KINGDOM OF CAMBODIA
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The Fifth National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS

(2019-2023)

Moving Toward Ending AIDS as a Public Health Threat by 2025

November 2019

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Foreword

1. Cambodia is one of seven countries globally to have achieved the 90-90-90 targets in 2017. These achievements have been driven by strong support from the Royal Government of Cambodia and the work of local civil society organizations dedicated to the response; however, the HIV response in Cambodia is largely funded by external sources.
2. The Royal Government of Cambodia is committed to ending AIDS as a public health threat by 2025. The vision of the *Fifth National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023)* (NSP V) is a "**Cambodia free of HIV, with better health and well-being for all people**."
3. Over the next five years, in the transition period, we must start thinking 'out of the box' and foster innovations that strengthen our leadership, improve partnership, and increase our domestic investment to achieve the vision of NSP V.

Leadership

- **Samdech Techo Hun Sen Prime Minister** calls for a national movement to engage a national and subnational response to end the AIDS epidemic. This strong political will needs to be translated into reality with the application of the "Dynamic of Stakeholders Participation" of the rectangular strategy that assists different sectors to collaborate and share responsibility in the last battle against AIDS.
- Leadership at all levels should decode the principles of the NSP V to contribute to the achievement of 95-95-95 targets with a dynamic, integrated, and sustainable response to AIDS.
- The NSP V focuses on multi-sectoral aspects involving multiple government ministries and partners to effectively engage in the HIV response. The effort of different ministries, coordinating bodies, and partners will be guided by implementation arrangements according to their specific sectoral indicators of achievement NSP V strategies and sub-strategies.
- To align the HIV response with government policies and reforms, leaders need to strengthen country systems at national and sub-national levels by making use of the right data, the right tools, and existing networks and mechanisms to critically contribute to ending the AIDS epidemic.

Partnership

- Evidence shows us that the Cambodia epidemic has grown much more complex as HIV risks and vulnerabilities are rapidly changing. Hence, partnership for the AIDS response needs to be much more strategically tailored to meet the needs of all at risk and vulnerable people—especially those who are hard-to-reach with differentiated prevention and care and treatment models.
- We need to continue to support civil society organizations and community mobilization efforts to critically complement government efforts. At all levels, the success of the implementation of the NSP V depends on good coordination between government institutions in active partnerships with nongovernmental/civil society organizations and key populations.

- To leave no one behind, local authority, police, healthcare workers, and social workers should apply "people-centered" approaches to emphasize the necessity of listening and learning among stakeholders and collectively remove human barriers, enabling key populations and people living with HIV to have access to quality services in an equitable manner.

Investment

- With its graduation as a low-middle-income country in 2016, Cambodia is transitioning toward building a country system for a sustainable HIV response. The NSP V has been using the results of the Investment Case and the recommendations of the Transition Readiness Assessment and the Sustainability Roadmap.
- To secure front-loading investment for the AIDS response, over the next five years, concerned institutions need to translate the SCN 213 with six policy measures to generate domestic funding to support an effective and efficient HIV response at national and sub-national levels.

4. On behalf of the National AIDS Authority, I call for active engagement and strong support of all health personnel, relevant ministries and agencies, sub-national administrations, development partners, nongovernmental organizations, the private sector, key populations, people living with HIV, and communities to work closely in a concerted and synergic national movement to implement the NSP V and end AIDS in Cambodia by 2025.

Ieng Mouly

Senior Minister in charge of special mission and Chairman of National AIDS Authority

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The National AIDS Authority would like to express thanks to the Joint United Nations Program on HIV/AIDS (UNAIDS) and the Health Policy Plus (HP+) project—funded by the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)—for their financial and technical support in developing this report.

Many government partners, namely the National Authority for Combatting Drugs; the Ministry of Health; the National Centre for HIV/AIDS, Dermatology, and STDs; Ministry of Planning; the Ministry of Economy and Finance; the Ministry of Education, Youth, and Sports; the Ministry of Social Affairs, Veterans, and Youth Rehabilitation; the Ministry of Labor and Vocational Training; the Ministry of National Defense; the Ministry of Interior; the Ministry of Women's Affairs; the Ministry of Tourism; the Ministry of Information; Phnom Penh Health Municipality; Provincial Health Departments of Battambang, Banteay Meanchey, and Siem Reap; and the National Social Protection Council, as well various nongovernmental organizations, such as KHANA; FHI360; Health Action Coordinating Committee; Catholic Relief Services; Reproductive Health Association of Cambodia; Cambodia Women for Peace and Development; AIDS Healthcare Foundation; Population Services International - Cambodia; Cambodia Health and Education for Community; Women's Network for Unity; ARV Users Association; Clinton Health Access Initiative; Cambodian Network of People Living with HIV; UN agencies; and bilateral donors, such as USAID and Australia's Department of Foreign Affairs and Trade, have participated in various discussions, including the visioning workshop and steering committee meetings.

Our sincere thanks to the Secretariat General of National AIDS Authority, including four departments—in particular, the Department of Planning, Monitoring, Evaluation, and Research—for their overall coordination and input. The quality and content of this report have been greatly strengthened thanks to critical technical inputs from HP+ and UNAIDS.

Finally, thanks are due to the consultants who drafted this document.

Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
CPA	Complementary package of activities
CSO	Civil society organization
GDP	Gross domestic product
HEF	Health Equity Fund
HIV	Human immunodeficiency virus
HP+	Health Policy Plus
KP	Key population
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
MPA	Minimum package of activities
NAA	National AIDS Authority
NCHADS	National Centre for HIV/AIDS, Dermatology and STIs
NGO	Nongovernmental organization
NSP V	The Fifth National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
RGC	Royal Government of Cambodia
SCN	Sor Cho Nor (Government circular)
SDG	Sustainable Development Goal
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USD	U.S. dollar

Executive Summary

Cambodia has substantially reduced the prevalence of HIV in adults ages 15 to 49 years, from 1.7% in 1998 to 0.8% in 2010 to 0.5% in 2019 (NCHADS, 2016; UNAIDS, 2018). There were an estimated 880 new infections within the population in 2018—a 62% decline since 2010—and AIDS-related deaths declined by 48% between 2010 and 2018 to an estimated 1,300 (UNAIDS, 2018).

