	Names/Positions	Respondents to Part A
NAA	H.E Dr Tia Phalla	A1,A2,A3,A4,A5,A6
NAA	H.E Dr Teng Kunthy	A1,A2,A3,A4,A5,A6
NAA	H,E Dr Hor Bun Leng	A1,A2,A3,A4,A5,A6
MoLVT	HE Dr Huy Han Song	A2,A3
NACD	Dr Thong Sokunthea	A1,A3,A4
MoLVT	Dr. Chuor Eangly	A1,A2,A3
NCAHDS	Dr Ly Penh Sun	A1,A2,A3,A4,A5,A6
DRHC/MoRD	Mr. Chhim Chansovanna	A1,A2,A3
NACD	Lut. Meas Vyrith	A2,A3,A4
CENAT	Mr Chea Manith	A1,A2,A3,A4,A5,A6
CENAT	Dr Khun Kim Eam	A1,A2,A3,A4,A5,A6
NAA	Dr Huot Serey Roth	A1,A2,A3
NAA	Dr Ngin Lina	A1,A2,A3,A4,A5,A6
NAA	Ms Khet Saly	A6
NAA	Mr Chea Punleu	A6
MoEYS	Mr KimSanh	A1,A2,A3,A4,A5,A6
NAA	Dr Voeung Yanath	A1,A2,A3
CENA	Dr Khun Kim Eam	A1,A2,A3,A4,A5,A6
MoWA	Dr Hou Nirmita	A1,A2,A4,A6
MoWA	Dr Seng Phaldavine	A1,A2,A4,A6
MoLVT	HE Dr Huy Han Song	A2,A3
NCWC	Ms Chan Sotheavy	A2,A3
MoSVY	MR Khlong Vichetr	A1,A2,A3,A4,A5,A6
CRC	Mrs Dy Dara	A1,A2,A3
NMCH	Dr Tuon Sovanna	A1,A2,A3,A4,A5,A6
CARD	Dr Say Ung	A1,A2,A3
NMCH	Dr Tuon Sovanna	A1,A2,A3,A4,A5,A6
NMCH	Mr Keo Sothy	A1,A2,A3,A4,A5,A6
PAS/ BMC	Dr Che Pichet	A1,A2,A3,A4
PAS/KRT	Mr. Thann Chroy	A1,A2,A3,A4
PAC/Pursat	H.E Chhun Song	A1,A2,A3,A4
PAS/SRP	Mr Moung Narin	A1,A2,A3,A4
PAS/Pursat	Mr Tek Sopheap	A1,A2,A3,A4,A5
MoJ	Mr. Phan Chanly	A1,A2,A3,A4,A5
NCHADS	Mr. Mom Chandara	A4,A5
NCHADS	Dr. Samrith Sovannarith	A4,A5
NCAHDS	Dr. Lon Say Heng	A4,A5
NCAHDS	Dr Kim Bunna	A4,A5
NAA	Dr. Ly Chanravuth	A1,A2,A3,A4,A5,A6
NAA	Dr. Sou Sophy	A1,A2,A3,A4,A5,A6
NAA	Dr. Thong Dalina	A1,A2,A3,A4,A5,A6
NAA	Dr. Tan Sokkey	A1,A2,A3,A4,A5,A6
NAA	Mr. Keo Chamnan	A1,A2,A3,A4,A5,A6
MoNASRI	Mr. Un Sopheap	A1,A2,A3,A4,A5,A6

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

Organization	Names/Positions	Respondents to Part B
HACC	Mr. Tim Vora	B1,B2,B3,B4,B5
HACC	Mr. Nhim Dalen	B1,B2,B3,B4,B5
HACC	Mr. Heng Koy	B1,B2,B3,B4,B5
HACC	Mr. CheavSamphy	B1,B2,B3,B4,B5
HACC	Mr. Hoy Leangseng	B1,B2,B3,B4,B5
UNAIDS	Mrs. Marie Odille Emond	
UNAIDS	Mrs. Namada Acharya Dakal	B1,B2,B3,B4,B5
UNAIDS	Ms. Holly Norrie	B1,B2,B3,B4,B5
MHC	Phert Soriya	B1,B2,B3,B5
WVC	Ho Daravuth	B1,B2,B3,B4,B5
WOSO	Sot Vanarith	B1,B2,B3,B4,B5
WOSO	Khat Sokha	B1,B2,B3,B4,B5
WOMEN	Chum Nak	B1,B2,B3,B4,B5
WNU	Pech Sokchea	B1,B2,B3,B4,B5
WHO	Eng Pary	B1,B2,B3,B4,B5
WDA	Chea Sovanny	B1,B2,B3,B4,B5
VC	Hout Totem	B1,B2,B3,B4,B5
URC	Leng Kuoy	B1,B2,B3,B4,B5
UNODC	Aaron Waton	B1,B2,B3,B4,B5
TASK	Yau Malosya	B1,B2,B3,B4,B5
TASK	Doeun Vuthea	B1,B2,B3,B4,B5
SHCH	Chha Valith	B1,B2,B3,B4,B5
SEADO	Va Kimyan	B1,B2,B3,B4,B5
SEADO	Kong Chanphana	B1,B2,B3,B4,B5
SCC	Som Piseth	B1,B2,B3,B4,B5
SCC	San Bon	B1,B2,B3,B4,B5
SCC	Chea Phal	B1,B2,B3,B4,B5
SCC	Vorn Van	B1,B2,B3,B4,B5
SCC	Chhay Soheang	B1,B2,B3,B4,B5
SCC	Ling Khun	B1,B2,B3,B4,B5
SCC	Lay Kimsorn	B1,B2,B3,B4,B5
SCC	Cheng Sovanratha	B1,B2,B3,B4,B5
SCC	Touch Dara	B1,B2,B3,B4,B5
SCC	Heab Sin	B1,B2,B3,B4,B5
RHAK	Hun Rady	B1,B2,B3,B4,B5
RHAK	Min Samart	B1,B2,B3,B4,B5
RHAC	Voun Charithy	B1,B2,B3,B4,B5
RHAC	Ty Sotheavy	B1,B2,B3,B4,B5
RHAC	EK Sreyneang	B1,B2,B3,B4,B5
RHAC	Moeun Meng	B1,B2,B3,B4,B5
RHAC	Moeun Vithy	B1,B2,B3,B4,B5
RHAC	Heang Samoeun	B1,B2,B3,B4,B5
RHAC	Cheng Sinuon	B1,B2,B3,B4,B5
RHAC	Heng Tha	B1,B2,B3,B4,B5
PWHO	Kheng Sophal	B1,B2,B3,B4,B5
PSI	Chum Bunly	B1,B2,B3,B4,B5
PPN+	Nhem Saran	B1,B2,B3,B4,B5
PPN+	Ngoun Sreymom	B1,B2,B3,B4,B5
PPN+	Van Chanthou	B1,B2,B3,B4,B5
PFD	Nhem Naryroth	B1,B2,B3,B4,B5
PFD	Yert Neroth	B1,B2,B3,B4,B5
PFD	Nhem Narith	B1,B2,B3,B4,B5
PC	Hem Kim Eng	B1,B2,B3,B4,B5
PC	Sao Veng	B1,B2,B3,B4,B5
PC	Pen Savy	B1,B2,B3,B4,B5
PC	Vuth Sokhom	B1,B2,B3,B4,B5
NAA	Ly Chanravuth	B1,B2,B3,B4,B5
MSPC	Phorn Sotheavuth	B1,B2,B3,B4,B5
MS	Kem Soleil	B1,B2,B3,B4,B5

