

KINGDOM OF CAMBODIA
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NATIONAL AIDS AUTHORITY

CAMBODIAN REPORT
ON
FOLLOW UP TO THE DECLARATION OF
COMMITMENT ON HIV/AIDS
(UNGASS)

With Technical Assistance provided by Technical Board of NAA, UNAIDS,
Technical Officers of United Nations Agencies, Donors and NGOs
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ABBREVIATIONS

ADB: Asian Development Bank
AEM: Asian Epidemic Model
ANC : Ante Natal Clinic
ARV : Anti Retro Viral
BSS: Behavioral Sentinel Surveillance
CAA: Children Affected by AIDS
CBR: Crude Birth Rate
CC: Commune Councils
CHDR: Cambodian Human Development Report
CHRHAN: Cambodian Human Right and HIV/AIDS Network
COM: Council of Ministers
CPA: Complimentary Packages of Activities
CWPD: Cambodian Women for Peace and Development
DAC: District AIDS Committee
DHS: Demographic Health Survey
DSWs: Direct Sex Workers
FHI: Family Health International
GIPA: Greater Involvement of PLWAs
GFATM: Global Fund for AIDS Tuberculosis and Malaria
GFWs: Garment Factory Workers
GMS: Greater Mekong Sub Region
HACC: HIV/AIDS Coordination Committee
HSS: HIV Sentinel Surveillance
IEC: Information Education and Communications
ILO: International Labor Organization
IDSW GFATM s: Indirect Sex Workers
IDUs: Injecting Drug users
JBIC: Japanese Bank for International Cooperation
JFPR: Japanese Fund for Poverty Reduction
MDG: Millennium Declaration Goals
MERS WG: Working Group on Monitoring, Evaluation and Research System
MOEYS: Ministry of Education, Youth and Sport
MOND: Ministry of National Defense
MOP: Ministry of Planning
MORD: Ministry of Rural Development
MOU: Memorandum Of Understanding
MOWVA: Ministry of Women and Veteran Affairs
MSM: Men have sex with Men
MMM: Mondol Mith choi Mith (Friendly Care Center)
MPA: Minimum Packages of Activities
NAA: National AIDS Authority
NCHADS: National Center for HIV/AIDS Dermatology and STIs
NGO: Non Governmental Organization

NRT: National Research Team
NMCHC: National Mother and Child Health Center
NPRSP: National Poverty Reduction Strategy Papers
NSP: National Strategic Plan (for Multi-Sectoral and Comprehensive Response to HIV/AIDS 2001-2005)
NSEDP: National Socio Economic Development Plan
PAC: Provincial AIDS Committee
PAS: Provincial AIDS Secretariat
PATH: Program of Advanced Technology in Health
PLWA: People Living With HIV/AIDS
PMATU: Poverty Monitoring and Analysis Technical Unit
PMTCT: Prevention of Mother to Child Transmission
PRDC: Provincial Rural Development Committee
Pro CoCoM: Provincial Coordination Committee Meeting.
PSI: Population Service International
SAPI: Special Assistance for Project Implementation
SES: Socio Economic Survey
UNGASS: United Nations General Assembly Special Session
VDC: Village Development Committee
VTC: Voluntary Testing and Counseling
WVC: World Vision Cambodia

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EXECUTIVE SUMMARY

With an HIV prevalence rate at 2.6% among the adult population aged from (15-49 years), Cambodia is the country most affected by the HIV/AIDS epidemic in the Asia-Pacific Region. It is more than 10 years since the first case of HIV infection was detected; to date, the Monitoring and Evaluation of this disease relies mainly on information from the Health Sector where the Demographic Health Survey (DHS), HIV Sentinel Surveillance (HSS), and Behavioral Sentinel Surveillance (BSS) remain the main sources of data. When the National Strategic plan (NSP) for Multi-Sectoral and Comprehensive Response to HIV/AIDS 2001-2005 was launched, the Monitoring and Evaluation mechanism was envisaged as an important tool to ensure the implementation of the Strategies of the NSP with the broader participation of several sectors of development.

This report, which is a desk review of existing information, was developed to respond to the need to report on the follow up to the Declaration of Commitment on HIV/AIDS, with the support of a Core Group and a Consultative Group working on a set of indicators (UNGASS).

Findings

1. From the desk review exercise, it is known that there was almost complete information about the National Composite Policy index.
2. However, as far as National Program and Behavior and Impact alleviation are concerned, this report fails to respond to most indicators, as they call for a large population sample representing the national level through Population-based survey, School-based survey, Health Facilities based survey and Workplace Survey. So far, very few large-scale surveys have been conducted in Cambodia. The ones that have been conducted are the National Census, Demographic Health Survey and Socio Economic Survey. Information from these surveys has been used wherever possible.
3. Moreover, since the Working Group on Monitoring, Evaluation and Research System (MERS WG) is not operational so far, no system is in place for the purpose of Monitoring & Evaluation of HIV/AIDS and to measure the impact of this epidemic. However, several operational research / baseline studies were done by different institutions (GOs, NGOs and UN) to provide particular information on a specific target group, in a specified geographic area and with certain focus.
4. As for Monitoring & Evaluation Environment, it is clear that there is a need to fill the gap between the concept of the NSP and the real situation where the MERS WG needs to actively and constantly orchestrate the response to HIV/AIDS in the country.

INTRODUCTION

In June 2001, the Royal Government of Cambodia joined the States and Governments of the world for the United Nations General Assembly Special Session on HIV/AIDS. The Declaration of Commitment on HIV/AIDS – Global crisis, Global action – clearly sets out a roadmap for the response to HIV/AIDS in the country.

The UNGASS Declaration calls for the conduct of national periodic reviews involving the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, in order to track progress achieved in realizing these commitments and to identify problems and obstacles to achieving progress as well as to ensure wide dissemination of the results of these reviews.

Further the Declaration states that nations should develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, develop appropriate monitoring and evaluation instruments, with adequate epidemiological data.

This report, which is a desk review on existing information, was developed to respond to the follow up to the Declaration of Commitment on HIV/AIDS (UNGASS). In order to perform the task, the National AIDS Authority which is the holding the coordinating role in the HIV/AIDS response in the country , issued official letters to relevant institutions asking for their involvement in two Working Groups , the Core Group and the Consultative Group.

- **A Core Group** of resource persons from National AIDS Authority (NAA) , National Center for HIV/AIDS , Dermatology and STIs (NCHADS) , Technical Officers of United Nations Agencies and NGOs was established. From this group, three technical Officers of NAA were responsible for the collection of existing publications from government institutions and various organizations in the country, which could be the sources of data. In some cases, information was obtained through telephone conversations and face-to-face discussions. Based on these documents and information, the Core Group conducted a review, in line with the UNGASS indicators and provided insightful comments on the methodology, the population sample, the scope, area of focus and the limitations of those data. The review b this group had two main objectives: 1) to scrutinize the list of UNGASS indicators to see if they are relevant to the Millennium Declaration Goals (MDG) as operationalised for Cambodia; and 2) more importantly, to find out whether the information required matched with the national needs and National Strategic Plan. Several meetings were held in February to discuss the sources of information and the details of data as responding to specific indicators of UNGASS. A first draft Report was developed on 25th March and forwarded to the Consultative Group. A second meeting was held to discuss comments to

this draft and additional inputs, and a revised draft prepared. Lastly, the report was edited in the first week of April leading to the final version of the report.

- **Consultative Group** has a broader participation of Technical Officers from Governments Institutions (Technical Board of NAA, National Researchers (NRT and PMATU)), United Nations Agencies, Donors and Civil Society.

