TOWARDS ENDING AIDS IN CAMBODIA

Sustainability Roadmap

Service Delivery & Health Systems

Civil Society Organizations

Costs and Financing

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December 2018

Foreword

Cambodia's HIV response over the past two decades has been highly successful and has led the country to be one of seven globally to achieve the 90-90-90 targets in 2017. The strong support of Samdech Techo the Prime Minister and other leaders within the Royal Government of Cambodia to the HIV response has greatly contributed to its success. In 1991 the first case of HIV was reported in Cambodia, and by 1995 there were over 23,000 new infections. The Royal Government of Cambodia worked closely with civil society and partners in building an evidence based program that has reduced the number of new infections to less than 1000 in 2018 and massively increased the number of people living with HIV who are on anti-retroviral therapy.

Over the past two decades, a wide range of multilateral and bilateral donor agencies and international NGOs have supported national HIV efforts while engaging proactively in the broader reconstruction and development of Cambodia through the implementation of numerous economic, infrastructural, and social programs. The national AIDS response has been heavily dependent on external financial and technical support. International investments amounted to 82% of financing for the HIV response in 2015. Cambodia has made significant economic and social progress and became a lower middle-income country, affecting its Global Fund allocation. Analyses conducted in 2017 show that donor support is likely to continue to diminish in the coming years.

Recognizing the increasing need to safeguard the outcomes from Cambodia's HIV program, the Sustainability Technical Working Group led by the National AIDS Authority and UNAIDS, has initiated a Transition Readiness Assessment and development of a Sustainability Roadmap. The recommendations presented in the Sustainability Roadmap will help to mitigate potential risks and thus protect and further advance the progress Cambodia has made towards the 90-90-90 targets and the eventual elimination of HIV by 2025.

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Acronyms

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
ART	Antiretroviral therapy
AUA	ART Users Association
CAF	Community Action Framework
CBOs	Community Based Organisations
CCHR	Cambodian Centre for Human Rights
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CNPUD	Cambodian Network for People who Use Drugs
CPA	Complementary Package of Activities
CDP	Commune Development Plan
CIP	Commune Investment Plan
CPN+	Cambodian PLHIV Network
CQI	Continuous Quality Improvement
CRS	Catholic Relief Services
CSO	Civil Society Organization
DMHSA	Department of Mental Health and Substance Abuse
DPHI	Department of Planning and Health Information
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HEF	Health Equity Fund
H-EQUIP	Health Equity and Quality Improvement Project
HIS- TWG	Health Information Systems Technical Working Group
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HSP	Health Strategic Plan 2016-2020
HSSP-HIV	Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector 2016-2020
KP	Key Populations (Men who have sex with men; Sex workers; People who use drugs; and Transgender people)
LMIS	Logistics Management Information Systems
LR	Linked Response
LSMU	Logistics and Supply Management Unit
M&E	Monitoring and evaluation

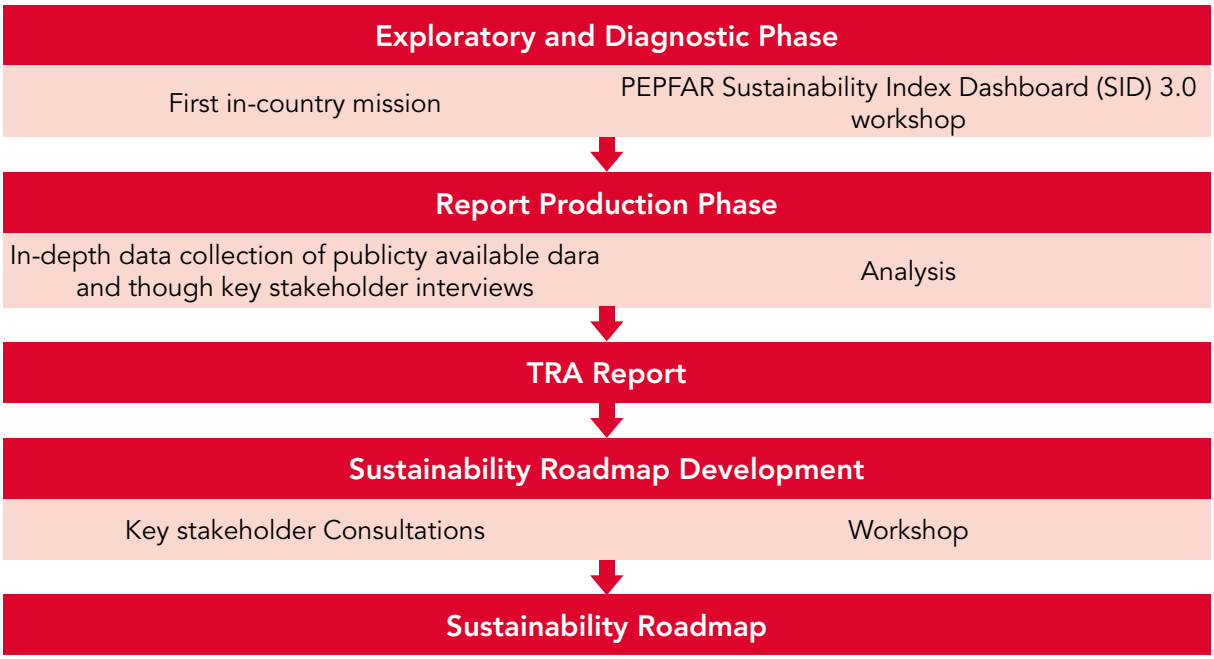
MEF	Ministry of Economy and Finance
MTEF	Medium Term Expenditure Frameworks
MOI	Ministry of Interior
MOH	Ministry of Health
MOH -LIT	Ministry of Health- Lead Implementation Team for the GF grant 2018-2020
MPA	Minimum Package of Activities
NAA	National AIDS Authority
NASA	National AIDS Spending Assessment
NCHADS	National Centre for HIV/AIDS, Dermatology and STD Control
NGOs	Non-Governmental organizations
NHA	National Health Accounts
NSSF	National Social Security Fund
NP-SNDD	National Program for Sub-National Democratic Development
NSP	National Strategic Plan
OD	Operational District
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PBB	Programme Based Budgeting
PR	Principal Recipient
PSI	Population Services International
PSM	Procurement and Supply Chain Management
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RBF	Results-Based Financing
RGC	Royal Government of Cambodia
SOP	Standard Operating Procedure
SR	Sub-Recipient
STWG	Sustainability Technical Working Group
TA	Technical Assistance
TRA	Transition Readiness Assessment
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
USD	United States Dollars
WHO	World Health Organization

I. Introduction and Methodology

Cambodia is one of seven countries globally to have achieved the 90-90-90 targets.[1] Eighty eight percent of People Living with HIV (PLHIV) know their status, 87% are on anti-retroviral therapy (ART) , and an estimated 83% of PLHIV on ART have achieved viral suppression.[2] These achievements have been driven by the strong support from the Royal Government of Cambodia and the work of local Civil Society Organizations (CSOs) dedicated to the response, however, the HIV response in Cambodia is largely funded by external sources.[3] In 2015, Cambodia became a lower middle-income country and donor support has already begun to decline.[4] As external support continues to decline in Cambodia and the country eventually transitions to a HIV response funded entirely from domestic sources, it is critical for Cambodia to sustain the gains that have been achieved in prevention, treatment, care and support.

In recognition of the need for a sustainable response, the Sustainability Technical Working Group, led by the National AIDS Authority (NAA) and UNAIDS, commissioned the development of a Transition Readiness Assessment (TRA) and a Sustainability Roadmap to guide and inform the longer-term transition process. Figure 1 below provides an overview of the approach to developing the TRA and the roadmap.

Figure 1



1 *UNAIDS; Ending AIDS: Progress towards the 90-90-90 targets (July 2017)*
2 *Aidsinfo.unaids.org*
3 *NASA, 2015*
4 *The World Bank in Cambodia. Overview. http://www.worldbank.org/en/country/cambodia/overview.*

The Transition Readiness Assessment was completed in May 2018 after extensive consultation with stakeholders and describes the work carried out, findings and 13 important transition risks . The next step in the approach required the development of a Sustainability Roadmap (this document) which articulates mitigating actions for each risk.[5] The development of the roadmap comprised the following steps:

- Development of a draft list of possible mitigating actions
- Consulting with stakeholders to refine and add to the list of draft actions
- Presenting the draft list of mitigating actions to a broad spectrum of stakeholders (See Annex A for details) in a Sustainability Roadmap Workshop (30-31 May 2018) to discuss, refine and approve mitigating actions for the 13 identified risks.

This Sustainability Roadmap consolidates the findings from the workshop and presents actions and implementation steps that can be implemented as early as mid-2018 to mitigate the most critical transition risks.

As depicted in the figure above, the development of a roadmap is not the end of the process nor should it be viewed as a set of actions which are cast in stone. Instead, it is a dynamic document, as is the TRA, which should be updated from time to time and should guide the development of a more detailed action plan that draws from this report to define concrete steps for implementing these mitigating actions.

