Joint UN High Level Country Mission in Support of Universal Access for HIV Prevention, Treatment, Care and Support
CAMBODIA
16-17 November 2009

Aide-Mémoire
Summary of Findings & Recommendations
November 2009

Background

At the 2006 United Nations (UN) General Assembly High-Level Meeting on HIV/AIDS, Member States agreed to work towards the goal of "universal access to comprehensive prevention programmes, treatment, care and support" by 2010. As a result countries around the world revised their national strategic plans guiding the response to the epidemic and set indicators and targets to track progress towards Universal Access (UA). Since then much progress has been achieved, but significant challenges remain in most countries to reaching these ambitious targets in the coming year.

Achieving UA is seen as a crucial mid-way point to realizing the Millennium Development Goal (MDG) to '*halt and reverse the AIDS epidemic'*. In order to focus the support of the UN to help countries achieve UA, the Regional Support Team for Asia and the Pacific (RST-AP) of the Joint UN Programme on HIV/AIDS (UNAIDS) together with the Western-Pacific Regional Office (WPRO) of the World Health Organisation (WHO) embarked on a series of Joint High Level Missions (HLM) in the region. HLM were scheduled in Cambodia, China, Thailand, India, Indonesia and Papua New Guinea which together make up over 80% of infections in the region.

The HLM mission to Cambodia took place from 16 to 17 November 2009 and involved the Director of RST-AP UNAIDS and the Director for Communicable Diseases of WPRO, the Chair of Cambodia's UN Theme Group on AIDS and the heads of the UNAIDS and WHO country offices. Concurrently, the UN Secretary General's Special Envoy on HIV/AIDS in Asia–Pacific conducted a visit to Cambodia which provided an opportunity for several joint meetings and audiences with senior officials.

Objectives

The overall objectives of the HLM mission to Cambodia were:

1. To advocate with the Royal Government of Cambodia (RGC), civil society and UN on meeting the country's commitments to Universal Access;
2. To gain a comprehensive and realistic understanding of the current status of the Cambodia's progress towards meeting its 2010 UA targets and make a realistic projection of progress by 2011;
3. To identify barriers to achieving Universal Access in Cambodia and agree on appropriate strategies for overcoming these; and
4. To identify technical and financial support needs for addressing barriers identified that are constraining scale-up of UA.

Overall comments[1]

During the two-day visit the HLM members had several meetings with senior government officials and leaders including the Prime Minister Samdech Hun Sen; the First Lady Lok Chumteav Bun Rany Hun Sen, President of the Cambodian Red Cross (CRC) and National Champion on HIV and AIDS; the Deputy Prime Minister and Chairperson of the National Authority for Combating Drugs (NACD), the Senior Minister and Chairperson and senior officials of the National AIDS Authority (NAA) as well as the Minister of Health and the Director of the National Centre for HIV/AIDS, Dermatology and Sexual Transmitted Infections (STIs) (NCHADS). In addition the team met with representatives from civil

[1] List of Cambodia UA indicators and targets, agenda, meeting participation and abbreviations are included as Annex 1 to 4.

society, UN and donor agencies.

Prior to the HLM visit a national consultation was organized by the NAA with participation from representatives of government institutions, civil society and development partners to review progress made towards the achievement of UA targets. The consultation also aimed to identify major obstacles and to formulate recommendations to overcome the recognized barriers. The findings were presented to the HLM team and to the UN Secretary General's Special Envoy at the beginning of their mission.

The mission delegates noted the progress Cambodia has made in addressing HIV and AIDS. Cambodia is one of the few countries worldwide that will be able reach the 6th MDG. Cambodia's progress toward achievement of the Treatment and Care Universal Access targets is remarkable. The Three Ones principle is effectively being implemented making Cambodia a good example in how to provide effective leadership and management of a multi-sectoral response to HIV.

The HLM encouraged Cambodia to continue scaling up the national response to accelerate progress towards the achievement of UA by 2010. In pursing this aim the Royal Government of Cambodia will have to address some outstanding issues especially regarding prevention for key populations at risk of HIV, mother to child transmission, stigma and discrimination against people living with HIV (PLHIV), civil society involvement and human rights. This report on the HLM outlines the main challenges that need to be dealt with and recommendations that will help Cambodia to build on and accelerate efforts to reach Universal Access.

Findings of the mission

1. The Three Ones in Cambodia

The first HIV and AIDS cases in Cambodia were detected in 1991 and 1994 respectively and as a response the Royal Government of Cambodia established the first National AIDS Coordination entity in 1992. This body was transformed into the National AIDS Authority in 1999 by sub-decree[2]. The membership of NAA includes representatives from 26 ministries, the Cambodian Red Cross, the HIV/AIDS Coordinating Committee (HACC) and 24 provincial governments.

Unresolved issues in the institutional, governance, policy and programmatic environment of the national response (national and sub-national) continue to create challenges for more effective and efficient management and delivery. These issues need to be clearly identified and mitigation steps put in place to address them.

According to the recent Report of the Commission on AIDS in Asia, Cambodia has reached a mature response stage since 2006, following consistent mobilization of necessary financial, human and institutional resources to achieve a sustainable and comprehensive AIDS response. According to the Commission, contrary to many of the other Asian countries, Cambodia's AIDS response has already passed the denial phase, ad-hoc phase and informed phase.

The NAA has since then provided focused leadership in coordinating and managing the response. The second National Strategic Plan 2006-2010 (NSP II) which guides the multi-sectoral response is nearing completion. The NSP II entails seven strategies and has an attached monitoring and evaluation (M&E) framework with 54 core indicators to monitor the progress of the national multi-sectoral response. The third NSP for the years 2011 to 2015 will be developed in early 2010.

The Royal Government of Cambodia has been very active and successful in generating strategic information to track the epidemic and to monitor the national response. Routine program data collected by NCHADS regarding health sector interventions include geographical coverage of services, patients' coverage, drug regimens, treatment outcomes and patients' mobility across health facilities. Moreover, Cambodia has a well-established surveillance system that monitors trends in behaviours (Behavioural Sentinel Surveys – BSS), HIV prevalence (HIV Sentinel Surveys – HSS) and STI prevalence (HIV Sentinel Surveys – SSS). HIV Drug Resistance Surveillance has been started Significant progress has also been made with building one single, well integrated national multi-

[2] The sub-decree was revised in 2006

sectoral M&E system covering both health and non-health interventions. An innovative proposal to strengthen the national multi-sectoral HIV M&E system was approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in Round 9 and will enable system strengthening and consolidation over 5 years.

National AIDS Spending Assessments (NASAs) are conducted, Universal Access country reports are prepared every year and United Nations General Assembly Special Session on AIDS (UNGASS) Country Progress Reports prepared every 2 years. The NASAs have shown that USD 46 million was spent on HIV in 2006[3] and USD 53 and 52 million respectively in 2007 and in 2008[4]. Approximately 10% of AIDS spending was covered with domestic sources[5]. This makes the response in Cambodia heavily dependent on external funding and has implications for sustainability and national ownership.

2. Civil society involvement

The efforts of civil society are a fundamental part of the national response to HIV and AIDS in Cambodia. To date, civil society organizations (CSOs) have played an important role in informing and educating the public about their legal rights and entitlements under Cambodia's Constitution, as well as encouraging Cambodians to exercise these rights peacefully through administrative, judicial and legislative institutions. Non-governmental organisations (NGOs) are also playing a complementary role to that of the State, in delivering social services in education, health, rural development, sanitation and social welfare.

Civil society networks represented in the multi-sectoral AIDS response in Cambodia can be divided into three main categories, i.e. HIV/AIDS coordination networks, PLHIV networks, key populations at risk networks. *The HIV/AIDS Coordination Committee*, established in 1993, represents more than a hundred organizations working on HIV. *The Cambodian Network of People Living with HIV (CPN+)* and the *Cambodian Community of Women living with HIV and AIDS (CCW) Network,* established respectively in 2001 and in 2008, both work to create an enabling environment for the active involvement of PLHIV in all aspects of the national response and to promote a human rights-based approach to HIV prevention, treatment, care and support. CPN+ supports the work of 15 provincial networks, home based care teams, support groups, self-help groups and MMM (Mondul Mith Chuoy Mith, or "Friends help friends"), with additional support from a range of partners. CCW represents women living with HIV in 12 provinces and sixteen self-help groups in Phnom Penh.