On 7 February 2003, the Core Group introduced the objectives of the report to the Consultative Group to inform about the needs (UNGASS indicators) and the process of the desk review. All the attendees were asked to provide relevant documents/information to NAA staff. On 3rd March 2003, the Core Group consulted the National Research Team (NRT) for the Development of the Cambodian Human Development Report (CHDR 2002-2004), and Poverty Monitoring Analysis Technical Unit (PMATU) at the Ministry of Planning to seek their input in this desk review. Another consultative group meeting was held on Wednesday 05, March 2003 with the rest of Consultative Group. The last meeting of the Consultative Group was held on 3rd April 2003.

In fact the MRES WG should have been responsible to coordinate the above mentioned tasks. The lack of both technical and financial support for the MRES WG is the main reason for the slow progress of this group. The Monitoring and Evaluation Environment on HIV/AIDS in Cambodia will be elaborated in the last chapter of this report.

I-Situation at a glance

The most recent surveillance data (HSS, NCHADS, 2002) shows a decline of HIV prevalence rates among a number of selected target populations, such as direct and indirect sex workers, and the police. Overall, the situation appears to be stabilizing. However, the present surveillance data on the HIV/AIDS epidemic in Cambodia indicates that HIV infection is not uniformly distributed throughout the country, and there is a possibility that the epidemic may evolve rapidly and unpredictably. Cambodia may need to consider a number of crucial issues that can reverse the course of the epidemic and more importantly undo all achievements undertaken by government institutions and civil society in the development arena.

A positive outcome of the situation and response analysis done within the process of National Strategic Plan Development is that HIV/AIDS is now considered as a development issue. It is part of the Poverty Reduction Strategy Paper, and is included as a key concern of the Social Sector Local Consultative Sub-group.

Some of the areas of concern are related to changing social norms and sexual as well as drug-use behavior patterns. A number of factors appear to be leading to an increase in extra- and premarital sexual contact. From the civil war the social fabric of the society has been broken, family bonding is weak, and men seek additional partners, particularly when they are working far away from home. With the abrupt change from a planned economy to free market economy a large number of the population are on the move inside the country and crossing the border to seek better jobs and employment. Internal and regional instability may also affect an individual's job opportunity and livelihood and cause the social safety net to break down, which results subsequently into increase in vulnerability to HIV/AIDS.

There is increasing recognition that vulnerability to infection, especially for women, stems from the influence of socio-cultural, economic and political factors. It is also influenced by realities that compound individual risk by significantly limiting an individual's choice and options for risk reduction. Girls in Cambodia are often withdrawn from school before completing high-school, limiting job options (CHDR, Ministry of Planning 2002). The few studies conducted (PSI, 2002) indicate a fairly high acceptance of violence linked to sexual activities, which reduces women's ability to negotiating safer sex. Discrimination and marginalization of certain groups of people such as sex workers and persons living with HIV/AIDS, illiteracy and lack of educational opportunity, and ignorance about STI/HIV/AIDS further heighten vulnerability and risk. In spite of significant advances in the legal environment and commitment on the part of the government, illustrated by the passage of a

Law related to HIV/AIDS prevention and care, the vision of a comprehensive, decentralized effective response is yet to be fully realized.

With an abrupt open contact to the outside world after decades of civil wars, the traditional values of Cambodian society have deviated gradually from the unique and beautiful cultural traditions and simple life to a belief in the power of money and materialism. Besides, as an effect of globalization the culture at home and the environment has drastically changed over the last three decades. The increase of drug use, violence at home and outside resulting in a diminishment of safety for life and property along with a decline of moral values, social contact and mutual assistance clearly means that the glue which holds every element of society together is severely affected. These determinants are the root cause of the HIV/AIDS epidemic in Cambodia because they increase the people's vulnerability to the epidemic. In other words the Immune System of the whole society is severely threatened.

In the era of HIV/AIDS a sustainable response to this epidemic is the ability to orchestrate a social movement to repair the Social Immune System. This requires the creation of a social safety net for all Cambodian people. Each person needs to move from being a passive object of change to becoming an active subject of change. However, Cambodia does not have a history of people organizing for social justice and social change such as environmental movements, consumer protection movements, the women's movement, movements of peasants and the landless, etc. There have been instances of political or social agitation, demonstrations against corruption or for democratic principles, strikes for better working conditions. Where people live with a sense of insecurity and without the protection of the law, social movements are slow to emerge. In such settings, discussion of change is taken as criticism of the status quo. However, for the on going survival of the human species and especially Cambodian people, the imperative for change should be enacted at all levels starting from the individual and family.

II-Overview of the HIV/AIDS epidemic

Since the first case of HIV infection was detected in 1991, it is estimated that out of the population of 13 million Cambodia now has 157,500 people living with HIV/AIDS (HSS, NCHADS, 2002). Although the estimated prevalence among adults aged 15-49 has shown a steady decline from 3.3 % in 1997 to 2.6% in 2002, Cambodia is still the worst affected country in the region.

The Ministry of Health reported in the last HSS round (2002) that Cambodia has effectively reduced new infections, with a fall in new HIV case from approximately 40,000 cases in 1994 (the peak of HIV/AIDS epidemic) to about 7,000 in 2002 (Source Asian Epidemic Model).

The Asian Epidemic Model (AEM) developed by NCHADS (National Center for HIV/AIDS, Dermatology and STDs) with East West Center by Cambodian working group on HIV/AIDS Projection (2002) estimated that since the beginning of the epidemic there were 94,000 people who died of AIDS. More importantly, the group predicted that there would be 237,821 AIDS related death by 2010. The striking fact is that this number even exceeds the combined active population of four provinces (Sihanoukville, Stung Treng , Mondulakiri and Ratanakiri). This human resources loss means a lot for a small country which is trying very hard to recover from two decades of civil war and instability.

With regard to controlling the spread of HIV/AIDS, AIDS is presently spreading from groups at higher risk to the general population. It is estimated that in 2002, out of new infections 42% are from husbands to wives (Source AEM). With an active HIV/AIDS prevention program addressing brothel based sex work, unsafe sex with direct Sex Workers is remarkably reduced. Condom use in brothels is estimated to be almost 90% (BSS, 2001). Perinatal transmission is then ranked as the second highest route of transmission.

As for social and economic consequences, Cambodia is losing human resources that ought rightly to be in their prime. Households are losing their heads and children who escape HIV infection are losing their chance for an education. The burden of rearing children is falling to survived grandparents from Khmer Rouge period. The net impact is to slow the development of society.

Although the latest data demonstrates gradual decrease of the incidence of HIV infection in the selected target groups who are vulnerable to HIV/AIDS, a number of emerging issues need a serious consideration.

Urbanization: The rapid growth of urban centers implies that large numbers of young people leave secure, protected rural communities, and move into an environment where they are outside the usual norms of social and cultural behavior-control. Loneliness, exposure to different cultural patterns of social and sexual interaction, greater exposure to media which projects alternative life-styles as attractive, money to spend, and increased access to partners in crowded surroundings, all combine with the adventurousness of youth to resulting an increase in un-safe sex. Reports from Provincial authorities indicate an increase in abortion rates and STIs, pointing to unsafe sex and therefore increased vulnerability.

Cambodia is promoting Tourism as a major industry and source of foreign exchange for the country. In order to make the country an attractive destination for overseas tourists, hotels, bars, casinos and other forms of hospitality and entertainment are encouraged. Early studies (Gambling with

One's Health, CARE, 2002) indicate there are more than 10,000 casino workers in the country, at "heightened vulnerability for STIs and HIV/AIDS". Most of these workers were not familiar with the use of condoms. Anecdotal evidence shows that indirect sex work is increasing through massage parlors, karaoke and other venues.