MHSS	Phel Sophy	B1,B2,B3,B4,B5
MHSS	Chhorn Sona	B1,B2,B3,B4,B5
MHSS	Chhorn Sona	B1,B2,B3,B4,B5
MHSS	Bo Putreatrey	B1,B2,B3,B4,B5
MHSS	So Sovan	B1,B2,B3,B4,B5
MHSS	Mean Makara	B1,B2,B3,B4,B5
MHSS	DeabVeasna	B1,B2,B3,B4,B5
MHSS	Phum Phearun	B1,B2,B3,B4,B5
MHSS	San Say	B1,B2,B3,B4,B5
MHSS	HortVireak	B1,B2,B3,B4,B5
MHSS	Leam La	B1,B2,B3,B4,B5
MHSS	Sao Ratha	B1,B2,B3,B4,B5
LWD	KhimVichit	B1,B2,B3,B4,B5
KYA	Mith Nak	B1,B2,B3,B4,B5
KWCD	Say Nara	B1,B2,B3,B4,B5
KWCD	Torn Sreychin	B1,B2,B3,B4,B5
KOSHER	Nguon San	B1,B2,B3,B4,B5
Korsang	Taing Phoeuk	B1,B2,B3,B4,B5
KHANA	Chuob Sokchamrouen	B1,B2,B3,B4,B5
KHANA	Tith Kimuy	B1,B2,B3,B4,B5
KBA	Mrs. Yan Somaly	B1,B2,B3,B4,B5
KBA	Yan Somally	B1,B2,B3,B4,B5
ILO	Chhung Por	B1,B2,B3,B4,B5
IDA	Pan Sopheap	B1,B2,B3,B4,B5
HoF	Chorm Vichit	B1,B2,B3,B4,B5
HOF	Ven Savath	B1,B2,B3,B4,B5
HI-F	Hou Navy	B1,B2,B3,B4,B5
HAI	Klout Phally	B1,B2,B3,B4,B5
GENEROUS	Chhon Sokhoeun	B1,B4,B5
FRC	Mr. Neng Vannak	B1,B2,B3,B4,B5
FRC	Neng Vannak	B1,B2,B3,B4,B5
FHD	Sim Rattana	B1,B2,B3,B4,B5
Esther	Nhim Sovanvuty	B1,B2,B3,B4,B5
EOS	Phan Sovann	B1,B2,B3,B4,B5
EOS	Phan Sovann	B1,B2,B3,B4,B5
EOS	Dy Na	B1,B2,B3,B4,B5
EOS	Phin Bunly	B1,B2,B3,B4,B5
DYMB	Nhem Sopheap	B1,B2,B3,B4,B5
DCWO	Som Sophat	B1,B2,B3,B4,B5
CWPP	Meas Chakriya	B1,B2,B3,B4,B5
CWPP	Kron Sarith	B1,B2,B3,B4,B5
CWPP	Chhorn Ann	B1,B2,B3,B4,B5
CWPP	Kry SoNornn	B1,B2,B3,B4,B5
CWPP	Kong Sopheap	B1,B2,B3,B4,B5
CWPP	Som Soyim	B1,B2,B3,B4,B5
CWPP	Sleas Riya	B1,B2,B3,B4,B5
CWPP	Eang Sreyvan	B1,B2,B3,B4,B5
CWPP	Meas Sokhum	B1,B2,B3,B4,B5
CWPP	Kron Sarith	B1,B2,B3,B4,B5
CWPP	Sun Sopheak	B1,B2,B3,B4,B5
CWPP	Keo Savin	B1,B2,B3,B4,B5
CWPP	Keo Sichan	B1,B2,B3,B4,B5
CWPP	Ouk Phalla	B1,B2,B3,B4,B5
CSSD	So Sophany	B1,B2,B3,B4,B5
CSO	So Sophany	B1,B2,B3,B4,B5
CSDA	Chorg Phat	B1,B2,B3,B4,B5
CSCN	Nget Sobarak	B1,B2,B3,B4,B5
CRC	Thaing Kimrin	B1,B2,B3,B4,B5
CRC	Sao Sitou	B1,B2,B3,B4,B5
CPR	Seng Tack	B1,B2,B3,B5

CPR	SengTak	B1,B2,B3,B4,B5
CPR	Sin Sophun	B1,B2,B3,B4,B5
CPR	Seng Tack	B1,B2,B3,B4,B5
CPR	Mok Karona	B1,B2,B3,B4,B5
CPN+	Sorn Sothearidh	B1,B2,B3,B4,B5
CPN+	Sang Sopha	B1,B2,B3,B4,B5
CPN+	Kim Kong	B1,B2,B3,B4,B5
CNMWD	Sou Sotheavy	B1,B2,B3,B4,B5
Chhouksor	Sos Mary	B1,B2,B3,B4,B5
CHETRIG	Chan Vuthea	B1,B2,B3,B4,B5
CHETRIG	Ealt Sakphear	B1,B2,B3,B4,B5
CHETRIG	Mean Ben	B1,B2,B3,B4,B5
CHETRIG	Kim Socheata	B1,B2,B3,B4,B5
CHEC	KasemKolnary	B1,B2,B3,B4,B5
CHC	Ung Choun	B1,B2,B3,B4,B5
CHC	Meas Bora	B1,B2,B3,B4,B5
CDRCP	Leng Sothea	B1,B2,B3,B4,B5
CCW	Prum Dalish	B1,B2,B3,B4,B5
CARITAS	Song Bunthan	B1,B2,B3,B4,B5
CARITAS	Liv Sharon	B1,B2,B3,B4,B5
CARITAS	Kim Sokha	B1,B2,B3,B4,B5
CARAM	Yin Sokunmah	B1,B2,B3,B4,B5
BFD	An Reoun	B1,B2,B3,B4,B5
BFD	Nhoek Sophy	B1,B2,B3,B4,B5
BC	Bun than	B1,B2,B3,B4,B5
Austria Aid	Chhun Bunmeng	B1,B2,B3,B4,B5
AUA	Heng Chheang Kim	B1,B2,B3,B4,B5
AUA	Han Sienghorn	B1,B2,B3,B4,B5
ARM	Sok Serm	B1,B2,B3,B4,B5
ARM	Serng Sopin	B1,B2,B3,B4,B5
APHEDA	Ly Kimsong	B1,B2,B3,B4,B5
APCASO	RD Marte	B1,B2,B3,B4,B5
ANKO	Kong Samnang	B1,B2,B3,B4,B5
AHF	Than Meak/PFD	B1,B2,B3,B4,B5
AHF	Gneap Sina	B1,B2,B3,B4,B5
AHF	Dy Chenda	B1,B2,B3,B4,B5
AHF	Tem Seyha	B1,B2,B3,B4,B5
AHF	Choeun Sinoeun	B1,B2,B3,B4,B5
AHEAD	Heng Bunseth/	B1,B2,B3,B4,B5
AFESIP	So Sopkeak/	B1,B2,B3,B4,B5
AFESIP	Sopyrun	B1,B2,B3,B4,B5
AFESIP	So Sopheak	B1,B2,B3,B4,B5
AFD	Chan Sophan	B1,B2,B3,B4,B5
CHETRIG	Ealt Sakphear	B1,B2,B3,B4,B5
CHETRIG	Mean Ben	B1,B2,B3,B4,B5
CHETRIG	Kim Socheata	B1,B2,B3,B4,B5
CHEC	KasemKolnary	B1,B2,B3,B4,B5
CHC	Ung Choun	B1,B2,B3,B4,B5
CHC	Meas Bora	B1,B2,B3,B4,B5
CDRCP	Leng Sothea	B1,B2,B3,B4,B5
CCW	Prum Dalish	B1,B2,B3,B4,B5
CARITAS	Song Bunthan	B1,B2,B3,B4,B5
CARITAS	Liv Sharon	B1,B2,B3,B4,B5
CARITAS	Kim Sokha	B1,B2,B3,B4,B5
CARAM	Yin Sokunmah	B1,B2,B3,B4,B5
BFD	An Reoun	B1,B2,B3,B4,B5
BFD	Nhoek Sophy	B1,B2,B3,B4,B5
BC	Bun than	B1,B2,B3,B4,B5
Austria Aid	Chhun Bunmeng	B1,B2,B3,B4,B5
AUA	Heng Chheang Kim	B1,B2,B3,B4,B5