II. Overview of Identified Transition Risks

Based on findings from the Transition Readiness Assessment and multiple stakeholder conversations, 13 risks were identified as detailed in Table 1. These risks were grouped into three different categories:

- Service Delivery and Health Systems,
- Civil Society Organisations and
- Costs and Financing.

In order to facilitate the prioritisation of risks the risks were scored by the Sustainability Technical Working Group during a workshop in November 2017. Participants were asked to score three criteria for each risk using a scale of 1 to 3 with 3 being the most severe or most probable. The three criteria were a) severity, which is indicative of the level of impact should the risk materialise, b) probability that the risk might materialise in the period from 2018-2020, and c) probability again but for the period from 2021-2025. The risks and scores are presented here as context for the mitigating actions and a detailed description of each risk is presented in the Transition Readiness Assessment. Although risks were prioritised, mitigating actions were developed for all risks and thoroughly discussed with country stakeholders at the Sustainability Roadmap workshop.

5 *Transition Readiness Assessment, Cambodia May 2018*

Table 1: Identified Risks

AREA		RISK	Severity	Probability (2018-2020)	Probability (2021-2025)
Service Delivery & Health Systems	1.	In the context of declining external support, failure to develop a common long-term implementation mechanism after 2020, defining the respective roles of the health sector, CSOs in the HIV response, results in confusion and reduced efficiency.	2	N/A	2
	2.	Government health staff are unable to absorb the workload when AHF externally-funded posts supporting treatment (currently receiving one year of Global Fund support in 2018) are phased out in facilities at the end of 2018	2	2	1.5
	3.	NCHADS is not able to retain key contract staff as the RGC takes over the funding of their posts from the Global Fund, especially after 2020, thus reducing the effectiveness of this key agency in planning, managing, and monitoring the health sector response to HIV	2.5	1	2
	4.	Development partner budget cuts and refocusing leads to the elimination of high-level technical posts providing support in areas such as forecasting, quantification, and strategic information, thereby diminishing the speed, coverage, and quality of key supporting services.	3	2	2
	5.	Quality control and monitoring systems for service delivery currently supported by the Global Fund are not diligently maintained by NCHADS/MOH as external support (TA and funds) is decreased and as donors withdraw from Cambodia	2	1	2
	6.	Current PEPFAR funded projects to integrate (increase interoperability) and strengthen HIV and health information systems are discontinued as PEPFAR winds down its funding in Cambodia	2	2	2
	7.	MOH takes over ARV and other HIV commodity procurement, without first establishing the necessary capacity of the national procurement mechanism, resulting in a shift to less efficient processes and higher costs	2.5	N/A	3

AREA		RISK	Severity	Probability (2018-2020)	Probability (2021-2025)
CSOs	8.	The new Global Fund grant (started in January 2018) which provides funding for prevention services fails to achieve the required prevention coverage, negatively impacting new case finding and treatment adherence and causing Cambodia not to continue achieving its 90-90-90 targets.	2	1	2
	9.	Prevention, care and support services for key populations and PLHIV are implemented by the MOH rather than contracting CSOs (with proven track record in implementation) to provide these services; but in practice, MOH prevention, care and support services fail to reach key populations and PLHIV, leading to declines in coverage and quality.	3	1	2.5
	10.	In an environment of declining donor financial support, CSOs are unable to secure adequate funding to operate effectively, which erodes established capacity for advocacy.	2	1	2
Costs and Financing	11.	The Government is unable to mobilize sufficient domestic funding for the HIV response, because of fiscal constraints and (mis)perceptions that the HIV program is "over-funded".	3	1.5	2
	12.	In the event that Global Fund puts Cambodia on a path to full transition by the late-2020s the Government may not be in a position to react fast enough to expand its budget to cover the resulting funding gaps, which could amount to as much as $5 million a year.	3	1	2
	13.	A larger than expected funding gap emerges because future financing needs are higher than envisaged (e.g., more patients must be treated, patient monitoring and adherence is more labour-intensive, program management cannot be fully rationalized, etc.).	3	1	2

III. Overview of Mitigating Actions to Sustain the AIDS Response

The mitigating actions approved by stakeholders in the Sustainability Roadmap workshop are summarized below and explained in further detail in Section IV of this report.

Service Delivery & Health Systems

	RISK	MITIGATING ACTIONS
1	In the context of declining external support, failure to develop a common long-term implementation mechanism after 2020, defining the respective roles of the health sector, CSOs in the HIV response, results in confusion and reduced efficiency.	a. Develop a common, long-term vision for a sustainable AIDS response after 2020 and the implementation mechanism required to ensure successful implementation

	RISK	MITIGATING ACTIONS
2	Government health staff are unable to absorb the workload when AHF externally-funded posts supporting treatment (currently receiving one year of Global Fund support in 2018) are phased out in facilities at the end of 2018	a. Conduct a detailed review of affected facilities, assess their capacity and based on the assessment either employ additional personnel and/or re-allocate staff to compensate for withdrawal of AHF staff b. MOH fully implements differentiated care model and reduces health care workload at ART sites c. Leverage the implementation of the Community Action Framework (CAF) to cover adherence and counselling needs
3	NCHADS is not able to retain key contract staff as the RGC takes over the funding of their posts from the Global Fund, especially after 2020, thus reducing the effectiveness of this key agency in planning, managing, and monitoring the health sector response to HIV	a. Contracted positions are transitioned to staff positions within MOH / NCHADS at government pay scales b. As part of decentralization some positions (e.g. data capturers) are absorbed by provinces and a highly capacitated but trimmed down NCHADS staff are absorbed into the government service centrally
4	Development partner budget cuts and refocusing leads to the elimination of high-level technical posts providing support in areas such as forecasting, quantification, and strategic information, thereby diminishing the speed, coverage, and quality of key supporting services.	a. Develop and implement a detailed transition plan which provides for skills transfer and capacity building of government staff or the integration of affected technical posts and capacities into the MOH.
5	Quality control and monitoring systems for service delivery currently supported by the Global Fund are not diligently maintained by NCHADS/MOH as external support (TA and funds) is decreased and as donors withdraw from Cambodia	a. Develop a detailed plan to integrate quality assessment and control practices (including monitoring the success of the implementation of this plan) into routine M&E as part of the existing quality management strategy of MOH/NCHADS
6	Current PEPFAR funded projects to integrate (increase interoperability) and strengthen HIV and health information systems are discontinued as PEPFAR winds down its funding in Cambodia	a. Develop a PEPFAR transition plan specific to Cambodia, which motivates for and includes developing the technical expertise of the government (Department of Planning and Health Information) to ensure interoperability of the HIV systems and the Health Information System
7	MOH takes over ARV and other HIV commodity procurement, without first establishing the necessary capacity of the national procurement mechanism, resulting in a shift to less efficient processes and higher costs	a. MOH builds and strengthens the capacity of the central procurement unit to procure ARVs and commodities including the LMIS and transfers the procurement function from the procurement agent - with close independent monitoring and review to ensure that the best competitive prices are being obtained

Civil Society Organizations

	RISK	MITIGATING ACTIONS
8	The new Global Fund grant (started in January 2018) which provides funding for prevention services fails to achieve the required prevention coverage, negatively impacting new case finding and treatment adherence and causing Cambodia not to continue achieving its 90-90-90 targets.	a. NCHADS and PRs intensify monitoring and evaluation activities to assess performance of programme activities starting immediately, with a focus on coverage and gaps, consumer satisfaction, and other metrics b. The MOH starts to allocate budget for prevention activities using government funding but aligned to existing prevention activities
9	Prevention, care and support services for key populations and PLHIV are implemented by the MOH rather than contracting CSOs (with proven track record in implementation) to provide these services; but in practice, MOH prevention, care and support services fail to reach key populations and PLHIV, leading to declines in coverage and quality.	a. Conduct an assessment of which services are best delivered by CSOs vs MOH and develop a policy and performance-based framework for contracting CSOs for relevant services b. Subject to findings in mitigating action 9a, MOH (National, provincial or OD) hires CSO staff as contract workers and includes required funding in routine budget request c. NCHADS intensifies support, monitoring and evaluation of MOH-implemented activities to assess performance and adjust as necessary
10	In an environment of declining donor financial support, CSOs are unable to secure adequate funding to operate effectively, which erodes established capacity for advocacy and service delivery.	a. CSOs are assisted in developing resource mobilization strategies for their advocacy and involvement in service delivery (prevention, care an d support activities) and improved sustainability. Closely related to the above is the need to build institutional capacity, specifically in financial management and business planning

