

Kingdom of Cambodia
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UNGASS COUNTRY PROGRESS REPORT
Cambodia

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Submitted by: National AIDS Authority
Kingdom of Cambodia

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Data on the UNGASS indicators were provided by the Ministry of Education, Youth and Sports (MoEYS) and several national health programmes of the Ministry of Health, such as the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), the National Blood Transfusion Centre (NBTC), the National Maternal and Child Health Centre (NMCHC) and the National Centre for Tuberculosis and Leprosy Control (CENAT).

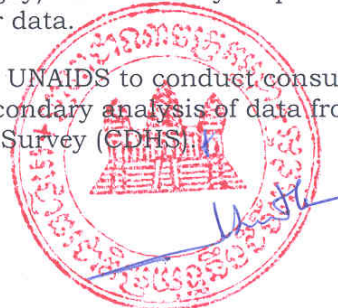
Dr. Kem Ley (Secretary General of HACC) and his staff organized various consultations with civil society organizations at both national and sub-national levels concerning the completion of Part B of the National Composite Policy Index (NCPI). As a result of their efforts, this report represents the inputs and manifold views of civil society organizations at various levels.

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Acronyms and Abbreviations

AIDS	Acute Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASC	AIDS Spending Categories
BSS	Behavioural Sentinel Surveillance
CDHS	Cambodia Demographic and Health Survey
CENAT	National Centre for Tuberculosis and Leprosy Control
CoC	Continuum of Care
CQI-ATR	Continued Quality Improvement for Anti-Retroviral Therapy
CRIS	Country Response Information System
DFID	Department for International Development
GDJ-TWG	Government-Donor Joint Technical Working Group on HIV/AIDS
HACC	HIV/AIDS Coordination Committee
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IDU	Injecting Drug Users
MARPs	Most-At-Risk Populations
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MSM	Men who have sex with men
MoEYS	Ministry of Education, Youth and Sports
NAA	National AIDS Authority
NACD	National Authority for Combating Drugs
NASA	National AIDS Spending Assessment
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NCPI	National Composite Policy Index
NGO	Non-Governmental Organization
NMCHC	National Maternal and Child Health Centre
NSP II	National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS, 2006-2010
OD	Operational (Health) District
OI	Opportunistic Infections
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PSI	Population Services International
STD	Sexually Transmitted Disease
SRA	Situation and Response Analysis
SSS	STI Sentinel Surveillance
TB	Tuberculosis
VCCT	Voluntary Confidential Counselling and Testing
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

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II. Status at a glance

(A) INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS

Cambodia's 2008 UNGASS Country Progress Report was prepared through a consultative process and involving key stakeholders in the national response to HIV, such as government institutions, civil society organizations, the private sector and development partners (bi- and multilateral organizations).

A team consisting of staff from the National AIDS Authority (NAA), UNAIDS staff and a consultant was appointed to manage and oversee the reporting process. The first step in the reporting process was the preparation of a concept note that explained the purpose and proposed methodology of preparing the 2008 UNGASS report. This concept note was sent to a large number of stakeholders in the national response to HIV in Cambodia.

Data on the UNGASS indicators were collected by the NAA from various sources, including key national programmes under the Ministry of Health, such as the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), the National Blood Transfusion Centre (NBTC), the National Maternal and Child Health Centre (NMCHC) and the National Centre for Tuberculosis and Leprosy Control (CENAT). Moreover, data were collected from the Ministry of Education, Youth and Sports (MoEYS).

The National Composite Policy Index (NCPI) was completed through a highly participatory and bottom-up process, involving several rounds of consultation with key stakeholders operating at different levels.

Part A of the NCPI questionnaire was administered to representatives from key government ministries and departments during a national-level consultation meeting.

Completion of Part B of the NCPI questionnaire involved (i) consultation of civil society organizations at the provincial level, (ii) completion of selected questions by a large number of civil society organizations working at provincial and/or national level, and (iii) a national-level UNGASS consultation which ensured incorporation of the views and perspectives of bi- and multi-lateral organizations.

The National AIDS Spending Assessment (NASA) was conducted for the first time in Cambodia as part of the 2008 UNGASS reporting process. Government and non-governmental organizations and development partners were asked to complete the AIDS Spending Matrix. A team consisting of NAA staff and with the assistance of an international consultant was in charge of tabulating and analysing the HIV/AIDS spending data.

A draft version of this Country Progress Report was circulated to stakeholders that participated in the process for their comments and suggestions. Finally the report was presented and discussed during a half-day national validation meeting.

(B) STATUS OF THE EPIDEMIC

The latest data on HIV prevalence were provided by the 2006 HIV Sentinel Surveillance (HSS) and the 2005 Cambodia Demographic and Health Survey (CDHS). New estimates of HIV prevalence in Cambodia were released following

calculations and modelling performed by a team of national and international experts at Cambodia's Consensus Workshop on HIV Estimates and Projections in June 2007.

The new estimates show that HIV prevalence among adults aged 15 to 49 decreased to 0.9% in 2006 from a revised estimate of 1.2% in 2003.

Projections indicate that, if interventions are sustained at current levels, HIV prevalence will further decline before stabilising at 0.6% by 2011. However, a resurgence of the epidemic cannot be ruled out as there is a risk of a second-wave of HIV infections among most-at-risk populations, including female sex workers, their clients and other sexual partners, men who have sex with men (MSM) and injecting drug users (IDUs).

Based on the new HIV prevalence estimates and projections, the number of people living with HIV (PLHIV) was estimated at 64,750 (including 3,350 children under the age of 15) in 2007. Approximately 29,200 adults were in need of antiretroviral therapy (ART) and this number is expected to increase to 35,100 by 2010.

(C) THE POLICY AND PROGRAMMATIC RESPONSE

Cambodia's Situation and Response Analysis (SRA), conducted in 2005 to inform the development of the second National Strategic Plan for a Multisectoral Response to HIV/AIDS for 2006-2010 (NSP II), was updated in October 2007 to reflect the new HIV prevalence estimates and projections as well as changing circumstances and priorities. The overall conclusion of the up-dated SRA was that good progress and tangible results were realized during the years 2006 and 2007.

The up-dated SRA and the subsequent mid-term review of the NSP II were timely in the light of Cambodia's efforts to set Universal Access (UA) indicators and targets for 2008 and 2010. The UA target-setting process reconfirmed that remarkable progress has been made in the health sector response to HIV through the rapid scaling-up of the Continuum of Care (CoC).

Progress has also been made in prevention and impact mitigation, although investments in these areas will need to be stepped up. To sustain the achievements to date, more attention will need to be given to the prevention of new infections. Extensive evidence-based and strategic planning of interventions with MSM and IDUs has already been completed. Moreover, better informed and more substantive interventions have been designed to mitigate the impact of the epidemic, in particular to improve the situation of orphans and vulnerable children.

In general, the design, planning and implementation of policies and interventions have benefited from greater commitment at the highest levels of government and society as well as from a growing engagement of all sectors in Cambodia's response to HIV. Several new policies have been developed and various existing policies have been revised to better reflect the challenges that are arising in the national response to HIV.

Recognition of the important role of civil society in the national response is greater than it has ever been before, resulting in much stronger relationships and coordination between government and non-government sectors. With the

assistance of bi- and multi-lateral partners, the role and involvement civil society organizations has been strengthened and expanded.

(D) OVERVIEW OF UNGASS INDICATOR DATA

Most of the required UNGASS indicators have been reported either completely or partially:

- The NASA provided the necessary data for the AIDS Spending Matrix, which has been included in section VII of this report.
- The completed NCPI has been attached (Annex 2)
- Eleven indicators have been reported in full, i.e. including data for numerators and denominators and with the required disaggregations by sex and/or age.
- Five indicators (#4, #8, #18, #23 and #24) were completed only in part,
- Another five indicators could not be reported at all (#6, #9, #14, #20 and #21).
- Indicator #10 was not reported because of the fact that HIV prevalence is less than 5% in Cambodia.
- Indicator #25 will be modelled and hence, did not need to be reported.

A summary report is presented in table 1 below.