1- New vulnerable groups :

- Garment Factory Workers (GFWs) : Since Cambodia is granted MFN (Most Favored Nations) status , an estimated 200,000 young people where an absolute majority are single young female, are moving from countryside to work in the garment industry. Owing to the research of some NGOs (e.g. CARE) and NCHADS (2002), it is known that there are evidences of active unprotected sexual relation among this group (increase of STIs and also abortion). The lack of resources and advocacy are the main factor for the low support to introduce HIV/AIDS and Reproductive Health program to the GFWs (only 20 out of 200 factories did have such a program).
- Mobile population: Separated from spouses mobile people (internal and cross border) indulge in relation with partners other than spouses. It is known that there are 50,000 Cambodian people working in Thailand as construction workers, farmers, seafarers... (Source: PATH). Asian Highway development may also increase vulnerability of Road Construction Workers as well as that of the communities they work in. Because of the lack of support, the joint effort from Ministry of Health, Ministry of Public Work and Transport, Local Authority and Civil Society is still limited to really cover the need of mobile population. On the other hand, local mobile population who are on seasonal migration from rural population to urban cities in Phnom Penh and some provincial town should also be taken into consideration.
- The increase of drug use (including injecting drugs) is another concern as it can also foster the risk taking behavior with an increase vulnerability to HIV/AIDS. Drug sellers are now searching for new clients from in and out of school youth, garment factory workers, direct and indirect sex workers ... Drug users might forget to use condom or agree to exchange no condom sex for drugs when they turn to be drug dependant. Small studies ("Drug Use and HIV Vulnerability" Mith Samlanh-Friends, 2002) indicate that about 18% of drug users in Phnom Penh are or have used injecting. This is a sharp increase from even three years ago.
- Indirect sex workers : So far 100% Condom Use Program covers mainly the brothel based sex workers with an increase of condom use up to 86% (Source : BSS 2001). But actually men are now moving to buy sex from indirect sex workers such as Karaoke, Beer Girls, and Massage

parlor. The difficulty of the control on these types' sex services is caused by the fact that singing, selling beer or massage is just the meeting point between girls and clients. While some girls might argue that those relationships are their personal affairs it is known that sometime owners provide the support for this extra job. The BSS (2001) shows that condom use by beer promoters is 56.3% with clients, and 37% with "sweethearts".

- With the rapid change of the social environment young people (in and out of school) could be another group of concern. Nowadays, young men can easily buy sex from Sex Workers while others choose to court young girls who are not involved in sex industry. Sex with these "sweethearts" is often unprotected. As study by PSI ("Sweetheart Relationships in Cambodia", PSI, 2002) points to a disturbing trend of violence associated with sexual activity. This includes threats, coercion and gang-rape. This kind of violence is accepted by male respondents as a legitimate way of overcoming the natural and cultural reticence of women regarding sex.
- MSM (Men have sex with Men) is another group that requires attention. A study by FHI in 2000 (Sexual behavior, STIs and HIV among Men who have Sex with Men in Phnom Penh, Cambodia), although a small study in one city, suggests that the risk of HIV is high. Overall, 26.5% of the respondents tested positive for at least one STI, including HIV. 14.4% of respondents tested positive for HIV. Risk factors for HIV infection were anal sex with multiple partners, as well as unprotected vaginal sex with commercial sex partners. While these figures represent a population that is at higher risk as many of the respondents appear to be male sex workers, another study by Khana (2002) also indicates high risk and vulnerability.

2- Children and old people Affected by AIDS

With a mature epidemic, social problems are now emerging with rising numbers of orphans and affected households. The loss of income due to AIDS coupled with the costs of care and treatment is widening the gap between the rich and the poor and increasingly the vulnerability of the latter. Untreated HIV infection leads to death; which in turn creates serious social problems caused by children and the elderly being left unsupported. Treated, it becomes a chronic illness but places heavy demands on health care systems. This may divert scarce public resources from basic health needs. The cost of treatment impoverishes households, depleting household savings and assets, and creating a new class of the poor out of those previously better endowed.

- Up to the year 2002 ,the Ministry of Health estimated that there are around 94,000 deaths due to AIDS leaving behind almost 100,000 children and old people without support (Source : AEM).

- If there is no access to ARV by 2010, the cumulative death could be from 230,000 to 250,000 with 110,000 CAA (Children Affected by AIDS) and 100,000 hopeless elderly (Source AEM).
- It is known that 36% of Cambodia's population lives under the poverty line (Source: SES), therefore the coping mechanism is and will be overwhelmed by such a heavy burden. Activities of some pagodas (Wat Norea and Wat Kien Kess in Battambang and Wat Opoat in Takeo) should be expanded to the other 3,800 pagodas countrywide in order to alleviate this burden.

III- National Response to HIV/AIDS Epidemic

1- National Commitment and Action

National Composite Policy index

In the period from January – December 2002, notable action has been undertaken by various stakeholders:

Country has HIV/AIDS integrated into part of their general development plan
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- Since HIV/AIDS is considered as a development issue (based on the National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS 2001-2005), Cambodia has HIV/AIDS integrated into the National Poverty Reduction Strategy (NPRS) and the Second Economic and Development plan (SEDP II).
- The Development of the HIV/AIDS **Law** by the Health, Social and Women Affairs Commission of the National Assembly was undertaken with subsequent consultation with the Council of Ministers, United Nations agencies, various governmental institutions and civil society including PLWAs. Finally the Law has been approved by His Majesty the King on 29 July 2002.

Country has functional, national, multi-sectoral HIV/AIDS management/coordination body Country has a functional public/private forum for interaction between Government, the private sector and civil society
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- As for the mechanism of multi-sectoral coordination , the National AIDS Authority (**NAA**) was created in January 1999 with the legal mandate and the broad representation to be at the centre of multi-sectoral coordination of multi-level and multi-dimensional activities. The NAA consists of: I) a Secretariat, ii) 26 line ministries, iii) the Cambodia Red Cross and IV) 24 provinces and towns. This network includes cooperating projects supported by donors and financial support from the Royal Government of Cambodia through the national budget. The functions of the NAA include:
 - policy development;
 - strengthening partnership relations with all stakeholders and coordinating the multi-sectoral response to HIV/AIDS;
 - mobilizing resources from national and international institutions and agencies;
 - advocating for legislative support and for research on the socio-economic impact of HIV/AIDS and coordinating the research agenda; and
 - Reviewing and approving the IEC program in all sectors.

For functional interaction between Government, Private sector and civil society, different forums of coordination have been identified:

At the central level:

The NAA works through a Policy Board (PB), made up of the Secretaries of State from the member ministries and the 3rd Deputy Governor from 24 provinces and towns. The main tasks of the Policy Board is to ensure that policy development in the specific sectors is consistent with the national policy framework and to support enactment and enforcement of appropriate laws and policies related to HIV/AIDS.

At the Technical level, the member line Ministries work in collaboration and coordination with the NAA Secretariat in a Technical Board (TB). It is envisaged that the members of the TB will be the engines behind the process of enhanced strategic planning in the ministries.

Topic-specific Working Groups have been constituted to take forward the thinking, strategy and programming for a particular area of work. Each working Group convened by NCHADS for the Ministry of Health, and NAA includes representatives of civil society, PLWAs, Donors, and the UN.