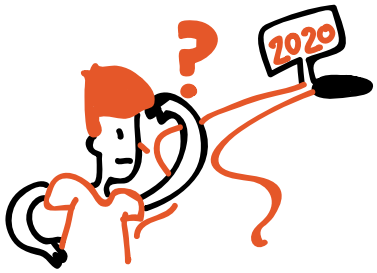
Costs and Financing

	RISK	MITIGATING ACTIONS
11	The Government is unable to mobilize sufficient domestic funding for the HIV response, because of fiscal constraints and (mis)perceptions that the HIV program is "over-funded".	a. MOH/ NCHADS works closely with MEF to exploit opportunities associated with PBB*, and provincial budgets to build a stronger case for and secure increased and more diversified funding for the HIV services. b. Integrate HIV treatment, care and selected prevention and outreach services into social health insurance scheme benefit packages (NSSF/HEF) to leverage additional contributions to the HIV Programme and secure more robust funding. c. Explore the opportunities for co-financing and leveraging private sector corporate social responsibility programmes d. Explore how HIV prevention care and support activities at grass-roots could be integrated in the CDP and CIP (Commune Development Plan and Commune Investment Plan) and / or funded by HealthEQIP funds and who should implement them
12	In the event that Global Fund puts Cambodia on a path to full transition by the late-2020s the Government may not be in a position to react fast enough to expand its budget to cover the resulting funding gaps, which could amount to as much as $5 million a year.	a. Engages with GF (and other donors) and proactively seek clarity for a timetable for transition and nature of transition (extent of reduction) to maximize the planning horizon b. NCHADS and NAA Work closely with the MOH and MEF and ensure participation in the development of the national transition strategy over the next three years, to defend the HIV programme as a priority in the face of competing demands and develop and overall financing strategy for HIV
13	A larger than expected funding gap emerges because future financing needs are higher than envisaged (e.g., more patients must be treated, patient monitoring and adherence is more labour-intensive, program management cannot be fully rationalized, etc.).	a. Review and revise the resource need periodically and issue early warnings if actual and anticipated expenditure exceed estimated need / funding

IV. Mitigating Actions

In this section, the mitigating actions summarized in Section III are presented with more detail, including the responsible implementing body, proposed timeline for implementation, implementation steps and a concise description of the mitigating actions and implementation steps.

Service Delivery and Health Systems



Risk 1: In the context of declining external support, failure to develop a common, long-term implementation mechanism after 2020, defining the respective roles of the health sector, CSOs in the HIV response – results in confusion and reduced efficiency.

Mitigating Action	Lead Agency	Implementation steps
Develop a common, long-term vision for a sustainable AIDS response after 2020 and the implementation mechanism required to ensure successful implementation	NAA, MOH and NCHADS with the support from partners[6] **Timing: Align with existing planning cycles**	• In close alignment with the NSP review process, facilitate stakeholder meetings and a workshop to confirm the vision and mission of a sustainable HIV programme including its structural components and implementation mechanisms. • Develop and objectively assess implementation options for implementing HIV-related services (MOH vs CSOs, other ministries) and select the most cost-effective and efficient mechanism to be incorporated into a post-2020 implementation plan. • Develop a detailed post 2020 implementation plan for the response.

The anticipated decline in external funding and refocusing from service delivery to technical assistance required a number of significant changes in the broad approach to implementation, which are reflected in guidelines, updated Standard Operations Procedures (SOPs) and the concept note of the current Global Fund (GF) grant.

At the same time, Cambodia is now preparing to review the Health Strategic Plan 2016-2020 (HSP) , National Strategic Plan IV 2015-2020 (NSP) and the Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector 2016-2020 (HSSP-HIV) and to start work on the next set of strategic plans.

6 *Unless otherwise specified, this refers to UNAIDS, Joint UN Team on AIDS, PEPFAR, Global Fund and other development partners active in the AIDS response*

These activities are likely to unfold in late 2018 and 2019. The NSP and the HSSP-HIV address a new stage in the response as the country seeks to eliminate HIV by 2025 as a public health threat. Uncertainties remain about many issues in the post 2020 period and in particular how the Ministry of Health (MOH) will engage with other government and non-government sectors.

Participants in the workshop were of the view that the development of the post 2020 vision and defining the implementation roles and responsibilities would be fully addressed during the development of the multi-sectoral NSP and described in the strategic plan and the costed implementation plan. Completing the costed implementation plan is therefore critically important as it will need to address implementation arrangements in detail. The NAA has played a critical role in coordinating different sectors for the AIDS response and should lead the implementation of these initiatives.

However, in order to select the most appropriate strategies and implementation arrangements, it is important to conduct a thorough review of the current NSP and HSSP-HIV and provide planners with sufficient quality research and information to guide decision making for the development of new strategies. The second implementation step therefore proposes an objective assessment of various implementation options (both existing and new) in an effort to identify the most cost effective and efficient implementation approach for the various components that make up the HIV Programme.

More specifically a better understanding needs to be developed of those treatment, care and prevention services which are most effectively implemented by the ministry vis a vis those, where CSOs are better placed to provide effective and efficient services, especially with respect to key populations. In a similar vein, the feasibility of involving existing community structures and volunteers in the delivery of services should be assessed new para.

Based on these findings, the study must also address the roles and responsibilities of KP networks, implementing CSOs and CBOs in a sustainable response and what contribution can be made by other sectors and importantly, how these efforts will be coordinated and monitored in the long run. This research needs to be completed before the main planning processes begins and should be initiated in 2018. It is likely that some technical assistance will be required to complete this work.

Risk 2: Government health staff are unable to absorb the workload when AHF externally-funded posts supporting treatment (currently receiving one year of Global Fund support in 2018) are phased out in facilities at the end of 2018

Mitigating Action	Lead Agency	Implementation steps
a. Conduct a detailed review of affected facilities, assess their capacity and based on the assessment either employ additional personnel and/or re-allocate staff to compensate for withdrawal of AHF staff	NCHADS **Timing:** Late 2018	• Establish a working group to oversee the review. • Define the scope of work for the review and secure skills to compete the review. • Based on the review develop a transition plan with AHF for the affected facilities to ensure a smooth handover at the end of 2018.[7] • Support those sites to implement the transition plan where the impact is significant and monitor implementation.

HIV care and treatment services are currently being supported by AIDS Healthcare Foundation (AHF) at a large number of ART sites (currently 38 sites). The current GF grant includes only one year of funding for these support services, which expires at the end of 2018. What is not clear is how the termination of support activities will affect the various sites where support is being provided.

This mitigating action therefore proposes that National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS) conduct a detailed review of the affected sites to establish how each site might be impacted and to identify those sites where the impact will be acute; i.e. existing staff may not be able to absorb the additional workload. The review should therefore consider the patient load and the current staff structure including vacancies. The review should also consider the impacted of the lapse in Global Fund funding for these sites from January through to March of 2018. This could provide key insights into how termination of donor funding for AHF sites will impact on the continuation of care and treatment for PLHIV.

Based on the findings of the review it is recommended that the working group, established under the first implementation step, oversees the development of a detailed transition plan for this intervention that addresses the required responses at each site.

7 *Although not described as a separate risk in the list of prioritised risks, a similar process of assessment and transition planning should be implemented to facilitate a smooth transition at the Chhuok Sar or Sihanouk Center of Hope clinics to ensure that HIV-related service provision is not disrupted.*

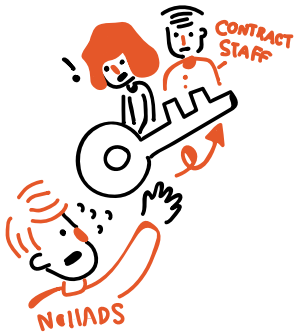
These required responses could include re-allocation of staff within or between facilities. Where patient loads are relatively low and capacity building has been completed, the response may be limited to creating awareness about the hand-over. In addition to consulting with facilities the completed transition plan must be shared with affected sites and these must be supported to implement the proposed solution.

Mitigating Action	Lead Agency	Implementation steps
b. MOH prioritises implementation differentiated care model and reduces health care workload and c. Leverage the implementation of the CAF to cover adherence and counselling needs	NCHADS and partners **Timing:** Prioritisation should start as soon as the findings of the review become available	• Task team shares the transition plan with officials responsible for implementing the differentiated care model and the community action framework • Prioritize those sites identified as most affected by the termination of AHF support for the implementation of the differentiated care model and the CAF • As part of a broader monitoring process, assess to what extent the implementation of differentiated care and the CAF have had an impact on the ART site workload and whether good quality ART services have been maintained.

The implementation of differentiated care and the Community Action Framework (CAF) are expected to reduce the treatment and care workload as a whole. It is also anticipated that some of the workload will be shifted from ART site government staff to other cadres, such as the facility-based community workers.

It is recommended that the task team, referred to above under mitigating action a, shares the transition plan with those officials responsible for the implementation of differentiated treatment and care and the CAF which will allow for the prioritization of those sites which are most likely to feel the impact of the transition. Village Health Support Groups could potentially be harnessed to support the provision of ART-related services, eventually reducing workload especially at facilities.