AUA	Han Sienghorn	B1,B2,B3,B4,B5
ARM	Sok Serm	B1,B2,B3,B4,B5
ARM	Serng Sopin	B1,B2,B3,B4,B5
APHEDA	Ly Kimsong	B1,B2,B3,B4,B5
APCASO	RD Marte	B1,B2,B3,B4,B5
ANKO	Kong Samnang	B1,B2,B3,B4,B5
AHF	Than Meak/PFD	B1,B2,B3,B4,B5
AHF	Gneap Sina	B1,B2,B3,B4,B5
AHF	Dy Chenda	B1,B2,B3,B4,B5
AHF	Tem Seyha	B1,B2,B3,B4,B5
AHF	Choeun Sinoeun	B1,B2,B3,B4,B5
AHEAD	Heng Bunseth/	B1,B2,B3,B4,B5
AFESIP	So Sopkeak/	B1,B2,B3,B4,B5
AFESIP	Sopyrun	B1,B2,B3,B4,B5
AFESIP	So Sopheak	B1,B2,B3,B4,B5
AFD	Chan Sophan	B1,B2,B3,B4,B5

A.I Strategic plan

1. Has the country developed a national multisectoral strategy to respond to HIV?: Yes

IF YES, what is the period covered: 2011-2015

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.: The current National Strategic Plan for Multi-sectoral and Comprehensive response to HIV and AIDS (NSP III) is covering the period 2011-2015 The National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS 2011-2015 is built on the key guiding principles and apply to all its strategies, objectives and activities. Moreover, this strategic plan has built on the findings of the Functional Task Analysis (FTA) commissioned by NAA at the end of 2009 which provides comprehensive recommendations for organizational, management and leadership strengthening. To maintain the declining incidence prevalence of HIV, prevention efforts need to prioritized to achieve the Three Zero targets i.e. 1) high coverage of quality of continuum of preventions and care services for most-at-risk population (MARPs), 2) Provision of quality care services for PLHIV 3) reduce stigma and discrimination on KAPs (Key Affected Populations) Other key areas of focus are to increase technical and organizational of the National AIDS Authority and CBOs networks to effectively apply the recommendations of Cost-effectiveness of HIV prevention and impact mitigation for prioritizing interventions of the NSP III and making the best use of limited resources for concentrated HIV and AIDS epidemic. The National AIDS Authority needs to engage key stakeholders to contribute to the development effectiveness innovations. More support is needed to support country system to act as the country accountability mechanism for HIV and AIDS response in Cambodia with the application of Program Based Approach (PBA).

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

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: There are 29 ministries and secretariat involve for the development and implement of the National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS. They are: MoWA, MoND, MoInt, MoInf, MoT, MoEYS, MoLVT, MoH, MoNASRI, MoSVY, MoRC, MoCFA, MoP, MoPTC, MoIME, MoRD, MoLUMUC, Office of Council Minister, MoPWT, MoEF, MoAFF, MoEnv, MoFAIC, SoPC, MoCA and CRC.

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

Education:

Included in Strategy: Yes

Earmarked Budget: Yes

Health:

Included in Strategy: Yes

Earmarked Budget: Yes

Labour:

Included in Strategy: Yes

Earmarked Budget: Yes

Military/Police:

Included in Strategy: Yes

Earmarked Budget: No

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: Yes

Transportation:

Included in Strategy: Yes

Earmarked Budget: No

Women:

Included in Strategy: Yes

Earmarked Budget: Yes

Young People:

Included in Strategy: Yes

Earmarked Budget: Yes

Other: Infrastructure development

Included in Strategy: No

Earmarked Budget: No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?: With the concentrated epidemic, it was hard to mobilize the funding support for Uniformed Services especially for young military recruits who have been deployed to border areas. Not enough support to implement the recommendations of the survey on Most At Risk Young People Not adequate attention to workers (both Khmer and Chinese) involved Infrastructure development such as road and bridge or hydropower dam on HIV prevention. The contribution of private companies for HIV response as corporate policy has been not been reactivated for a

long time.

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

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: Yes

Elderly persons: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: No

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: Yes

HIV and poverty: No

Human rights protection: Yes

Involvement of people living with HIV: Yes

IF NO, explain how key populations were identified?: Migrants/mobile populations especially cross-border to Thailand in remarkably increased over the past two years causing a difficulty to reach them on continuum of prevention , treatment , care and support. Retention rate of ART is only 83% in 24Month and 76% at 60Months (data in 2012). Sex Workers: The term sex worker is no longer use in current Cambodia context. The favorite word is entertainment worker (EW) instead of sex work worker. EWs are including both direct and indirect people who sell sex. This target group is among Most-at Risk Population and is a focus group that needs to be prioritized with highly attention on high quality of effective prevention intervention alike MSM and IDU groups. Come up with that MARPs Community Partnership Initiative (MCPI)provides a framework and operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach) to access to quality of service for PLHIV and integration of HIV impact mitigation into broader and national protection strategy of Royal Government of Cambodia.

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

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: Yes

People who inject drugs: No

Prison inmates: No

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific key populations/vulnerable subpopulations [write in]::

: No

1.5 Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?: No

1.6. Does the multisectoral strategy include an operational plan?: Yes

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?: Yes

b) Clear targets or milestones?: Yes

c) Detailed costs for each programmatic area?: Yes

d) An indication of funding sources to support programme implementation?: Yes

e) A monitoring and evaluation framework?: Yes

1.8. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?: Active involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised.: CSO had significantly contributed to support the government to put it commitment toward the United Nations Political Declaration on HIV and AIDS - In the NSPIII development and the implementation of The National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS 2011-2015. - In the establishment and implementation of Conceptual Framework of health sector for eliminating new HIV infection in Cambodia by 2020 aiming at eliminating HIV and AIDS. - In joining important platform for program design, policies and guidelines development and decision making process at country level such as CCC/GFATM and GDJ TWG

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:

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

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

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why: Over the past two years, there was uneven engagement of key stakeholders to contribute to the development effectiveness innovations which has been guided through the Joint Government and Donors platforms of coordination. Based on the exercise in the development of Investment Framework for an Effective and Efficient response to HIV/AIDS, it is found that it was no easy to move stakeholders from HIV specificity toward HIV sensitivity. In this regard, not enough support for moving needed HIV affected households from dependency to resilience with appropriate livelihood and microfinance support.

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

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: Yes

Poverty Reduction Strategy: Yes

National Social Protection Strategic Plan: Yes

Sector-wide approach: Yes

Other [write in]: Program Based Approach (PBA) has been applied mostly in health sector (not effective)

: Yes

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

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws: No

HIV impact alleviation (including palliative care for adults and children): Yes

Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support: Yes

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support: Yes

Reduction of stigma and discrimination: Yes

Treatment, care, and support (including social protection or other schemes): Yes

Women's economic empowerment (e.g. access to credit, access to land, training): Yes

Other [write in]:

: No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?: Yes

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evalua¬tion informed resource allocation decisions?: 3

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

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications? HIV and AIDS program has remarkably contributed in strengthening health system (from national to sub-national level through the use of 100 M USD over the past two years . The Cambodia 3.0 framework encapsulates the key steps to be taken in eliminating of new HIV infections through (1) early diagnosis of HIV infection and early access to ART as prevention and a boosted continuum of care, (2) boosted prevention of mother-to-child HIV transmission, (3) boosted access to -- and utilization of -- prevention, care and treatment services by most-at-risk populations, (4) strengthening of community-based health services, and (5) enhanced monitoring and evaluation of impacts.

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

a) HIV Counselling & Testing with Sexual & Reproductive Health: Many

b) HIV Counselling & Testing and Tuberculosis: Many

c) HIV Counselling & Testing and general outpatient care: Many

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: None

e) ART and Tuberculosis: Many

f) ART and general outpatient care: None

g) ART and chronic Non-Communicable Diseases: None

h) PMTCT with Antenatal Care/Maternal & Child Health: Many

i) Other comments on HIV integration: :

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?: 8

Since 2011, what have been key achievements in this area: Since 2011, health sector has been implementing a new conceptual framework for elimination of new HIV infections in Cambodia by 2020 (“Cambodia 3.0”). There was a continued overall decline of national HIV prevalence in the population at large from a peak of 2% in 1998 to 0.7% in 2012, according to estimation and projection models. Associated with a considerable scale-up of HIV counselling, testing, care and treatment, the estimated number of new HIV infections plummeted from almost 15 000 to 20 000 annually in the early 1990s to around 1300 in 2012. To bring the mother-to-child transmission rate of HIV to below 5%,“boosting strategy” has been implemented to successfully scale up routine voluntary testing and counselling at point-of-care and provide, simultaneously, antiretroviral therapy to all eligible women. The treatment coverage rate among PLHIV was higher in 2009 than in 2012. This seeming decline has to be interpreted against the background of changing criteria for starting ART, from CD4<200-250 in 2009 to CD4<350 in 2012.