- So far the Ministry of Health has created the following Working Groups:

- Continuum of Care Working group (With sub-groups on Continuum of Care; Voluntary Counseling and Testing; Institutional Care)

- TB/ HIV Working Group
 - PMTCT Working Group
 - Sexually Transmitted Infections Working group
 - HIV/AIDS Related Research Working Group
- The National AIDS Authority has initiated the following Working Groups:
- Legal working group
 - IEC working group
 - Monitoring Working Group

In addition, NAA is bringing together and facilitating dialogue between the National Research Team (NRT) for the preparation of the Cambodian Human Development Report (CHDR) and the Poverty Monitoring and Analysis Technical Unit (PMATU), the team that is responsible for Millennium Development Goals (MDG). This is important as the CHDR for the period 2002 to 2004 focus on HIV/AIDS.

At Provincial level:

Within the institutional framework of the National Strategic Plan (NSP), the collaboration between the sectors is done through the PAC (Provincial AIDS Committee), PAS (Provincial AIDS Secretariat) and DAC (District AIDS Committee). As for interaction with local partners especially NGOs, each province has integrated HIV/AIDS into the Provincial Coordination Committee (Pro CoCoM) Meeting.

- Last year, three additional Ministries (Ministry of National Defence , Ministry of Rural Development , Ministry of Social Affairs ,Labor , Vocational training and Youth Rehabilitation) and two Provinces (Battambang and Siem Reap) developed their own Strategic Plan with the vision of the National Strategic Plan for Multi-sectoral and Comprehensive Response to HIV/AIDS, where AIDS is considered as a development issue.
- Although the Ministry of Education Youth and Sport had developed its Strategic Plan in 2000, as part of its involvement of the Comprehensive and Multi-sectoral response to HIV/AIDS, a careful impact analysis on youth and the workforce had not been done so far. (From the rough estimation by the use of National prevalence rate it is estimated that 2000 Teachers (Primary and Secondary) may have been infected with HIV in 2003.

Country has a coordinating forum for civil society organizations

For the coordination with civil Society, HACC (HIV/AIDS Coordination Committee) and CHRHAN (Cambodian Human Right and HIV/AIDS Network) play as coordinating bodies with NGOs all over the country.

Country has a strategy that addresses HIV/AIDS among national uniformed services including armed forces and civil defence forces

- With support from donors, peer education has been expanded among the **Uniform services** (covering almost 70% of the Military and 25 % of the Police (Activities report of FHI/IMPACT, Cambodia). However, the Ministry of Interior has not yet developed a Strategic Plan for HIV prevention and care...

Country has a policy on reproductive and sexual health education for young people

- Regarding the policy on **reproductive and sexual health education for young people** , the Ministry of Health and the Ministry of Education Youth and Sport have initiated the following :

- There is no specific Policy on Reproductive Health but the Ministry of Health developed a Birth Spacing Policy since 1995. MOEYS has initiated a School based Reproductive Health Program .The Ministry of Education, Youth and Sports has created an Interdepartmental Committee on HIV/AIDS gathering staff from 12 different departments. The objective of this committee is to mainstream HIV/AIDS into the various networks of the MoEYS. These networks represent the huge opportunity of targeting 3.5 millions learners, 70,000 educators and more than 20,000 non-teaching staff.

Various projects are being implemented by the MoEYS such as the training of trainers, including sports instructors and literacy teachers; the production of teaching and learning materials for all levels of the education system; the launching of youth risk behavior survey; the development of communication campaign for youth; the preparation of a module for distance education and the development of pilot project for the involvement of Parent Teacher Association.

Others initiatives are happening at schools levels in cooperation with the NGO sector and others organizations such as peer education at secondary schools and universities [Cambodian Red Cross, World Education, Reproductive Health Association in Cambodia and Save the Children UK], the development of youth clubs [Sovanna Phoum]. Moreover, various NGOs working in Non

Formal Education with Street Children are conducting specific projects on HIV/AIDS.

The MoEYS is also considering evaluating the impact on AIDS on the education sector to better responds to the HIV/AIDS epidemic.

Supportive environment for reproductive health. While there is no specific policy on Reproductive health, condom social marketing is widely and frequently promoted through media (TV, radio) , Peer Education Program for in and out of school Youth , mass campaigns (Water Festival , World AIDS Day & Candle light Memorial) and also in the workplace (Garment factories). We can therefore safely assume that there is a fairly supportive environment for condom promotion and distribution.

Country has a policy and prevention programmes to promote and protect the health of groups with a high or increasing rate of HIV infection

The 100% Condom Use Program is now expanded to all provinces countrywide to circumscribe HIV/AIDS infection within high risk groups (Direct Sex Workers and clients) . However, efforts should be made to address Indirect Sex Workers, MSM, and IDUs.

Country has a policy and prevention programs for migrants and mobile workers :

The Ministry of Public and Transport has just been appointed as a member of NAA. The MOU of the GMS (Greater Mekong Sub Region) countries is seen as an important tool for initiating intervention addressing migrant workers (Internal and Cross border). Because of the lack of support, a joint effort from the Ministry of Health, Ministry of Public Work and Transport, Local Authority and Civil Society is still limited in terms of coverage of the needs of mobile populations. Nevertheless , efforts have been made by local NGOs to reduce vulnerability of people using or living near some National roads (NR1-6) and those who cross the border to work as fishermen in Thailand (CWPD and PATH). Pre- departure prevention activities have been also been done for migrants workers leaving for Malaysia (CARAM). Some initiatives have been made by CARE international to provide information and services to Garment Factory Workers who represent an important internal mobile population (200,000 mostly young and single women).

Country has a policy to expand information, education and communication in HIV and access to essential commodities

- Based on the HIV/AIDS Law and the National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS, it is known that Cambodia has a policy to expand information, education and communication on HIV and access to essential commodities for high risk groups and the general population.
 - Condoms are openly promoted and marketed through the media (TV, radio). From 1994 to 2002, more than 100 million Number 1 condoms (PSI Brand) have been sold.
 - IEC is now moving to empower the target population through Life Skills training. The result will be the development of a positive attitude and self- efficiency in addition to the empirical knowledge on HIV/AIDS Prevention.
 - Besides, PLWAs are encouraged to participate in all possible platforms to reduce stigma and discrimination through the GIPA principle.
 - The Ministry of Health has developed a Policy for Testing and Counseling as well as protocols for STIs and HIV/AIDS case Management. Simultaneously, a Continuum of care plan has been set up to provide access to health services for at risk populations and PLWAs.
 - The expansion of the Home Based Care, VCT and PLWAs Support Group throughout the country will be the network to ensure increased access to more comprehensive and improved services for PLWAs.

Country has a policy to reduce MTCT

- In 2002, The Ministry of Health developed the National Policy for the Prevention of HIV infection from Mother to Child. Currently 3 sites provide services for the PMTCT of HIV infection.

Country has legislation, regulation and/or other measures to eliminate all forms of discrimination against the rights of people living with HIV/AIDS

- Based on the HIV/AIDS Law, GIPA principles and the National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS, it is known that Cambodia has legislation, regulation and /or other measures to eliminate all forms of discrimination against the right of people living with HIV/AIDS. However, mechanisms for the enforcement of this law are yet to be developed.

Country has a legal and policy framework that protects the rights of workers living with and affected by HIV/AIDS in the workplace.

- Based on the HIV/AIDS Law, GIPA principles and the National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS, it is known that Cambodia has a legal and policy framework that protects the rights of workers living with HIV/AIDS in the workplace. However, the Cambodia Business Coalition on HIV/AIDS it yet to be formed. Other mechanisms to enhance the effectiveness of law enforcement for supporting and protecting the rights of those who have been affected by HIV/AIDS are also yet to be developed.