The national MSM network*, Bandanh Chaktomuk* was established in 2006 to promote and protect the human rights aspects of MSM and transgender people and to ensure the provision of services free from stigma and discrimination. Apart from Bandanh Chaktomuk, there are a number of NGOs and Community Based Organisations (CBOs) that actively work on service delivery for MSM, chief among them, Men's Health Social Service and Men's Health Cambodia. There are five sex worker networks and two main NGOs providing services to sex workers, *Agir Pour les Femmes en Situation Précaire* (take action to protect vulnerable and trafficked women) and End Child Prostitution, Abuse and Trafficking in Cambodia. Currently there are no networks specifically dealing with people who use drugs. However, the two organizations Mith Samlanh and Korsang are working on needle and syringe programmes (NSP) and referral for Methadone Maintenance Therapy (MMT). The only human rights-based organization working specifically on HIV, Cambodian Human Rights and HIV/AIDS Network (CHRHAN), no longer exists leaving a gap yet to be filled.

Civil society organizations participate in technical working groups as well as in national and sub-national consultations such as those organized within the framework of the annual national multi-stakeholder reviews, development of national and sectoral or population specific strategic plans, the UNGASS reporting process and Universal Access target setting and reviews of progress.

3. Care and Treatment

The HIV prevalence rate among the general population of adults aged 15-49 years decreased from

[3] NAA (2008) National AIDS Spending Assessment (NASA) Year 2006
[4] NAA (2009) National AIDS Spending Assessment (NASA) Years 2007/2008
[5] Ibid

2% in 1998 to 0.9% in 2006 and is estimated at 0.7% in 2009[6]. The HIV epidemic is now concentrated among entertainment workers, injecting drug users and men who have sex with men. The maturing nature of the HIV epidemic leaves Cambodia with more than 60,000 people living with HIV in 2008[7]. By 2008 there were voluntary and confidential counselling and testing (VCCT) services offered in 212 sites with 396,510 adults tested for HIV.

With a dramatic scale up of care and treatment, which was started in 2003 by NCHADS, Cambodia is now one of the first developing countries to have over 90% of adults living with HIV already on ART. As of September 2009 36,077 active patients (17,341 male and 18,736 female) were receiving ART[8]. The health sector's response to HIV builds upon the five World Health Organization strategic directions towards Universal Access.

Care and treatment for PLHIV is implemented through the Continuum of Care (CoC) framework that includes strong referral networks between the community based services (Home Based Care (HBC)) and health services with effective involvement of PLHIV. Over the last six years, Cambodia has dramatically expanded availability and access to comprehensive care and treatment services for HIV/AIDS, which include opportunistic infections (OI) prophylaxis and antiretroviral treatment. Second line Antiretroviral (ARV) regimens are available. In December 2008, 51 health facilities offered OI and ART services in 39 (>50%) operational districts in 20 (83%) provinces. Twenty seven sites also provided paediatric care. Close to 90% of adults and children with HIV were still experiencing good health and on treatment 12 months after initiation of antiretroviral therapy.

Now that Cambodia has succeeded its ART scale up towards Universal Access, efforts are being made to focus on quality and cost-effectiveness through the Continuous Quality Improvement (CQI) strategy under which operational districts health teams collect indicators measuring the quality of patient management across the CoC and improve their performance. In 2008, OI and ARV guidelines for adults and adolescents have been revised to increase the CD4 threshold for ART starting at <250. An addendum has been made to the paediatric ARV guidelines recommending the start of Highly Active Antiretroviral Therapy (HAART) for confirmed HIV infected children < 12 months, irrespective of clinical and immunological stage. CD4 count determination is widely available through a network of four regional laboratories. Polymerase chain reaction test for early infant diagnosis is also available and collected on dried blood spots. Viral load testing has been slower to scale up although Standard Operating Procedures (SOP) for regular monitoring of viral load among patients on ART is available.

The Cambodian Continuum of Care model has made community links a central theme throughout the entire country through MMM groups and home-based care teams managed by local NGOs. The role of HBC has evolved as ART has become widely available, focusing more attention on referral and follow up to support adherence to treatment. The number of HBC teams and PLHIV support groups has increased at a rapid pace. At the end of 2008 there were more than 300 HBC teams in Cambodia and 72% of all health centres were linked to at least one HBC team, supporting a total of 27,280 PLHIV. At that time there were also 912 active PLHIV support groups in 15 provinces supporting 36,588 PLHIV.

Tuberculosis (TB)-HIV collaborative activities were initiated in 2006. In the last quarter of 2008, about 59% of new TB patients were tested for HIV. The number of PLHIV screened for TB is unknown because this data was not reported in 2008. Isoniazid preventive therapy (IPT) has not yet been rolled out in Cambodia. Efforts are being made to improve intensified TB case finding among PLHIV, IPT and infection control (called the 3 Is).

Health Systems Strengthening has been supported by NCHADS in four major areas: paediatric care, integrated laboratory services, the Linked Response between HIV and Reproductive Health (RH) including maternal and new born health and operational district management and coordination capacity building.

The successful health sector response to HIV is a result of strong political commitment, technical

[6] NCHADS (2007) Report of Consensus Workshop – HIV Estimates and Projections for Cambodia 2006-2012
[7] Ibid
[8] NCHADS (2009) Third Quarterly Report on OI and ART

leadership and ownership, clear policies and strategies and adequate funding including five rounds of GFATM for a total of USD 149.6 million as well as United States Agency for International Development and other donor support.

4. Prevention of mother-to-child transmission (PMTCT)

A prevention of mother-to-child transmission guidelines (PMTCT) was issued in 2006 including Zidovudine + Nevirapine (AZT + NVP) for prophylaxis, and in 2008 the CD4 threshold to start HAART during pregnancy was raised to 350. A PMTCT joint program review was conducted in 2007 with results showing limited coverage of PMTCT services. Although the National Maternal and Child Health Centre (NMCHC) had set up 151 PMTCT services in 66 of 76 Operational Districts in 2008, coverage remained still far from UA targets. The percentage of pregnant women tested for HIV at Ante-Natal Care (ANC) sites and who received their test result increased from 16% in 2007 to 30% in 2008 and the percentage of HIV-infected pregnant women receiving ARV prophylaxis for PMTCT has increased from 11% in 2007 to 27% in 2008, averting more than 600 estimated new HIV infections among infants in 2008. In June 2009 39% of pregnant women were tested for HIV and received their result and 31% of HIV infected pregnant women received ARV prophylaxis or HAART.

The Linked Response involving PMTCT, maternal and newborn health and reproductive health services is proving effective coverage of these combined services. This innovative strategy was initiated in five demonstration operational districts in 2008 with the aim of strengthening the linkages, referrals and follow up of pregnant women between the community and health services under operational districts level coordination. This new approach was scaled up in 2009 to 25 operational districts 67 health centre satellites and 33 linked health centres to date, and will have nationwide coverage with GFATM Round 9 funding.

5. Prevention for key populations at risk

The epidemic in Cambodia is concentrated among key populations at risk with a prevalence rate among entertainment workers (EW) of 14.7%[9], injecting drug users of 24.4%[10] and men who have sex with men of 8.7% (in Phnom Penh)[11]. Very significant results have been achieved through the 100% Condom Use Programme (CUP) that has been a central component of HIV prevention efforts. STI services, condoms and education were effectively provided to sex workers and their clients and prevention efforts focused on high risk men such as the uniformed services.

Prevention involving people living with HIV is essential to protect and support individuals to make informed decisions on their sexual and reproductive health and to decrease possibilities of re-infection and HIV transmission. Based on NCHADS surveillance data, it was estimated that in 2007, 68% of EW, 57% of MSM and 54% of IDU had been tested for HIV in the last 12 months and knew their HIV test result[12].

Sex workers (SW) and Entertainment workers (EW)

There are more than 34,000 entertainment workers in Cambodia according to recent estimates and 45.1% of them are between 20-24 years[13]. NCHADS 2007 BSS[14] showed that the condom use with clients is high among both brothel-based and non brothel-based sex workers (beer garden, peer promotion and karaoke girls); 94% of brothel-based female sex workers and 83% of non brothel-based female sex workers reported condom use at last sexual intercourse with client. Despite the high condom use, 30% of non brothel-based sex workers and 31% of brothel-based sex workers reported that they had had an abortion in the past 12 months[15] and the number of unwanted pregnancies is high.

The Law on Suppression of Human Trafficking and Sexual Exploitation, approved in 2008, has led to

[9] NCHADS (2007) 2006 HSS
[10] NCHADS (2008) HIV Prevalence among Drug Users 2007
[11] NCHADS (2006) 2005 SSS
[12] NCHADS (2008) HIV Prevalence among Drug Users 2007
[13] NCHADS (2009) First Quarterly Report
[14] NCHADS (2008) BSS 2007
[15] NCHADS (2008) BSS 2007

a change in the entertainment establishment landscape with the strict enforcement of brothel closures and where sex workers continue to endure harassment and arrests. In effect, the new law has had a negative effect on the successful 100% Condom Use Programme enforced in brothels, as sex exchange takes place in new settings. This emphasizes the need for new guidelines on the existing Prime Minister's Prakas 66 (100% CUP Policy). The guidelines need to call for the implementation of the 100% CUP with wider reach and in new environments. The programme needs to be rolled out in all entertainment establishments (EW and MSM) and ensure compliance among establishment owners and law enforcement bodies. In a context where patterns of sex work keep changing to become indirect it is important to adopt a pragmatic approach to ensure condom use remains 'normalized'.

A single new structure called the National Committee to Combat Human Trafficking has been established by Prakas, chaired by Ministry of Interior and co-chaired by Ministry of Women's Affairs and Ministry of Social Affairs, Veterans and Youth (MoSVY).

In 2009, the Ministry of Health (MoH)/NCHADS designed a new SOP for a continuum of prevention to care and treatment for female entertainment workers within the CoC and a demonstration project started in Siem Reap. This revised strategy aims to adapt the prevention strategy to focus on EWs and reflects a shift from brothel-based to non brothel-based activity. It aims to improve access to sexual and reproductive health (SRH), family planning (FP) services and care and treatment for this key population by improving SRH-FP linkages and referral mechanisms between community-based prevention services, HIV testing and STI services, and facilities providing OI/ART.

Drug users (DU) and injecting drug users (IDU)
The Law on Drug Control, adopted in 1997, contains a number of weaknesses which led to misinterpretations in its implementation. Therefore the National Authority for Combating Drugs with the support of UN Office on Drugs and Crime (UNODC) decided to redraft the law. WHO, UNODC and UNAIDS actively joined in the process securing the inclusion of sections on harm reduction, HIV prevention and treatment, and rehabilitation of drug users. The draft Drug Law is a positive step in order to decriminalize voluntary access by drug users to HIV harm reduction programmes (methadone and needle and syringe programmes) and drug treatment. The revised law is currently under the review of the Council of Ministers before submission to the National Assembly.

Men who have sex with men (MSM)
MSM is a key group at risk which has received little actual attention in the response. There is a costed National Strategic Framework and Operational Plan for MSM, but a lack of resources and effective coordination has hampered its implementation. Some STI clinics currently provide specific services for MSM, although the demand for these services remains limited. A Guideline to manage MSM prevention, treatment and support is being developed by NAA in collaboration with NCHADS and other relevant stakeholders.

There is a National MSM TWG which should look at substantial issues such as overall coordination, policy environment, comprehensive package, stigma and discrimination, coverage and access to services, mechanisms to record MSM data, management guideline and policy finalization, awareness and implementation

6. Impact mitigation / Orphans and vulnerable children (OVC)

The Cambodia Health and Demographic Survey (2005) revealed that one out of seven (14%) of children aged 0 to 17 years were either orphans or vulnerable due to the chronic illness of a parent and many thousands are estimated to be vulnerable as a result of extreme poverty and food insecurity, especially in the current worsening economic climate.

The OVC situation and response assessment highlights that:

- AIDS affected households have significantly lower income than non HIV affected households, while coping with higher health care expenditures.
- Chronic illness among parents is significantly linked to lower wealth status; rural households fare worse.

- Children who have lost their mothers are significantly more likely to be severely stunted than other children.
- Children in AIDS affected households are more likely to eat fewer meals and experience hunger than peers.
- Girls have lower rates of school enrolment than boys, and this is more pronounced for girls affected by HIV.
- Orphans also fare considerably worse in terms of school attendance.
- Discrimination and hunger are the 2 biggest factors of psychological distress among children infected with HIV.
- Coverage of social services is limited: only 6 provinces have OVC impact mitigation services in more than 70% of communes, while coverage is less than 30% in 13 provinces.

In 2006, the National Multi-sectoral Orphans and Vulnerable Children Task Force was established. Its role is to facilitate coordination amongst key stakeholders, to jointly identify programme priorities and harmonize activities, and to review and address policy gaps and strategic issues and advocate for quality services. After one year of implementation, a rapid review of progress revealed that during 2008: 38,855 OVC were supported for their education; 41,229 households with OVC received food support; more than 40% of communes in the country had at least one organization providing HIV related care and support to families with OVC; 3,067 children were on ART and a number of conditional cash transfer initiatives have started.

7. Stigma and discrimination

Stigma and discrimination against people living with HIV continues to require special attention as recent research revealed they remain high. In a recent study 62% of respondents agreed that HIV and AIDS is a punishment for bad behaviour and over 60% felt that people living with HIV should feel ashamed[16].

The Law on the Prevention and Control of HIV/AIDS was approved in 2002. While the law is considered relatively robust, mechanisms for its monitoring and enforcement remain weak. For example, the law was recently undermined with the eviction and relocation of 42 HIV affected households to Tuol Sambo. The families were grouped into one site where new accommodation did not meet basic minimum standards for housing, livelihood opportunities were severely constrained, and where food insecurity plus water and sanitation issues have added to increased health concerns amongst PLHIV. The case highlights the lack of attention to discrimination and stigma shown by authorities when resettling families.

Recommendations

The Three Ones in Cambodia

Coordination, management and governance of the response

- Collaboration between different technical working groups and other entities needs strengthening and the Government Donor Joint TWG has to be empowered to provide space and opportunity for civil society engagement in more effective and efficient policy and programming formulation and decision-making. A National Partnership Forum should be established to enhance horizontal coordination among different TWGs. Support to the different TWGs should be provided so they can function properly.

- Institutional and human capacity at NAA needs further strengthening to lead, coordinate, manage and monitor the multi-sectoral response. The capacity of some core line ministries and government departments also has to be strengthened.

- The Royal Government of Cambodia needs to develop strategies to increase domestic resource allocation to the national response, in particular to intensify HIV prevention over the medium to

[16] BBC World Service Trust (2009) Cambodia Sentinel Survey 2008 (Media and Discussion, knowledge, attitudes and practices about sexual matters, HIV and AIDS, Risks, Condoms, VCCT, PLHIV and MSM)

long term. The findings of the Aids2031 Cambodia Financing study provide an opportunity to develop a medium-term financing framework for the national response.

- Undertake a functional task analysis of the national response and develop a mitigation plan to address unresolved issues in the institutional, governance, policy and programmatic environment of the national response (national and sub-national).

- The importance of using resources more effectively cannot be understated. Low cost – high impact interventions should be adopted in line with the Commission on AIDS in Asia Report recommendations. Achieving Universal Access means stretching available resources further, and not simply mobilizing new ones. Cambodia should foster a response which it can afford. It is of concern that the GFATM is the sole source of financing ART and that condom availability may soon become a problem when two major donors (United Kingdom's Department for International Development and the Kreditanstalt für Wiederaufbau) are completing their commitments by 2011.

Third National Strategic Plan (NSP III) 2011-2015

- Additional technical and financial support for the development and costing of the NSP III shall be mobilized and UNAIDS will assist the NAA with this important task.

- Linkages with major development support frameworks such as the UN Development Assistance Framework (UNDAF) should be ensured to harmonize interventions across different levels.

- The recommendations outlined in this Aide-Mémoire, and those identified in the recently conducted national consultation to review progress and to identify bottlenecks and constraints towards achievement of Universal Access in Cambodia, should inform the development of NSP III.

- National Strategy Application should be considered by the Royal Government of Cambodia.

M&E and strategic information

- M&E of HIV prevention for key populations at risk is a critical area requiring more investment.

- Cambodia has a significant evidence base to inform and calibrate the response; however more effort is needed to streamline M&E, surveillance and research efforts. Integrated Behavioural and Biological Surveillance (IBBS) should be considered to save resources and improve the data that is obtained. Updating size estimations of key populations at risk such as drug users (DU), injecting drug users (IDU) and men who have sex with men (MSM) will help to better plan and strategize coverage for HIV prevention.

- Improved strategic information analysis and data triangulation are needed at both national and sub-national levels, and findings should be used more consistently to inform policies and programmes.

- Integrated analysis of data from different sources is needed in 2010 especially with a focus on progress toward UA targets. In regards to the UA targets, it is also recommended that Cambodia revises and updates 2010 targets where needed to reflect the changes in the situation.

- National AIDS Spending Assessments in 2006, 2007 and 2008 are a major achievement. These assessments should continue and data obtained so far be further analyzed to provide strategic information on how best to resource the response over the short and medium term.

- The Universal Access country report should be strengthened to include data on ART cohorts short and long term outcomes as well as intensified TB case finding among PLHA and Isoniazid Preventive Therapy.

- The UNGASS Country Progress report is a national product that is owned by all stakeholders in the national response. It is therefore vital that all stakeholders including civil society participate in a meaningful way in its preparation and presentation.

- Active follow up on recommendations and action points from the recent UA progress review is needed to scale up efforts in those areas where progress is lagging behind targets and to provide an improved environment for the Royal Government of Cambodia and partners to realize UA targets by 2010.

Civil society involvement

- It is important to secure genuine and meaningful participation of and consultation among all stakeholders by providing sufficient space for civil society in the national response. Civil society participation should be ensured in all stages when developing new laws and programmes and reviewing results achieved by the response, and their voice should be given due consideration. Appropriate representation of civil society and community networks should also be reflected in key mechanisms or working groups (e.g. the Entertainment Worker Core Group, the National MSM Technical Working Group).

- Parliamentarians and the political leadership in Cambodia should provide space for:
  - Public hearings on the effectiveness of relevant laws and programmes;
  - Public hearings with key populations at risk community networks on areas of particular concern;
  - Discussions on care and treatment – are service providers reaching out to people and making a difference?; and
  - Consultations on whether HIV prevention is targeted efficiently scaled and intensified to ensure a difference is made in averting new infections.

- Encourage the engagement of human rights organizations in disseminating and building understanding of the HIV Law and monitoring human rights across the national response for improved governance and accountability.

Care and Treatment

- Examine ways to enhance the quality of service provision and involve all stakeholders in the process.

- Improved understanding about HIV drug resistance would benefit the response and the resistance monitoring system will need to be strengthened.

- The availability of second line antiretroviral regimens is a positive step. The detection of treatment failure and switch to second line regimen has to be strengthened.

- More cost effective solutions should be considered to scale uptake of HIV testing services.

- Cost effective approaches and strategies should also be developed to sustain home based care in the medium to long-term.

- Recognize and maximize the contributions of the health sector HIV response in strengthening health systems in general with the aim of addressing other concerns (e.g. maternal and newborn health, sexual and reproductive health, tuberculosis, paediatric care, laboratory services, and infection control).

Prevention of mother-to-child transmission (PMTCT)

- Sustained efforts, through initiatives like the Linked Response, are required to eliminate this mode of HIV transmission as soon as possible. Positive steps have been taken to introduce multi-drug therapy (AZT + NVP). Recent (November 2009) WHO recommendations on ARV use for PMTCT will have to be considered.

- There is a need to develop a stronger collaboration between NCHADS and NMCHC and to strengthen linkages to maternal and newborn as well as sexual and reproductive health.

Prevention for key populations at risk

- Establish regular sound population size estimations using appropriate methodologies to capture hidden groups. It is also important to harmonize and align service delivery monitoring systems to obtain comprehensive output data that can consistently be collated in order to calculate the number of people reached by prevention interventions.

- To ensure reliable monitoring and reporting we must be clear on what exactly 'prevention interventions' consist of. This of course varies from one high risk group to another. Cambodia has to have clear standard operating procedures to be able to determine what precisely implementation should look like or what the minimum package of support is in practice. From experience we know that effective HIV prevention interventions cannot only include education – in the case of IDU it must include sterile needles and syringes and opioid substitution treatment; in the case of SW and MSM it must involve lubricant in addition to condoms, education as well as referral to STI/VCCT services.

- People and especially key populations at risk are still tested late (stage ¾) and therefore do not access treatment early enough. There is a need to consider point of care rapid testing primarily with key populations at risk including through private service providers. Expanding access to treatment for key populations at risk should be a priority.

- Entertainment and sex workers as well as MSM and drug users/injecting drug users must not be the subject of or fear harassment, arrests or punishment when seeking prevention, care and treatment services. The human rights of key populations at risk and people living with HIV should be respected.

- Awareness of the local authority and law enforcement agencies needs to be raised so they fully understand the intent of laws impacting upon HIV prevention and public health efforts (and subsequently, of sub-decrees and procedures). The Community-Police Partnership Programme established under the Ministry of the Interior (MoI) Strategic Plan (2009-2013) needs to be initiated to ensure an enabling environment for all HIV service provision concerning key populations at risk.

- Ensure there is no unwarranted censorship regarding TV-ads and other forms of mass communication for HIV prevention as well as with specific targeted communication for key populations at risk. Continue to use mass communications to normalize condom use. Develop a National Communications Framework and Strategic Plan that facilitates effective evidence-based strategic behaviour communications for the national response.

- Positive prevention as well as the promotion of condom use as a responsibility by both men and women with all partners requires greater attention. Ensure NCHADS SOP on positive prevention is initiated across the country.

- Although the HIV epidemic is now concentrated among key populations at risk of HIV, recommendations from the regional Intimate Partner Transmission consultation should be used to expand access to reproductive health and family planning by males and to promote couple counselling and testing.

- Develop a unified, well integrated prevention package for key populations at risk of HIV to ensure different strategies and SOPs are not in contradiction with each other.

- Prioritize resources and attention on intensifying HIV prevention based on evidence regarding new infections and modes of transmission ("Know your epidemic").

Sex workers (SW) and Entertainment workers (EW)

- Outreach, SRH-FP, care and treatment services to entertainment and sex workers have to be effectively carried out. The enforcement of the *Human Trafficking and Sexual Exploitation Law*[17] should not hamper these activities. It is important that work is continued with all relevant stakeholders to ensure increased compliance with Prakas 66 (100% Condom Use Programme Policy) among entertainment establishment owners and law enforcement bodies. A guideline outlining the involvement of police, local authorities, health workers and communities in the implementation of the Prakas 66 at different types of entertainment establishments should be developed. Such Prakas should be aligned with the new SOP for Entertainment Workers and guidelines to manage the MSM response.

- Orientation for different stakeholders (police, local authorities, health workers, communities) to ensure their familiarity and adherence to the guideline and the new SOP should be organized.

- Increase attention on male clients of entertainment workers and develop specific approaches to address their risk behaviours.

Drug users (DU) and injecting drug users (IDU)

- The draft Drug Law is a positive step in order to decriminalize voluntary access by drug users to HIV harm reduction programmes (methadone and needle and syringe programmes) and drug treatment. However, substantive multi-stakeholder discussion and transparency in law and programme formulation taking the concerns of the community, service providers and other stakeholders into account is required, especially when steps will be taken to turn the law into action.

- Drug user detention centres are counter productive and will not solve the issue of drug addiction, are more expensive and less effective than community-based alternatives. Drug user detention centres should gradually be phased out as they could become a breading ground for HIV and TB. Community based approaches to drug treatment and rehabilitation are required to provide adequate prevention and improved referrals to health services (HIV, SRH, and TB).

- Government should scale up evidence-informed harm reduction, ensuring that programmes address the emerging trend of crystal methamphetamine injecting.

- Community participation should be improved through the establishment of a drug user networks.

- Additional outreach programs for drug users and injecting drug users are needed because currently there are insufficient numbers of trained and skilled service providers in this important area of HIV prevention, especially in rural areas. Best practices should be established also through study visits and professional attachments in other countries with the overall aim of expanding and improving evidence-based, quality outreach services.

- Coverage of prevention interventions amongst injecting drug users should focus on and be measured with specific reference to needles and syringes as well as methadone maintenance therapy (a fixed-facility pilot programme to commence in March 2010). Traditional measurements relying on educational activities, outreaches etc. will not be appropriate.

- Inadequate attention is being given to the HIV response in closed settings. Intensify support to HIV and TB prevention, treatment and care in prisons. The MoH/Prison Department SOP and Memorandum of Understanding needs to be operationalized nationally and with resources from Global Fund Round 10.

Men who have sex with men (MSM)

- Continue to question the strengths and limitations of the data. The BSS 2007 result, showing 96% of MSM were exposed to HIV prevention interventions, seems too high. More work is needed to verify the findings and to triangulate these data with those that can be obtained from other

[17] The clause in the draft penal code where condition of arrest of SW/EW for soliciting for sex services has been removed; fines remains.

sources such as routine monitoring data obtained from programme implementers. A national MSM population size estimation should be undertaken (including transgender and hidden MSM).

- The minimum package of evidence-based prevention interventions to MSM should entail condoms and lubricants, education as well as STI/VCCT referral. Unify and standardize existing minimum package of services and protocols ensuring there is national consistency.

- MSM partners (men and women) should be targeted for prevention interventions as well.

- There are a limited number of technically skilled service providers; hence the scale up of outreach and coverage is proving difficult. Global Fund Round 7 and Round 10 needs to address this to identify and build capacity of new service providers.

- Unifying and standardizing the existing minimum package of services and protocols by ensuring there is national consistency is another step that is required.

Impact mitigation / Orphans and vulnerable children (OVC)

- OVC should not be addressed in isolation but as part of national social protection/social safety net and ID Poor programmes in which HIV should be integrated as well as other measures such as health equity funds and cash transfers to households to keep children in school.

- Social protection has been agreed as a key component in the UNDAF by the UN Country Team which enables a coordinated effort from the UN in terms of policy and systems development while mainstreaming HIV into the broader development agenda.

- However, increased focus and attention is needed to provide an improved environment and support for orphans and vulnerable children. More resources should be invested in this area.

Stigma and discrimination

- Stigma and discrimination against people living with HIV needs to be addressed with more determination and with the goal of elimination. This is of particular importance when providing prevention, care and treatment services to PLHIV.

- Ensure that community education and the police-community partnership programme directly addresses stigma and discrimination barriers to HIV outreach with key populations at risk of HIV infection.

- Intensify orientation of relevant health workers around the needs of MSM, IDU and EW/SW to reduce discrimination as a barrier to services.

- Isolation of people living with or affected by HIV in one place or as a group promotes stigma and discrimination and is seriously in contradiction with the AIDS Law.

- Situations like the one of Borei Keila and Toul Sambo should never happen again. We must actively fight against stigma and discrimination as a cornerstone of the national response.

- Mass communications need to be used effectively to normalize HIV and reduce stigma and discrimination.

- Use the findings of the Stigma Index being carried out by CPN+ to calibrate and re-focus stigma and discrimination programming.

Taking forward the recommendations

It is important that the Royal Government of Cambodia receives the appropriate financial and technical support required to address the recommendations in this Aid-Mémoire and identified in the recent national consultation to review progress and identify bottlenecks and constraints. In some

instances the support will be in terms of initial technical support to trigger further domestic commitment by the Royal Government of Cambodia and from other partners in the response.

It is suggested that development partners and government officials convene a series of results oriented consultation meetings to identify the priority of recommendations, the sequencing thereof, roles and responsibilities as well as financial and technical assistance needs.

The detailed support from the UN will be identified in the Joint Support Plan and Operational Plan and Budget 2011-2015 which will be in line with the NSP III and UNDAF. The UN Country Team in Cambodia will undertake periodic reviews of the Aide-Memoir and its recommendations to monitor progress.

The Mission thanks Samdech Prime Minister Hun Sen, First Lady Lok Chumteav Bun Rany Hun Sen, Deputy Prime Minister and Chairperson of the National Authority for Combating Drugs H.E. Senior Minister of the National AIDS Authority and all officials of the Royal Government of Cambodia, civil society partners, the UN Country Team with staff for their participation and cooperation.

The mission acknowledges with thanks the excellent support provided by the UNAIDS Country Coordinator and WHO acting representative with their teams during the visit.

Dr. Prasada Rao
Director UNAIDS RST-AP
Date
Bangkok, Kingdom of Thailand

Dr. Tee Ah Sian
Director of Communicable Diseases, WPRO
Date
Manila, Republic of the Philippines

Annex 1 **Cambodia's UA indicators and targets with identified barriers, opportunities and recommendations**

From the presentation Progress and Actions towards Universal Access in the Kingdom of Cambodia, given to the HLM team on 16 November 2009 by NAA

Indicator 1: Number of large organizations that have workplace policies and interventions

Baseline 2005 (MoLVT/ILO)	Observed 2008	Target 2008	Observed Q2/2009	Target 2010
14	25	30	80	60

Barriers
- Quality and sustainability of private sector HIV interventions are a concern
- Lack of leadership, commitment and capacity in private sector on HIV

Opportunities
- As expected, target will be exceeded
- Measurement is planned in 2010

Recommendations
- Review implementation of Prakas 86 and make adjustments
- Advocate for leadership and action from private sector
- NSP for Private Sector to focus on entertainment establishments
- Improve quality of workplace interventions

Indicator 2: Percentage of respondents who say that an HIV+ teacher who is not sick should be allowed to continue teaching.

Baseline 2005 (CDHS)	Observed 2008	Target 2008	Observed 2009	Target 2010
79%	N/A	85%	N/A	90%

Barriers
- Recent studies indicate stigma & discrimination remain a concern
- Cases were reported where children are asked to test before being enrolled

Opportunities
- As expected, target will be reached
- Stigma Index will be conducted
- National HIV Communications Framework and Strategy will be developed
- Measurement is planned in 2010

Recommendations
- Use Stigma Index results to inform policies and programs
- Address stigma and discrimination in National Communications Framework and Strategic Plan
- Enhance work with Parliamentarians
- Promote community strengthening strategies
- CDHS to cover HIV including testing

Indicator 3: Number of ministries that are actively implementing an HIV/AIDS plan, as per their sectoral strategies

Baseline 2005 (NAA)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
6	13	9	19	18

Barriers
- Several ministries and AIDS Committees still lack interest & capacity in developing HIV strategies and plans
- Lack of understanding of HIV as multi-sectoral issue
- Shortage of financial support for advocacy and capacity building

Opportunities
- 2010 target was already reached
- Technical and capacity building support is planned by NAA
- GFATM funds are available for capacity building
- Measurement is planned in 2010

Recommendations
- Advocate for more engagement of policy makers
- Promote implementation of strategies and work plans
- Resource mobilization (national budget)
- Build capacity to develop, cost and monitor strategic plans
- Improve quality of interventions under priority ministry plans

Indicator 4: Percentage of households with OVC that receive minimum package of support

Baseline 2005 (GFATM)	Observed 2008 (NGOs)	Target 2008	Observed Q2, 2009	Target 2010
TBD	40,373 OVC	30%	44,371 OVC	50%

Barriers
- No percentage measurement possible because lack of consensus on definitions and no denominator available
- Fragmented and inadequate OVC data available
- Social protection measures not well coordinated or guided by overall national framework incorporating

Opportunities
- As expected, target cannot be reached
- Target could be measured in 2010
- GFATM R7 being used to scale up interventions
- National social protection policy, system and programme capturing needs of vulnerable OVC due to HIV under development.

Recommendations
- Strengthen implementation of national OVC framework and ensure linkages with current social protection programmes and measures
- Ensure OVC issues tackled in commune investment plans
- Strengthen capacity of OVC Task Force
- Develop M&E system allowing to capture OVC data including size estimations

Indicator 5: Percentage of communes with at least one organization providing care and

support to households with OVC

Baseline 2005 GFATM	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
TBD	N/A	50%	78%	100%

Barriers
- Too ambitious with target as 100%
- Achievements lagging behind
- Problems of measurement because of a lack of data

Opportunities
- This target could be measured in 2010
- GFATM R7 can help scale up to achieve target in 2010
- HBC teams coverage is being extended

Recommendations
- Use existing social protection programmes to address the OVC needs including HBC teams
- Strengthen implementation of OVC Action Plan and role and actions of OVC Task Force
- Establish a routine harmonized monitoring system to monitor , analyze and report on the basic essential services for OVC

Indicator 6: Percentage of commune development strategies that address HIV/AIDS.

Baseline 2005 (NAA)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
3%	N/A	25%	29%	50%

Barriers
- Progress is far behind the target
- Coverage of HIV/AIDS integration through decentralization remains limited
- Commune AIDS Committees (CAC) do not exist in all communes and capacity weak
- Support from provincial development committee to integrate HIV plans remains limited

Opportunities
- HIV already integrated into decentralization strategic framework
- Capacity building of CAC through decentralized network is being scaled up

Recommendations
- Resource mobilization to scale up HIV/AIDS decentralization
- Extend coverage of CAC
- Strengthen the partnership between NAA and MoI (D&D) and advocate for increased funding allocation at decentralised level to social development issues
- Support integration of HIV work into commune investment plans

Indicator 7: Percentage of high risk men who report consistent condom use with commercial sexual partners

Baseline 2003 BSS	Observed 2007 BSS	Target 2008	Observed 2009	Target 2010
89%	87%	95%	N/A	98%

Barriers
- In 2007 achievement of this target was behind target
- Lack of clear profile of high risk men
- HIV prevention efforts were scaled down with high-risk men (i.e., moto-taxi driver, uniformed services, mobile populations)
- HIV prevention with this group is not being intensified.

Opportunities
- As expectation, the result will be close to the target
- Measurement is planned in 2010

Recommendations
- Sustain and scale up comprehensive prevention package to all high-risk men
- Promote Prakas 66 to entertainment establishments to facilitate 100% CUP and MoI Police-Community Partnership programme
- Collect strategic information on high risk males to ensure changing patterns and trends are reflected in programming

Indicator 8: Percentage of direct female sex workers who report consistent condom use.

Baseline 2003 BSS	Observed 2007 BSS	Target 2008	Observed 2009	Target 2010
96%	99%	96%	N/A	98%

Barriers
- Brothel are going to be out of date due to many factors
- Limited coverage of HIV prevention to all entertainment workers
- Prevention interventions and condom use is drawn back
- No standardized routine programme monitoring available making it difficult to track progress
- Lack of collaboration NAA & MoI

Opportunities
- In 2007, 2010 target was passed but coverage may have decreased
- Measurement is planned in 2010
- National strategy for EW is in place and enforced
- 100% CUP remains top priority

Recommendations
- Sustain and scale up prevention to all entertainment establishments
- Make no barriers to condom availability, affordability and quality
- Promote Prakas 66 to entertainment establishments (EE) and roll-out orientation sessions with police, owners of EE
- Focus interventions more specifically on clients
- Promote Police-Community partnership Programme

Indicator 9: Percentage of indirect sex workers who report consistent condom use

Baseline 2003 BSS	Observed 2007 BSS	Target 2008	Observed 2009	Target 2010
82%	92%	90%	N/A	98%

Barriers
- Limited coverage of HIV prevention interventions in all entertainment workers
- Limited accessibility to affordable and quality condoms
- No standardized routine programme monitoring available making it difficult to track progress
- Lack of collaboration NAA & MoI

Opportunities
- In 2007, 2008 target was passed but coverage may have decreased
- Measurement is planned in 2010
- National strategy for EW is in place and enforced
- 100% CUP is adopted to scale up to all entertainment establishments

Recommendations
- Sustain and scale up prevention to all entertainment establishments
- Make no barriers to condom availability, affordability and quality
- Promote Prakas 66 to entertainment establishments (EE) and roll-out orientation sessions with police, owners of EE
- Focus interventions more specifically on clients
- Promote Police-Community partnership Programme

Indicator 10: Percentage of IDUs who are exposed to HIV prevention interventions.

Baseline 2005	Observed 2007 DUS	Target 2008	Observed 2009	Target 2010
N/A	56%	40%	N/A	80%

Barriers
- Prevention interventions do not have sufficient coverage
- Quality and consistency of interventions remains a key issue
- IDU is still a hidden population facing discrimination
- Service data is not reported consistently so difficult to track coverage and quality of prevention services
- Lack of endorsed size estimation
- No DU survey planned in 2010

Opportunities
- In 2007, 2008 target was passed
- Prevention intervention program targeted IDU user is starting to scale up even in the lower speed
- Resources for IDU work (harm reduction) is expected to be increased in 2010
- Draft Drug Law recognizes harm reduction and decriminalizes drug users voluntarily seeking HIV prevention (harm reduction - NSP, Opioid Substitution Therapy) services

Recommendations
- Advocate for passage of Drug Law which recognized HIV prevention
- Advocate with NADC to issue licences to qualified service providers
- Develop national operational guidance for Prevention, Care and Treatment for IDU and M&E framework to capture routine programme monitoring data
- Consider introduction of rapid testing and increased access to provider initiated male SRH services
- Produce population size estimation
- Repeat Drug User Survey

Indicator 11: Percentage of ATS users who are exposed to HIV prevention interventions.

Baseline 2005	Observed 2007 DUS	Target 2008	Observed 2009	Target 2010
N/A	TBD	40%	N/A	50%

Barriers
- Target not yet measured
- Prevention interventions for ATS users do not have sufficient coverage
- ATS still a hidden population having limited access to health services
- ATS use and increased HIV vulnerability not well documented
- Service data is not reported consistently so difficult to track coverage and quality of prevention services
- Lack of endorsed size estimation
- No DU survey planned in 2010

Opportunities
- Prevention intervention program targeted ATS user is starting to scale up even in the lower speed
- Funding support is expected to be increased in 2010

Recommendations
- Develop national operational guidance for Prevention to Care and Treatment of IDU and M&E framework to obtain standardized routine data
- Develop sustainable models for community-based drug treatment programmes which can be scaled up with GFATM resources
- Support the development of drug treatment policy & protocol engaging health and law enforcement sectors
- Strengthen programme links with condom interventions
- Increase engagement of police

Indicator 12: Percentage of MSM who are exposed to HIV prevention intervention.

Baseline 2005	Observed 2007 BSS	Target 2008	Observe 2009	Target 2010
N/A	96%	60%	N/A	90%

Barriers
- Insufficient coverage of HIV prevention interventions
- Quality and consistency of interventions remains a key issue
- Service data is not reported consistently by partners so difficult to track coverage and quality.
- MSM still largely a hidden population
- MSM and transgender have very little access to health services due to self and public discrimination and stigmatization
- There is no national figure on MSM population size that includes the population of hidden MSM

Opportunities
- In 2007 the 2010 target was passed
- Measurement is planned in BSS

Recommendations
- Develop national operational guidance to deliver prevention package, especially hidden MSM and transgender and harmonize routine data collections, data use & analysis
- Target communications strategies
- Expand private sector service access for male sexual health services, including STI and rapid HIV testing

- Reconcile/produce size estimations
- Enforce HIV law and policy related to discrimination and stigmatization in respect to MSM and transgender

Indicator 13: Number of OD with at least one PMTCT sites offering the minimum package of PMTCT service.

Baseline 2005 (NMCHC)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
18	66	49	67	59

Barriers
- There are none because the target in 2010 is already reached

Opportunities
- 2010 target has been passed
- Promising results from Linked Response and integration of HIV with SRH and FP services
- Measurement planned in 2010

Recommendations
- Number of facilities providing PMTCT services should be scaled to support the achievement of other PMTCT indicators targets
- Lessons learned should be utilised to establish national coverage utilizing the Linked Response approach
- Consider introduction and expansion of point of care rapid testing as a screening measure at HC level
- Continue build demand for couple counselling, with focus on reaching partners of positive pregnant women

Indicator 14: Percentage of pregnant women attending ANC at PMTCT services who receive counselling and testing for HIV.

Baseline 2005 (NMCHC)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
53%	81%	70%	69%	80%

Barriers
- Insufficient coverage of number of PMTCT site
- Shortage of HIV test kit and number of competent staff
- Limited technical capacity of staff especially on counselling
- Percentage in 2009 is low because data is incomplete as data from private services are lacking

Opportunities
- As expected, the target will be reached or almost reached
- Promising results from Linked Response and integration of HIV with SRH and FP services
- Measurement planned in 2010

Recommendations
- Scale number of facilities that provide PMTCT services
- Ensuring timely and regular supply of HIV test kits
- Improve the collection and quality of data from public/private

- Build capacity of PMTCT staff
- Strengthen collaboration of NMCHC & NCHADS to harmonize interventions and monitoring
- Consider introduction of rapid testing at health centre level and/or maternity (delivery) sites
- Build demand for couple testing

Indicator 15: Percentage of pregnant women attending ANC services who receive testing and counselling

Baseline 2005 (NMCHC)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
5%	30%	20%	25%	50%

Barriers
- Are similar to those identified for Indicator 14
- Insufficient coverage of number of PMTCT site
- Shortage of HIV test kit and number of competent staff
- Limited technical capacity of staff especially on counselling

Opportunities
- Are similar to those identified for Indicator 14
- As expected, the target will be reached or almost reached
- Promising results from Linked Response and integration of HIV with SRH and FP services
- Measurement planned in 2010

Recommendations
- Scale number of facilities that provide PMTCT services
- Ensuring timely and regular supply of HIV test kits
- Improve the collection, quality and reliability of data
- Build capacity of PMTCT staff
- -Strengthen collaboration of NMCHC & NCHADS to harmonize interventions and monitoring
- Consider introduction of rapid testing at health centre level and/or maternity (delivery) sites
- Build demand for couple testing

Indicator 16: Number of VCCT sites offering counselling and testing services.

Baseline 2005 (NCHADS)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
109	212	230	216	300

Barriers
- Quality of counselling and testing remains an issue
- High turnover in staff is a problem and requires repeated training and refresher training

Opportunities
- Original target was reduced as 250 VCCT sites were deemed sufficient
- Measurement is planned in 2010
- As expectation, target will be reached with more participation and support from the NGOs and from the private sector

Recommendations
- Improve access to and quality of VCCT services for MARPs
- Increase and track referrals from VCCT to other health services at OD level

- Consider point of care rapid testing as a screening measure for private service providers serving MARPs and in Family Health RR covers all ODs, Option 1 (refer patients for HIV testing) and 2 (draw blood and refer for HIV testing) should be done at non-LR sites
- Enhance capacity building

Indicator 17: Number of ODs with a full CoC package of service.

Baseline 2005 (NCHADS)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
22	39	34	39	34

Barriers
- None because target has already been achieved since 2009

Opportunities
- It is expected to have more ODs (>39 ODs) with full CoC by 2010
- Measurement is planed in 2010

Recommendations
- Even though this target was passed, results should be sustained to facilitate achievement of the other targets

Indicator 18: Number and percentage of PLHIV on ART with access to CoC (OI and ART services).

Baseline 2005	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
12,355 (49%)	28,932 (94%)	22,000 (80%)	34,384 (93%)	25,000 (95%)

Barriers
- If new criteria for CD4 count for ART eligibility are introduced this will increase denominator, therefore the target would be affected

Opportunities
- 2010 target is almost achieved
- By Q2 2009, there were 34,384 PLHIV on ART with access to CoC. Therefore, the target set in 2010 (25,000) has already been reached. In Q2 2009, of the estimated 33,500 adults PLHIV in need of ART, 31,018 adults were already on ART (93% coverage)

Recommendations
- High ART coverage should be sustained
- CoC needs to continue focus on increasing quality through CQI
- Drugs supplies should be timely and meet the demand
- MARPs need to be attracted to VCCT for early treatment and care
- If criteria for ART eligibility change, human resources, HIV test kits, ARV drugs, should be well planned to ensure 2010 target can be met

Indicator 19: Number of health centres with Home-based Care Team support.

Baseline 2005 (NCHADS)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010

350	675	452	706	471

Barriers
- There are none because the target is already over reached although funding for HBC teams has been reduced

Opportunities
- 2010 target has already been achieved and will be maintained
- Most of NGOs who are working actively on HBC program do have funding secured up to 2010
- Measurement is planned in 2010

Recommendations
- Even though, this target is expected to be passed by 2010, the number of HBC team should be further scale-up to cover other health centre coverage to support other PLHIV who are in the need
- Management of HBC teams should be shifted from NGO service providers to community networks at the OD level to ensure sustainability and cost effectiveness over the long term

Indicator 20: Numbers of health centres providing support to TB patients for HIV testing.

Baseline 2005 (CENAT)	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
150	N/A	350	900	470

Barriers
- Target measurement represents an estimate because data is not available

Opportunities
- As expectation, the target is over reached
- Measurement is planned in 2010
- Interventions to get new TB patients to have HIV test is a top priority for CENAT program to scale up with full support from development partners by 2010

Recommendations
- NAA should work closely with the CENAT to ensure the data quality that is accuracy based on the UA guideline
- Sustain the intervention to refer new TB patients to get HIV tested

Indicator 21: Number of condoms sold and distributed.

Baseline 2005	Observed 2008	Target 2008	Observed Q2, 2009	Target 2010
21M (PSI)	29M	27.4M	26M	29.4 M

Barriers
- Display of condom in the entertainment establishment and carrying condom with individual is concerned of being court based on the implementation of human trafficking and exploitation law
- KfW and DfID funding for condom procurement is coming to an end in the next 24 months

Opportunities
- The condom is well accepted at all levels in the society
- As expectation, the target is reached
- Measurement is planned in 2010

Recommendations

- Sustain and scale up the condom sale and distribution giving emphasis to subsidized condom availability
- National strategy on condom to prevent HIV/AIDS (availability, affordability, and quality)
- Ensure that there is no ambiguity for condom access under the law
- Expand scope of work to private sector contribution and involvement
- Strengthen 100% CUP and enforce in EE through Prakas 66
- Promote dual marketing of condoms and lubricants

Annex 2: HLM participants and Agenda

Joint UN High Level Country Mission in support of Universal Access for HIV Prevention, Treatment, Care and Support

CAMBODIA
16-18 November 2009

Programme

UN Joint High Level Country Mission to support Universal Access (HLM)	Dr. Prasada Rao, Director UNAIDS Regional Support Team (RST) Asia and Pacific Dr. Tee Ah Sian, Director of Communicable Diseases at WPRO Ms. Alice Levisay, Chair of the Theme Group on HIV/AIDS, UNFPA Cambodia Dr. Michel Thieren, Acting WHO Representative, Cambodia Mr. Tony Lisle, UNAIDS Country Coordinator, Cambodia Ms. Geeta Sethi, APLF Manager & Focal Point for Cambodia, UNAIDS RST Asia and Pacific Ms. Madelene Eichhorn, Programme Officer, UNAIDS Cambodia

Monday 16 November 2009	**Tuesday 17 November 2009**
8.00-9.00 Courtesy visit at National AIDS Authority (NAA) Courtesy visit together with UNSG's Special Envoy on HIV/AIDS in Asia Dr. Nafis Sadik to meet HE Dr. Nuth Sokhom, Senior Minister & Chairperson and high level representatives of NAA and of its member organizations *Venue: National AIDS Authority*	**08.45-11.00** APLF Achievement Award First Lady Lok Chumteav Bun Rany Hun Sen – APLF Achievement Award Engagement of Dr. Sadik and HLM delegates in the ceremony *Venue: Cambodia Red Cross HQ*
9.00-11.30 Review of progress toward UA targets HE Dr. Teng Kunthy (Chair) and HE Dr Mean Chhi Vun (Vice-Chair) Participants: High level representatives of NAA and of its members and HLM delegates. *Venue: National AIDS Authority*	**11.00-12.00** - TBC Debriefing on HLM findings and key recommendations HLM delegates to debrief the National AIDS Authority (NAA) and the National Centre for HIV/AIDS, STI and Dermatology (NCHADS) on HLM findings and key recommendations H.E. Dr. Kunthy, S-G, NAA H.E. Dr. Mean Chi Vun, Director, NCHADS J.V.R Prasada Rao, Director UNAIDS RST-AP Dr. Tee Ah Sian, Director of Communicable Diseases at WPRO Ms. Geeta Sethi, RPA, UNAIDS RST-AP Tony E. Lisle, UCC Dr. Michel Thieren, WR (a.i.) WHO Savina Ammassari, M&E Adviser , UNAIDS CO Madelene Eichhorn, Programme Officer, UNAIDS CO *Venue: National AIDS Authority*
12.00-13.00 Lunch Briefing on HLM and UA Objectives Briefing to the UN Theme Group on AIDS by HLM delegates	**12.30-14.00 -** Confirmed Lunch Meeting with Commissions 6 & 8 of National Assembly Dr. Prasada Rao and Ms. Geeta Sethi to attend Lunch

Venue: UNDP LAD Conference Room	Meeting with Dr. Sadik and Chairs/Vice-Chairs of Commissions 6 and 8 of National Assembly *Venue: Cambodiana Hotel*
14.00-15.30 - Confirmed Stakeholder consultation meeting Stakeholder consultation with representatives of civil society, FBOs, CBCA, community networks, including MARPS (MSM, IDU, SW &EW), PLHIV (CPN+ ART User Group, CCW), national NGO and INGO service providers *Venue: UNDP LAD Conference Room*	**15.30 – 16.45** - Confirmed Meeting with H.E. Ke Kim Yan, Deputy Prime Minister and Chairperson of the National Authority for Combating Drugs (also responsible to PM on HIV issues) *Venue: Council of Ministers*
	16.45-17.45 - Confirmed Debriefing on HLM findings and key recommendations De-Briefing on HLM on UA findings and key recommendations to UN Theme Group on AIDS and Development Partners Forum on AIDS by HLM delegates *Venue: UNDP LAD Conference Room*
16.00-17.00 - Confirmed Meeting with Prime Minister Hun Sen *Venue: National Assembly*	
17.30 Aide Mémoire/preliminary findings and recommendations Preparation work on the HLM Aide Mémoire by HLM delegates *Venue: UNAIDS Country Office*	

Annex 3: People consulted

Royal Government of Cambodia

Prime Minister Samdech Hun Sen
First Lady Lok Chumteav Bun Rany Hun Sen

HE. Ho Naun, Head of the Commission 8 (Public Health, Social Works, Labour and Women's Affairs), National Assembly
HE. Min Sean, Deputy Head of the Commission 8 (Public Health, Social Works, Labour and Women's Affairs), National Assembly
HE. Ouk Damry, Member of the Commission 6 (Legislation), National Assembly

HE. Gen. Ke Kim Yan, Chairperson of NACD
HE. Lt-Gen. Ly Kimlong, Deputy Secretary General, NACD
HE. Lt-Gen. Thou Sun, Director of DPM Ke Kim Yan Cabinet, NACD
Mr. Lay Kimly, Director of the Administration and Finance Department, NACD
Mr. Neak Yuthea, Director of the Education, Prevention and Legislation Department, NACD
Dr. Thong Sokunthea, Deputy Director of the Education, Prevention and Legislation Department, NACD

HE. Dr. Nuth Sokhom, Senior Minister & Chairperson, NAA
HE. Dr. Ly Po, Vice Chair, NAA
HE. Dr. Tia Phalla, Vice Chair, NAA
HE. Mrs. Sim Kheng Kham, Vice Chair, NAA
HE. Dr. Chea Sam An, Vice Chair, NAA
HE. Dr. Sim Kimsen, Vice Chair, NAA
HE. Dr. Thai Hoa, Advisor to NAA
HE. Dr. Mean Chhivun, Director, NCHADS
HE. Dr. Teng Kunthy, Secretary General, NAA
HE. Dr. Hor Bunleng, Deputy Secretary General, NAA
Dr. Sieng Sorya, Deputy Secretary General, NAA
Dr. Ros Seilavath, Deputy Secretary General, NAA
Dr. Lors Soum, Director Cabinet, NAA
Mr. Heng Siv Leng, Vice chief Cabinet, NAA
Dr. Ngin Lina, Director PMERD, NAA
Dr. Sim Kim San, Director CRM, NAA
Dr. Yong Sovatana, Director PCS, NAA
Mr. Chhim Khin Dareth, Director Admin & Finance, NAA
Dr. Chor Rany, Deputy Director CRMD, NAA
Mr. Dy Chan Bunloeur, Deputy Director A&F, NAA
Mr. Sok Serey, M&E Specialist, NAA
Ms. Sovann Vitou, Data Base Officer, NAA
Ms. Siek Sopheak, M&E Assistant, NAA
HE. Chan Sam An, Deputy Governor, Phnom Penh
HE. Sathya Vuth, Deputy Governor, Kg. Speu
Dr. Chor Vicheth, Director PAS, Kandal
Dr. Or Vanthen, Director PAS, Kg. Speu

HE. Meach Sam On, Secretary of State, Ministry of Justice
HE. Mak Vann, Secretary of State, Ministry of Education, Youth and Sports
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Annex 4: Abbreviations

AIDS	Acquire Immunodeficiency Syndrome
ART	Anti Retroviral Therapy
ANC	Ante-Natal Care
ARV	Anti Retroviral
AZT	Zidovudine
BSS	Behavioural Sentinel Surveillance
CBO	Community Based Organisations
CCW	Cambodian Community Women Living with HIV and AIDS
CHRHAN	Cambodian Human Rights and HIV/AIDS Network
CoC	Continuum of Care
CPN+	Cambodian People Living with HIV and AIDS Network
CQI	Continuous Quality Improvement
CRC	Cambodian Red Cross
CSOs	Civil Society Organisations
CUP	Condom Use Programme
DU	Drug Users
EW	Entertainment workers
FP	Family Planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Therapy
HACC	HIV and AIDS Coordinating Committee
HBC	Home-based care
HIV	Human Immunodeficiency Virus
HLM	High Level Mission
HSS	HIV and AIDS Sentinel Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Intravenous Drug User
IPT	Isoniazid preventive therapy
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MMT	Methadone Maintenance Therapy (MMT).
MOH	Ministry of Health
MoSVY	Ministry of Social Affairs, Veterans and Youth
MSM	Men who have Sex with Men
MMM	Mondul Mith Chuoy Mith
NAA	National AIDS Authority
NACD	National Authority for Combating Drugs
NASA	National AIDS Spending Assessment
NCHADS	National Centre for HIV/AIDS Dermatology and STDs
NGOs	Non-Governmental Organisations
NMCHC	National Maternal and Child Health Centre
NSP	Needle and Syringe Programme
NSPII / NSPIII	Second (2006-10) / Third (2011-15) National Strategic Plan
NVP	Nevirapine
OI	Opportunistic Infections
OVC	Orphans and vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
RCG	Royal Government of Cambodia
RH	Reproductive Health
RST-AP	Regional Support Team for Asia and the Pacific
SOP	Standard Operating Procedures
SRH	Sexual and reproductive health
SSS	Sexual Transmitted Infections Sentinel Surveillance
STD/I	Sexual transmitted diseases/infections
SW	Sex Workers
TB	Tuberculosis

TWG	Technical Working Group
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDAF	United Nations Development Assistance Framework
UNGASS	United Nations General Assembly Special Session on AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organisation
WPRO	Western-Pacific Regional Office of the WHO