The government has clearly articulated the country's development objectives. Its *Rectangular Strategy for Growth, Employment, Equity, and Efficiency (Phase IV)* places good governance at the center of the strategy and prioritizes human resource development, economic diversification, private sector employment, and inclusive and sustainable development (RGC, 2018). This agenda is operationalized through the *National Strategic Development Plan*, which integrates the Sustainable Development Goals (SDGs) and other long-term development goals articulated in Vision 2030—a roadmap to move toward upper-middle-income status—and Vision 2050, which outlines Cambodia's path toward becoming a high-income country (RGC, 2014).

The Royal Government of Cambodia is committed to ending AIDS as a public health threat, which is aligned with SDG 3 (**ensuring healthy lives and promoting well-being for all at all ages,** including universal access to HIV prevention services, sexual and reproductive health services, and drug dependence treatment and harm reduction services) (UNDP, 2019a). Under SDG 3, there are two targets relevant to HIV/AIDS: **target 3.3** (end AIDS as a public health threat by 2030) and **target 3.8** (achieve universal health coverage, access to quality healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all).

The vision of this *Fifth National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023)* (NSP V) is a Cambodia free of HIV/AIDS, with better health and well-being for all people. It is closely aligned with the vision, articulated in the *Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector 2016-2020*, to "reach the 90-90-90 targets by 2020 and the virtual elimination of new HIV infections in Cambodia by 2025 through high-quality prevention, care, and treatment services for HIV/AIDS and [sexually transmitted infections] within the health sector" (MOH, 2016, pg. 16). It is also closely linked to the HIV Joint Monitoring Indicator outcome for 2019-2023 of AIDS elimination as a public health threat by 2025, with 95-95-95 targets achieved (see Annex 4) (RGC, 2019a). The Ministry of Health is currently developing the fourth Health Sector Plan (2020-2025) and the National Centre for HIV/AIDS, Dermatology, and STIs is undergoing a joint HIV program review and developing a strategic plan for HIV in the health sector for 2020-2025.

Mission

The mission of Cambodia's National AIDS Authority (NAA) is to lead the country toward a dynamic, integrated, and sustainable response to AIDS.

Goal

The goal of the NSP V is to move toward ending AIDS as a public health threat by 2025.

Specific Objectives

There are four specific objectives of the NSP V:

1. Ensure inclusive delivery of evidence-based HIV interventions through a coordinated, multi-sectoral approach
2. Integrate prevention, care, and treatment within the health system for a more efficient and sustainable HIV response
3. Improve access to social protection mechanisms and social services for people living with HIV (PLHIV)
4. Increase government funding and support delivery of critical services by civil society organizations to strengthen the sustainability of the HIV response

Principles

The following principles guided the development of the NSP V: national ownership; alignment with the SDGs and government policies; sustainable financing through increased allocation of government funding and efficient use of resources; multi-sectoral collaboration; people-centered approaches and equity; gender equality; civil society participation; and evidence-based interventions.

Special Characteristics

Unlike previous national strategic plans, the NSP V possesses a number of special characteristics. NSP V has greater political commitment to increase the government's focus on the HIV response and increased domestic financing is apparent, as evidenced by the issuance of *Sar Chor Nor #213* with approval from the Prime Minister. The NSP V was developed at a time when external support to HIV response is decreasing. It was developed while the National Centre for HIV/AIDS, Dermatology, and STIs (NCHADS) was developing its own review and strategic plan.[1]

Several nongovernmental organizations (NGOs) and civil society organizations (CSOs) have reduced their scopes of work due to the reduction of external support—as a result, greater emphasis has been placed on effectiveness and efficiency. The Ministry of Interior has agreed to include the AIDS response in its revised *Villages and Communes Safety Policy*; as a result, the enabling environment has been emphasized here. The NSP V is the first strategy to identify a path toward HIV elimination by 2025. The NSP V will be used by NAA, relevant ministries and partners, especially the Ministry of Economy and Finance, to plan and budget HIV activities and consider increased allocation of domestic resources for the HIV response.

[1] NCHADS' Joint Program Review and Strategy Plan development was shortly after the completion of the NSP V, which means that some elements of the NSP V might need to be updated and aligned with the Joint Program Review and Strategy Plan.

Strategies

Strategy 1: Deliver comprehensive prevention, care, treatment, and support through a multi-sectoral approach

This remains the core of an effective AIDS response, wherein all PLHIVs and key populations are reached by a diverse range of services, enabling them to know their HIV status, protect themselves and others, start and maintain antiretroviral therapy, and achieve undetectable viral loads throughout their lifetime, regardless of age, sex, sexual orientation, gender identity and expression, or drug use status.

Strategy 2: Integrate AIDS response activities into the health system, relevant ministries, and national coordinating bodies

Comprehensive access to services should not be a vertical or stand-alone activity. In recognition of the relationships between HIV, sexual and reproductive health and rights, and universal health coverage; and using the framework of resilient and sustainable systems for health, increased integration of HIV services into health programs and other sectors should be pursued.

Strategy 3: Expand social protection coverage and improve access to social and legal services

Legal and other barriers—notably stigma, discrimination, and all forms of criminalization—must be reduced to increase access to HIV services. This is especially true for young people and key populations such as female entertainment workers, men who have sex with men, transgender people, and people who inject drugs. Social protection schemes should cover PLHIV and key populations. Civil society and nongovernmental organizations that provide essential services for key populations should be supported by the government as donor funding declines.

Strategy 4: Increase government financing to 50% of all HIV expenditures by 2023, and allocate a share of the government budget to civil society organizations for delivery of critical HIV services

To move toward sustainable financing of the HIV response, the government must increase its budget allocation to HIV programming and plan for the transition away from external assistance. Particular attention must be given to financing key components of the response, such as health worker salaries, antiretroviral medications, and prevention. The government must also plan to finance the provision of critical interventions by civil society in the context of declining donor funding. There are opportunities to promote both sustainability and integration by incorporating HIV interventions in the national social protection system's benefit package.