Country has a policy for the promotion of the rights of women and girls who are affected or at-risk for HIV/AIDS

- In 2001, the Ministry of Women Affairs has developed a Country policy for the promotion of the rights of women and girls who are affected or at-risk for HIV/AIDS.

Country has regulations that ensure evaluation of research protocols for HIV-related treatment by an independent committee of ethics

- In 2001, the Ministry of health has formed an Ethical Committee to ensure that evaluation and research protocols for HIV- related treatment is done in accordance with globally accepted ethical standards...

Country has reviewed and or revised national pharmaceutical policies and practices concerning antiretroviral drugs and other HIV/AIDS-related drugs

- The Ministry of Health has developed the National Protocol on AIDS Case management including the use of ARV and other HIV-AIDS related drugs, and is presently reviewing and revising the definitions and protocols. Cambodia has yet to review and revise National Pharmaceutical Policies and practices concerning these drugs.

Country has a policy to strengthen health care systems, including factors affecting the provision of HIV-related drugs

However, efforts have been made by the Ministry of Health to develop the policy of Continuum of Care by strengthening Health Care system for the provision of HIV- related drugs and other services. Mondol Mith choi Mith (MMM) or a Friendly Care Center, where friends help friends will be created at OD level. Facilities for counseling, testing, follow up

services and treatment of opportunistic infections as well as ARVs will be provided. Linkages to support groups of PLWHA will be made. Advocacy with the community to reduce stigma and discrimination will also be undertaken. Referral Hospitals, Operational Districts and Health Centers are currently providing services through CPA (Complimentary Packages of Activities) and MPA (Minimum Packages of Activities) for different level of care. Health center staff also participates in home-based care teams, along with NGOs.

Country has a policy and or strategy to provide psychosocial care for those affected by HIV/AIDS, including for marginalized groups

- Based on the HIV/AIDS Law , GIPA principles and the National Strategic Plan for Comprehensive , the Multi-sectoral Response to HIV/AIDS and the HIV/AIDS Strategic Plan of Ministry of Health , it is known that Cambodia has a policy and strategies to provide psychosocial care for those affected by HIV/AIDS , including marginalized groups.

Country has a policy that addresses orphans and vulnerable children

- Within the Strategic Plan of the Ministry of Social Action, Labor and Youth rehabilitation, orphans and Vulnerable children have been identified in the different strategies; however the policy for those groups is yet to be developed.

Government funds spent on HIV/AIDS

- **The National Budget** has been increased to close to 2 Million Dollars in the special Priority Action Program where the Ministry of Education Youth and Sport is joining the Ministry of Health and the National AIDS Authority. Even though the focus of the multi-sectoral NSP has veered away from a predominantly medical response, the role of the Ministry of Health remains extremely important, both within its own health networks and in providing technical support to other sectors at the national and local levels. The strategies for the health sector (2001-2005) have been incorporated in the National Strategic Plan and it is recognized that the MOH should take the lead in more health-oriented prevention, care and support actions. Although the structure for the HIV/AIDS response has been expanded to cover 26 Ministries and 24 provinces , only few institutions had access to Priority Action Program (PAP) in 2002 , namely :
 - Ministry of Health : 816 920 USD (or 3186 Million Riels)

- Ministry of Education, Youth and Sport: 256, 000 USD (or 1000 Million Riels).
- National AIDS Authority: 589, 740 USD (or 2,300 Million Riels).

Remark:

In 2002, this National Budget is just a small proportion of the total budget for the HIV/AIDS Program originating from the United Nations Agencies, Bilateral and Multilateral donors. On the other hand, in 2002 civil society reportedly to received 10 Million US dollars from donors to respond to HIV/AIDS in the field of prevention care and support.

2. National Program and Behavior

In the period from January – December 2002, notable actions have been undertaken by various stakeholders:

National Program at a glance

Prevention Percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last curriculum year.

So far there is no School-based survey to illustrate this percentage. But there are program where life-skills are being introduced in the training for school teachers as well as other staff and students. Programmes initiated through networks of the MOEYS cover 3.5 millions learners, 70,000 educators and more than 20,000 non-teaching staff. In addition, NGOs such as the Cambodian Red Cross, World Education, Reproductive Health Association in Cambodia and Save the Children UK, conduct prevention programmes with school children. Others promote the development of youth clubs [Sovanna Phoum]. Moreover, various NGOs working in Non Formal Education with Street Children are conducting specific projects on HIV/AIDS.

Percentage of large enterprises/companies that have HIV/AIDS prevention and care policies and program.

So far the was no workplace survey to depict this indicator. However, there are some programs in place supported by the Ministry of Social Action, Labor and Youth Rehabilitation, CARE, SAPI/JBIC, KHANA, WVC, FHI/IMPACT and ILO work to address the needs of employees of private

enterprises. They work with Garment factories, port-reconstruction workers, the uniformed services, casino and entertainment industries, but so far their coverage reaches a small proportion of the total workforce. On the other hand for the public sector, program and policies have been initiated in the Ministries of Health, Social Action & Labor, Rural Development, Defense, Religious Affairs, Women Affairs and Interior.

Percentage of HIV positive pregnant women attending antenatal clinics receiving a complete course of ARV therapy to prevent MTCT

a. Numerator : Number of HIV infected mothers attending ANC clinic and receiving full course of ARV.
Presently, 118 mothers are receiving a full course of ARV to prevent the transmission of HIV infection to their babies. (Source : MOH : Battambang Province 2 (NCHADS); National Mother and Child Health Center, 12 (NMCHC) and Calmette Hospital , 104 (Pericam Project))

b. Denominator : Number of HIV infected mothers attending ANC clinic.

- Total population : 13,000,000 (Source : Projection from Census for 2003)
- CBR : 27.7 /1,000 population (Source DHS)
- ANC Attendance : 45% (NMCHC)
- HIV+ among ANC attendees : 2.8 % (HSS 2002)
- Number of HIV infected mothers attending ANC clinics = $13,000,000 \times 27.7 \times 45 \times 2.8 / 1,000 \times 100 \times 100 = 4,536$

c . Percentage: $118 / 4536 = 2.6\%$

Care / Treatment

Percentage of patients with STIs at health care facilities, who are appropriately diagnosed, treated and counseled.

There is no large scale Health Facilities Survey to depict the above mentioned indicator.

However, from the baseline Health facilities survey (Source: JFPR/ADB / NCHADS) in 4 provinces (Battambang, Koh Kong, Prey Veng, Svay Rieng) done in 2002, to assess on the Syndromic Approach for the Management of STIs

- Special STI clinic (High Risk Population):
 - 60% properly diagnosed

- 59% (of the above) properly treated
- i.e. 35.40%
- STI services integrated into health Center (General Population)
 - 47% properly diagnosed
 - 88% (of the above)properly treated
 - ie.41.36%

Percentage of people with advanced HIV infection receiving ARV combination therapy.

a- Numerator : People with advanced HIV infection receiving ARV therapy. Through the report of the Ministry of Health (NCHADS) it is known that 650 adults are using ARV supported by a number of NGOs and public hospitals at Central level. There is no data from private clinics. It is worth mentioning that 70 pediatric cases are using ARV drugs.

b- Denominator: People with advanced HIV infection in need of ARV therapy. By using the estimation procedure of UNGASS (Number of patients eligible for ARV therapy = 15% of the total number of HIV infected people) = $157,500 \times 15\% = 23,625$

c- Percentage: $650 / 23,625 = 2.75\%$ ***of people with advanced HIV infection are receiving ARV combination therapy***

National behavior at a glance:

Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

From DHS 2000 it is known that 69% of young people aged 15-24 correctly identify ways of preventing the sexual transmission of HIV. However , the percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission is not known.