However, the implementation of differentiated care and the employment and deployment of community workers at the facility is likely to be a protracted process and cannot be expected to bring immediate relief to ART sites with a high workload. Prioritization will accelerate the process and provide relief where it is needed most. It will be important to study the impact that these initiatives have on the general workload at ART sites. This assessment should be included in the ongoing monitoring and evaluation of these new service delivery methods.



Risk 3: NCHADS is not able to retain key contract staff as the RGC takes over the funding of their posts from the Global Fund especially after 2020, thus reducing the effectiveness of this key agency in planning, managing, and monitoring the health sector response to HIV

Mitigating Action	Lead Agency	Implementation steps
a. Contracted positions are transitioned to staff positions within MOH / NCHADS at government pay scales	NCHADS and partners **Timing:** Initiate capacity needs assessment in late 2018 (given the need to extend annual contracts for 2019)	• Develop a HR strategy for NCHADS which aligns with the strategic planning process (see above), which spells out capacity requirements, available skills and capacity gaps • Based on the above, develop a feasible schedule for transitioning posts into the government service over the next three years, which shows where staff are best placed in the health system (national, provincial, OD). • Using the strategy and timeline, advocate with MEF to allow the employment of non-clinical staff in the government service (see also next action) • Develop and implement a retention strategy to retain highly skilled staff • Together with the planning (budget) and HR units in the MOH, initiate the employment of staff in line with the approved schedule and provide for salaries in the MOH budget

Many NCHADS staff are currently employed on contract and paid for by domestic funds. However, in order to retain skills and experience to manage and guide the HIV response and the GF grant, rates of compensation are higher than those in similar government staff positions. Although these higher rates are provided for through the contracting mechanism, a more sustainable approach would be the absorption of these positions in the government service. Some contract staff are reluctant to be employed by government given the lower pay scales which may not recognise the high level of expertise of some of the staff.

As a way forward, it is recommended that NCHADS develops a HR strategy which reflects the transition and change in the HIV response and the underlying funding. The strategy should clearly reflect the skills and expertise requirements, the extent that these skills are present in the current staff establishment, any surplus staff and HR gaps which need to be filled. Given the above, a schedule for transitioning required contract staff over the next three years will guide the employment process and inform the budget. (Funding needs to transition from the special funding mechanism into the MOH routine budget). One complication faced by NCHADS is a perceived reluctance, by the Ministry of Economy and Finance (MEF) and the MOH, to fund the employment of NCHADS non-clinical contract staff. This is a challenge given

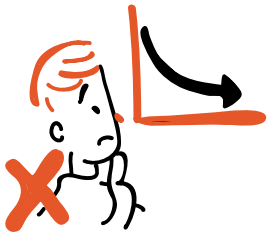
that many data capturers and other non-clinical staff provide key support services. The third implementation step therefore uses advocacy to have this directive changed and to permit the employment of required non-clinical staff. (See also the mitigation action below). Given the discrepancy between government pay scales and the current contract values, especially for highly skilled staff, a retention strategy must be developed to entice the skilled staff to join the government service in the first place and then to retain these key staff members. Attempting to employ these skilled staff at low rates is not likely to be sustainable and even if they do join the government service, turnover is likely to be high as experts seek more rewarding employment opportunities.

Lastly, the process of employing staff in line with the schedule must be initiated in close collaboration with the planning unit in the MOH, the MEF, and the Ministry of Civil Servants to make sure that required funding is allocated in the MOH budget and effectively transferred from the current special funding mechanism for contract staff.

Mitigating Action	Lead Agency	Implementation steps
b. As part of decentralization some positions (e.g. data capturers) are absorbed by provinces and a highly capacitated but trimmed down NCHADS staff are absorbed into the government service centrally	NCHADS **Timing:** As part of next budget cycle	• As part of the HR strategy referred to above, identify which contract positions should be absorbed at lower levels of the health system, mainly provincial or OD • Using a phased approach, engage with provinces and request the inclusion of mainly non-clinical staff in their budget requests as part of a broader process of decentralization and shifting responsibility for managing HIV services from NCHADS to lower levels of the health system • Liaise closely with MOH and MEF to facilitate the transfer of budget associated with these contract positions to provinces.

The employment of staff at provincial and Operational District (OD) levels was proposed by the planning unit in the MOH as a feasible and desirable option for converting contract staff positions to permanent government positions. Given that many of the data capturers, for example, are already based in provinces, this transfer seems to fit well with a broader process of decentralization and a gradual handing over of management responsibility for HIV services to lower levels in the system.

It is recommended that the implementation of this action be dealt with in a phased approach, with phase one setting the precedent for subsequent phases; i.e. the transfer of staff to provinces should be tested in a selected sample of provinces and then rolled out in subsequent years. Key to the success of this action is a process of ongoing planning and collaboration with the planning unit in MOH and the MEF to ensure that the budget attached to contract staff is transferred to the provinces. There needs to be broad approval at the higher level for this approach (from MOH or MEF) so that provinces can expect their requests for additional staff to be approved.



Risk 4: Development partner budget cuts and refocusing (mainly CHAI) leads to the elimination of high-level technical posts providing support in areas such as forecasting, quantification, and strategic information, thereby diminishing the speed, coverage, and quality of key supporting services.

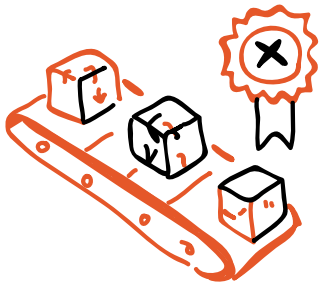
Mitigating Action	Lead Agency	Implementation steps
Develop and implement a detailed transition plan which provides for skills transfer and capacity building of government staff or the integration of affected technical posts and capacities into the MOH.	NCHADS **Timing:** Dove-tail with action a. above (Second half of 2018)	• Conduct a detailed audit of all externally-funded technical experts supporting the HIV response. • Based on the above audit and consultations determine which positions and capacities should be established in the MOH over the medium term. • Develop and implement a strategy for each functional area which indicates whether skills should be transferred, technical experts employed in the government service or both.

A number of key technical experts are supporting the HIV response and continue to be funded by development partners. Most experts are 'allocated' on a full-time basis to units in the MOH or NCHADS and provide technical support to critical functions such as the planning for the procurement of ARVs and maintaining strategic information systems. Workshop participants provided an example of a unit in NCHADS which is reliant on only one expert, in other words, if this person left there would be a significant capacity gap.

It is recommended that as a first step an audit be carried out to find out not only where experts are supporting important functions but the number of experts providing support and the existing capacity amongst other staff in those functional areas. This would facilitate a better assessment of the vulnerability in those functions but also an understanding of whether the training of existing government staff is a good option. Based on the audit and consultations with management in the MOH, the next step requires the development of a long term 'picture' of which technical skills are required on a permanent basis vs. those which are required temporarily. Examples of the latter may relate to the design of a new information system or the completion of a discrete planning exercise.

Finally, a transition and capacity building plan should be developed as part of the broader initiative to strengthen human resources for health as provided for under HSP III. The plan should provide for the establishment of capacity in those functional areas where long-term technical capacity is required. This may include the training of and skills transfer to existing government employees, absorbing the externally funded posts into the MOH or recruiting other experts. These implementation steps should be aligned with those described above for absorbing or retaining contract staff. One overriding challenge remains and relates to the difference in pay scales between the government and the expectations of experienced technical experts. To some extent this challenge may be overcome by the retention strategy referred to above under risk 3.

NOTE: Mitigating actions a) and d) as presented on the original feedback template were merged in the table above



Risk 5: Quality control and monitoring systems for service delivery currently supported by the Global Fund are not diligently maintained by NCHADS/MOH as external support (TA and funds) is decreased and as donors withdraw from Cambodia

Mitigating Action	Lead Agency	Implementation steps
a. Develop a detailed plan to integrate quality assessment and control practices (including monitoring the success of the implementation of this plan) into routine M&E as part of the existing quality management strategy of MOH/ NCHADS	NCHADS and partners **Timing:** 2019	• Coordinate multi stakeholder meetings to develop and describe quality control and M&E activities for each of the 11 components of the HSSP-HIV • Seek endorsement from the Strategic Information working group and Include the proposed quality control and M&E strategies and activities in the plan • Ensure that MOH and CSO service delivery plans incorporate quality control and monitoring procedures

Quality Control and M&E activities, including site visits, are already conducted for MOH-run service delivery activities. Workshop participants noted that when the MOH takes over Global Fund-supported activities these will be subject to the M&E and quality control activities that are currently in place for MOH services. The midterm review of the current strategy should report on the extent to which the quality control mechanisms, including CQI have actually been implemented at all ART sites.

NCHADS should ensure that quality control and M&E activities are conducted for all 11 components of the current Health Sector Strategic Plan-HIV. Incorporating M&E and quality control activities into this plan will require multi-stakeholder meetings to discuss what should be included and to facilitate endorsement by the Strategic Information working group. Funding may be required to coordinate these meetings.