The outcomes of the four strategies include:

- By 2025, new infections will be reduced from 880 per year (in 2018) to less than 250 per year (UNAIDS, 2018). Ninety-five percent of all estimated PLHIV will know their HIV status; 95% of those who know their status will be on treatment; and 95% of those on treatment will have a suppressed viral load. If achieved, this would meet the UNAIDS fast track target prior to 2030.

- By 2023, an initial assessment and suggested framework for integration of HIV into the health system will be developed with full engagement of all partners.
- By 2023, 100% of PLHIV will be covered by a social protection mechanism and will have increased access to health, social, and legal support services.
- Fifty percent of the HIV response in Cambodia will be domestically financed (up from 24% in 2017), and civil society organizations will be co-financed by public funding (Population Council, Unpublished).

Implementation

Implementation of the NSP V, led by the NAA, will be a collaborative effort between multiple government ministries and partners, guided by their specific responsibilities linked to the four strategies. The NAA's primary roles will include coordination, facilitation, and advocacy for the integration of HIV into the health system. Advocacy is also needed to influence the Ministry of Economy and Finance to increase domestic funding for the HIV response.

Monitoring and Evaluation

The NSP V monitoring framework is presented in Table 9. It will build on indicators that are already being collected regularly, such as the *National AIDS Spending Assessment*, the Global AIDS Monitoring Report, the Stigma Index, the Sor Chor Nor 213 implementation work plan, and the Joint Monitoring Indicators (Annex 5). The Planning, Monitoring, Evaluation, and Research Unit of the NAA and its partners will develop a detailed operational plan, monitoring plan, and indicators, which will be monitored yearly and reported on at the agency's annual policy board meetings. A midterm review is proposed for December 2021. In this elimination phase, granular strategic information (similar to the UNAIDS Key Populations Atlas) needs to be collected to address gaps, prioritize investments, and introduce innovative programming approaches to prevention, treatment, care, and support.

Process

With financial and technical assistance from UNAIDS and Health Policy Plus (HP+) project—funded by the U.S. President's Emergency Fund for AIDS Relief's (PEPFAR's) Sustainable Financing Initiative for HIV/AIDS at the U.S. Agency for International Development (USAID)—the NAA built on the outcomes of the NSP IV review and consulted multiple ministries, nongovernmental organizations, civil society organizations, and key stakeholders between February and October 2019 to develop the NSP V. The initial draft was shared and discussed during six formal sessions of the Technical Board and Steering Committee, which includes representatives of nearly all of the relevant ministries and key stakeholders working in the field of HIV/AIDS in Cambodia. The Policy Board fully endorsed the NSP V at their meeting in November 2019.

1. Introduction and Methodology

1.1 Socioeconomic Development and Health Context

Cambodia's population reached 15.3 million in 2019 (NIS, 2019). With an annual growth rate of 1.2%, it is projected to reach 19 million by 2030.

Seventy-eight percent of the population lives in rural areas, but urbanization is increasing rapidly. The male to female ratio is 94.8. Adult male literacy is 84%, but just 76% of adult females can read. The population's median age is young, at 24.6 years, but the percentage of the population age 14 years and younger declined from 44% in 1998 to 31% in 2018, due to a decline in fertility rates and increased life expectancy (NIS, 2019).

Cambodia met most of its Millennium Development Goal targets for infant and maternal mortality, malaria mortality, percentage of births attended by skilled birth attendants, water supply, and sanitation (RGC, 2018). The proportion of the population living in poverty has also decreased significantly, from 47.8% in 2007 to 13.5% in 2014, according to official government statistics (UNDP, 2019b). However, the World Bank estimates that 4.5 million people in Cambodia are "near-poor" and vulnerable to falling into poverty if economic shocks occur (World Bank, 2019a). Fueled by the garment industry and tourism, Cambodia's economy grew at an annual average rate of 7.7% between 1995 and 2018, making it one of the fastest growing in the world (World Bank, 2019a). Gross domestic product (GDP) per capita increased from USD 471 in 2005 to USD 1,380 in 2018 (RGC, 2018). Cambodia became a lower-middle-income country in 2015.

The Royal Government of Cambodia (RGC) has clearly articulated the country's development objectives. Its *Rectangular Strategy for Growth, Employment, Equity, and Efficiency (Phase IV)* places good governance at the center of the strategy and prioritizes human resource development, economic diversification, private sector employment, and inclusive and sustainable development (RGC, 2018). This agenda is operationalized through the *National Strategic Development Plan*, which integrates the Sustainable Development Goals (SDGs) and other long-term development goals articulated in Vision 2030—a roadmap to move toward upper-middle-income status—and Vision 2050, which outlines Cambodia's path toward becoming a high-income country (RGC, 2014).

The RGC is committed to ending AIDS as a public health threat, which is aligned with SDG 3 (**ensuring healthy lives and promoting well-being for all at all ages,** including universal access to HIV prevention services, sexual and reproductive health services, and drug dependence treatment and harm reduction services) (UNDP, 2019a). Under SDG 3, there are two targets relevant to HIV/AIDS: **target 3.3** (end AIDS as a public health threat by 2030) and **target 3.8** (achieve universal health coverage, access to quality healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all).

1.2 HIV Situation and Trends

Cambodia substantially reduced the prevalence of HIV in adults ages 15 to 49 years, from 1.7% in 1998 to 0.8% in 2010 to 0.5% in 2019 (UNAIDS, 2018). There were an estimated 880 new infections in 2018, a 62% decline since 2010. AIDS-related deaths declined by 48% between 2010 and 2018 to an estimated 1,300 (Table 1).