Remark:

There is no data survey on the on going Peer education projects with Military personnel, Police , Students , GFWs (Garment Factories Workers) , Mobile Population (National Road 1- 6) , Condom social Marketing (PSI) and other interventions of Government institutions and civil societies to increase accurate information through out reach activities and the media .

Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner.

So far there is no population based survey illustrating this indicator. However, from the BSS 2000, it is known that 82% of young males aged 15-24 reported the use of a condom during sexual intercourse with brothel based sex workers.

Remark:

Comment on BSS Male Survey in 2000

- Household BSS was conducted in 2000 with a sample of 3,166 males in Phnom Penh and 4 Provinces, with a mean of age 29 years and a median age of 29 Years. BSS 2000 covers students, Military & police, Salesmen, Office Workers, Moto taxi drivers, Farmers, Fishermen, Laborers .This male household survey had a relatively small sample.
- Besides, there must be a segregation of data on condom use with Sex Workers and Sweet hearts.

Comment on Female:

- In the Cambodian context, women are supposed to preserve virginity. A very large proportion of sexually active women have only one partner, their husband. Those who have many partners are usually those who are part of the sex industry (direct or indirect). Besides, the average age of women at marriage is 19.9 years and for the majority of women this is where the first sexual intercourse occurs. (Source: DHS 2000). Therefore the lower age limit of the age-range 15-24 is not relevant for Cambodia.
- The data available only refers to SWs (DSWs and IDSWs).

Percentage of injecting Drug users who have adopted behaviors that reduce transmission of HIV:

- a. **Numerator:** IDUs who have adopted behavior that reduce transmission of HIV.
- b. **Denominator:** Number of all IDUs.

From the available resource especially National Authority on Drug Control and Mith Samlanh, an active NGO working with street children the full picture of drug abuse and the adoption of safe behavior are not known. The available data does indicate that drug use is increasing among young people and that among drug users the proportion of those who have ever injected is also increasing.

Impact alleviation at a glance:

Ratio of orphaned to non-orphaned children aged 10-14 who are currently attending school*

There is no large Population-based survey to depict this indicator.

IV - Major Challenges / Action to achieve Goals / Target

Challenges

- Although the structure of the framework for the HIV/AIDS response has been expanded to cover 26 Ministries and 24 provinces , only a few institutions can have access to National Budget and donors (Both grant and loan). Some Ministries and provinces have prepared Plans that incorporate HIV into their work, but these plans have not been coasted and resourced.
- The lack of self- reliance for a sustained response to HIV/AIDS is the most important reason for the delay in mobilizing the vertical and horizontal network. Since the concept of the National Strategic Plan is not yet very well understood, the concern and the responsibility across sectors are not very well perceived... Likewise, only a very few local authorities are moving from being passive recipients of funds to proactive actors in mobilizing internal resources for a comprehensive HIV/AIDS response.
- There is a need to map the response from GOs, NGOs and the private sector in order to better coordinate the response and more importantly to optimize the reach of resources by preventing an overlapped response.
- The vision of National Strategic Plan (NSP): Two complementary approaches in support of decreasing the vulnerability to HIV/AIDS at the individual, community and societal level have emerged, according to the review of the current situation and the analysis of obstacles and opportunities for change.
The first approach concentrates on influencing individuals to understand that safer behavior is a more attractive option, whereas the second strategy focuses on changing aspects of the existing socio-economic context to support individuals to protect themselves from HIV infection and to cope with the consequences of HIV/AIDS.
- The development of the NSP calls for a change to the existing paradigm for HIV/AIDS actions from a segmented, health centered, and top-down approach to a more holistic development approach that

is gender sensitive and people centered with a focus on empowering individuals, communities and society.

- The enactment of a Law on prevention and care for HIV/AIDS provides tremendous scope to expand the response as well as to decrease stigma and discrimination. For this to happen, the Law has to be translated into enforceable rules and regulations. A massive effort for people's and law enforcers' education on the Law is also required.

Proposed remedial actions

- Therefore the new vision of HIV/AIDS has not been fully implanted. There are number of reform processes that should be considered in expanding the response :
 - Reform of the armed forces, especially military demobilization
 - Public administration reform, including decentralization and deconcentration:
 - Economic reform, for sustainable and equitable growth and poverty reduction:
 - the need to put in place programs to keep HIV infection rates as low as possible amongst public sector personnel and in particular amongst personnel critical to the supply of public goods such as education and health, in order to reduce poverty as well as to reduce the vulnerability to HIV/AIDS.
- Two potential mechanisms can be tapped for better response to HIV/AIDS :
 - ▶ Integration of HIV/AIDS into existing development programs such as gender , Human rights, Agriculture, Credit...This can be seen as a better way to save the funding for wider expansion of HIV/AIDS Program . The Seila Program which a Multi-sectoral Program for Development can provide a good entry point for this attempt.
 - ▶ The decentralization of the response to Commune Councils could be seen as another potential local body to ensure sustainable and effective response at the local level. The bottom up planning and budgeting at Commune Councils clearly demonstrates the responsibility and ownership of local administration in the response.
- The strengthening of Multi-sectoral response to HIV/ASIDSD can be done :

▶ Strengthening the existing structure such as Technical Board and Policy Board of the National AIDS Authority, Provincial AIDS Committee, and District AIDS Committee.

▶ There must be a coordinating mechanism for closer and effective interaction with the development program at the local level such as Sheila Task Force , PRDC (Provincial Rural Development Committee) , CC (Commune Councils) ,VDC (Village Development Committee) and civil society .

▶ These bodies should work collaboratively in planning and in mobilizing the resource required, based upon their terms of reference.

Data collection plan:

Data collection plan	2003	2004	2005
Household surveys	No plan so far	No plan so far	DHS
Health facilities survey	No plan so far	No Plan so far	No plan so far
School based surveys	MOEYS	No plan so far	No plan so far
Workplace surveys	No plan so far	No plan so far	No plan so far
Desk Review	NRT , GFATM , UNGASS , WG on M&E PMATU	NRT , GFATM , UNGASS , WG on M&E PMATU	NRT , GFATM , UNGASS , WG on M&E PMATU
Other	BSS , HSS	BSS , HSS SES Light survey	BSS , HSS

Comments:

1- Household Survey: Only DHS (Demographic Health Survey) and Socio Economic Survey (SES) done by Ministry of Planning and National Institute of Statistics.

2- School based surveys: Is the responsibility of the Ministry of Education Youth and Sport

3- Health Facilities Survey: Undertaken by NIPH (National Institute of Public Health) and Ministry of Health where NIPH (National Institute of Public Health) can play an active role.

4- Workplace Survey: Is the responsibility of the Ministry of Social Action Labor and Youth Rehabilitation.

5- Desk review: There is mechanism of review of HIV/AIDS Program for different purpose:

- NRT: National Research Team for the Development of Cambodian Human Development Report.
- GFATM for the Monitoring of activities in the GFATM.
- Working Group on Monitoring, Evaluation and Research System (MERS WG) of HIV/AIDS Program (NAA).