What challenges remain in this area:: Structures, capacities and services dedicated to HIV and STI prevention, care and treatment and the early diagnosis and treatment of HIV/tuberculosis co-infection Access to services by the MARPs should be expanded, and in some cases revitalized, in a supportive legal and policy environment. Follow-up along the cascade of services, from creation of and demand VCCT to sustained and efficiently-monitored use of care and treatment should be strengthened through effective and more strategic information management, linkage of data bases and tighter communication and collaboration among service providers. Sharper epidemiological targeting and more effective interventions introduced at sufficient intensity and scale geared to identifying new HIV infections and introducing early treatment Access to, and voluntary use of, VCCT by pregnant women attending ANC expanded with full and timely provision of ART for life during pregnancy and/or shortly before delivery to protect their offspring from HIV infection. Stronger synergy fostered within the health sector and across other sectors of development. Greater support to health personnel provided through improved salary, skills upgrading and incentives to ensure staff retention . External financing sustained and a growing financial share secured from national sources.

A.II Political support and leadership

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

A. Government ministers: Yes

B. Other high officials at sub-national level: Yes

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

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: Samdach Akak Moha Sena Padei Techo Hun Sen, Prime Minister orders the Council of Cabinets to issue the Seven Points Policy directives to guide actions toward key areas for the response to HIV and AIDS in Cambodia. Cambodia’s successes in its fight against HIV and AIDS can largely be identified as the result of political commitment at the highest level of government, supported by the leadership, dedication and mobilization of the First Lady Samdach Kittiprit Bandit Bun Rany Hun Sen. First Lady does a critical role model with her empathy, passion to marginalized people in both national and sub-national level. For example, she always support to vulnerable children, pregnant women and disable people.

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

IF NO, briefly explain why not and how HIV programmes are being managed::

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

Have terms of reference?: Yes

Have active government leadership and participation?: Yes

Have an official chair person?: Yes

IF YES, what is his/her name and position title?:

Have a defined membership?: Yes

IF YES, how many members?:

Include civil society representatives?: Yes

IF YES, how many?:

Include people living with HIV?: No

IF YES, how many?:

Include the private sector?: Yes

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?: Yes

3. Does the country have a mechanism to promote coordinationbetween government, civil societyorganizations, and the private sector for implementing HIV strategies/programmes?: Yes

IF YES, briefly describe the main achievements:: CSO representative sits in important coordination forum such as the GDJTWG on HIV and AIDS, in CCM/GFATM and Technical Advisory Board. CSO had joined in the meetings and workshops as well as joining in developing some policies and guidelines such as NSP review among CSO, Technical Support Plan, Boosted CoPCT, and other nation standard and guideline for better response to HIV and AIDS. CSOs member and representative had contributed to strengthen commitment of the government through being a full member of other national TWGs. The CBCA (Cambodian Business Coalition on AIDS) has been able to engage employers of private companies to apply non stigma and discrimination against PLHIV and install enabling environment in the workplace. GMAC and CAMFEBA has been stronger supporter of the integration of HIV and AIDS in the workplace issue by the Ministry of Labor Vocational Training.

What challenges remain in this area:: • The connection between grass root Out Reach workers, Self Help Groups with upper level is somehow not well coordinated . In this regard, evident based findings for decision making among CSOs especially at the sub-national level is somehow not well reported to national level. • Participation of Key affected populations (KAP) in M/E process is limited.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 0

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

Capacity-building: Yes

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: Yes

Technical guidance: No

Other [write in]:

: No

6. Has the country reviewed national policies and laws to determine which, if any, are incon-sistent with the National HIV Control policies?: Yes

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

IF YES, name and describe how the policies / laws were amended: • Ministry of Justice Explanatory Notes on the Law on the Suppression of Human Trafficking and Sexual Exploitation particularly in relation to prohibition on use of condoms as evidence, the legality of selling sex in private (which is legal between consenting adults), and the restrictive meaning of 'soliciting'. • The 7 points Policy Directives suggests added the fight against AIDS and mother health-care as additional points in the Village-Commune Safety policy of the Ministry of Interior.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:: As far as the law and policies is concerned , there was no major inconsistency between HIV and AIDS policies and other ministerial order or other sector law or policies instrument. The joint efforts between NAA, NACD, Ministry of Interior and local with support of UNAIDS, MOH, WHO, UNODC, FHI, HARP in the Police Community Partnership has been addressing remaining negative attitudes to a harm reduction approach, 100% Condom use Program in 34 hot spots in the country.

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

Since 2011, what have been key achievements in this area:: • Outstanding national leadership, commitment and progress towards the achievement of MDG 6, particularly in working towards halting and reversing the spread of HIV. By averting large numbers of 'downstream' infections, the early Cambodian response curbed the transmission that was driving the epidemic, later enabling the programme to reach universal access to antiretroviral treatment. • Strong political support from the Royal Government of Cambodia. 7-points policy directives has been issued by the Council of Ministers in December 2013 to guide focus interventions and to strengthen coordination with key stakeholders. • Support for country mechanism to mobilize resource for HIV and AIDS response in the country : o Mobilization at least 100 MUSD in 2012 and 2013 for HIV and AIDS response in Cambodia (referring to NASA (50.9 MUSD for 2012 where 11% was generated from government) o Joint efforts in securing 71 MUSD for Phase II of SSF / GFATM for 2014-2015 • New Conceptual Framework for the elimination of new HIV infections in Cambodia by 2020 ("Cambodia 3.0") developed by NCHADS/Ministry of Health and apply in 2012 and 2013 with different sources of funding. • Some thematic reviews of NSPIII have been undertaken (Health sector, gender assessment, HIV sensitivity and social protection, Legal and policies review…) • Key stakeholders have been working to formulate the contribution of HIV and AIDS in the NSDP 2014-2018

What challenges remain in this area:: • Not enough cross-border collaboration to address the need of migrant and mobile populations (continuum of prevention, treatment, care and support) as well as social and legal services to reduce their vulnerability. • Poor health seeking behavior among MSM/TG and poorer networking of MSM/TG as compared to EWs. • Room for improvement of engaging private sector as social corporate responsibility for the response to HIV and AIDS. • More engagement of young people in contributing to policy and program design and resource mobilization for HIV and AIDS response.

A.III Human rights

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

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

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

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:: The Law on the Prevention and Control of HIV/AIDS, which was enacted by the National Assembly since 2002. Under chapter VIII it is clear state on nondiscrimination to people living with HIV/AIDS such as they should have equal rights to access public services, testing working and other involvement of the preparation any strategy and policy. This Law also has its implementing guidelines (2005) outlines measures to combat discrimination. Prohibit discrimination against people living with HIV by law enforcement officers and in prisons and detention / rehabilitation centres. Moreover, the national Law does not have a specific law on non-discrimination. However, Article 31 of the Constitution states all citizens shall be equal before the law and have the same freedoms and obligations. Protection is afforded to PLHIV and key affected populations through a number of policies and other legislation.

Briefly explain what mechanisms are in place to ensure these laws are implemented:: • The enforcement of HIV/AIDS Laws and policies use the mechanism consist various commissions of the National Assembly such as Human Rights, Health & Women & Social Welfare; and oversight mechanisms at the national (ministry) and local (sub-national democratic development institutions) levels. The Legal and policy technical working group is a committee to oversight and monitor the implement of HIV/AIDS Laws. The member of technical working group include. ministry of Justice, Ministry of Interior and other respect institution • To inform efforts to develop new legal service options to address HIV-related legal problems, a Toolkit for Scaling up Comprehensive Legal Services in the context of HIV is being developed by CPN+ with support from UNAIDS and KHANA. • Visit to National Assembly and Senate has been planned as results of the implementation of PCPI and especially the recommendations of Legal and Policies review related to HIV and AIDS.