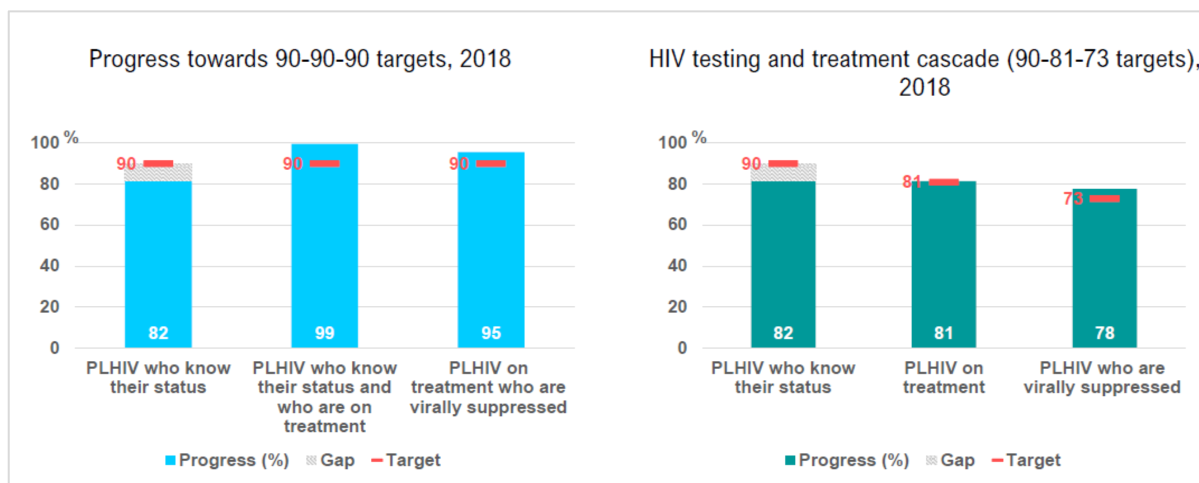
Table 1: HIV Estimates in Cambodia, 2010-2018

Group	Indicator	2010	2015	2018
New HIV infections	All ages	2,300 (2,100-2,600)	1,300 (1,200-1,500)	880 (780-990)
	Ages 0-14	<500 (<500-<500)	<200 (<200-<500)	<200 (<100-<200)
	Female, 15+ years	1,100 (930-1,200)	550 (<500-610)	<500 (<500-<500)
	Male, 15+ years	890 (780-990)	620 (550-680)	<500 (<500-<500)
	New incidences per 1,000 population	0.16 (0.14-.18)	0.09 (0.08-0.009)	0.05 (0.05-0.06)
AIDS-related deaths	All ages	2,500 (1,900-3,400)	1,500 (1,100-2,400)	1,300 (920-1,900)
	Ages 0-14	<500 (<200-<500)	<100 (<100-<200)	<100 (<100-<100)
	Female, 15+ years	1,100 (820-1,500)	670 (<500-1,100)	<620 (<500-970)
	Male, 15+ years	1,200 (870-1,700)	770 (550-1,200)	<640 (<500-<880)
People Living with HIV (PLHIV)	All ages	79,000 (68,000-93,000)	76,000 (66,000-88,000)	73,000 (64,000-84,000)
	Ages 0-14	4,700 (4,000-5,500)	4,000 (3,400-4,800)	3,300 (2,800-3,900)
	Female, 15+ years	39,000 (3,400-4,500)	38,000 (3,300-4,300)	37,000 (3,200-4,200)
	Male, 15+ years	36,000 (30,000-43,000)	34,000 (29,000-39,000)	33,000 (28,000-38,000)
	HIV prevalence ages 15-49	0.8 (0.7-1)	0.6 (0.5-0.7)	0.5 (0.5-0.6)

Source: UNAIDS, 2018.

Cambodia has one of the highest HIV treatment coverage rates in the region, with 81% of the estimated population of people living with HIV (PLHIV) receiving antiretroviral therapy (ART) in 2018 (AIDS Data Hub, n.d.). Seventy-eight percent of those on treatment showed viral suppression (Figure 1 and Table 2).

Figure 1: Cambodia's Progress toward 90-90-90 targets, 2018



Source: AIDS Data Hub, n.d.

Table 2: Scaling-Up HIV Care and Treatment Services, 2018

Indicator	Value	Progress toward 90-90-90 targets		Testing and treatment cascade (90-81-73 targets)	
Estimated number of PLHIV	73,177	Value	Target	Value	Target
PLHIV who know their HIV status	59,837	82%	90%	82%	90%
People on ARV treatment	59,526	99%	90%	81%	81%
People newly initiating ARV treatment	3,527	NA	NA	NA	NA
People on ARV treatment who have suppressed viral load	56,844	95%	90%	78%	73%
People who are virally suppressed among those tested	47,112	NA	NA	NA	NA
People receiving a routine viral load test among those on ARV treatment	49,335	NA	NA	NA	NA

NA: Not Applicable
Source AIDS Data Hub, n.d .

Globally, UNAIDS is leading a process for the development of 2025 target setting, which was launched in mid-2018 and will last until mid-2021. Cambodia's success in this area has been the result of the government's commitment and leadership and active engagement from multiple sectors. This has been coordinated by the National AIDS Authority (NAA) with strong partnership from civil society organizations (CSOs), United Nations agencies and other development partners, and active engagement of PLHIV and key populations (KPs). Though the data are impressive, there remains a gap in the "first 90"—the percentage of the estimated total number of PLHIV in Cambodia who know their HIV status is 82% (AIDS Data Hub, n.d.). Once people are diagnosed, treatment rates are very high; however, new modalities are required to expand access to testing and counseling beyond current program approaches.

1.3 Recommendations from the NSP IV Review

Box 1 presents a brief summary of the main recommendations from the review of the NSP IV, completed in March 2019 (NAA, 2019). These recommendations informed the development of the NSP V.

Box 1. Summary of Recommendations from the NSP IV Review

Prevention

Prevention efforts should be combined/strongly linked to care and treatment and other services, especially outreach activities. In cooperation with the Ministry of Education, Youth, and Sports, the NAA and partners must strengthen the youth network and scale up education on HIV and sexually transmitted infection prevention. Teachers should be oriented to the social challenges faced by men who have sex with men and transgender people. Training and coaching of CSOs should be organized based on new approaches, such as boosted integrated active case management and the community action approach.