In addition to the quality control mechanisms provided for in the HSSP-HIV, quality control and M&E activities should also be incorporated into CSO service delivery arrangements post GF funding. According to workshop participants, most CSO activities already have some monitoring plan in place. This should be maintained following the exit of Global Fund support. The routine government quality control mechanism may not be able to accommodate the monitoring of CSOs and this should be provided for in future operational planning and budgeting.

Risk 6: Current PEPFAR funded projects to integrate (increase interoperability) and strengthen HIV and health information systems are discontinued as PEPFAR winds down its funding in Cambodia.

Mitigating Action	Lead Agency	Implementation steps
a. Develop a PEPFAR transition plan specific to Cambodia, which motivates for and includes developing the technical expertise of the government (Department of Planning and Health Information) to ensure interoperability of the HIV systems and the Health Information System	MOH and PEPFAR **Timing:** early 2019	• Engage PEPFAR and begin the transition discussion in mid to late 2018 with key stakeholders, in particular the Department of Planning and Health Information (DPHI) • Working with partners to appoint a consultant and build a roadmap for transitioning the maintenance of the HIV strategic information system to DPHI in MOH. • Build the capacity within MOH to maintain the HIV strategic information system and interoperability functionality • PEPFAR, jointly with the DPHI, creates a report that can be used for advocacy to the Ministry of Health to justify the investment of maintaining the HIV strategic information system

Although PEPFAR will have completed the interoperability project to strengthen and streamline Cambodia's HIV and Health Information systems before it ends its support to Cambodia, there is a possibility that Cambodia will not allocate the necessary funds to maintain these systems. The MOH understands the utility of having such a system, however, it will be important for the DPHI to have the tools to advocate for funds to maintain this system within the MOH budget.

PEPFAR should therefore work directly with the Department of Planning and Health Information (DPHI) to create a set of tools that will justify the expense to maintain the interoperability project and show how an integrated system could be used to improve efficiencies in the HIV and health sectors. It is important that the DPHI is motivated and has the technical expertise to project and advocate for funding so that this system is maintained following the conclusion of PEPFAR support. Although the interoperability project sits within the MOH, there is sentiment that it is a PEPFAR-led initiative; this feeling of leadership needs to be transferred before PEPFAR withdraws support. This could be transferred through capacity building activities so that the technical support from PEPFAR is no longer needed. It is also critical that PEPFAR clearly dictates its plans for transition so that there is adequate time to hand over these critical systems.

Risk 7: MOH takes over ARV and other HIV commodity procurement, without first establishing the necessary capacity of the national procurement mechanism, resulting in a shift to less efficient processes and higher costs.

Mitigating Action	Lead Agency	Implementation steps
a. MOH builds and strengthens the capacity of the central procurement unit to procure ARVs and commodities and LMIS and transfers the procurement function from the procurement agent - with close independent monitoring and review to ensure that the best competitive prices are being obtained	MOH **Timing:** 2019-2020	• Assess existing capacity for procurement and specifically for ARV and HIV commodities procurement • Develop a competency framework for procurement of ARVs and HIV commodities • Design capacity building initiatives to address competency gaps in procurement and logistics management and information systems • Implement capacity building initiatives with support from UNOPS (current procurement agent and as detailed in the current contract) and CHAI. • Develop a hand-over strategy for ARVs from UNOPS to central procurement which provide for independent monitoring of ARV purchases.

Under the 2018-2020 Global Fund grant ARVs are procured through a procurement agent, UNOPS. The current policy framework in Cambodia dictates that pooled procurement should be used. Therefore, steps should be taken over the next three years to ensure that the central procurement unit within the MOH has the capacity to procure ARVs at a competitive price and to improve their logistics management and information systems to ensure little leakage or inefficiency.

UNOPS is required to provide capacity building under the current contract, however, because UNOPS has little experience procuring ARVs CHAI should also participate in the assessment, design and implementation of these capacity building activities. The cost of ARVs, timeliness of delivery, and the effectiveness of logistical management generally will show whether these capacity building activities have been successful, all issues which can be assessed by the independent monitor mechanism.

Civil Society Organizations

Risk 8: The new Global Fund grant (started in January 2018) which provides funding for prevention services fails to achieve the required prevention coverage, negatively impacting new case finding and treatment adherence causing Cambodia not to adhere to its 90-90-90 targets.

Mitigating Action	Lead Agency	Implementation steps
a. **MOH-LIT intensifies monitoring and evaluation activities to assess performance of programme activities starting immediately, with a focus on coverage and gaps, consumer satisfaction, and other metrics**	MOH-LIT with support from NCHADS DMHSA, , and partners **Timing:** 2019	• Consolidate and analyze M&E data, related to prevention services, to facilitate more frequent and closer scrutiny of the performance of prevention interventions. • Conduct a cost analyses to understand if the current model is cost efficient and if other key players can be engaged to improve efficiencies.

The current Global Fund grant allocates $3.5 million to prevention activities. This allocation of funds is based on the assumption that efficiencies will be achieved in the delivery of prevention services. To make sure that these efficiencies are being achieved existing M&E systems should be utilized to conduct data monitoring that consolidates and analyzes data on a more frequent basis than the GF performance monitoring mechanism. Routine quarterly reporting may not capture issues that must be addressed swiftly. Intensified performance monitoring will allow for quicker action.

Results from the monitoring and evaluation of the performance of prevention interventions are critical to inform NCHADS and the Department of Mental Health and Substance Abuse (DMHSA) , if any immediate actions or changes should be made to address the coverage gaps and other prevention issues.

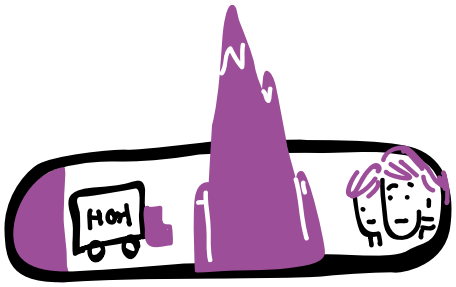
A cost efficiency study is also recommended to determine if the current prevention services delivery model is in fact the most cost-efficient way to deliver these services. This assessment could examine the roles of the different prevention service providers to understand if there is a role for other key players such as health centres or commune councils.

It will be important to consider the availability of adequate financial and technical resources when planning for the implementation of these analyses.

Mitigating Action	Lead Agency	Implementation steps
b. The MOH starts to allocate budget for prevention activities using government funding but aligned to existing prevention activities	MOH **Timeline:** early 2020	• Conduct an analysis of prevention expenditure and identify expenditure items where a funding shortfall is most likely to occur • Develop an evidence-based business case for the inclusion of certain prevention expenditure items in the budget request • NCHADS and DMHSA include prevention activities in the annual budget request to MOH • MOH to work with the MEF for an incremental increase in national co-financing for prevention

The majority of prevention activities in Cambodia are currently funded by the Global Fund. Funding for prevention in the next Global Fund funding cycle is uncertain. This uncertainty and the possibility that funding may not be sufficient to sustain the required level of prevention activities in the short term, establishes a need to secure funding through the MOH budget process for selected prevention activities will help to mitigate this risk. In order to achieve this, NCHADS and DMHSA will need to submit a strong results-based business case for the inclusion of prevention activities in the budget request. The business case should promote a gradual inclusion of prevention activities, include an analysis of why certain items should be funded through the budget and how these complement the funding already available from the GF.

As Global Fund funding for prevention decreases in subsequent grant cycles or as the financial resources needed for prevention increase, NCHADS and the DMHSA can increase the budget request for these activities as necessary. Gradually increasing the budget request will be made easier once a budget line for prevention has been approved and funding allocated.



Risk 9: Prevention, care and support services for key populations and PLHIV are implemented by the MOH rather than contracting CSOs (with proven track record in implementation) to provide these services; but in practice, MOH prevention, care and support services fail to reach key populations and PLHIV, leading to declines in coverage and quality.

Mitigating Action	Lead Agency	Implementation steps
a. Conduct an assessment of which services are best delivered by CSOs vs MOH and develop a policy and performance-based framework for contracting CSOs for relevant services	MOH, NAA and partners **Timing:** 2020	• Design an assessment to assess which entities are best suited to delivering different HIV services • Mobilize resources to carry out the assessment and implement the assessment • Based on the findings of the assessment, develop a policy to contract CSOs to deliver those services which the assessment deemed most suited for civil society organisations

Currently, most services for key populations, including care and support for PLHIV are delivered by CSOs, and are supported by the Global Fund. Over time the country must take over the funding for prevention, care and support services for key population and PLHIV. In this context the MOH may choose to deliver these services using government health facilities and staff. Concerns have been raised about the ability of government health services to meet the needs of KPs and the possibility that KPs will not access services for a number of reasons including stigmatization and lack of trust. It is currently not clear which services can and should be carried out by government health services and which are more appropriately provided by CSOs. It is therefore recommended that a study be carried out to objectively assess how services for KPs are most effectively delivered and by which mechanism and institutions. Funding for this study could be supported by development partners as a part of the overall sustainability efforts.