Briefly comment on the degree to which they are currently implemented:: Although, there are clear structures and mechanism for implementing and monitoring HIV/AIDS Laws and its policy, there are still remain challenges with limited capacity and no enough financial support to the implementation of Laws and policies.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?: No

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

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

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

A.IV Prevention

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

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: Yes

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: Yes

Know your HIV status: Yes

Males to get circumcised under medical supervision: No

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: Yes

Reduce the number of sexual partners: Yes

Use clean needles and syringes: Yes

Use condoms consistently: No

Other [write in]::

: No

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

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

2.1. Is HIV education part of the curriculum in:

Primary schools?: Yes

Secondary schools?: Yes

Teacher training?: Yes

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: Yes

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

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

Briefly describe the content of this policy or strategy::

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

People who inject drugs: Condom promotion,Drug substitution therapy,HIV testing and counseling,Needle & syringe exchange,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Men who have sex with men: Condom promotion,Drug substitution therapy,HIV testing and counseling,Needle & syringe exchange,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Sex workers: Condom promotion,Drug substitution therapy,HIV testing and counseling,Needle & syringe exchange,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination

reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Customers of sex workers: Condom promotion,HIV testing and counseling,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Prison inmates: Condom promotion,HIV testing and counseling

Other populations [write in]::

:

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2013?: 8

Since 2011, what have been key achievements in this area:: • Cambodia 3.0 Framework with Boosted CoCPCT through accelerating HIV Case Detection and Maximizing Retention towards Zero AIDS Deaths in Cambodia. New innovative approach has been applied in the streamlined HTC Model to Accelerate HIV Case Detection where every Health Center and Hospitals and meeting point such as (Karaoke, sauna, massage..) or CBO send to HTC. • Policy change to streamline testing procedures (Finger-Prick, Task Shifting) for community testing targeting KAP has been advocated • HTC for partners and adolescent has been established along with TAsP • Introduce maintenance of ART for KP at the community level • Positive prevention • Harm Reduction • PCPI

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

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

IF YES, how were these specific needs determined?: Sharper epidemiological targeting to optimize Boosted CoPCT : The objective should be to reach remaining pockets of individuals at very high risk of acquiring HIV/STI and of transmitting infections to new partners

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

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Strongly agree

Condom promotion: Strongly agree

Economic support e.g. cash transfers: Agree

Harm reduction for people who inject drugs: Agree

HIV prevention for out-of-school young people: Agree

HIV prevention in the workplace: Agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Strongly agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: Strongly agree

Risk reduction for sex workers: Strongly agree

Reduction of gender based violence: Strongly agree

School-based HIV education for young people: Strongly agree

Treatment as prevention: Strongly agree

Universal precautions in health care settings: Strongly agree

Other [write in]::

: N/A

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2013?: 8

A.V Treatment, care and support

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

If YES, Briefly identify the elements and what has been prioritized:: Boosted COC , LR, TAsP

Briefly identify how HIV treatment, care and support services are being scaled-up?: Increase the level of CD4 Count up to 350 since mid 2010 TAsP to cover MARPS, serodiscordant couple(CD4 Up to 500), Option B+ (prg women), TB patients (regardless), Partner tracing Increase uptake of HTC among MARPs by CPITC (including lay counselor by using finger prick) D4T Phase out ; Increase ART sites ; expand services to close setting Starting UIS in Battambang; Will start UIC for MARPs (Flagship) Active case management for PLHIV to support patient access to treatment on time and reduce loss to follow up

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

The majority of people in need have access to…:

Antiretroviral therapy: Strongly agree

ART for TB patients: Strongly agree

Cotrimoxazole prophylaxis in people living with HIV: Strongly agree

Early infant diagnosis: Disagree

Economic support: Strongly agree

Family based care and support: Strongly agree

HIV care and support in the workplace (including alternative working arrangements): Strongly agree

HIV testing and counselling for people with TB: Strongly agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Agree

Nutritional care: Disagree

Paediatric AIDS treatment: Strongly agree

Palliative care for children and adults Palliative care for children and adults: Disagree

Post-delivery ART provision to women: Strongly agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Strongly disagree

Post-exposure prophylaxis for occupational exposures to HIV: Strongly agree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Strongly agree

TB infection control in HIV treatment and care facilities: Strongly agree

TB preventive therapy for people living with HIV: Strongly agree

TB screening for people living with HIV: Strongly agree

Treatment of common HIV-related infections: Strongly agree

Other [write in]::

: N/A

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

Please clarify which social and economic support is provided: The HIV Sensitive social Protection : A review of Cambodia’s social protection schemes for incorporating HIV sensitivity , CARD mentions about Health Equity Fund, education scholarship, school meals, health vouchers, microfinance

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

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

IF YES, for which commodities?: Condoms , test kids, OI/ARV drugs and other lab equipment's

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?: 8

Since 2011, what have been key achievements in this area:: -If the denominator is the eligible PLHIV for ART, currently right now the current rate of ART users is as high as 82.6%) -Good collaboration between Health facilities and community -See above

What challenges remain in this area:: 1. Retention and adherence due to poverty and migration 2. Quality of care limited and incentive support/ motivation 3. Staff turnover in big scale 4. Logistic supply management

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

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

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

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?: 6

Since 2011, what have been key achievements in this area:: -School attendance of OVC through Community Based Health Care -Access to School feeding program -AIDS care on CIA -Succession plan for OVC -Social Protection -Network of Women and Child focal point at commune level

What challenges remain in this area:: -WFP support ends since the end of 2012 … leave to 50% cut off as compared to before 2012 -HIV and AIDS donors put less priority of food support -More disaster (flood and drought) climate change ; Land certificate were used by HIV affected households to borrow the money from the bank or microfinance institution.

A.VI Monitoring and evaluation

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

Briefly describe any challenges in development or implementation:: The National HIV and AIDS M&E Guidelines has updated to the second edition in 2011 to ensure a coherent and integrated framework for Monitoring progress and evaluating the outcomes of Cambodia's multi-sectoral response to the HIV/AIDS epidemic as outlined in NSP III. National Monitoring and Evaluation Working Group has been created, which composed by government sectors, development partners, bilateral and multi-lateral donors. This national working group has clear ToRs and specific tasks to ensure the sound of the strategic information response to HIV/AIDS in Cambodia. Several challenges have been faced during implementation of the comprehensive plan and mechanism, however. The main challenges of the implantation are: -Lack of common understanding at different levels of implement the M&E plan; -Harmonization and alignment of understanding indicators 'definition and lead to law data quality; -Insufficient partnership between national stakeholders and development partners; -Lack of adequate and consistent evidence –based data and monitoring indicators related to gender and HIV, gender and Gender-based Violence (GBV) and social welfare for orphan and vulnerable children (OVC) ; -Timeline for most population-based surveys, for example CDHS are not aligned to the reporting period of GARPR; -Translating commitment from the M&E plan into action remains challenging because of limited capacity, structural complication and institutional disagreement; -Limited discussion on the protocol, questionnaire and methodologies of conducting survey, surveillance and any studies; -Insufficient resources to support the function of M&E components

1.1. IF YES, years covered: 2010-2015

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?: Yes, some partners

Briefly describe what the issues are:: Since the NSP III has been developed, the M&E Framework is available for implementation. Under leadership of NAA, we have subsequent meetings and consultation process to harmonize national indicators and update the National Monitoring and Evaluation Guidelines to the second edition with clear definition. There were 56 harmonized indicators for both UA health and multi-sectoral indicators to track the progress of the national response to HIV/AIDS in Cambodia. In the process of developing these indicators; all the key partners such as UNAIDS, CSOs, Ministries, PLHA network and MARPR groups have been involved. However, there was likely fairly involvement from bilateral partners and private sectors.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: No