Care and treatment

HIV/AIDS services should be integrated into other healthcare services. The Group of Champions in priority operational districts—a forum for providers and partners to review the HIV cascade in their respective districts—should be expanded. Potential sources of financing include the Health Equity Fund, service delivery grants, and commune budgets. Partnership with the private sector for HIV testing and provision of comprehensive HIV and sexually transmitted infection services for KPs should be explored.

Impact mitigation

The NAA should work with the National Social Protection Council, Ministry of Health, and Ministry of Planning to strengthen social protection for PLHIV. The NAA should negotiate with the Ministry of Health and the Ministry of Economy and Finance to enable the use of service delivery grants to support a) poor PLHIV and KPs to access HIV services, b) funding for staff in key HIV support positions, and c) key HIV activities at health facility and community levels.

Leadership and coordination

Policy recommendations from the Policy Advisory Board and technical advisory boards through Technical Working Groups and departments at the national and provincial levels should be better implemented. The use of local mechanisms and budgets at referral hospitals, health centers, and commune levels to support key HIV activities and CSOs should be explored. The NAA, National Centre for HIV/AIDS, Dermatology, and STIs (NCHADS), the Ministry of Economy and Finance, and development partners should agree on how to fill workforce gaps at ART and HIV testing sites. Access to care and treatment for PLHIV in rehabilitation centers and prisons should be discussed with relevant stakeholders.

Box 1 continues on following page…

Enabling environment

The NAA should organize trainings in hotspot provinces using the new training curriculum, including behavior change, to ensure that stakeholders understand relevant laws and policies as well as the new roles of police and local authorities in the HIV response. PLHIV and KPs should participate in key platforms, such as the Country Coordinating Committee of the Global Fund to Fight AIDS, Tuberculosis and Malaria meeting. The HIV/AIDS law should be amended to include access to HIV testing, care, treatment, and budget support through the Health Equity Fund for youth, especially those younger than 18 years of age. The NAA should facilitate reduction of stigma and discrimination against KPs into relevant policy documents and strategic plans.

Monitoring and evaluation

A Technical Working Group for Monitoring and Evaluation should be established to oversee implementation of the NSP V. A clear monitoring framework of indicators, targets, timeframe, and responsible actors must be developed. Systematic progress reports from each ministry should be presented at each Policy Advisory Board meeting. HIV/AIDS should be integrated into the existing mechanisms of relevant ministries. NCHADS should ensure that its Database Management Unit, including provincial networks, is well-monitored and consistently online, to facilitate timely reporting. The NAA, NCHADS, and partners must develop a consolidated plan for monitoring and evaluation capacity building for staff of relevant institutions and ministries.

1.4 Main Stakeholders

The NAA led development of the NSP V as part of its mission to lead Cambodia toward achieving a dynamic, integrated, and sustainable response to HIV. The NAA is a government institution mandated to lead, manage, coordinate, and facilitate a comprehensive, multi-sectoral response to HIV in Cambodia through the “Three Ones Principle”: one national coordinating body, one national strategic plan, and one national monitoring and evaluation system.

Having already succeeded in achieving UNAIDS 90-90-90 targets, the NAA has built on lessons learned to revise the national approach to reinvigorate implementation of HIV programming in order to “go the last mile” to ensure more effective, comprehensive, and sustained coverage of HIV-related services. The next five years are critical. Continued investment in coordination, quality service delivery, and strengthening national systems will result in substantive progress toward achieving the goal of ending AIDS as a public health threat in Cambodia by 2025.

The major stakeholders for HIV/AIDS in Cambodia are the Ministry of Health (MOH) and the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS). Other ministries with important roles are the Ministry of Economy and Finance (MEF); the Ministry of Interior; the Ministry of Education, Youth, and Sports; the Ministry of Social Affairs, Veterans, and Youth Rehabilitation; the Ministry of Women’s Affairs; the Ministry of National Defense; the Ministry of Labor and Vocational Training; the Ministry of Information; and the Ministry of Tourism. National authorities, such as the NAA, the National Authority for Combatting Drugs, the Cambodian Human Rights Committee, the National Social Protection Council, and the National Committee for Sub-National Democratic Development also play important roles. With the decentralization and de-concentration of reforms and increased autonomy of local structures, the roles of provincial-, commune-, and village-level authorities, as well as the health system at the subnational level, are also increasingly important in the HIV response.

Other supporters include development partners, bilateral donors such as USAID, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the United Nations system.

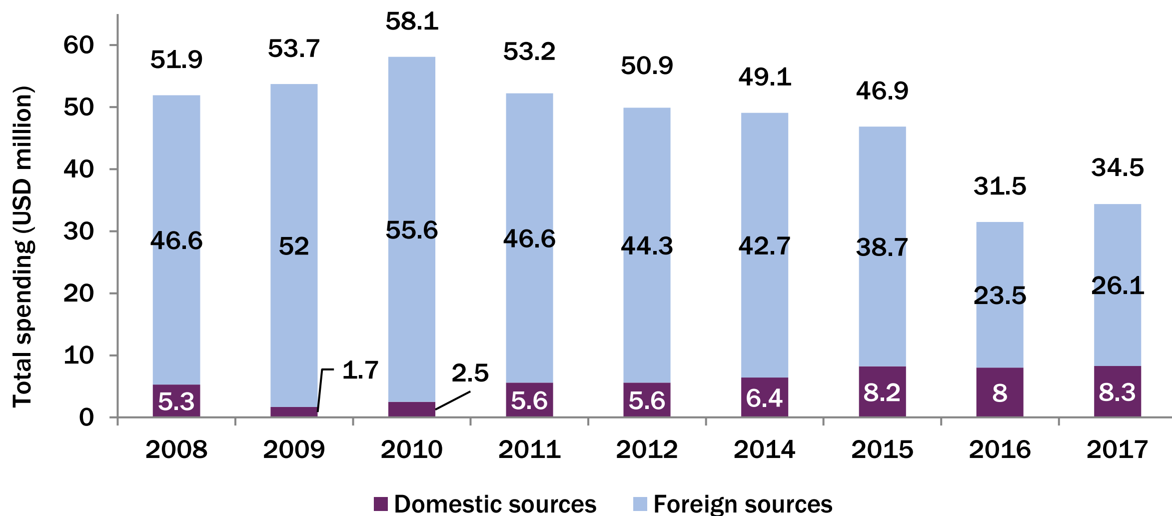
CSOs have been indispensable partners throughout all stages of the cascade, from preventing HIV to diagnosing PLHIV to initiating treatment and ensuring treatment adherence, particularly for KPs. Reductions in external funding have led many CSOs to scale down activities, which has reduced outreach activities, prevention work with KPs, and follow-up of PLHIV on treatment. CSOs, networks of KPs, and PLHIV associations must be supported, as the government has limited access to KPs. The NAA's Policy Advisory Board recognizes the importance of CSOs and will continue to advocate for their participation in the national HIV response. One of the policy measures in *Sor Chor Nor (Circular #213)* also directs the government to provide public funding for CSOs working on the HIV response; more details are provided in section 1.6 (RGC, 2019b).