- Working Group for the follow up to the declaration of Commitment on HIV/AIDS (UNGASS)
- 6- Others:**
- Ministry of Health:
 - HSS, BSS on yearly Basis
 - STD Prevalence survey for 2004
 - Ministerial database:
 - Ministry of Education Youth and Sport
 - Ministry of Interior
 - SEILA (Development Program)
 - Operational research done by Ministries and NGOs

V- Support Required from country's Development Partners

Owing to the above mentioned challenges and proposed remedial solutions it is clear that the support from country's development partners should focus on capacity building for different ministries , members of NAA by mainstreaming HIV/AIDS into existing development programs such as Gender , Environment , Credit, Governance , Agriculture , Community Infrastructure Development ... Since 70% of Commune Councilors take HIV/AIDS as their local priority there should be an extended support to this decentralized mechanism to ensure sustainable and effective response at the local level starting from the reduction of vulnerability to HIV/AIDS. Therefore, there must be a support for capacity building to Community Enhancement to enable local people to own the project by using as much as possible their potential local resource for an active response to HIV/AIDS. However, this move requires a tremendous effort for strong advocacy from different stake holders at Central and Provincial level so that the vision and the strategies of the National Strategic Plan could really be implemented. All the effort will direct towards empowering individuals, families and communities to prevent HIV/AIDS and to provide care and support to those affected by this epidemic.

For the need of PLWAs there must a preparation for a sustainable national response to provide optimal care and support (especially access to drugs OIs and ARV) so that their children will no longer exposed to HIV/AIDS and are equipped with a positive thought and enough skills to participate in the development of the country.

As for Monitoring and Evaluation, there is a need to enhance the capacity of relevant institutions working for development, Health and HIV/AIDS. Moreover, there must be good coordination among institutions (namely NRT, PMATU,

UNGASS, GFATM, MERS WG ...) to better share their experiences for a more coherent and more effective mechanism of Monitoring and Evaluation of HIV/AIDS epidemic.

VI – Monitoring & Evaluation Environment

From this desk review, it is worth mentioning about Monitoring & Evaluation Environment related to HIV/AIDS of the country:

- 1- The information within this report could be considered as a part of an overall Monitoring, Evaluation and Research System (MERS) data related to the response to HIV/AIDS in the country.
- 2- The empirical objectives of MERS are :
 - To provide continuous critical information about course of the HIV/AIDS epidemic in the country.
 - To monitor progress and the level of achievement of the set objectives.
- 3- It is worth to mention that within the framework of the NSP, a concept paper on Monitoring, Evaluation and Research has been conceptualized as a directive to guide a Working Group that need to be established.
- 4- The concept of that paper is built with deeper understanding of the epidemic's spreading mechanisms, an essential goal of the MERS is just referring to above mentioned objectives but also to help early warning regarding changes in the socio-economic environment, leading to early response to eventual new bursts of the HIV/AIDS epidemic and will address the epidemic from its roots. In the other words, this paper strongly suggests a mechanism that supports the concept of paradigm shift of the NSP where HIV/AIDS is no just as health but also as a development issue. Therefore, the scope of MERS is broadening to cover other development sectors (e.g. economic, poverty alleviation, gender, governance and human rights programs).
- 5- To meet both empirical and new objectives, an effective and efficient national coordinated Monitoring, Evaluation and Research System is imperative.

In view of the quantity and the quality of the information that is required from the different sectors involved in the national response, the NAA should ensure the establishment of a National Monitoring Evaluation Research System Working Group. This group should develop national research agenda and most importantly should coordinate with relevant institutions to ensure that large scale survey such as Population-based

survey, School-based survey, Health Facilities based survey and Workplace Survey did respond to the need for MERS on HIV/AIDS.

- 6- From the desk review exercise, one of most important limitation of this report is the failure to respond to most UNGASS indicators which call for a large population sample representing a national level through Population-based survey, School-based survey; Health Facilities based survey and Workplace Survey. So far, very few large scale survey were conducted in Cambodia such as National Census, Demographic Health Survey and Socio Economic Survey.

Moreover, since MERS WG is not yet working, the design of the questionnaires was not well prepared for the purpose of Monitoring & Evaluation of HIV/AIDS and to measure the impact of this epidemic. However, several operational research / baseline studies were done by different institutions (GOs, NGOs and UNs) to provide particular information on a specific target group, in a specified geographic areas and with certain focus.

- 7- Some indicators are not reflecting the Cambodian context such as Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner. Because in Cambodia, women are supposed to preserve virginity. A very large proportion of sexually active women have only one partner, their husbands. Those who have many partners are usually those who are part of the sex industry (direct or indirect). Besides, the average age of women at marriage is 19.9 years and for the majority of women this is where the first sexual intercourse occurs. (Source: DHS 2000). Therefore the lower age limit of the age-range 15-24 is not relevant for Cambodia.
- 8- We need to emphasize that the MERS is far from being a list of indicators. Firstly, because some of the essential information cannot be quantified in a way appropriate for monitoring purpose and qualitative means of follow up will have to be designed. Secondly because research has to accompany the monitoring system. The necessary watch on immediate local stressors such as Highway construction, Flood and drought, Labor market fluctuation ... should be part of this research. Thirdly because, as the two previous statements clearly show, the MERS is a living system, feeding itself from the evolving situation and maintaining exchanges with other teams involved in development issues (such as the actions of the NGOs targeting garment factories workers). This calls for involving capable and adequate human resources as constitutive part of the system.

Conclusion:

The complexity of the MERS in linking different types of databases and institutions requires adequate composition of the working group, with a broad spectrum of expertise and skills in quantitative and qualitative research in health and development sectors. This requires a well thought off design of the composition of the WG.

Since development and implementation of the NSP is the responsibility of Government and civil society, the MERS WG has to be enabled access, and to a certain extend ownership of the available data in the country. This requires a continuous dialogue with the producers of data useful to follow the main identified stressors and political support, and adequate human resources (institutional and personal). A challenge is to get access to the multitude of (mostly good quality) data, which are generally under-used, and often not clearly understood. More advocacy among decision makers and relevant institutions is envisaged before the official establishment of the MERS WG is a fact.

For an effective continuous functioning of the MERS WG the following is required:

- Continuing commitment from stakeholders to support the MERS ,
- Strong support for continuing capacity building for the MERS WG,
- Effective collaboration and coordination between the different institutions that are represented in the Working Group. To this effect, an appropriate framework allowing the actual monitoring and evaluation work is a prerequisite for the functioning of the MERS.

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ANNEXES

Minute of the Core Group meeting of the UNGASS On Thursday 27, February 2003 at NAA meeting room.

1.Presents:

-Ms. Karen Heckert	Senior M&E Advisor	USAID	012 907 910
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-H.E Dr. Tia Phalla	Secretary General	NAA	012 900 091
-Ms.GeetaSethi	Country prog. advisor	UNAIDS	012 990 645
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-Dr. Tuy Amrith	PPMER	NAA	012 911 100
-Dr. Sok Bunna	Senior Tech. Officer	NAA	012 866 176
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-Mr. Chun Bora	TA	NAA	012 909 968
-Mr.Etienne Poirot	HIV/AIDS	UNICEF	023 426 214
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-Dr. Ly Penh Sun		NCHADS	012 850 053
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-Dr. Ngin Lina	PPMER	NAA	012 659 388
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-Dr. Sou Sophy	PPMER	NAA	012683 329

2.Agenda : Discussion detail on the development of country report to submit to UNGASS.

The meeting was chaired by H.E Dr. Tia Phalla , Secretary General of NAA.