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate): Yes

Guidelines on tools for data collection: Yes

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

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?: 11

4. Is there a functional national M&E Unit?: Yes

Briefly describe any obstacles:: There is an M&E Unit under the Department of Planning Monitoring Evaluation and Research at NAA. In this Unit, there are five government staffs working for. The unit functioning somehow remains challenges. The most obstacles are: (1) inadequate capacity of staffs to deal with their daily work; and, (2) lack of equipment to support the M&E function, especially at sub-national level. Moreover, the M&E system is still not properly functioning. Moreover, M&E system of various organizations are not parallel. The second edition of the National M&E Guidelines has been developed since 2011, but it is not yet fully implemented due to insufficient capacity to translate the commitment into action.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?: Yes

In the National HIV Commission (or equivalent)?: Yes

Elsewhere?: Yes

If elsewhere, please specify:

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

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Director Department of Planning Monitoring	Full-time	2001
Deputy Director of Department in charge of M&E	Full-time	2001
Deputy Director of Department in charge of Database	Full-time	2002
M& E chief unit	Full-time	2010
Junior researcher	Full-time	2001

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
M&E Specialist	Full-time	2007
M&E officer	Full-time	2013
Database and reporting	Full-time	2013
M&E Coordinator	Temps plein	2007

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

Briefly describe the data-sharing mechanisms:: The 2nd edition of the National M&E Guidelines has clearly stated; the mechanism of data flow at national and sub-national level is shared by vertical and horizontal flows (ranging from the provincial to national levels and ministerial levels). The National M&E Technical Working Group is another mechanism to reinforce the flow data to verity sources. Moreover, data collection and reporting mechanisms have been developed, piloted, disseminated and documented. Also, after the GFATM approval grant on M&E sub-component, training to officers in data collection and reporting specific data has been started. Civil society organizations and development partners have also their own M&E systems in place to capture data and generate reliable and useful information. These systems are mostly initiative supported by PEPFAR and GFATM. Civil society organizations and development partners have also their own M&E systems in place to capture data and generate reliable and useful information. These systems are mostly initiative supported by PEPFAR and GFATM.

What are the major challenges in this area:: The National M&E System aims to track input and output indicators as well as outcome and impact indicators. However, these data is not frequently found by direct relevant ministries, neither the National Monitoring and Evaluation system, particularly routine monitoring data. Some challenges have faced during implementation: -Staff have limited capacity to fully function M&E system -Structural obstacles and institutional disagreement -Lack of coordination efforts from key players -Lack of routine monitoring data and report from key partners and ministries even though the -Data collecting roles are clearly defined -Insufficient resources support to the function of the current national database (Human resources, equipments, and software) -Lack of Staff motivation for both national and sub-national level

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

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

IF YES, briefly describe the national database and who manages it.: With support from UNAIDS, a new network server was installed at the NAA to improve the management and storage of data in the national multi-sectoral HIV/AIDS database. Many progresses has been achieved in collecting data and promoting the use of data from different sources. However, the effort is needed to strengthen and fix up the current database and make compatible with other major database in the health sector and CamInfo for easy integration of HIVV/AIDS data from other sectors NCHADS has also data management in place and data collect from partners is quarterly basis. Data collect and store at NCHAD Database are mostly related to health services.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?: Yes, but only some of the above

IF YES, but only some of the above, which aspects does it include?: Several studies among key population have been conducted recently. Such as MSM size estimation and evaluation; IBBS for DU/IDU, Bros Khmer Survey for MSM, TrakC by PSK

for young population.

6.2. Is there a functional Health Information System?

At national level: Yes

At subnational level: Yes

IF YES, at what level(s)?:

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?: Estimates of Current and Future Needs

7.2. Is HIV programme coverage being monitored?: Yes

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

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

IF YES, for which population groups?: EWs, MSM, DUs/IDUs, young peoples, Gender, OVC etc

Briefly explain how this information is used:: The information have been use in annual workshop, the national congress; publication through quarterly and annually report, newsletters; upload into website and storage into national database

(c) Is coverage monitored by geographical area?: Yes

IF YES, at which geographical levels (provincial, district, other)?: -At national level -At provincial level -At district level

Briefly explain how this information is used:: Through coordination Meetings and disseminate as hard copies

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

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: Yes

Other [write in]::

: No

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

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

At national level?: Yes

IF YES, what was the number trained::

At subnational level?: Yes

IF YES, what was the number trained:

At service delivery level including civil society?: Yes

IF YES, how many?:

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

IF YES, describe what types of activities:

11. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?: 6

Since 2011, what have been key achievements in this area:: -M&E Capacity trainings -TraC 2012 -BSS 2013 -IBBS 2013 -National AIDS Spending Assessment (NASA) IV -HLM Mid Term Review -Health Sector Review

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

B.I Civil Society involvement

1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contrib¬uted to strengthening the political commitment of top leaders and national strategy/policy formulations?: 4

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

2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society repre¬sentatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?: 4

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

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

a. The national HIV strategy?: 3

b. The national HIV budget?: 3

c. The national HIV reports?: 3

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

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

a. Developing the national M&E plan?: 3

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 4

c. Participate in using data for decision-making?: 3

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

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 3

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

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

a. Adequate financial support to implement its HIV activities?: 3

b. Adequate technical support to implement its HIV activities?: 3

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

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

Prevention for key-populations:

People living with HIV: 51–75%

Men who have sex with men: 51–75%

People who inject drugs: 25-50%

Sex workers: >75%

Transgender people: 51–75%

Palliative care : <25%

Testing and Counselling: <25%

Know your Rights/ Legal services: 51–75%

Reduction of Stigma and Discrimination: >75%

Clinical services (ART/OI): <25%

Home-based care: >75%

Programmes for OVC: 51–75%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2013?: 7

Since 2011, what have been key achievements in this area:: • The government is a crucial partner of the CSO in the fight against HIV, however almost all of the activated and service are provided by CSO. • Based on NASA-IV 2011-2012, around 90% of the total budget spent on HIV and AIDS in Cambodia came from CSO and development partners. CSO through its representation of vulnerable group, MARPs, PLHIV, and NGOs working on HIV have significantly contributed to the NSP review, technical support plan, national standard operation procedure (boosted SoP), and other new initiative of the government at both national and sub-national level. • For example: the Flagship consortium worked in close collaboration with NCHADS to conduct the comprehensive GIS mapping of MARPs in 11 ODs in 5 provinces and municipality include Phnom Penh, Kampong Cham, Siem Reap, Banteay Meanchey, and Preah Sihanuk to provide strategic information of MARPs’ hotspotto guide the national response to the right targeted area (high risk hotspots) for HIV intervention. • CSOs play an important role in supporting both technical and financial support the government to ensure its effective implementation of NSP and nation standard operation procedure especially on the prevention intervention, strategic planning, and monitoring and evaluation of HIV and AIDS program in the Country. • CSO worked to support and strengthening the implementation of M&E systems among their own organizations in response to changes in the national M&E systems. For example, HACC has provided the capacity building to NGOs working with MARPs and OVC on M&E through 5-day training including basic M&E technique, data collection,

data compilation, data cleaning, data analysis and data use. Other comments: •

What challenges remain in this area:: • CSO are involved in the planning, implementing, monitoring and evaluation of the HIV and AIDS response still face limited financial support. This limits their ability to deliver and monitor activities and services. • It can be difficult to create the environment where MARPs feel comfortable accessing and engaging with services, activities and supports. For example; CSO reported that many MARPs do not feel comfortable leaving their homes or are constantly on the move. Other comments • MHC, CPWD and SCC report that it is still difficult to reach MARPs especially PWID, MSM and TG as they do not engage in society (often they remain at home for long periods of time) and are worried about being arrested by police; • There is less implementation from the government concerning the prevention intervention activities of the HIV response; • Clinical services for MARPs (Pre-ART/ART) are rare among CSO as there is only ChhouckSar clinic that provide HIV/AIDS servicesspecifically to MARPs; • The HIV testing and counseling at community level has not been sufficiently implemented by NGOs. For example, the finger-prick testing was only implemented in semester of 2013.