1.5 Financing the HIV Response

According to the 2016-2017 *National AIDS Spending Assessment*, total spending on the HIV response in Cambodia amounted to USD 34.4 million in 2017—a decrease of 41% from the peak of USD 58.1 million in 2010 in nominal amounts (Figure 2) (NAA, 2019). Though the RGC continues to rely heavily on external assistance to fund its HIV response, its contribution increased to 24% of all spending in 2017 (USD 8.3 million), compared to 17% in 2014 (USD 6.4 million). The government continues to rely heavily on external assistance (USD 26.1 million or 76% in 2017). Some key components, such as prevention activities for KPs implemented by CSOs, are almost completely financed by donors. More than 90% of viral load testing is financed externally (PEPFAR, 2017). The Global Fund's contribution increased from 59% of all donor funding in 2014 to 70% in 2017 (NAA, 2019). Bilateral donors (primarily the United States) accounted for 18% in 2017, down from 29% in 2014. The dollar value of external assistance to Cambodia has stagnated overall, not just in the health sector. Given strong economic growth, this has resulted in total external assistance declining relative to GDP, from around 5.7% (US$807 million) of GDP in 2012 to 3.8% (US$843 million) of GDP in 2017 (World Bank, 2019b).

Salaries accounted for the largest share (USD 7.38 million, or 21%) of the total expenditure on HIV in 2017, followed by ARVs (USD 6.6 million, or 19%) (NAA, 2019). The government financed 47% of total salaries and 13% of total ARVs expenditure in 2017 (USD 0.8 million out of USD 6.6 million). Expenditure related to program management, administration, and technical assistance accounted for 17% (USD 5.9 million) of the government HIV spending in 2017, more than double the proportion in 2014 (8%). With expected reductions in future donor financing, this proportion is likely to reduce as the RGC increasingly contributes to commodities and service delivery activities. Only about 2% of the government's budget for HIV activities goes toward prevention activities. The country's Global Fund grant for 2018-2020 (HM-C-MEF, GA Number: 1526) includes the following distribution of funding: ARVs: 33.3%; opportunistic infections and patient care: 12.4%; lab agents: 13.1%; and planning and monitoring and evaluation: 10.8% (Global Fund, n.d.).

Figure 2: Spending on HIV by Main Financing Source, 2008-2017



Source: NAA, 2019.
Note: Data for 2013 not available.

1.6 Government Political Commitment: *Sor Chor Nor #213*

Policy circular *Sor Chor Nor* (SCN) *#213*, issued in February 2019, instructs the NAA and relevant ministries to adopt six new policy measures (Annex 1). These include the use of local budgets to support the HIV response and CSOs; social protection, including the Health Equity Fund (HEF), for PLHIV; budget packages for operational districts; supporting referral hospitals and health centers to implement the HIV response; conducting fiscal space for HIV; and increasing the MOH's efficiency by strengthening human resources, procurement, and information systems (RGC, 2019b) (Annex 1).

The importance of SCN 213 cannot be understated; it gives impetus to developing further policy measures, pushing for incorporation of a well-established and accomplished—but largely vertical—program into the MOH, and allocating resources for HIV. SCN 213 has informed the development of the NSP, the next Health Sector Strategic Plan, and the Joint Program Review of HIV. In close collaboration with MOH, the MEF, the Ministry of Planning, the Ministry of Interior, the Supreme National Economic Council, and the Council of Ministers, the NAA is leading the planning for the implementation, follow-up, and monitoring of SCN 213. The NAA organized an inter-ministerial meeting on the circular in March 2019 and further follow-up activities are underway to ensure effective implementation, with technical support from development partners. SCN 213 is a core government policy document that helps the NAA advocate for active participation from other ministries in the HIV response. It is the ultimate guiding tool to support the NAA's work with all partners to achieve the objectives of the NSP V.

1.7 Methodology

The NSP V was primarily written by a team of international and local consultants. The team reviewed various reports and documents, starting with the NSP IV. After a visioning exercise in March 2019, the team developed a series of drafts that were presented to five steering committee meetings held between May and August 2019. Special consultations were held with the NAA team, CSO partners, UNAIDS, and selected ministries. The final draft was presented

at a validation workshop on September 9, 2019. NAA officials, other government ministries and coordinating bodies, CSOs, KP representatives, UNAIDS, and development partners such as USAID reviewed the drafts and attended the meetings and workshops. Financial support for the development of the NSP V was provided by UNAIDS and the Health Policy Plus (HP+) project—funded by the U.S. President's Emergency Fund for AIDS Relief's (PEPFAR's) Sustainable Financing Initiative for HIV/AIDS at the U.S. Agency for International Development (USAID).