Table 1: UNGASS Indicators at a Glance

Code	Indicator	Status	
Government HIV and AIDS Policies			
1	AIDS Spending	Partially filled out	
National Programme Indicators			
3	Blood Safety	Completed	97.33%
4	HIV Treatment: Antiretroviral Therapy - 2006	Completed	Missing
4	HIV Treatment: Antiretroviral Therapy - 2007	Completed	Missing
5	Prevention of Mother-to-Child Transmission - 2006	Completed	7.04%
5	Prevention of Mother-to-Child Transmission - 2007	Completed	11.20%
6	Co-Management of Tuberculosis and HIV Treatment	Completed	No data available
7	HIV Testing in the General Population	Completed	4.10%
8	HIV Testing in Most-at-Risk Populations - Sex Workers	Completed	68.07%
8	HIV Testing in Most-at-Risk Populations - Men Who have Sex with Men	Completed	58.05%
8	HIV Testing in Most-at-Risk Populations - Injecting Drug Users	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Sex Workers	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Men Who have Sex with Men	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users	Completed	No data available
10	Support for Children Affected by HIV and AIDS	Completed	Not relevant
11	Life Skills-based HIV Education in Schools	Completed	25.61%
11	Life Skills-based HIV Education in Schools	Completed	26.36%
11	Life Skills-based HIV Education in Schools	Completed	21.35%
Knowledge and Behaviour Indicators			
12	Orphans: School Attendance - Part A	Completed	76.10%
12	Orphans: School Attendance - Part B	Completed	91.60%
13	Young People: Knowledge about HIV Prevention	Completed	47.40%
14	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers	Completed	No data available
14	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex with Men	Completed	No data available
14	Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users	Completed	No data available
15	Sex Before the Age of 15	Completed	0.60%
16	Higher-risk Sex	Completed	2.80%
17	Condom Use During Higher-risk Sex	Completed	39.20%
18	Sex Workers: Condom Use	Completed	98.99%
19	Men Who Have Sex with Men: Condom Use	Completed	86.46%
20	Injecting Drug Users: Condom Use	Completed	No data available
21	Injecting Drug Users: Safe Injecting Practices	Completed	No data available
Impact Indicators			
22	Reduction in HIV Prevalence	Completed	0.41%
23	Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers	Completed	12.69%
23	Most-at-risk Populations: Reduction in HIV Prevalence - Men Who have Sex with Men	Completed	4.50%
23	Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users	Completed	No data available
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	Completed	87.62%

III. Overview of the AIDS Epidemic

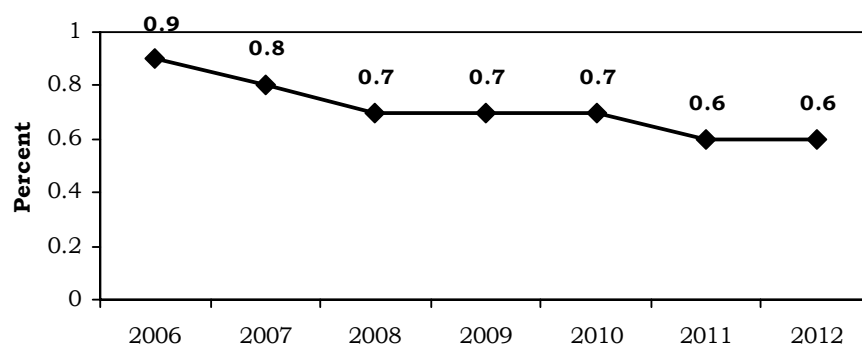
HIV Prevalence in the General Population

HIV prevalence in the adult population aged 15 to 49 was estimated at 0.9% in 2006 based on data from the 2006 HSS and the 2005 CDHS. Previous estimations and forecasts, which were adjusted by using an improved methodology, show that HIV prevalence in the adult population has come down from 1.2% in 2003.

The estimated number of people living with HIV was 67,200 in 2006 (figure 2); 35,000 women and 32,200 men.

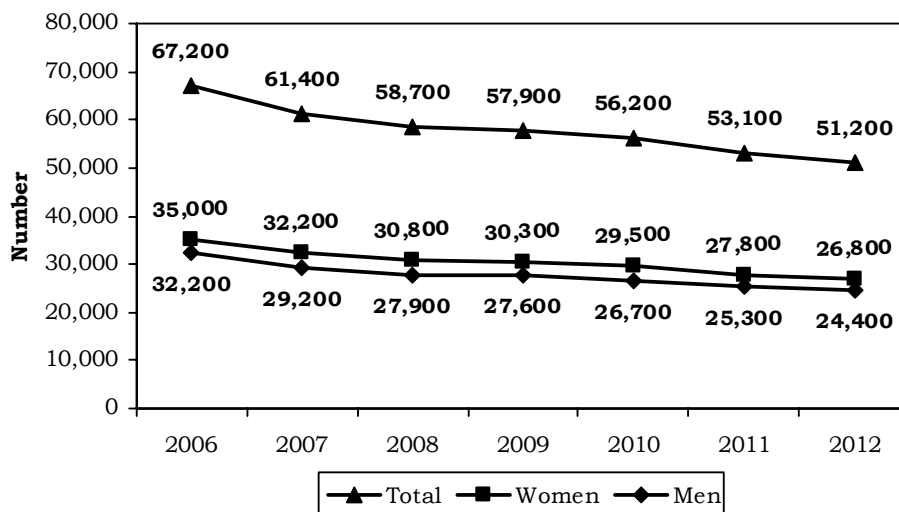
Projections show that HIV prevalence is expected to further decline and to stabilise at 0.6% after 2010 (figure 1).

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



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

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



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

UNGASS Indicator 22: HIV Prevalence in Young People

HIV prevalence in young people is estimated using data from pregnant women aged 15-24 attending antenatal clinics, which is available from the HSS.

The HIV prevalence among pregnant women aged 15-24 attending antenatal clinics is estimated at 0.41% (HSS 2006). The table below (table 2) shows that HIV prevalence for the age groups 15 to 19 and 20 to 24 is almost the same.

Table 2: HIV prevalence among pregnant women aged 15 to 24 attending antenatal clinics, HSS 2006

	15-19 Years	20-24 Years	15-24 Years
HIV Prevalence	0.40	0.41	0.41

Source: Preliminary data from the HIV Sentinel Surveillance (HSS) 2006, provided by the National Centre for HIV/AIDS, Dermatology and STDs

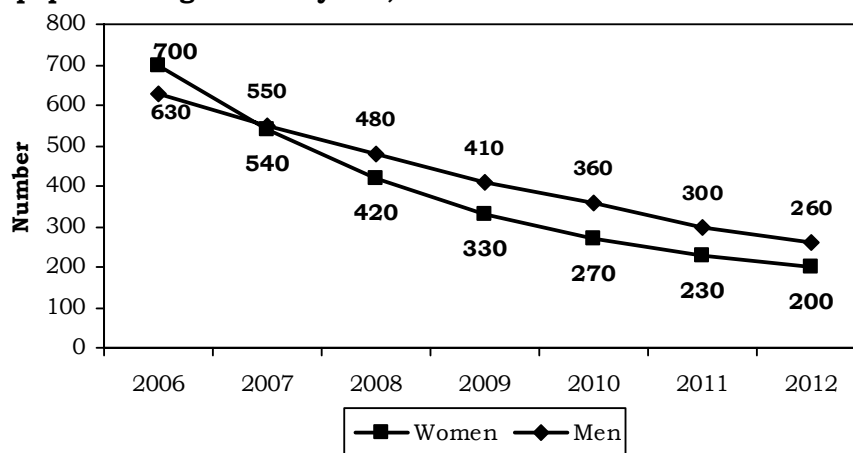
The 2005 CDHS reports a HIV prevalence rate for women and men aged 15-24 of 0.2%. Prevalence was estimated to be 0.3% in young women and 0.1% in young men.

The previous Country Progress Report included data on the HIV prevalence among all women aged 15 to 24 years, which was estimated at 0.36% in 2003 (HSS 2003).

HIV Incidence in the General Population

Falling prevalence goes hand in hand with a decreasing number of new HIV infections (Figure 3). Projections suggest that the number of newly infected men and women was more or less equal in 2007. Thereafter, HIV incidence in the male population is projected to be higher than in the female population.

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



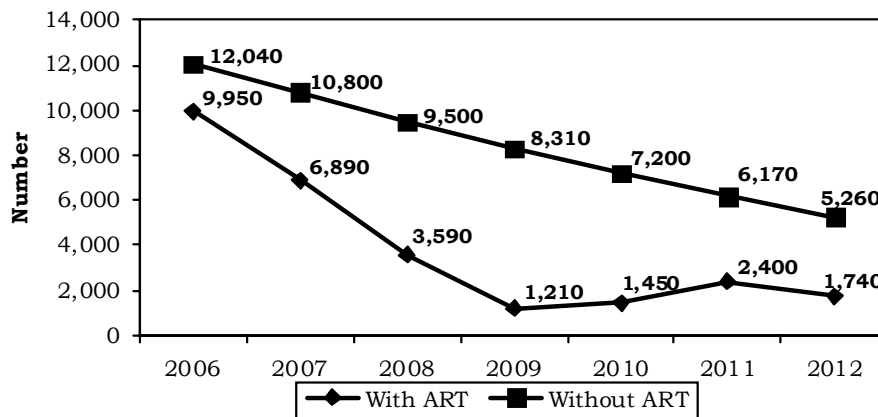
Source: Report on Consensus Workshop on HIV Estimates and Projections for Cambodia 2006-2012; Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs; 25-29 June 2007.