B.II Political support and leadership

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

IF YES, describe some examples of when and how this has happened:: Key populations and vulnerable group's networks became members of the national Joint Government Donor TWG, were included as voting member in the Global Fund country coordinating committee and were members of working groups of Boosted Continuum of Prevention to Care and Treatment (CoPCT), TWG of NCHADS and other national strategies and national technical working groups.

B.III Human rights

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

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:: Law on the prevention and control of HIV/AIDS in Cambodia, Law on the Protection and the Promotion of the Rights of Persons with Disability, The Convention on the Elimination of All Form of Discrimination against Women (CEDAW), Domestic Violence Law. National Policy On Cambodia Youth Development, Child protection policy, Prison law. There is no specific non-discrimination law for specific high-risk group such MSM, TG, EW, and PWID

: Yes

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

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:: • Constitutional Law that protect all general people in Cambodia • Law on the prevention and control of HIV/AIDS in Cambodia • The Convention on the Elimination of All Form of Discrimination against Women (CEDAW) • Law on the Protection and the Promotion of the Rights of Persons with Disability • Child protection policy

Briefly explain what mechanisms are in place to ensure that these laws are implemented:: • Establishment of Provincial Orphan and Vulnerable Children Task Force (POVCTF),Commune Council of Women and Children (CCWC), District AIDS Committee (DAC), Commune AIDS Committee (CAC), Commune Council (CC), TCC, MAC, Provincial AIDS Committee (PAS), Provincial AIDS and STI Program (PASP), and Village Health Support Group (VHSG).CSO report that there is significant overlap in the area that these committees are working. Consolidation of these committees could make them more effective. • The establishment of the monitoring and evaluation of HIV and AIDS programs and care and support services for OVC and victims of gender base violence has been positive, however there is still significant challenges in implementing and enforcing the law and regulation in this area.

Briefly comment on the degree to which they are currently implemented:: • There are documentation available concerns the legal framework related to non-discrimination of PLHIV and other vulnerable groups. However the implementation of these laws and policy isstill a challenge because some may conflict with other recent law and policy formulated by the government. For example, the 100% condom use program which was endorsed by the government through Prakas 066 to be implemented for HIV intervention in Cambodia since 1999 is contradicting with the commune and village safety policy and Law on the suppression of anti-human trafficking and sexual exploitation. • The report of national review of legal and policy frameworks 2013 has identified that implementation of the protective Laws is very limited in particular to those which are related to PLHIV and key affected population (KAPs).

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

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: No

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

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

Briefly comment on how they pose barriers:: • There have been several discussion has been made since 2009 among key playerssuch as Ministry of Interior, Ministry of Health, NAA, NCHADS, NACD, and CSO on the contradictions between the implementation of these policies and HIV program implementation, those parties had clarify and remove the barrier of misunderstanding and interpretation of law by agreeing that possession of a condom is not evidence of sexual trafficking anymore (until the 2013 explanatory note endorse by the Ministry of Justice. • However the implementation of these explanatory note by some local authority is still a big problem that leads MARPs especially EW not carry condom because they fear arrest. • NGO report that there is still the perception within the Cambodia society that sex workers, PWID, MSM, and TG are considered as anti-social elements. This makes it difficult to work with MARPs freely. • Sex workers are arrested in public parks for soliciting sex, disturbing the peace and social security, etc. Condoms are still used as evidence for soliciting sex (All NGOs reported this is still the case). The baseline survey on the enabling environment for MARPs (PCPI) in Phnom Penh in 2012 by FHI 360 mentioned that 15.5% of EW participants reported having been arrested in the past 12 months. • The same situation has been raised by PWUD and PWID as the police still arrest people who use drugsbut do not sell orcirculate drugs even though the law has clarifiedthat use of drugs is not illegal. In the 2012 PCPI baseline survey mentioned that 40.7% of PWUD were arrested in the past 12 months; of these, more than half (54%) were arrested due to using drug.

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

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

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

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

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?: No

IF YES, briefly describe this mechanism:: • Despite the existence of laws on the prevention and control of HIV/AIDS, which clearly prohibits discrimination on the perceived or actual status of HIV, there is a lack of functioning mechanisms for recording, documenting or addressing discrimination faced by PLHIV. • Stigma Index 2010 provides evidence that discrimination based on the HIV status exists in communities, health institutions, education sector and for employment. In the same study, 67% of PLHIV who had their rights violated had attempted to access legal assistance but only 6% knew about any legal service NGOs to approach for help. 39% of all physical harassment/threats experienced by WLHIV had been due to their HIV status. • 89% of all physical assaults on WLHIV had been perpetrated by those living in the same household and they were

also discriminated by their neighbors (23%). • WLHIV were about twice as likely to suffer from psychological pressure from their spouse/partner (45%) or be subjected to gossip (31%). • In the absence of a functioning mechanism, not a single case has beenreported. National review of Legal framework (2013) has strongly recommended theestablishment of a functioning mechanism for reporting HR violations and providing legal services. • There are few cases of HIV related discrimination that have beenrecorded separately by NGOs and their networks for case study or success stories to be included in their own report, yet there is no clear mechanism for tracking and advocating in these areas of discrimination, • CSO through HACC should create acomplaint mechanism and track all cases of discrimination. CSO and HACC should advocate to the government and development better solutions and outcomes for the victims of discrimination.

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

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Programmes for members of the judiciary and law enforcement46 on HIV and human rights issues that may come up in the context of their work?: Yes

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

a. Legal aid systems for HIV casework: No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: No

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

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: Yes

Other [write in]::

: No

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?: 4

Since 2011, what have been key achievements in this area:: • There is some documentation concerning the legal framework related to non-discrimination of PLHIV and other vulnerable group in Cambodia such as Law on the Protection and the Promotion of the Rights of Persons with Disability, The Convention on the Elimination of All Form of Discrimination against Women (CEDAW), Polygamy Law, Domestic Violence Law, Law on the prevention and control of HIV/AIDS in Cambodia, Marriage Law, National Policy On Cambodia Youth Development, Child protection policy, and Prison law that is still valid and implemented. • ThePolice Partnership Community Initiative (PCPI) was implemented in recent year which was considered as the community dialogue among local authority, HIV program implementer and key affected population as well health actors to discuss on the real issue happened in community and find out the solution and ways forward.

What challenges remain in this area:: • There is onelegal framework exist in the country to protect people living with HIV and related discrimination issue, yet there is no specific law or regulation to protect the rights ofspecific population at risk such as EW, MSM, TG, PWID and PWUD. • There are 21.8% of EW, 6.9% of MSM, and 10.4% of TG who carry condom in the past 6 months reported fear of arrest by police for carrying condom (2012 PCPI baseline survey, FHI 360). • The prevention program for HIV among MARPs including harm reduction program, needle and syringe program (NSP)and methadone maintenance therapy (MMT) for PWID and PWUD exist in the Country, but there is still low awareness and even heard that program among police official is limited. In 2012 PCPI baseline survey mentioned that there is only 57% of police participants reported ever heard of harm reduction programs, 63% ever heard of NSP and only 11% ever heard of MMT service. • Those legal frameworks on rights related HIV should be applied for all sector including the private companies, but some companies do not fully respect the law. There is no monitoring of the implementation of this law in the private sector.

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?: 3

Since 2011, what have been key achievements in this area:: • Even there are some legal framework exist in the country, yet the implementation of those mentioned law and policy are still a challenge while some of those policy may conflict to the recent law and policy formulated by the government. • NAA, NCHADS, NCMH, and CSO play an important role in advocatingtobuild better enabling environments for HIV and AIDS program implementation. For example, working to resolve the conflict in the laws relating to HIV and AIDS. • The implementation of the PCPI has starting to build better working environment at the community level by bringing all relevant key players including the local authority, police, health care worker, PLHIV and MARP to discuss on any obstacle and find out the solution. • CSO has also put significant effort into improving non-discrimination of HIV and AIDS at grass roots level. For example, CPN+ and AUAare working with the health sector to create environments for treatment and services that are free from discrimination.

