KINGDOM OF CAMBODIA

NATION RELIGION KING

Cambodia Country Progress Report

Monitoring Progress Towards the 2011 UN Political Declaration on HIV and AIDS

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Prepared and Submitted

By

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FOREWORD

In June 2011, in the UN General Assembly High-Level Meeting on AIDS in New York, Cambodia renewed its commitment to the HIV response and adopted new targets by signing the 2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS.

On behalf of the National AIDS Authority (NAA), it is my pleasure to submit the 7th Country Report on Global AIDS Response Progress Reporting. The purpose of this report is to provide updates with respect to the goals agreed upon and progress made in Cambodia's response on HIV and AIDS using global indicators for the period 1 January 2014 to 31 December 2014. The period under this review falls within the timeframe of implementation of the Third National Strategic Plan for a Comprehensive and Multi-sectoral response to HIV and AIDS 2011-2015 (NSP III) and the Rectangular Strategy Phase II of the Royal Government of Cambodia(RGC).

Over the past one year, Cambodia has undertaken innovative approaches to assist national leaders, policy makers, programme implementers, and Civil Society Organization (CSO) and Key population (KP) community to gain more confidence and competence in contributing to a more strategic and sustainable HIV response. The efforts in the past year have taken into account the changing HIV epidemic, global context of resource reduction for HIV/AIDS and the need for increasing domestic contribution along with the enhancement of country ownership. The national response has adopted a more focused and targeted approach for further increasing effectiveness and efficiency of HIV prevention, care and treatment services at all levels.

In closing the gap Cambodia has been committed to improve the country score cards of HIV and AIDS response. We understand that without scale-up, the AIDS epidemic will continue to outrun the response, increasing the long-term need for HIV treatment and increasing future costs. Efforts have been mobilized to a rapid scale-up of essential HIV prevention and treatment approaches will enable us to join global commitment in achieving the 90–90–90 targets by 2020.

With respect to the human rights, efforts have been made on strengthening partnerships between government, development partners, CSOs and representatives of PLHIV/KP from the national to the local levels to improve the policy and legal environment to support HIV and AIDS programmatic interventions.

The challenging task for Government institutions, CSOs, development partners and especially Key Affected Populations in the next five years is to organize an effective and efficient use of resources in implementing the Strategic Plan for HIV/AIDS and STI Prevention and Control in

the Health Sector in Cambodia 2015-2020 and the National Strategic Plan for Comprehensive and Multi-sectoral response to HIV and AIDS 2015-2020 (NSP IV).

When the HIV prevalence is decreasing, the rise in prevalence of non-communicable diseases is indeed raising as a potential competitor for national attention. However, as low income country Cambodia needs to undergo a long process to put HIV as part of, and inform strategies for, other types of health and social programmes to secure sustainable response when external support is reducing. Cambodia will need to bring domestic funding into line with our national wealth and HIV burden. This will demand increases in the amount of domestic funding for the response. The contribution of national budget for anti-retroviral drugs is an indication of government commitment for the coming years

Finally, I would like to express my deep appreciation and thanks to all the individuals, institutions and organizations who involved in the development of this report. These include Government ministries, UN agencies, development partners, CSO and representatives of KPs and PLHIV. We strongly believe that the open dialogue between duty bearers and rights holders at various levels has enabled the marginalized, the disadvantaged and the excluded to regain their rights to equitable access to health and non-health services.

IENG MOULY

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The attendees at the national validation meeting held on April 10, 2015 provided valuable inputs and feedback to ensure that the information in this report and on the online indicators 'data is as accurate as possible and best reflects the current status of the HIV epidemic and response in the country.

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ACRONYMS AND ABBREVIATIONS

ACRONYMS	ABBREVIATION
ACM	Active case management
ART	Antiretroviral treatment
ARV	Antiretroviral (drugs)
BK	Bros Khmer (a study published in 2010)
BSS	Behavioral Surveillance Survey
CBO	Community-based organization
CBPCS	Community-Based Prevention, Care and Support
CCM	Country Coordinating Mechanism
CDC	Council of Development of Cambodia
CDHS	Cambodia Demographic and Health Survey
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CENAT	National Center for Tuberculosis and Leprosy Control
CoPCT	Continuum of Prevention to Care and Treatment
CPITC	Community peer-initiated testing and counseling
CQI	Continuous quality improvement
CRDB	Council of Rehabilitation and Development Board
CSO	Civil society organization
EC	European Commission
EW	Entertainment worker
FEI	Francais Expertise Initiative
FONPAMs	Forum of Networks of PLHIV and MARPs
GARPR	Global AIDS Response Progress Reporting
GBV	Gender-based violence
GDJ TWG	Government-Donor Joint Technical Working Group
GF/GFATM	Global Fund / Global Fund to fight AIDS, Tuberculosis and Malaria
HAARP	HIV/AIDS Asia Regional Program
HACC	HIV/AIDS Coordinating Committee
HIS	Health Information System
HSS	HIV Sentinel Survey
HSSP	Health Sector Support Project
IBBS	Integrated Biological and Behavioral Survey
INGO	International NGO
KAP	Key affected population
KP	Key population
KHANA	Khmer HIV/AIDS NGO Alliance
LMIS	Logistic management information system
M&E	Monitoring and evaluation
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoLVT	Ministry of Labor and Vocational Training
MoSVY	Ministry of Social Affairs, Veterans, and Youth Rehabilitation
MoWA	Ministry of Women Affairs
MSM	Men who have sex with men

NAA	National AIDS Authority
NACD	National Authority for Combating Drugs
NAPVAW	National Action Plan on Violence Against Women
NAPVAW	National Action Plan to End Violence Against Women
NASA	National AIDS Spending Assessment
NCHADS	National Centre for HIV/AIDS, Dermatology and STD
NGO	Non-governmental organization
NMCHC	National Maternal and Child Health Center
NSP	Needle and syringe programme
NSP	National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS, 2011-2015
OD	Operational district
OI	Opportunistic infection
OST	Opioid substitution therapy
OVC	Orphans and vulnerable children
PCPI	Police-Community Partnership Initiative
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMERD	Planning, Monitoring, Evaluation and Research Department
PMTCT	Prevention of mother-to-child transmission
PSK	Population Services Khmer
PSM	Procurement system managment
PWID	People who inject drugs
PWUD	People who use drugs
SOP	Standard operating procedure
SRH	Sexual Reproductive Health
SSF	Single stream funding
SSS	STI surveillance survey
TB	Tuberculosis
TG	Transgender
TWG	Technical working group
UIC	Unique identifier code
UIS	Unique identifier system
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	UN Development Assistance Framework
UNICEF	United Nations Children's Fund
USG	US Government
VCT	Voluntary counseling and testing
VHSGV	Village health support group volunteer
WHO	World Health Organization
WLHIV	Women Living with HIV

Contents

GLOBAL AIDS RESPONSE PROGRESS REPORTING (GARPR)

STATUS AT A GLANCE

A. Inclusiveness of stakeholders in the report writing process

The 2015 Global AIDS Response Progress Reporting (GARPR) process was led by the NAA with support from the National Center for HIV/AIDS, Dermatology and STDs (NCHADS), UNAIDS, HIV/AIDS Coordinating Committee (HACC), Clinton Health Access Initiatives (CHAI) and WHO. Stakeholders working in all sectors of the HIV/AIDS response in Cambodia participated in the process and provided valuable contributions to the 2015 GARPR, including: government ministries and secretariats, national and international non-governmental organizations (NGOs), bilateral organizations, UN agencies, and CSOs including networks of people living with HIV (PLHIV) and other members of KP.

Data for this report were gathered from routine monitoring systems, national programmatic data, the National AIDS Spending Assessment (NASA) for 2011-2012, Spectrum software outputs, and various studies and surveys, namely HIV Sentinel Surveys (HSS), Behavioral Surveillance Surveys (BSS), IBBS 2012, and the Cambodia Demographic and Health Survey (CDHS). Particularly, the health related data were collected from NCHADS database and laboratory. Many meetings were organized to have a better understanding of data required and to help develop responses to the policy and WHO/AMDS survey questionnaires.

Government institutions which provided majority of the indicators' data for this year's GARPR include: the NAA, NCHADS, National Maternal and Child Health Centre (NMCHC), National Centre for Tuberculosis and Leprosy Control (CENAT), Ministry of Education Youth and Sports (MoEYS), Ministry of Planning (MoP), KHANA, FHI360, UNWomen and CHAI.

Data for the GARPR indicators and Programmatic/policy questionnaire were validated at a national workshop held in Phnom Penh on April 10, 2015, and comments and feedback from the participants has been incorporated into this report.

B. Status of Cambodia AIDS Epidemic

HIV prevalence in Cambodia among general population adults aged 15-49 has been steadily declining over the past decade from 2.0% in 1998 [1] and 0.9% in 2006 to 0.7% in 2013 [2]. Along with the decline in HIV prevalence among the general population, it was noted that key populations (KP) such as entertainment workers (EW), drug users, transgender people and

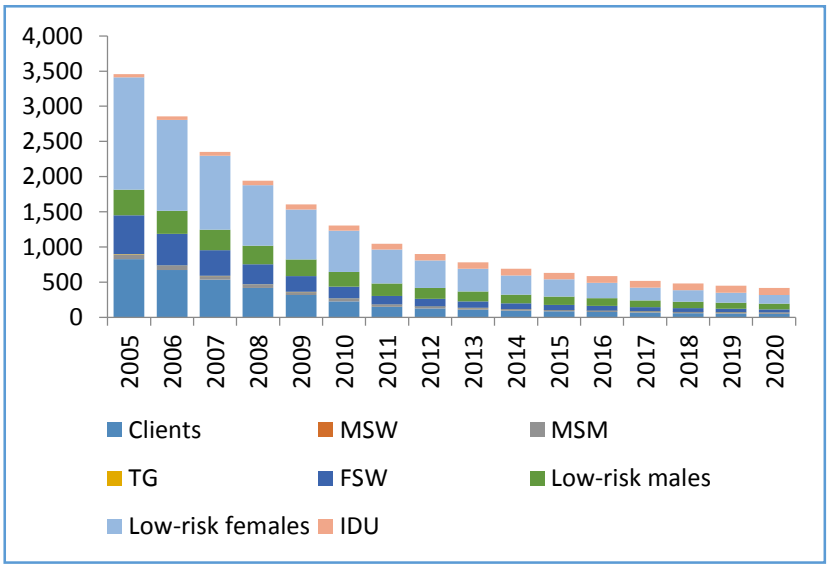
men who have sex with men (MSM) has remained the target group that required special attention in the provision of prevention, care and treatment services.

The prevalence of HIV among female entertainment workers (FEW) has gone down from 20.8% in 2003 to 14% in 2010 [3]. Additionally, the prevalence of HIV among MSM was 2.16% in 2010 [4], 24.4% among people who inject drugs (PWID) in 2012 [5]. Further details on HIV prevalence, HIV incidence, and AIDS-related mortality are shown in the section of this report titled "Overview of the AIDS epidemic".

C. Policy and Programmatic Response

In 2013, HIV prevalence in Cambodia among general population adults aged 15 to 49 was estimated at 0.7% [2]. Modelled estimates suggest that HIV prevalence peaked in 1998 and has been steadily declining ever since. In 2014, using the AIDS Epidemic Model (AEM) there were an estimated 694 new infections (figure 1). According to recent estimations and projections developed using Spectrum 5.3, there are some 75,000 people living with HIV (PLHIV) in Cambodia in 2014 [6]. With continued targeted and effective interventions and by maintaining the current high level of coverage of ART among PLHIV, Cambodia is poised to become the first low-income country to achieve virtual elimination of HIV transmission by 2020.

Figure 1. Annual new HIV infections in Cambodia by risk population (AEM 2014)



a. An urban epidemic among 3 key populations and their partners, driven by sexual transmission

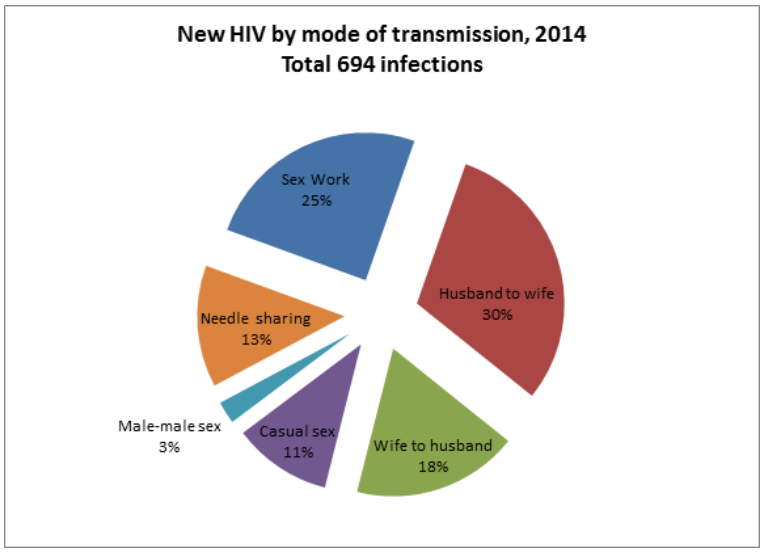
Cambodia's HIV epidemic remains concentrated among certain populations at higher risk of HIV infection: EW[1], MSM, including TG, and people who inject drugs (PWID). It is likely

[1] EWs are defined as women or girls who exchange sexual services for money or goods, either regularly or occasionally, where the sex worker may not consciously define such activity as income-generating. Entertainment establishment include but are not limited to: karaoke, massage, beer promotion girls, beer garden, and freelance; however, currently there is no standardized definition. Source: Boosted COPCT SOP, http://www.nchads.org/SOPs/Book%20CoPCT%20English.pdf (page vi and 1)

that prisoners are also at higher risk although there are few data available on HIV prevalence among these groups.

Since the closure of all brothels following the implementation of the 2008 Law on Suppression of Human Trafficking and Sexual Exploitation[2] and the subsequent migration of sex workers to entertainment establishments[3] or more hidden street-based work, the category now includes both high-risk EW – those with more than seven or more clients on average per week - and lower-risk entertainment workers who have fewer clients on average per week.

Figure 2. New HIV infection by mode of transmission (AEM 2014)



Modelling suggests that sexual transmission is the driving force behind the epidemic in Cambodia, with around 48% of all new infections resulting from spousal transmission, 25% through sex work, and a further 11% of estimated new infections resulting from casual sex [7]. Sexual transmission among MSM is estimated to account for 3% of new HIV infections in 2014 (figure 2). HIV transmission through needle sharing currently comprises a relatively small proportion at just 13%; the high HIV prevalence among PWID, however, may allow this proportion to increase rapidly if unchecked. The recent cluster of newly discovered HIV infections in Battambang province also suggests that there is a proportion of new HIV infections, as yet unquantified, resulting from use of non-sterile needles by unlicensed medical practitioners.

b. Geographic concentration

While the strategic information on geographic HIV prevalence is currently quite weak, based on reported HIV cases and estimated ART needs, HIV incidence is likely largely concentrated in urban areas, particularly the large cities of Phnom Penh, Siem Reap, Battambang, and Sihanouk Ville. Utilizing a range of data sources and in consultation between key partners and implementing agencies, 32 out of a total of 88 operational districts (OD)[4] are identified as having high HIV burden, including eleven ODs that require particular attention.

[2] From NCHADS, Conceptual Framework for Elimination of New HIV Infections in Cambodia by 2020. 2012 Cambodia.

[3] Same reference as footnote 4.

[4] Please note: There is currently ongoing redistricting of operational districts within Cambodia which may lead to some inconsistencies with the number of OD reported in earlier grant component submission.

These cities are also where the majority of KPs are located. Utilizing routine reports from NGOs implementing HIV prevention and other services, in consultation with the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS, former GF PR) and provincial health department, geographical dispersion of KP has been mapped (aggregate, only). There are some indications that the geographical dispersion of PLHIV may be different from that of KPs, due to the fact that many PLHIV were infected at an earlier stage, when Cambodia's epidemic was more of a generalized nature.

C.1. Policy towards AIDS response

High level policy support has been the key to drive a programmatic response success through the national wide implementation. Cambodia has been sharpening its policies and programmatic response in the fight against HIV/AIDS to "getting to zero": zero new infections, zero AIDS-related deaths, and zero discrimination. National leaders, policy makers, programme implementers, and CSO and KPs representatives have been contributing to a more strategic and sustainable HIV response. The efforts in the past year have taken into account the changing HIV epidemic, global context of resource constraints and increasing domestic contribution along with the enhancement of country ownership.

"Seven-point policy directives" for HIV/AIDS responses issued in late 2013 under the order of Cambodian Council of Ministers. The directives were the key drive to reactivate the collaboration of stakeholders for optimizing the use of all sources of funding to achieve the tangible, effective, and efficient results and move forwards to the HIV/AIDS elimination strategy. As a result, many government agencies, CSOs and community networks have been collaborating with each other to develop and to implement a new conceptual framework called "Cambodia 3.0" for the elimination of new HIV infections by 2020.

C.2. Programmatic Effort to AIDS response

Efforts have been made on strengthening partnerships between government, development partners, CSOs and representatives of PLHIV/KPs from the national to the local level to improve the policies and legal environment to support programmatic interventions on HIV prevention, treatment and care, and impact mitigation. These efforts include the following:

1. With the directive of the Council of Rehabilitation and Development Board (CRDB) of the Council for Development of Cambodia (CDC), HACC has been selected as the NGO representative to sit on the Government-Donor Joint Technical Working Group (GDJTWG) on HIV/AIDS.

2. With support from UNs and Development Partners, the Forum of Networks of PLHIV and MARPs (FONPAMs) has been used to select the representation of CSOs/CBOs for the new membership of the Country Coordinating Mechanism (CCM) for the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), in response to eligibility criteria of the New Funding Model approach.
3. At the grassroots level, the Cambodia 3.0 initiative (with its associated standard operating procedures (SOPs)) has been guiding the selection of proportionate numbers of outreach workers and Self Help Groups to connect with KPs in hot spot areas and PLHIV in affected communities, respectively.
4. Cambodia's National Strategic Plan for a comprehensive and multi-sectoral response to HIV/AIDS (NSPIV) is being developed for the period 2015-2020. The overall goals of NSP IV in the context of the vision of Three-Zeros are:

    a. **Socio-Behavioral Prevention**: Eliminate new HIV infections through targeted M&E evidenced-based prevention strategies;
    b. **Stigma and Discrimination:** Eliminate stigma & Discrimination through boosted rollout of and advocacy for Laws and Policies in general population, among those most at risk, and throughout the Ministries of Health, Education Youth and Sports, and the Interior;
    c. **Sustain the health and well-being of PLHIV;**
    d. **Reduce Deaths due to AIDS:** Through treatment, quality care and support to PLHIV and those affected;
    e. **Mitigation**: Alleviate socioeconomic and human impact of HIV AIDS on individuals, family, community and society; and
    f. **Boosted Enabling Environments:** for MARPs & for PLHIV their families, communities and the general population

        a) Advocate for rights-based, gender responsive Laws and Policies,

        b) Reduce Stigma and Discrimination, and

        c) Empowering VHSGVs at the commune level

    The NSP-IV includes three main intervention areas (prevention, care and treatment, and impact mitigation) that directly contribute to the overall goals, as well as three cross-cutting strategies that support the progress of the interventions - Leadership and Coordination of Stakeholders for Financial Resource allocations; Enabling supportive Environments through better understanding and implementation of Laws and Policies *and;* Boost and Advocate the NAA One-System M&E protocols for Strategic Information within the Health Sector and among Stakeholders. The NSPIV is expected to be endorsed in mid-2015.

5. The multi-sectoral NSP-IV is the umbrella framework for the national HIV response (covering health and non-health sectors) while specific other NSPs have been developed to address specific health interventions (National HIV Health sector Plan) and harm reduction (National Harm reduction Strategy) see below. The National Strategy on HIV/AIDS and STI Prevention and Control in the Health Sector:

The goal of the National HIV Health Strategy is the elimination of new HIV infection by 2020 and reduction of HIV/AIDS related mortality. The Strategy is organized under three primary objectives:

i. Reduce the estimated HIV incidence among the population aged 15 years and older from 18/100,000 to 3/100,000 or less by 2020.

ii. Reduce the HIV transmission rate from HIV positive mothers to their infants from 13% in 2010 to 5% or less by 2020

iii. Maintain the estimated current HIV/AIDS-related mortality rate at or below 0.05/100,000.

Strong efforts by many partners over the past two decades have resulted in very high rates of coverage for many prevention, treatment and care services. As such, efforts in the coming phase will focus on maintaining that coverage and improving retention across all the cascades from prevention to diagnosis to life-long high quality care. This involves the identification of a new balance between relevant prevention, treatment and care efforts that matches Cambodia's current needs and response stage in the HIV epidemic This will be achieved through a shift towards a more streamlined, intensified and targeted approach, known as Active Case Management.

The national HIV Health Strategy is characterized by efforts to prioritize and streamline, adopting an integrated approach to HIV health service delivery, aimed at the primary impact results: reduced mortality and elimination of new infections. Rather than focusing on program areas as discrete entities, the National Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector aims to provide a synergistic a comprehensive, synergistic approach for three situations:

1. KP prevention and links to health services, known as the *Boosted Continuum of Prevention to Care and Treatment*. This approach aims to identify and reach new infections, to ensure they are brought into and retained in treatment. This component is targeted specifically where new infections are occurring, among KPs.
2. *Boosted Continuum Of Car*e for those already in treatment, to ensure they are retained in the highest quality of care; and
3. e-MTCT, known as *Boosted Linked Response*, to eliminate new infections among children, while addressing the needs of their mothers.

In addition, this strategy addresses weaknesses in the health information system, and includes new strategies to incorporate private sector reporting and expand the use of information and communication technology, as well as strategic efforts to improve both active and passive surveillance at all levels.

The 2014 Cambodia AIDS Epidemic Modelling (AEM)

AEM work took place in 2014 with a view to optimizing investments for maximised impact against the epidemic. Three sets of scenarios having different scales of programmatic intervention options with associated option of unit costs (including current baseline unit cost, reduced unit cost and reduced unit cost with integration) were explored and considered, and the associated outputs weighted for possible impacts in terms of new HIV infections and deaths averted.

The relevant government-led TWG considered the subset of scenario III-C under the 'Elimination of new HIV infection' Policy Scenarios as having the maximum epidemiological impact, as well as best cost-effectiveness in the current context of the epidemic – in line with the overarching objective of elimination of new infections by 2020, as envisioned in the Cambodia 3.0 framework.

This scenario, which includes the intensification and scaling up of HIV prevention services for all KAP (as well as a significant scale up of ART) was used for developing the Concept Note to GFATM and the associated intervention packages. In addition, analytical and modelling work under the AEM informed the development of the Health Sector HIV Strategy (2015-2020) and its associated prioritization process.

6. National Strategic Plan on Harm Reduction

The goal of this first national Harm Reduction Strategy is to intensify innovative HIV prevention, treatment and care services for high-risk drug users, particularly PWID, females and adolescents.

The national Harm Reduction Strategy comprises 5 objectives:

i. NSP: Expand the needle and syringe program to reached and unreached PWID, including females, adolescents and those PWID with multiple HIV-risk behaviours

ii. MMT: Scale up the provision of Opiate Substitution Therapy (OST) to PWID, especially to females and PWID with multiple HIV-risk behaviours

iii. Other key health interventions: Scale-up access to and provision of other key health interventions for PWID, especially females and adolescents

iv. Strengthening of Strategic information base

v. Enabling Environment: Ensuring an effective enabling environment in support of harm reduction interventions for PWID.

First and foremost, the national Harm Reduction strategy aims to identify and reach as yet unreached PWID, connecting them to prevention, testing, treatment and care services, while retaining those who are already reached in the continuum services. Expanding coverage of the existing needle syringe program and improving the quality of MMT services to promote both uptake and retention are key activities under this strategy. This strategy is currently in draft form and is expected to be finalized by early 2015, with Government approval following soon after

C.3. Challenges in Policy and Programmatic Response

a. Reaching and retaining those at highest risk HIV

Reaching those at highest risk and then retaining them in the cascade of care is the key limitation in Cambodia's current HIV response. Cambodia had made an impressive response to the HIV epidemic, in particular with regard to prevention strategies among sex workers. Nonetheless, current response faces some continuing challenges, particularly in light of the target to eliminate new HIV infections under Cambodia 3.0. Current efforts are focused on increasing HIV testing, along with standard prevention interventions among defined populations believed to be at highest risk – EWs, MSM, TGs and drug users. However, risks within these populations are highly variable. As a result, it is assumed that currently, many people at relatively low risk are reached and tested frequently, while others at highest risk may not be reached at all. Community-driven finger prick testing for HIV, implemented among KP since 2013, has returned very low rates of positivity, supporting the idea that while overall coverage is high, those at highest risk are not being reached.

Once in the cascade of prevention, diagnosis, treatment and care, drop-out occurs at every juncture. The rate of drop-out at different points can be difficult to measure due to gaps in strategic information, such as determining how many PLHIV are actually diagnosed.

b. Gaps in Strategic Information

There are still gaps in the data and strategic information on the HIV situation and response, in particular among key affected populations, to help inform prioritization and choice of interventions. The health sector strategic plan (2018-2015) and NSP-IV (2015-2020) includes strategies for strengthening of strategic information base for the national response as one of its cross-cutting strategy.

c. Costly models of community care

The previous model of community and home-based care has been working well in

Cambodia. The changing characteristics of the epidemic (increasing numbers of PLHIV who are healthy and active) and the newly highly constrained financial landscape. However, mean that the previous model is too costly to maintain at current levels and needs to be adapted to meet specific, rather than general, needs. Prioritizing those most in need, providing streamlined services to those with fewer needs, focusing services in areas with greatest numbers of PLHIV in most need, and integration of existing, vertical programs is required in order to improve the efficacy and efficiency of this sector and to maximise the role this sector can play in delivering high-quality HIV services.

HIV is a chronic condition that requires regular follow up to improve retention in the continuum of care. The improvement in treatment adherence and viral load suppression will not only improve health outcome of PLHIV, but will also optimize the use of treatment as prevention, decreasing the likelihood of HIV transmission. As the HIV epidemic is evolving rapidly, so must the care and support provided to PLHIV to adequately respond to their real needs. Program data obtained from the USAID SAHACOM program suggests that PLHIV with the greatest need make up approximately 30% of the entire PLHIV population. The new model is being integrated into the active case management mechanism to provide segmented support to different sub-groups of PLHIV and focus limited resources to those who need it the most. Furthermore, the mechanisms to deliver Community-Based Prevention care and support (CBPCS) package of support through local primary health care structures can, in the long-term, be effectively utilized to also provide care and support to other chronic diseases such as diabetes.

D. Indicator Data in an Overview Table

1. Core indicators

The table 1 shows the GARPR core indicators for the current reporting period, as well as the GARPR 2014 reporting period for comparison. Note the following:

- The “Status” column indicates whether an indicator has decreased (↓), increased (↑), or remained roughly stable (—) between GARPR 2014 and GARPR 2015.
- The “Online data” columns show whether complete data were submitted online for a given indicator. “Completed” means data which adhere to the GARPR definitions were submitted online. “Partially” means data were submitted online, but the data did not exactly match the GARPR definitions. This includes cases where an indicator is based on multiple variables (e.g. multiple questions from a population-based survey) but not all of the variables had data available, or when disaggregated data were not available. “Incomplete” means no data were submitted online for that indicator.

2. Notes on data sources

The integration of indicators from UA and GARPR was provided and guided by Global team. There are ten targets to be reported. The need for a multi-sectoral collaboration is vital to compile data for all the required indicators. As a result, the inputs were collected from the NCHADS, NMCHC, CENAT, MoEYS, MoWA, MoP, Ministry of Social Affairs, Veteran and Youth Rehabilitation (MoSVY), National Authority for Combating Drugs (NACD), UNICEF, WHO, and CSOs such as KHANA and Population Service Khmer (PSK).

Furthermore, there are three main sources of data which were being used for this narrative report and online report: (A) NCHADS database 2014, (B) AIDS Epidemic Model (AEM), and (C) Spectrum V5.30.

Table 1. Summary of GARPR Indicators for 2014-2015

Indicators	GARPR 2014			GARPR 2015			Status
	Value	Source	Online data	Value	Source	Online data	
Target 1: Reduce sexual transmission of HIV by 50% by 2015							
General population							
1.1 Young people: Knowledge about HIV prevention	44.2%	CDHS (2010)	Completed	39.6%	CDHS (2014)	Completed	↓
1.2 Sex before the age of 15	0.36%	CDHS (2010)	Completed	11.7%	GSHS (2013)	Completed	↑
1.3 Multiple sexual partners	0.47%	CDHS (2010)	Completed	0.7%	CDHS (2014)	Completed	↑
1.4 Condom use at last sex among people with multiple sexual partnerships	40.9%	CDHS (2010)	Completed	22.0%[5]	CDHS (2014)	Completed	↓
1.5 HIV testing in the general population	7.1%	CDHS (2010)	Completed	9.3%	CDHS (2014)	Completed	↑
1.6 HIV prevalence in young people	0.2%	HSS (2010)	Partially	0.1%[6]	NMCH (2014)	Completed	↓
Sex workers (entertainment workers)							
1.7 Sex Workers: prevention programmes							
1.7.1 Correct answer to question 1 "Do you know where you can go if you wish to receive an HIV test?"	75.7%	BSS (2013)	Partially	75.7%	BSS (2013)	Completed	—
1.7.2 Correct answer to question 2 "In the last twelve months, have you been given condoms?"	43.1%	BSS (2013)	Partially	43.1%	BSS (2013)	Completed	—
1.8 Sex workers: condom use	80.6%	BSS (2013)	Partially	80.6%	BSS (2013)	Completed	—
1.9 HIV testing in sex workers	68.3%	BSS (2013)	Partially	68.3%	BSS (2013)	Completed	—
1.10 HIV prevalence in sex workers	13.9%	HSS (2010)	Partially	13.9%	HSS (2010)	Completed	—
Men who have sex with men							
1.11 Men who have sex with men: prevention programmes	69.5%	BK[7] (2010)	Partially	58%	NCHADS 2014	Completed	↓
1.11.1 Correct answer to question 1 "Do you know where you can go if you wish to receive an HIV test?"	86.7%	BSS (2013)	Partially	86.7%	BSS (2013)	Completed	—
1.11.2 Correct answer to question 2 "In the last twelve months, have you been given condoms?"	49.2%	PSK (2012)	Partially	49.2%	PSK (2012)	Completed	—
1.12 Men who have sex with men: condom use	87%	PSK (2012)	Partially	87%	PSK (2012)	Completed	—
1.13 HIV testing in men who have sex with men	86.8%	BSS (2013)	Completed	86.8%	BSS (2013)	Completed	—

[5] CDHS 2014 reported only condom use among males.

[6] Guideline in GARPR 2015, the denominator must be from antenatal data

[7] BROS Khmer study (2010)

1.14	HIV prevalence in men who have sex with men	2.1%	BK (2010)	Completed	2.1%	BK (2010)	Completed	—
1.15	Number of health facilities that provide HIV testing and Counselling services*	N/A			924	NCHADS (2014)	Completed	
1.16	HIV Testing and counselling in women and men – children aged 0-14 years*	N/A			6,428	NCHADS (2014)	Completed	
1.17. Sexually Transmitted Infections (STIs)								
1.17.1.	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis	N/A		Not reported	44.9%	NMCHC (2014)	Completed	
1.17.2.	Percentage of antenatal care attendees who were positive for syphilis	N/A		Not reported	0.02%	NMCHC (2014)	Completed	
1.17.3.	Percentage of antenatal care attendees positive for syphilis who received treatment	N/A		Not reported	97.3%	NMCHC (2014)	Completed	
1.17.4	Percentage of sex workers (SWs) with active syphilis	N/A		Not reported	0.12%	NMCHC (2014)	Completed	
1.17.9.	Number of men reported with urethral discharge in the past 12 months	N/A		Not reported	18,132	HIS 14	Completed	
1.17.10.	Number of adults reported with genital ulcer disease in the past 12 months	N/A		Not reported	3753	HIS 14	Completed	
1.19.	Diagnosis of HIV and AIDS cases	N/A		Not reported	N/A		Incomplete	
2 Reduce transmission of HIV among people who inject drugs by 50% by 2015								
People who inject drugs								
2.1	Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	1,140	NACD (2012)	Completed	912	NACD (2014)	Completed	↓
2.2	People who inject drugs: condom use	65.2%	NACD (2012)	Partially	65.2%	IBBS (2012)	Completed	—
2.3	People who inject drugs: safe injecting practices	34.0%	NACD (2012)	Partially	34.0%	IBBS (2012)	Completed	—
2.4	HIV testing in people who inject drugs			Incomplete	15%	IBBS (2010)	Completed	

2.5	HIV prevalence in people who inject drugs	24.8%	NACD (2012)	Partially	24.8%	IBBS (2012)	Completed	—
2.6a	Estimated number of opiate users (injectors and non-injectors)	1170	IBBS (2012)		1170	IBBS (2012)	Completed	—
2.6b	Number of people on opioid substitution therapy (OST)	252	NACD (2013)		130	NACD (2014)	Completed	↓
2.7a	Number of needle and syringe programme sites	N/A			5	NACD (2014)	Completed	↑
2.7b	Number of opioid substitution therapy (OST) sites	1	NACD (2013)		1	NACD (2014)	Completed	—
3 Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths								
3.1	Prevention of mother-to-child transmission	72.3%	NMCHC (2013)	Partially	75.7%	NMCHC (2014)	Completed	↑
3.1a	Prevention of mother-to-child transmission during breastfeeding	N/A		Incomplete	43.1%	NMCHC (2014)	Completed	↑
3.2	Early infant diagnosis	45.4%	NCHADS (2013)	Completed	39.1%	NCHADS 2014	Completed	↓
3.3	Mother-to-child transmission of HIV (modelled)	7.11%	NCHADS (2013)	Completed	16.6%	SPECTRUM 5.0	Completed	↓
3.3a	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	N/A		Incomplete	24.6%	NMCHC (2014)	Completed	↑
3.4	Percentage of pregnant women who know their HIV status (tested for HIV and received their results-during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	73.4%	NMCHC (2013)	Incomplete	74.7%	NMCHC (2014)	Completed	↑
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	16.6%	MNCHC (2013)	Incomplete	16.8%	NMCH (2014)	Completed	↑
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	N/A		Incomplete	N/A	Option B+	Incomplete	---
3.7	Percentage of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks	73.2%	NMCHC (2013)	Incomplete	61.8%	NMCH (2014)	Completed	↓
3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	N/A		Incomplete	39.3%	NCHADS (2014)	Completed	
3.10.1	Number of infants born to HIV positive mothers (“HIV-exposed infants”) born in 2013 (or latest data available) Reported number of infants born to HIV-positive mothers within a defined calendar year (2013).	N/A		Incomplete	666	NCHADS (2014)	Completed	

3.10.2 Number of infants, born in 2013 (or latest data available) to HIV positive mothers, classified as indeterminate (i.e.: all lost to follow up, death before definitive diagnosis, indeterminate lab results)	N/A		Incomplete	120	NCHADS (2014)	Completed	
3.10.3 Number of infants born in 2013 (or latest data available) to HIV positive mothers that are diagnosed as positive for HIV	N/A		Incomplete	31	NCHADS (2014)	Completed	
3.10.4 Number of infants born to HIV positive mothers in 2013 (or latest data available) that are diagnosed as negative for HIV	N/A		Incomplete	324	NCHADS (2014	Completed	
3.11. Number of pregnant women attending ANC at least once during the reporting period	N/A		Incomplete	365,828	NMCHC (2014)	Completed	
3.12.1 Number of antenatal care facilities providing HIV testing and counselling services	N/A		Incomplete	924	NMCHC (2014)	Partially	
3.12.2 Number of antenatal care facilities providing HIV testing and counselling services and dispensing antiretroviral	N/A		Incomplete	62	Program Report	Completed	
3.12.3 Percentage of health facilities that provide virological testing services (e.g. polymerase chain reaction) for diagnosis of HIV in infants on site or from dried blood spots	N/A		Incomplete	100%	Program Report	completed	
4 Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015							
4.1 HIV treatment: antiretroviral therapy	68.0%	NCHADS (2013)	Partially	78.9%	NCHADS (2014)	Partially	↑
4.2a 12 months retention on antiretroviral therapy	84.5%	NCHADS (2013)	Partially	75.9%	NCHADS (2014)	Completed	↓
4.2b. Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	N/A		Incomplete	78.02%	NCHADS (2014)	Partially	
4.2c Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy	75%	NCHADS (2013)	Completed	74.6%	NCHADS (2014)	Completed	↓
4.3a Number of health facilities that offer antiretroviral therapy (ART)	61	NCHADS (2013)	Completed	62	NCHADS (2014)	Completed	↑
4.3b Number of health facilities that offer paediatric antiretroviral therapy	N/A		Completed	32	NCHADS (2014)	Completed	
4.4 Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months	100%	NCHADS (2013)	Completed	0%	NCHADS (2014)	Completed	↓
4.5 Percentage of HIV positive persons with first CD4 cell count < 200 cells/µL in 2014	N/A		Incomplete	44.4%	NCHADS (2014)	Completed	
4.6a Percentage of people on ART tested for viral load (VL) who were virally suppressed in the reporting period	N/A		Incomplete	7.2%	NCHADS (2014)	Completed	

4.6b Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy	N/A		Incomplete	N/A		Incomplete	
4.6c Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period	N/A		Incomplete	11.9%	NCHADS (2014)	Completed	
5 Reduce tuberculosis deaths in people living with HIV by 50% by 2015							
5.1 Co-management of tuberculosis and HIV treatment	1,100	CENAT(2013)	Partially	938	CENAT 2014	Partially	↓
5.2 Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	18.03%	CENAT (2013)	Completed	18.93%	CENAT 2013	Completed	—
5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	57.2%	NCHADS (2013)	Completed	23.6%	NCHADS 2014	Completed	↓
5.4 Percentage of adults and children enrolled in HIV care who had their TB status assessed and recorded during their last visit	2.45%	NCHADS (2013)	Completed	7.4%	NCHADS 2014	Completer	↑
6 Close the global AIDS resource gap by 2015							
6.1 AIDS spending	51M	NAA (2013)	Completed	51M	NAA (2013)	Completed	↓
7 Eliminating gender inequalities							
7.1 Prevalence of recent intimate partner violence	9.0%	CDHS (2010)	Partially	9.0%	CDHS (2010)	Partially	—
8 Eliminating stigma and discrimination							
8.1 Discriminatory attitudes towards people living with HIV	18%	CDHS 2010	Incomplete	18%	CDHS 2010	Completed	
10 Strengthening HIV integration							
10.1.1 Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	69.7%	CDHS (2010)	Partially	45.8%	EMIS 2014	Completed	↓
10.1.2 Current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent	81.5%	CDHS (2010)	Partially	80%	EMIS 2014	Completed	↓
10.2External economic support to the poorest households			Incomplete	8.55%	KHANA 2014	Completed	

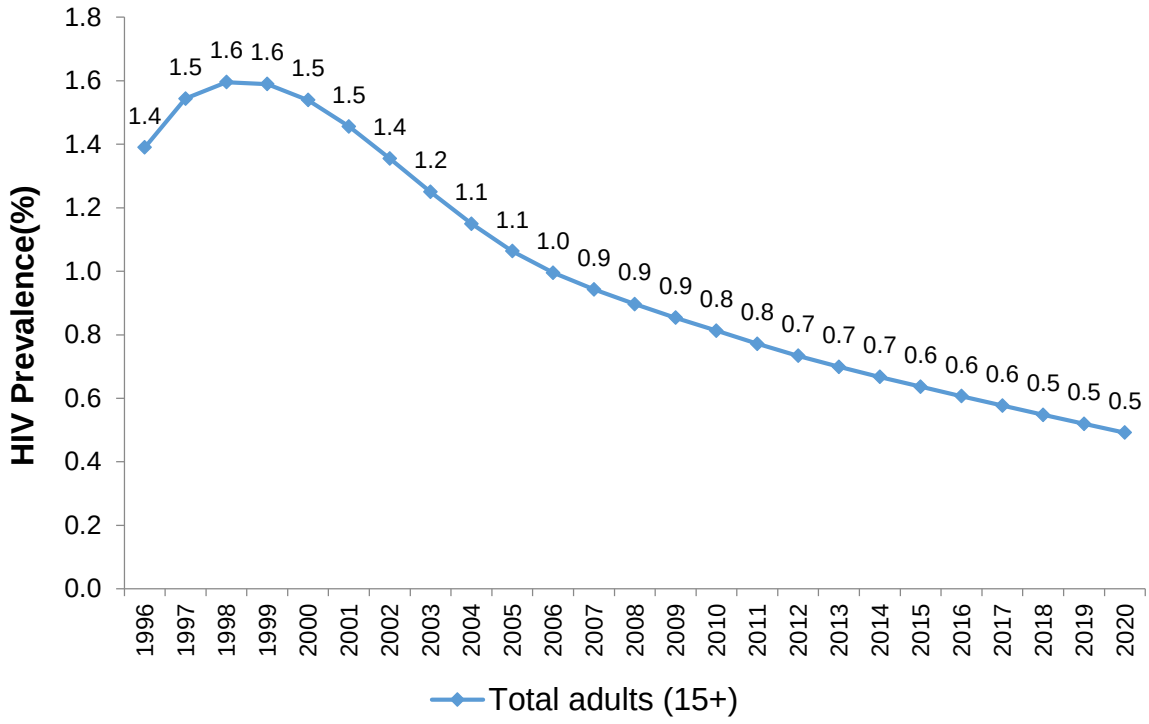
Note: ↓ decrease ↑ increase — stable; EMIS = Educational Management Information System

OVERVIEW OF THE AIDS EPIDEMIC

A. HIV Prevalence in the country

The HIV prevalence in Cambodia among general population aged 15-49 decreased gradually from 1998. The prevalence has dropped gradually after large scale program interventions across the country which led to drop in HIV prevalence among general population aged 15-49 to 0.9% in 2006 and 0.7% in 2013 [1, 2]. This reduction in HIV prevalence shows impact of high level coverage of antiretroviral treatment and HIV prevention programmes for general population over the last decade.

Figure 3: HIV prevalence among general population, aged 15-49



Source: AEM 2014: Impact Modeling and Analysis Cambodia case study

However, along with the decline in HIV prevalence among the general population, it was noted that KPs such as EWs, drug users, TGs and MSM has remained the target group that required special attention in the provision of prevention, care and treatment services. The prevalence of HIV among female entertainment workers (FEW) were down from 20.8% in 2003 to 13.9% in 2010 [8, 9]. The HIV epidemic among males having sex with males (MSM) went down gradually from 2.6% in 2005 and 2008 to 2.16% in 2010 [4]. On the other hand, the prevalence of HIV among TGs was 9.8% [10, 11, 13]. Moreover, the burden of HIV epidemic on drug users also came to the concerns for prevention, care and treatment

intervention. It is estimated that around 1,300 people inject drugs [12]. The HIV prevalence among people who inject drug (PWID) was 24.4% in 2012 [12] (See Table 2).

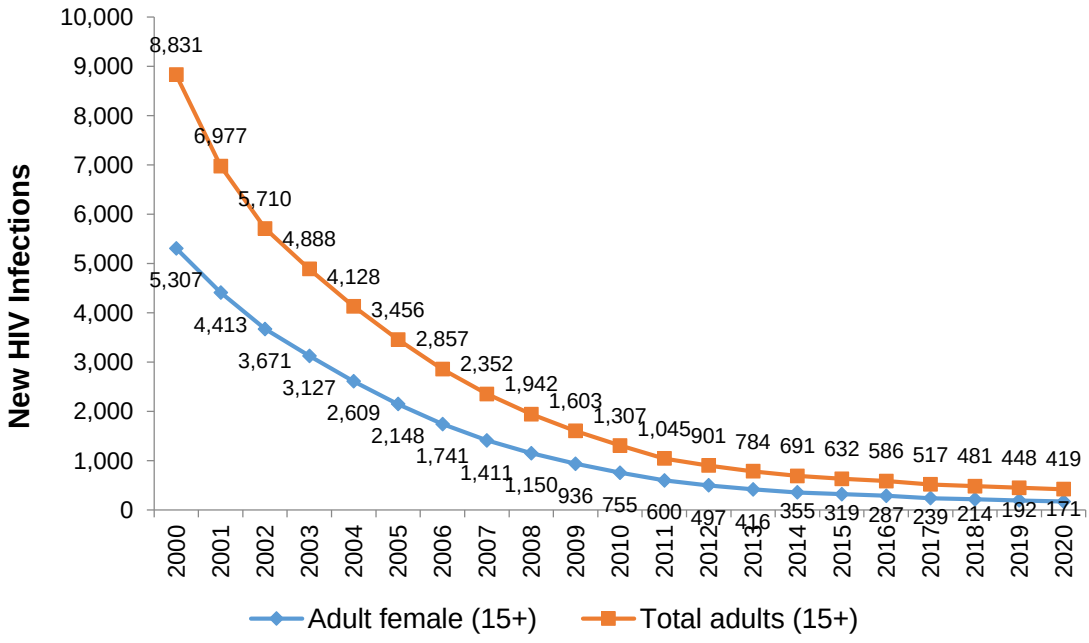
Table 2. The prevalence of HIV/AIDS among MARPs in Cambodia

Most-at-risk population	Estimated HIV prevalence	Data source
Men who have sex with men	2.1%	BROS Khmer study (2010) [12]
Female entertainment workers (Group 1)	14.0%	HSS 2010
Female entertainment workers (Group 2)	3.6%	HSS 2010
People who inject drugs	24.4%	IBBS 2012
Transgender sex workers	5.4%	IBBS 2012 [13]
Transgender with casual sex partner	2.7%	IBBSS 2012
Transgender with regular partner	1.8%	IBSS 2012
Transgender overall	9.8%	IBBS 2012
Prisoners	-	Not available

B. HIV Incidence in the country

Figure 4 shows the incidence of HIV infection among general population projected by NCHADS. The HIV incidence among general population went down from the highest number of 8,831 cases in 2000 to 419 cases in 2020. The number of female aged 15+ got new HIV infected were also going down to the prevalence of the graphs below show that HIV incidence has also been decreasing, among both adults and children.

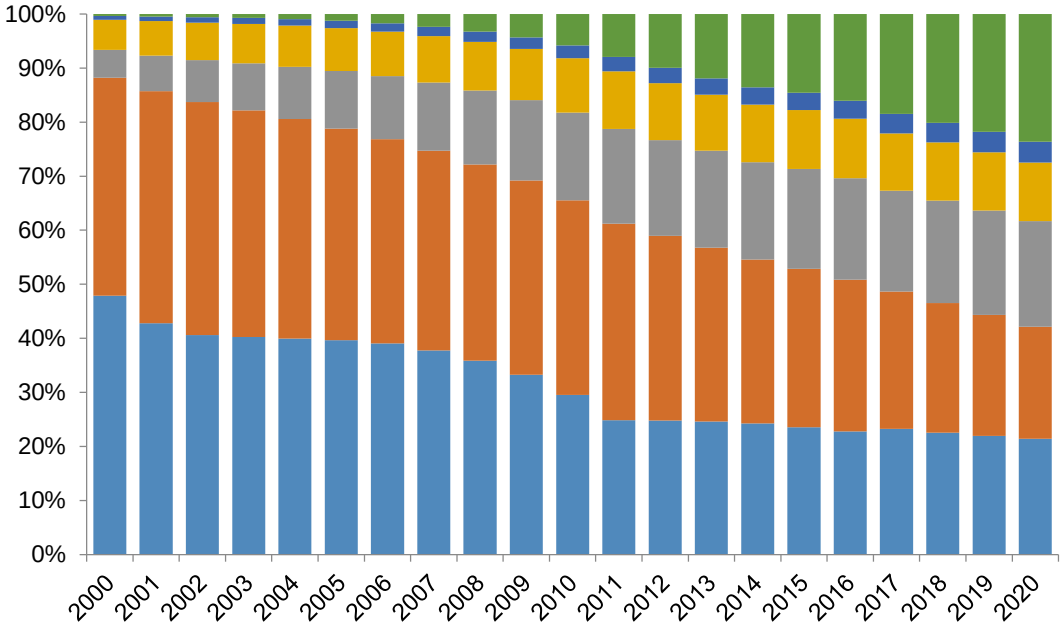
Figure 4 - Number of individuals and females aged 15+ newly infected with HIV



Source: AEM 2014: Impact Modeling and Analysis Cambodia case study [7]

Figure 5 illustrates the mode of HIV transmission among different groups of people. The HIV transmission among sex workers is still consistent since 2000. The mode of HIV transmission from wife to husband increases while from husband to wife goes down.

Figure 5. Number of new HIV cases by different modes of transmission, 2000-2015



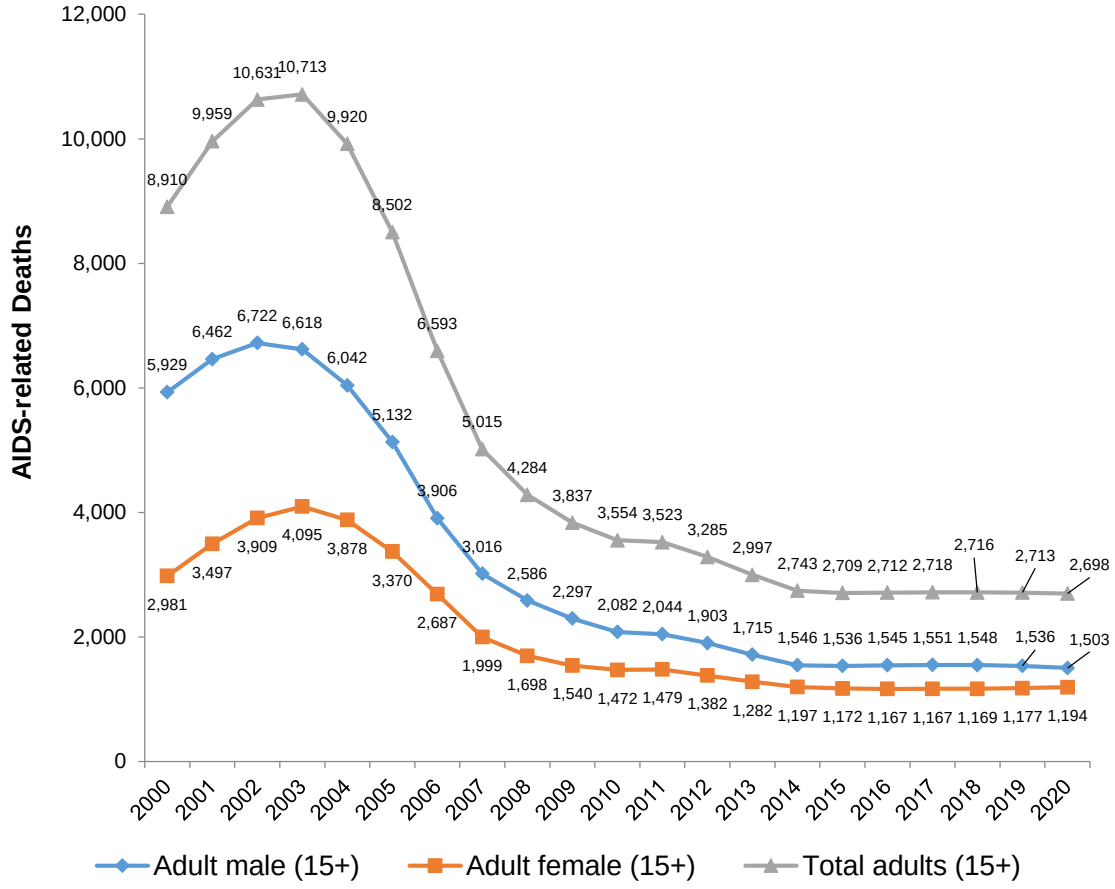
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
External infections	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Needle sharing	30	32	34	36	39	43	50	56	63	70	76	83	90	93	94	92	94	96	97	98	99
Male-male sex	62	60	57	54	49	46	43	40	37	34	31	28	26	24	22	21	19	19	18	17	16
Casual sex	493	447	396	356	315	275	236	202	175	152	131	111	95	82	74	69	64	55	52	48	45
Wife to husband	459	457	442	426	400	368	333	297	265	238	212	183	159	140	124	117	110	96	91	86	82
Husband to wife	3,559	2,994	2,461	2,048	1,676	1,353	1,080	868	706	576	471	380	308	252	209	186	164	131	115	100	87
Sex Work	4,229	2,987	2,320	1,969	1,649	1,371	1,116	889	697	533	386	260	223	193	168	149	133	120	109	99	90

Source: AEM 2014 – Mode of HIV trasmission

C. AIDS-Related Mortality

The trends for AIDS-related mortality have declined since 2003. The projection using AEM modeling tool shows that number of AIDS-related death cases among adults aged 15+ -is 2,698 in 2020 [7]. Figure 5 highlighted the number of AIDS-related cases among females aged 15+ were almost 44.3% out of the total cases. Overall, AIDS-related deaths among adults were projected to plateau after the steep decline before 2010.

Figure 6. Number of AIDS deaths among adults aged 15+, 2000-2020



Source: AIDS Epidemic Model, 2014

NATIONAL RESPONSE TO THE AIDS EPIDEMIC

A. Target 1: Halve sexual transmission of HIV by 2015

1. General population

The preliminary data from Cambodia Health Demographic Survey (CDHS) 2014 was published in early 2015. Few indicators were not yet ready to issue officially. In general population section, indicators 1.1 through 1.6 were recently updated based on three sources, namely CDHS, Global School Health Survey (GSHS) and antenatal care report based on the GARPR guideline. Indicator 1.2 was quoted from GSHS 2013 and indicator 1.6 was from antenatal registry or link response report [14].

Overall, the knowledge about HIV prevention was going little down among general population according to DHS 2010 and 2014 respectively. The knowledge about HIV prevention among young people in 2014 was 39.6% while it was 44.2% in 2010. Since DHS 2014 was not looking at the indicator of having sex before the age of 15, GSHS 2013 reported that 11.7% of school adolescents aged 13-17 year had sex before the age of 15 [19]. It was significantly increasing from 0.36% to 11.7%.

Interestingly, the multiple sexual partners among general population increased almost double (0.7%) compared with DHS 2010; while the condoms use at last sex among people with multiple sexual partnerships decreased almost double (22.0%). Furthermore, the HIV testing in the general population went up over 2% comparing with CDHS 2010 [23].

2. Sex workers (Entertainment workers)

There was no new data for EWs. The most recent relevant data for indicators related to EWs come from the BSS 2013 and HSS 2010. However, the program estimation projected that there are 34,400 EWs across that country [7]. As mentioned earlier in this report, the closure of brothels in 2008 made it harder to identify and reach women engaged in sex work. Many women who previously sold sex directly moved to entertainment establishments such as karaoke bars, beer gardens, casinos, bars, and night clubs, and have therefore been reclassified as “entertainment workers”. AEM 2014 classified the sex workers into two typologies. Group 1 includes sex workers who have 7 or more clients weekly and Group 2: includes those who have clients less than 7 per week.

It was estimated that around 0.83% of adult female aged 15-49 are involved in sex workers. Since the group of them were clearly distinguished, around 11.3% (3,800) of them were female sex worker group 1 and 88.7% (30,200) were in group 2. Prevention programme to reduce HIV transmission include:

a. **Condom distribution and use**: Condom use among sex workers with their last paid client has remained stable. The consistence of condom use among EWs with their last clients were over 80% according to BSS 2013.

b. **HIV testing in sex workers**: HIV testing is intended to reach all KAPs including sex workers. According to BSS 2013 68.3% of sex workers were tested for HIV in 2013.
c. **Sexually transmitted infections (STIs) care and treatment**: Not only EWs, but also pregnant women are required to have STI and syphilis tested. There is no specific study done so far. The data reported just only monitoring report from NCHADS 2014. Which indicates that 0.12% of sex workers had contracted active syphilis in 2014.

3. Other prevention promotion at the community level: New initiatives have been rolled out in recent years targeting EWs. Among these is the national Cambodia 3.0 strategy which aims to eliminate new HIV infections by 2020, in part by improving and better targeting prevention services for KPs through the implementation of the Boosted Continuum of Prevention to Care and Treatment SOP along with several initiatives such as finger prick testing, partners tracing, etc. In order to ensure that services can be provided well to KPs (including EWs) a comprehensive GIS Mapping exercise of KPs was conducted in late 2013 by the Flagship Team covering Phnom Penh (all five operational districts) and five hotspot provinces.
4. Men who have sex with men (MSM)
   Similar to female sex workers and MSM data are not directly comparable from GARPR 2014 to 2015 in terms of knowledge and HIV testing. The total size of MSM in the country is estimated to be 2.5% (102,600) of adult males aged 15-49 years. Among this number only 20,000 is considered to be reachable and are targeted by the HIV prevention programmes. .

   a. **Condom awareness and use**: Since there is no new data for GARPR 2015, the proportion of MSM using condom is still the same (87%) while the knowledge regarding where to get condom is the same as reported last year (BSS 2013).
   b. **HIV testing in MSM**: The available data show an increase in the proportion of MSM who know where to get an HIV test, from 80% in 2010 (BROS Khmer study) to 87% in BSS 2013.

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

The HIV transmission reduction among people who inject drugs (PWID) in Cambodia is challenging due to certain programmatic and policy barriers. The number of needles and syringes distributed person per year was 1,140. However, the number goes down in 2014 using program report data to 912.

Efforts to reduce HIV transmission amongst people who inject drug have been hampered by the current legal and policy environment (i.e. the Law on Human Trafficking and Sexual Exploitation, the Village Commune Safety Policy, and most recently, the new law on drug

control) which have driven people underground, while at the same time disturbed current needle and syringe programme (NSP) service delivery. There are not many studies on PWID in the country. The 2012 size estimation and IBBS suggests that there are around 1,300 PWID in the country, of whom more than 90% are believed to be opiate injectors.

A recent preliminary exploration of unreached PWID in Phnom Penh suggested that apart from EWs who inject heroin, there are also other PWID amongst other populations such as rubbish collectors, construction workers, etc., that have not been reached by any NSP. Having found those, the government and some NGOs have been implementing some activities to reduce the HIV transmission among PWID stated in harm reduction policy as following:

a. **Needle and Syringes Programmes (NSP)**: The NSP is being implementing by two main NGOs in Cambodia (KHANA and Friends International). Both of them are implementing the programmes in Phnom Penh. It was estimated that 1,170 PWID are opioid user and 130 of them are on OST (opioid substitution therapy). This number dropped from 252 in GARPR 2014. The total sites of NSP are 5.
b. **OST drop-In centers**: OST is provided through a single site in Phnom Penh located in the Khmer-Soviet Friendship Hospital.
c. **Condom use**: The outreach model uses outreach workers and peers to reach the target population. There is a condom vending machine at the fix-site to sell condom and to dispense needles and syringes. Condom use demonstration has been integrated in the outreach activities.

C. Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

Elimination of mother to child transmission policy has been implemented and adopted in Cambodia using the strategy of Link Response. It is implemented nation-wide under the guidance of National Center of Maternal and Child Health (NCMCH). NCMCH is the implementer to rollout the activities in collaboration with NCHADS. As a result, using the programme monitoring report, the coverage of PMTCT was 72.3% in GARPR 2014 and 82.1% in GARPR 2015. At the same time, around 45.4% of children born to HIV+ mothers were diagnosed of HIV in GARPR 2014 and 36.8% in GARPR 2015. Some of the achievements of the response made so far:

a. **Antenatal care package**: 924 (100%) of health facilities including health centers and hospital provided the HIV testing and counselling services to all pregnant women in every visit for their ANC. At the same time, Cambodia also ensures that husbands of pregnant women have HIV tested. As a result, around 17% of male partners were tested for HIV.

   Finger prick testing implementation in the communities has been initiated recently in order to scale up HIV testing. Additionally, syphilis screening at health center level is also done using the test strip. There are around 44.9% of pregnant women

accessed to syphilis testing in 2014 and 0.02% of them were syphilis positive. Over 97% of them received syphilis treatment.

b. **Safe Delivery and Postpartum Care**: Since Cambodia adopted and implemented Option B+, the percentage of pregnant women with known status get delivered the babies and received the ARV increased by almost 10% compared with GARPR 2014. However, the breast feeding went down a little to 39.1% in 2014. In the meantime, 74.7% of pregnant women who known their HIV status were tested for HIV and received results during pregnancy, during labour and delivery, and during postpartum period (72 hours).

   Using SPECTRUM 5.30 to generate the numerator and denominator, it was estimated that 156 children are newly infected as nominator. The denominator was guided to use number of HIV positive women who delivered in the previous 12 months. Around 16.0% of children HIV infections were estimated to deliver from HIV-positive women in the last 12 months. However, the program implementation found that approximately 24.6% of children were newly HIV infected using the denominator provided in SPECTRUM 5.30.

c. **Child Care:** Initially, the early infant diagnosis (EID) was managed by NCHADS. Proximately, 39.1% of children were receiving the EID. At the same time, the proportion of infants born to HIV infected women provided with ART prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks were 61.8%. This figure dropped from 73.2% in GARGR 2014.

D. Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

1. ART coverage

Cambodia currently implementing the guideline of CD4 at 350 among general population and option B+ for PMTCT. The current coverage of ART is around 78.9% for adults and 74.6% for children. The current responses to the target number 4 in order to reach the goal, Cambodia has introduced: The treatment guidelines are being revised in 2015 and the country will adopt WHO 2013 guidelines this year.

a. The relatively high coverage of ART among those eligible for treatment can be attributed to solid political commitment, as well as the strong collaboration between health facilities and the communities which are built into national strategies. Such strategies include the Boosted Continuum of Care and Treatment, and Treatment as Prevention, both of which have been rolled out in the past two years.

b. In order to maintain high coverage and quality of treatment services, Cambodia has in 2014 phase out D4T, increased the number of ART sites, and expands services to closed settings to endure access to treatment.

2. ART retention

ART retention at 12 months decreased slightly from 84.5% in GARPR 2014 to 75.9% in GARPR 2015. Furthermore, the retention at 60 months is the same level at 75% both in GARPR 2014 and 2015. One possible factor that could be contributing to this reduction in ART retention may be the migration of Cambodians to neighboring countries or across the nation and not adhering to treatment and reported as lost to follow up.

The government has been collaborating with related partners on activities which should increase retention in the near future. Currently, 6 provinces have been equipped and trained on a unique identifier system, which should decrease loss-to-follow-up by making it easier to track patients through the health system. Further, active case management (ACM) for PLHIV has been piloted, which would also decrease loss-to-follow-up and ensure timely access to ARVs. ACM is now being expanded from 15 ODs to 33 high priority ODs.

In 2013, WHO released new guidelines which set the eligibility for ART at a CD4 count of 500 cell/mm^3. When Cambodia adopts these guidelines, there will be an increase in the number of people who are eligible for ART. In the coming years, attention will need to be given to securing sufficient resources to ensure an adequate supply of ARVs, improving treatment adherence and reduce drug resistance, and introducing second and third line regimens. Potential actions to contribute to these include strengthening procurement and supply management capacity and performance, and utilizing public health-related TRIPS flexibilities to ensure continued access to affordable generic ARVs.

Guided by the global guidelines and the implementation of Cambodia 3.0, the 2013 Health Sector HIV Program Review helped identify priority actions to accelerate case detection, maximize retention, and prepare for sustainability. NCHADS came up with the following game changers to address the prioritized action on continuum of prevention, care and treatment by a) empowering community for Finger-Prick Testing among KPs to accelerate case detection, b) engaging key implementers across continuum of care to maximize retention and c) innovating monitoring system to track cases throughout HIV cascades.

E. Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

The Co-management of tuberculosis and HIV treatment was calculated from the routine monitoring data from CENAT in 2014. Only 938 cases were reported on co-management of TB and HIV treatment. The percentage of adults and children living with HIV newly enrolled in care did not see any significant increase compared with GARPR 2014 at 18.9%.

The percentage of referral cases for both sides (TB and HIV and AIDS) increased gradually from 40% in 2007, to 70% in 2009, and to over 80% in 2011-2012 (source: CENAT 2014). The proportion of HIV+ incident TB cases receiving treatment for both HIV and TB decreased from 57.2% in GARPR 2014 to 23.6% in GARPR 2015. This may be an underestimate of the actual proportion of co-infected case receiving treatment, since this percentage is based only on data from CENAT and not from NCHADS. Stratified data by age and gender are not available for this indicator.

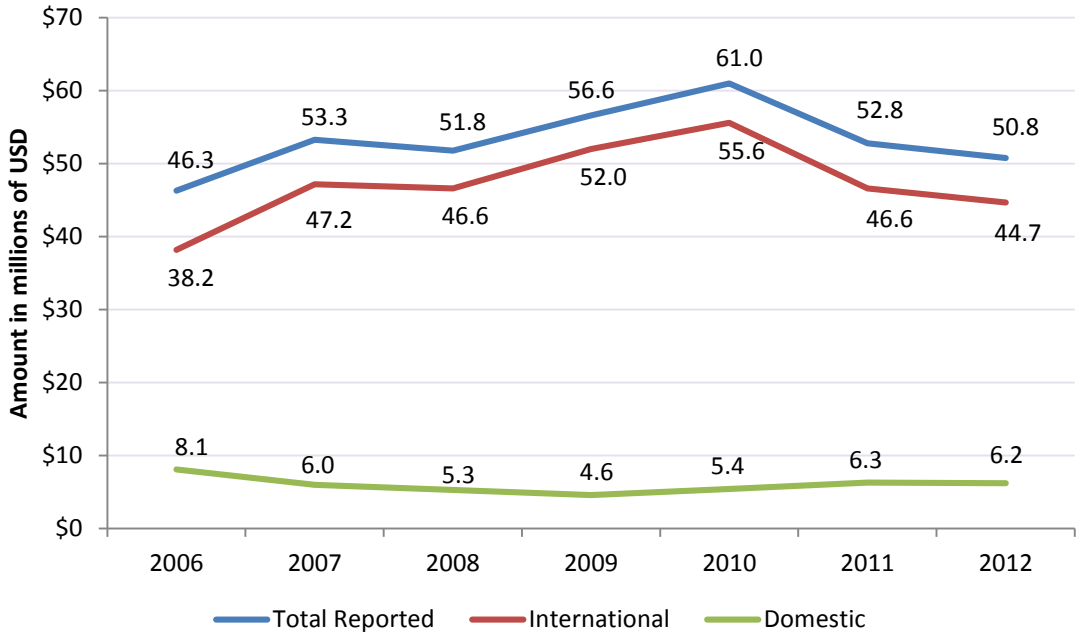
Cambodia has made progress towards this target in recent years, through continued implementation of the three I's strategy (intensified case-finding, Isoniazid preventive therapy, infection control) and expansion of TB control activities to closed settings. The national clinical guidelines for HIV-TB management have also been revised.

However, there is still a need to strengthen reporting and coordination between the OI/ART clinics and TB clinics in order to provide more accurate data for future analyses and decisions. There are also challenges in terms of finding sufficient funding to provide incentives for staff and to implement the strategic plan for TB. Furthermore, TB detection and case management in closed settings need to be further improved, as stated in the SOP for HIV, STI, and TB-HIV prevention, care, treatment, and support in prisons (and correctional centers) in Cambodia.

F. Target 6: Close the global AIDS resource gap by 2015

The fifth National AIDS Spending Assessment (NASA V) has not yet conducted, due to no fund support. Thus, there was no new data to report on the NASA for GARPR 2015. The newest data was the data from NASA IV (covered 2011-2012). HIV spending in Cambodia has been tracked since 2006 through the National AIDS Spending Assessments. The graph below shows a general trend of increasing funding for HIV/AIDS from 2006-2010, after which spending dropped significantly, primarily due to decreases in funding from international NGOs and the UN.

Figure 7: Total spending on HIV and AIDS, 2006-2012 [15][8]



The Cambodian national HIV/AIDS response still relies for almost 90% of its funding from external sources, although the proportion of funding for the HIV/AIDS response coming from the government has increased.

Further details about spending on HIV and AIDS are provided in the section of this report titled "Support from the country's development partners".

G. Target 7: Eliminating gender inequalities

1. Progress made

In 2014, the following progress was made in the efforts to eliminate gender inequalities and gender-based abuse and violence at the policy level:

- Approval of the 2nd National Action Plan to Prevent Violence Against Women, which is HIV-sensitive.
- MoWA Policy Brief on Gender and HIV developed and launched in 2014.
- Reformulation of the National Policy on Women, the Girl Child and HIV/AIDS/STIs, to reflect changes in the epidemic and in the policy environment, initiated.
- "Gender Analysis in the HIV/AIDS Response"- report initiated in support of developing gender-specific inputs for NSP IV (to be developed in 2015).
- Working Conditions, Occupational Safety and Health Rules of Entertainment Service Enterprises, Establishment and Companies-Prakas no: 194 adopted in August 2014.

[8]Note that the NASA for 2009 and 2010 (NASA III) did not collect government salary data. However, the 2009 and 2010 totals in this graph include *estimates* of government salary expenditure in order to make them comparable to the other years. This is why the totals in this graph for 2009 and 2010 are higher than what is shown in the NASA III report.

At the operational/programming level, activities reported on in the previous GARPR report have for the most part continued[9]. In addition, the following progress has been made:

- Three Smart Guides developed for trade unions on non-discrimination and equality, maternity protection and action against sexual harassment and violence at work.
- The first "National Guidelines for Managing Violence Against Women and Children in the Health System" developed.
- Capacity development of WLHIV and female MARPs for joint advocacy and communication to support engagement in policy dialogue processes.
- Enhanced collaboration between gender equality- and HIV- NGOs and community networks, including in the context of CEDAW dialogues and 2nd National Action Plan to End Violence Against Women (NAPEAW) implementation planning.

In the area of monitoring, evaluation and research, the following progress was made:

- Finalization and launching of the National Prevalence Study on Violence Against Children.
- Finalization and launching of the "Being LGBT in Asia: Cambodia Country Report."
- Initiation of the CDHS, including indicators related to HIV as well as GBV, and data collection.
- Initiation of a National Prevalence Survey on Violence Against Women.
- Capacity development for gender-responsive monitoring and evaluation of HIV at national level implemented.
- Preliminary discussions initiated to include GBV within the IBBS for key populations to enhance understanding of issues and help design policies and programming.

2. Challenges

The relationship between HIV and gender inequality/GBV remains a significant issue in Cambodia. Regressive gender norms and -expectations have a negative influence on risky behaviors among both women and men, and on their access to resources required for advancing their status. This is not well captured through the national M&E system at present.

While integration of gender and HIV has moved forward, including in the context of MoWA policy processes detailed above, limited funding and capacities for implementation of programming is an issue.

[9] With the exception of HIV-specific economic empowerment programming for WLHIV, which has been down-scaled considerably, with a push towards HIV-sensitive, integrated approaches, partly due to a decrease in vertical HIV funding.

Capacities particularly at sub-national levels for gender-responsive planning, monitoring and evaluation of the HIV response, and for linking HIV with GBV response as well as with SRH programming responsive to the specific needs of women and girls in line with national guidelines and agreed procedures, are limited.

Awareness among female key populations of their rights and entitlements needs further strengthening in order to increase demand for services and to protect their health and wellbeing.

3. Remedial actions

Remedial actions to respond to challenges in the response to eliminating gender inequalities, additional to those reported on in 2014, include:

- Strengthen availability of data on linkages between gender inequality, GBV and HIV and female KAPs, including through the 2015 IBBS among entertainment workers.
- Develop capacities for gender-responsive, CEDAW compliant planning, M&E and budgeting for the HIV response.
- Continue to promote integration of HIV within gender equality programming, including in the context of the 2nd NAPVAW and awareness-raising and reporting related to CEDAW.
- Specifically, develop capacities for development of gender-responsive M&E Framework for NSP IV.
- Advocacy for increased domestic budget to gender and HIV activities at national and sub-national levels.
- Reformulation of National Policy on Women, the Girl Child and HIV/AIDS/STIs by MoWA, addressing the need for strengthening linkages and integration (in process of finalization).
- Develop capacities of female KAPs on their rights and entitlements, including for participation in local decision-making processes.

H. Target 8: Eliminating stigma and discrimination

This indicator was reported based on what CDHS 2010 stated in GARPR 2014. The questionnaire in CDHS 2010 was same in term of close-ended questions by answering “Yes, No, don’t know”. However, regarding the stigma and discrimination indicator is looking at reversed question generating to “No”. There is no new data from CDHS 2014. This indicator was not reported in the CDHS 2014 preliminary results. Therefore, around 18% of PLHIV found that they were discriminated.

Although there are no new data for this indicator which is based on the CDHS, the introduction of game changers in the continuum of prevention to care and treatment, and

universal access to ART might have some positive impacts on the progress towards reducing discriminatory attitudes, and support for anti-discriminatory policies. Accelerated HIV case detection, efforts to maximize retention on ART, the introduction of the Cambodia 3.0 framework, and the application of new testing and counseling technology and approaches (e.g. Community Peer Initiated Testing and Counseling (CPITC) and finger prick testing are contributing to dramatic changes in the landscape of health care services for PLHIV and all HIV-affected households in the country.

I. Target 10: Strengthening HIV integration

Data for this indicator were extracted from CDHS 2010 for GARPR 2014. However, since there was no new data, the team decided to use the data from Education Management Information System (EMIS) and MoEYS monitoring data and ID-Poor program from Ministry of Planning for this reporting period. The percentage of school attendant rate of orphans aged 10-14 primary school age and secondary school age were 45.8% (EMIS, 2014). The school attendant rate of children at the same ages whose parents are alive and who live with at least one parent were 80%. The EMIS report and CDHS 2010 looked similar among those who had parents, but the proportion dropped down among orphans.

There was no new data for the schooling of HIV affected households in EMIS. EMIS reported only number of student enrolled and class as well as the location of the school. Only the data available from 2010 which was done by UNDP. This data was reported in GARPR 2014. For GARPR 2015, the old data was used.

Regarding the phase out of direct food support to HIV and AIDS-Affected households in December 2012, the indicator 10.2 (external economic support to the poorest households) were still included in this GARPR. It is hard to provide data for this indicator when external economic support is defined as free economic help (cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter). Some community base NGOs were still working on and tried to support. As a result, only 8.55% were receiving the support from external supporters, KHANA

BEST PRACTICES

Cambodia during the last two years of implementation of HIV prevention and treatment services has learnt a lot from the implementation of active case management (ACM), identifying the new approaches to prioritization to maximize impact.

AMC is a specific client-oriented approach to better respond to individual needs along the HIV service cascades. It is a proactive activity under the coordination and responsibility of the operational district Case Management Coordinator (CMC) in collaboration with other prevention, treatment, and care networks. It cuts across all service delivery areas, at each

step of the prevention, diagnosis, care and treatment cascade, and aims to provide appropriate support to individual cases to receive needed HIV services. It requires proactive monitoring and communication mechanisms to identify cases in need of specific follow-up and share the information through the CMC. Adoption of the ACM approach represents a shift from mass management of HIV cases to individual case follow up in order to maximize retention at all stages of the cascade. Currently, NCHADS has implemented the ACM in 15 ODs and has planned to expand it to additional 18 ODs to cover all the 33 high priority operational districts.

MAJOR CHALLENGES AND REMEDIAL ACTIONS

A. Funding for HIV response

High dependence of the national response on external resources particularly on GFATM and with its drastic and sudden decline in 2014 required a significant budget reprogramming, strong prioritization for more effective and cost efficient approaches, advocacy for national funding and intensive work to adopt a more targeted and focused approach in prevention and treatment, care and support strategies and programmes implementation. .

B. Institutional and Human Capacity

The service provision is one of the key challenges for all key players. The staff retention and capacity at both national and sub-national level is a big challenge for the national response. NCHADS and development partners have built the capacity of staff over the years however, with the declining resources and lack of incentives for staff some competent staff has either left or leaving the HIV sector while on another hand retirement of the more experienced staff is ongoing as a regular process and leading to human resource shortage. So far NCHADS and Ministry of Health (MoH) have been implementing several remedial measures to address staffing issues including:

- ✓ Recruitment of the new generation of medical doctors to work in provinces: this is really challenging because most of new medical doctors need to train and take over the responsibilities. The staff deployment from MoH would be slow due to several factors related to administration. Sometimes, the staff moved out from the province due to salary and benefits.
- ✓ Recruitment of contracted staff to work full-time on information technology (IT) was difficult to overcome because of most IT staff do not want to work in the province. The people in the province had limited knowledge on IT, especially managing the database.

C. Enabling environment (social protection, legal barriers and gender issue)

In the light of the evolving HIV epidemic in Cambodia, revisions are planned for implementation during 2016 and 2017 in order to help address challenges with the enabling environment for the successful implementation of outreach activities for key affected populations. From on-going work on the National Strategic Plan developing challenges have been identified, such as the needs of an increasingly mobile population. ASEAN integration, improved transport links, better educated and skilled young people all suggest that this will be an area requiring greater vigilance. Also to ensure that the costs of reaching the remaining MARP Community Partnership Initiative (MCPI) eases the path for key preventative NGOs working in this complex area.

The revision also is designed to incorporate the lessons learnt from the evaluation of the initial implementation, with early feedback suggesting that these include:

- ✓ results of the formal evaluation against the 2010 baseline study, initial feedback suggest a major change where training has been comprehensively implemented notably among PWID;
- ✓ changes in the method of delivery of training, notably to more actively include community groups including KP in the service delivery through role play;
- ✓ an alignment of the MCPI mechanism with the revised network of Outreach Workers (OWs) in the Prioritizing Interventions and Management for KP and Community Support Volunteers (CSV) of the Community Based for Prevention Care and Support (CBPC) of NCHADS;
- ✓ inclusion of frontline police officers as well as police leaders in relevant training

1. Social Protection

There is an ongoing need to ensure that existing and developing social protection schemes in Cambodia are HIV-sensitive and HIV affected population are considered in these schemes. The National AIDS Authority with the support of UNAIDS and UNDP is working with implementing Ministries to embed HIV sensitive criteria in any social protection programmes and schemes, as recommended by UNDP report: HIV Sensitive Social protection: A Review of Cambodia's social protection schemes for incorporating HIV sensitivity (2013). Two key areas are prioritized:

a. The inclusion of an accounting code in the Commune Development Plan. The inclusion of this code will allow allocation for HIV services from commune level budgets. This requires advocacy with the Ministries of Planning, Economy and Finance, and the Council for Agriculture and Rural development.
b. Advocacy with Ministry of Planning to ensure that PLHIV, especially those in urban areas and not living in family households, as well as female-headed HIV-affected households are eligible for the ID poor social protection scheme. Follow up work at the sub-national level in priority provinces to ensure the

implementation of these schemes forms the second element of this intervention.

2. Removing Legal Barriers

In order to improve access to HIV services for KAP, in particular PWID and PWUD, MCPI and associated operating procedures will be revised to reflect and cater for recent changes including the Village-Commune Safety Policy, Anti-human trafficking Law, the Drug law and Commune Based Treatment. Implementation of the revised initiative will be supported in 32 hotspot Operational Districts in 16 provinces, with evaluation through KAPs network and the stigma index, (last carried out in 2010). Revision will be enabled through inter-ministerial meeting with technical assistance to revise the MCPI and develop revised operation procedures, followed by implementation meetings in hotspots with evaluation via KAPs network and the stigma index.

3. Gender issues

Levels of tolerance for GBV are high among women and men in Cambodia as demonstrated by the 2010 CDHS, and the 2013 Partners For Prevention Survey [18], which indicated that male perpetration of sexual violence and rape against women and girls persists at a high level (>20%) in Cambodia. Not much is known of specific experiences of GBV among KAPs, in response to which the draft NSP IV activities incorporate the generation of data on GBV, and discussions are in process to integrate related indicators on GBV (and access to contraception) within the IBBS in support of designing effective, targeted approaches for different KAPs. At a general level, the forthcoming SDGs and their localization process will provide an opportunity for joint planning and reflection on data needs and gaps vis-à-vis gender inequalities, abuse and violence, and how to address these.

There is a need to scale up prevention interventions and increase the availability of legal aid for all women and girls who are victims of gender based abuse and rape, as this is currently not available across the country. Planning for these is underway in the context of the 2nd NAPVAW implementation planning, with HIV stakeholders also participating in this process.

Overall, there is also a recognized need to increase awareness of women's human rights including among authorities and service providers as well as female KAPs themselves and to enhance understanding of key national and international legal frameworks. Such efforts are taking place, and examples include CEDAW related capacity development and monitoring and reporting led by the Cambodian National Council for Women (CNCW); training for members of the Bar Association, which includes learning on CEDAW; "Know Your Rights"-trainings for KAPs organized by NGOs and CBOs; and

national and sub-national dialogues and consultations led by NAA, MoWA (for example: in the context of participatory policy formulation) and NGOs, involving service providers, authorities and community members.

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

A. Key support received from Development Partner

Well-targeted programmatic and financial investment efforts are needed to realize the goals of NSP-IV including the health sector strategic plan particularly in light of significantly reduced investments from bilateral and multilateral partners including the Global Fund. While there has been a steep decline of new HIV infections from 1995 to 2014, the recent AIDS Epidemic Model (AEM) indicates that if current successes can be maintained and as more targeted and focuses approach adopted - new infections are likely to be less than 300 cases per year by 2020; thereby accomplishing Goal 1 of the national strategy.

The HIV response in Cambodia has relied heavily on the on-going support of external resources primarily the GFATM, and USG via their PEPFAR program. However a sudden and significant reduction of resources anticipated from the Global Fund, combined with a steady decrease of USG funding has rallied all partners to better maximize the impact of HIV services. Overall there has been a decreasing trend between 2013 and 2017 in external resources targeting HIV and AIDS, and there are no major financial commitments other than USGPEPFAR and the Global Fund (GF) beyond 2014.

The PEPFAR HIV Flagship Project has recently confirmed a decrease in funding for the coming period 2015-2017 translating into a 27.7% decrease by USG when comparing 2013-2014 with 2015-2017. Similarly over the same periods GF has also reduced their commitment by around 26.8% [17].

While funding expected from other donors is considerably smaller than allocations from GF and USG, the impact has been heightened with a combined 55.3% decrease comparing the same periods 2013-2014 and 2015-2017.

The cessation of the Australia Government's HAARP program from December 2014 has meant that activities under HAARP particularly MMT treatment services have been absorbed by the RCG, with only transport costs for PWID and NSP services included in this request. The RCG will absorb some anticipated small additional costs for opioid substitution therapy (OST). The USAID funded PEPFAR HIV Flagship program has been underway in Cambodia since 2006 and together with GF represents the bulk of external financing to the HIV program.