Based on the findings of the abovementioned assessment and once it is clear which institutions are best suited for the delivery of KP services, a policy should be developed to provide a framework for social contracting. Through social contracting CSOs can continue to carry out relevant services with MOH funding. By first determining which activities are best delivered by CSOs, NCHADS and the MOH in partnership with NAA can make the best case to the MEF for the financing of KP prevention, PLHIV care and support services through social contracting.

Mitigating Action	Lead Agency	Implementation steps
b. Subject to findings in mitigating action 9a, MOH (National, provincial or OD) hires CSO staff as contract workers and includes required funding in routine budget request	MOH and NAA **Timing:** 2020	• MOH projects workforce needs for prevention, care and support in its annual plan and budgeting • Based on the social contracting framework, identify which posts at OD/Facility level could be contracted for prevention • Request approval from the Ministry of Civil Servants to hire contract staff • Assist lower levels to include funding for these contracted staff in their routine budget requests • Liaise closely with the team implementing the steps for risk 11 which explore more broadly which expenditure line items could be funded from the routine MOH budget

By hiring CSO staff directly as contract staff, the technical capacity that has been established over many years of service delivery to KP and PLHIV will be maintained. This has been done successfully by the MOH for other technical positions such as IT. In order to implement this successfully the MOH will first need to determine how many contract staff they will need to deliver prevention, care and support services effectively and at what levels of the health system these contract staff are most appropriately deployed.

This assessment should take into account the framework for social contracting referred to above, which will provide guidance on when this option is appropriate. They will then need to include this in their annual plan and budget, and lower levels in the MOH should be assisted in developing budget requests that include funds for these contracted staff.

Challenges in carrying out this mitigating action exist as the MOH has competing needs related to the absorption of contract staff mainly at the national and provincial level as described elsewhere in this roadmap. In addition, to hire contract staff government ministries need to seek approval from the Ministry of Civil Servants and these staff need to be included in the MOH's human resource/workforce plan.

Therefore, the process for advocating for contracting CSO staff should begin early during the HSP3 mid-term review to allow for a consideration of MOH staff needs in the workforce plan, adequate time for including these staff in annual operational plans and budgets and to ensure that there are no gaps in service delivery.

Mitigating Action	Lead Agency	Implementation steps
c. NCHADS and DMHSA intensifies support, monitoring and evaluation of MOH-implemented activities to assess performance and adjust as necessary	MOH-LIT, NCHADS, DHMSA and partners **Timing:** 2019-2020	• NCHADS and DMHSA develops and implements a more targeted M&E plan, tracking results as well as inputs for prevention activities implemented by the MOH • Findings from intensified M&E activities are reported at senior level and corrective actions formulated and implemented where necessary

The purpose of the intensified M&E is to understand as soon as possible if prevention care and support services are being delivered successfully by the MOH so that corrective action can be taken immediately. For those services which the MOH decides to deliver, a more detailed and targeted M&E plan should be developed to provide for close and ongoing scrutiny of the activities being implemented in terms of the quality of services being provided and the extent to which these are being accessed by KPs.

Increased supervision visits, weekly reporting, and client interviews should be conducted in addition to the routine data collection that will determine the number of people being reached and adherence to prevention and treatment targets. Any deviance from current targets should be noted and the delivery of certain activities should be changed as necessary.

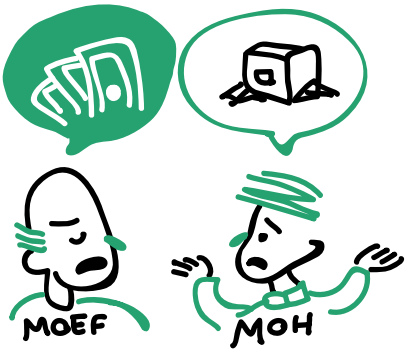
Risk 10: In an environment of declining donor financial support, CSOs are unable to secure adequate funding to operate effectively, which erodes established capacity for advocacy and service delivery.

Mitigating Action	Lead Agency	Implementation steps
a. CSOs are assisted in developing resource mobilization strategies for their advocacy and involvement in service delivery (prevention, care and support activities) and improved sustainability	NAA and Partners **Timing:** 2019-2020	• Develop capacity of CSOs to design and implement resource mobilization strategies for alternative funding, including self-financing, specifically for their advocacy and involvement in service delivery , including their capacity in financial and organizational management • Assist CSOs in implementing these resource mobilization strategies • See also capacity building activities under Risk 9, mitigating action b.

CSOs should be supported in developing a resource mobilization strategy for their advocacy and service delivery as part of a CSO transition strategy as Global Fund support for CSOs declines. CSOs have established relationships with the key population communities and have significant experience in providing services for KP and PLHIV. Further, it is critical for CSOs to maintain their independence from government funding for their advocacy activities so that this funding does not influence their advocacy platform. The comparative advantage of CSOs with regards to HIV advocacy should be made clear to the alternative funding sources.

Once the resource mobilization strategies are developed it is recommended that CSOs are assisted in implementing these strategies. As CSOs have little prior experience raising funds for their activities, technical assistance will be important to ensure the successful implementation of their resource mobilization strategies. This technical assistance should include capacity building on financial and organizational management so that funds secured through resource mobilization will be managed efficiently. Financial assistance will also be required for the development and implementation of these strategies.

Costs and Financing



Risk 11: The Government is unable to mobilize sufficient domestic funding for the HIV response, because of fiscal constraints and (mis)perceptions that the HIV program is "over-funded"

Mitigating Action	Lead Agency	Implementation steps
a. MOH/ NCHADS works closely with MEF to exploit opportunities associated with PBB*, and provincial budgets to build a stronger case for and secure increased and more diversified funding for the HIV services.	MOH, MEF and NAA	• Establish a task team comprising of representatives from the MEF budget unit, NCHADS and the planning and budget unit in MOH to oversee the tasks associated with integrating HIV requirements into routine budgeting. • Conduct a detailed analysis of the NCHADS and GF budget line items and identify items for possible inclusion in routine budgeting under the HIV sub-programme and at national level. • For national-level items (mainly ARV's, selected HR including contract positions), develop a convincing business case to support an increase in domestic funding of these items over the medium term. • Identify a small sample of facilities at which to pilot the inclusion of HIV expenditure in the routine budget request supported by an activity based budget calculation tied to measurable outputs. This budget request must also demonstrate the ability of the facilities to absorb increases in domestic funding. • Provide orientation and education of the health facility staff, OD and province to secure their participation and support and create awareness with respect to their responsibility to provide HIV services in terms of the MPA / CPA • If necessary, assist the MOH to formulate a directive (prakas) to ensure that HIV related expenditure is classified eligible

Several sub-programmes, including HIV, have been identified for piloting output-based budgeting, presenting an opportunity to leverage increased domestic funding. This reform is referred to as Programme Based Budgeting (PBB). Implementation of PBB has however been limited. NCHADS is well positioned to capitalise on this opportunity given that it has developed expertise in GF grant management which requires the development of results based budgets using an activity framework. Representative of the MOH and the MEF had repeatedly indicated that the best way to access domestic funding is to include HIV related expenditure items in the routine budget process, to provide strong motivation for the inclusion of these items and to make sure that the MOH defends the budget request in budget negotiations with the MEF. The MEF cannot engage directly with NCHADS or the HIV programme. It is however uncertain how including HIV funding needs in routine budgeting might be achieved and the reluctance by many facilities to take responsibility for HIV services constitutes a barrier to implementation.

Therefore, a practical way forward is to implement PBB reforms in a small sample of pilot sites through the HIV sub-programme before attempting a wider implementation of PBB. In order to implement this pilot a task team should be established to oversee the design and implementation. The task team should include representatives from NCHADS, the MOH planning and budget unit, MEF budget unit, the province and the OD. As a first step the budgets for NCHADS and the GF should be analysed and in consultation with programme experts, specific expenditure line items should be selected which can easily be accommodated in the routine budgeting process and address an unmet funding need. Initially the request for additional funding could be small contributions for transport costs to facilitate outreach, community follow-up or M&E visits. Importantly, these must be provided for under the HIV sub-programme in order to ring-fence the request and should be tied to clear and measureable outputs and deliverables.