What challenges remain in this area:: • Most of law enforcersare still not clear onfew articles of law relating to the suppression of anti-human trafficking and sexual exploitation (SAHTSE) and commune/village safety policy that lead to miss interpretation and implementation which resulting contradicting with the HIV program implementation. For example; there are only 26% of EEs and hotspots where MARPs gather have condom available on site (GIS mapping of MARPs in 2013), this is because EE owner fear arrest or fine. • The dissemination of law is not widely conducted in national and sub-national levels.This means that the laws are implemented and interpreted by police and local authority only. • In the 2012 PCPI baseline survey conducted by FHI 360 mentioned that nearly 94% of police participants believed arresting and detaining MARPs was an appropriate solution for reducing HIV and AIDS as well as drug use. Additionally, a high proportion of police participants believed that MARPs should be arrested for using drugs (97%), selling sex (88%) and carrying needles and syringes (55%). • Human rights related HIV violation still a huge concern among MARPs in recent year. In In the 2012 PCPI baseline survey conducted by FHI 360 shown that nearly one-fifth (17%) of MARP participants reported having been arrested and 70% of police participants reported having arrested a most-at-risk individual in the past year. PWUD participants had significantly higher rates of self-reported arrests than the other population of interest. • Some private sector company especially bank and micro-finance institution do not fully respect or implement the law related HIV and they not allow PLHIV to be employed in their firm (CPN+ and PLHIV)

B.IV Prevention

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

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

IF YES, what are these specific needs? : -Capacity of Most-at Risk Population (MARPs) network and young people; -Harm reduction programmes through community health-based Methadone maintenance therapy; -Fostering the implementation of Police Community Partnership Initiative (PCPI);

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Strongly agree

Condom promotion: Agree

Harm reduction for people who inject drugs: Agree

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Disagree

IEC on stigma and discrimination reduction: Strongly disagree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Strongly agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: Agree

Risk reduction for sex workers: Agree

School-based HIV education for young people: Agree

Universal precautions in health care settings: Agree

Other [write in]::

: N/A

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: • Conceptual Framework for Elimination of New HIV infections in Cambodia by 2020 • Boosted CoPCTSoP • Finger prick testing has been implemented by lay counselors (outreach workers) of MARPs • Comprehensive GIS mapping of most at risk population hotspot • Sharpening the Boosted response for population at highest risk • Treatment As Prevention • The unique identifier code (UIC) among most at risk population (MARPs) is being designed in late 2013 and will implement in early 2014 to avoid double counting and track all information service delivery with protecting the confidentiality • 100% Condom Use Program (CUP100%) has been reactivated and reinforced in 2013 • Brand program (smart girl, Mstyle, TG package) – TG package launching on March 2014 at Siem Reap province • Garment Manufacturers Association in Cambodia (GMAC) and Cambodia Federation Employers and Business Association (CAMFEBA) in the response to HIV AIDS in the workplace that help not only to reduce stigma and discrimination toward workers LWH in the workplace, but also to promote behavior change in preventing HIV in the workplace.

What challenges remain in this area:: • The financial support is decreasing for HIV and AIDS programs in Cambodia and as a result there are some NGOs(KWCD, KDFO, CUD and others) working on HIV that areclose to, or beginning to, change their target areas to those other than HIV and AIDS. • Misinterpretation and enforcement of HIV relatedlaw and policyis still a challenge for HIV program; as in the GIS mapping of MARPs finding shown that there is only 26% of entertainment establishment (EE) where condom is available on-site and there is 5% of EW hotspot were not cover by NGOs. • There is an increasing duplication risk of MARPs while most of them are mobile • Lack of IEC materials and condom distribution • Difficult to reach MARP for prevention program because they often move from place to place and hidden as well, • Most of beneficiaries are mobilized from place to place for income generating • Behavior changes of MARPs are slightly increased for accessing to health care services. They still rely heavy on NGO support

B.V Treatment, care and support

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

IF YES, Briefly identify the elements and what has been prioritized:: • Clear national standard and guideline such as Boosted Link Response, Boosted CoC, and Treatment as Prevention; • Pre ART/ART; • Clear linkage from community to health facility (Referral System); • MMM and home and community based care; • Social and child protection; • Continues Quality Control (CQI); • TB – HIV and HIV – TB program;

Briefly identify how HIV treatment, care and support services are being scaled-up?: • Increased number of Pre ART/ART site enables PLHIV to access those services; • More than 90% of eligible PLHIV received ART; • Clear linkage and referral system from community to health facility (HBC, MMM, CoC, Health Facility)

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

The majority of people in need have access to…:

Antiretroviral therapy: Agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Strongly agree

HIV care and support in the workplace (including alternative working arrangements): Disagree

HIV testing and counselling for people with TB: Strongly agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Strongly disagree

Nutritional care: Agree

Paediatric AIDS treatment: Agree

Post-delivery ART provision to women: Strongly agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Strongly disagree

Post-exposure prophylaxis for occupational exposures to HIV: Agree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Strongly agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Strongly agree

TB screening for people living with HIV: Strongly agree

Treatment of common HIV-related infections: Strongly agree

Other [write in]::

: N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 6

Since 2011, what have been key achievements in this area:: • More than 90% of eligible PLHIV accesses to ART; • Clear national standard and guideline such as Boosted Link Response, Boosted CoC, and Treatment as Prevention; • Home based care nationwide; • Impact mitigation program has been carried out by the Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY).MoSVY has developed the national standard and guideline on package of support need to be provided to OVC including, education, health, economic, food & nutrition, psychosocial support, and other support (legal, shelter…) and has rolled out its implementation across nationwide. In addition, several NGOs such as World Vision, ICC, Save the Children, Plan International, and others, implement livelihoods, care and support programmes for PLHIV, MARPS and OVC households; • The treatment service for PLHIV isconsidered high both in terms of coverage and quality, but care and support services are still limited.

What challenges remain in this area:: • Stigma Index 2010 shows that even though most PLHIV currently are on treatment 23% do not have free and available access to ART (this relates to transportation cost); • Some specific HIV food and nutrition programmes (WFP) have stopped. PLHIV and OVC are in principle covered under broader social protection, livelihoods and school feeding programmes but this is not systematically monitored; • A review of HIV-sensitivity of social protection was conducted in 2013 but key recommendations to further improve HIV integration into existing or emerging social protection schemes and access to key services need to be implemented; • The WFP food support service is provided through a broader social protection mechanism since its project on food supply to PLHIV and OVC was over in late 2012; • The finding of the Expired ARV drug survey among 257 PLHIV in three different provinces of Cambodia include Battambang, BanteayMeanchey and Siem Reapin early 2013 shown that there is 13.3% of PLHIV on ART participants received expired ARV drug in the last quarter; and 8.5% received nearly expired ARV drugs – this is an anecdotal record reviewed by HACC not representative of the whole population living with HIV; • There is limited support in providingtransportation to access ARV treatment, in particular to poor PLHIV; • Patients are required to receive ARV for a short time, frequently, and this leads them to spend more money to access ARV treatment; • Lack of equipment to check viral-load leads to lost follow-up; • Quality care and treatment training needed to improveskillsof health care service providers; • There are some problem with planning and procurement of ARV and OI drugs. We must ensure that all those drugs are well planned prepared and procured to avoid any delay or expiry.

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

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

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

3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: • Over 90% of infected children received ARV treatment; • Impact mitigation program has been carried out MoSVY. MoSVY has developed the national standard and guideline on package of support need to be provided to OVC including, education, health, economic, food & nutrition, psychosocial support, and other support (legal, shelter…) and roll out its implementation across nation wide; • The treatment service for PLHIV is considered high both coverage and its quality yet care and support service still limited.

What challenges remain in this area:: • There is no longer a full package of food and nutrition support to OVC by the World Food Program since itsend in2012;but the WFP had integrate this support into the social protection component – the same support still in place but they change supporting model and most of NGO working on PLHIV and OVC had not familiar to the new supporting model that make them hard to access thatsupport. This is due to the lack of information from national to province level NGOs; • There is limited support of transportation to access ARV treatment among infected OVC; . • The economic support for those households with OVC needs to be scaled up by merging requirements for both financial and vocational skill; • Positive prevention among young adolescent on ART needed to be strengthened because they are at high risk.