AIDS related Mortality in the General Population

Falling prevalence is also correlated with a decreasing number of AIDS-related deaths. Approximately 10,000 people are estimated to have died from AIDS in 2006 and projections show that this number is expected to drop sharply until 2009 (figure 4). The number of deaths is expected to double between 2009 and 2011, before it will start decreasing again.

In the absence of ART, the projected number of AIDS-related deaths would have declined more gradually from 12,040 deaths in 2006 to 5,260 in 2012. The difference between the two curves in figure 4 represents the number of lives that can be saved each year due to ART.

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



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

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

(i) HIV Prevalence among Female Sex Workers

HIV prevalence among female sex workers was estimated at 12.7% in 2006 (HSS 2006), down from 21.4% in 2003 (HSS 2003).

A comparison of HIV prevalence in different age groups shows that 7.2% of young female sex workers (younger than 25) are estimated to be HIV positive, against 20.9% of sex workers aged 25 and older.

Prevalence data are not available for male sex workers as this high-risk group was not included in HIV surveillance studies.

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

The 2005 STI Sentinel Surveillance¹ (SSS) included for the first time MSM as a sentinel group. SSS 2005 surveyed MSM in Phnom Penh and in two provincial towns (Battambang and Siem Reap).

The 2005 SSS found that HIV prevalence was highest among MSM in Phnom Penh (8.7% against 0.8% in the two provincial towns) and among transgender groups (7.9%, against 2% for non-transgender MSM). HIV prevalence was especially high among transgender groups in Phnom Penh, which was estimated to be as high as 17%.

¹ Survey on Sexually Transmitted Diseases among brothel based female sex-workers, men who have sex with men and Police in Cambodia, 2007

Data reported for this indicator through the Country Response Information System (CRIS) is for non-transgender MSM in Phnom Penh only. This group represent the largest sub-sample in the 2005 SSS and HIV prevalence for this group was estimated at 4.5%.

(iii) HIV Prevalence among Injecting Drug Users

A HIV prevalence and behavioural survey among drug users was conducted during the second half of 2007. The results of this survey are not yet available, but are expected to be published during the second quarter of 2008.

The 2006 Report on Illicit Drug Data and Routine Surveillance Systems in Cambodia prepared by the National Authority for Combating Drugs (NACD) includes data gathered by two NGOs working with drug users in Phnom Penh. Data shows that 14.3% of a total of 63 injecting drug users tested during the first six month of 2006 was HIV positive.

IV. National Response to the AIDS Epidemic

The data presented in this chapter demonstrate that considerable progress has been made in Cambodia since the 2006 UNGASS Country Progress Report in the areas of prevention, care and treatment and impact mitigation.

There is still limited information available concerning MSM and IDUs, but data on female sex workers show increased levels of HIV testing, high coverage of prevention programmes and very high levels of consistent condom use. Efforts to gather similar information for other most-at-risk populations have already started and hence, it should be expected that Cambodia will be able to report progress made in prevention efforts targeting MSM and IDUs in future reporting rounds.

The data also demonstrate the fruits of prevention interventions targeting the general population. Although there is still much room for improvement, a relatively large and growing number of people know their status (i.e. have been tested and know the result). Progress has been made in HIV education as demonstrated by the fact that most young people know how to prevent getting infected. Much work remains to be done in this area as the majority of young people still lack comprehensive knowledge about HIV prevention (i.e. correctly identify ways to prevent sexual transmission and reject major misconceptions about HIV transmission).

Most significant has been the progress made during the last two years in the area of care and treatment. Data presented below show that the number of PLHIV with advanced HIV infection on ART has more than doubled since early 2006. Furthermore, the survival of PLHIV on ART after 12 months is currently estimated to be close to 90% for adults and over 90% for children.

Impact mitigation efforts have especially focussed on orphans and vulnerable children affected by AIDS. Although there is insufficient data available to assess the effectiveness of these interventions, CDHS data show that progress has been made in narrowing the gap in school attendance for orphans and non-orphans.

(A) PREVENTION

The 2007 update of the SRA 2007 acknowledges the success of prevention efforts in reversing the epidemic, resulting in declining HIV prevalence and incidence rates. However, the SRA 2007 Update also points out that progress in scaling-up targeted prevention interventions has been less significant during the last two years and warns against complacency.

Epidemiological and other risk assessment data indicate that it cannot be assumed that incidence will remain low and that there is a risk of a second-wave of HIV infections occurring in Cambodia. The main risk is related to the situation and behaviour of female sex workers, their clients and sweethearts as a result of a high turnover of female sex workers and of recent changes in the structure of the sex industry. Behaviour of MSM and IDU may also act as potential drivers of the epidemic.

Progress made in the implementation of HIV prevention programmes is reflected in the NCPI. Part B of the NCPI states that the coverage of key prevention programmes has improved. Most communities are being reached by crucial prevention messages, resulting in high levels of awareness and knowledge and positive changes in behaviour.

UNGASS Indicator 3: Blood Safety

The NBTC reported that 97.3% of all blood units donated in 2007 (31,802 units) were screened for HIV in blood banks that followed documented standard operating procedures and participated in an external quality assurance programme.

Despite this good result, blood safety still remains a concern due to the relatively limited number of voluntary blood donors (approximately 25% of all blood units) and the relatively limited use of blood components (approximately 70% of all blood use involves whole blood).

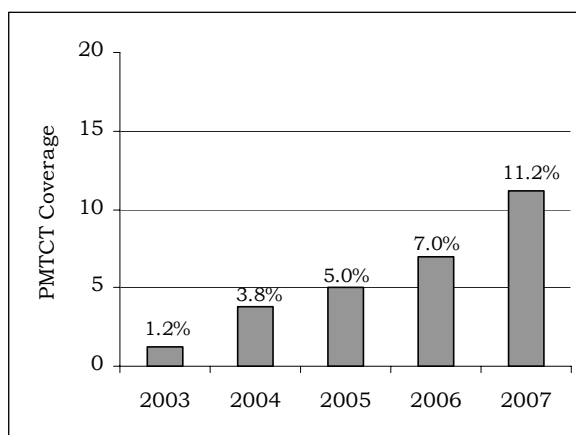
UNGASS Indicator 5: Prevention of Mother-to-Child Transmission (PMTCT)

In 2006, 311 HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission. In 2007, this number increased to 505.

The PMTCT programme of the NMCHC estimated the number of HIV-infected pregnant women (the denominator) at 4,417 for 2006 and 4,509 for 2007. These estimates are based on Ministry of Health estimates concerning the number of expected pregnancies and a 1.1% HIV prevalence among pregnant women (HSS 2006).

Figure 5 shows that there has been a gradual increase in the percentage of HIV-infected pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission from 1.2% in 2003 to 11.2% in 2007.

Figure 5: Percentage of HIV-infected pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission



Source: PMTCT Program of the National Maternal and Child Health Centre, 2003-2007

The geographical coverage of PMTCT services increased from only 27 sites in 16 Operational Health Districts (ODs) by December 2005 to 98 sites in 58 ODs by September 2007.

UNGASS Indicator 7: HIV Testing in the General Population

The 2005 CDHS found that 4.1% of adults aged 15-49 had received an HIV test in the 12 months preceding the survey and knew their result. This

percentage is higher for men than for women and is highest for the age group 20-24 years (table 3).

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

	All	Male	Female	15-19	20-24	25-49
Percentage tested and know their result	4.1%	5.1%	3.3%	1.8%	6.4%	4.3%

Source: Cambodia Demographic and Health Survey 2005

Although not comparable² with the 2005 CDHS figures, more up-to-date information is available from routine programme monitoring efforts carried out by NCHADS. These data show that:

- By December 2006, the number of health facilities that provided voluntary confidential counselling and testing (VCCT) had increased from 109 in December 2005 to 140. By September 2007, VCCT services were available at 190 health facilities.
- In 2006 a total of 212,789 people were tested, compared with 152,147 in 2005. Of the total number of people tested 54.7% were female and 90% were aged 15-49. Almost 99% of the people tested received their result through post-test counselling.
- During the first nine months of 2007, a total of 190,401 people had been tested. 53.2% of all those tested were female and 89.6% were in the age group 15-49. Almost 98% of the total number of people tested in this period received their test result through post-test counselling.

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

(i) HIV Testing among Female Sex Workers

The 2007 Behavioural Sentinel Survey (BSS) found that 68.1% of brothel-based (direct) female sex workers had been tested for HIV and knew their result, against 51% reported in the previous BSS (2003).