In order for the pilot to succeed it will be essential to orientate the provincial, OD and facility management and articulate a clear purpose of the pilot. This orientation can also be used to sensitise the facility management about their responsibility to deliver HIV services; to explain the current funding of the response; and the benefits to the facility of using the HEF correctly for ID poor card holders. This process should be carefully documented to establish a platform for a user-friendly guide, which can be used at a later stage to bring more facilities on board. If there are any regulatory barriers to using facility funds for HIV expenditure, these should be addressed as well and an appropriate prakas (proclamation) should be issued by the MOH. If there is no regulatory barrier, then this should be addressed in the orientation. It was suggested by some workshop participants that the MOH should issue a letter to the selected facilities to inform them that HIV expenditure constituted eligible expenditure to dispel any doubt or concerns regarding the expenditure of public funds on HIV services given the history of external funding.

Mitigating Action	Lead Agency	Implementation steps
b. Integrate HIV treatment, care and selected prevention and outreach services into social health insurance scheme benefit packages (NSSF/HEF) to leverage additional contributions to the HIV Programme and secure more robust funding.	MOH, NAA, MEF and partners **Timing:** 2018-2020	• Establish clarity regarding the interpretation HIV-related services and expenditure provided for in the current HEF benefit package. • Develop an education and awareness campaigned aimed at health facilities to educate staff about the HEF and HIV-related benefits, due to those clients classified as ID-poor. • Establish a task team to engage with the broader process of establishing social protection mechanisms to represent and advocate for the interests of all HIV stakeholders (including PLHIV) and ensure inclusion of HIV-related services in the definition of benefit packages.

As part of long-term health financing reforms, the government is assessing opportunities to expand financial risk protection. The Health Equity Fund (HEF) has been established and covers the cost of those health services included in the benefit package for the ID-poor population. Initiatives are underway to expand the coverage of the HEF to additional populations, such as the urban poor and children under the age of five. Currently, facilities are reimbursed for items such as transport subsidies and user fees and other costs associated with treating opportunistic infections of those PLHIV that are classified as ID poor. Consultations with stakeholders indicated that the implementation of the HEF is however inconsistent at facility level due to both a poor understanding of the HEF rules and benefits and a reluctance to take responsibility for implementing HIV-related services (see comment above). Although at an early stage, under the National Social Protection Policy Framework (2016-2025) (NSPPF), the government is proposing the development of a comprehensive, sustainable social health protection system for all citizens. Facilitated by P4H Social Health Protection Network, the benefit package design is currently under discussion.

The consistent implementation of the HEF at facilities will be beneficial, even if it does not leverage significant additional resources directed at the HIV programme, as it is likely to improve service delivery at facilities and help to establish the responsibility for providing HIV-services by hospitals. As a first step, the HIV-related benefits which are currently included in the benefit package, and the implementation of these benefits must be clarified. Once this has been achieved, and dovetailing with other initiatives aimed at supporting facilities, a simple guide should be developed for facilities, explaining how the HEF works in relation to HIV-services and other services provided to PLHIV. Initially, educating staff and creating awareness can be tested at the pilot sites referred to above before refining and expanding the education and awareness initiative to other facilities.

The third implementation step aims to establish a task team, representing HIV-stakeholders, to engage proactively with the ongoing process of refining the HEF benefit package, guiding the implementation of the HEF and contributing to the development of the comprehensive social health protection system and associated benefit packages. In this way the HEF and future benefit packages can be developed and shaped to provide not only treatment and care costs but also selected prevention and outreach activities.

Mitigating Action	Lead Agency	Implementation steps
c. **Explore the opportunities for co-financing and leveraging private sector corporate social responsibility programmes**	NAA and partners **Timing:** 2018-2020	• Research the existence of previously established social responsibility / co-financing platforms both in Cambodia and those that have worked in the region, e.g. India • Assess the feasibility for leveraging existing platforms or establishing a co-financing platform in Cambodia to fund specific needs which will not be funded by government or donors. • If considered feasible, develop and implement a strategy for co-financing with the private sector.

The purpose of this mitigating action is to mobilise additional funding for those HIV services which are unlikely to attract funding from government or donors. This is assuming that large corporations exist with social responsibility programmes or workplace wellness programmes which may cover certain elements that would contribute to the HIV response. It is also possible that employees of large companies seek health services within the workplace or affiliated private sector providers rather than visiting public facilities. In theory, the opportunity exists for these large corporations to make a contribution or in some way improve the socio-economic environment for those most likely to engage in risky behaviour.

To understand if this could be a feasible solution in the Cambodian context, research should be carried out to establish whether:

- A previously established co-financing mechanism still exists and if not, why these have fallen into disuse
- Selected large corporations have social responsibility programmes / employee wellness programmes and are willing to engage in the discussion and show interest
- There are working models in the region which could be adapted for use in Cambodia.

Using these findings, a high-level feasibility assessment should be conducted to determine if a mechanism to leverage private sector resources for activities which will support the HIV response could be established and the best approach to do this. Based on the outcome from this feasibility assessment, the next steps can be planned. If the assessment indicates it would be possible, the third step proposes strategic and operational planning to realise and implement the mechanism over the next three years, which will include piloting the concepts and establishing a working model.

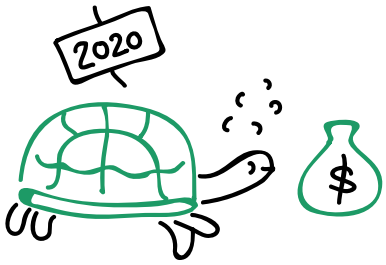
Mitigating Action	Lead Agency	Implementation steps
d. Explore how HIV prevention care and support activities at grass-roots could be integrated in the CDP and CIP (Commune Development Plan and Commune Investment Plan) and / or funded by HealthEQIP funds and who should implement them.	MOI and NAA 2018-2020	• Initiate discussions with the Ministry of Interior to establish if certain HIV-activities aimed at the community level, can be provided for in the CDP and potentially funded through the CIP. • Closely related to the above, engage with the HealthEQIP programme and key partners (e.g. World Bank, USAID, GIZ) to establish whether the list of eligible expenditure (for discretionary resources managed by facilities) can be expanded to provide for community level HIV services. • Based on the outcomes of above discussions, develop a clear concept and conduct a pilot to test the concepts. • If successful, document the pilot and its outcomes and generate a policy brief and advocate for the adoption of the policy.

This action builds on the development planning carried out at the commune level, supported by the Ministry of Interior through the Commune Investment Plan (CIP) . The scope of the activities included in the plan is broad and reflects commune priorities, which typically include health-related issues. In principle, some of the resources could support trained community members to provide selected HIV-services such as follow-up and prevention activities. Some workshop participants believed that the current grant and the Community Action Framework does not provide adequately for activities within the community, and that these could be augmented by leveraging the Commune Development Pan (CDP) and CIP.

Similarly, the HealthEQIP programme also provides grant funding to facilities. The grants comprise different components, including a fixed amount, a performance based portion and a small discretionary grant to cover minor operational costs. The performance-based grants need to be spent on facility improvements and cannot be spent on outreach services or community level service delivery. As a result some of the grant funding is not being spent effectively and in some cases not at all due to confusion in what constitutes eligible expenses. By adding HIV services to the list of acceptable expenditures, more resources may be made available to fund HIV services in the community by the facility.

The first and second implementation steps require a discussion with the Ministry of Interior and the HealthEQIP team at the World Bank to explore how these two sources of funds could be utilised to support effective HIV services at the community level. Close collaboration between all stakeholders will be required to find a workable solution.

Assuming that a workable solution can be established, in principle, step three will also consist of the development of a concept note which will spell out in detail how these two funding streams might be used at the commune level to directly support HIV services. The concept note should include the framework for a pilot study to test the concept. Step three includes the implementation of the pilot over a reasonable period of time and subsequent evaluation. If the evaluation demonstrates an effective service delivery and funding model a policy brief should be prepared for use as an advocacy tool to influence policy in the affected ministries.



Risk 12: In the event that Global Fund puts Cambodia on a path to full transition by the late-2020s the Government may not be in a position to react fast enough to expand its budget to cover the resulting funding gaps, which could amount to as much as $5 million a year.

Mitigating Action	Lead Agency	Implementation steps
a. **Engages with GF (and other donors) and proactively seek clarity for a timetable for transition and nature of transition (extent of reduction) to maximize the planning horizon.**	MEF, MOH and NAA **Timing:** ongoing	• Secure a dialogue with the GF Country Portfolio Manager and other GF representatives during each GF country visit to discuss their intentions for future funding in terms of total grant value for the next funding cycle, interventions eligible for funding and items earmarked for domestic funding. • Conduct similar discussions with other development partners to ensure that prioritized activities are supported and to seek an indication of future funding.

This action seeks to reduce the level of uncertainty around the funding gap over time by proactively engaging with the topic during GF country team visits. Similarly, regular discussion with development partners may help the NAA and others to develop a better understanding of future funding levels for short and long term technical assistance (TA) and create opportunities to maximise the benefit of TA interventions. Even if it is not possible to establish with any degree of certainty what those funding levels might be, sharing NAA and government assumptions about donor funding as part of long term planning may result in some indirect guidance and inform future funding envelopes. This is essential to better understand the total financing gap between the resource need and available funding.

