Cambodia Report NCPI

NCPI Header

COUNTRY

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:
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Describe the process used for NCPI data gathering and validation:
The National AIDS Authority (NAA) led to facilitate and coordinate with NAA members and civil societies to discuss how to gather and validate document. National Composite Policy Index (NCPI) has been translated into KHMER language for easy understanding. NCPI part “A” administered by government which coordinated by department planning monitoring evaluation and research department (PMERD)has sent to all NAA members for pre-filling and send back to NAA. Part “B” is coordinated and led by HIV/AIDS Coordination Committee (HACC) that organized three consultation workshops with three regional networks. Both part “A and B” have sent to NAA for discussion in national consultation workshop on 6 March 2012. All development partners involved civil society to discuss and provide more inputs in part “B”. NAA and UNAIDS working together to combine all inputs gathered from members and networks, then NAA organized another validation workshop on 13 March 2012 for more concisely validate inputs that we captured from partners and previous workshop.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
There are some disagreement and different point of views for some questions. However, we try to facilitate and vote for the majority people which base on common understanding and scientific information. For example, some questions such as “Yes” and “No” answer and scale questions are difficult to judge because participants have different opinions according to their fact situation.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
As the previous round, the question with ranking is the most concern on potential judgment due to people filled-in the questions and people participated in the consultation meeting are working in different areas. Some areas are strongly agreement, while others less agreement.

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

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
Respondent The National AIDS Authority (NAA)	Dr. Tia Phalla, Vice Chair	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Teng Kunthy, Secretary General	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Hor Bun Leng, Deputy Secretary General	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Ngin Lina, Director Planning Monitoring Evaluation and Research Department	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Sou Sophy, Deputy Director of Planning Monitoring Evaluation and Research	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Lim Kalay, Deputy Director of Planning Monitoring Evaluation and Research	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority	Dr. Thong Dalina, Chief of Monitoring and						

Respondent The National AIDS Authority (NAA)	Dr. Thong Dalina, Chief of Monitoring and Evaluation Office	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Seng Sutwantha, HIV and AIDS Gender Technical Advisor	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Ms. Hou Sophallika, M&E Technical Assistant	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Mr. Poch Vuthea, National Data Analysis and Reporting Coordinator	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Ms. Sovann Vitou, Database Management & Reporting Specialist	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Ms. Siek Sopheak, Senior M&E HIV and AIDS Coordinator	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Ros Seilavath	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Yong Sovatana, Director of Prevention Care and Support	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National AIDS Authority (NAA)	Dr. Sim Kimsan, Director of Communication Resource Mobilization	Yes	Yes	Yes	Yes	Yes	Yes
Respondent National Center for HIV/AIDS, Dematology and STD (NCHADS)	Dr Mok Sokuntheary, M&E officer	Yes	Yes	Yes	Yes	Yes	Yes
Respondent National Center for Tuberculosis and Leprosy Control (CENAT)	Dr. Khun Kim Eam, Chief of Technical Affair	Yes	Yes	Yes	Yes	Yes	Yes
Respondent Ministry of Education, Youth and Sports (MoEYS)	Mr. Mom Mov, M&E Focal Point at MoEYS	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National Maternal and Child Health Center (NMCHC)	Dr. Tuon Sovanna, M&E Focal Point at MNCHC	Yes	Yes	Yes	Yes	Yes	Yes
Respondent The National Authority for Combating Drugs (NACD)	H.E. Neak Yuthea, M&E Focal Point at NACD	Yes	Yes	Yes	Yes	Yes	Yes
Respondent Ministry of Labour and Vocational Training (MoLVT)	Ms. Chea Sokny, M&E Focal Point at MoLVT	Yes	Yes	Yes	Yes	Yes	Yes
Respondent Ministry of National Defence (MoND)	Mr. Him Sitha, M&E Focal Point at MoND	Yes	Yes	Yes	Yes	Yes	Yes
Respondent Ministry of Interior (MoI)	Dr. Hy Someth, HIV/AIDS Program Manager	Yes	Yes	Yes	Yes	Yes	Yes
Respondent Ministry of Women Affairs (MoWA)	Dr. Sengphal Davine, HIV/AIDS Officer	Yes	Yes	Yes	Yes	Yes	Yes
Respondent Ministry of Social Affairs Verterians and Youth Rehabilitation (MoSVY)	Ms. Keo Maly, M&E Focal Point	Yes	Yes	Yes	Yes	Yes	Yes

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

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
Respondent HIV&AIDS Coordinating Committee (HACC)	Mr. Tim Vora, Executive Director	Yes	Yes	Yes	Yes	Yes
Respondent UNAIDS Cambodia	Mr. Tony Lisle, Country Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent UNAIDS Cambodia	Dr. Savina Ammassari, M&E Advisor	Yes	Yes	Yes	Yes	Yes
Respondent UNAIDS Cambodia	Ms. Kathy Keary, UNV M&E Programme Officer	Yes	Yes	Yes	Yes	Yes
Respondent UNAIDS Cambodia	Ms. Jessica Reidies, M&E Fellow	Yes	Yes	Yes	Yes	Yes
Respondent KBA	Yan Somaly/PC	Yes	Yes	Yes	Yes	Yes
Respondent RHAC	Ouer Sadat/PC	Yes	Yes	Yes	Yes	Yes

Respondent KDFO	Soeurn Prunden/PM	Yes	Yes	Yes	Yes	Yes
Respondent CHEC	Heng Phirum/DD	Yes	Yes	Yes	Yes	Yes
Respondent CARAM	Yin Sokunmah/PO	Yes	Yes	Yes	Yes	Yes
Respondent KOSHER	Nguon San/ED	Yes	Yes	Yes	Yes	Yes
Respondent WOMEN	Chum Nak/PO	Yes	Yes	Yes	Yes	Yes
Respondent TASK	Yau Malosya/PO	Yes	Yes	Yes	Yes	Yes
Respondent FHD	Sim Rattana/QHS	Yes	Yes	Yes	Yes	Yes
Respondent KHANA	Mey Sovannara/Officer	Yes	Yes	Yes	Yes	Yes
Respondent CPR	Seng Tack/PM	Yes	Yes	Yes	Yes	Yes
Respondent UNODC	Aaron Waton/CBT officer	Yes	Yes	Yes	Yes	Yes
Respondent MS	Kem Soleil/HIV&AIDS Specialist	Yes	Yes	Yes	Yes	Yes
Respondent TASK	Doeun Vuthea/PM	Yes	Yes	Yes	Yes	Yes
Respondent VC	Hout Totem/ED	Yes	Yes	Yes	Yes	Yes
Respondent SC	Prang Chanthy/PC	Yes	Yes	Yes	Yes	Yes
Respondent CCW	Prum Dalish/PO	Yes	Yes	Yes	Yes	Yes
Respondent Esther	Nhim Sovanvuty/Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent WNU	Pech Sokchea/Staff	Yes	Yes	Yes	Yes	Yes
Respondent KWCD	Sum Satum/ED	Yes	Yes	Yes	Yes	Yes
Respondent AUA	Heng Chheang Kim/PM	Yes	Yes	Yes	Yes	Yes
Respondent SFODA	Va Sophat/PM	Yes	Yes	Yes	Yes	Yes
Respondent CSSD	Meas Chanthan/ED	Yes	Yes	Yes	Yes	Yes
Respondent Chhouksor	Sos Mary/Director	Yes	Yes	Yes	Yes	Yes
Respondent Korsang	Taing Phoeuk/ED	Yes	Yes	Yes	Yes	Yes
Respondent IDA	Pan Sopheap/Program Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent WNU	Keo Tha/Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent CWDA	Keo Tha/Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent SHCH	Chhavehth/Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent PWHO	Kheng Sophal/ED	Yes	Yes	Yes	Yes	Yes
Respondent MHSS	Phel Sophy/ED	Yes	Yes	Yes	Yes	Yes
Respondent BC	Leng Monyneath/National Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent ILO	Chhung Por	Yes	Yes	Yes	Yes	Yes
Respondent WFP	Suntakna	Yes	Yes	Yes	Yes	Yes
Respondent PC	Hem Kim Eng/PO	Yes	Yes	Yes	Yes	Yes
Respondent KYA	Mith Nak/Director	Yes	Yes	Yes	Yes	Yes
Respondent CDRCP	Leng Sothea/ED	Yes	Yes	Yes	Yes	Yes
Respondent PNKS	Prum Maiyim/Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent WDA	Chea Sovanny/PM	Yes	Yes	Yes	Yes	Yes
Respondent CHC	Ung Choun/Staff	Yes	Yes	Yes	Yes	Yes
Respondent CWDA	Ouk Phalla/Staff	Yes	Yes	Yes	Yes	Yes
Respondent CRC	Thaing Kimrin/Staff	Yes	Yes	Yes	Yes	Yes
Respondent WOSO	Sot Vanarith/Staff	Yes	Yes	Yes	Yes	Yes
Respondent CHETRIG	Chan Vuthea/ED	Yes	Yes	Yes	Yes	Yes
Respondent WVC	Ho Daravuth/PM	Yes	Yes	Yes	Yes	Yes
Respondent MHC	So Sovanvasw/Program Staff	Yes	Yes	Yes	Yes	Yes

Respondent AFESIP	So Sopkeak/Social Worker	Yes	Yes	Yes	Yes	Yes
Repondent CWPD	Kron Sarith/OW	Yes	Yes	Yes	Yes	Yes
Respondent PSI	Chum Bunly/IPC Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent LWD	Khim Vichit/Assitant PM	Yes	Yes	Yes	Yes	Yes
Respondent KWCD	Say Nara/Coordinator	Yes	Yes	Yes	Yes	Yes
Respondent HoF	Chorm Vichit/Project Officer	Yes	Yes	Yes	Yes	Yes
Respondent Caritas	Song Bunthan/Admin and IT	Yes	Yes	Yes	Yes	Yes
Respondent DCWO	Som Sophat/Program	Yes	Yes	Yes	Yes	Yes
Responent MHC	Phert Soriya/PC	Yes	Yes	Yes	Yes	Yes
Respondent FAP	Nhem Naryroth/PM	Yes	Yes	Yes	Yes	Yes
Respondent FAP	Yert Neroth/PC	Yes	Yes	Yes	Yes	Yes
Respondent DYMB	Nhem Sopheap/Communciation Manager	Yes	Yes	Yes	Yes	Yes
Respondent HAI	Klout Phally/CO	Yes	Yes	Yes	Yes	Yes
Respondent CSDA	Chorg Phat/Staff	Yes	Yes	Yes	Yes	Yes
Respondent KBA	Yan Somaly/PC	Yes	Yes	Yes	Yes	Yes
Respondent SEADO	Va Kimyan/S/W	Yes	Yes	Yes	Yes	Yes
Respondent HI-F	Hou Navy/Staff	Yes	Yes	Yes	Yes	Yes
Respondent CWPD	Kry SoNornn/PC	Yes	Yes	Yes	Yes	Yes
Respondent AS	Hach Syna/PC	Yes	Yes	Yes	Yes	Yes
Respondent ARM	Sok Serm/Staff	Yes	Yes	Yes	Yes	Yes
Respondent SCC	Som Piseth/PC	Yes	Yes	Yes	Yes	Yes
Respondent CPR	Seng Tak/PM	Yes	Yes	Yes	Yes	Yes
Respondent ARM	Serng Sopin/Consular	Yes	Yes	Yes	Yes	Yes
Respondent CSCN	Nget Sobarak/ED	Yes	Yes	Yes	Yes	Yes

A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):
Yes
IF YES, what was the period covered:
11 years; NSPI (2001-2005), NSPII (2006-2010), NSPIII (2011-2015)
IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.
IF NO or NOT APPLICABLE, briefly explain why.:
The National Strategic Plan for Comprehensive and Multi Sectoral Response to HIV/AIDS 2011-2015 is built on the key guiding principles and apply to all its strategies, objectives and activities. Moreover, this strategic plan has built on the findings of the Functional Task Analysis (FTA) commissioned by NAA at the end of 2009 which provides comprehensive recommendations for organizational, management and leadership strengthening. To maintain the declining incidence prevalence of HIV and advert a second wave of the epidemic, prevention efforts need to prioritized to achieve high coverage and high rates of correct and consistent condom use among the most-at-risk population (MARPs). Other key areas of focus are to increase technical and organizational of the national AIDS Authority network to use effectively its administrative power both at the national and sub-national level in respect to Three-Ones Principles and basic principle of the ownership and alignment to better strengthen management that lead to non cost efficiency and to gain more meaningful participation of all stakeholders, including civil society. More efforts also is needed to regularly update information in a streamlined and cost-effective way including routinely integrating behavioral and biological surveillance among key population.

1.1 Which government ministries or agencies

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

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

SECTORS

Included in Strategy	Earmarked Budget
Yes	Yes
Yes	Yes
Yes	Yes
Yes	Yes
Yes	Yes
Yes	Yes
Yes	Yes

Other [write in]:
CRC, MoSVY, MoT and other members of NAA
IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specifc activities?:
Actually, all members under NAA umbrella have receiving national budget support to the ministry AIDS secretariat coordination meeting. However, some key ministries have receiving budget from other donors such as GFATM, ADB, UNICEF, UNAIDS, UNFPA and USAID; and other international and national non-governmental organization to support their program intervention.

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

Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
No
People who inject drugs:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations:
Yes
Prisons:
Yes
Schools:
Yes
Workplace:
Yes
Addressing stigma and discrimination:
Yes
Gender empowerment and/or gender equality:
Yes
HIV and poverty:
Yes
Human rights protection:
Yes
Involvement of people living with HIV:
Yes

IF NO, explain how key populations were identifed?:

People with disability group does not identify as target group in NSP III. However, this group has included in action plan of Handicap International which collaborates with Operational Health District and the National AIDS Authority. Handicap International works with group and aims to improve access to HIV prevention and sexual violence protection and support systems for persons with disabilities, with a special focus put on persons with sensory impairment. The project focuses at both national and local level and intends to work with mainstream stakeholders (HIV AIDS or gender organizations, local authorities etc) and Disabled People Organizations and/or organizations working for persons with disabilities. The project includes activities for awareness raising, training as well as supportive mechanism for referring sexual violence survivors with disabilities to appropriate services (health, psycho social and legal). Topics addressed encompassed HIV prevention, reproductive health and sexual violence. Sex Workers: The term sex worker is no longer use in current Cambodia context. The favorite word is entertainment worker (EW) instead of sex work worker. EWs are including both direct and indirect people who sell sex. This target group is among Most-at Risk Population and is a focus group that needs to be prioritized with highly attention on high quality of effective prevention intervention alike MSM and IDU groups. Come up with that MARPs Community Partnership Initiative (MCPI)provides a framework and operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach) to access to quality of service for PLHIV and integration of HIV impact mitigation into broader and national protection strategy of Royal Government of Cambodia.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:
Beside EWs, MSM, IDU, Mobile Population, Youth (in and out of school), Prisoners, Pregnant women, high risk males and OVC are also identified among MARPs group. Through MPCI, Cambodia recently has a range of nationally agreed standard operational procedures (SOP) to ensure suitable approaches and strategies to cover key affected populations with quality HIV prevention, treatment, care and impact mitigation programming. There are several SOPs been developed for particular groups such as EWs, PLHA, and PMTCT through national consultation meetings and participation by the representative of PLHA and civil society.

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

1.6. Does the multisectoral strategy or operational plan include

a) Formal programme goals?:
Yes
b) Clear targets or milestones?:
Yes
c) Detailed costs for each programmatic area?:
Yes
d) An indication of funding sources to support programme implementation?:
Yes
e) A monitoring and evaluation framework?:
Yes

1.7

1.7. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?:
Active involvement
IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
Cambodia The development of the multi-sectoral strategy engages and closely involves CSOs and community representatives from the start the Situation Response Analysis; development of NSP III at the beginning stages through the end; and all 7 thematic technical working groups. Moreover, COs also helps to coordinate with among their umbrella to disseminate the NSP III and other HIV and AIDS policies.

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

1.9

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:
Yes, some partners
IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:
The National AIDS Authority has involved internal and external development partners into the development process of HIV and AIDS strategy in order harmonize the response and avoid double program intervention and geographic areas. However, not all development partners are put in their plan into national strategic plan. Somehow they direct work with communities or respect ministries. Most of them are UNs, bilateral and some NGOs .

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:
Yes

2.1. IF YES, is support for HIV integrated in the following specifc development plans?

Common Country Assessment/UN Development Assistance Framework:
Yes

National Development Plan:
Yes
Poverty Reduction Strategy:
Yes
Sector-wide approach:
Yes
Other [write in]:
Response to CMDG indicators and Targets

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

HIV impact alleviation:
Yes
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of stigma and discrimination:
Yes
Treatment, care, and support (including social security or other schemes):
Yes
Women's economic empowerment (e.g. access to credit, access to land, training):
-
Other[write in below]:
Provide microcredit to marginalized and vulnerable groups

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:
Yes
3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?:
4
4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:
Yes
5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:
Yes
5.1. Have the national strategy and national HIV budget been revised accordingly?:
Yes
5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:
Estimates of Current and Future Needs
5.3. Is HIV programme coverage being monitored?:
Yes

5.3

(a) IF YES, is coverage monitored by sex (male, female)?:
Yes
(b) IF YES, is coverage monitored by population groups?:
Yes
IF YES, for which population groups?:
Country has identified MARPs as high target groups in the NSP III program intervention has been made and focused on these particular groups. As results, several SOPs had developed and resources allocations also provided to those program interventions. Some program evaluation has been conducted and being conducted such EW, MSM, OVC, General population and Mobile population.
Briefly explain how this information is used:
The findings of prevention programmes among MARPs have had produced significant results. However, the observation not that HIV prevalence among them continues to be high, if the information of each evaluation does not use well by policy makers and decision makers. Through MARPs Community partnership, NAA in collaboration with Provincial AIDS Committee and some development partners conducted sensitization workshops to inform key issues related to these particular groups and to discuss on necessary and effective steps in enforcing the implementation of 100 % condom use program in order to control the spread of HIV/AIDS at entertainment establishments and making common effort to facilitate the most at risk population able to access to services appropriately. Moreover, the information also use in each technical working at national levels.
(c) Is coverage monitored by geographical area:
Yes
IF YES, at which geographical levels (provincial, district, other)?:
The sensitization workshop has organized at both national and sub-national levels. Moreover, dissemination information also made through technical working meetings and workshops.

Briefly explain how this information is used:
Dissemination information also made through technical working meetings and workshops. Moreover, some publications have been delivered to particular groups and as well as post on the NAA website.

5.4. Has the country developed a plan to strengthen health systems?:
Yes
Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
The Ministry of Health received grant from Global Fund Round 9 for Health System Strengthening (HSS) cross-cutting intervention. This cross-cutting health systems strengthening proposal focuses on creating demand for health services at the community level and improving access, availability and quality of the health services on the supply side. NCHADS is a department to coordinate and facilitate procuring HIV-related infrastructure, human resources and logical systems to deliver medication. The objectives of strengthening health system are: to develop a national quantification system for all required items related to HIV/AIDS care and treatment (ARV and OI medications, CD 4 and VCCT reagents, consumables, equipment) and the care and treatment of sexually transmitted infections (STI - medications, reagents, consumables and equipment); to establish quantification for all required items related to HIV/AIDS and STI care and treatment; to guarantee storage under suitable conditions for all relevant supplies, in collaboration with Essential Drug Bureau (EDB) and Central Medical Stores (CMS) and other partners; to ensure the timely supply and distribution of all required items to all relevant sites following a distribution table for each region; to track all supplies received at NCHADS warehouse by source of funding; to collaborate with all relevant units within NCHADS and all sites and partners that form part of the NCHADS Program; to establish a well functioning inventory system that will ensure the avoidance of stock outs and expiry of stock; to establish a quality control system for receipt and acceptance of new stock; to supervise the rational storage and distribution of HIV and STI related supplies at NCHADS and all relevant sites and to build human resource capacity at the provincial, referral hospital and operational district level by training, monitoring and supervision.
6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?:
9
Since 2009, what have been key achievements in this area:
There are many things have been achieved since 2009. High level political support has been the key to Cambodia's success under the second National Strategic Plan (NSP II). The epidemic is in decline and over 90% of eligible PLHIV receive treatment. Progress has been made in the prevention of HIV in several areas, including establishment of technical working groups (TWGs) and development of standard operating procedures (SOPs) for interventions with MARPs. The introduction of the innovative four-pronged Linked Response approach for Prevention of Mother to Child Transmission (PMTCT) has increased the coverage and quality of services, as well as referral linkages. Coverage of screening of blood transfusion has reached 100% and condom and lubricant sales are expected to reach 2010 targets.
What challenges remain in this area:
The gains made in reversing the epidemic trends will remain fragile as long as pockets of high prevalence persist among sub-populations of entertainment workers, men who have sex with men (MSM) and injecting drug users (IDU). The prim the gains made in reversing the epidemic trends will remain fragile as long as pockets of high prevalence persist among sub-populations of entertainment workers, men who have sex with men (MSM) and injecting drug users (IDU). The primary driver of Cambodia's HIV epidemic continues to be heterosexual transmission between entertainment workers and their clients and other sexual partners. Spousal transmission occurs when clients of entertainment workers infect their wives and subsequently, the infants born to infected mothers. There are still wide-scale problems accessing key populations including EW and IDU because of their fear of arrest and detention by the police. 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. - Grassroots level - Implementation of NSP III at sub-national level - Time constrain for NSP III implementation.

A - II. POLITICAL SUPPORT AND LEADERSHIP

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

A. Government ministers:
Yes
B. Other high offcials at sub-national level:
Yes

1.1

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

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
Cambodia's successes in its fight against HIV and AIDS can largely be identified as the result of political commitment at the highest level of government, supported by the leadership, dedication and mobilization of the First Lady Lok Chumtiev Bun

Rany Hun Sen. First Lady does a critical role model with her empathy, passion to marginalized people in both national and sub-national level. For example, she always support to vulnerable children, pregnant women and disable people. Moreover, high level leaders commit more national resources to rectify the identified weaknesses in the HIV response; talking of HIV as a human rights issue in public places and domestic/international forum; and doing some social activities such as visiting VCTC, PMCTC center etc.) 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.

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

Yes

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

Have terms of reference?:

Yes

Have active government leadership and participation?:

Yes

Have an official chair person?:

Yes

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

H.E Dr. Nuth Sokhom, Senior Minister and Chair of the National AIDS Authority

Have a defined membership?:

Yes

IF YES, how many members?:

24 provinces and 29 ministries

Include civil society representatives?:

Yes

IF YES, how many?:

HACC's members - 139 NGOs

Include people living with HIV?:

Yes

IF YES, how many?:

Representative from people living with HIV were include in the national membership such as representative from CPN+both national and sub-national, CCW, CACHA

Include the private sector?:

Yes

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

Yes

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

Yes

IF YES, briefly describe the main achievements:

The NAA provides the coordination role to all members, stakeholders, civil society and private sectors. There are many forums that engage and encourage the involvement of the development partners and civil society. As results, Cambodia has Joint Donors and Government Technical Working Group (JDG-TWG) that has regularly meeting every two-month. The role of responsibilities of this working group is oversight the whole response; determine priority action for the response to HIV/AIDS and to mobilize resources to support to priority setting actions. Moreover, the establishments of seven National Technical Working Groups have been functioning to coordinate and facilitate with partners to achieve the goal and objectives of each strategy of NSP III. Furthermore, there is other forum called CBCA that enable the interaction between government, development partners and private sectors in responding to HIV/AIDS on the world workplace. In addition, other mechanism is also encourage promote the interaction between government, CSO and private sector called Country Coordinating Committee (CCC) of the Global Fund.

What challenges remain in this area:

- Limited capacity to strengthen to all seven national working groups - Some development partners are likely not much involve in the development process of strategic plan and other related policy and do not share their plan to the government such as USAID and US-CDC. - Harmonization and alignment mechanism and procedure between government and development partners need to strengthen. - Strengthening existing system such as Provincial AIDS Committee and Provincial AIDS Secretariat to manage to the response and funding flow.

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

0%

5.