- The Group reviewed of the list of indicators and assign job for the NAA staff to collect the data .
- Comments were provided to UNGASS indicators as followed :

1.% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV/AIDS and who reject major misconceptions about HIV transmission:

- This information can be extracted from DHS . However , there must be a good knowledge on sample size of this Household Survey and on the questionnaires that have been asked .
- Apart from DHS , information on young people aged from 15-24 year olds can be extracted from other population group such as students in school, out school youth , garment factory workers and farmers through a number of KABP Studies .

2.% of young people aged 15-24 reporting the use of condom during sexual intercourse with a non-regular sex partner:

- The BSS (in 2000) was done on small simple size focusing on males. This is the only one household survey done in BSS so far.
- In the other hand, the question also address Females. However, the average age for women having first sexual intercourse in Cambodia is known to be around 20 years olds (BSS 2000).

3.Ratio of orphaned to non orphaned children aged 10-14 who are currently attending school.

N Orphaned attending school.

D non-orphaned attending school.

- So far there is no School based Survey to respond to this indicator.
- However, there were some information :
 - From Schools (Contact Mr. Pen Saroeun from MoEYS)
 - From commune database of Seila program (This database covers only 6 to 7 provinces).
 - From UNICEF (2002) document (AIDS Orphans on the brink (UNICEF,)
 - MoSALVY document : vulnerable families affected, contact with Ms. Judit Van Gevtelen).

4. % of school with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last curriculum year:

- AIDS have been integrated in School curriculum of I&II education. There must be a contact with Ms. Ta Sa Im (Punhea Hok Pedagogy Research Dpt).
- Number of teachers who have been trained on HIV/AIDS.
- Other information can be drawn from UNFPA, SCFUK, World Education.

5.% of large enterprise/companies that have HIV/AIDS prevention and care policies and program.

- There is no Work Place survey done in the country.
- There must be a concern also about the Public and Private Companies .
 - From public sector : Public teachers from MoEYS around 80.000, MoH 20.000.
 - From private sector : With Heinken Beer Company (a small scale), Coca Cola and from garment factories.

6.% of injecting drug users who have adopted behaviors that reduce transmission of HIV.
-very small in urban base.

In closing the meeting, the group unanimously recommend that should be a meeting between the core group and PMATU and NRT members.

Note by Dr. Lina
PPMER unit of NAA.

**Minutes Consultative Group Meeting of UNGASS
on Wednesday 05, March 2003 at 2:30 at NAA meeting room**

Presents:

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Process discussion:

The meeting was chaired by Dr. Tia Phalla , Secretary General of NAA . The agenda was :

1. To review the minute of the Core Group meeting on Thursday 27, March 2003 where the UNGASS Indicators 1-6 were brought into the discussion.
2. To provide comments on Indicators below 7.

For National Programme.

7. % of patients with STIs at health care facilities, who are appropriately diagnosed, treated and counseled.

The group felt that “Appropriate “ Diagnosed, treated and counseled refers to the use of Syndromic Approach . But so far there was no National Health Facilities survey done. However, there were a number of activities related to the issue of STIs services:

- a. FHI has a big scale survey where Dr. Hya Tun conducted with NCHADS.
- b. Medicam, PSF they have the small scale.

c. MoND: Since more than 600 HCWs in military have been trained on SA, the network of Ministry of National Defense prescribed by the use of Syndromic Approach.

d. MoWVA : Has done Reproductive Health Survey including STIs 2002 in 8 provincial such as Battambang, Siem Reap, Kampong Chhnaing, Kampot, Kandal, SvayRieng, Kampong Cham, Prey Veng .Contact with Dr. Hou Nimmita, Deputy director of Women Health Department (012 823 552).

E. Health Center and Operational District has service on SA (CPA, MPA) contact with Dr. Phal Sano, Dr. Seng Sopheap (NCHADS) and Ms Such Sokunthea (FHI).

f. From the BSS of NCHADS, a number of information can be extracted:

- % treated of Health Care Facilities.
- % by self medicament.
- % through drug seller, pharmacies, traditional health.

8. % of HIV positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent MTCT.

$$\frac{N}{D} = \frac{\text{HIV+ ♀ attending ANC and receiving ARV}}{\text{HIV+ ♀ attending ANC}}$$

D HIV+ ♀ attending ANC

a. For the use of ANC services, there is a need to contact Dr. Kum Kanal, Dr. Seng Sut Wantha.

b. The coverage of VTC is limited. For the whole country, there are only 29VTC (6 VTC at RHAC, 7 VTC at WVI, and 16 VTC at NCHADS). Not all ANC clinics can have access to VTC.

d. PMTCT is just started as a pilot project (Calmette hospital, NMCHC).

9. % of people with advanced HIV infection receiving ARV therapy.

$$\frac{N}{D} = \frac{\text{\# PLWAS with advanced HIV infection receiving ARV}}{\text{\# of PLWAS with advanced HIV infection}}$$

D # of PLWAS with advanced HIV infection

a. There should be a reference to the National Protocol of HIV therapy based on the CD4 count. All care facilities such as PBNRS hospital, Center of Hope and Calmette Hospital should use it.

b. From the contact with NCHADS it is known that 600 PLWAS with advanced HIV infection receiving ARV in public Hospital. However, there was no information from private clinic.

c. Continuum of care working group may have more information (e.g. MSF started its ARV therapy for patients in Siem Reap).

d. The denominator can be the estimation of # of PLWAS from Asian Epidemic Model (2002).

e. Another concern is that there is a very limited capacity in the country for CD4 count. So far only, Institute Pasteur du Cambodge and Kuntha Bopha Hospital in Phnom Penh have capacity to perform CD4 count.

For Impact Assessment:

1. % of young people (pregnant women) aged 15-24 who are HIV infected.
 - a. There should be a clarification from PMATU.
 - b. The first sexual experience of Young women in Cambodia is about 20 year's olds. (From reproductive health that support by UNFPA).
- $$\frac{N}{D} = \frac{\text{\# of young people (15-24) HIV+}}{\text{\# of young people 15-24 year olds}}$$
- c. HIV+ ♀ attending ANC was 2.8% all ages.
 - d. HSS has ANC break down by ages (Dr. LPS).

2. % of infants born to HIV infected mothers who are infected.

$$\frac{N}{D} = \frac{\text{\# of infant HIV+ on HIV mothers}}{\text{\# of infant born on HIV+ mothers}}$$

Information can be drawn from the PMTCT Pilot project on in Calmette Hospital, Kuntha Bopha Hospital, National Pediatric, Hospital, Jayavaraman VII Siem Riep, and NMCHC.

National Composite Policy Index.

1. Country has HIV/AIDS integrated into part of their general development plan.
 - Information can be drawn from Population Development Strategy (Ministry of Plan , Council of Ministers , WPP supported by UNFPA)
 - NPRS (2001-2003).
 - SEDP II (2001-2005).

Geeta : We must be look at the format report , that very important and we have not the time, should be make ready the draft in mid March and organize the meeting for circulate these draft report and make the final report to submit to UNGASS the end of March.

Descriptive:

1. Status at a glance: Along with the indicators, there must be information on Socio Economic Situation, population movement, political environment, Global Fund, DFID, drug use, Eco-system imbalance, drug, flood, landlessness, health reproductive and law enforcement, poverty...
2. Overview of the HIV/AIDS epidemic:

- New target groups: Migrants, Young people, MSM, GFW, drug user.

3. National response to the HIV/AIDS epidemic:

- National commitment and action: coordinating of funding (WB, DFID)
- National program and behavior.
- Move from health to Development,
- Strategy for BCC.

4-Major challenges faced and actions needed to achieve the goals/targets:

