



Cambodia Country Progress Report

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

**Reporting Period:
January 2010-December 2011**

**Prepared and submitted by
The National AIDS Authority**



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Foreword

I am pleased to present the 2010-2011 Country Progress Report on Cambodia's achievements toward its fulfilment of the Declaration of Commitment on HIV/AIDS adopted in June, 2011, during the 65th United Nations General Assembly Special Session on HIV/AIDS.


This is the fifth time that Cambodia is called to report their results on a number of indicators of progress, measured worldwide, alongside which Cambodia can proudly display her achievements in the areas of leading, managing and facilitating HIV prevention, care and treatment and impact mitigation.

This report is the product of extensive stakeholder input, led by the National AIDS Authority to involve all available partners, in a coordinated response to the national HIV/AIDS epidemic. Our invaluable consultants include government ministries and departments, development partners and civil society, alongside representatives of people living with HIV and people belonging to high-risk groups, all of whom deserve the recognition for their contributions to this document which is of the highest standard.

During this time of global financial austerity, the National AIDS Authority is aware that we need to learn to do more with less. At first glance, funding for the activities of fiscal year 2010 appear to have increased from 2009, but we know this apparent increase can be explained by a process of more judicious book-keeping – just one example of how the National AIDS Authority is building capacity within its ranks to become a world-class leader in the global response to HIV/AIDS.

We have achieved a great deal so far and have been presented with the MDG Award for our outstanding national leadership, commitment and progress towards meeting Goal 6 of MDG, aimed at halting and reversing the spread of HIV. However, we need to consolidate these achievements in order to reach the Three Zeros. For this purpose, we have to further enhance coordination and aligning of efforts and reaffirm our commitment. We need to work harder to improve our interventions and to find new creative ways to make a better, lasting impact for all those in need.

I am also proud to note that with each round of global reporting the data and analysis are strengthened, capacity is built, and information used more effectively to inform programming efforts and policy decisions.

In the future, be our coffers bursting or lean, I am confident that Cambodia will continue to manage its activities based on evidence and with commitment and competence. 



H.E. DR. NUTH SOKHOM
Senior Minister, Chairperson of NAA

Acknowledgements

The 2012 Country Progress Report was written by the National AIDS Authority (NAA) with supporting input from the national monitoring and evaluation system of the NAA and from the HIV/AIDS Coordinating Committee (HACC) and UNAIDS Country Office (CO) of Cambodia. The development of this report would not be possible without the gracious contributions of a broad array of stakeholders, including ministries and departments of the Royal Government of Cambodia; both national and international non-governmental organizations; bilateral and multilateral donor agencies; faith-based organizations and representatives from the private sector.

The NAA's Planning Monitoring Evaluation and Research department (PMERD), under the leadership of Secretary General H.E.Dr. Teng Kunthy was responsible for coordinating the data compilation and entry and for the reporting. Grateful acknowledgement is extended to Dr. Hor Bun Leng, Deputy Secretary General and Dr. Ngin Lina, Director of PMER, for their exceptional leadership in this important endeavour and to the members of the PMER department including Dr Sou Sophy, Mrs. Sovann Vitou, Mr. Poch Vuthea, Ms. Siek Sopheak, Dr. Seng Sut Wantha, Dr. Thong Dalina and Dr. Lim Kalay for all of their hard efforts.

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

Assistance with the preparation of this report that was provided by Tony Lisle, Savina Ammassari, Jessica Reidies and Kathy Keary from the UNAIDS Cambodia CO is gratefully acknowledged.

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This 2012 GARP report was developed with financial support by the Global Fund is also very gratefully acknowledged.



H.E Teng Kunthy
Secretary General

Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome.
ANC	Ante-natal Care
ART	Antiretroviral Therapy
ARV	Anti-retroviral
BSS	Behavioural Surveillance Survey
CamInfo	Cambodia's socio-economic database system
CBCA	Cambodian Business Coalition on HIV/AIDS
CDC	Centre for Disease Control
CCC	Country Coordinating Committee
CCWC	Commune Council for Women and Children
CDHS	Cambodia Demographic and Health Survey
CEA	Cost Effectiveness Analysis
CENAT	National Centre for Tuberculosis and Leprosy Control.
CoC	Continuum of Care
CoPCT	Continuum of Prevention to Care and Treatment
CPN+	Cambodian Network of People Living with HIV/AIDS
CQI	Continued Quality Improvement
CSO	Civil Society Organisation
DU	Drug User
EW	Entertainment Workers
FHI	Family Health International
GARPR	Global Access Response Progress Report
GF	Global Fund
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HACC	HIV/AIDS Coordinating committee
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug User
KHANA	Khmer HIV/AIDS NGO Alliance
M&E SS	Monitoring and Evaluation System Strengthening
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MDG	Millennium Development Goal
MER	Monitoring, Evaluation and Research
MoEYS	Ministry of Education Youth and Sport
MoH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoWA	Ministry of Women's Affairs
MSM	Men who have Sex with Men
MSMO	Men who have Sex with Men Only
MSMW	Men who have Sex with Men and Women

NAA	National AIDS Authority
NASA III	National AIDS Spending Assessment, 2009-2010
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs.
NCPI	National Composite Policy Index
NGO	Non-Governmental Organisation
NMCHC	National Maternal and Child Health Centre
NSP II	National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS, 2006-2010
NSP III	National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS, 2011-2015
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMER	Planning, Monitoring, Evaluation and Research.
PMTCT	Prevention of Mother-to-Child Transmission
PR	Primary Recipient
PSI	Population Services International
PWID	People Who Inject Drugs
SOP	Standard Operating Procedures
SR	Sub-recipient
SRA	Situation Response Analysis
SSF	Single Stream Funding
SSS	Sentinel Surveillance Surveys
STI	Sexually Transmitted Infection
TB	Tuberculosis
TSP	Technical Support Plan
TWG	Technical Working Group
UA	Universal Access
UAI	Universal Access Indicators
UIC	Unique Identifier Code
UN JSP-OPB	UN Joint Support Programme Operational Plan and Budget
UN	United Nations
UNAIDS CO	Joint United Nations Programme on HIV/AIDS Country Office
UNDAF UN	Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNSG	United Nations Secretary General
VCCT	Voluntary Confidential Counselling and Testing

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I. Status at a Glance

A. The Inclusiveness of the Stakeholders in the Report Writing Process

The compilation of this report has involved contributions and cooperation from a broad spectrum of government ministries and secretariats, from different national and sub-national levels, in partnership with NGOs and CSOs, who work as part of the national response to HIV and AIDS in Cambodia. The preparation of this Global AIDS Progress Report (GAPR) was led by the National AIDS Authority (NAA) with assistance and support provided by the HIV/AIDS Coordinating Committee (HACC) and the UNAIDS Cambodian Country Office (UNAIDS CO). In addition, all stakeholders were invited to participate in the reporting process including government institutions, civil society organizations and bilateral and multilateral agencies. A concept note was produced to inform all stakeholders of the process and their role in it.

As in previous years the reporting process includes three main elements: a narrative report, a National Funding Matrix and a National Composite Policy Index (NCPI). The reporting process includes the submission of a comprehensive report and online submission of data on the GAPR indicators as before, but this year data is also required on the Universal Access (UA) indicators that in previous years would have been submitted separately. The report is submitted to the UNAIDS headquarters via the online reporting tool.¹

The data included in this report was gathered from a number of sources including: routine monitoring systems, sentinel surveillance surveys, the Cambodia Health Demography Survey (CDHS), and specific studies. Several institutions were involved in providing the data including all Ministries and Secretariats who are members of the NAA, specifically, the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), the National Maternal and Child Health Centre (NMCHC), the National Centre for Tuberculosis and Leprosy Control (CENAT) and the Ministry of Womens Affairs (MOWA).

The information for AIDS spending was gathered through National AIDS Spending Assessments (NASA). The NCPI acquired information through questionnaires administered to government officials and representatives from non-governmental organizations (NGOs), bilateral agencies and multilateral organizations.

A number of different meetings were organized at both national and sub-national levels in order to compile the NCPI. A wide range of stakeholders were involved in the process, including government institutions, civil society organizations, representatives of people living with HIV (PLHIV) and most-at-risk populations (MARPs) networks, in addition to development partners including the United Nations (UN).

¹ www.aidsreportingtool.unaids.org

During a national level consultation meeting, Part A of the NCPI was compiled with information gathered from officials from government ministries and departments. Part B was filled through consultation workshops held at the regional and national level with CSOs, to ensure their perspectives and views were adequately represented. It was finalised by CSOs in collaboration with bilateral and multilateral agencies at a national consultative meeting.

When the report was completed it was circulated to stakeholders so that they could make comments and recommendations before the final submission date. The data was vetted at a national validation meeting involving all relevant stakeholders. It presents trends in the epidemic and progress in the national response and is used as a platform for discussions about achievements so far and future challenges and actions.

B. Status of the Epidemic

During the reporting period a large amount of new data became available. A Biological Sentinel Survey (BSS²) and a HIV Sentinel Survey (HSS)³ were both carried out in 2010 focusing on entertainment workers (EW), moto-taxi drivers and people who are living with HIV (PLHIV). In addition, a new Cambodia Demographic and Health Survey (CDHS) was conducted as well as the Bros Khmer Study⁴ which gathered data on high risk urban men including men who have sex with men (MSM).

In 2011, NCHADS developed new estimations and projections of HIV/AIDS in Cambodia for the years 2010-2015 including on the modes of transmission of HIV. However, at the time of reporting these figures have not yet officially been endorsed and so cannot be included in this report. The older estimates, from 2007, show that the prevalence of HIV in the general population (aged 15-49) will have dropped to 0.6 percent in 2011, from 0.9 percent in 2006.⁵ The prevalence is expected to continue to decline, although the rate of decline has been slowing down. These projections are based on the assumption that current interventions will continue and treatment will continue to be provided to all who need it.

The vast majority of the individuals infected with HIV remain concentrated within a number of sub-groups of the overall population. EW, MSM, transgender people (TG) and injecting drug users (IDU) have all been identified as the most at risk sections of the population, where infection is most widespread. Because of their level of risk, prevention programmes have been specifically targeted at these sections of the population.

² NCHADS (2011) Behavioural Sentinel Surveillance 2010.

³ NCHADS (2011) HIV Sentinel Surveillance 2010.

⁴ Liu, K. L. and Chhorvann, C. (2011) Bros Khmer 2010: Behavioural Risks On-Site Serosurvey among At-Risk Men in Cambodia.

⁵ MoH, NCHADS (June 2007) Estimations and Projections of HIV/AIDS in Cambodia 2006-2012

There are a number of global reporting indicators that have been altered since the last report, following the adoption of the Political Declaration on HIV/AIDS in June 2011 at the UN General Assembly. Indicators dealing with blood safety, knowledge about HIV and AIDS among the general population, and coverage of IDU prevention were dropped and three new indicators were added. They cover the number of syringes distributed per person who injects drugs per year by needle and syringe programmes (indicator 2.1), the percentage of infants born to HIV-positive women receiving virological test for HIV within two months of birth (indicator 3.2), and the proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months (indicator 7.2).

C. Policy and Programmatic Response

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 Samdech Hun Sen, Prime Minister of Cambodia and the First Lady Lok Chumtiev Bun Rany Hun Sen, Chair of the Cambodia Red Cross.

In addition to high level leaders there are many more government agencies, civil society organisations and community networks collaborating with each other to develop comprehensive HIV/AIDS policies for the country and implement programmes that have real, lasting positive consequences for the people most at risk of HIV infection and those living with infection.

During the last two years many developments have been seen in terms of policy, new policies have been drafted and old ones revised to ensure their relevance and to better reflect the current situation. For example, standard operational procedures (SOPs) have been introduced for the Continuum of Prevention to Care and Treatment (CoPCT) for MSM and TG, and HIV and TB in Prisons and the SOP is currently being developed for DU/IDU. However, some laws and policies have in practice served to hamper and counteract some of the progress that had previously been made in terms of HIV prevention and of care and treatment. For example, the Law on Drug Control, which has been revised, and the Village/Commune Safety Policy which was newly introduced have served to make people who use drugs increasingly more difficult to access and have made service provision for their benefit very difficult due to misunderstanding of law enforcement officers, especially at the commune level.

After reaching the targets for 2008 and 2010, a set of new Universal Access (UA) indicators were selected and targets for 2013 and 2015 were produced. A new National Strategic Plan (NSP III) was drawn up to cover the years 2011-2015, building on the two plans that preceded it. In addition, a new cost-effectiveness analyses and revised costing report was drafted to assess economic efficiency of different programme interventions and whether there is space for improvement. It is still generally recognised that if the country is going to continue to make progress in the reduction

of HIV prevalence, populations that are most at risk must be specifically targeted and programmes that can make the most difference for these people, in terms of preventing new infections, must be strengthened. The establishment of the MARPS Community Partnership Initiative (MCPI) strives to create a more supportive and enabling environment for key populations who are identified as being most at risk.

It must be acknowledged that civil society plays a critical role in policy formation and service provision in the country. Government agencies and departments are increasingly including CSOs in their work and incorporating them into their working groups and policy formation meetings. Improvement in the CSOs ability to influence government policy and practices can only be seen as a positive development. However, CSOs have also registered their belief that while they are present at these meetings, they are not really active participants.⁶ Changes must be made to ensure that all stakeholders feel that their participation in the exercise of policy review and development is capable and appreciated.

The availability of quality data and information has also improved in the two years covered by this report. New HIV estimations and projections were produced in 2011, covering the period up until 2015, and were due for release in early 2012. The NAA also carried out a new Situation Response Analysis (SRA) which was released in 2010 and informed the formulation of the NSP III. The NSP III was compiled with input and assistance from a wide range of stakeholders, including government agencies and departments, CSOs and community networks and development partners.

D. Overview of GARP Indicator Data

During the biennial period covered by this report a number of important studies and surveillance projects were carried out and a large amount of new data has become available. This data is derived from sources such as the new HSS and BSS, in addition to the new CDHS⁷ and studies such as the Bros Khmer Study. Routine surveillance data from health centres and service providers is also included where it was available.

No new data became available for HIV and people who use drugs and as a result the information used in this report comes from the 2007 Prevalence Study among Drug Users.

The status of all the indicators and their data is summarised below:

- NASA III⁸ (indicator 6.1) covers the years 2009-2010. A summary of the findings of this report are included in section six of this report and the funding matrices are included in Annex 3.

⁶ See the NCPI Part B in Annex II of this report.

⁷ NIS (2010) Cambodia Demographic and Health Survey.

⁸ NAA (2011) National AIDS Spending Assessment for 2009/2010 (NASA III)

- The final result of the NCPI, Part A and Part B (indicator 7.1) are included in Annex 2 of this report.
- 15 indicators were reported in full (1.1, 1.2, 1.3, 1.4, 1.5, 1.11, 1.12, 1.13, 1.14, 2.1, 3.1, 3.2, 6.1, 7.1, 7.3).
- Other indicators are could only be partially reported on because the necessary disaggregation of the data was not always available (1.10, 2.2, 2.3, 2.4, 2.5, 4.1, 4.2, 5.5, 7.4).
- A few indicators could not be reported on at all because of the lack of reliable data (1.6, 1.7, 1.8, 1.9, 3.3, 7.2).

Table 1: GARP Indicators at Glance

GARPR Indicators		Status			2011
Description		2008	2010	2011	Value
Target 1	Halve sexual transmission of HIV by 2015				
1.1	Young people: Knowledge about HIV prevention	Completed	Completed	Completed	45%
1.2	Sex before the age of 15	Completed	Completed	Completed	0.40%
1.3	Multiple sexual partnerships	Completed	Completed	Completed	0.80%
1.4	Condom use at last sex among people with multiple sexual partnerships	Completed	Completed	Completed	40.90%
1.5	HIV testing in the general population	Completed	Completed	Completed	7.1%
1.6	HIV prevalence in young people	N/A	N/A	No Data	X
1.7	Sex workers: Prevention programmes	No Data	No Data	No Data	X
1.8	Sex workers: condom use	Partially Completed	Partially Completed	No Data	X
1.9	HIV testing in sex workers	Partially Completed	Partially Completed	No Data	X
1.10.	HIV prevalence in sex workers (Female only)	Partially Completed	Partially Completed	Partially Completed	13.90%
1.11	Men who have sex with men: prevention programmes	No Data	No Data	Completed	69.50%
1.12	Men who have sex with men: condom use	Completed	Completed	Completed	66.40%
1.13	HIV testing in men who have sex with men	Partially Completed	Partially Completed	Completed	34%
1.14	HIV prevalence in men who have sex with men	Completed	Completed	Completed	2.10%
Target 2	Reduce transmission of HIV among people who inject drugs by 50% by 2015				
2.1	People who inject drugs: prevention programmes (No. of Syringes distributed per PWID per year by NSP)	No Data	Partially Completed	Completed	120.2

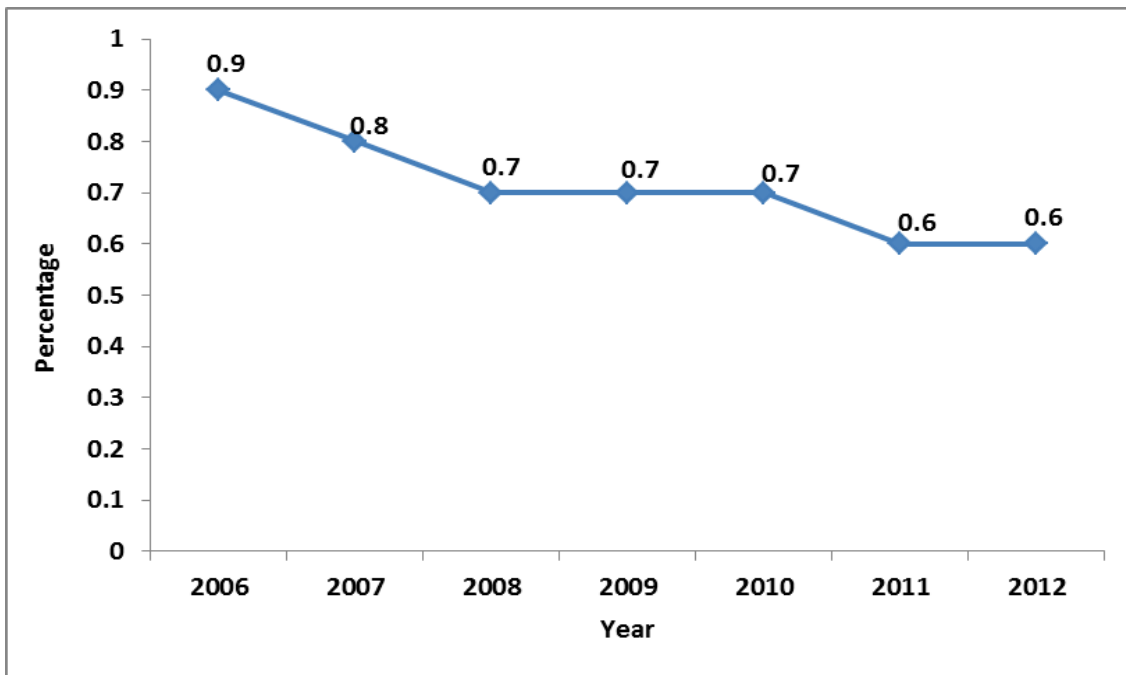
2.2	People who inject drugs: condom use	No Data	No Data	Partially Completed	81.30%
2.3	People who inject drugs: safe injecting practices	No Data	No Data	Partially Completed	62.20%
2.4	HIV testing in people who inject drugs	No Data	Partially Completed	Partially Completed	35.30%
2.5	HIV prevalence in people who inject drugs	No Data	Partially Completed	Partially Completed	24.10%
Target 3	Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
3.1	Prevention of mother-to-child transmission	Completed	Completed	Completed	63.50%
3.2	Early infant diagnosis	N/A	N/A	Completed	61%
3.3	Mother-to-child transmission of HIV (modeled)	No Data	No Data	No Data	X
Target 4	Have 15 million people living with HIV on antiretroviral treatment by 2015				
4.1	HIV treatment: antiretroviral therapy	Partially Completed	Partially Completed	Partially Completed	89.50%
4.2	Twelve month retention on antiretroviral therapy	No Data	Partially Completed	Partially Completed	92.60%
Target 5	Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015				
5.1	Co-management of tuberculosis and HIV treatment	No Data	Partially Completed	Partially Completed	32.70%
Target 6	Reach a significant level of annual global expenditure (between \$22 billion and \$24 billion) in low- and middle-income countries				
6.1	AIDS spending	Completed	Completed	Completed	
Target 7	Critical enablers and synergies with development sectors				
7.1	Government HIV and AIDS policies (NCPI)	Completed	Completed	Completed	
7.2	Prevalence of recent intimate partner violence	N/A	N/A	No Data	X
7.3	Orphan school attendance. Part A: Orphans Part B: Non-orphans	Completed	Completed	Completed	69.70%
7.4	External economic support to the poorest households	N/A	N/A	Partially Completed	27.20%

II. Overview of the AIDS Epidemic

A. HIV Prevalence in the General Population

According to the NCHADS report on Estimations and Projections of HIV/AIDS in Cambodia 2006-2012, the HIV prevalence among the general population in 2011, age 15-49 years, is calculated at 0.6 percent down from 0.9 percent in 2006⁹. This figure is expected to continue to decline, albeit at a slower rate.

Figure 1: The trend of HIV prevalence among the general population aged 15-49, 2006-2012



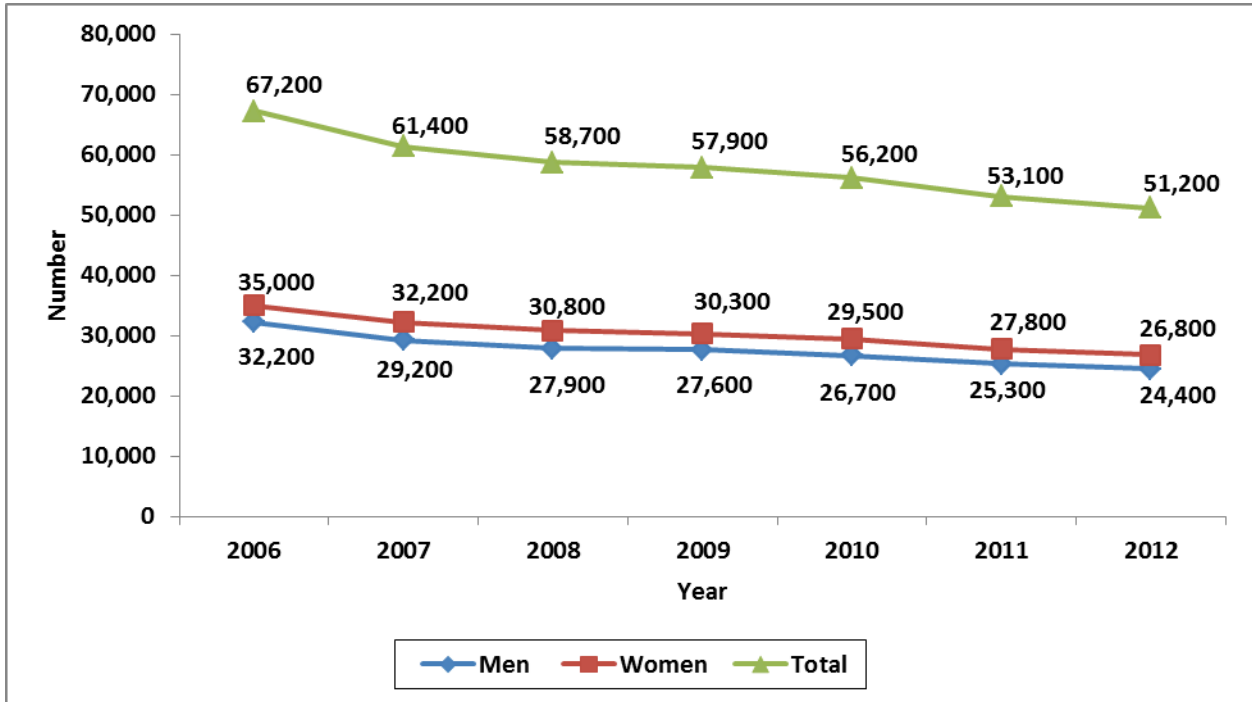
Source: Estimations and Projections of HIV/AIDS in Cambodia 2006-2012, Ministry of Health, National Centre for HIV/AIDS Dermatology and STD, June 2007.

The continued decline in the number of PLHIV can be ascribed to decreasing numbers of new infections, in conjunction with increasing ART coverage, which reduces the infectiousness of individuals infected with HIV, and the success of targeted HIV prevention activities. Increased ART coverage has resulted in lowering the mortality rate of HIV infected individuals and as a result the rate of decline is slowing down.

⁹

In numerical terms it was estimated that there were 53,100 people (aged 15+) living with HIV in 2011. 52 percent, or 27,800, of these individuals are estimated to be female; this rate has not changed significantly since 2006.

Figure 2: The trend of number of individuals living with HIV aged 15+ HIV, by sex, 2006-2012



Source: Estimations and Projections of HIV/AIDS in Cambodia 2016-2012, Ministry of Health, National Centre for HIV/AIDS Dermatology and STD, June 2007.

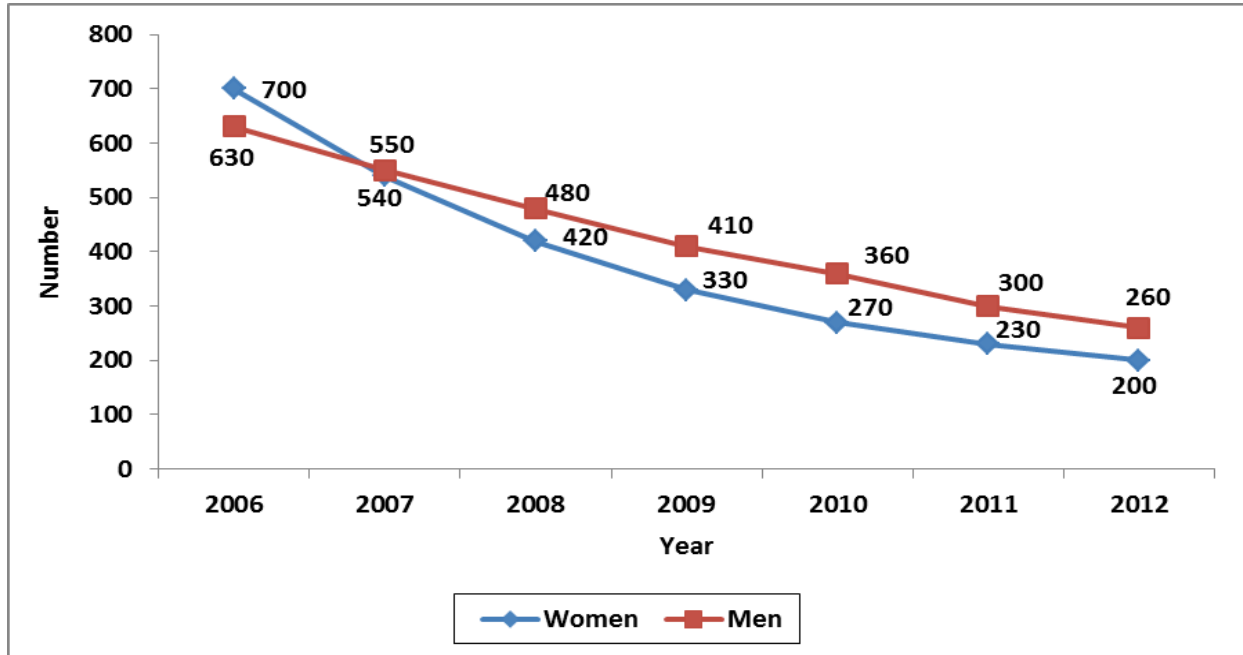
In looking at the modes of transmission, heterosexual sex remains the primary way in which HIV infections occur, this includes sex work and transmission between spouses. In addition needle sharing among people who inject drugs (PWID) should also be noted as a main route of HIV infection.

B. HIV Incidence in the General Population

The falling HIV prevalence in the population is due in part to the decreasing number of new HIV infections. It can be taken from figure 3 below that until 2007 the number of females newly infected was surpassing the number of newly infected men, this has since turned around. In 2011, 43 percent of new infections were women and this rate is expected to continue to decrease gradually.

In numerical terms, of the 530 new infections expected in the general population (aged 15-49) in 2011, 230 of these were estimated to be female.

Figure 3: The trend of number of individuals newly infected with HIV aged 15-49, by sex, 2006-2012

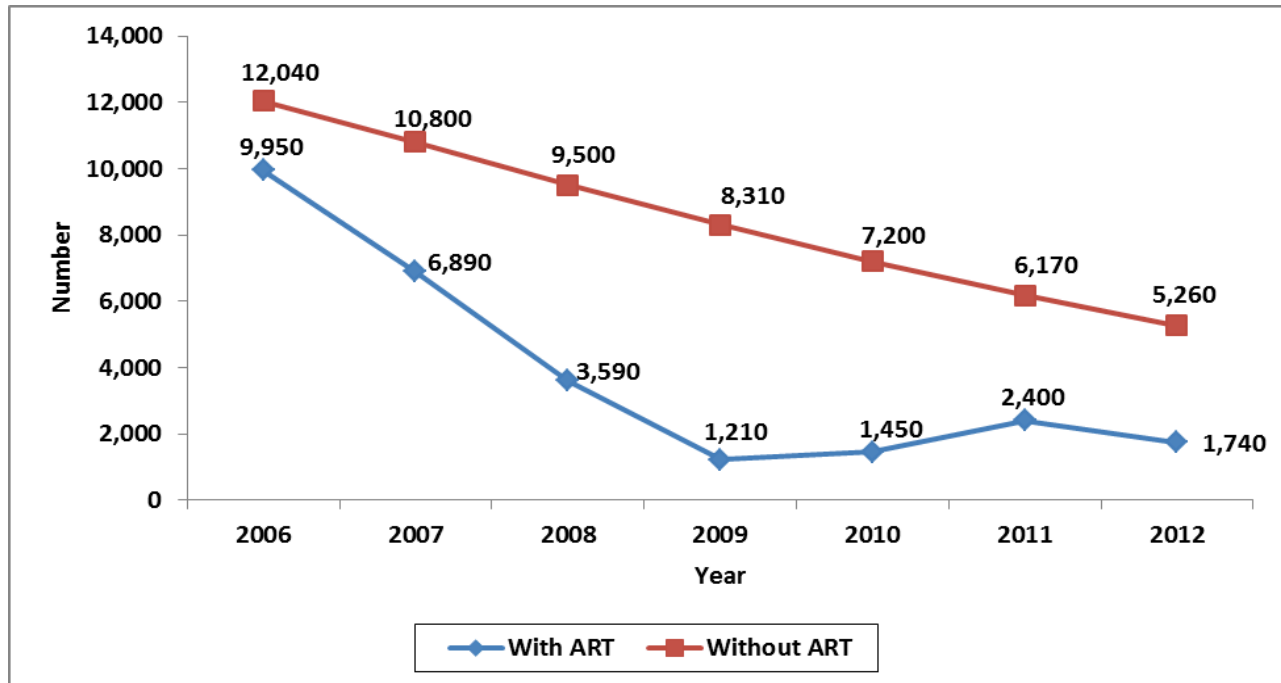


Source: Estimations and Projections of HIV/AIDS in Cambodia 2016-2012, Ministry of Health, National Centre for HIV/AIDS Dermatology and STD, June 2007.

C. AIDS related Mortality in the General Population

As pointed out in figure 4, the number of AIDS related deaths in the general population (aged 15+), in 2011, with ART available, was estimated at 2,400. This figure is down from 9,950 in 2006, a drop of almost 75 percent. This dramatic decline can be attributed to the continuing decline in the number of new infections each year and increasing numbers of people who are in need of ART accessing services. As the graph shows, the availability of ART has a significant impact on the number of AIDS related deaths over a period of time. It was estimated that in 2010 and 2011 alone, 9,520 fewer people would die because of the widespread availability of ART.

Figure 4: The trend of number of AIDS deaths among the adult population aged 15+, with and without availability of ART, 2006-2012



Source: *Estimations and Projections of HIV/AIDS in Cambodia 2006-2012*, Ministry of Health, National Centre for HIV/AIDS Dermatology and STD, June 2007.

III. National Response to the AIDS Epidemic

Target 1: Halve sexual transmission of HIV by 2015

1.1. Young people: knowledge about HIV prevention

Young people's knowledge has not improved much in the past five years. Indicator 1.1 measures knowledge of HIV transmission among young people by asking them questions about common misconceptions. Data collected on this indicator demonstrates that less than half of respondents (45.1 percent) were able to correctly answer all five questions, which was a slight decrease from 2005 (47.6 percent). Older age cohorts across sexes were more likely to answer correctly than younger cohorts (47.9 percent vs. 42.8) and women in both age groups were slightly more likely to answer questions correctly than men (46.2 percent vs. 43.7 percent).

The question most likely to be answered correctly by all respondents was Question 5 ("Can a person get HIV by sharing food with someone who is infected?") with a 90.9 percent correct response rate. This rate for all respondents is a 1.2 percent increase from the 2005 data. In addition to Question 5, between 2005 and 2010 rates of aggregated correct answers rose for Question 1 ("Can the risk of HIV transmission be reduced by having sex with only one uninfected and faithful partner?") from 88.1 percent to 88.3 percent and Question 4 ("Can a person get HIV from mosquito bites?") from 72.4 percent to 74.8 percent.

The question most likely to be answered correctly in 2005, Question 2 ("Can a person reduce the risk of getting HIV by using a condom every time they have sex?") with 90.2 percent accuracy, fell to 84.1 percent accuracy in 2010. The question respondents were least likely to answer correctly was the same in 2005 and 2010: "Can a healthy-looking person have HIV?" with 66.1 percent correct in 2005 but only 63.4 percent in 2010. This data suggests that prevention programmes need considerable improvement to change knowledge and behaviour.

Table 2: The percentage of young people aged 15-24 years who correctly identify ways to prevent sexual transmission and reject major misconceptions about HIV transmission

Questions	All	Male			Female		
		All	15-19	20-24	All	15-19	20-24
Question 1: Can the risk of HIV transmission be reduced by having sex with only one uninfected and faithful partner?	88.3%	87.8%	86.5%	89.7%	88.7%	88.0%	89.7%
Question 2: Can a person reduce the risk of getting HIV by using a condom every time they have sex?	84.1%	84.3%	83.0%	86.0%	83.9%	84.4%	83.4%
Question 3: Can a healthy-looking person have HIV?	63.4%	59.8%	57.8%	62.4%	66.9%	66.2%	67.8%
Question 4: Can a person get HIV from mosquito bites?	74.8%	75.4%	73.0%	78.6%	74.2%	72.3%	76.4%
Question 5: Can a person get HIV by sharing food with someone who is infected?	90.9%	91.2%	88.8%	94.4%	90.6%	88.9%	92.7%
Correctly answered all five questions	45.1%	43.7%	41.0%	47.6%	46.2%	44.6%	48.2%

Source: Cambodia Demographic and Health Survey 2010

1.2. Sex before the age of 15

In 2005, 0.6 percent of total respondents indicated sexual activity prior to age 15 whereas that figure fell to 0.4 percent in 2010. Also in 2010, 9 percent of respondents reported engaging in sexual intercourse prior to age 18 compared to 19 percent in 2005.¹⁰ This decreasing trend in early sexual activity, surveyors caution, may be due to an underreporting of sexual activity, especially among women.

Women were more likely than men to begin early sexual activity (< age 15: 0.6 percent vs. 0.1 percent, < age 18: 13.7 percent vs. 3.8 percent), though age 15 figures for both women and men have fallen since 2005 when data reported 0.9 percent of women and 0.3 percent of men. In support of the 2005 data, results from the 2010 survey show that more women aged 20-24

¹⁰ In countries where sexual activity prior to age 15 is very low, such as Cambodia, protocol allows for the question to be asked for sex prior to age 18. The CDHS surveys from 2010 have data available for both age benchmarks.

reported early sexual activity than women aged 15-19 (0.8 percent vs. 0.4 percent), however, the figures for men remained the same for both age cohorts (0.1 percent).¹¹

1.3. Multiple sexual partnerships

Indicator 1.3 measures the prevalence of having multiple sex partners in the previous 12 months for men and women aged 15-49. The 2010 figure is 0.8 percent for all respondents, a drop of 2.2 percent from 2005. Men were much more likely to report having multiple sex partners than women (1.6 percent vs. 0.1 percent) but this may be due to underreporting, particularly among women.

These figures would suggest a dramatic decrease in the prevalence of multiple sexual partnerships among men since 2005, when the reported prevalence was 6 percent. Prevalence among women also dropped, though not as precipitously, from 0.2 percent.

Slightly different trends are visible in the 2010 data when disaggregated by sex: women in the first two age cohorts (15-19 and 20-24) were equally likely to engage in multiple sexual partnerships (0.1 percent) while the prevalence among women over 24 fell to 0 percent. Alternatively, the results suggest a positive correlation between age and incidence of multiple sexual partnerships for male respondents: 0.3 percent among men 15-19, 1.1 percent among men 20-24, and 2.1 percent among men 25-49.

1.4. Condom use at last sex among people with multiple sexual partnerships

Indicator 1.4 is a continuation of Indicator 1.3, which probes condom use among adults, aged 15-49, who reported having more than one sexual partner in the previous 12 months. Of the survey respondents who indicated having multiple sexual partnerships in the past year, 40.6 percent of them reported using a condom at the time of last intercourse. This figure is a slight increase from the 2005 CDHS data of 39.9 percent.

Women were almost twice as likely (80 percent) to report having used a condom at last intercourse as men (39.4 percent). But when considering the implications of the data disaggregated by sex, the reader should be aware that the true prevalence is likely considerably skewed since women made up only 4 percent of the sample for this question, due to suspected underreporting. Younger age cohorts among both gender groups were more likely to report condom use than older cohorts (see Table 2), a trend consistent from 2005 among men only.

¹¹ For indicators 1.2, 1.3 and 1.4 that are measured with data from CDHS it should be noted that the process of data collection was complicated by the fact that eligible women were interviewed from every household surveyed, but eligible men were only interviewed at every second household. Therefore, in the interest of data consistency, only the data collected from homes where both sexes were interviewed was used to calculate these statistics.

Reported condom use was particularly robust among both male and female respondents, aged 15-19, with both cohorts reporting 100 percent prevalence – a rise from 85.7 percent in 2005 among men and 0 percent among women.

Table 3: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months reporting the use of a condom

All	Male				Female			
	All	15-19	20-24	25-49	All	15-19	20-24	25-49
40.6%	39.4%	100%	75%	31.3%	80%	100%	100%	50%

Source: Cambodia Demographic and Health Survey 2010

1.5. HIV testing among the general population

Indicator 1.5 measures the number of men and women in the general population who have taken an HIV test and returned for their results. Results from the 2010 CDHS survey suggest that 7.1 percent of survey respondents reported having taken an HIV test and received the results. This statistic is a 3.0 percent increase from 2005.

Disaggregated by sex, women were more likely than men to know their HIV status; male respondents indicated a prevalence of 6.1 percent (a rise from 5.1 percent in 2005) and female respondents 8.0 percent, which is a robust improvement from the 2005 prevalence of 3.2 percent.

For both sexes, young people aged 20-24 were more likely to have taken an HIV test and received the result than younger or older age cohorts, which is consistent with data trends in 2005. People aged 25-49 were also much more likely than people aged 15-19 to know their HIV status (7.4 percent vs. 2.7 percent). Overall, the group most likely to report having taken an HIV test and know the result is women, aged 20-24 with 13.3 percent prevalence (5.4 percent in 2005). The group least likely to report having taken an HIV test and know the result is men, aged 15-19 with 1.8 percent prevalence (1.3 percent in 2005). These findings are interesting considering the promotion of early testing and treatment is an important priority.

1.6. HIV prevalence among young people

Indicator 1.6 measures HIV prevalence among people aged 15-24, using routine monitoring data from antenatal care (ANC) clinics. HSS 2010 found HIV prevalence among this population was 0.2 percent, a fall from 0.4 percent ANC prevalence found by the HSS 2006.

1.7. Entertainment workers: Prevention programmes

Indicator 1.7 measures the number of sex workers who reported affirmatively when asked if they knew where they would go to receive an HIV test and if they had ever been given condoms in the last 12 months.¹² 81.5 percent of entertainment workers with an average of more than 14 sexual clients per week answered “yes” to both questions, while only 68.8 percent of entertainment workers with an average of 14 or fewer clients per week answered “yes” to both questions.¹³ The 2010 BSS was the first instrument that asked these specific questions and thus no comparative data is available.

1.8. Entertainment workers: condom use

Indicator 1.8 measures condom use, among male and female sex workers, during last transactional sex with a client. For female entertainment workers averaging more than 14 clients per week, reported rate of condom use was 88.7 percent, which, when compared to brothel-based direct sex workers surveyed in 2007, demonstrates a fall from 99.0 percent use. For entertainment workers having, on average, 14 or fewer clients per week, condom use at last sex was reported at 84.3 percent, which is also a decrease in since 2007 when reported rates of use were 94 percent among indirect sex workers. This data suggests that the efficacy of prevention programmes has diminished, perhaps due to a less enabling environment where people are reluctant to carry condoms because of fear of arrest or harassment.

1.9. HIV testing among entertainment workers

Indicator 1.9 tracks the number of male and female entertainment workers, who know their results of an HIV test taken over the past 12 months. Data reported is from 2010 BSS data on female EWs only and shows that 81.5 percent of respondents averaging more than 14 clients per week indicated having taken an HIV test in the past 12 months, and returned for their results. This figure is a robust increase from the 68.1 percent of direct female sex workers who replied yes to the question asked on this indicator in the 2007 BSS. Among entertainment workers averaging fewer than 14 clients per week, this figure is 63.7 percent; an increase of 11.9 percent since 2007 when 51.8 percent of indirect female sex workers responded affirmatively to this question.

¹² Since the last Country Progress Report, Cambodia passed legislation in 2008 banning the operation of brothels. In consequence, Cambodia’s direct sex trade has gone underground and commercial sex is now most easily available through indirect sex workers. Therefore, the BSS methodology has changed from previous surveys distinguishing between direct sex workers and indirect sex workers to only recognizing indirect sex workers - “entertainment workers” – and determining whether or not they are also selling sex by their reported average number of sexual partners per week. The group that is believed to most closely match that of those people who previously were called direct sex workers are entertainment workers with more than 14 clients per week.

¹³ Data for indicators 1.7 to 1.10 is available on females only and is taken from the BSS 2010.

1.10. HIV prevalence among entertainment workers

Indicator 1.10 measures HIV infection prevalence among entertainment workers. Data for this indicator is taken from the 2010 HSS, and is available on females only. 2010 rates of infection were 13.9 percent among entertainment workers averaging more than 14 clients per week, a reduction from 14.7 percent among the brothel-based direct sex workers surveyed in the 2006 HSS. Among entertainment workers with 14 or fewer clients per week, HIV prevalence was only 4.1 percent.

1.11. Men who have sex with men: prevention programmes

Indicator 1.11 measures the effectiveness of outreach programs targeting MSM, by asking MSM the following two questions:

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

Data for this indicator was taken from the 2010 Bros Khmer study. Of the 774 MSM surveyed, 538 or 69.5 percent answered “yes” to both questions; 79.8 percent answered “yes” to Question 1 and 81.4 percent answered “yes” to Question 2.

There was very little variation when the data was disaggregated by age cohort. MSM aged 24 and younger were slightly more likely than MSM aged 25 and older (70.7 percent vs. 67.7 percent) to answer “yes” to both questions, as well as report they had been given condoms (Question 2 only – 82.3 percent vs. 80 percent). MSM aged 25 and older were just 0.2 percent more likely than their younger cohort to report knowing where to go if they wished to receive an HIV test (Question 2 – 80 percent vs. 79.8 percent).

Comparison over time is not appropriate for this indicator since the previous Country Progress Report only reported on whether or not MSM had received HIV education in the previous six months with data from the 2007 BSS.

1.12. Men who have sex with men: condom use

Indicator 1.12 asked MSM whether or not they used a condom the last time they had anal sex with a male partner. Bros Khmer data from 2010 reports that 66.4 percent of MSM surveyed answered “yes” to this question, which is a precipitous drop from the 86.5 percent condom use rate reported by MSM in the 2007 BSS.

Among younger MSM (aged 24 and younger) the reported figure was 68.7 percent; 6.6 percent higher than older MSM (aged 25 and older) reporting only 62.1 percent. In 2007, younger MSM

were also more likely to report having used a condom at last anal sex than their older cohort, with a much higher prevalence but similar differential of 7 percent (88.7 percent vs. 81.7 percent).

1.13. HIV testing among men who have sex with men

Data from the 2010 Bros Khmer study shows that 34 percent of MSM surveyed received an HIV test in the last 12 months and know their results. This figure demonstrates a significant decline from the 2007 BSS when 58 percent of those surveyed had been tested in the last 12 months and received their results, in comparison with 20 percent in the 2005 SSS¹⁴. When disaggregated by age, 24 and younger and 25 and older, it emerges that the older MSM are more likely to have had a HIV test and acquired the results in the previous year (35.9 percent) than men in the younger age bracket.

1.14. HIV prevalence among men who have sex with men

Indicator 1.14 measures the prevalence of HIV among MSM, a sub-population at elevated risk of infection in Cambodia. 2010 Bros Khmer data suggests the rate of infection among all MSM as 2.1 percent – 2.1 percent among men who have sex with other men only (MSMO) and a slightly higher 2.2 percent among men who have sex with both men and women (MSMW). Disaggregated by age, there is a notable difference in HIV prevalence between MSM aged 24 and younger and MSM aged 25 and over. Prevalence among the younger cohort is 1.1 percent vs. 4.1 percent among older MSM.

Data reported on this indicator in the past, from the 2005 SSS, did not report on all MSM but disaggregated by three testing sites in Phnom Penh (8.7 percent), Siem Reap (0.8 percent) and Battambang (0.8 percent). 2010 Bros Khmer data suggests that among all MSM tested, respondents tested positive for HIV highest in Siem Reap at 4.9 percent prevalence – a notable rise since the 2005 SSS, - followed by a notable fall in Phnom Penh to 3.4 percent, the rate was tied at 1.2 percent in Serei Saophoan, Paoy Paet, and Kampong Cham and 0.9 percent in Kandal. The Bros Khmer study identified 0 percent HIV infection among MSM in both Preah Sihanouk and Battambang, the prevalence in the latter of which dropped from 0.8 percent.

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

2.1. People who inject drugs: prevention programmes

Indicator 2.1 is a new indicator for 2012 that has not previously been reported on. This indicator divides the number of syringes distributed by Needle and Syringe Programs (NSP) in the previous

¹⁴ NCHADS (2005) Cambodia STI Prevalence Sentinel Survey (SSS)

12 months by the total number of people who inject drugs (PWID) in Cambodia. In 2011, 228,362 clean needles and syringes were distributed to 375 individual PWID by two Cambodian civil society organizations: Mith Samlanh (223,400 needles and syringes) and KHANA (4,962 needles and syringes). The latest population size estimate of PWID is 1,900 from the 2007 NCHADS survey¹⁵, which would result in a national average of 120.2 sterile needles and syringes distributed per PWID, per year, or 0.3 sterile needles and syringes per PWID, per day.

2.2. People who inject drugs: condom use

Indicator 2.2 measures the proportion of PWID who used a condom during their last sexual intercourse. The most recent data on this indicator (2007 Prevalence Study among Drug Users) was also reported in the 2010 Country Progress Report – 81.3 percent of PWID reported using a condom at last sexual intercourse. Disaggregation by age and gender is not available for this indicator.

2.3. People who inject drugs: safe injecting practices

Indicator 2.3 measures safer drug-injecting practices by tracking how many PWID reported using sterile equipment at the last time of injection. There is no new data available on this indicator since the last Country Progress Report, which used data from the 2007 Prevalence Study among Drug Users. The study reported that 62 percent of respondents used clean needles and syringes, which includes both new and cleaned needles but not necessarily sterile ones.¹⁶ Further disaggregation by age and sex is not available for this indicator.

2.4. HIV testing among people who inject drugs

Indicator 2.4 measures HIV prevalence among PWID. There is no new data on this indicator since the 2007 results of the Drug User Prevalence Study. At that time 35.3 percent of PWID who responded to the survey had received an HIV test in the past 12 months and returned to learn the results. PWID aged less than 25 years were more likely to have tested for HIV and to have got results (36.3 percent) compared to PWID aged 25 and more years (33.8 percent). No sex disaggregated data is available for this indicator.

2.5. HIV prevalence among people who inject drugs

Indicator 2.5 measures HIV prevalence among PWID. The most recent data on this indicator (2007 Drug User Prevalence Survey) was also reported in the 2010 Country Progress Report – 24 percent of people who inject drugs are living with HIV. Disaggregation by gender and age is not available.

¹⁵ NCHADS (2007) HIV Prevalence Among Drug Users Study.

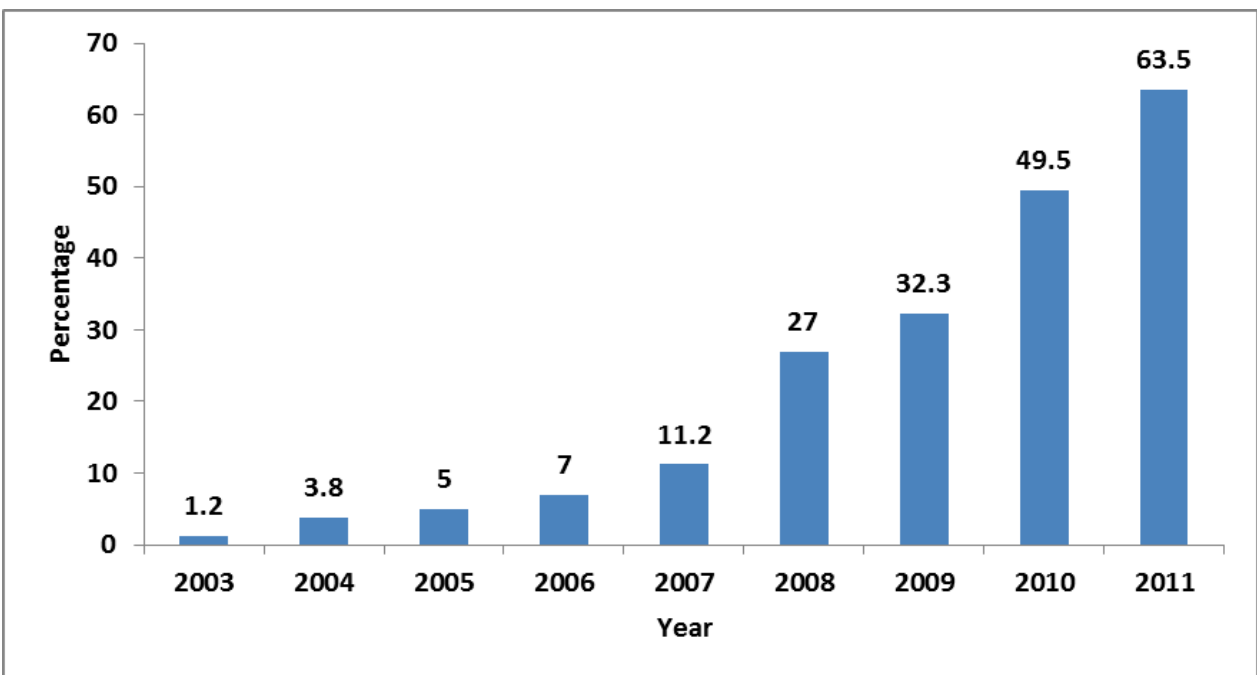
¹⁶ The question will need to be reformulated in the next survey to ensure this indicator can adequately be reported.

Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

3.1. Prevention of mother-to-child transmission

Indicator 3.1 measures how many HIV-positive pregnant women received antiretrovirals to reduce the risk of transmitting the virus to their child. Since last reporting, routine monitoring data from 2010 and 2011 has become available from the National Mother and Child Health Centre (NMCHC). In 2010, just under half (49.5 percent) of eligible women received antiretroviral (ARV) prophylaxis for prevention of mother to child transmission (PMTCT) and coverage increased to 63.5 percent in 2011, the peak of a nine-year trend in increasing coverage (see Figure 5).

Figure 5: HIV-positive pregnant women who received antiretrovirals



Source: NCHADS and NMCHC routine monitoring data.

3.2. Early infant diagnosis

Indicator 3.2 measures the degree to which the health sector recognizes new HIV cases among infants, by testing babies born to HIV-positive women within two months of their birth. In 2011, according to routine monitoring records, 61.1 percent of infants born to HIV-positive mothers received an HIV test within two months of birth, a notable increase from the 40 percent testing

rate reported for this indicator in 2010. Of the 249 newborns that met these criteria in 2011, 16 (6.4 percent) tested HIV-positive.

3.3. Mother-to-child transmission of HIV (modeled)

Indicator 3.3 provides an estimate of the number of infants born to HIV-positive mothers over the past 12 months who are, themselves, HIV-positive. New HIV estimates and projections were produced in 2011 but the results have not yet been officially released and therefore cannot be used to calculate this indicator.

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015

4.1. HIV treatment: antiretroviral therapy

Indicator 4.1 measures how many of Cambodia's adults and children eligible to receive ART, for advanced HIV infection, are receiving treatment. Estimates suggest the number of eligible people living with HIV in Cambodia to be 51,935.¹⁷ Data from an NCHADS quarterly report shows 46,473 people – 42,034 adults and 4,439 children under the age of 15 – are receiving ART; suggesting adequate ART coverage for 89.5 percent of the total eligible population.¹⁸ Children under the age of 15 were more likely than adults and adolescents age 15 and older to be receiving adequate coverage (94.4 percent vs. 89 percent). Further population data disaggregation by gender and age is not available.

4.2. Twelve month retention on antiretroviral therapy

Indicator 4.2 measures adherence to treatment among HIV-positive children and adults 12 months after beginning ART. According to routine monitoring records maintained by the National Centre for HIV/AIDS, Dermatology and STD, of the 3,666 people having begun ART during the 2010 reporting period, 92.6 percent (3,393) were still alive and adhering to treatment 12 months later in 2011. This statistic demonstrates a gain of 5.9 percent on the 86.7 percent figure in the previous Country Progress Report. In addition, data is available on this indicator for patients on ART for 24- and 60-month periods of 84.2 percent and 78 percent, respectively. Corresponding NCHADS data for comparison from the previous report is only available for the adherence period of 24 months, which shows a rate of adherence of 79 percent - 5.2 percent lower than figures from 2011.

For the most recent data, of the 273 non-adherent patients, 128 (46.9 percent) were lost to follow-up and 145 (53.1 percent) were known to be deceased. Data show that there were more female

¹⁷ In 2011 NCHADS produced new HIV estimates and projections and modes of transmission estimations. Because they are still awaiting official approval they could not be utilised in this reporting round. This is why HIV estimates of 2007 were used to calculate indicators 4.1 and 3.3.

¹⁸ NCHADS Quarterly Reports at www.nchads.org.

patients receiving ART than males (57.4 percent vs. 42.6 percent) but in terms of adherence to treatment, there was very little variation between the sexes (92.1 percent of men vs. 92.9 percent of women). Disaggregation by age (pediatric vs. adult) is not available for this reporting period.

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

5.1. Co-management of tuberculosis and HIV treatment

Indicator 5.1 measures the number of people co-infected with advanced HIV and tuberculosis (TB) who are receiving treatment for both conditions. Routine monitoring data provided by the National Center for Tuberculosis and Leprosy Control (CENAT) is available from 2011 and 2009. New data shows that nearly one-third (32.7 percent) of co-infected patients are receiving treatment for both HIV and TB, a strong rise from 4.8 percent in 2009. Stratified data on gender and age group is not available.

Target 6: Reach a significant level of annual global expenditure (between \$22 billion and \$24 billion) in low- and middle-income countries

6.1 AIDS spending

AIDS spending in Cambodia is monitored through the NASA, the third of which was carried out in 2011 and covers the years 2009 and 2010. The new data, in conjunction with the data from the two previous rounds of NASA, gave us a picture of what HIV/AIDS spending looked like in the country from 2006-2010, including details such as where the money is coming from, who is allocating it, who is spending it and what it is being spent on. New methodologies used in this round of NASA have greatly improved the quality of the information gathered. While on paper it seems that financing for HIV and AIDS is increasing (from US\$51,846,997 to US\$58,059,469 in 2010), in reality this rise is mostly attributable to improved monitoring techniques, as opposed to an actual increase in spending. NASA III also includes information concerning beneficiaries of the funds that was absent from previous rounds.

More detailed information on AIDS spending in Cambodia is available in section VI of this report and the funding matrices are contained in Annex 3.

Target 7: Critical enablers and synergies with development sectors

7.1. Government HIV and AIDS policies

The objective of the National Commitments and Policy Index (NCPI) is to measure the progress made in the implementation of national HIV/AIDS laws and policies. The NCPI is divided into two

different questionnaires, Part A which is administered to government officials and representatives of government agencies and Part B which is compiled by CSOs, bilateral organisations and UN agencies. Both parts of the NCPI were compiled during consultative meetings with the relevant stakeholders in the first few months of 2012. Part A was compiled at one meeting of government representatives in Phnom Penh, while Part B was compiled over the course of a number of different meetings, held in various locations around the country in an attempt to include as many stakeholders as possible.

The results of the NCPI are available in Annex 2, but in general the NCPI identifies examples of progress and good practice, highlights areas where further improvement is needed and overall provides a deeper understanding of the present situation in the country.

7.2. Prevalence of recent intimate partner violence

Indicator 7.2 measures the prevalence of physical or sexual violence against women from a male intimate partner, a factor that has been shown to be highly correlated with risk of HIV infection. The most recent data available for this new indicator comes from the 2005 CDHS¹⁹, which asked this question of women about their *husbands* only, which excludes women in other cohabiting relationships.

According to 2005 data, 63.9 percent of women aged 15-49 reported having experienced physical or sexual violence by their husbands in the 12 months leading up to the survey. The figures disaggregated by age suggest that the likelihood of being targeted for violence decreases with age.²⁰ Figures for women aged 15-19 are not available. Among women aged 20-29, 72.4 percent were the targets of violence, compared to 66.9 percent among women aged 30-39, and 53.1 percent among women aged 40-49.²¹

A more recent (2009) baseline survey conducted on violence against women, produced by MOWA, provided some additional insight about the specifics of the physical violence initiated against Cambodian wives by their husbands.²² In comparison to figures of general prevalence reported by the CDHS 2005, the figures recounting specific acts of violence were very low. For example, the most common form of physical violence - being the target of a thrown object, having been pushed or grabbed – was reported by only 7.2 percent of the sample. 5.6 percent reported having had their hair pulled or been knocked on the head, slapped, kicked, bitten, shaken, or punched, 2 percent were hit while tied up, attacked with a blunt object, or assaulted repeatedly, 0.9 percent

¹⁹ NIS (2005) Cambodia Demographic and Health Survey

²⁰ Note that the age cohorts reported by the CDHS 2005 are different than the cohorts requested by this indicator.

²¹ CDHS 2010 no longer asked questions on physical or sexual violence because these questions were raised in specific surveys by the MOWA. These questions should be included again in CDHS 2015 so that comparable data is produced to measure indicators over time and identify trends.

²² MoWA (2009) Violence Against Women, 2009 Follow-Up Survey, Final Study Report.

burned or choked, 2.1 percent threatened with a gun or sharp object, and 0.4 percent actually stabbed or shot or else made the victim of an acid attack.

7.3. Orphans school attendance

Indicator 7.3 measures the rate of primary school attendance of male and female double-orphans against the rate of school attendance of non-orphans. CDHS survey data for this indicator is available for years 2000, 2005 and 2010.

In 2010, primary school attendance among orphans was 69.7% vs. 81.5% for non-orphans. Attendance among girls was lower than boys for both orphans (70.8 percent vs. 68.4 percent) and non-orphans (82.1 percent vs. 80.8 percent), though attendance for female non-orphans was still higher than attendance for male orphans (80.8 percent vs. 70.8 percent).

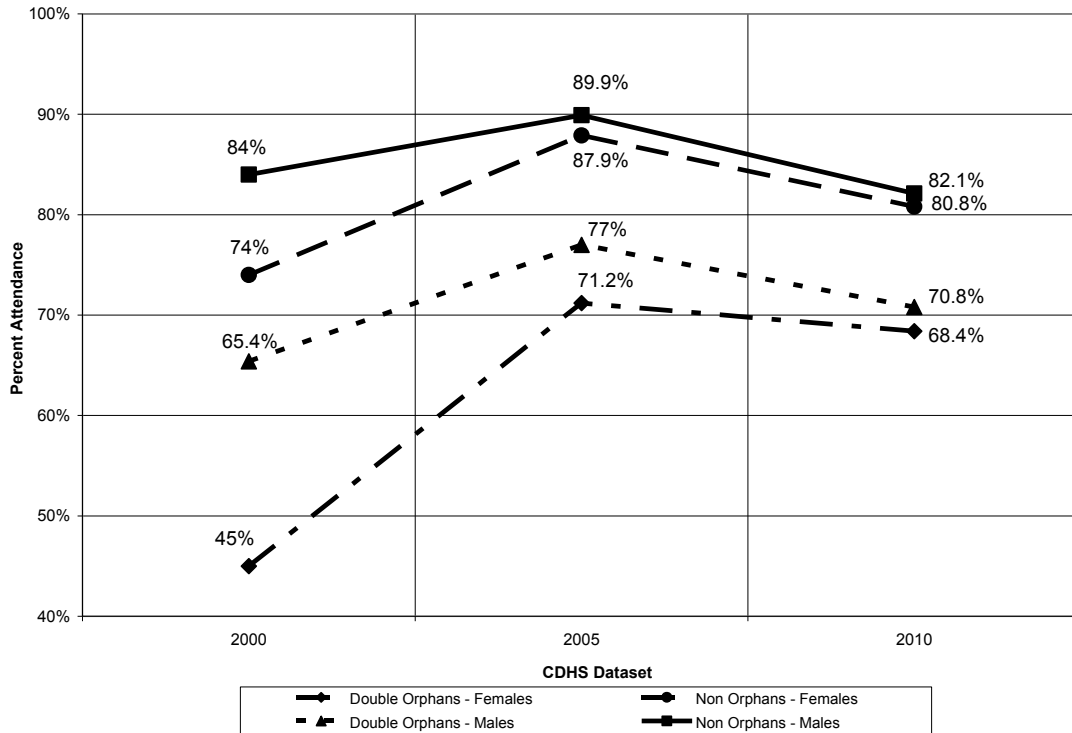
The trends displayed over time in table 3 show an increase in primary school attendance for all children, regardless of orphan-status, between 2000 and 2005, and then a slight regression from 2005 to 2010. However, the gap in school attendance between orphans and non-orphans narrows consistently over time; from 23.8 percent (2000) to 14.8 percent (2005) to 11.8 percent (2010). This trend in reduction of unequal school attendance from 2000 to 2010 among orphans and non-orphans remains consistent when disaggregated by gender for both boys and girls. Likewise, the gap in school attendance between boys and girls (orphans and non-orphans) has also narrowed with time; from 15.2 percent (2000) to 3.9 percent (2005) to 1.85 percent (2010).

Table 4: Primary school attendance of children by number of parents who have died

Orphan	Maternal	Paternal	Double	Non-Orphan
CDHS 2000 - Females	52.7%	61.4%	45%	74%
CDHS 2000 - Males	67.6%	74.9%	65.4%	84%
CDHS 2005 - Females	82.3%	80.4%	71.2%	87.9%
CDHS 2005 - Males	85.1%	83.8%	77%	89.9%
CDHS 2010 - Females	-	-	68.4%	80.8%
CDHS 2010 - Males	-	-	70.8%	82.1%
CDHS 2010 - All	-	-	69.7%	81.5%

Source: Cambodia Demographic and Health Survey 2010

Figure 6: Primary school attendance of children by number of parents who have died



Source: Cambodia Demographic and Health Survey 2010

7.4 External economic support to the poorest households

Indicator 7.4 measures the proportion of both HIV-affected and non-affected households, in the bottom quintile of the national income bracket, who received external economic support in the past three months. In Cambodia, the eligibility criterion for this indicator was defined by the CDHS to mean only households having received free or subsidized healthcare in the last three months. In 2010, only 27.2 percent of households in the lowest income quintile met this criterion. Data on this indicator from 2005 was not reported.

IV. Best Practices

HIV/AIDS in Cambodia evolved to a declining epidemic few years ago and during this period, some best practices have emerged that may serve as a model to other countries facing an epidemic of similar demographic proportion.

The tireless work completed by both government agencies and civil society with support from development partners has seen a steady fall in the prevalence of HIV in the general population. The new estimates show that HIV prevalence among adults aged 15 to 49 decreased to 0.9% in 2006 from a revised estimate of 1.2% in 2003. In addition, today over 90 percent of those in need of treatment are receiving it – indicating that Cambodia has nearly reached treatment Universal Access. Collaboration between the NAA, the National Agency for Combating Drugs (NADC) and the Ministry of Interior (MoI) has been strengthened and facilitates the scale-up of interventions such as Needle Syringe Programmes among IDUs and the 100% Condom Use Policy among EWs. Multi-sectoral cooperation between different government institutions and with civil society has resulted in the successful introduction of the Community MARPs Partnership Initiative and linking this with the Continuum of Prevention, Treatment and Care (CoPTC) to create an enabling environment for prevention interventions. These efforts have started to show results in mitigating the unintended impact of recently introduced legislation such as the Law on the Suppression of Human Trafficking and Sexual Exploitation, the new Drug Law and the Commune/Sangkat Safety Policy.

Political commitment at the highest levels in the Royal Government of Cambodia, especially from Samdech Hun Sen, Prime Minister, is recognized to be an important factor in Cambodia's success creating a supportive legal and policy environment and building a strong national response to HIV. Prevention initiatives that target outreach to most-at-risk populations based on sound strategic evidence and largely participatory programming and planning have been effective. It was for these reasons Cambodia was singled out for the Millennium Development Goals (MDG) Award in 2010.

The Royal Government has received praise by the international Awards Committee for its leadership, commitment and progress towards achievement of MDG Goal 6. The Awards Committee was particularly impressed by Cambodia's success in scaling up its programmes in cooperation with all stakeholders, through strong leadership and social mobilisation. It was also recognised that progress made in Cambodia on HIV and AIDS had a direct effect on other MDGs, including Goals 4 and 5 dealing with child mortality and maternal health.

High-level political support with multi-sectoral responses set the tone: The 21st of February was adopted by the Royal Government as the national day for maternal, newborn and child health, which shows remarkable awareness and initiative by officials at even the highest levels of policy-making. This early showing of support fostered the creation of a multi-sectoral response that prioritized HIV/AIDS and enlisted a wide variety of national participants in the response.

One notable participant is Cambodia's First Lady, H.E. Lok Chumteav Bun Rany Hun Sen, who is also the National Champion for the Asia Pacific leadership Forum on HIV/AIDS and Development (APLF) has demonstrated her strong commitment and that of the RGC in responding to HIV. Recognized as a national champion for maternal and child health as well as HIV, the president of Cambodian Red Cross' response to evidence of a serious emerging epidemic with a proactive commitment to addressing the leading causes of child and maternal morbidity and mortality continues to the present, with unrelenting dedication. Her charismatic directness of addressing this threat is what first placed HIV/AIDS on the development agenda, encouraging constant and candid national contributions to eliminating mother-to-child transmission of HIV. This focus on vertical transmission is important to tempering the second wave of the AIDS epidemic, rescuing the lives of women, promoting family harmony and social wellbeing and in making progress toward Cambodia's Vision of zero new infections, zero discrimination and zero HIV-related deaths in 2011.

V. Major challenges and remedial actions

A. Progress made on key challenges reported in 2010-2011 Country Progress Report

The lack of individual and institutional national capacity was an important challenge that was identified in the last report. Progress has been made, although elimination of this challenge will require far more than only two years. Capacity in both government and non-governmental sectors has steadily grown over time and so has the national ownership of the national response to the epidemic. There are numerous examples of how complex technical tasks are now carried out with no or only limited foreign technical assistance. The history of Cambodia's HIV estimates and projections constitutes a good example.²³ Another good example is represented by the three NASA that were led by the NAA since 2007. Through these assessments a lot of national capacity has been built and a proper financial resource tracking system has been institutionalised, the first of its kind across social sectors in Cambodia.

Capacity of community networks and their ability to govern their organisations remains a major challenge. This is why efforts were intensified, to build the capacity and empower communities according to clearly defined standards, as a strategy to create an environment that enables key at risk populations and PLHIV to access and fully utilise HIV and related services.

A critical challenge that was emphasised in the previous progress report was related to the unintended effects produced by newly introduced legislation. The 2008 Law on the Suppressions of Human Trafficking and Sexual Exploitation, for example, resulted in the widespread closure of brothels and has complicated efforts to reach out to EWs who sell sex with HIV prevention services, including provision of condoms and lubricant and referral to HIV and STI testing. The Commune Safety Policy too has made it more difficult to ensure access, by people who inject drugs, to vital HIV prevention and harm reduction services, because of their fears of arrest or compulsory rehabilitation. These types of policies have also made the running of sentinel surveillance surveys and population size estimations more problematic, which could negatively impact on the reliability of their results.

In spite of these challenges, meaningful progress has been made to promote a better enabling environment, which assists engagement with the most at risk among key populations including EW, MSM, TG and PWID to avert new infections. The revised Drug Control Law, includes important provisions for harm reduction and public health initiatives targeting PWID. HIV prevention strategies targeting PWID and other key populations were recalibrated and clear guidance was provided in standard operational procedures (SOP) for a Continuum of Prevention to Care and Treatment. The SOPs contain M&E frameworks and provide both programmatic and M&E

²³ NCHADS (March 2012) The History of Cambodian HIV Estimates and Projections (Draft).

guidance to service providers. Still the quality of service delivery and of monitoring efforts requires improvement to ensure the hardest to reach, who are most at risk, can benefit from interventions.

Stigma and discrimination and the weak enforcement of specific policies and laws protecting the human rights of PLHIV have remained a challenge in the current reporting period. To address these challenges a Community Legal Service was established for entertainment workers. This is currently being piloted and will be rolled out in the coming years.

Still another major challenge outlined in Cambodia's 2010-2011 Country Progress report was the cessation of salary supplementation for civil servants. Meanwhile, this has been reintroduced though it is being phased out again this year. The suppression of salary supplements and incentives has had negative consequences, some key government staff have moved to the private sector, or have undertaken better paid free-lance consultancy work.

B. Challenges faced throughout the reporting period (2010-2011) that hindered the national response, in general, and the progress towards achieving targets, in particular

Work to improve the policy and legal environment, to enable partners implementing HIV prevention, treatment and care and impact mitigation in an effective and efficient way, continued to prove challenging.

While progress has been made, policy and legislative barriers continue to inhibit the national response, especially in respect of key affected populations. The revised Drug Control Law has enshrined harm reduction approaches but has increased periods of incarceration for minor drug offenders. In addition, the inconsistent implementation of the Commune Safety Policy, continues to interrupt access and utilisation of HIV services for key affected populations, in particular PWID and entertainment workers who sell sex and their clients.

The quality of prevention interventions among key populations is uneven and overall needs considerable strengthening. For example, the needle and syringes exchange programme is not working well and the distribution of condoms and lubricant for MSM and TG is largely insufficient. The cost-effectiveness analyses and new costing of interventions that was conducted in late 2011, show that greater investment is needed not only in the expansion of the coverage of interventions, but especially in the improvement of the quality of services. The most cost-effective investment is in prevention among entertainment workers and their clients. Interventions targeted at IDUs are also very cost-effective provided they are brought to a larger scale. MSM and TG prevention interventions are much less cost-effective.

The Continuum of Prevention to Care and Treatment (CoPCT) model for EW, MSM/TG and PWID needs to be systematically reviewed and simplified and its strategies need integration with the Community Peer Initiated Counselling and Testing (CPICT) model and the MARPS Community Partnership Initiative (MCPI), as the most effective approach to averting the predicted 1,300 new infections each year. These are occurring among the people who are hardest to reach and whose targeting involves a very high cost.

While there have been significant improvements in technical knowledge, skills and experience in key national institutions, capacity gains are not keeping pace with the complexity of programming and of other technical needs. As a result there has been insufficient ability to absorb financial resources, evidenced in under-spending and the type, nature and timing of re-programming, particularly of Global Fund resources, by a number of recipients.

The past two years have witnessed some improvements in EW and MSM networks and in their capacity to get involved with and respond to key issues. However, community networks of MARPs and PLHIV largely remain fragmented and weak, lacking strategic direction and good governance. Chronic internal management issues continue to impact the work of the National Network of PLHIV (CPN+) despite concerted efforts by its partners to resolve these issues through institutional strengthening measures. The MSM network functions more as an NGO than as a network and MSM are poorly represented in its Secretariat. A coalition of EW was formed but institutional challenges remain.

The recommendations of the Functional Task Analysis, conducted in 2010, suggesting a reform in the approaches and types of mechanisms required for the coordination and management of the national response, have yet to be operationalised.

The Stigma Index²⁴ and the Study on the Socio-economic Impact of HIV²⁵ have provided several valuable insights and recommendations, to improve approaches, to more effectively address stigma and discrimination and to mitigate the impact of HIV within the framework of growing social protection initiatives. The key challenge is that both human and financial resources to carry this work forward are lacking. Moreover, a number of food and other support programmes for PLHIV are likely to be phased out at the end of 2012 and alternate options to secure support for PLHIV and their families are lacking.

Cambodia has achieved a high coverage for treatment and care. In 2010, more than 90% of all those in need of ART were receiving it, but in the long run it may prove challenging to sustain these results. New treatment eligibility criteria and difficulties getting people to test and enrol on treatment early, are among the main factors exacerbating this challenge. The biggest challenge

²⁴ CPN+ (2010) People Living with HIV Stigma Index.

²⁵ Sanigest International & the Centre for Advanced Study (2010) The Socioeconomic Impact of HIV at the Household Level in Cambodia.

however, is represented by the financial resource constraints which have become more clearly apparent in the current reporting period. Cambodia currently relies completely on the GF for the financing of antiretroviral treatment, which constitutes a major risk should this financing source cease to exist.

Cambodia now has much stronger M&E systems than five years ago and richer data. Its quality has improved and it is increasingly being used for programming and policy making purposes. However, data from routine monitoring systems, to assess the coverage and quality of HIV prevention interventions among key populations, OVC support and impact mitigation activities, is still lacking. A unique identifier code system has yet to be created and new and better population size estimations need to be produced to establish service coverage.

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

The Royal Government of Cambodia committed to achieving the Three Zeros – zero new HIV infection, zero AIDS related deaths and zero stigma and discrimination, by adopting the Political Declaration on HIV/AIDS in June 2011 at the UN General Assembly. New Universal Access (UA) indicators were selected for prevention, treatment and impact mitigation and targets were set for 2013 and 2015. The achievement of the UA targets remains a fundamental priority for Cambodia and represents a major milestone towards reaching Cambodia’s MDG No. 6, as set out in the National Strategic Development Plan (2008-2013). The strategies and activities that will be implemented from 2011 to 2015, to achieve HIV/AIDS targets, are included in the costed NSP III (2011-2015). The costs of the NSP III were recently assessed again in the light of cost-effectiveness considerations.

In fact, in a context of declining financial resources for development in general and for HIV and AIDS more specifically, a major challenge ahead is to find ways to ensure long term, sustainable and predictable funding for the national response, in order to be able to consolidate the outstanding results achieved so far. This will mean that more will need to be done with less, by better prioritisation and focusing interventions and overall by becoming more cost-effective in delivering vital services for all those in need. Work to examine the cost-effectiveness of different combinations of interventions will continue, with the aim of operationalising the improved investment framework in view of developing the next GF funding application.

There is now a greater awareness among stakeholders that a prioritisation of strategies, based on cost-effectiveness analyses and “improved investment” approaches, will be essential in coming years. This is important considering Cambodia remains heavily reliant on external funding (96 percent of spending on HIV and AIDS is from external sources). A Fiscal Management Plan to manage the incremental shift from external to domestic financing will be an important

requirement in 2012-13. This will be a critical step also because the GF requires that 5% of proposals be financed from domestic resources.

Given Cambodia's concentrated epidemic, efforts are being concentrated on intensifying prevention efforts among MARPs – the main drivers of the epidemic – in order to avert the greatest number of new HIV infections. Evidence-informed, targeted and innovative approaches are being rolled out to reach the hardest to reach among the MARPs (including street based sex workers) and their intimate partners. The CoPCT model is currently being revised to enhance its efficiency and effectiveness and to expand its impact. This will also be better linked with efforts promoted under the MCPI, to create a better enabling environment and “safe space” for HIV prevention and to off-set the negative implications related to the application of specific policies and legislation.

Of critical importance in the next two years will be investments in the promotion of early HIV testing, especially testing and counselling among population groups at highest risk of infection. This is being done through CPITC because if infected people are aware of their HIV status, they can start treatment early, which will result in better treatment outcomes and in a lower likelihood of infecting others. The CoPCT will help to strengthen referral systems and promote early testing and treatment.

Universal access to treatment and care will be promoted, with the aim of realising a situation where there are no more AIDS related deaths and no more new HIV infections. Efforts are being intensified to expand TB and HIV services in prisons with clear programmatic guidance. Strong linkages and integration of HIV into health systems is being promoted, especially through the “Linked Response” approach, which seeks to integrate PMTCT with maternal and newborn health and with sexual and reproductive and family planning services. These efforts are contributing to the strengthening of health care systems generally, including through the integration of different laboratory services.

Stigma and discrimination will have to be addressed with more vigour, as it restricts key populations' access to health care (including to early testing) and access for PLHIV to social and other forms of support. The work of the First Lady, as National HIV/AIDS Champion and as National Champion for the UNSG's Joint Action Plan for Women and Children's Health, and of community networks, will further be promoted including through implementation of the National Advocacy and Communication Strategy.²⁶

Social mobilization and partnership efforts will seek to strengthen the capacity and institutional structures of community networks, to ensure they are sufficiently robust to enable PLHIV and MARPs gain access to and increase utilisation of quality services, and actively participate in policy development and planning.

²⁶ NAA (2011) National Advocacy and Communication Strategy

Improvements will be made in the quantity and quality of available strategic information, through investments in strengthening surveillance and routine monitoring systems and producing data allowing assessment of the coverage and quality of MARPs prevention and impact mitigation interventions. A unique identifier code (UIC) system is already under development and new population size estimates will be improved. Estimates for people who use drugs will be produced in 2012, as part of an integrated biological and behavioural surveillance (IBBS) survey focusing on this group. An IBBS focusing on MSM and TG is planned in 2013, followed by one targeting EW in 2014. A fourth round of NASA will be started at the beginning of 2012 and together with the previous NASA will provide seven years of spending data. This data will be used to inform financial resource allocation and mobilization efforts including through the GF.

Data from different sources will be triangulated and used to inform programme planning and policy making. Through CQI and M&E system strengthening activities, capacity of service providers at national and sub-national level, will be developed to analyse and interpret the data and to take concrete action to improve interventions.

VI. Support from the Country's Development Partners

A. Key Support Received from Development Partners to Ensure Achievement of GARP Targets

GARP indicator 1 is a good measure to track support provided by development partners. This indicator is measured with information concerning AIDS spending in Cambodia. So far, the NAA has conducted three NASA.²⁷

NASA III, the results of which are presented in this report produced more comprehensive and reliable results than past rounds.²⁸ It used an improved methodology and upgraded definitions and classifications and reflected a growing national commitment and capacity to report spending data. NASA III produced information concerning financing sources, financing agents and service providers as well as beneficiary populations.

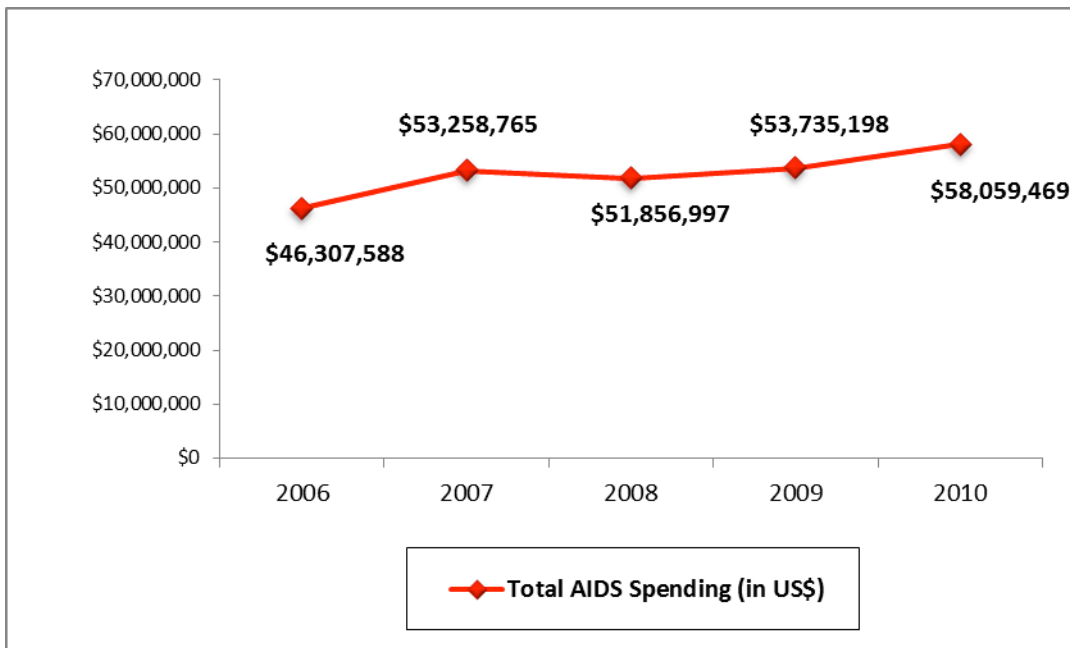
Figure 7 illustrates that in general spending on HIV and AIDS in Cambodia has continued to rise, with a drop from 2007 to 2008 the only exception to the trend. Spending in 2010 was US\$ 58,059,469 which is a 25 percent increase from the US\$ 46,307,588 documented for 2006. It should be noted that this increase is not necessarily due to an actual increase in spending or in available funding. It is thought to be in large part due to methodological improvements in the

²⁷ The first NASA was implemented in 2007 and focused on 2006. The second NASA was carried out in 2009 with a focus on 2007 and 2008. The third NASA focusing on 2009 and 2010 was conducted in 2011.

²⁸ Data from NASA III are presented in the National Funding Matrix included in the Annex.

NASA, which allow for a more accurate reflection of total AIDS spending in the country than in previous years.

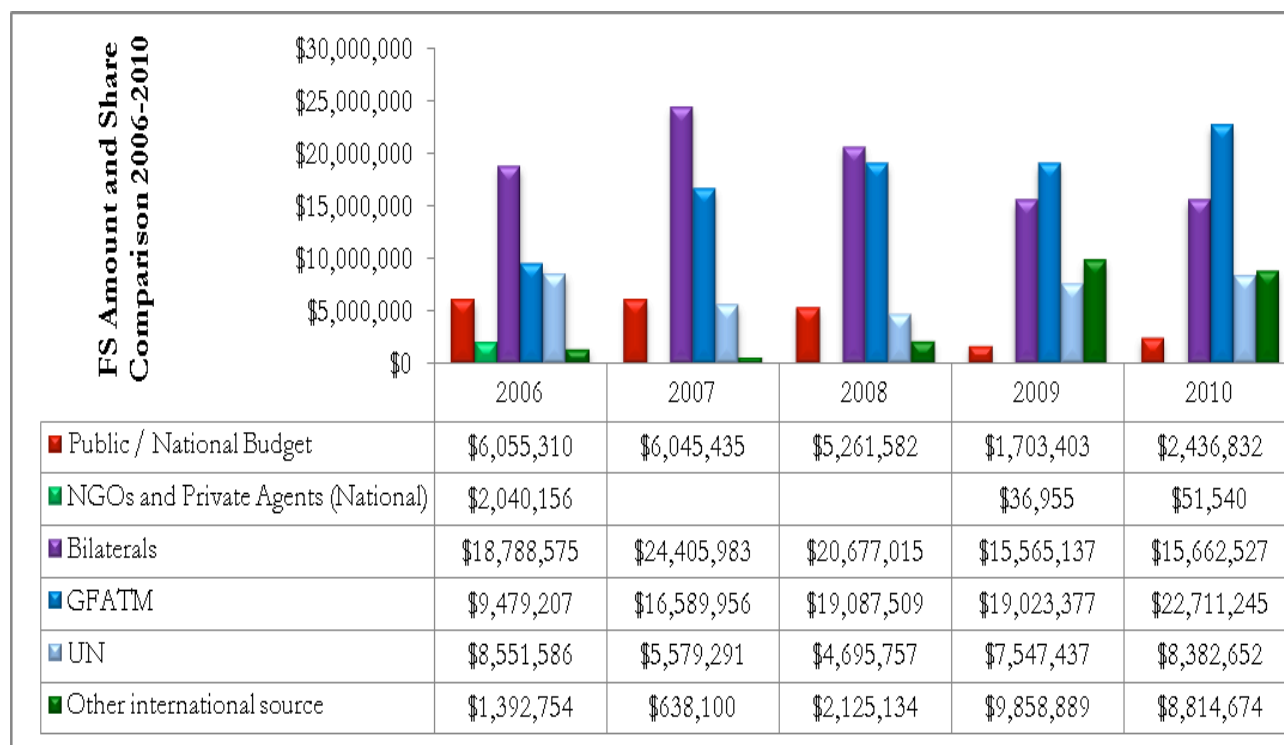
Figure 7: The trend of Total Spending on HIV and AIDS, 2006-2010 (in US\$)



Source: National AIDS Spending Assessment III

The primary financing sources for the national response to were the GF and bilateral agencies. The GF's financial contributions have steadily grown over the past number of years. Among the bilateral sources the United States was by far the biggest contributor providing 82 percent of total bilateral funding, which is 22 percent of all AIDS funding. Other important sources include UN agencies and international NGOs.

Figure 8: Total spending by financing source, 2006-2010 (in US\$)

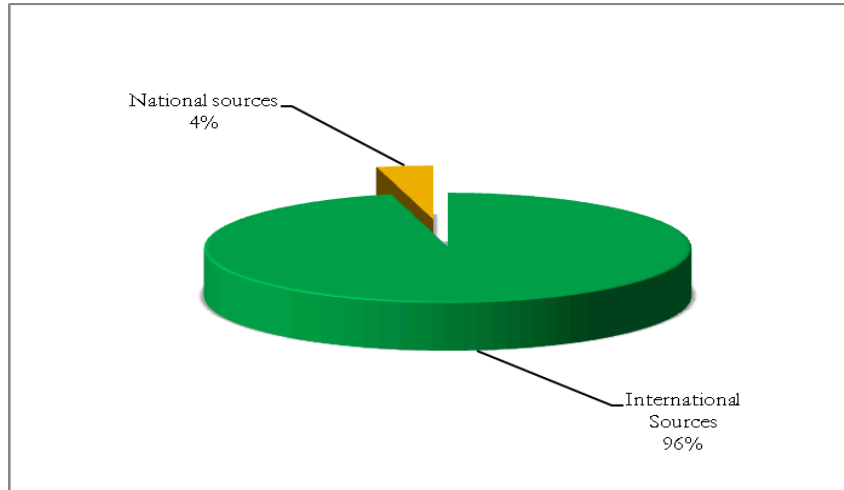


Source: National AIDS Spending Assessment III

The Royal Government of Cambodia financed 4 percent of all AIDS spending in the biennium (see Figure 9). Their share of financing has remained constant since 2006.²⁹

²⁹ From 2006 to 2009 there was a decrease in expenditures sourced from the National Budget because NASA I and NASA II included expenditures on blood safety not only to prevent HIV but also to avert other infections as well as expenses for the management of the whole national blood safety programme. Since NASA III only includes HIV-related expenditures on blood safety, the amount spent originating from public funds is much lower. This is why the data shows a considerable drop in spending of public funds in both absolute and relative terms, as most of these were used for blood safety in 2007 and in 2008.