Capacity-building:

Yes

Coordination with other implementing partners:

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

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:
Yes
6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:
Yes
IF YES, name and describe how the policies / laws were amended:
- Law on the CONTROL OF DRUGS endorsed by national Assembly adopted the Law on the on 09 December 1996. This law has amended in 2005.The National Needle and Syringe Guidelines has developed and Harm reduction policy has revised according to the current situation - Establishment of a minimum standard package for OVC, efforts to re-calibrate and intensify HIV prevention through inputs into the design of standard operational procedures (SOP) for the Continuum of Prevention to Care & Treatment (CoPCT) for entertainment workers, MSM/TG and PWID/PWUD and into the framework (SOP) for the delivery of TB/HIV services in prisons - Standard operating procedures (SOPs) for interventions with most-at-risk populations (MARPs) have been developed to strengthen the enabling environment/create “safe space” for access to and utilization of HIV and related services - Policy on workplace for both government and private sectors - Policy on 1% of donors funding support to national response
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
- The implementation of the Sanghat/Commune Safety Policy is a key concern of the implementation of National Needle and Syringe guideline - Human Trafficking policy remains an inconsistence in use of 100% condom use. For example, while Human Trafficking Policy introduced, sex workers are hiding from police officers. As a result, outreach workers are face difficulty to access them and implement of the 100% condom use.
7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2011?:
10
Since 2009, what have been key achievements in this area:
High level governments still play an important role in the response to HIV and AIDS. As a result, Cambodia was awarded from UN as HIV/AIDS Champion. Moreover, the achievement again national and UA indicators and targets are over achieved. Under political support and leadership of high ranking governments, there are many things we have solved and developed as following: - Functional Task Analysis has developed - 1% policy has developed - Harmonization and alignment of key national indicators for national M&E and Universal Access indicator and targets setting - Socio-economic impact on HIV/AIDS study - Revision of laws on the Control Drug - Standard operational procedure for CoPCT and MARPS - A comprehensive Cost Effectiveness Analysis of HIV Prevention and Impact Mitigation was conducted in 2011
What challenges remain in this area:
- Limited participation from sub-national level in the process of development strategic plan and policy - The capacity of sub-national people must be afforded increased attention if the national response is to be further “localised” and sustained. - Implementation of Drug law with HIV prevention intervention is still a concern - Limit participation in the from bi- and multi-lateral representatives in the policies and national strategic plan development - Limitation funding to support to the national response is still a consideration. Cambodia received lots fund from external donors, however, this fund are mostly direct use by development partners and they spent too much for international consultants.

A - III. HUMAN RIGHTS

1.1

People living with HIV:
Yes
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
Yes
Prison inmates:

Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
-

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes
IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
The Law on the Prevention and Control of HIV/AIDS, which was enacted by the National Assembly since 2002. Under chapter VIII it is clear state on non discrimination to people living with HIV/AIDS such as they should have equal rights to access public services, testing working and other involvement of the preparation any strategy and policy. This Law also has its implementing guidelines (2005) outlines measures to combat discrimination. Moreover, in 2011 the NAA developed and endorsed the National Guideline For STI and HIV/AIDS Response Among MSM, Transgender And Transsexual People. The guidelines recognizes the right of Cambodian citizens to the full and free expression of their sexual identity and where sexual identity is not a barrier or impediment to Prakas 066 (the 100% Condom Use Policy) ensures access to condoms in all high risk settings in respect of discrimination or negative actions by law enforcement authorities in entertainment venues. Moreover, the national Law does not have a specific law on non-discrimination. However, Article 31 of the Constitution states all citizens shall be equal before the law and have the same freedoms and obligations. Protection is afforded to PLHIV and key affected populations through a number of policies and other legislation.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
The enforcement of HIV/AIDS Laws and policies use the mechanism consist various commissions of the National Assembly such as Human Rights, Health & Women & Social Welfare; and oversight mechanisms at the national (ministry) and local (sub-national democratic development institutions) levels. The Legal and policy technical working group is a committee to oversight and monitor the implement of HIV/AIDS Laws. The member of technical working group include. ministry of Justice, Ministry of Interior and other respect institution.
Briefly comment on the degree to which they are currently implemented:
Although, there are clear structures and mechanism for implementing and monitoring HIV/AIDS Laws and its policy, there are still remain challenges with limited capacity and no enough financial support to the implementation of Laws and policies.
2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
Yes

IF YES, for which subpopulations?

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

Briefly describe the content of these laws, regulations or policies:
The revision of Drug and Trafficking laws is still present concern for EWs and IDU prevention and treatment, while at the same time as including provisions for public health and harm reduction, it also extends periods of incarceration for minor drug

offenders. The commune/sangkat safety policy is also a concern for our outreach workers to work with EWs and DU/IDUs. These high risk groups pretend to high themselves from local authority and police.

Briefly comment on how they pose barriers:

It concerns that there are significant often unintended consequences from the inconsistent application of the Policy at the local level. For example, there have been hesitant by outreach workers to gather in groups or to carry HIV prevention paraphernalia (needles/syringes, condoms) for fear of arrest by local law enforcement agents. This needs further effort collaboration from government to address the shortfalls in the application of the Policy. Giving that, the reinforcement of Prakas 66 by the NAA and the implementation of the SOP for CoPCT for entertainment workers have rearranged the most serious unintended consequences of the application of the Laws and policies. The MCPI is a forum to resolve all unintended consequences among MARPs groups.

A - IV. PREVENTION

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

Yes

IF YES, what key messages are explicitly promoted?

Abstain from injecting drugs:
Yes
Avoid commercial sex:
Yes
Avoid inter-generational sex:
No
Be faithful:
Yes
Be sexually abstinent:
Yes
Delay sexual debut:
Yes
Engage in safe(r) sex:
Yes
Fight against violence against women:
Yes
Greater acceptance and involvement of people living with HIV:
Yes
Greater involvement of men in reproductive health programmes:
Yes
Know your HIV status:
Yes
Males to get circumcised under medical supervision:
Yes
Prevent mother-to-child transmission of HIV:
Yes
Promote greater equality between men and women:
Yes
Reduce the number of sexual partners:
Yes
Use clean needles and syringes:
Yes
Use condoms consistently:
Yes
Other [write in below]:
Safe migration, faith base organization, positive prevention

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

Yes

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

Yes

2.1. Is HIV education part of the curriculum in

Primary schools?:
Yes
Secondary schools?:
Yes
Teacher training?:

Yes

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:
Yes
2.3. Does the country have an HIV education strategy for out-of-school young people?:
Yes
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:
Yes
Briefly describe the content of this policy or strategy:
NAA has formulated a set of advocacy and communications strategies to support these seven main strategies. These advocacy and communication strategies are distinct from other strategies, such as providing clinical services or training, or monitoring and evaluating programmes. Advocacy and communication strategies add value to HIV/AIDS programming landscape in two ways: through advocacy aimed at policy makers, and by publicizing policies and services. In some cases advocacy will focus on broad-based goals to gain support for a range of strategies. In other cases advocacy efforts will target the need for expanding specific programming. Communication efforts will not only publicize specific programmes, but also work hand in hand with clinical workers who conduct training sessions, and help bring professionals together to share lessons learned and best practices. As policy makers and programme planners move forward, NAA hopes that its advocacy and communication activities will provide significant support not only for HIV/AIDS programming, but also for broader policy goals of reducing poverty, improving access to health and education services, and developing Cambodia.

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

IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
Yes	Yes	Yes	Yes	Yes	-
Yes	Yes	No	No	No	-
Yes	Yes	Yes	Yes	No	-
Yes	Yes	No	No	No	-
Yes	Yes	Yes	No	No	-
Yes	Yes	Yes	Yes	Yes	-
Yes	Yes	Yes	Yes	Yes	-
Yes	Yes	Yes	No	No	-

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?:
8
Since 2009, what have been key achievements in this area:
There much has been achieved in HIV prevention with high risk population. In respect of harm reduction, the most singular achievement was the establishment of Cambodia's Methadone Maintenance Therapy Clinic which is now dosing over 165 patients. MCPI for CoPCT has for the first time brought testing and counseling to the community, increasing demand and uptake for testing and referral to other services (STI and importantly OI/ART where required). PMTCT uptake has steadily increased. For example in 2011, 87% of pregnant women(PW) (366,080) were tested and 64% of those who need it (930/1464) received ART or ARV prophylaxis. 57% of infants born to an HIV+ mother received ART prophylaxis. ANC prevalence is 0.4% while in 1990s was over 2 per cent. The contribution in the "linked response" is contributing to the success of PMTCT and at the same time increasing PW uptake of MSC services, especially ANC 1 & 2. HIV prevention efforts with Men-who-have-Sex-with-Men & Transgender People has been informed by both the National Strategic Framework and Costed Operational Plan (2008-11) and the national SOP for the CoPCT in the health sector. The innovative programmes is reaching self identified MSM and TG with information, commodities and services and there is greater acceptance of MSM/TG within local communities. 100% condom use policy is still practical for EWs and ensured that a wider network of entertainment establishments and venues are ensuring access to condoms and lubricants.
What challenges remain in this area:
Although, there have been much achieved in respect of HIV/AIDS prevention among high risk group, some challenges are remain key concern for program intervention as following: - Not all ministries do not have HIV related policy - Alignment and harmonization within and between government and bilateral for program coverage and targets are still needed - The VCCT protocol with respect to pre- and post-test counseling is not always followed. Some MSM who test positive for HIV have been unaccounted for as a result, - Significant (GFATM related procedure) procurement constraints have interrupted the free delivery of condoms and lubricants - adequately capacitated some ministries to deliver scaled programmes - It remains very difficult to effectively target mobile populations including migrant workers.
4. Has the country identified specifc needs for HIV prevention programmes?:
No
IF NO, how are HIV prevention programmes being scaled-up?:
Following the universal access to HIV/AIDS prevention, care and treatment, there were consensus meetings to set indicators and targets for 2006-2010. HIV prevention is being scaled up according to the target setting. Most indicators are over achieved.

4.1. To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Strongly Agree
Harm reduction for people who inject drugs:
Agree
HIV prevention for out-of-school young people:
Agree
HIV prevention in the workplace:
Agree
HIV testing and counseling:
Strongly Agree
IEC on risk reduction:
Agree
IEC on stigma and discrimination reduction:
Agree
Prevention of mother-to-child transmission of HIV:
Strongly Agree
Prevention for people living with HIV:
Strongly Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Agree
Risk reduction for men who have sex with men:
Agree
Risk reduction for sex workers:
Strongly Agree
School-based HIV education for young people:
Strongly Agree
Universal precautions in health care settings:
Agree
Other[write in]:
-

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:
8

A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:
Yes
If YES, Briefly identify the elements and what has been prioritized:
The HIV treatment, care and support services have implemented though a comprehensive packages of the Continuum of Care in Cambodia since 2003. The package of services including: • The Facility-Based Health Services Delivery: include services available at MPA level such as ANC, birth spacing, HIV testing through VCCT and PITC offers for the all clients who attend the STI and TB patients, ANC attendees including HIV testing during/at labor, and services available at CPA level such as OI/ART services for adult, Pediatric AIDS Care (PAC), laboratory support, STI services (in high-risk ODs) and delivery services for PLHIV. The palliative care will also be integrated part in the CoC packages. • The Integrate the Linked Response between HIV, STI, MCH/RH and TB into the CoC; • The Community-based prevention, care and support (CBPCS): the purpose to reduce stigma and discrimination associated with HIV prevention and care service delivery; to facilitate service linkage to ensure user-friendly HIV care and treatment services; to support successful ART through adherence support and close follow-up of the patients, and the implementation of other activities according to the up-to-date the CoC framework, such as positive prevention for PLHIV, Three "I" Strategy; and to assist PLHIV to access other social support.
Briefly identify how HIV treatment, care and support services are being scaled-up?:
• Work in partnership with all partners to scaling up treatment, care and support services through expansion of scope and scale of the comprehensive packages of CoC for PLHIV. • Expand and strengthen the CoC for adult and children living with HIV at OD level; • Building and maintaining the capacity of health staff in the continuum of care; • Integrate the Linked Response between HIV, STI, MCH/RH and TB into the CoC; • Integrate activities to support positive prevention for PLHIV including access to STI and birth spacing /condom services into CoC packages; • Work towards integration of the CoC into the health care system; • Strengthen the coordination of linkages within and among the various Health Services Delivery (HSD) and community based prevention, care and support (CBPCS) and health facilities based care; • Support PLHIV peer support activities