Mitigating Action	Lead Agency	Implementation steps
b. NCHADS and NAA Work closely with the MOH and MEF and ensure participation in the development of the strategy over the next three years, to defend the HIV programme as a priority in the face of competing demands and develop an overall financing strategy for HIV.	MOH, NAA, MEF and partners **Timing:** 2019-2020	• Explore whether the review of NSP IV and the development of NSPV can include research to determine which other health programmes and significant non-health programmes have been identified for transitioning over the medium term and will exert pressure on the national budget . • Develop a strong business case for the AIDS response to ensure that the response is prioritized in the context of competing development programmes • Given the above context, compile an overall financing strategy for the AIDS response. • On an ongoing basis and with the assistance of the MEF, closely monitor any other possible, simultaneous transitions (e.g., Gavi) to ensure that these can be managed together.

Interviews with key informants at the MEF highlighted the fact that the ministry is aware of a number of grant funded programmes which could potentially transition over the medium term. These are development programmes both within and outside of the health sector. The simultaneous transitioning of several programmes at approximately the same time will exert considerable pressure on domestic resources despite rapid economic growth. In order to plan for these transitions, the MEF indicated that they are starting a process of developing a multi-sector transition plan to manage the financial implications of these transitions on domestic resources.

The steps listed above are aimed at making sure that the MEF is aware of the importance of the HIV programme and prioritises the programme when allocating scarce resources. A first step in this action is for a meeting to establish whether this process of developing a national level transition plan has begun, how the process will unfold and most importantly, how the MOH can participate in this process. In order to build a strong HIV business case to use for advocacy and negotiation purposes it is important to understand which development programmes are preparing for transition and the timelines associated with these transitions. The second task suggests that it may be possible to carry out this research as part of the NSP IV review and preparing for the development of NSP V Having secured this information, NAA and NCHADS can build a strong HIV business case to advocate for the prioritisation of the HIV response; initially within the MOH and subsequently by the MOH to the MEF. This business case should be developed in conjunction with an overall financing strategy for the HIV response.

Lastly it is recommended that NCHADS and the NAA monitor those programmes identified as transitioning in the medium term, to maintain an understanding of their progress on the transition journey and the likely impact on the fiscus and health budget.

Risk 13: A larger than expected funding gap emerges because future financing needs are higher than envisaged (e.g., more patients must be treated, patient monitoring and adherence is more labor-intensive, program management cannot be fully rationalized, etc.).

Mitigating Action	Lead Agency	Implementation steps
a. Review and revise the resource need periodically and issue early warnings if actual and anticipated expenditure exceed estimated need / funding.	MOH-LIT, NCHADS, NAA and partners **Timing:** ongoing	• Closely monitor actual expenditure and achievements (e.g. number people on treatment) and continuously compare these indicators to underlying costing assumptions of the IC. • If necessary, revise the resource need projections based on a refined set of assumptions. • Set clear targets for domestic financing of the HIV Programme after each revision of the resource need projection and funding gap and integrate into the domestic funding business plan referred to in Risk 11. • Routinely communicate actual expenditure and revised projections to the MOH and MEF, highlighting any significant changes.

It is possible that some of the anticipated efficiency gains, detailed in the current GF grant and programme design, do not materialize. The consequence of this would be the need to escalate certain interventions to achieve the same outputs and outcomes. This in turn would require additional resources and may lead to an unmet funding need.

As a mitigating response, actual expenditure should be monitored closely in relation to the outputs being achieved. Similarly, the actual value of key indicators must be monitored closely and compared to underlying assumptions in the IC and other projections. In particular the number of people on treatment and the annual average cost of treatment should be documented.

Where this comparison reflects significant differences, the current estimate of resource need should be revised to reflect more accurate values. Based on these revised values the anticipated funding gap can be refined. It is recommended that this routine funding gap analysis be carried out by component within the HIV programme, which may also inform the possible reallocation of resources between components. The last step in the routine analysis of the funding gap is to update targets for domestic funding in line with the Medium Term Expenditure Frameworks (MTEF) period but also for 2025 and by 2030. Routine reporting and use of these analyses to inform the funding business case and the deliberations of the task team (proposed in risk 11) is critical to strengthening the business case.

Although many uncertainties make calculating the funding gap and targets difficult, an ongoing consideration of the resource need and the gap will result in better planning within the MOH and allow the MEF to respond more easily. If requests for increased funding are submitted only after the next allocation letter has been received from the GF, these are likely to be less successful.

V. Conclusion and Next Steps

Cambodia has made substantial progress over the past two decades in the fight against HIV and achieving the 90-90-90 target. These efforts must be sustained to achieve the goal of eliminating AIDS as a public health threat by 2025. This Sustainability Roadmap provides a framework of mitigating actions and implementation steps, which if implemented, will improve the sustainability of the response and facilitate a gradual transition from a high dependency on external funding to a response funded substantially from domestic sources. This will allow Cambodia to continue on its current path to elimination of AIDS as a public health threat. It is recommended that the NAA, in collaboration with the Sustainability Technical Working Group, drives the process of developing a detailed action plan that references these approaches but provides more concrete steps for implementation and related indicators to monitor progress. This Roadmap should be updated as necessary to reflect the latest evidence and implementation experiences and to ensure alignment with strategic planning processes (NSP and HSSP-HIV) which are about to unfold. If Cambodia begins to implement this framework of mitigating actions in 2018, a platform will be established for a smooth transition from external donor funding and a sustainable HIV response.

Annex A: List of Workshop Participants (30-31 May 2018)

Name	Agency
H.E Ieng Mouly	National AIDS Authority
H.E Dr. Tia Phalla	National AIDS Authority
Dr. Ros Seilavath	National AIDS Authority
Dr. Sim Kimsan	National AIDS Authority
Dr. Voeung Yanath	National AIDS Authority
Dr. Chhea Setthi	National AIDS Authority
Dr. Tep Navuth	National AIDS Authority
Dr. Ly Chanravuth	National AIDS Authority
Dr. Tan Sokhey	National AIDS Authority
Dr. Lon Chanrasmey	Ministry of Health - Lead Implementation Team
Khan Kong	Ministry of Health - Lead Implementation Team
Phon Leang	Ministry of Health
Dr.Ly Penh Sun	National Center for HIV/AIDS, Dermatology and STD
Dr. Ouk Vichea	National Center for HIV/AIDS, Dermatology and STD
Ms. Marie Ryan	National Center for HIV/AIDS, Dermatology and STD
Deng Kheang	National Maternal and Child Health Center
Keo Vibol	Ministry of Economy and Finance
Keo Ouly	Ministry of Planning
Ratha Rorthiyak	Ministry of Interior
Eamonn Murphy	Joint United Nations Programme on HIV/AIDS
Vladanka Andreeva	Joint United Nations Programme on HIV/AIDS
Saleem Muhammad	Joint United Nations Programme on HIV/AIDS
Polin Ung	Joint United Nations Programme on HIV/AIDS
Nertila Tavanxhi	Joint United Nations Programme on HIV/AIDS
Lori Newman	President's Emergency Plan for AIDS Relief
Ly Vanthy	United States Centers for Disease Control and Prevention
Bunna Sok	United States Agency for International Development
Robert Stanley	United States Agency for International Development
Caroline Barrett	Clinton Health Access Initiative
Andrew McCracken	Clinton Health Access Initiative

Bernd Appelt	Deutsche Gesellschaft für Internationale Zusammenarbeit
Kayla Song	The World Bank
Violette Genex	French Embassy
Phorng Chan Phal	Cambodian Network of People who Use Drugs
Han Sienghorn	ARV Users Association
Taing Phoeuk	KORSANG
Un Chenda	KORSANG
Tim Vora	Health Action Coordinating Committee
Prach Sinath	Reproductive Health Association of Cambodia
Mony Srey	Health Policy Plus
Shreeshant Prabhakaran	Health Policy Plus
Bhavesh Jain	Health Policy Plus
Am Vichet	Health Policy Plus
Etienne Poirot	United Nations Children Fund
Alexandra Thenot	Global Fund Prospective Country Evaluations/ Angkor Research and Consulting
Ly Chansophal	KHANA
Prom Chanrith	KHANA
Steve Wignall	LINKAGES/FHI360
Heng Kheng	Population Services International
Ouk Somalay	Smartgirl Network
Sem Sithat	Friends International
Deng Serongkea	World Health Organization
Chong Vandara	United Nations Population Fund
Peang Sereywath	Health Action Coordinating Committee
Chris Vickery	Department of Foreign Affairs and Trade of the Government of Australia
Olivier Segeral	ANRS – France Recherche Nord&Sud Sida-hiv Hépatites
Robert Hecht	Pharos Global Health Advisors
Carl Schutte	Pharos Global Health Advisors
Kelly Flanagan	Pharos Global Health Advisors
Tea Phauly	Freelance Consultant
Chhoeurn Chhuna	Freelance Consultant