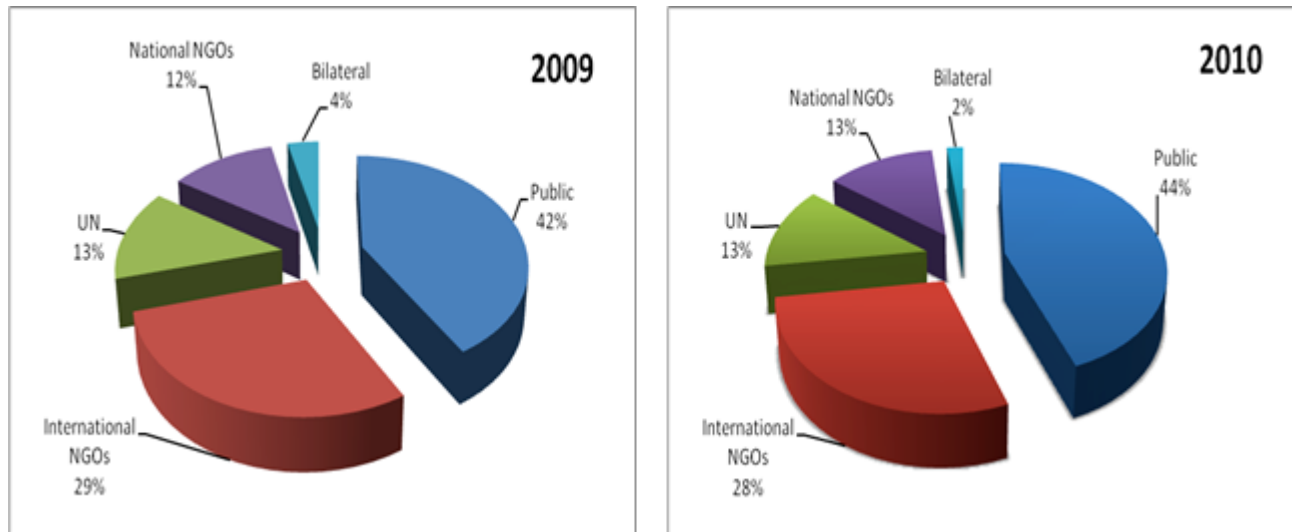
Figure 9: The components of total spending by type of financing sources (Average 2009/2010)



Source: National AIDS Spending Assessment III

Figure 10 indicates the agencies who managed the funding for the HIV/AIDS response in 2009 and 2010. More than 40 percent of HIV spending was managed by government agencies, while international organizations made programmatic decisions concerning 29 percent of expenditure (average for 2009/10); followed by the UN who administered 13 percent each year; national NGOs who controlled 12 percent and 13 percent; and bilateral entities with 4 percent and 2 percent.

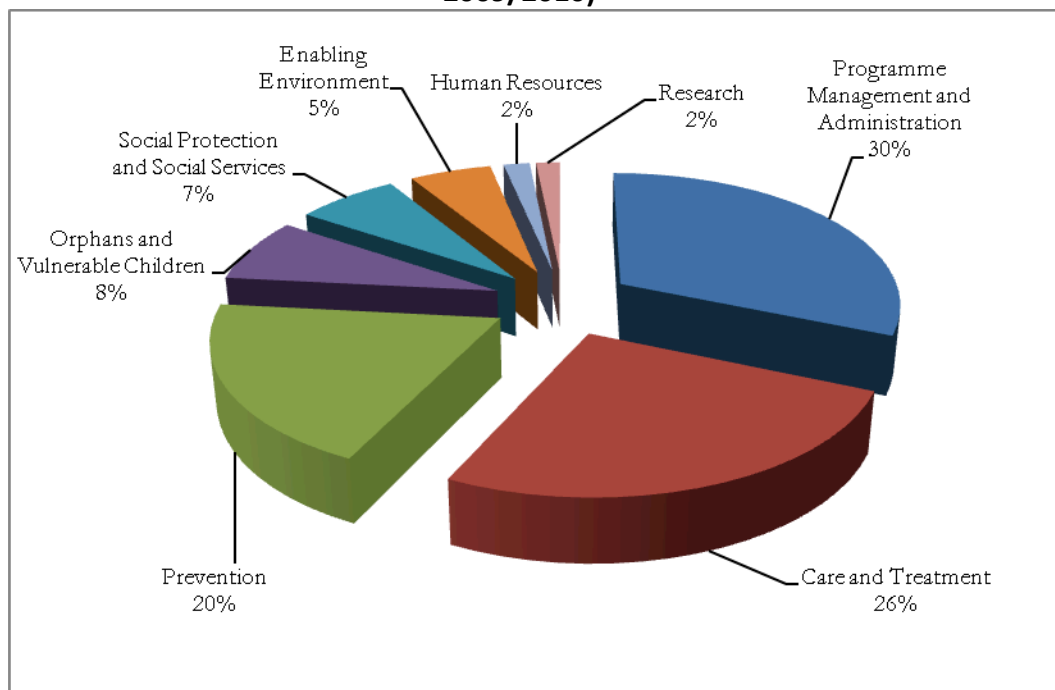
Figure 10: The components of AIDS financing agents (Average 2009/2010)



Source: National AIDS Spending Assessment III

Figure 11 shows a breakdown of expenditure by main spending categories. It illustrates that in 2009 and 2010, 20 percent of total spending was on prevention and 26 percent on care and treatment, whereas 30 percent was spent on programme management and administration. Only 8 percent was spent on OVC support and impact mitigation.

Figure 11: The components of total spending by main AIDS spending categories (Average 2009/2010)



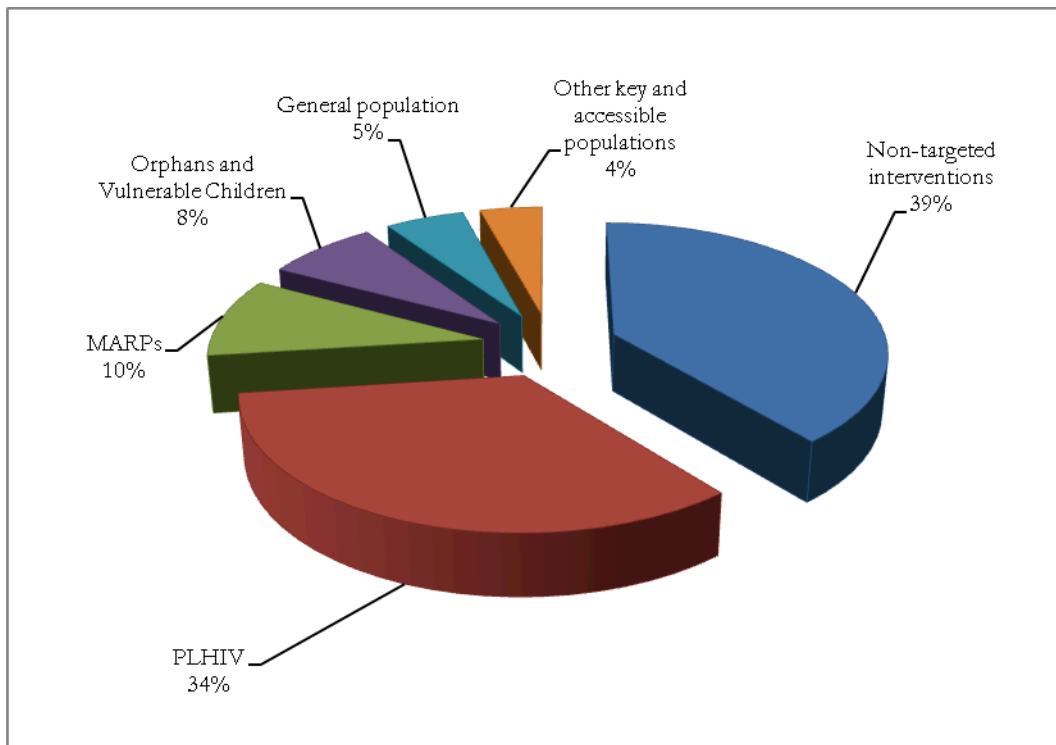
Source: National AIDS spending Assessment III, 2009-2010.

Analysis of data from all of the past NASA reveals that spending on prevention declined over the years. This may be related to a change in definitions and classifications, meaning activities that would previously have fallen under prevention now are classified under programme management and administration. Spending on this category only, from 2009 to 2010, rose from 29 percent to 34 percent. Spending on care and treatment, although it had been increasing up until 2009, dropped between 2009 and 2010 from 29 percent to 24 percent.

Data on the beneficiary populations was captured for the first time during this round of the NASA. Figure 12 highlights the main target populations who received HIV/AIDS related benefits and services for the period 2009-2010. Non-targeted population interventions (39 percent) and PLHIV (34 percent) were the largest spending categories for the period, followed by MARPs (10 percent), OVC (8 percent), the general population (5 percent) and other key and accessible populations (4 percent). 'Non-targeted interventions' covers such activities as programme management,

administration and human resources. The spending on PLHIV was mostly for care and treatment, social protection projects and social services.

Figure 12: The components of total spending by beneficiary population (Average 2009/2010)



Source: National AIDS Spending Assessment III

B. Actions that Need to be Taken by Development Partners to Ensure Achievement of Targets

In the past two years, development partners have continued their financial and technical assistance to the Royal Government and to civil society organizations, to help them in addressing the epidemic and to consolidate the good results achieved so far, in view of reaching the Three Zeros. This despite the fact that this reporting period has been characterized by the global financial crisis, which has seen a reduction in resources for HIV and AIDS, globally and nationally, and in development assistance from advanced countries.

There has been an increasing awareness of declines in external financing for HIV and AIDS and the need to see corresponding increases in domestic financing. Still, three rounds of NASA have shown that spending on HIV and AIDS from domestic sources has remained steady since 2005 at 4 percent of total expenditure. This has led stakeholders to engage in a major cost effectiveness analysis and

scenario building exercise, to forecast trends in the epidemic and examine the best programming options that will help achieve the best results at the least cost.

Efforts started with the study of the Long Run Costs and Financing of HIV/AIDS in Cambodia, conducted by NCHADS, NAA and the Ministry of Economy & Finance.³⁰ The Results of this study – often called aids2031 Study - were published in 2010. It examines trends in the epidemic until its 50th anniversary in 2031 and estimates what it would cost to address it effectively in the long run. The study reviewed financing of HIV/AIDS in the past, forecasted resources available to finance HIV/AIDS programmes in Cambodia from 2010 to 2031 and examined how resources that could be available for HIV/AIDS in the future compare to future costs of programme interventions. Its methodological approach involved epidemiological modelling and costing with regard to three possible future scenarios: an optimistic scenario, a moderate scenario and a pessimistic scenario. For each of these scenarios, the size of the gap in financial resources was estimated if government maintained the present share of public expenditure that is allocated to the social sectors and the current share of the social sector budget allocated to HIV/AIDS. The financing gap was also examined over time under the assumption that government would progressively increase domestic financing of HIV/AIDS interventions in the future.

The cost-effectiveness analyses carried out in 2011, with widespread stakeholder engagement, examined different intervention areas more in depth.³¹ The focus was on HIV prevention among key populations and on impact mitigation interventions. The results show that, to avert the greatest number of new HIV infections and AIDS related deaths at the least cost in the coming years, interventions need to be far better prioritised and focused. More attention will need to be paid to improving the quality of interventions and not only to expansion of their coverage. A geographic focus on key hot spots is advisable and will need to be promoted along with improvements in routine monitoring systems, surveillance and outreach efforts and population size estimates at these sites. The rationalisation and improvement of interventions and the harmonization of service delivery and of monitoring and reporting across service providers has to remain a top priority.

Donor support, both financial and technical, not only decreased in the biennium because of a lack of financial resources, it also declined because national capacity has grown and the need for foreign technical assistance, which generally is quite costly, has decreased. This is an important indicator of success showing that past investments in the development of individual and institutional capacity, including through training and technical assistance, are paying off. In some specific technical areas, capacity strengthening needs remain and are being included in a new Technical Support Plan (TSP)(2012-2014). Cambodia's last TSP which was informed by a Technical Needs Assessment in 2007 has largely achieved its expected results.

³⁰ Saphonn, V; Chhorvann, C; Sopheab, H; Luyna, U; & Seilava, R (2010) The Long-Run Costs and Financing of HIV/AIDS in Cambodia

³¹ NAA (2012) Cost and Cost Effectiveness of HIV Prevention and Impact Mitigation Interventions in Cambodia (Draft)

There is no doubt that donor support arrangements have changed over time. Most noticeable is the decrease in foreign investment in implementation arrangements, such as projects or programmes that are carried out directly by international agencies. Funding is increasingly pooled to support national entities in carrying out their mandate, while ensuring technical innovation and high quality results. Foreign investment is still significant in areas where it has been demonstrated that the greatest impact can be achieved and where contributions can leverage concrete, lasting results.

The most important mechanism to exchange information on progress, to discuss challenges and to find solutions, is the Government Donor Joint TWG. The role and responsibilities of this group needs to be better recognized and its operations strengthened so that its potential can be fully unleashed.

Representatives from bi-lateral agencies, UN organizations and selected international NGOs also continue to regularly meet as part of the Development Partners Forum to exchange views and to coordinate their efforts.

In 2010, UN agencies have produced a new Joint UN Support Programme Operational Plan and Budget (UN JSP-OPB) for 2011-2015 in alignment with the NSP III. The plan was developed with the active involvement of representatives of Government and of other stakeholder organizations. Annual planning and reporting exercises continue to be conducted systematically every year.

The UN Development Assistance Framework (UNDAF) for 2011-2015 deals with HIV as a cross-cutting issue that needs to be addressed in all of the outcome areas including social protection, economic growth and sustainable development, health and education and gender and governance. The indicators included in the UNDAF are consistent with the national core indicators included in the second edition of the National HIV/AIDS M&E Guidelines reflecting the NSP III.

VII. Monitoring and Evaluation Environment

The national HIV/AIDS M&E system is consistently developing and growing. A second edition of the national M&E guidelines has been developed to provide the framework for monitoring the progress and evaluating the results of the multi-sectoral response to the epidemic, as outlined in the NSP III. The information and instructions contained in these guidelines are fully consistent with those of sector-specific M&E frameworks and guidelines, such as those developed by MoSVY to monitor and evaluate support provided to OVC.