The percentage of non-brothel based (indirect) female sex workers that had been tested and knew their result was 51.8% (BSS 2007).

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

According to the 2007 BSS, more than half of MSM (58.1%) surveyed had been tested and knew their result.

It should be noted that this is much higher than figures reported by the 2005 SSS, which was the first surveillance survey to include MSM. The 2005 SSS reported that only 20% of MSM had been tested in the 12 months preceding the survey and knew their results.

(iii) HIV Testing among Injecting Drug Users

It was already mentioned that a HIV prevalence and behavioural survey among drug users was conducted recently and that the results of this survey are expected to be published during the second quarter of 2008.

² CDHS is a population-based survey, while NCHADS reports the number of people tested in VCCT sites. The latter includes people that were tested twice or more often during the 12 month reporting period.

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

This indicator can not be reported as defined in the 2008 Guidelines on Construction of Core Indicators. The Guidelines describe this indicator as measured based on the following two questions:

- Do you know where you can go if you wish to receive an HIV test?
- In the last 12 months, have you been given condoms?

These questions were not included in Cambodia's BSS, which instead asked the question "have you ever received HIV/AIDS education in the past 6 months?"

(i) Prevention Programmes with Female Sex Workers

The most recent round of the BSS in 2007 found that 93.8% of brothel-based (direct) female sex workers and 90.6% on the non-brothel based (indirect) female sex workers had received HIV/AIDS education in the 6 months preceding the survey.

Table 4 shows that younger female sex workers (< 25 years) are somewhat less likely to be exposed to HIV/AIDS education.

Table 4: Percentage of most-at-risk populations (female sex workers and MSM) who received HIV/AIDS education in the past 12 months

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

Source: Behavioural Sentinel Surveillance 2007

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

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

The BSS 2007 found that 96.2% of MSM surveyed had received HIV education in the 6 months preceding the survey.

(iii) Prevention Programmes with Injecting Drug Users

The results of the recently conducted HIV prevalence and behavioural survey among drug users are expected to be published during the second quarter of 2008.

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

During the school year 2006-2007, 25.6% of all schools in the country were involved in efforts aimed at providing life skills-based HIV education. This was the case for 26.4% of all primary schools and 21.4% of all secondary schools in the country.

It needs to be noted that the MoEYS implemented life-skills based HIV education in just 14 out of 24 provinces and municipalities. MoEYS reported that 38.4% of all schools, 39.3% of primary schools and 33% of secondary

schools in these 14 provinces implemented life skills-based HIV education during the school year 2006-2007.

(B) CARE, TREATMENT AND SUPPORT

Progress towards reaching the Universal Access targets for care and treatment has been significant during the reporting period. Most noteworthy is the increase in the number of PLHIV on ART, which has more than doubled since the last round of UNGASS reporting.

HIV-related health services expanded in coverage with the establishment of additional ART sites during the last two years. Yet, access to these services remains curtailed due to travel distances and the high costs of transportation, which especially affects the poor and people living in remote rural areas. More will need to be done to support PLHIV and their families who can not afford specialized health care that caters for patients affected by HIV and AIDS.

The quality of available HIV-related services requires close monitoring and further improvement. Quality improvement efforts have already started through the Continued Quality Improvement (CQI-ART) initiative that was spearheaded by NCHADS since the end of 2007.

UNGASS Indicator 4: Antiretroviral Therapy

Access to ART increased during the reporting period due to the expansion of the number of health facilities with ART services. The number of facilities that provide ART services increased from 30 to 48 (60% increase), while the number of facilities with paediatric ART doubled (Table 5).

Table 5 shows that the number of patients on ART has more than doubled since the last UNGASS report (107% increase), while the number of children (younger than 15) on ART has increased by almost 120% since the end of 2005. By September 2007, 78.7% of the estimated number of adults with advanced HIV infection received ART, up from 60.9% in December 2006.

Table 5: Coverage of Antiretroviral Therapy, 2005-2007

	Dec. 2005	Dec. 2006	Sept. 2007
Facilities with ART	30	44	48
Provinces covered (out of 24)	16	19	20
ODs covered (out of 78)	22	30	38
Facilities with paediatric ART	11	19	22
Active patients			
- Total	12,247	20,131	25,353
- Adults	11,168	18,344	22,981
- Children (<15 years)	1,079	1,787	2,372

Source: Annual Reports 2005 and 2006 & Third Comprehensive Quarterly Report 2007, National Centre for HIV/AIDS, Dermatology and STDs

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

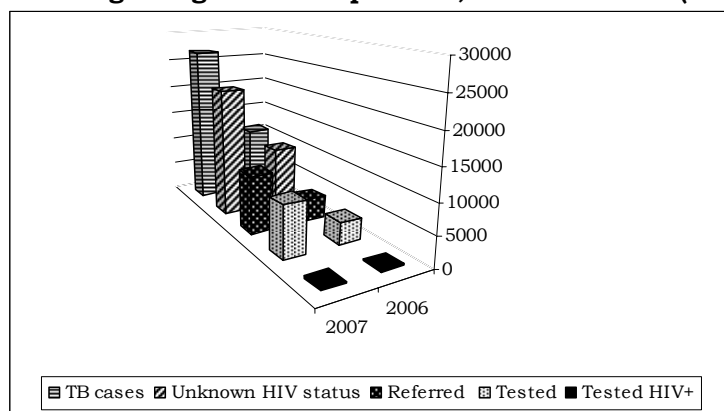
This indicator cannot be reported due to a lack of data on the number of adults with advanced HIV infection who are currently receiving antiretroviral therapy and who have started TB treatment.

NCHADS and CENAT have developed standard operating procedures for TB-HIV collaboration and are currently working to improve TB-HIV programme monitoring and reporting systems.

In 2006, CENAT started TB-HIV data collection as part of its routine reporting system in a limited number of provinces (covering 32.2% of all reported TB cases in 2006). The data show that out of total of 11,156 registered TB patients, 1,286 were known to be HIV-positive. Of the remaining 9,870 registered TB patients with unknown HIV status 3,871 (39.2%) were referred for HIV testing, 3,547 (35.9%) were actually tested and 342 (9.6%) tested HIV-positive.

In 2007, TB-HIV data collection was extended to all 24 provinces. TB-HIV data for the period January to September 2007 show a considerable increase in the number of TB patients tested (figure 6). By September 2007, 45% (9,687) of registered TB patients with unknown HIV status had been referred and 40% (8,492 TB patients) had actually been tested for HIV

Figure 6: HIV testing of registered TB patients, 2006 and 2007 (9 months)



Source: TB Programme Routine Reporting System, CENAT, 2006 & 2007

UNGASS Indicator 24: Survival after 12 months on Antiretroviral Therapy

Preliminary data on survival after 12 months on ART are available for patients who started ART at seven adult ART sites and four paediatric sites in 2005. This cohort consists of 3,731 adult and paediatric patients and represents 49% of the total number of patients that were started on ART in 2005.

Of a total number of 3,731 patients who started ART in 2005 and were not transferred to another ART site (transferred out), 3,269 or 87.6% were still on ART after 12 months.

Survival of adult patients after 12 months on ART was estimated at 87.1% (2,980 out of 3,422 adult patients started on ART at the seven adult ART sites in 2005), ranging from 79.7% to 96.0% for the seven individual sites.

Of the 309 children who started on ART in four paediatric sites in 2005, 289 (93.5%) were still on ART after 12 months. The survival rate for children on ART ranged from 90.4% to 95.6% for the four individual sites.

(C) KNOWLEDGE AND BEHAVIOUR CHANGE

While data on HIV knowledge and behaviour is still relatively limited, trends in condom use have been monitored for several years. Data presented here show that condom use in commercial sex settings is generally very high. However, condom use among women involved in non-commercial higher-risk sexual relations and their partners (e.g. relationships between sweethearts and other regular, but non-faithful partners) remains very low.

This is a major challenge the revised NSP II is seeking to address as experience to date demonstrated the difficulties of reaching women working in various forms of entertainment establishments. The situation of women working in environments and professions at risk of sexual and other forms of exploitation needs more attention and in-depth study in order to prevent abuse and manipulation.

UNGASS Indicator 13: Knowledge about HIV Prevention among Young People

The 2005 CDHS asked the same five questions regarding the knowledge about HIV prevention among young people as outlined in the 2008 Guidelines on Construction of Core Indicators.

Most young people aged 15 to 24 correctly identified ways to prevent sexual transmission of HIV (questions 1 and 2 in table 6)). Young males were somewhat more likely to give the correct answers to these two questions.