The Flagship program has been implemented via KHANA comprising a consortium of international NGO's including PSI and FHI360. The Flagship Program will focus on high-risk groups (MSM, TG, and EW). HTC activities for MSM and TG are co-financed with 11% provided by the Flagship program, while a corresponding 26% of costs are also supplemented by Flagship to deliver the core prevention package and innovation package to EW (please see section 3.2 KAP prevention and links to health services for detail on stratified core prevention package and innovation package). In collaboration with the US-CDC and other technical partners PEPFAR Cambodia will provide technical assistance to improve laboratory capacity and quality for HIV care and treatment, and improve the ability of the MoH to collect and analyze information about the HIV epidemic. Development partners including GF funded projects have worked in close coordination with the PEPFAR Flagship program to maximize efficiencies for targeted interventions.

The UN organizations will continue to support the national response from the platform of the Joint UN team on AIDS (JUTH) chaired by UNAIDS with thirteen UN agencies as members, supporting Government, NGOs and Community Based Organizations through an annual work plan based on national priorities. All JUTH members follow a globally agreed UN division of labor at country level and provide support according to their area of expertise.

Francais Expertise Initiative (FEI) 5% on behalf of the French Government has supplied technical assistance to the MoH disease programs including HIV/AIDS in the development of Concept Notes to the GF. The Clinton Health Access Initiative (CHAI) has been involved in supporting provision of technical assistance for PMTCT and as well as strengthening the procurement system management (PSM) chain (quantification, forecasting and Logistic Management Information system (LMIS)) and will continue to work in these areas to 2017.

B. Actions taken by development partners to ensure achievement of targets

The Concept note to Global Fund in early 2015 partially addresses the financial needs of the Health Sector National HIV Strategic Plan 2015-2020. The RGC allocation will continue to contribute to the provision of salaries for health staff, maintenance and operating expenses of offices at central, provincial and district levels. UNAIDS and other partners are advocating with the Government of Cambodia for more public sector allocation beyond 2017 when GFATM and other partners support is expected to decline further. UNAIDS is partnership with the NAA, NCHADS and other partners are working towards development of advocacy material using the AEM outputs to develop evidence informed advocacy material to be used for resource mobilization internally as well as with external donors.

MONITORING AND EVALUATION ENVIRONMENT

A. An overview of the current monitoring and evaluation (M&E) system

Significant progress has been made in the past few years with the development of one single, coherent M&E system to obtain strategic information from different sources (i.e., surveillance, routine monitoring, research, evaluation, modeling) to track progress made through the national response to HIV and AIDS in Cambodia. The importance of M&E is now better recognized by stakeholders.

Efforts to strengthen the national M&E system have been guided by Strategy 6 of the NSP III whose aim is to "ensure availability and use of strategic information for decision-making through monitoring, evaluation and research". This strategy is articulated around the 12 elements of a functional HIV/AIDS M&E system.

The NAA is responsible for overall coordination of the national multi-sectoral M&E system. It also has a central data storage function and the role to produce and disseminate information on progress made by the national response as a whole, across different sectors. The Planning, Monitoring, Evaluation and Research Department (PMERD) of the NAA deals with strategic planning and M&E/research issues.

NCHADS/MoH collects health sector data regarding prevention, treatment and care and together with NMCHC/MoH gathers PMTCT data and with CENAT/MoH TB/HIV related data. Data regarding blood safety is obtained by NAA from the National Blood Transfusion Centre (NBTC). The MoH is also responsible for operating the Health Information System (HIS) and implements CDHS which is an important source of HIV related data. In the non-health sectors, the Ministry of Education, Youth and Sports (MoEYS) collects data on teaching of life skills in schools whose focus includes HIV and from NGOs who are involved with the Life Skills for HIV/AIDS Education Programme targeting youth and children out of school. The Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) compiles data from different sources to track support to OVC and households of PLHIV. NGOs and other civil society organizations report a variety of data to line ministries and to different donors.

Data collection roles and responsibilities are clearly defined in national guidelines. NCHADS and NMCHC have the strongest structures and systems and the longest experience and strongest capacity. However, there has been progress too at MoEYS, MoSVY and across smaller NGOs who are benefitting through Khana, HACC from GFATM and other investments and assistance to upgrade their capacity, infrastructure and equipment so that they can properly perform their M&E functions.

The Boosted CoPCT, PMTCT and the surveillance TWG are forums where significant discussions around M&E and data use also take place. It is here that concrete work is accomplished to advance the national M&E systems and its various sub-systems. The aim is to align and harmonizes routine monitoring systems and practices across all service providers operating under the Boosted CoPCT. UNAIDS has been a driving force in these meetings and is looked upon at as an expert advisor [20].

1. Routine programme monitoring

Routine monitoring indicators are mainly described in the M&E frameworks of sector- and population-specific strategic plans. The indicators used in the health sector response are the most numerous and important ones. They are listed in several programme documents including in the Boosted CoPCT SOP, the Boosted Linked Response SOP and the National PMTCT Strategic Plan and the Boosted Continuum of Care SOP. The M&E frameworks included in SOPs developed by NCHADS constitute the strongest foundation for standardized reporting of data as well as the set of indicators used by GFATM and PEPFAR recipients. Today all of them are close to being fully aligned and harmonized due to NCHADS's leadership and efforts together with service providers to develop common service delivery package. Apart from the health sector indicators there are several important indicators used to monitor the outputs and outcomes of impact mitigation measures and of OVC support.

2. Surveys and surveillance

Cambodia has a relatively good surveillance system. Surveillance has been conducted regularly since the first cases of HIV were detected in the early 1990s including BSS, HSS and SSS and other prevalence studies. A decision has recently been taken to combine BSS and HSS into IBBS in order to save resources. UNAIDS and CDC has worked with partners to improve surveillance methods and tools and to ensure the data obtained can be used for national and international reporting.

Population size estimates (PSE) have improved. Different methods have been utilized such as capture-recapture and mapping methodologies. Clearly, size estimates remain a major area requiring further investment for regularly updating methodologies and estimates, HIV evaluation and research.

More need to be done to assess the relevance and efficacy of new intervention models and approaches under the Cambodia 3.0 initiative. A new evaluation and research agenda will have to be developed by NAA and NCHADS and UNAIDS shall be supporting this effort.

UNAIDS has made a major contribution by supporting National AIDS Spending Assessments (NASA) since 2007. By now four NASAs have already been conducted which have made valuable spending data available for 2006-2012.

3. Data dissemination and use

Data is used much more than in the past both for national and international reporting and for planning and resource mobilization purposes. Cambodia submitted on time Country Progress Reports (UNGASS and GARP) in 2003, 2004 (interim report), 2006, 2008, 2011 and 2012. An increasing number of indicators were reported upon and civil society involvement in the reporting process grew.

Importantly, the use of data to analyze the situation and to inform strategic plans has much increased. People have also gained a better understanding of the strengths and weaknesses of data from different sources such as routine monitoring, surveillance, studies and assessments. Access to data and information on national websites has improved. Still more effort is needed to make up-to-date HIV/AIDS data and relevant M&E documents and materials available, including in Khmer language, on the website of the NAA and on the websites of other organizations.

4. Outbreak monitoring and response

> *"A mass HIV outbreak in a Cambodian village was most likely caused by contaminated medical equipment",*
> *WHO and MoH said in 2014.*

A mass HIV outbreak in Roka commune in western Battambang province emerged in late November 2014. Until 31 March 2015, the 251 new cases of HIV infection were discovered among 2,246 people who came to HIV testing at the HTC sites. This epidemic affected mainly in 2 out of 5 villages of Roka commune in where 11,000 people live [19].

A joint study carried out by the Ministry of Health (MoH), WHO, CDC, UNAIDS and others in January 2015 found 212 people have now been found to be carrying the virus out of 1,940 people tested so far – with contaminated equipment the most likely cause. The study showed that the percentage of people that reported receiving an injection or intravenous infusion as parts of their health treatment which were significantly higher among the people who tested positive for HIV than the people who were HIV negative. Researchers added that other potential transmission routes - such as unprotected sex, drug use and mother-to-child transmission - had been ruled unlikely.

Immediate actions had been undertaken by local authority, health care system with the support of high level representatives of the Royal Government of Cambodia, Cambodian Red Cross, National Assembly, Senates, Ministry of Health and other government institutions along with assistance of NGOs, private sector and humanitarian

organizations to address social and medical need of affected people and families. Besides, Ministry of health reinforced implementation of the policy to stop unlicensed informal medical practices. A medium term and long term plan has been initiated by Samdech Decho Hun Sen to alleviate the impact of this HIV outbreak with the involvement of key ministries such as Health, Social Affairs , Veteran and Youth Rehabilitation, Women Affairs and Local Authority of Battambang . In this plan, a hospital is now under construction to upgrade and bring quality services close to affected patients while road has been enlarged and renovated to ease the transportation between Roka and other surrounding facilities. Besides, ID Poor has been proposed to HIV affected households to open access to health equity fund and sponsorship for HIV infected students.

B. Challenges faced in the implementation of a comprehensive M&E system

There are still gaps in the data and strategic information on the HIV situation and response, in particular among key affected populations, to help inform prioritization and choice of interventions. Some of the key issues and actions in the area of surveillance and M&E system strengthening outlined in the 2013 Joint Review of the Cambodian National Health Sector Response to HIV include:

- ✓ Standardization for mapping and KPs size estimations
- ✓ Lack in the frequency of surveillance data among the key populations on a regular basis
- ✓ The need for a comprehensive epidemiological analysis and epidemic and response profiles at national and local level, beginning with larger and higher-burden cities/provinces
- ✓ Unique identifier systems are still in pilot and not yet available to be used to measure coverage of services for key population
- ✓ Challenges remain in monitoring linkages and loss to follow up along the services cascades
- ✓ Limited capacity particularly at the decentralized level and high turnover of skilled staff.

C. Remedial actions planned to overcome the challenges

A number of key M&E activities are planned for the next two year to obtain quality Strategic information. These include activities to address gaps identified as well as those meant to reach objectives under the Cambodia 3.0. The most significant activities are summarized below:

- The health sector strategic plan (2008-2015) and NSP-IV includes strategies for strengthening of strategic information base for the national response as one of its cross-cutting strategy. It includes size estimation studies for KP using standardised

methodologies with generation of city specific estimates and integrated biological and behavioural surveillance will be conducted at regular interval of 2-3 years [20].

- Unique identifier code (UIC) is being expanded to all cities having KP intervention, which will strengthen programmatic coverage monitoring.

- The Unique identifier system (UIS) has been planned to be expanded to all pre-ART, ART, and VCT sites. The current diagnosis for HIV infection is captured by the active case management (ACM) initiative implemented in 2014. However, this initiative is currently implemented in 15 operational districts is to be expanded to 18 additional ODs in 2015.

- Since the Cambodia epidemic currently is concentrated among key populations it has been recognized that Cambodia does not conduct surveillance on key populations on regular basis to understand and effectively address these high risk and high burden groups. In light of the fact that the most high risk of EWs and IDUs have not reduced in HIV prevalence in the past 5 years, suggest more frequent monitoring is needed. For this reason 3 populations will be surveyed during the next two years. Two Integrated Biological and Behavioural Surveillance Surveys are planned. One will combine MSMs and IDU/DU (2015) as they share geographical hotspots which provide economies of scale. The second will include IBBS among EWs (2014). In order to assess progress of Cambodia 3.0 towards its objectives, surveys alone are not enough. More routine monitoring is needed, particularly at the field level and from the demand side. For this reasons, investments are being made to develop a community based monitoring system which can record, analyse and report issues of access and quality to services including stock outs, expired drugs, responsiveness of health staff, incidents of stigma and discrimination or human rights violations, and need for legal services.

- Despite an electronic database system, electronic data quality is not checked regularly yet, and the use of data by ART site team (clinician, data management, nurses, ART site manager etc.) to monitor quality of patients' management at their own facility is still limited. The CQI is meant to improve the quality and use of data related to standard criteria at pre-ART/ART sites, improve communication between clinician team, community support teams and data management team at pre-ART/ART sites to work together in improving the quality of patient care, and to develop a continuous quality improvement system at pre-ART/ART sites. This protocol will be expanded to more sites and will include assessment for new sites and evaluate old sites.
- Promoting sharing of information and advocating effective use of information by all stakeholders in the national responses to HIV/AIDS through strengthened and organized dissemination of data, and the use of data for strategic planning.

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ANNEXES

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

(Attached)

ANNEX 2: List of Participants in the validation workshop

No	Name	Sex	Position	Organization	Telephone
1. Honorarium Guest Speaker					
1	HE. Ieng Mouly	M	Chair MAN	NAA	
2	HE. Tia Phalla	M	Vice Chair	NAA	012 900 091
3	HE. Sim Kim Sen	M	Vice Chair	NAA	012 345 670
4	HE. Teng Kunthy	M	Secretary General	NAA	012 456 956
5	HE. Ly Kim Long	M	Deputy Secretary General	NACD	078 388 389
2. Coordinator/ Facilitators					
1	Dr. Ros Seilavath	M	Deputy SG	NAA	012 518 393
2	Dr. Sou Sophy	F	Deputy PMER	NAA	016 829 936
3	Dr. Ly Chanravuth	M	Deputy PMER	NAA	012 345 783
4	Dr. Ngin Lina	F	Director PMER	NAA	012 659 388
5	HE. Chea Por	M	Deputy SG	NAA	012 666 008
6	Cheng Tha	M	Planning Officer	NAA	012 688 567
7	Keth Saly	F	TA- PMER	NAA	012 876 966
8	Ry Pilong	M	Contract Staff	NAA	012 622 134
9	Tan Sokhy	M	NAA	NAA	016 915 230
10	Roath Kanel	M	NAA	NAA	070 820 221
11	Chea Punleu	M	NAA	NAA	017 666 638
12	Tep Navuth	M	NAA	NAA	012 774 797
13	Phal Sophat	M	Fhi 360	Fhi 360	012 893 138
14	Khieu Kimlee	M	Consultant	Consultant	070 988 976
15	Pich Sochea	TG	BC member	P.P B C	096 841 7201
16	Keo Tha	F	Health Educator	WWU	012 471 093
17	Dr. Ly Vanthy	M	Deputy Director	US. CAC	012 222 052
18	Mai	F		UNAIDS	012 990 647
19	Loun Monyl	F	E.D	Inthanou	012 911 664
20	Karm Solchan	M	PO	CRC	017 566 485
21	Khlang Pichet	M	Program Coordinator	NoVCTF	012 558 132
22	Chong Vandara	F	PO	UNFPA	012 913 094
23	Prach Sinath	F	PC	KORSANG	089 212 003
24	Lonsay Teng	M	Chief Bu	MRD	012 938 268
25	Kim Rathana	F	PMTCT Program Manager	NMCHC	012 880 745
26	Lim Bunthy	M	PMTCT	NMCHC	017 707 073
27	Phoun Piseysamanak	M	Driver	NAA	092 382 351
28	Sok Sarath	M	Staff	NAA	012 452 232
29	Hang Vibol	M	Deputy of Admin/Finance	NAA	012 870 211
30	Um Sienghorm	F	E.D	NAA	017 847 356
31	Silja Rajander	F	HIV Focal Point	UN WOMAN	012 300 971
32	Thong Dalina	F	Deputy of PMER	NAA	012 891 144

33	Panela Teichman	F	Sr. HIV Prevention	Advisor USAID	
34	Mith Sophal	M		TVK	076 505 0507
35	Dr. Veung Yanath	M	Director PCS	NAA	012 255 273
36	Leng Kuoy	M	M&E	URC	012 280 818
37	Sok Sreyleak	F	Officer	MoWA	089 884 591
38	Saman Dimara	M	Senior ME Officer	KHANA	012 947 988
39	Bunmeng Chhun	M	PM	Australia Embassy	012 981 943
40	Koy Phallany	F	E.D	Khemara	097 8744 745
41	Khan Kong	M	PM	CPN+	017 546 266
42	Ly Cheaty	M	Research	PCK	016 966 779
43	Khun Kim Eam	M	Deputy Chief of DB	CENAT	012 856 146
44	Chea Sokny	F	Deputy Director General	MoLVT	012 654 499
45	Ouk Vichea	M	DD	NCHADS	012 512 425
46	Va Sopheak	M	Health	CAC	099 333 888
47	Kim Sanh	M	Deputy Director	MoEYs	077 383 438
48	Peang Sereywath	M	M&E Coodinator	HACC	012 873 218
49	Keb Sovann	M	COS	MHC	011 616 472
50	Seng Sopheap	M			012 233 417
51	Un Sopheap	M	Deputy Director	MONASRI	012 666 010
52	Gre	F	Program Analicy	UNAIDS	089 927 249
53	M. Saleem	M	Sr. Advisor	UNAIDS	089 980 957
54	Por Chuong	F	HIV Focal Point	ILO	012 844 575
55	Phan Chanly	F	Director Deputy	MOJ	011 833 707
56	Lim Tong luot	M	Director Deputy	NACD	012 777 761
57	Lim kalay	M	DD of PMER	NAA	012 861 037
58	Huot Serayrath	M	Chief of Traning	NAA	011 958 889
59	Kien Serey Phal	F	Freeland Consultant	NSP-IV-NAA	012 999 995
60	Seng Sutwanth	F	IC	Freeland	012 212 277
61	Ponn Samkhann	M	Deputy Secretary General	NCCT (MOI)	012 775 734
62	Nop Bunthorn	M	Driver	NAA	012 857 814
63	Ou Ratanak	M	ED / Rop	PHD / UNi73	017 855 969
64	Chor Rany	M	Deputy A/F	NAA	012 907 873
65	Dy Chanbou	M	Deputy A/F	NAA	012 913 882
66	Chhum Ratha	F	Staff	NAA	093 842 123

APPENDIX 2. NATIONAL FUNDING MATRIX

Total spending

HIV and AIDS spending in Cambodia evolved throughout the years of assessment, both as a total and as per capita. It was on its pick in 2010, amounting to over $58 million in total, $4.1 per capita and $764 per person living with HIV.

Table 1. Total HIV and AIDS spending in Cambodia from 2009-2012

	2009	2010	2011	2012
Total HIV/AIDS expenditure ($US)	$53,735,198	$58,059,469	$53,218,646	$50,927,401
Total population of Cambodia[10]	14,138,000	14,138,000	14,138,000	14,138,000
Expenditure per capita ($US)	$3.8	$4.1	$3.76	$3.6
Estimated number of PLHIV (Spectrum 2012)	77,049	76,042	75,344	74,572
Expenditure per PLHIV ($US)	$697	$764	$706	$683

Financing sources of the HIV response

UN and International NGOs started to provide less funding to HIV in Cambodia. The assessment of the future contributions of the key external donors of the financial and technical assistance in the country revealed that their contributions will continue decreasing in the coming years.

Due to savings and operational bottlenecks in the Global Fund single-stream funding Phase I implementation the country didn't spend all the money that was anticipated for 2011 and 2012 in the grant workplan and budget. The country has recently submitted the reprogrammed workplan and budget for 2013 for the approval of the Global Fund, and applied for the continued funding of the ongoing grant. If it is approved, there might be an increase in the Global Fund-originated spending in 2013 and 2014.

Table 2. Classification of financing sources of the HIV response 2009-2012

	2009		2010		2011		2012	
Royal Government of Cambodia	$1,703,403	3%	$2,436,832	4%	$5,644,947	11%	$5,671,862	11%
Private	$36,955	<1%	$51,540	<1%	$963,952	<2%	$956,837	<2%
Bilateral organizations	$15,565,137	29%	$15,662,527	27%	$15,713,795	29%	$15,872,474	31%
International NGOs	$9,119,295	17%	$7,516,331	13%	$3,736,224	7%	$2,855,882	6%
GFATM	$19,023,377	35%	$22,711,245	39%	$18,030,595	34%	$20,027,132	39%
United Nations agencies	$7,547,437	14%	$8,382,652	14%	$7,128,857	13%	$4,320,352	8%
Other Multilateral organizations (excluding GFATM and UN)	$612,307	1%	$1,043,168	2%	$1,745,621	3%	$1,165,243	2%
International Rest of the World	$127,286	<1%	$255,175	<1%	$254,654	<1%	$57,619	<1%

[10] Presented data reflect population size for the year 2010, Constant fertility variant. Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2010 Revision*, http://esa.un.org/unpd/wpp/index.htm National Bureau of Statistics, 2008 data has been used in NASA III to estimate per capita spending. In NASA IV the source of data has been changed which caused changes also in the per capita estimates.

Financing agents of the HIV response

Royal Government of Cambodia remains the largest fund manager (Financing Agent - in NASA): in 2011 and 2012 it was responsible for the decision-making for up to 50% of all HIV spending in the country.

Table 3. Financial agent of HIV response, 2009-2012

FINANCING AGENTS	2009		2010		2011		2012	
Public sector organizations	$22,366,790	42%	$25,740,278	44%	$24,609,667	46%	$26,373,149	51%
Bilateral	$1,948,145	4%	$1,121,900	2%	$1,636,289	3%	$1,763,109	3%
International NGOs	$15,642,457	29%	$16,501,376	28%	$15,145,798	28%	$13,205,583	25%
UN	$7,277,948	14%	$7,288,577	13%	$6,040,515	11%	$4,450,995	8%
National NGOs	$6,499,858	12%	$7,407,339	13%	$5,786,377	10%	$5,134,565	10%

The analysis of the spending against beneficiary populations revealed that PLHIV consumed 32% of the overall spending in 2011 and 30% in 2012. MARPs benefited from 18% (in 2011) and 15% (in 2012) of the national HIV-related spending in Cambodia. Non-targeted interventions (policy and management, research etc.) remain large: 31% of total HIV expenditure in in 2011 and 35% in 2012.

Table 4. HIV and AIDS spending by categories, 2009-2012

	2009		2010		2011		2012	
BP.01 People living with HIV	$19,362,361	36%	$18,579,570	32%	$17,055,836	32%	$15,436,939	30%
BP.02 Most-at-risk populations	$5,018,419	9%	$5,945,850	10%	$9,461,270	18%	$7,788,469	15%
BP.03.01 Orphans and Vulnerable children	$4,073,178	8%	$4,425,541	8%	$4,720,584	9%	$3,350,943	7%
BP.03 and BP.04 (combined) Other key and accessible populations (excl. OVC)	$2,181,406	4%	$2,598,743	5%	$3,931,790	7%	$4,683,911	9%
BP. 05 General population	$3,450,029	6%	$2,552,841	4%	$1,724,611	3%	$1,957,406	4%
BP.06 Non-targeted interventions	$19,649,805	37%	$23,956,924	41%	$16,324,555	31%	$17,709,733	35%

Government spending on HIV

Government spending didn't increase in 2011-2012 compared to 2009-2010 as it may appear on the Table 2 and 3 This happened due to the fact that information on the Government-paid salaries on the staff at the central level and on the provincial/district level was only partially collected in NASA III, while in NASA IV the data on this expenditure were available in full.

According to the NASA IV findings the Royal Government of Cambodia financed the salaries of the health care workers (45% of all Government HIV spending), PMTCT or Linked Response (17% of the overall Government HIV spending) and Policy development and coordination activities (10% of the overall Government spending on HIV).

Since it was not possible to collect and properly analyze the data on the Government-paid cost of the maintenance of the health care facilities11 in Cambodia, this remains a gap in NASA IV as well as in

[11] We assume that the health care facilities' maintenance cost may be rather large, especially for the settings with laboratories, drug inventories etc.

NASA III. If this cost is added up to the Government contribution to the HIV response financing, the share of the RGC-originated expenditure will increase.

HIV Spending broken down by the AIDS Spending categories

Information table in the Figure 8 represents a breakdown of the key eight AIDS Spending Categories – as an absolute figure and as a percentage of the total spending.

Almost 90% of the total HIV spending goes to Prevention, Care and Treatment, and Program management activities.

Table 5. HIV spending broken down by the AIDS spending categories

	2009		2010		2011		2012	
ASC.01 Prevention	$10,806,903	20%	$11,048,070	19%	$14,272,159	27%	$13,533,253	27%
ASC.02 Care and Treatment	$15,128,794	28%	$13,653,403	24%	$15,716,094	30%	$14,355,571	28%
ASC.03 Orphans and Vulnerable Children	$4,185,535	8%	$4,418,420	8%	$4,666,336	9%	$3,350,943	7%
ASC.04 Program management and Administration Strengthening	$15,841,868	30%	$19,211,252	33%	$14,100,083	26%	$16,172,444	32%
ASC.05.03Training	$955,575	2%	$999,166	2%	$1,345,227	3%	$932,088	2%
ASC.06 Social protection and social services (excl. OVC)	$3,434,866	6%	$4,212,826	7%	$1,183,583	2%	$898,745	2%
ASC.07 Enabling environment	$2,708,324	5%	$3,410,437	6%	$1,273,239	2%	$1,140,106	2%
ASC.08 HIV-related research	$673,333	1%	$1,105,895	2%	$661,926	<2%	$544,250	<2%
Total	**$53,735,198**	**100%**	**$58,059,469**	**100%**	**$53,218,646**	**100%**	**$50,927,401**	**100%**

Prevention

Prevention spending increased both in the absolute values and as a share of the total – from 19% in 2010 (NASA III) to 27% in 2012 (from $11 million in 2010 to over $13,5 million in 2012). However, within two assessed year in NASA IV, the prevention funding dropped by almost $1 million from 2011 to 2012.

The largest financing source for prevention spending was bilateral funds (44% of total expenditure), most of which came from the US Government.

The majority of prevention spending from the Royal Government of Cambodia supported VCCT for general population, blood safety, PMTCT, and social mobilization (see details in the Table 6).

Table 6. HIV and AIDS spending for prevention broken down by category

	2011		2012	
	$US	**%**	**$US**	**%**
Behavior Change Communication (BCC) in general population	**$694,454**	**4.9%**	**$261,842**	**1.9%**
Social mobilization	**$379,609**	**2.7%**	**$1,381,841**	**10.2%**
Voluntary counseling and testing (VCT) in general population	**$349,177**	**2.5%**	**$335,676**	**2.5%**
STI treatment (in the health settings)	**$86,373**	**0.6%**	**$142,944**	**1.1%**
Blood safety	**$438,750**	**3.1%**	**$635,090**	**4.7%**

Condoms and social marketing[12]	**$724,088**	**5.1%**	**$562,764**	**4.2%**
Harm reduction among IDUs	**$749,458**	**5.3%**	**$626,843**	**4.6%**
Prevention among MSM	**$2,925,520**	**20.5%**	**$2,047,558**	**15.1%**
Prevention among sex workers and their clients	**$4,642,173**	**32.5%**	**$4,025,227**	**29.7%**
PMTCT	**$1,923,397**	**13.5%**	**$2,438,163**	**18%**
Positive prevention	**$30,750**	**0.2%**	**$42,371**	**0.3%**
Prevention among key populations:	**$576,542**	**4%**	**$278,795**	**2%**
MARPs not broken down by type -	*$66,897*	-	-	-
Migrants/mobile populations -	-	-	*$53,329*	-
Military -	*$286,220*	-	-	-
Other key populations -	*$1,207*	-	*$1,268*	-
Police -	*$73,062*	-	*$73,571*	-
Prisoners -	*$25,309*	-	*$38,109*	-
PWUD -	*$80,995*	-	*$112,342*	-
Street children -	*$42,852*	-	-	-
Youth in school	**$379,046**	**2.7%**	**$461,055**	**3.4%**
Youth out of school	**$61,470**	**0.4%**	**$33,475**	**0.3%**
Universal precautions	**$1,960**	**<0.1%**	**$2,933**	**<0.1%**
Workplace prevention	**$74,054**	**0.5%**	**$62,689**	**0.5%**
Prevention not broken down by intervention	**$235,338**	**1.7%**	**$193,988**	**1.4%**
Total	**$14,272,159**	**100%**	**$13,533,253**	**100%**

[12] Ideally this section should only include the distribution of free or subsidized condoms to general population, since all other condoms distributed to most-at-risk populations or PLHIV should be captured under the respective codes inside prevention packages for these populations. However, due to the lack of the disaggregated data on the targeted (beneficiary) populations, a large portion of spending on condoms for not broken down most-at-risk populations is captured in this line.