The guidelines identify 50 core indicators and targets for M&E of the response to HIV/AIDS. Significant progress has been made in the development and implementation of various sectoral and population specific M&E frameworks and guidelines.

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

The NAA manages the national multi-sectoral M&E system with assistance from the M&E TWG. Members of this M&E TWG include representatives from government agencies, civil society organisations, private sector institutions and development partners. Cooperation between the NAA and the M&E TWG has resulted in the overall strengthening and continuous development of the national M&E system.

During the reporting period (2010-2011) there have been a number of important achievements in the area of M&E. These have contributed to the strengthening of the national multi-sectoral HIV/AIDS M&E system and its various sub-systems. Better data is now available for M&E purposes and it has resulted in improved programming, policy-making and resource allocation.

In 2010 the NAA developed a National M&E System Strengthening (M&E SS) Plan (2011-2015). The plan outlines all of the activities that will need to be implemented over the next five years to improve the national multi-sectoral HIV/AIDS M&E system and its various sub-systems. Its focus is on the areas where weaknesses and gaps have been identified through the 2007 M&E SS assessment. M&E system strengthening needs have mostly been identified in the non-health sectors and concern the M&E frameworks, systems and capacity of relevant institutions like MoSVY, MoEYS and MoWA, as well as those of the NAA, NMCHC and non-governmental organizations.

The majority of the activities outlined in the National M&E SS Plan have been included under GF's successful Round 9 funding application. Since July 2011, they are being implemented as part of the Single Stream Funding (SSF) that resulted from a merger of Round 9 and Round 7. NCHADS is the primary recipient (PR), with the NAA and HACC as the two main sub-recipients (SR) of the M&E systems strengthening component under the SSF. The largest share of funds for M&E will be

invested in institutional and individual capacity building; these efforts have already started and will be adjusted and fine-tuned over a protracted period of time to achieve a meaningful and lasting impact. Large amounts of money will also be invested in the strengthening of organizational structures, including through the procurement of equipment and through research and evaluation activities.

The evidence generated through evaluation and research and by monitoring programmes will be utilised to assess what works and what does not work so well. It will help to improve interventions and ensure that the right things are done right. Increasing emphasis has been focused in the past two years on identifying the most cost-effective mix of interventions which will avert the greatest number of new HIV infections and AIDS-related deaths.

The design of the new OVC M&E system was concluded by MoSVY in 2011. A comprehensive M&E framework with a selected number of well-defined indicators is now available. Data collection and reporting mechanisms have been devised, tested and documented. Training of officers in data collection and in reporting specific data has started and will be rolled out by MoSVY in 2012 and beyond.

The other M&E routine monitoring systems that have been strengthened in this biennium are those needed to obtain routine monitoring data to assess the coverage and efficacy of MARPs prevention interventions. An important step forward was made by ensuring that all SOP for the CoPCT include relevant indicators and guidance on what data needs to be collected, by whom the data needs to be collected and on how and when data needs to be collected, as well as for which purpose the data needs to be collected.

The M&E framework included in the CoPCT SOP focusing on EW has now been working for more than one year. Currently lessons are being drawn to simplify and improve data collection and reporting mechanisms and to enhance data management and use. Lessons will also help inform the operationalisation of the SOP for a CoPCT for MSM and for IDU/DU. Baseline data against which progress and impact can be assessed has already been collected by NCHADS for EW and will next be collected for MSM and TG. For this MARPs group the SOP has already been completed whereas the SOP for a CoPCT focusing on IDU/DU has yet to be finalised, including the M&E framework and system. Soon the SOPs for MARPs will be consolidated into one SOP with one single integrated M&E framework and system.

An M&E framework and system were also developed in 2011, under the leadership of the MoLVT in collaboration with Cambodian Business Coalition on AIDS (CBCA), to capture the results of HIV prevention in the workplace. This system is now being operationalised with recognition that HIV prevention will need to be prioritised in high risk settings and especially in entertainment establishments where sex is sold.

Several surveillance and other surveys were carried out in the reporting period and thus critical new data has been obtained and used for programming and policy making.

Data from the CDHS became available in 2011. The CDHS data from the HIV module was recoded and analysed to establish measurements of key national and global indicators. Results of the analysis have been included in this report.

In 2010, new BSS and HSS surveys were carried out with focus on entertainment workers, moto-taxi drivers and PLHIV. In 2010, the Bros Khmer Study made useful new behavioural and biological data available on MSM and other high-risk males. Although the data cannot readily be compared with earlier data from STI Sentinel Surveillance Surveys (SSS) or BSS', they have been used for estimation of trends and for the calibration of targets. A new SSS was carried out in 2011 by NCHADS with support from the US Centre for Disease Control (CDC) and the results will become available in 2012.

Consensus was reached that BSS and HSS will in the future be carried out in an integrated fashion. Each year, another of the three MARPs groups will be surveyed, with each population surveyed every three years. Preparation for a new IBBS for IDU/DU, including new population size estimation, was planned and piloted and resources were mobilised. There is now general agreement that the IBBS also need to focus on one MARP at a time in a three year cycle.

The new surveillance data has been used to develop new HIV estimates and projections in 2011 and to reassess trends in the modes of HIV transmission. Revised estimates of the main modes of transmission are now available. Although they have yet to be officially released, they have informed a scenario building, prioritization and costing exercise. Its objective is to determine the cost-effectiveness of different mixes of interventions in order to identify those that will avert the greatest number of new HIV infections and AIDS related deaths at the least cost. This exercise was preceded by a major national consultative process, led by the NAA, to set new national UA indicators and targets and to prioritise NSP III interventions to reach the Three Zeros based on their efficacy and cost-effectiveness.

The process also involved a useful data triangulation and epidemiological modelling exercise that helped to develop scenarios for prevention, including PMTCT, and calibrating targets. The modelling shows clearly that HIV prevention, with a clear strategic focus on key MARPs - particularly EWs and PWID - will avert the most new infections at the least cost. The exercise has resulted in a better prioritization of declining financial resources to fit Cambodia's current and future modes of transmission.

In 2011 the third NASA focusing on 2009 and 2010 was completed. More comprehensive and accurate spending data was obtained than in the past, because of the improved data collection methodology, which resulted in many more organizations reporting their spending. Now spending

data is available for five consecutive years, from 2006 to 2010. The data is very widely used for analyses of trends in spending and to identify financial gaps, in order to improve resource allocation and resource mobilization.

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. Efforts are currently underway to strengthen the database through the use of an improved system that is adequately linked to the broader national database, containing all development indicators, called CamInfo. Meanwhile, efforts have been made in the health sector to integrate ART/OI, VCCT and STI databases.

The Continued Quality Improvement Initiative (CQI) was further expanded by NCHADS in the biennium, to ensure data was analysed and interpreted directly at points of care. The aim is to identify problems and to take prompt action to resolve them, to improve service delivery and programmes. Operational data management teams are expanding CQI activities with some very promising results. Because it has proven a successful tool to ensure analysis of practical and structural problems, and more timely problem solving and action by those at the service delivery level, CQI will also in the future be introduced in the area of prevention.

With a very large proportion of those in need of treatment receiving treatment, there is increasingly a growing need to ensure adequate regimens and treatment adherence. In the past two years, NCHADS continued to strengthen the monitoring of HIV drug resistance, with 32 sites monitoring OI/ART early warning indicators. The change in eligibility of treatment, from 250 to 350 CD4 count, represents a number of challenges; one is obviously financial, finding the funds to supply the extra treatment, others are programmatic, such as getting people to test and to seek treatment earlier.

Several important studies and research were also conducted in the reporting period. For example, the Study on the Socio-economic Impact of HIV at the Household Level in Cambodia was completed in 2011. This made a lot of valuable data available that is now being used to mainstream HIV into social protection programmes. In addition, the first Stigma Index, was concluded in 2011 and at the end of 2010, the MoEYS conducted the Most at Risk Young People Study.

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

Relevant progress has been achieved since the comprehensive M&E SS assessment was conducted in 2007. The assessment used the M&E SS tool and found that important system strengthening needs remained, especially in the non-health related sectors. Several remedial actions were devised to fill the gap in the national multi-sectoral M&E system operated by the NAA, with its various sub-systems run by various government and non-governmental institutions. These were included both in the National M&E SS Plan and in the GF Round 9 proposal, which brought

considerable financial resources to Cambodia to conduct M&E SS activities, including institutional and individual capacity development, over five years.

However, several challenges to the implementation of a comprehensive system remain. The main challenges, in relation to the twelve elements that constitute a functional national M&E system, can be summarised as follows:

1. Multi-sectoral leadership and coordination to pool data from multiple sources into one single national HIV/AIDS database has improved but requires further strengthening.
2. M&E roles and responsibilities and data flow mechanisms are clearly defined in the National M&E Guidelines, but lack of common understanding and contradictory communication at different levels and in different forums tends to create confusion especially from development partners.
3. National M&E, surveillance and research capacity has improved, especially through learning by doing, but it remains weak in some areas and organizations, due to high staff turn-over and still inadequate training and follow up.
4. The National M&E SS Plan is being implemented under GF SSF, but due to changes in the situation considerable reprogramming would be required, this is proving difficult because of inflexible GF procedures and limited grant management experience of principal and sub-recipients.
5. Annual costed national HIV M&E workplans are prepared, but a stronger link needs to be established between activities included in these and in GF SS M&E related plans.
6. A good understanding of the importance of M&E has been achieved through advocacy and communication; however, translating commitment into action remains problematic because of limited capacity, structural obstacles and institutional disagreements.
7. Routine monitoring systems in the areas of prevention and impact mitigation have been designed but their operationalisation is complicated by the large number of service providers who do not always deliver services in line with standard operating procedures or monitor and report according to national M&E guidelines.
8. An integrated behavioural and biological sentinel surveillance survey will be conducted according to a three-year cycle, but major methodological issues remain which have been created by the unintended effects of newly introduced legislation (e.g., the anti-trafficking legislation that has resulted in brothel closure; and the commune safety policy that makes it difficult to reach out and survey people who use drugs).

9. The national multi-sectoral HIV/AIDS database will need to be improved and made compatible with other major databases in the health sector and with CamInfo, for easy integration of HIV/AIDS data with data from other development sectors.
10. More efforts are needed to improve the quality of data through supportive supervision and data auditing. This will require investment in the development capacity of data producers and data users in data analysis and interpretation.
11. Insufficient time and attention has been focused on conducting meaningful evaluations. A national research agenda will have to be produced and implemented.
12. A lot of progress has been achieved in promoting the use of data from different sources through data triangulation, strategic planning and costing initiatives that have also facilitated resource mobilization efforts. Still, data is not always disseminated and shared with all relevant stakeholders or put into a format that allows for easy understanding and decision-making.

C. Remedial Actions Planned to Overcome the Challenges

1. Greater multi-sectoral leadership and coordination in M&E and research should be exercised by the NAA through the National MER TWG whose members should include senior technical staff from all of the designated stakeholder organisations.
2. M&E roles and responsibilities and data flow mechanisms should be further clarified in operational terms in line with the National M&E Guidelines.
3. More investment is needed in the development of M&E, surveillance and research capacity, based on rigorous capacity building needs assessments and a strategic training plan with sound training curricula.
4. PR and SRs need to be trained and assisted to undertake reprogramming of M&E activities under GF SSF, in a more carefully thought through way, on the basis of evidence, to ensure optimal M&E SS outcomes and impacts.
5. All major M&E SS activities, funded by GF SSF and by other sources, should be included in the annual plan and monitored with the help of the National MER TWG. More effort should also be made to ensure that GF M&E SS systems are well integrated in operational terms into the national HIV/AIDS M&E system.

6. Stronger partnerships need to be forged between NAA and line ministries, to ensure they play their role in the national multi-sectoral M&E system and submit data from their respective sectors to the NAA in a timely fashion.
7. Improvement of routine monitoring systems should be seen as one of the more important priorities in the coming years, as well as the development of a UIC system and improved population size estimations.
8. A better enabling environment needs to be created, including through the MCPI, to ensure sentinel surveillance surveys can be carried out without too many difficulties and produce reliable results.
9. A new system and software will have to be adopted for the national multi-sectoral HIV/AIDS database based on lessons from the past.
10. Supportive supervision and data auditing should be intensified, including through training, follow up and oversight.
11. Much more attention has to be focused, in the next few years, on conducting evaluations and research that demonstrates what works, what does not work and what is worth investing in, in a context of decreasing resources for HIV/AIDS. These programmes should be implemented on the basis of a commonly agreed to agenda.
12. Dissemination of data through various means should be undertaken, according to a concrete plan that seeks to enhance access to information by all of the relevant stakeholders.

D. The Need for M&E Technical Assistance and Capacity Building

The development of both institutional and individual capacity for effective M&E will remain an important priority in the coming years. Dedicated human resources with the right set of knowledge, skills and experience will be critical in a strong HIV/AIDS M&E system. Capacity building has already started in mid-2011, under SSF of the GF, and involves the NAA and HACC, as well as some of its key members (i.e., MoEYS, MoSVY, NMCHC, MoWA and selected NGOs).

Capacity strengthening efforts will have to be further specified, to ensure they meet the capacity development needs existing in different areas of the national multi-sectoral system. Because the M&E training needs in the areas of prevention, treatment and care and in impact mitigation are not the same, a comprehensive capacity needs assessment will have to be undertaken in view of developing a strategically informed M&E capacity building plan, as well as relevant, well-tailored training curricula. Training should not only focus narrowly on M&E and its technical aspects, but

also be aimed at developing leadership, programming, coordination, management, facilitation, communication and advocacy skills.

M&E capacity development efforts need to acknowledge that needs are uneven. While some organisations already have relevant M&E capacity, others are still in need of considerable strengthening activities. This means that the beneficiaries of the training efforts need to be very well selected and trainings need to be delivered in a modular manner, which allows them to meet different training needs, depending also on the professional role and responsibility of different types of staff dealing with M&E.

Beneficiaries will learn by participating in training as well as on the job. For the latter to happen, there will need to be adequate follow up. After the trainings, follow up will be required to monitor and ensure that the people who have been trained apply in practice what they have learned. Efforts under GF SSF aim to promote learning by doing, as part of the yearly cycle put in place to monitor the implementation of the NSP III. In particular, people will learn to analyse and interpret data, during sub-national level meetings and sectoral reviews, which each year lead up to the annual national multi-sectoral review, to take stock of progress and to discuss actions needed in the subsequent year. Special emphasis is given to enhancing capacity in analyzing, interpreting and using data to inform programme planning and policy making because this is an area where capacity remains most limited.

Annexes

Annex 1: Consultation/preparation process for the country report on monitoring the process towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

Annex 2: National Commitments and Policy Instrument (NCPI)

Annex 3: National Funding Matrix for 2009 and 2010