Table 6: The percentage of young people aged 15-24 years who correctly identify ways to prevent sexual transmission and reject major misconceptions about HIV transmission

Questions	All	Male	Female
Question 1: Can the risk of HIV transmission be reduced by having sex with only one uninfected and faithful partner?	88.6%	89.8%	87.6%
Question 2: Can a person reduce the risk of getting HIV by using a condom every time they have sex?	90.7%	92.0%	89.6%
Question 3: Can a healthy looking person have HIV?	66.3%	60.0%	71.9%
Question 4: Can a person get HIV from mosquito bites?	71.6%	75.6%	68.1%
Question 5: Can a person get HIV by sharing food with someone who is infected?	89.6%	89.1%	90.0%
Correct answer to all five question	47.4%	45.3%	49.2%

Source: Cambodia Demographic and Health Survey 2005

Two-thirds (66.3%) of young people who were surveyed by the 2005 CDHS knew that a healthy looking person can have HIV, while 71.6% knew that one cannot get HIV from mosquito bites. The majority of young people surveyed (89.6%) answered correctly that a person cannot get HIV from sharing food with an HIV-infected person.

Despite these positive results, less than half (47.4%) of all young people aged 15-24 answered all of the five questions correctly. The findings show that young women were more likely than young men to answer all five questions correctly, demonstrating a more comprehensive knowledge about HIV prevention.

The previous Country Progress Report includes estimates concerning young people's knowledge of HIV based on two much smaller sample surveys conducted by Population Services International (PSI) in 2003 and 2005. The 2005 estimates are in strong contrast with the findings of the CDHS conducted in the same year. The PSI survey found that only 12% of young people correctly answered all five questions against 47.4% as reported by the 2005 CDHS. These differences are most likely the result of the different sampling and of survey methodologies applied by these surveys.

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

Neither the last BSS in 2007, nor the recently conducted Drug User Survey (survey results are yet to become available) included questions that would have allowed measurement of the knowledge about HIV preventions among MARPs. It is therefore not possible to report on this particular UNGASS indicator.

UNGASS Indicator 15: Sex before the Age of 15

Secondary analysis of data derived from the 2005 CDHS found that 0.6% of interviewed men and women aged 15-24 reported having engaged in sexual intercourse before the age of 15. This percentage is higher for women (0.8%) than for men (0.4%).

It should be noted that there is suspicion of under-reporting by women in the 2005 CDHS of pre-marital and extra-marital sex, to the extent that virtually no-one admitted to either. The percentage of young women who reported to have had sexual intercourse before the age of 15 is therefore believed to be under-reported.

The reported percentage of young women and men aged 18-24 who had sexual intercourse before age 18 is much higher: 17.1% for women and 7.4% for men (CDHS 2005).

UNGASS Indicator 16: Higher-risk Sex

In the 2008 Guidelines on Construction of Core Indicator higher risk sex is defined as having had sexual intercourse with more than one partner in the past 12 months preceding the survey.

Secondary analysis of data from the 2005 CDHS found that 2.8% of surveyed adults aged 15-49 reported to have engaged in higher-risk sex. For males this percentage was 6.1, compared to only 0.2% for females.

As mentioned under indicator 15, there is suspicion of under-reporting by women in the 2005 CDHS of pre- and extra-marital sex. This will have resulted in under-reporting of the percentage of women who reported to have engaged in sexual intercourse with more than one partner in the 12 months preceding the survey.

UNGASS Indicator 17: Condom Use during Higher-risk Sex

Secondary analysis of data from the 2005 CDHS shows that 39.2% of all adults aged 15-49 who had engaged in higher-risk sex (i.e. who had sexual

intercourse with more than one partner in the 12 months preceding the survey) reported the use of a condom the last time they had sex.

Table 7 shows that 40.4% of men reported to have used a condom against only 12.3% of the women that had engaged in higher-risk sex. Young people aged 15-24 years reported a higher level of condom use during high-risk sex.

Table 7: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months reporting the use of a condom

All	Male	Female	15-19	20-24	25-49
39.2%	40.4%	12.3%	83.2%	73.0%	22.7%

Source: Secondary analysis of data from the Cambodia Demographic and Health Survey 2005

UNGASS Indicator 18: Condom Use among Sex Workers

Almost all (99%) brothel-based (direct) female sex workers included in the 2007 BSS reported the use of a condom with their most recent client. This is an improvement in comparison with the previous BSS (2003), which reported consistent condom use by 96% of female sex workers.

The percentage of non-brothel based (indirect) female sex workers that reported the use of a condom with their most recent client was 94%, up from 80% in 2003. It should be noted that only 30.7% of the sample of non-brothel based sex workers reported having engaged in commercial sex in the last 12 months preceding the survey (BSS 2007).

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

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

According to the BSS 2007, 86.5% of MSM reported the use of a condom during the last time they had anal sex.

Condom use is highest among younger MSM (aged 15-24) with 88.7% reporting condom use during most recent anal sex, against 81.7% for the age group 25 and older.

UNGASS Indicator 20: Condom Use among Injecting Drug Users

As mentioned earlier, an HIV prevalence and behavioural survey among drug users was conducted recently. The results of this survey are expected to be published during the second quarter of 2008.

UNGASS Indicator 21: Safe Injecting Practices among Injecting Drug Users

Pending the publication of the results of the recent HIV prevalence and behavioural survey among drug users, only limited data are available concerning drug users.

Based on information derived from various small-scale surveys and data gathered by organizations working with drug users, an Expert Consensus

Estimate (2004) put the approximate number of injecting drug users at 1,750 (90% confidence interval, ranging from 1,000 to 7,000 injecting drug users).

The 2006 Report on Illicit Drug Data and Routine Surveillance Systems in Cambodia prepared by the NACD states that the limited data available have shown that knowledge of HIV transmission through needles and syringes is poor among injecting drug users. Moreover, the limited data available appear to indicate high levels of reusing and sharing of needles and syringes.

(D) IMPACT ALLEVIATION

In the absence of functioning social services, impact mitigation programmes and interventions that are geared towards PLHIV and their families and orphans and vulnerable children are primarily provided by non-governmental organizations (NGOs) through home based care teams. This important support is reflected in the NCPI.

A national action plan for orphans and vulnerable children was developed in 2007 and a growing number of orphans and vulnerable children has been reached by essential care and support services.

An important constraint is the lack of data concerning the coverage and outcomes of impact mitigation efforts. A main challenge for the near future will be to gather data from the large number of NGOs that are involved in service provision in often remote rural settings and with modest geographical coverage.

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

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

It would have been impossible to report this indicator as only partial information is available concerning the number of orphaned children aged 0-17 years who live in households that received medical support, school assistance, emotional/psychological support or social support.

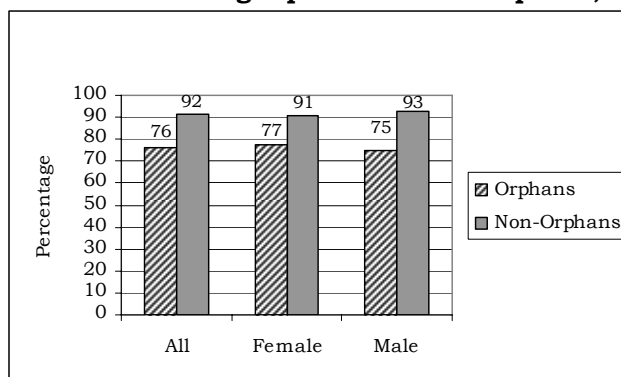
Cambodia's 2006 UNGASS Country Progress Report states that no information was available on the number of orphans and vulnerable children. Secondary analysis of 2005 CDHS data provided the following estimates concerning the number of orphans and vulnerable children in Cambodia:

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

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

The 2005 CDHS reports that school attendance among orphans was much lower (76.1%) than among non-orphans (91.6%).

Figure 7: School attendance among orphans and non-orphans, 2005



Source: Cambodia Demographic and Health Survey, 2005

The previous CDHS (2000) did not report this indicator. However, data provided by secondary analysis of both the 2000 CDHS and the 2005 CDHS allows for a comparison between both surveys. The following conclusions can be drawn from the data presented in table 8:

- School attendance is lowest among double orphans for both years.
- School attendance is considerably higher in 2005 for all types of orphans and for boys as well as for girls.
- The gap between orphans and non-orphans decreased between 2000 and 2005. For example, school attendance for female orphans was 45% in the year 2000, against 74% for female non-orphans. By 2005 this gap had been reduced to 71% versus 87%.

Table 8: School attendance among children aged 10-14 years, by orphan status and gender (non-weighted values), 2000 and 2005

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

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

V. Best practices

Political commitment at the highest level in the Royal Government of Cambodia, including vivid and strong support from the First Lady, is recognised to be an important factor in Cambodia's success in building a strong national response to HIV in the country. Political support has contributed to and resulted in a legal and policy environment that is supportive of a vibrant national response to HIV.