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

Antiretroviral therapy:
Strongly Agree
ART for TB patients:
Strongly Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Strongly Agree
HIV care and support in the workplace (including alternative working arrangements):
Agree
HIV testing and counselling for people with TB:
Strongly Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Agree
Nutritional care:
Agree
Paediatric AIDS treatment:
Strongly Agree
Post-delivery ART provision to women:
Strongly Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Agree
Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Strongly Agree
TB infection control in HIV treatment and care facilities:
Strongly Agree
TB preventive therapy for people living with HIV:
Strongly Agree
TB screening for people living with HIV:
Strongly Agree
Treatment of common HIV-related infections:
Strongly Agree
Other [write in]:
-

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:
Yes
Please clarify which social and economic support is provided:
Recently, MoSVY has developed a policy for social protection to support to vulnerable children and people living with HIV/AIDS. This policy serves rights for marginalized people and helps them to avoid any exploitation from the power groups. Also, this policy has sensitized to national and sub-national levels for further application.
3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:
No
4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:
Yes
IF YES, for which commodities?:
Condoms, Test Kits, OI/ARV drugs and other laboratory equipments
5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
Key Achievements in this areas since 2009 to the end of 2011: • VCCT sites were expanded from 233 to 255 in 2011, with the numbers of clients tested rising from 363,789 to 411,657 by the end of 2011; • Adult ART services were scaled up with 52 to 59 sites, with the numbers of adult patients on ART rising from 33,677 to 42,034 in 2011; • Pediatric AIDS Care was scaled up from 29 to 33 sites, with the number of children patients rising from 3,638 to 4,439 children on ART in 2011; • Home-based care teams working within the CoC have expanded to 348 by the end of September 2011 covering 864 health centers and supporting over 32,101 PLHA; • Up to the end of 2011, 66 ODs covering 885 health centers are implementing the linked response approach. 109,618 pregnant women attending the ANC services, and among them, there were 88,240 were

accepted to do HIV testing, with the positive rate was 0.20%; • The guideline for Implementation for Positive Prevention has been developed and started to implement in 20 ODs during the last quarter of 2010 • Standard Operating Procedures for Implementing The "3'Is activities in Continuum of Care Setting were approved by MoH on 23 April 2010 and stated to implement in 25 OI/ART sites in April 2010 and increase to 32 sites by 2011; • Integrated HIV laboratory support into Health Service Delivery – Increase in the uptake of CD4 testing from 70,000 in 2010 to 90,000 in 2011 within 7 sites; – Viral load testing has been started at NCHADS Lab since April 2011 (7,000 VL to be tested until December 2011) – Other laboratory tests are integrated into general laboratory at RH • Quality Assurance of CoC services – CQI for OI and ART Services: started in 2009, and now 13 OI and ART sites are implementing CQI. – Early Warning Indicator: started in 2008, and conducted every year at OI and ART sites by focus on Logistic Supply Management and adherence issues and feedback results were sent to OI/ART sites Threshold Survey for ARV drug resistance: Collaborate with a laboratory in Canada (samples sent and await results).

What challenges remain in this area:

Human Resources: • Workload for Health workers and community support teams because of large number of patients and large number of data to be collected; • Low motivation (low salary) at all levels; • Limited number and capacity of HIV care teams at district level • Poor communication and coordination between health workers and community support groups. Health care system and infrastructure: • Difficulty in accessing health facilities at peripheral level (bad road, long distance, no transportation); • Poor data management at peripheral level. PLHIV and families: • Poor (no money for transportation); • Moving around the country and across the border (for jobs); • Low education, especially at peripheral level.

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

Yes

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

Yes

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

Yes

IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:

Yes

IF YES, what percentage of orphans and vulnerable children is being reached? :

70%

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:

7

Since 2009, what have been key achievements in this area:

- Task Force for OVC has created to support and oversight the implement of HIV program for OVC - Provides Technical advisors to OVC Task Force - provides some related trainings to MoSVY - National OVC action plan also developed - National M&E guidelines for OVC developed - Since report in previous round we have no denominator in previous; but this year show about denominator OVC. It is helpful for data analysis.

What challenges remain in this area:

- Expand the services for all OVC intervention - Definition on OVC is still a key concern as different organization use different definition. This affects data analysis as well

A - VI. MONITORING AND EVALUATION

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

Yes

Briefly describe any challenges in development or implementation:

Several challenges to the implementation of a comprehensive system remain. The main challenges that constitute a functional national M&E system can be noted as follows: - Multi-sectoral leadership and coordination to pool data from multiple sources into one single national HIV/AIDS database has improved but requires further strengthening. - 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. - 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. - 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. - 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). - 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.

1.1 IF YES, years covered:

2009-2015

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

Yes, some partners

Briefly describe what the issues are:
The national M&E framework and setting indicators and targets have developed using consultation meetings which was involved CSOs and development partners in the development process. Still, some indicators being set by developments partners without discuss with national program. Stronger partnerships need to be created between government and donors/bi-laterals 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. However, NAA is rarely receiving data from development partners, .particular fro bi and multi lateral organizations.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy:
Yes
Behavioural surveys:
Yes
Evaluation / research studies:
Yes
HIV Drug resistance surveillance:
Yes
HIV surveillance:
Yes
Routine programme monitoring:
Yes
A data analysis strategy:
Yes
A data dissemination and use strategy:
Yes
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):
Yes
Guidelines on tools for data collection:
Yes

3. Is there a budget for implementation of the M&E plan?:
Yes
3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :
4%
4. Is there a functional national M&E Unit?:
Yes
Briefly describe any obstacles:
- Capacity on M&E is still a key concern for implementation M&E system. - Budget for M&E is only 4% of the whole program response to HIV/AIDS.

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

In the Ministry of Health?:
Yes
In the National HIV Commission (or equivalent)?:
Yes
Elsewhere [write in]?:
National Center for HIV and AIDS, Dermatology and STI (NCHADS)

Permanent Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Director of Department	Full Time	-	2003
Deputy of Director in charge of Data	Full Time	-	2003
Deputy of Director of Planning	Full Time	-	2001
Deputy of Director in charge of M&E	Full Time	-	2002
Chief of M&E Office	Full Time	-	2009
M&E Office	Full Time	-	2002

Temporary Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
M&E Specialist	Full Time	-	2007
M&E Specialist	Full Time	-	2010

Senior M&E HIV&AIDS Coordinator	Full Time	-	2007
Database Management & Reporting Specialist	Full Time	-	2009
National Data Analysis and Reporting Coordinator	Full Time	-	2010

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:
No
Briefly describe the data-sharing mechanisms:
The NAA is called to report annually on progress made in the national, multi-sectoral response to HIV/AIDS. Annual reports are to be submitted to the National AIDS Authority's Policy Board and to the Royal Government of Cambodia as well as shared with development partners and various implementing agencies. The NAA also disseminates information through the publication of routine and specific reports and other thematic publications. NAA's website, which should be used to post comprehensive up-to-date HIV information in order to make it easily accessible in the public domain, has yet to be regularly updated and enhanced.
What are the major challenges in this area:
Government and non-governmental organizations often have their own annual reports from which information is synthesized into the national multi-sectoral Annual Report produced by the NAA. There are however some delays with which these reports are submitted to the NAA due to difficulties in data compilation, analysis and interpretation. Data reporting requirements are well defined in some sectors (such as the health sector) but less clear in others which further contributes to delays and incompleteness of dissemination. Different reporting requirements are set by different donors and have contributed considerably to the reporting burden. Data are often not accessible for use, particularly at sub-national level, as feedback and sharing are not systematically foreseen or undertaken due to lack of Internet accessibility.
5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:
Yes
6. Is there a central national database with HIV- related data?:
Yes
IF YES, briefly describe the national database and who manages it.:
The database is housed at the NAA and has been in use since 2005. CRIS is a flexible information management system that has been configured to fit national HIV/AIDS data storage needs. Since the database is populated by the core indicators as well as a few selected additional programme monitoring indicators, CRIS enables the NAA to monitor the national, multi-sectoral response and to prepare reports on progress toward the achievement of common objectives and agreed to targets. A new, more user-friendly version of CRIS was introduced in 2009 and staff have been trained in its use. However, CRIS could not solve all problems that formalized protocols do not yet exist for data management addressing the issues of quality assurance and systematic backup of the information.
6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:
Yes, but only some of the above
IF YES, but only some of the above, which aspects does it include?:
Some ministries, for example NCHADS, MoWA, MoEYS, MoSVY; except the MoLVT and Ministry of Tourist and rest of other ministries do not have information either geographical coverage of HIV services.

6.2. Is there a functional Health Information System?

At national level:
Yes
At subnational level:
Yes
IF YES, at what level(s)?:
-

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

8. How are M&E data used?

For programme improvement?:
Yes
In developing / revising the national HIV response?:
Yes
For resource allocation?:
Yes
Other [write in]:
-

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

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

At national level?:

Yes
IF YES, what was the number trained:
9
At subnational level?:
Yes
IF YES, what was the number trained:
7
At service delivery level including civil society?:
No

9.1. Were other M&E capacity-building activities conducted` other than training?:
Yes
IF YES, describe what types of activities:
Supervision and meeting coordination.
10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:
6
Since 2009, what have been key achievements in this area:
2 M&E focal points from ministries and provincial level were built capacity; progress annual reports were developed.
What challenges remain in this area:
Still limited information from NGOs; and lack of information of financing report.

B - I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:
4
Comments and examples:
CSOs indicated that they generally had good access to provincial level political leadership but found it more difficult to access national political and policy decision-makers. The Human Rights Commission of the National Assembly has indicated willingness to dialogue with representatives of community networks. Networks need to prepare common positions and take steps to initiate dialogue. CSOs developed and disseminated common advocacy messages around Universal Access for political leaders attending the High Level Meeting on AIDS at the UN General Assembly in June 2011 and especially for the First Lady's participation in the elimination of paediatric AIDS event at the high Level meeting and for her meetings with the UN Secretary-General. CSOs generally felt that they had contributed significantly at the technical level to the formulation of national strategies, policies and guidance. As an example they cited their involvement in the development of the revised Drug Control Law where they advocated successfully for the inclusion of harm reduction and public health related provisions. CSOs, through participation in technical working groups and task forces have positively influenced the content of policies and guidance. Examples include the establishment of a minimum standard package for OVC, efforts to re-calibrate and intensify HIV prevention through inputs into the design of standard operational procedures (SOP) for the Continuum of Prevention to Care & Treatment for entertainment workers, MSM/TG and PWID/PWUD and into the framework (SOP) for the delivery of TB/HIV services in prisons. Those CSO's who work with PWID participated at the invitation of the National Authority for Combating Drugs (NACD) in the revision of the National Needle and Syringe Guideline. CSOs also developed a joint statement to government on the implementation of the Sanghat/Commune Safety Policy and its unintended consequences of the delivery of HIV services to key affected populations. The NAA comprehensively engaged key affected populations, especially EW/SW and MSM/TG in design and orientation for the Most-at-Risk Populations Community Partnership Initiative, developed to strengthen the enabling environment/create "safe space" for access to and utilisation of HIV and related services. CSO's were comprehensively engaged in each of the seven strategy sub-working groups for the development of the costed National Strategic Plan lll and provided strategic inputs into the Situation & Response Analysis. Representatives from community networks reported that they still lack the skills to meaningfully participate and influence political leadership. The establishment of a Community Legal Service for Sex Workers/Entertainment Workers received the endorsement of government policy and decision-makers, following broad-based dialogue between key community networks representing sex workers/entertainment workers, the National AIDS Authority and concerned ministries. CSOs however identified a number of weaknesses and gaps that required reddressal. The CSOs felt they needed more power to influence the implementation of the Village Safety Policy to combat unintended negative consequences of policy implementation at the local level. Problems associated with the delivery and scaling of effective harm reduction services with PWID were also identified as an area where CSO's had little traction with political leaders and policy makers to mutually address the problems in programme delivery, especially needle & syringe programming where the NACD is reluctant to issue and/or renew licences to CSOs for NSP service delivery.
2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:
4
Comments and examples:
CSO's and representatives of community networks were comprehensively engaged in each of the seven strategy sub-working groups for the development of the costed National Strategic Plan lll and provided strategic inputs into the Situation & Response Analysis. CSOs have been engaged in annual planning and review processes of the National AIDS Authority and in

the health sector response (five year strategic plan, annual planning and review processes) over-sighted by NCHADS-MoH. CSOs and representatives of community networks are engaged by the National AIDS Authority (NAA) in annual planning and review processes and are included as observers or members in key policy, advisory and technical bodies such as the NAA's Policy and Technical Advisory Boards, the Government-Donor Technical Working Group on AIDS and specific technical working groups of both the NAA, the National Centre for HIV/AIDS, Dermatology and STI (NCHADS/MOH) and the Ministry of Social Affairs, in respect of HIV prevention with key affected populations (entertainment workers/sex workers, MSM, IDU/DU), treatment, care and impact mitigation. Each of these TWGs also contributed to the development of the National Strategic Plan (2011-2015) and to annual operational planning and review processes. A comprehensive Cost Effectiveness Analysis (CEA) of HIV Prevention and Impact Mitigation was conducted in 2011 with the participation of CSOs and community networks. The CEA is being used to prioritise national response interventions, based on the evidence for the most cost-effective deployment of resources to avert new infections and prevent AIDS-related deaths. While CSOs have been represented in key technical working groups, they do not feel that they are equal participants in dialogue or decision-making. In some cases they do not recognise the importance of their own role. Overall, CSO views and positions are not always adequately represented in decisions. The community networks perceived that the issues raised by them are not necessarily reflected in the national plans though they are provided with space to speak.

3.

a. The national HIV strategy?:
5
b. The national HIV budget?:
0
c. The national HIV reports?:
4
Comments and examples:
CSOs feel that their programmes and the services provided by them are comprehensively included in the national HIV strategy. It was pointed out that a significant proportion of services in care (Home Based Care and MMM/Self Help Groups) are provided by CSOs/community networks (>50%) and a significant proportion of HIV prevention (>80%) for key affected populations is directly delivered by CSOs. Most of the impact mitigation interventions for OVC and PLHIV are also delivered by and through CSOs. The CSOs indicated that government has not included the services (prevention, treatment/care, impact mitigation) of CSOs in national budget allocations to the national AIDS response. The majority of CSO finance is sourced from the Global Fund to Fight AIDS, TB & Malaria and/or from bilateral, multilateral and other international donors. (CSOs noted that previous NCPI reports interpreted "national budget" to mean all sources of funds provided to Cambodia for the national AIDS response. This report interprets "national budget" to mean funds specifically allocated in the state budget for CSOs to conduct HIV/AIDS activities). While CSOs are involved in reporting procedures at all levels and their work is monitored in national reporting mechanisms, there is no standard reporting procedure for CSOs resulting in reports being provided to multiple institutions. Community networks stressed that in the absence of standard reporting mechanisms and formats, information is often not included in national reports. In respect of reporting and monitoring, CSOs need a more active and systematic role in both monitoring and Continuous Quality Improvement in the delivery of HIV services, ensuring that standard operating procedures and national guidelines are adhered to and they need to be more instrumental and engaged in developing standards where they are still lacking. Monitoring of services is complicated by the fact that there are significant disparities in the services and interventions (quality and coverage) provided by the various CSOs. Although progress has been made in terms of the quantity and quality of data available there are still gaps and these will need to be addressed if programmes are to work effectively. CSOs are still not sufficiently organised at the sub-national level to consult jointly and analyse local data for quality improvement of programming. Apart from the health sector response, CSO data is not regularly reported.

4.

a. Developing the national M&E plan?:
3
b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?:
3
c. Participate in using data for decision-making?:
3
Comments and examples:
CSOs were of the opinion that CSOs and especially community networks were not adequately engaged in the development of the national M&E Plan/Guideline. M&E was used to make decisions at the level of the CSOs own programmes, more particularly by larger CSOs with significant M&E capacity. CSOs continue (with the exception of the health sector) to play a "passive" role in larger national and sub-national M&E systems and processes for monitoring and decision making on programme directions, improvement and re-calibration. Some CSO representatives stated that they had no experience or training in how to effectively carry out monitoring and evaluation exercises. The GFATM SSF grant for HIV has included an M&E strengthening component to specifically address this deficit. CSO participation in the National M&E Advisory Group remains inconsistent and generally "passive". CSOs pointed out that indicator variations in national standards and packages contributes to a lack of clarity in what needs to be monitored, how and by whom. This can create difficulty in contributing data to measure common results. Progress is being made in the development of routine monitoring systems for OVC and MARPS prevention however. Provincial and District AIDS Offices do involve CSOs in M&E work, (for example the Continuous Quality Improvement (CQI) system, for strategies to varying degrees. Representatives of CSOs were also invited to take part in the M&E working group. Community network representatives pointed out that use of data

and strategic information for major decision making in programming or for advocacy is a significant gap due to limitations in skills and knowledge within CSOs and community networks.

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

5

Comments and examples:

CSOs feel that all their organisations, regardless of what portion of the population they represent, are comprehensively included and representation of community networks in major policy, decision making and programme review and implementation bodies has significantly improved. For example, representatives of the national coalition of entertainment worker/sex worker networks and the MSM National Network (Bandagn Chaktomuk) have been elected to represent their constituencies on the GFATM CCM and network (PLHIV, MSM and entertainment workers/sex workers) representatives are members of key technical working groups in the areas of prevention, treatment and impact mitigation. Community Networks in Cambodia have established a representative's forum called FoNPAMS (Forum of PLHIV and MARPs Networks) which is mandated among other things, to oversight the quality and strategic engagement of key affected populations in the national AIDS response. The PLHIV network (CPN+) directly manages significant resources as a Sub-Recipient of the Global Fund HIV SSF (approximately US$400,000), to deliver community care and to manage self-help groups at the sub-national level. An indicator of the increased inclusiveness of communities in the response can be seen in the reported reduction of stigma and discrimination of PLHIV in health care settings, where the network of people living with HIV manage, in co-operation with local health staff, the friends-help-friends groups and engage in CQI activities at the local health and referral facilities. An independent evaluation of the national response with MSM showed a marked increase in inclusiveness in programming decisions and an overall reduction in reported stigma and discrimination over the last 4 years. The Ministry of Cults and Religion has actively encouraged the engagement of Faith-Based Organisations in the national response (Buddhists, Muslims and Christians). The Buddhist Leadership Initiative has played a critical role in engaging the Sangha (lay and clergy) in the provision of psycho-social support and care with OVC and PLHIV. The Cambodia Business Coalition on AIDS (which sits as a member on the GFATM Oversight Committee) has been instrumental in animating and promoting the engagement of small, medium and large enterprises, especially in the garment production and tourist sectors of the economy. The Community Legal Service for Sex Workers/Entertainment Workers is setting new standards as a "duty bearer" to uphold the rights of this community; it is assisting to build the inclusiveness of this community in the national response. The Most-at-Risk Populations Partnerships Initiative (and especially the proposed MCP Teams in "hot-spot" areas) provides a significant opportunity to consolidate the involvement of key affected populations (EW/SW, MSM/TG and IDU) in promoting an enabling environment and "safe space" with local actors (law enforcement agents and commune/district authorities) for these populations to effectively access and utilise HIV and related services. The re-design of a comprehensive Continuum of Prevention to Care & Treatment (CoPCT) programme, which includes point-of-care testing, is increasing the ability of key affected populations to make decisions about the type and quality of HIV and related services that are being delivered at the local level. CSOs indicated that the most critical gap for inclusiveness was the lack of genuine representation of PWID community groups in policy and programme decision making. Efforts to create a Methadone Maintenance User Group have not to date been successful.

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

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

2

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

4

Comments and examples:

In general, CSOs appear to have adequate resources to carry out their HIV prevention commitments in the national response (most particularly with key affected populations). However, some CSOs indicated that with the conclusion of the GFATM Round 5 Grant, there were serious deficits in financing their commitments to programming care and support for PLHIV and for covering the impact mitigation needs of OVC and PLHIV. Some CSOs, particularly small local entities expressed concern at their inability to access predictable funding to sustain their work. Ongoing difficulties were expressed by small CSOs in respect of accessing Global Fund and other resources due to the complexity of the application process and the limited capacity of organisations to develop well articulated proposals. The community networks expressed their concern about the lack of sustained and predictable funding to community strengthening and network efforts. Technical support needs, especially of local CSO's were increasingly being met particularly through, for example, large NGOs (national and international) who, within their partnership agreements with CSOs, provide packages of technical assistance, including ongoing mentoring and monitoring of the application of the technical assistance in programming. Capacity of CSOs is being developed and improved through their interaction and involvement in programming, (the CoPCT for HIV Prevention; the Linked Response for PMTCT; the Three Is Strategy to address TB/HIV co-infection etc. Provincial AIDS Offices and NCHADS are also providing direct technical support to CSOs. However, CSOs reported a lack of consistency and a mismatch between the technical assistance offered by technical assistance providers and the needs of end-users.

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

People living with HIV:

>75%

Men who have sex with men:

>75%

People who inject drugs:
51-75%
Sex workers:
>75%
Transgendered people:
>75%
Testing and Counselling:
<25%
Reduction of Stigma and Discrimination:
51-75%
Clinical services (ART/OI)*:
<25%
Home-based care:
51-75%
Programmes for OVC:**
>75%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?:
9
Since 2009, what have been key achievements in this area:
Civil Society organisations have increased their capacity to engage with advocacy, campaigning, policy, technical and programming working groups mandated and/or coordinated by government and other institutions. CSO participation at the policy table was evidenced in their engagement in dialogue with the NACD and the Ministry of Justice on the draft revised Drug Control Law where they successfully, together with partners, advocated for harm reduction and public health measures. The NAA has engaged CSOs in a range of coordination and policy mechanisms, however the quality of engagement and the space for CSOs to have a tangible influence on policy remains questionable. CSOs have increasingly been engaged and consulted on the design and formulation of plans (NSPIII, sectoral and population specific) and have been engaged in analysis work (for example, the 2011 Cost Effectiveness Analysis of HIV Prevention and Impact Mitigation). In the health sector, CSOs have contributed to strengthening the CoC and partnering the government in the rapid expansion of the Linked Response programme for the elimination of paediatric AIDS, with the added objective of increasing demand and uptake for MCH services. CSOs have also been important partners in conceiving and rolling out point-of-care testing for key affected populations (Community-Peer Initiated Testing & Counselling) and the development and implementation of a comprehensive Continuum of Prevention to Care and Treatment for Most-at-Risk Populations (EW/SW, MSM/TG and PWID/PWUD) to enable Cambodia to reach its Universal Access and Zero New Infections targets and to ensure linkages (referral and follow-up) to other key services, for example, SRH/FP. The PLHIV network has also provided critical inputs into recalibrating positive prevention services, to ensure discrimination free access and utilisation of SRH/FP services within OI/ART clinics, emphasising reproductive choice and rights, including access and referral to safe-mother-hood services. Increasing involvement in policy development has fostered increased levels of dialogue, cooperation and understanding between CSOs and government. This is assisting to better define the practical elements of integrating HIV services with other health related services (SRH/FP, TB, MCH) as well as into social protection strategies and services in respect of OVC and PLHIV. CSOs are increasingly involved in the production of strategic information. Key examples in 2011 were the Stigma Index and the Bros Khmer study (IBBS) for high risk males, both managed by CSOs.
What challenges remain in this area:
Accessing appropriate finance and technical resources which are predictable and sustained over time is of particular concern for community-based organisations and community networks. Local CSOs find it very difficult to meet the application requirements for financing requests from donors such as the Global Fund. The application process is too complex and demanding and as a result many CSOs are compelled to be sub-contractors for larger international NGOs. The capacity of local CSOs must be afforded increased attention if the national response is to be further "localised" and sustained, as the envelope of resources for the national response continues to decline. The challenge will be how to transition from large, often international NGOs to local-based service delivery agents. CSO discussions highlighted that community based CSOs and networks do not consider that they are viewed as equal-partners at the table in decision-making and implementation. Increased attention to innovative approaches in capacity development is required to address this deficit which will have medium to long term impacts on the national response if the status quo is maintained.

B - II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:
Yes
IF YES, describe some examples of when and how this has happened:
The government has engaged community networks of PLHIV and key affected populations in a number of important ways: In 2010-11 NCHADS-MoH provided intensive support to assist the PLHIV network to manage an increasingly larger share of self-help groups and community care functions under Cambodia's Continuum of Care. The PLHIV network is a Sub-Recipient under NCHADS-MoH with a budget of approximately US$400,000 to support this work. In 2011, the National AIDS Authority worked with community networks and community based organisations of entertainment workers and MSM/TG, to design and orient stakeholders on the Most-at-Risk Population Partnership Initiative, which aims to build MCP teams in "hot spots" as

rapid reaction groups to ensure an enabling environment and “safe space” for community access to HIV and related services. Over the last 4 years, the NAA has taken affirmative action to build the engagement of community networks in key decision-making bodies such as the Policy and Technical Advisory Boards of the NAA and more particularly in technical working groups such as the national MSM TWG. The national MSM network and MSM community-based organisations were actively involved in the development, monitoring and implementation of the National Strategic Framework and Operational Plan on HIV, AIDS and STI for Men who Have Sex with Men in Cambodia (July 2008 – June 2011) and actively took part in the independent evaluation of the strategic framework and operational plan in the fourth quarter of 2011. In 2010-2011, the Health sector response (NCHADS-MoH) has actively supported the entertainment/sex worker involvement in local oversight and management mechanisms in the Continuum of Prevention to Care and Support, to increase demand for and access to HIV and related (SRH/FP) services by the community. NCHADS has encouraged innovation and community ownership, for example, the “Smart Girls” programme. In 2010, the NAA has engaged community networks of PLHIV and key affected populations in a systematic review of Cambodia’s Universal Access to Prevention, Treatment and Impact Mitigation efforts and key policy and programme recommendations from community networks were included in key recommendations of the Country Aide Memoire. The government has taken into account the serious concerns of entertainment/sex worker networks in respect of human rights abuses and as a result endorsed the efforts of CSOs to establish Cambodia’s first Community Legal Service for entertainment/sex workers in 2011. Community based organisations of PWID were able to dialogue with the NACD and Ministry of Justice to successfully advocate for harm reduction and related public health measures in the revised Drug Control Law during 2011.

B - III. HUMAN RIGHTS

1.1.

People living with HIV:
Yes
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
Yes
Prison inmates:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
Ethnic minorities

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
No
If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Cambodia does not have a specific law on non-discrimination. However, Article 31 of the Constitution states all citizens shall be equal before the law and have the same freedoms and obligations. Protection is afforded to PLHIV and key affected populations through a number of policies and other legislation. The 2002 Law on the Prevention and Control of HIV/AIDS (Chapter 8, Clauses 36-42) and its Implementing Guidelines (2005) outlines measures to combat discrimination. In 2011 the National AIDS Authority developed and endorsed the National Guideline For STI and HIV/AIDS Response Among MSM, Transgender And Transsexual People which explicitly sets out the following policy in respect of MSM/TG: “Cambodia recognizes the right of its citizens to the full and free expression of their sexual identity and where sexual identity is not a barrier or impediment to the full enjoyment of human rights and equal participation in the life of society and community. MSM, transgender and transsexual people have the right to comprehensive access to HIV prevention, treatment, care and support and allied health services, including for sexual and reproductive health, free of stigma and discrimination.” Prakas 066 (the 100% Condom Use Policy) ensures access to condoms in all high risk settings and affords a measure of protection to key affected populations in respect of discrimination or negative actions by law enforcement authorities in entertainment venues. In 2011, the NAA initiated a campaign to build understanding and commitment of entertainment establishment and law enforcement authorities towards implementing Prakas 066. The Most-at-Risk Population Partnership Initiative aims to build MCP teams in “hot spots” as rapid reaction groups to ensure an enabling environment and “safe space” for community access to HIV and related services and thereby assists to prevent discriminatory acts against key affected populations. The Domestic

Violence Law and the Law on disability afford significant protection from discrimination to women, girls and people with disabilities. The revised Drug Control Law while increasing incarceration for minor drug offenses does afford a degree of protection from discrimination for PWID who voluntarily accept treatment (MMT etc). The Needle and Syringe Programme Guidance also affords non-discriminatory measures for access to needle and syringe services. The Standard Operational Procedures for HIV/TB in prisons also provides a framework for non-discriminatory access to HIV/TB services for prisoners. Non-discrimination is implicit in the Youth Development Policy approved in 2011 by Council of Ministers as does the Child Protection Policy.

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

Mechanisms for enforcement of Laws and policies include various commissions of the National Assembly (Human Rights, Health & Women & Social Welfare) and oversight mechanisms at the national (ministry) and local (sub-national democratic development institutions) levels. For example the Ministry of Women's Affairs employs Judicial Officers at the sub-national level to monitor and enforce the provisions of the Domestic Violence Law. Cambodia reports regularly on its adherence to international conventions and treaties which assists to monitor compliance. The judicial system is expected to oversight compliance to legislation.

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

While there are exiting structures and mechanisms such as the judiciary, these remain, on the whole weak, with limited capacity and budgetary support to monitor compliance and implementation of various laws and policy.

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

Yes

2.1. IF YES, for which sub-populations?

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

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

The revised Law on Drug Control, while at the same time as including provisions for public health and harm reduction (voluntary and compulsory treatment), it also extends periods of incarceration for minor drug offenders. In addition, highly dependent drug users are held in administrative detention, in Drug Rehabilitation Centres, for periods of 3-6 months, where basic drug treatment and HIV and TB services are not made available. The Sanghat and Commune Safety Policy has 5 targets: o No cases of stealing or robbery; o No illicit drug use and illicit drug circulation; o No prostitution, paedophilia, children and women trafficking and domestic violence; o No gangsters; o No gambling, illegal use of guns, and other crimes. The Law on Suppression of Human Trafficking and Sexual Exploitation does not outlaw sex-work/prostitution per se, however, specific clauses of the Law make soliciting for sex services or the provision of an establishment for the soliciting of sex services offences under the Law. The draft Prison Law does not make provision for harm reduction (NSP/MMT) or HIV prevention (condoms) in prison settings.

Briefly comment on how they pose barriers:

CSOs conducting programmes with entertainment workers/sex workers, MSM/TG and PWID indicate that there are significant often unintended consequences from the inconsistent application of the Policy at the local level, leading for example, to the arrest and detention of entertainment/sex workers (where the presence of condoms in venues has on occasion been used as evidence for arrest). CSOs indicate that EW/SW, MSM/TG and PWD have been reluctant to gather in groups or to carry HIV prevention paraphernalia (needles/syringes, condoms) for fear of arrest and/or harassment by local law enforcement agents. CSOs also report that in "hot-spot" areas with a high concentration of PWID, the community has "gone to ground" and is consequently hard to reach with harm reduction (NSP and MMT) and related HIV services. Efforts are being made by government to address the shortfalls in the application of the Policy and CSOs have advocated for a consistent application of the policy. The uneven and inconsistent application of the Suppression of Trafficking and Sexual Exploitation Law and

associated anti-trafficking campaigns, at the local level, by law enforcement officials, has in the past negatively impacted on CSO efforts to deliver effective HIV services to entertainment workers/sex workers. Government-CSO dialogue on the issue, reinforcement of Prakas 66 by the NAA and the implementation of the Standard Operational Procedures for the Continuum of Prevention to Care & Treatment for entertainment workers/sex workers has ameliorated the most serious unintended consequences of the application of the Law. However, CSOs report that some cohorts of entertainment workers/sex workers, particularly those working on the streets, remain negatively impacted and are unable to consistently access and utilise HIV and related services. CSOs consider the establishment of the Community Legal Service for Entertainment Workers/Sex Workers (endorsed by government) as a positive step towards building an enabling environment for the delivery of HIV services, free of discrimination, harassment and arrest. The revised National Needle & Syringe Guideline remains in draft form. The National Authority for Combating Drugs is not issuing new licences for NSP operations with CSOs for the time being. Currently, only one CSO holds a licence for NSP delivery. This is significantly impacting on the ability of CSOs to deliver evidence-based programmes that avert new infections with PWID. The unintended consequence is that fewer PWID in need are reaching MMT services. While CSOs appreciate the inclusion of harm reduction, treatment and other public health measures in the revised Drug Control Law, it will be important that commentaries and sub-decrees spell out the intention of the Law in this respect and that the training of local law enforcement officials (and appropriate follow-up and monitoring) is continued.

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

Yes

Briefly describe the content of the policy, law or regulation and the populations included:

Background Data CSO reports (the 2010-11 Stigma Index) indicated the following in respect of Women Living with HIV: - 39% of all physical harassment/threats experienced by WLHIV had been due to their HIV status. - 89% of all physical assaults on WLHIV had been perpetrated by those living in the same household. - WLHIV were about twice as likely to suffer from psychological pressure from their spouse/partner (45%) or be subjected to gossip (31%). CSO reports in 2005-2006 indicated the following in respect of entertainment/sex workers: - 38.3% freelance transgender sex workers were beaten by clients in the past year. - 48.5% freelance transgender sex workers were raped by a single client in the past year. - 43.9% freelance female sex workers were beaten by clients in the past year. - 57.1% freelance female sex workers were raped by a single client in the past year. - 54% female beer promotion workers, “indirect” sex workers reported physical abuse. - 38% female beer promotion workers reported coercion into sexual acts in the workplace. Domestic Violence The Law on the Prevention of Domestic Violence and the Protection of Victims, affords some measure of protection to victims of domestic violence and reflects the Government’s attempt to introduce legislation to address this problem. However, significant changes are needed to this law in order for it to adequately eradicate domestic violence. In its current form, the law contains ambiguous meanings in key provisions such as the definition of domestic violence, marital rape and the authorities responsible for protecting victims of domestic violence. The Ministry of Women’s Affairs has appointed Judicial Officers at the sub-national level to monitor and engage in implementation of the Law. Marriage The Law on Marriage and Family is very comprehensive and one of its stated aims is to ensure the equality of partners in a marriage. However, it’s complicated and drawn out procedures for divorce – which require that the courts attempt to “reconcile” husband and wife to remain together – are extremely problematic for women who are victims of domestic violence. Rape Existing rape legislation fails to adequately define the offence of rape, most significantly by not referring in any way to the issue of consent. Rape is defined in the law as sexual penetration committed through “cruelty, coercion or surprise” – which in practice leads the courts to consider that rape must involve serious violence and injuries. This ignores the fact that many rapes are committed without major injury; rapists in Cambodia are often armed with a weapon, and make threats of violence or death, which may prevent victims from struggling with their attackers, for fear of being further injured or killed. The deficiencies in the legal provisions against rape in some ways reinforce societal attitudes which tend to blame or shame women who are raped. Human Trafficking Cambodia is a source, transit and destination country for the trafficking of women. Although there are no clear statistics on the numbers of women being trafficked within Cambodia and out of the country, it is clear that this is a problem which affects a large number of women. Existing trafficking legislation fails to adequately define the offence of trafficking by not taking into account the multitude of complex acts that can be considered trafficking. Furthermore, trafficking legislation does not provide for the protection or rehabilitation of domestic and international trafficking victims. General Reflections Cambodia’s laws relating to violence against women are not providing robust and adequate protection to Cambodian women from violence, exploitation in any form, and discrimination. The laws need to be amended, drafted and implemented in accordance with the principles of the CEDAW. There is no specific legislation in respect of violence and/or sexual assault against women living with HIV.

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

Yes

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Article 42 of the Law on the Prevention and Control of HIV/AIDS states that a person living with HIV will enjoy the same rights as all citizens, as stated in Chapter 3 of the Constitution of the Kingdom Cambodia. The National Guideline For STI and HIV/AIDS Response Among MSM, Transgender And Transsexual People has specific policy clauses that enshrine the rights of MSM/TG.

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

Yes

IF YES, briefly describe this mechanism:

Background Data: The 2010-11 Stigma Index indicated the following in respect to discrimination: - PLHIV were most often discriminated by neighbours (23%); friends (13%); co-workers (11%); spouse & family members (7%). - 10% of PLHIV had been denied access to family planning and SRH services. - 79% of PLHIV had been advised by health staff not to have any children. - 19% of PLHIV had been strongly advised by health staff to use permanent sterilization. - 14% of WLHIV who were pregnant in the past year had been strongly advised to terminate their pregnancy by a health professional. - Health care professionals had disclosed the HIV status of almost 6% of PLHIV without consent. CSOs also report instances where

children have not been admitted to school as a result of their HIV status and where PLHIV have been discriminated against when trying to access other basic services. The 2002 Law on the Prevention and Control of HIV/AIDS and its Code of Conduct mandates protection against discrimination. It is against the law to discriminate against a person based on the knowledge or suspicion that the person, or a member of their family, has HIV/AIDS. Discrimination is prohibited in employment, education, the right to seek public office, and by providers of health care services and other services such as credit and insurance. It is also against the law to restrict a person's freedom of movement or place of residence based on the known or suspected HIV/AIDS status of that person or a member of their family. The Code of Conduct and 2005 Guidelines on Implementation of the Law states "Where possible, seek advice from a legal or human rights organization, which may be able to assist you in resolving problems with HIV/AIDS-related discrimination. At the end of the Implementing Guidelines is a list of organizations that can provide assistance to people who have suffered discrimination due to HIV/AIDS, together with contact information." CSO's indicate that mechanisms to record document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations are weak and where they do exist, are under utilized. Examples of progress in this area is the work of CSO human rights protectors in addressing the displacement of households with people living with HIV in urban resettlement efforts and the work of the Community Legal Service for Entertainment/Sex Workers which carries out, records, and documents case-finding, including on issues of discrimination. Other mechanisms where information and concerns are shared include: the MARPs Community Partnership Initiative and its associated Teams, which in the future will also monitor and record cases of discrimination; the Friends-Help-Friends groups and self help groups of the PLHIV network; the provincial and district AIDS Secretariats and AIDS Offices (the latter exclusively managing the health sector response) and HIV/AIDS Committees in the workplace, established in large and medium enterprises under the government's Prakas 86. The CCWC has regular meetings to collect data on cases of discrimination, but has no official mechanism to document the data is in place. CSOs have been documenting stigma and discrimination, specifically the work of the national PLHIV community network (CPN+) in researching and preparation of the Stigma Index. The results of the Stigma Index have informed changes in the health sector, more particularly the rights of WLHIV to choice in reproductive health, family planning and increased access to MCH services.

6. Does the country have a policy or strategy of free services for the following?

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Yes	-	-
Yes	-	-
Yes	-	-

If applicable, which populations have been identified as priority, and for which services?:
While the HIV/AIDS law states that people living with HIV/AIDS are entitled to receive primary health care (OI/ART and other services) free of charge in all public health services, in practice, health care facilities continue to recover costs in relation to services provided to people living with HIV/AIDS in the same way that they recover costs from people who are treated for other conditions. In order to avoid the financial disincentives for health services and health care workers which could result from an inability to recover health care costs from people living with HIV/AIDS, the National AIDS Authority, in conjunction with the Ministry of Health and donors, use external assistance from development partners (the Global Fund to Fight AIDS, Tuberculosis and Malaria, and from other sources) to cover the health care costs of people living with HIV/AIDS. HIV/AIDS patients shall also have access to free home based care and treatment from the local health care facilities. People who are at risk of exposure to HIV as a result of rape or health care staff exposed through needle stick or other workplace injuries also should receive free post exposure prophylaxis. Over time, an increasing proportion of HIV treatment and allied costs for PLHIV identified under the National ID Poor Programme will be met through the expansion of the Health Equity Fund scheme and other health related social insurance initiatives. Basic HIV prevention services (outreach education, testing and STI services) and the provision of commodities (condoms, lubricant, clean needles/syringes and methadone) for key affected populations (EW/SW, MSM/TG, PWID) are generally provided free of charge (mainly through development partner support) or significantly subsidised for low-income earners (most particularly condoms and lubricants which are socially marketed). PMTCT services (testing and prophylaxis for the mother and OI/ART for the infant) are provided free of charge under the Minimum Package of Activities and the Comprehensive Package of Activities at health centres and referral hospitals respectively. Basic Impact mitigation Services for PLHIV and their households and the minimum package of support for OVC have been provided, by-and large, free of cost, subsidised by external assistance. With development of Cambodia's National Social Protection Strategy for the Poor and Vulnerable (which is AIDS sensitive) and the expansion of social protection programming under the National ID Poor system, it is expected that an increasing number of the poorest and most vulnerable PLHIV and OVC will be covered by social protection schemes like Health Equity Funds, cash transfers and other forms of health and social insurance programmes.

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

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

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

IF YES, Briefly describe the content of this policy/strategy and the populations included:

The Law on the Prevention and Control of HIV/AIDS enshrines the right of all Cambodians to equal access to treatment, care and support for any person living with HIV including key affected populations. In respect of EW/SW, MSM/TG and PWID, standard operational procedures for the Continuum of Prevention to Care & Treatment, including "point-of-care" testing (Community-Peer Initiated Testing and Counseling) have been developed, with comprehensive consultation with CSOs working with key affected populations and with community representatives. The purpose of the CoPCT is to increase demand and coverage for quality HIV prevention services, with referral and linkages to other key health services that key affected populations need (SRH/FP, OI/ART, TB etc). The CoPCT is premised on prioritising key affected populations for prevention and treatment in a highly concentrated epidemic. The 100% condom use policy also emphasises equal access by key affected populations. The Cambodia 3.0 (getting to zero) strategy for the health sector provides a framework for significantly increased attention to key affected populations and is supported by the revised Cambodia Universal Access Targets and Indicators for 2013 and 2015. Additionally, the 2011 Cost Effectiveness Analysis, to which CSO partners provided input, demonstrated what was required for the most efficient and effective "spend" for HIV prevention with EW/SW, MSM/TG and PIWD. Significant resources have been aligned in the Global Fund SSF HIV grant to ensure Universal Access to treatment for all PLHIV in need (Cambodia's ART coverage currently stands at approximately 90%) and to move towards the virtual elimination of paediatric AIDS through national scaling of the "boosted" Linked Response for PMTCT.

8.1

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:
Yes
IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
Cambodia has a range of nationally agreed standard operational procedures (SOP), developed in close consultation and with the input of CSO partners, to ensure appropriate approaches and strategies to cover key affected populations with quality HIV prevention, treatment, care and impact mitigation programming. The following SOPs are in place and/or are being revised, based on programming experience: - Standard Operational Procedures for the Continuum of Prevention to Care & Treatment for Entertainment Workers - Standard Operational Procedures for the Continuum of Prevention to Care & Treatment for Men-who-have-Sex-with-Men & Transgender People - Standard Operational Procedures for the Continuum of Prevention to Care & Treatment & Rehabilitation for PWID/PWUD - Standard Operational Procedures for HIV/TB in Prisons - Standard Operational Procedures for the Linked Response for PMTCT ("SOP to Initiate a Linked Response for Prevention, Care, and Treatment of HIV/AIDS and Sexual and Reproductive Health Issues") Additionally, the MARPs Community Partnership Initiative provides a framework and operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach) to access services. The MCPI engages and closely involves CSOs and community representatives.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:
Yes
IF YES, briefly describe the content of the policy or law:
Under Chapter 7 (Articles 19-25) of the Law on the Prevention and Control of HIV/AIDS, Article 20 notes that mandatory testing for the purposes of employment is illegal in Cambodia. However, some foreign companies recruiting human resources to work abroad insist on a mandatory HIV test as part of candidate screening for employment. The MoH has a "provider initiated" testing and counselling policy in place offering confidential testing and counselling to patients attending specific health care services (MCH, STI and TB services example).

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

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:
Yes
b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:
No
IF YES on any of the above questions, describe some examples:
The government of Cambodia has established Commission No.1 for Human Rights under the National Assembly and Senate which is mandated to promote and protect human rights. Additionally, Commission No. 8 oversights issues in respect of public health and women's affairs. Commission No. 1 and 8 are open to dialogue with key affected populations and people living with HIV. The Ministry for National Assembly & Senate Relations and Inspections, together with commission No. 8 promote and build understanding about the HIV/AIDS Law. Cambodia does not have in place an independent ombudsperson system to monitor human rights. NGO Human Rights protectors monitor the Human Rights situation in respect of PLHIV and key affected populations and in the case of arrests and/or harassment of sex workers or PWID, have made interventions to government authorities. PLHIV communities displaced by urban development schemes have also sought and found reddressal for their issues through NGO Human Rights protectors. The Community Legal Service for entertainment workers/sex workers provides advice, legal counselling and representation to EW/SW but the reach is limited to Phnom Penh city. In the private sector, HIV/AIDS Committees in large enterprises provide an enabling environment for HIV service access in line with Prakas 086. Additionally, the MARPs Community Partnership Initiative provides a framework and operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach) to access services. The MCPI engages and closely involves CSOs and community representatives.

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

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:
Yes
b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:
Yes

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

a. Legal aid systems for HIV casework:
Yes
b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:
No

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

IF YES, what types of programmes?

Programmes for health care workers:
Yes
Programmes for the media:
Yes
Programmes in the work place:
Yes
Other [write in]:
Within the context of Continuum of Care, the continuum of Prevention to Care and Treatment for EW/SW, MSM/TG and PWID, the Community-Peer Initiated Counseling and the positive prevention programme roll-out including training with health workers at the local level, all address stigma and discrimination. Live to air phone in programmes and regular television talk shows; as well as media events featuring the First Lady as the National Champion on AIDS, speaking with audiences as diverse as local authorities and factory workers on AIDS issues; all assist in the reduction of discrimination in institutional and community settings. In 2011, the National AIDS Authority worked with CSOs to develop a comprehensive 5 year (to 2015) National Communications Framework and costed plan, which outlines 5 themed campaigns which all directly address issues of stigma and discrimination. The Cambodia Business Coalition on AIDS has continued throughout 2010-11 to mobilise and support workplace education programmes, especially in the hotel and garment industries, which are contributing to stigma and discrimination reduction. The Community Legal Service for entertainment workers/sex workers provides advice, legal counselling and representation to EW/SW but the reach is limited to Phnom Penh city.

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:
8
Since 2009, what have been key achievements in this area:
The 2002 Law on the Prevention and Control of HIV/AIDS provides a comprehensive framework for the protection of human rights of PLHIV, vulnerable and key affected populations. In addition there are supportive policies such as, Prakas 66 (the 100% condom use policy) and Prakas 86 (HIV policy in the workplace) and elements of the revised Drug control Law (treatment for highly dependent PIWD/PWUD and the sanctioning of harm reduction services, NSP/MMT). There are also laws such as the Domestic Violence Law and programmes such as the recently developed MARPs Community Partnership Initiative, which provide a framework and operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach), to access services. All of these initiatives together provide a reasonably strong framework to afford human rights protections to PLHIV and key affected populations.
What challenges remain in this area:
CSOs agree that the government should systematically engage CSOs and community actors early on in the process of legislative and policy development, to ensure that through broad-based consultation, legislation and policy can better reflect the needs of communities, especially key affected populations. Alignment and harmonisation among laws and policies need to be improved, some are contradictory. For example, there are policies to promote and protect human rights of key affected populations like PWID and EW, but NGO activities are still being curtailed by the Commune/Village Safety Policy. The enforcement of legislation and policies and the mechanisms for doing so need to be clarified and strengthened. Insurance Company/firms do not provide insurance to PLHIV and banks and a number of firms are still unwilling to issue loans to PLHIV.
15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:
8
Since 2009, what have been key achievements in this area:
Since 2009 a series of national operational policies and procedures (all framed within a human rights-based approach) have been operationalised, which have underpinned and supported the human rights intentions of the 2002 Law on the Prevention and Control of HIV/AIDS, with respect to people living with HIV and key affected populations. This includes the national scale up of the CoC to reach over 90% of all people in need with ART, increasing access to both testing and treatment through the

Community-Peer Initiated (point of care) Testing & Counselling programme and the implementation of the programmes to intensify and nationally scale HIV prevention with key affected populations (The Continuum of Prevention to Care & Treatment for Entertainment Workers; Men-who-have-Sex-with-Men & Transgender People; PWID/PWUD and addressing more systematically the need of prisoners in need of HIV/TB services). Additionally, national scaling of the "Linked Response" initiative for PMTCT puts Cambodia on the path to the virtual elimination of paediatric AIDS. Supportive policies such as Prakas 66 (the 100% condom use policy) have been reanimated to support and build space for HIV prevention work. Workplace committees have functioned to oversee HIV efforts in the workplace in key enterprises and sectors and the MARPs Community Partnership Initiative was launched as a key operational structure to build an enabling environment and safe space for key affected populations (especially the hard to reach) to access services with support from CSOs. The Community Legal Service for entertainment workers/sex workers provides advice, legal counselling and representation to EW/SW but the reach is limited to Phnom Penh city.

What challenges remain in this area:

Dissemination and comprehensive community education on the provision of the HIV/AIDS Law and its Guidelines as well as key policies relating to key affected populations is irregular and not sustained over time at national and sub-national levels. CSOs and community networks need to have opportunities to better monitor implementation of legislation and policies. Alignment and harmonisation among laws and policies needs to be improved, some are contradictory. For example, there are policies to promote and protect human rights of key affected populations like PWID and EW, but NGO activities are still being curtailed by the Commune/Village Safety Policy. Communities of key affected populations need to be more comprehensively engaged in designing, implementing and monitoring approaches (for example, the Continuum of Prevention to Care & Treatment model) for HIV prevention. NCHADS-MoH is calibrating its approach to ensure deeper and sustained community involvement. The enforcement of legislation and policies and the mechanisms for doing so need to be clarified and strengthened. The interpretation of and consistency in the implementation of legislation and policies is variable depending on individual or other interests. Contrary to the law, some private companies and microfinance agencies required candidates or staff to take an HIV test before being accepted as staff members and there have been instances where children have been rejected from school enrolment as a result of their HIV status.

B - IV. PREVENTION

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

Yes

IF YES, how were these specific needs determined?:

Specific needs were identified through the development of the Situation & Response Analysis and the costed National Strategic Plan III; this was complemented by Cambodia's UA indicator and target setting for 2013 and 2015 which engaged both CSOs and community networks. In addition the Cost-Effectiveness Analyses, AIDS2031 Cambodia Financing Study and the Functional Task Analysis continue to inform priorities for HIV prevention. Cambodia's pathway for achieving the three zeros and its HLM UNGA Political Declaration targets has been outlined in the health sector AIDS strategy "Cambodia 3.0". In addition a number of national studies and research pieces were undertaken to better inform HIV prevention, including among others: the Most-at-Risk young Peoples National Assessment, the Bros Khmer (IBBS) Study with high Risk Males and specific studies that looked at make client behaviour of entertainment workers. In addition the Cost-Effectiveness Analysis for HIV Prevention with key affected populations (EW/SW, MSM/TG and PWD) in 2011, assisted in focusing thinking around the most efficient approaches to programming, including addressing quality issues. Much of this work was conducted by CSOs in cooperation with government and community partners. Two Human Rights Watch Reports also focused on HIV related issues among EW/SW. New HIV estimates and projections workshops were carried out and the new data will be made available in early 2012. New surveillance programmes such as the HSS, the BSS, Modes of Transmission and CDHS secondary analysis were carried out, gathering new data and providing further information on the epidemic. Studies carried out by NGOs that informed the discourse include a TRaC study on contraceptive use, the Socio-Economic Impact Study and the Stigma Index.

1.1 To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Strongly Agree
Harm reduction for people who inject drugs:
Strongly Disagree
HIV prevention for out-of-school young people:
Disagree
HIV prevention in the workplace:
Disagree
HIV testing and counseling:
Strongly Agree
IEC on risk reduction:
Disagree
IEC on stigma and discrimination reduction:
Disagree
Prevention of mother-to-child transmission of HIV:
Agree
Prevention for people living with HIV:
Agree

Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Agree
Risk reduction for men who have sex with men:
Disagree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Agree
Universal precautions in health care settings:
Disagree
Other [write in]:
-

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:
7
Since 2009, what have been key achievements in this area:
While much has been achieved in HIV prevention with key affected populations, prevalence remains high (14% among entertainment workers; 2% among MSM and 24% among PIWD). In respect of harm reduction, the most singular achievement was the establishment of Cambodia's Methadone Maintenance Therapy Clinic which is now dosing over 165 patients. The Community-Peer Initiated (point of care) Testing & Counseling programme has for the first time brought testing and counselling to the community, increasing demand and uptake for testing and referral to other services (STI and importantly OI/ART where required). This is important as people continue to test late for HIV and therefore compromise the benefits of treatment over the medium to long-term. PMTCT uptake has steadily increased. For example in 2011, 87% of PW (366,080) were tested and 64% of those who need it (930/1464) received ART or ARV prophylaxis. 57% of infants born to an HIV+ mother received ART prophylaxis and only 45% received test within 2 months of birth. ANC prevalence is 0.4% (down from over 2 per cent in the 1990s) and the MTCT rate is ~12% compared to 31% (2007). The contribution to referral and follow-up by CSO's at the local level in the "linked response" is contributing to the success of PMTCT and at the same time increasing PW uptake of MSC services, especially ANC 1 & 2. Since 2009, the Continuum of Prevention to Care & Treatment for Entertainment Workers has managed to cover >70% EW/SW with a comprehensive programme, which addresses not only HIV prevention but provides a continuum of care to other services such as SRH/FP. The "Smart Girls" programme managed by a major CSO has contributed 50% of the coverage, with its partners using innovation and branding with great effect. HIV prevention efforts with Men-who-have-Sex-with-Men & Transgender People has been informed by both the National Strategic Framework and Costed Operational Plan (2008-11) and the national standard operational procedures for the continuum of prevention to care and treatment in the health sector. Branded and innovative programmes are reaching self identified MSM and TG with information, commodities and services and there is greater acceptance of MSM/TG within local communities. In respect of EW/SW and MSM/TG, the re-animation of the 100% condom use policy has ensured that a wider network of entertainment establishments and venues are ensuring access to condoms and lubricants.
What challenges remain in this area:
The Sangkat/Commune Safety Policy continues to place constraints on the delivery of HIV prevention, most particularly, harm reduction (NSP) outreach services with PWID. The inconsistent/uneven application of the policy also impacts to a lesser degree on HIV prevention programmes with EW/SE and MSM/TG, particularly street-based workers. The non-issuance of NSP licences to CBOs to deliver NSP outreach programmes remains a major constraint to scaling up NSP and MMT with PWID. Where NSP outreach is operating, insufficient quantities of needles and syringes are being supplied each day (less than 2 sets a day, when at least 4 are required to avert an HIV infection). Plans to commence NSP programming out of designated health facilities in "hot-spot" areas may assist to overcome this obstacle. At the current time, approximately 15% of PWID are covered with harm reduction programming. In respect of the HIV prevention response with MSM/TG, the scaled up delivery of strategic behaviour change communications, community outreach and peer education programmes for visible and hidden MSM, has shown mixed results. In spite of the efforts of peer outreach and communication activities of non-governmental organization (NGO) partners, significant barriers remain to MSM accessing STI, HIV and AIDS services. These include cost of transportation to service points and self-stigma, even as stigma and discrimination within the health services have reportedly declined. Voluntary confidential counselling and testing (VCCT) services are accessible through health and drop-in centres, "community peer initiated testing and counselling" (CPITC) and mobile clinics. However, the VCCT protocol with respect to pre- and post-test counselling is not always followed. Some MSM who test positive for HIV have been unaccounted for as a result, and significant (GFATM related) procurement constraints have interrupted the free delivery of condoms and lubricants. These together with the barriers to services are likely to undermine both the integrity and delivery of continuum of prevention care and treatment services (CoPCT) for which VCCT is the entry point. Additionally, adequately capacitated CBOs to deliver scaled programmes to cover hidden and self identified MSM remain far too small in number. Currently, coverage for MSM/TG programmes is no more than approximately 30% of the population. For all the HIV prevention work, there is a significant lack of high quality, 3rd generation communications materials and approaches. It remains very difficult to effectively target mobile populations including migrant workers. It is difficult to target injecting drug users who are at high risk of contracting HIV, without also targeting non-injecting drug users who have a much lower risk; this can result in spending limited funds on members of the population that were not intended to be targeted.

B - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:
Yes
IF YES, Briefly identify the elements and what has been prioritized:
Cambodia's Continuum of Care Model (testing services in over 200 sites and treatment services in a further 56 sites) linked to the work of over 150 community and home-based care teams, is delivering treatment to over 47,000 people (or 90% of all those in need). HIV Testing and treatment services (through the "3 Is Strategy") are linking patients to TB services and follow-up. The quality of service delivery continues to increase assisted by the Continuous Quality Improvement approach at the local level which engages government (health staff), CSO and community network partners in assessing performance data, analysing issues and problems and adjusting programme efforts accordingly. Community networks of PLHIV at the local level are partnering with health facilities to maintain self-help support groups (friends-help-friends) for both adults and children on OI/ART. Voluntary counselling care and treatment continue to be free for all people who test positive in Cambodia (OI/ART procurement is paid for primarily with support by the GFATM). When people test positive they are then referred to an OI/ART clinic to discuss their continued monitoring and care. Transport allowances are provided for people to access the treatment sites. In addition to receiving treatment PLHIV and households affected by HIV can also access other social services including food and nutritional support, home based care and income support and educational support for OVC. Home based care is provided by a number of different NGOs and government agencies. One problem that concerns all these services is that they are not regulated across all provinces to ensure consistency for all target beneficiaries.
Briefly identify how HIV treatment, care and support services are being scaled-up?:
-

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

Antiretroviral therapy:
Strongly Agree
ART for TB patients:
Strongly Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Agree
HIV care and support in the workplace (including alternative working arrangements):
Disagree
HIV testing and counselling for people with TB:
Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Agree
Nutritional care:
Disagree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Disagree
Post-exposure prophylaxis for occupational exposures to HIV:
Disagree
Psychosocial support for people living with HIV and their families:
Disagree
Sexually transmitted infection management:
Agree
TB infection control in HIV treatment and care facilities:
Agree
TB preventive therapy for people living with HIV:
Strongly Agree
TB screening for people living with HIV:
Strongly Agree
Treatment of common HIV-related infections:
Agree
Other [write in]:
PMTCT

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
The vast majority of PLHIV have access to ART (90% of all in need) and the three Is are being implemented to scale up TB/HIV co-infection treatment. Home based care has been scaled up nationwide. SOPs have been drawn up for the

continuum of prevention to care and treatment of EW and MSM, including point of care testing at community level to ensure early access to treatment and related services. The Linked Response approach across HIV prevention, (including PMTCT) and treatment is paying significant dividends in further reducing HIV incidence/prevalence while ensuring early access to treatment and allied services (TB, SRH/FP and MCH). A strategic plan of action and a well defined minimum package of support for impact mitigation with OVC are in place and over 60% of OVC are benefitting from the package. Much of this work has been delivered by CSOs. The national social protection strategy for the poor and vulnerable has been made "AIDS Sensitive" and increasingly through the national ID Poor system, the most vulnerable PLHIV and OVC are being targeted by social protection schemes like health equity funds and cash transfers.

What challenges remain in this area:

The most significant challenge in the area of treatment care and support services is the sustainability and predictability of financing for OI/ART and allied support services. Currently costs could be met through the current GFATM SSF HIV grant until the first quarter of 2015, unless the grant is given a negative rating in the periodic review (report due in March 2013) prior to the next financial replenishment. There are a number of challenges that were identified in the prevention care and treatment programmes in the country by CSOs. The resources available for impact mitigation and home-based care work have diminished; a number of NGOs have ceased service delivery because of financial constraints. Lost-to follow-up of OI/ART patients was also highlighted as a major issue. About 10% failed to return to the health facility for follow up. Early identification of infants exposed to HIV with early and appropriate follow-up was also considered a critical challenge. There were also a number of problems identified in relation to the actual testing and treatment itself. It was noted that there is a lack of second line ARV treatment and in addition that monitoring of the patients viral load is inadequate to ensure that the most appropriate treatment is being received. In some areas there are limited testing and counselling opportunities available and where treatment can be accessed there is sometimes a lack of proper equipment to undertake treatment monitoring. The shelf life of drugs and testing reagents is too short and can lead to either centres running out of in date drugs and reagents or trying to use materials that are out of date. Drug stock-outs and associated problems (including paediatric regimens) were identified as a challenge. Another very important challenge with regard to the drugs themselves, identified by CSOs, is ensuring appropriate legislation to guarantee TRIPS flexibilities for Cambodia's continued access to generic ARV drugs.

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

Yes

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

Yes

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

Yes

2.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:

Yes

2.4. IF YES, what percentage of orphans and vulnerable children is being reached? :

60%

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?":

-

Since 2009, what have been key achievements in this area:

3.0 repeats the same question as 1.2.

What challenges remain in this area:

3.0 repeats the same question as 1.2.