The national response also benefited from enhanced coordination by the NAA and its Secretariat. Apart from taking on greater leadership during the past two years in strategic planning and monitoring and evaluation of HIV interventions, the NAA also played a key role in organizing and convening crucial coordination forums. The NAA has been instrumental in coordinating the work of various technical working groups, including the Government-Donor Joint Technical Working Group on HIV/AIDS (GDJ-TWG).

The leadership and coordination provided by the NAA has proved to be a crucial factor in building strong partnerships between key government ministries and departments and especially between government and civil society. As a result, civil society plays a stronger role in the national response to HIV. The NAA has also built partnerships with the private sector and has been instrumental in boosting private sector involvement in the national response.

The many years invested in prevention programmes have contributed to Cambodia's success in reversing the epidemic. The outreach to brothels through the 100% condom use program has been especially successful. It is realised, however, that there is no place for complacency and that there is a continuing need for high quality prevention programmes. Moreover, a new and more strategic focus is needed for prevention programmes due to relatively new and emerging most-at-risk populations, such as women in entertainment establishment, MSM and IDUs.

Scaling up of care and treatment for PLHIV has been very fast and effective in Cambodia. The number of PLHIV receiving ART more than doubled since December 2005 and by September 2007 almost 80% of those in need were provided with ART. This has not only reduced mortality, but has also improved the quality of life of thousands of PLHIV in Cambodia.

These gains in prevention and in care and treatment were made possible by the significant financial and technical support provided by the development partners. However, past levels of support are not guaranteed for the years ahead and diminishing support could jeopardise the national response and possibly reverse the still fragile results achieved so far.

As a result of Cambodia's long-time efforts in monitoring, evaluation and research, there is extensive data and information on the epidemic and the response to it. Cambodia has an advanced surveillance system, which incorporates serological and behavioural data from a range of sentinel groups. This has allowed decision-makers and programme planners to detect trends in the epidemic at an early stage, enabling them to take timely action. In the future more efforts are needed to build systems that allow gathering of relevant programme monitoring data in order to assess the effectiveness and efficiency of various interventions.

Another best practice in Cambodia consists of the multistakeholder reviews that are led by the NAA on an annual basis. In the past year a wide range of stakeholders, including government, civil society, the private sector and development partners, were involved in reviewing the National Strategic Plan which now reflects the new HIV prevalence estimates and projections as well as Universal Access indicators and targets. The participatory planning process was guided by evidence on what has worked and what has not worked in Cambodia's response to HIV.

VI. Major challenges and remedial actions

(A) PROGRESS MADE ON KEY CHALLENGES REPORTED IN THE 2005 UNGASS COUNTRY PROGRESS REPORT

The 2006 UNGASS Country Progress Report included the following key challenges:

- Limited capacity of government institutions and poor staff motivation due to low salaries;
- Limited access to health services, in particular due to poverty
- Lack of effective prevention interventions targeting drug users and men who have sex with men;
- Disempowerment of women and sexual violence; and
- Financial sustainability, in particular the high dependence on a limited number of external donors.

Considerable investments have been made in building the capacity of key government institutions, and especially NCHADS, NAA and MoEYS have benefited from these initiatives. The Technical Needs Assessment conducted by the NAA in 2007 found significant variance in the organisational capacity of other government ministries and departments and concluded that despite the progress made (especially in the health sector) there is a pressing need to develop technical skills in some ministries. A technical support plan has been developed and steps have already been made to implement this plan.

Government salaries have increased during the reporting period, but remain well below salaries paid in other sectors, including civil society and international organizations. Some government agencies have addressed this constraint by paying salary supplements to key staff. NAA, NCHADS and the MoEYS received funding for this purpose from the UK Department for International Development (DFID) and from the Global Fund.

Access to health services has improved since the 2006 Country Progress Report as a result of the opening of new health facilities and the upgrading of existing facilities. Financial access for the poor improved as a result of the introduction and expansion of health equity funds and community health insurance. Secondary analysis of 2005 CDHS data shows that health services are effectively reaching the poor, but that transportation costs can be a considerable barrier for those living far away from a health centre. As shown in this Country Progress Report, the number of health facilities that provide free-of-charge HIV services (VCCT, OI (Opportunistic Infections)/ART, and PMTCT) has increased significantly. Moreover, a growing number of communities are now covered by NGO-operated home based care teams. These teams often support poor PLHIV to access HIV services by providing transport or reimbursement of travel costs.

The 2005 SSS produced for the first time HIV prevalence and behavioural data for MSM. MSM were also included in the most recent round of the BSS (2007), while a survey among drug users was conducted during the second half of 2007. Strategic planning efforts were undertaken for both MSM and drug users in 2007, resulting in strategic frameworks and costed operational plans for these most-at-risk populations. These plans are expected to provide a solid basis for scaling-up effective prevention programmes for these populations.

The Strategic Plan on Women, the Girl Child and HIV/AIDS in Cambodia 2008-2012 developed by the Ministry of Women's Affairs in October 2007, concludes that not enough has been done to address sexual and gender-based

violence. This issue will require far more attention in the future, especially to address the underlying causes of such violence.

Limited progress has been made in terms of the financial sustainability of the national response. The NASA that was conducted as part of the 2008 UNGASS reporting process found that domestic funding for AIDS was 13% of the total HIV/AIDS spending, making the national response heavily reliant on two main sources of funding, i.e. the Global Fund and the United States Government.

(B) CHALLENGES FACED THROUGHOUT THE REPORTING PERIOD (2006-2007) THAT HINDERED THE NATIONAL RESPONSE

The 2007 update of the SRA identifies as a major challenge the need to improve prevention, care and treatment and impact mitigation interventions and to ensure better quality of the services provided.

In order to avoid a resurgence of the epidemic and to keep incidence low, current prevention efforts need to be scaled-up and better targeted:

- Sex workers and their clients will need to be given the highest priority and the reach of prevention programmes will need to be extended beyond brothel-based settings to include freelance sex workers and women working in a wide variety of entertainment establishments.
- IDUs and MSM require better access to prevention and care and treatment services.
- Positive prevention programmes will need to be expanded and strengthened in order to meet the need of the growing number of PLHIV on ART.
- The coverage of the PMTCT services is still very limited and will need to be scaled up in order to ensure better access to VCCT services for pregnant women and to increase the number of HIV positive pregnant women who received antiretroviral drugs to reduce mother-to-child transmission.

The considerable scaling-up of care and treatment services during recent years has been a great success. However, more emphasis will need to be given to the quality of these services in order to maintain treatment adherence and to guarantee good treatment outcomes.

Impact mitigation programmes have largely focussed on orphans and vulnerable children, in particular those affected by HIV. The reach of these programmes will need to be extended to effectively support PLHIV and their families. The growing number of PLHIV on ART calls for their social and economic reintegration. There is a need to move towards sustainable community development models and to develop broader impact mitigation strategies, including income generation and micro-credit schemes.

Key challenges in scaling up prevention, care and treatment and impact mitigation interventions to reach UA targets by 2010 are the rapidly increasing costs of HIV programmes and the limited organisational and technical capacity of government ministries and civil society. While increasing resources will be required to meet long-term treatment obligations, sufficient resources will also need to be allocated to meet prevention needs of most-at-risk populations. Additional resources will also be required to scale up impact mitigation measures directed at orphans and vulnerable children and PLHIV and their

families. Furthermore, organizational and technical capacity will need to be strengthened to ensure a more effective and efficient response to HIV in Cambodia.

(C) CONCRETE REMEDIAL ACTIONS THAT ARE PLANNED TO ENSURE ACHIEVEMENT OF UNGASS TARGETS

There has been a growing awareness throughout the reporting period concerning the key challenges hindering the national response to HIV. This has led to the decision to revise the National Strategic Plan 2006-2010 (NSP II) with the aim to refine ongoing interventions and to develop more strategic, cost effective and sustainable interventions.

The revised NSP II (covering the years 2008-2010) sets clear targets and addresses gaps in an effort to ensure that UA targets will be met. In particular, the strategic plan focuses on scaling up well targeted prevention programmes with most-at risk populations, positive prevention and increased access to PMTCT services.

There continues to be a high level of commitment to meeting the growing care and treatment needs of PLHIV and there is increasing emphasis on improving the quality of services. In addition, a beginning has been made in developing better linkages between HIV related health services and other health services as part of Cambodia's Linked Response initiative.

The revised NSP II also identifies concrete actions to be taken to improve and expand impact mitigation programmes that target orphans and vulnerable children. Moreover, the need for impact mitigation programmes developed and implemented by PLHIV themselves is increasingly recognised.

In order to meet the growing resource needs of the national response to HIV, the revised NSP II has been costed and resource gaps have been identified. A resource tracking system is under development and will build on the NASA that was conducted as part of the UNGASS reporting process. Once AIDS spending data will become available on a regular basis, it will be easier to monitor resource allocations and to identify resource gaps. This in turn will facilitate the mobilization of resources for the national response to HIV.

The NAA has already developed a technical support plan, which identifies the immediate priorities in terms of organisational and technical capacity building needs. The implementation of this plan is supported by strategies and activities included in the revised NSP II.

VII. Support from the country's development partners

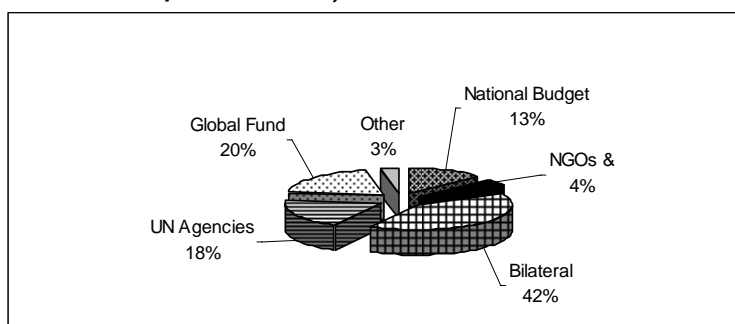
(A) KEY SUPPORT RECEIVED FROM DEVELOPMENT PARTNERS TO ENSURE ACHIEVEMENT OF UNGASS TARGETS

The NASA was conducted by the NAA as part of the current round of UNGASS reporting. NASA is a tool to collect data on AIDS spending and provides the data necessary to report on UNGASS indicator #1 (i.e. domestic and international spending by categories and financing source). The data collected through this assessment were used to complete the National Funding Matrix, which reports how HIV and AIDS funds were spent in 2006 in Cambodia and where those funds were sourced.

As with all new initiatives to establish baseline information on a national scale, there are inherent limitations in the completeness and validity of data. The main problem is the difference between donor transfers and government spending which is mainly due to difficulties in deciphering from their budgets actual spending on AIDS-related activities. Other key information missing was HIV and AIDS spending by individuals and private sector. The survey could not capture the HIV/AIDS spending by the private sector and research institutions. Instead, a special methodology was used to estimate the market size of NGOs and the AIDS Spending Categories (ASC) distribution of this sector.

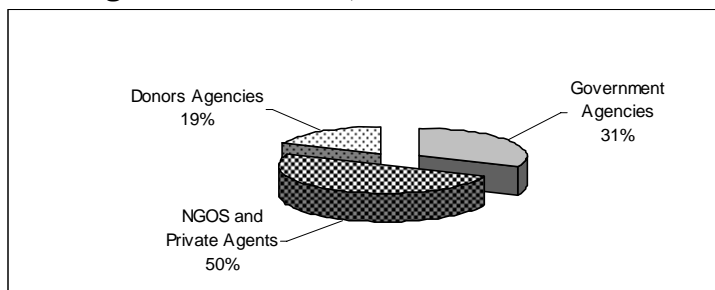
The NASA estimates that a total of US\$ 46.3 million was spent on HIV and AIDS in Cambodia in 2006. Figure 7 shows that the Donors agencies are the main financier of the AIDS sector (83% of total AIDS spending) with government contribution of 13% and as little as 4% funded by the private sector. The NASA results highlight the fact that the proportion of Donors spending is very high. This pattern of expenditures is reflective of the fact that Cambodia relies largely upon the Donors sector for the provision of HIV and AIDS services.

Figure 8: Sources of HIV/AIDS Funds, 2006



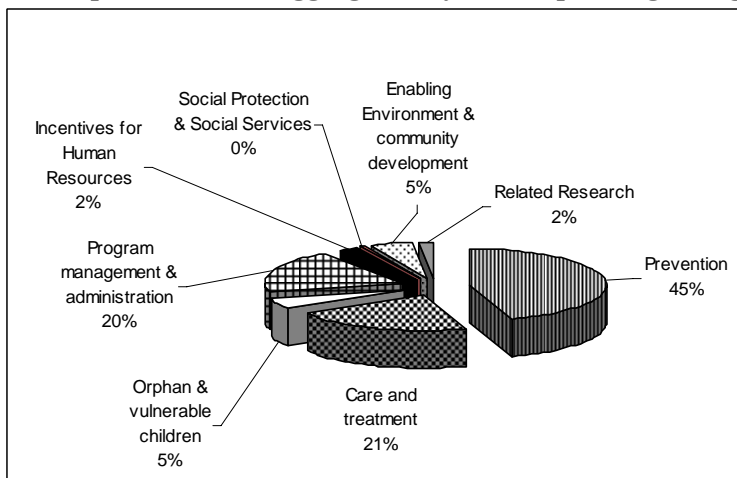
In terms of administration of HIV and AIDS funds, the NGOs are the main agents handling the HIV and AIDS funds (figure 9). NGOs' resource allocation is skewed mainly towards prevention, care and treatment as well as program management.

Figure 9 HIV/AIDS Agents in Cambodia, 2006



Expenditures have been disaggregated into AIDS Spending Categories (ASC) as defined in the UNGASS Guidelines on Construction of Core Indicators. A breakdown of total HIV and AIDS related expenditures by AIDS Spending Categories (ASC) indicates that almost 45% is spent on prevention, 20% on Program management and administration, 21% on treatment and care, 2% on incentives for human resources (e.g., training, benefits, monetary incentives) and 5% on orphans and vulnerable children (figure 10).

Figure 10: AIDS expenditures disaggregated by AIDS Spending Categories, 2006



The AIDS Spending Matrix below gives a detailed overview of AIDS spending by ASC and by financing source.

**AIDS Spending Matrix Data sheet by Financing Sources
Year 2006**

AIDS Spending Categories <i>Currency: (USD / Reels)</i>	Total Spending 2006	%	Public Sources	Private Sources	International Sources			
					Bilateral	Multilateral		
						UN Agencies	Global Fund	Other Internationals
1 PREVENTION	20,775,489	44.9%	5,133,639	827,955	7,122,992	3,048,158	3,958,634	684,111
1.1 Media	723,167		-	37,698	20,964	346,723	180,242	137,540
1.2 Community Mobilization	162,988		9,920	6,305	17,628	30,471	30,143	68,521
1.3 ABC	4,801		-	830	-	-	3,970	-
1.4 Counselling and testing	2,587,085		-	178	1,646,000	940,034	853	-
1.5 Program for vulnerable	216,117		-	2,839	-	87,656	13,572	112,050
1.6 Prevention Youth in School	2,237,551		-	330,089	155,000	174,235	1,578,227	-
1.7 Prevention Youth out of School	1,486,466		-	164,223	255,000	282,057	785,186	-
1.8 Prevention Programs inv people living with HIV	60,526		-	3,149	-	42,319	15,057	-
1.9 Prevention Programs involving sex workers	185,013		-	29,904	-	12,129	142,980	-
1.10 Programs involving men who have sex with men (MSM)	17,377		-	1,387	-	9,360	6,630	-
1.11 Harm-reduction for injecting drug users (IDU)	455,431		-	231	378,000	76,098	1,102	-
1.12 HIV Prevention Workplace Services	189,576		-	4,610	-	162,923	22,043	-
1.13 Condom and social marketing	4,344,051		-	632	3,974,400	-	3,020	366,000
1.14 Microbicides	363		-	63	-	-	301	-
1.15 Improving STIs management and treatment	44,697		-	7,731	-	-	36,966	-
1.16 Prevention of mother to child	267,558		-	2,513	-	253,028	12,017	-
1.17 Blood safety	6,270,929		4,129,509	199,883	676,000	309,851	955,686	-
1.18 Post-exposure prophylaxis	-		-	-	-	-	-	-
1.19 Safe medical injections	63,762		-	-	-	63,762	-	-
1.20 Universal precautions	2,529		-	437	-	-	2,091	-
1.21 Other preventions	1,455,520		994,210	35,252	-	257,512	168,547	-
2 CARE & TREATMENT	9,856,777	21.3%	-	165,370	5,303,000	3,597,739	790,669	-
2.1 Outpatient care	9,451,607		-	136,805	5,303,000	3,357,704	654,097	-
2.1.1 Providers testing	18,598		-	3,217	-	-	15,381	-
2.1.2 Opportunistic infections prophylaxis	37,057		-	6,410	-	-	30,647	-
2.1.3 Antiretroviral therapy	2,776,928		-	68,541	1,856,000	524,680	327,708	-
2.1.4 Nutritional support associated to antiretroviral (ARV) therapy	452,921		-	20,631	-	333,647	98,643	-
2.1.5 HIV related disease Lab monitoring	683,806		-	8,615	634,000	-	41,191	-
2.1.6 Dental care and services for PLWH	1,272		-	220	-	-	1,052	-
2.1.7 Psychological treatment and support services	12,612		-	2,181	-	-	10,430	-
2.1.8 Patient transport and emergency rescue	16,429		-	2,842	-	-	13,587	-
2.1.9 Palliative care	2,834,597		-	3,736	2,813,000	-	17,861	-
2.1.10 Home base care	2,576,419		-	13,326	-	2,499,377	63,716	-
2.1.11 Alternative care and informal services	40,967		-	7,086	-	-	33,881	-
2.2 Inpatient care	317,172		-	28,564	-	152,036	136,572	-
2.2.1 Opportunistic infections treatment	144,391		-	24,976	-	-	119,415	-
2.2.2 Other care and treatment services not elsewhere classified	172,781		-	3,588	-	152,036	17,156	-
3 Orphan & vulnerable children	2,177,112	4.7%	150,426	157,972	-	1,113,413	755,301	-
4 Program management & administration	9,133,465	19.7%	723,104	307,656	6,096,076	381,283	1,470,970	152,377
4.1 Program management	3,564,228		672,982	239,746	1,318,788	186,454	1,146,278	-
4.2 Planning and coordination	1,170,888		50,142	1,375	983,038	8,447	6,576	121,290
4.3 Monitoring and evaluation (M&E)	1,746,372		-	40,010	1,461,895	22,081	191,298	31,087
4.4 Operations Research	8,836		-	1,528	-	-	7,307	-
4.5 Surveillance	251,777		-	8,956	200,000	-	42,821	-
4.6 Drug supply system	2,268,520		-	4,304	2,100,788	142,849	20,579	-
4.7 Information technology	35,578		-	2,563	20,759	-	12,256	-
4.8 Supervision of personnel and patient tracking	11,708		-	2,025	-	-	9,683	-
4.9 Capital formation for provider institutions	75,580		-	7,147	12,808	21,452	34,172	-
5 Incentives for Human Resources	1,082,450	2.3%	48,142	122,430	133,637	192,878	585,363	-
6 Social Protection & Social Services	146,619	0.32%	-	57,564	-	89,055	-	-
7 Enabling Environment & community development	2,344,496	5.06%	-	389,795	44,672	46,336	1,863,693	-
8 Related Research	791,180	1.71%	-	11,415	86,198	82,724	54,578	556,266
T Total	46,307,588	100%	6,055,310	2,040,156	18,788,575	8,551,586	9,479,207	1,392,754

(B) ACTION THAT NEED TO BE TAKEN BY DEVELOPMENT PARTNERS TO ENSURE ACHIEVEMENT OF UNGASS TARGETS

Given the fragility of the gains, there is a need for continued commitment from development partners as well as from the Royal Government to support Cambodia's national response to HIV. The strategic priorities for the next three years (2008-2010) are identified in the revised and costed NSP II and it is important that development partners will align their assistance with the revised NSP II:

- Scaling up prevention programmes and in particular those targeted at most-at-risk populations (brothel-based sex workers and increasingly women working in entertainment establishments, MSM and IDU) and aimed at prevention of mother-to-child transmission.
- Further expansion of care and treatment for PLHIV and more emphasis on improving the quality of services.
- Scaling up of impact mitigation programmes for PLHIV and orphans and vulnerable children affected by AIDS.
- Strengthening of coordination and management of the national response through institutional and technical capacity building for key ministries and civil society organizations.
- Continued strengthening of the legal and policy framework, in particular the dissemination, implementation and enforcement of existing laws and policies.
- Further strengthening of monitoring and evaluation capacity of the NAA, key ministries and civil society organizations.
- Development of adequate systems (including resource tracking), that will help to ensure the alignment of resource allocations to agreed priorities.

VIII. Monitoring and evaluation environment

Considerable progress has been made in the area of monitoring and evaluation during the reporting period. The inclusion in the NSP II of a specific Monitoring and Evaluation (M&E) strategy has fostered increased focus in this area. M&E are recognised as critical tasks and as an integral part of the national response to HIV in Cambodia.

National M&E Guidelines have been developed in 2007 under leadership of the NAA and with the assistance of the M&E Advisory Group (consisting of M&E staff of government ministries, civil society organization and development partners). The purpose of the National M&E Guidelines is to provide a coherent and integrated framework for monitoring the progress and evaluating the outcomes of Cambodia's multisectoral response to the HIV epidemic as outlined in the NSP II.

(A) OVERVIEW OF THE CURRENT M&E SYSTEM

As indicated in Part A of the NCPI (section V on M&E) the National M&E Guidelines provide a comprehensive framework for a single and integrated M&E system, which is managed by the NAA.

The national M&E system links existing M&E systems of partner organization in government, civil society and development partners. The national M&E system brings together data on 54 core indicators, including the 21 UA indicators, Cambodia Millennium Development Goals and the indicators for 2008 UNGASS reporting. Data on the core indicators are stored in the CRIS database at the NAA. A detailed description of the core indicators (e.g. data sources, the frequency of data collection, etc.) has been included in the National M&E Guidelines.

Moreover, the national M&E system aims to monitor progress in the implementation of key interventions that are planned as part of the NSP II. This requires the collection and analysis of programme level data from organizations and agencies at national and sub-national levels.

Special mentioning needs to be made concerning the progress made in monitoring and evaluation of the health sector response to HIV and AIDS. NCHADS has further strengthened its information system, resulting in additional, reliable and timely programme level data. Moreover, NCHADS has put in place a strong surveillance system and has conducted several surveillance surveys during recent years:

- STI Sentinel Surveillance, 2005
- HIV Sentinel Surveillance, 2006
- Behavioural Sentinel Surveillance, 2007
- Drug User Survey, 2007

(B) CHALLENGES FACED IN THE IMPLEMENTATION OF A COMPREHENSIVE M&E SYSTEM

With the national M&E system in place, the NAA and partner organizations now face the challenge of maintaining and using the system:

- The NAA, other government institutions and non-government partners in the national response need to build sufficient human and institutional capacity for monitoring and evaluation.

- Systems and tools for data collection and storage need to be strengthened.
- More emphasis needs to be given to programme level and qualitative data, rather than the current emphasis on the collection of quantitative data and on measurement of higher level impact and outcome indicators.
- More operational research is required to provide additional data to better inform programming and policy making.
- Making sure that data is not only collected and stored, but also analysed and made available to programme planners and policy makers and used for improved priority setting.

(C) REMEDIAL ACTIONS PLANNED TO OVERCOME THE CHALLENGES

The above challenges are addressed in the revised NSP II for the next three years (2008-2010). Similar to the original NSP II, a separate monitoring and evaluation strategy has been included, together with three specific objectives:

- To strengthen the national multisectoral M&E system
- To ensure sound evidence-based HIV programming through monitoring, evaluation and research
- To promote sharing of information and advocate effective use of information by all stakeholders in the national response.

In order to implement this M&E strategy and to achieve M&E objectives, advocacy efforts need to be scaled up. Stakeholders and partner organizations need to understand the importance of and their specific roles in monitoring and evaluation of the national response.

Linked to increased advocacy efforts, additional resources need to be mobilised for monitoring and evaluation.

(D) THE NEED FOR M&E TECHNICAL ASSISTANCE AND CAPACITY BUILDING

M&E technical assistance for the NAA and partner organizations is already in place, which has resulted in considerable progress made in this area during the reporting period.

It is important that current levels of technical assistance are maintained throughout the next three years in support of the implementation of M&E strategies and objectives included in the revised NSP II.

The current lack of sufficient technical and institutional capacity was already identified as one of the main challenges in implementing the national M&E system. Current and future technical assistance will need to focus on building sufficient and sustainable M&E capacity at the NAA and key partner organizations through the transfer of knowledge and skills.

**ANNEX 1: Consultation/preparation process for the country report
on monitoring the progress towards the implementation
of the Declaration of Commitment on HIV/AIDS**

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

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

2) With inputs from Ministries:

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

(Please specify)

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

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

(Please specify)

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

- | | | |
|--|-------|----|
| 3) Was the report discussed in a large forum? | Yes ✓ | No |
| 4) Are the survey results stored centrally? | Yes ✓ | No |
| 5) Are data available for public consultation? | Yes ✓ | No |

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name/Title : Dr. Teng Kunthy
Secretary General of the National AIDS Authority

Date : 28 January 2008

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ANNEX 2: National Composite Policy Index questionnaire