2. Vision, Mission, Goal, Objectives, and Principles

2.1 Vision

The vision of this *Fifth National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023)* (NSP V) is a Cambodia free of HIV/AIDS, with better health and well-being for all people. It is closely aligned with the vision, articulated in the *Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector 2016-2020*, to "reach the 90-90-90 targets by 2020 and the virtual elimination of new HIV infections in Cambodia by 2025 through high-quality prevention, care, and treatment services for HIV/AIDS and [sexually transmitted infections] within the health sector" (MOH, 2016, pg. 16). It is also closely linked to the HIV Joint Monitoring Indicator outcome for 2019-2023 of AIDS elimination as a public health threat by 2025, with 95-95-95 targets achieved (see Annex 4) (RGC, 2019a). The Ministry of Health is currently developing the fourth Health Sector Plan (2020-2025) and the National Centre for HIV/AIDS, Dermatology, and STIs is undergoing a joint HIV program review and developing a strategic plan for HIV in the health sector for 2020-2025.[2]

2.2 Mission

The mission of Cambodia's National AIDS Authority (NAA) is to lead the country toward a dynamic, integrated, and sustainable response to HIV.

2.3 Goal

The goal of the NSP V is to move toward ending AIDS as a public health threat by 2025. Ending AIDS as a public health threat is defined in the 2030 Agenda on Sustainable Development as a 90% reduction in new HIV infections and AIDS-related deaths, compared to 2010 baseline estimates, while achieving 95-95-95 treatment targets (UNAIDS, 2017a).

2.4 Principles

The following principles guided the development of the NSP V: national ownership; alignment with the SDGs and government policies; sustainable financing through increased allocation of government funding and efficient use of resources; multi-sectoral collaboration; people-centered approaches and equity; gender equality; civil society participation; and evidence-based interventions.

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[2] Results and outcomes of the next health sector plan will be completed later this year, after the NSP V is finalized. MOH/NCHADS indicators and targets will be adapted by the NSP V once finalized.

2.5 Strategies

The NSP V goal of moving toward ending AIDS as a public health threat by 2025 will be achieved through implementation of the four strategies that were identified by the Steering Committee and key stakeholders during the review of NSP IV and the Visioning Workshop for NSP V (See Annex 2). Each of the strategies has a desired outcome to be achieved through the implementation of sub-strategies outlined below. The strategies and sub-strategies are presented in further detail in Section 3.

An implementation plan will be developed after the NSP V is formally launched. A monitoring framework to assess progress on implementation, with agreed-upon targets, timelines, indicators, and means of verification are presented in Section 6.

Strategy 1: Deliver comprehensive prevention, care, treatment, and support through a multi-sectoral approach

This remains the core of an effective response to HIV, wherein all PLHIVs and key populations are reached by a diverse range of services, enabling them to know their HIV status, protect themselves and others, start and maintain antiretroviral therapy, and achieve undetectable viral loads throughout their lifetime, regardless of age, sex, sexual orientation, gender identity and expression, or drug use status.

Strategy 2: Integrate HIV responses into the health system, relevant ministries, and national coordinating bodies

Comprehensive access to services should not be a vertical or stand-alone activity. In recognition of the relationships between HIV, sexual and reproductive health and rights, and universal health coverage; and using the framework of resilient and sustainable systems for health, increased integration of HIV services into health programs and other sectors should be pursued.

Strategy 3: Expand social protection coverage and improve access to health, social, and legal services for PLHIV and KPs

Legal and other barriers—notably stigma, discrimination, and all forms of criminalization—must be reduced to increase access to HIV services. This is especially true for young people and key populations such as female entertainment workers, men who have sex with men, transgender people, and people who inject drugs. Social protection schemes should cover PLHIV and key populations. Civil society and nongovernmental organizations (NGOs) that provide essential services for key populations should be supported by the government as donor funding declines.

Strategy 4: Increase government financing to 50% of all HIV expenditures by 2023, and allocate a share of the government budget to CSOs for delivery of critical HIV services

To move toward sustainable financing of the HIV response, the government must increase its budget allocation to HIV programming and plan for the transition away from external assistance. Particular attention must be given to financing key components of the response, such as health worker salaries, antiretroviral medications, and prevention. The government must also plan to finance the provision of critical interventions by civil society in the context of declining donor funding. There are opportunities to promote both sustainability and

integration by incorporating HIV interventions in the national social protection system's benefit package.

Figure 3 illustrates the relationship between the strategies and goal of the NSP V. Figure 4 shows the links between the vision, mission, outcomes, and strategies.

Figure 3: The Relationships between the Four Strategies and the Goal of NSP V

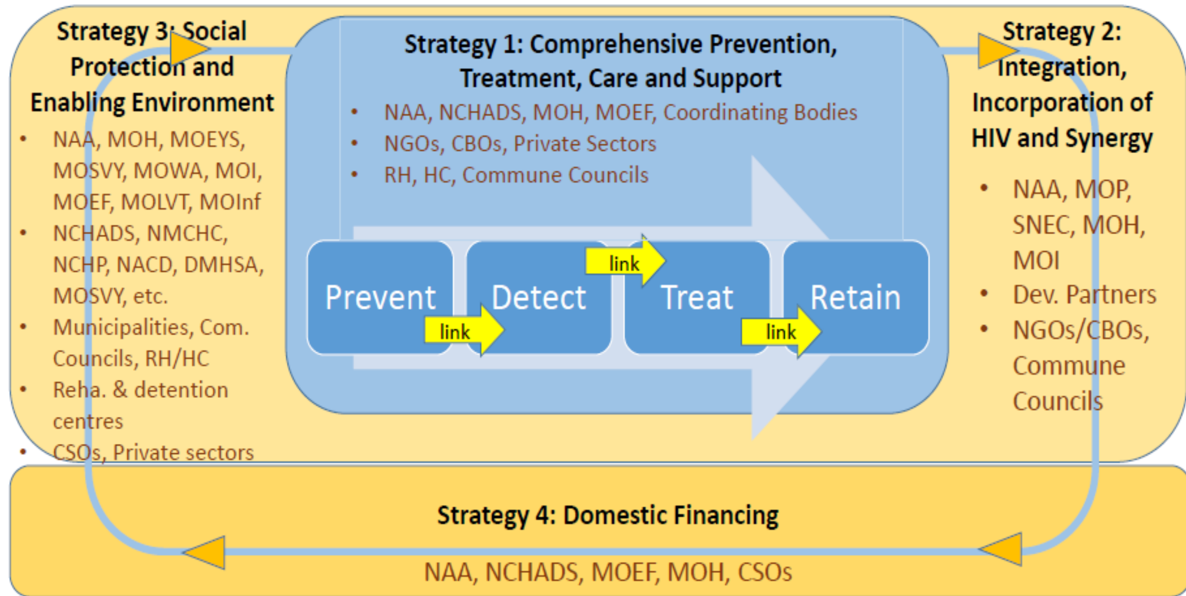
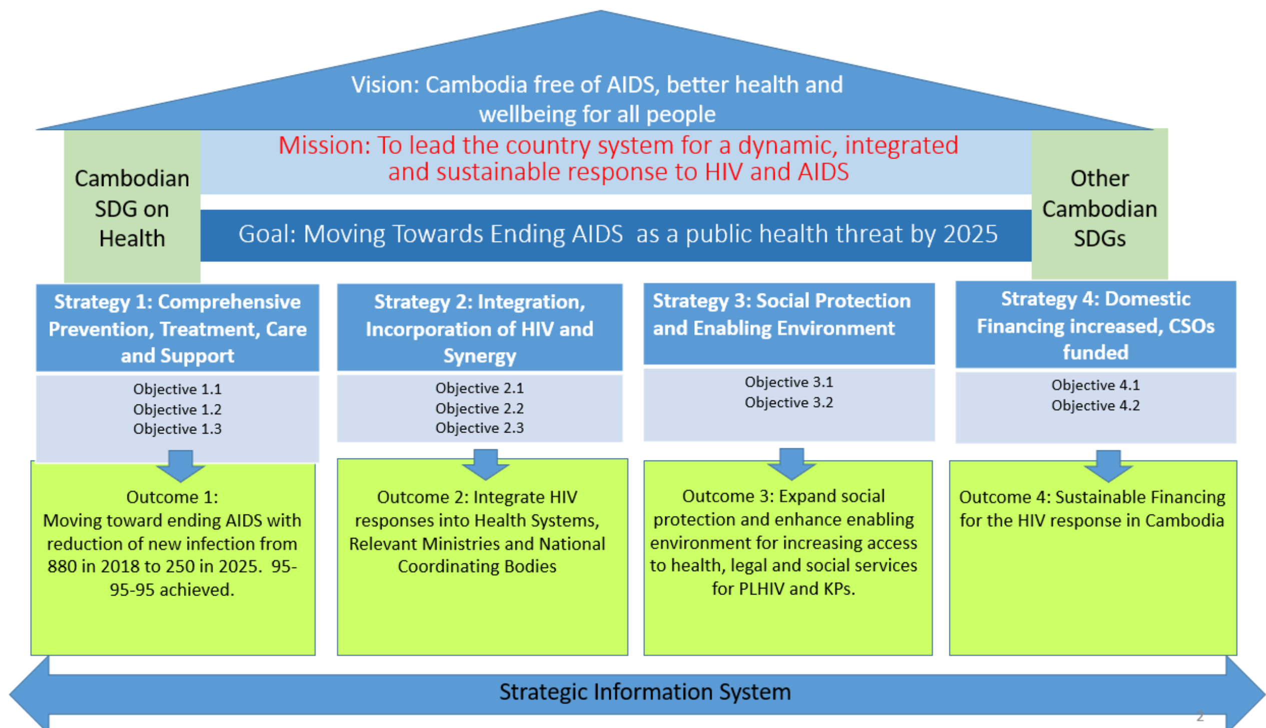


Figure 4: NSP V Vision, Mission, Outcomes, and Strategies



3. Strategies

Strategy 1: Deliver comprehensive prevention, care, treatment, and support through a multi-sectoral approach

Outcome: Moving toward ending AIDS by reducing new infections from 880 in 2018 to 250 in 2025.[3] Ninety-five percent of all estimated PLHIV know their HIV status; 95% of those who know their status are on treatment; and 95% of PLHIV on treatment have a suppressed viral load (known as "95-95-95").

The NAA will lead multi-sectoral collaboration and develop partnerships to help achieve these goals and targets. Reducing the number of new infections involves the following:

1. Knowing where new infections occur (e.g., provinces, populations, diagnostic facilities, etc.) by age group
2. Increasing access to various modalities of HIV testing in all sectors
3. Using effective prevention measures, including increasing condom use, clean needles, STI diagnosis and treatment, contact tracing, early initiation of treatment and enhanced retention, use of pre-exposure prophylaxis (PrEP), and expanding antenatal care testing and prevention of antenatal and perinatal transmission

Reaching "95-95-95" is a step toward ending AIDS as a public health threat by 2025 (UNAIDS, 2019). In practical terms, reaching these targets means expanding and accessing testing services, starting people on treatment as soon as their status is known, and keeping them on treatment in order to reduce viral load levels. Currently, as shown in Figure 1, 82% of PLHIV in Cambodia know their HIV status (AIDS Data Hub, n.d.). Raising this proportion to 95% will be the main challenge, as Cambodia's HIV response has already proven effective in linking newly identified PLHIV to ART and maintaining viral suppression.

Effective prevention means reducing the number of new infections toward elimination levels (UNAIDS, 2017a). HIV prevention in Cambodia remains challenging, with roughly one new infection occurring every 10 hours, or five new infections every two days.[4] The Cambodian epidemic is established in KPs such as men who have sex with men, transgender people, female entertainment workers, and people who inject drugs, wherein HIV rates are between 4 to 30 times higher than that of the general adult population, which is now estimated to be 0.54% (Figure 5) (AIDS Data Hub, n.d.). Long periods between national surveillance and delayed release of findings hinders responses to changes in the epidemic. HIV prevalence rates can rise rapidly in some sub-sections of KPs, such as people who inject drugs who share needles. Therefore, other sources of information, such as program data, must also be considered. CSOs that have proven their capacity to reach KPs and therefore should be prioritized for funding to implement prevention interventions.

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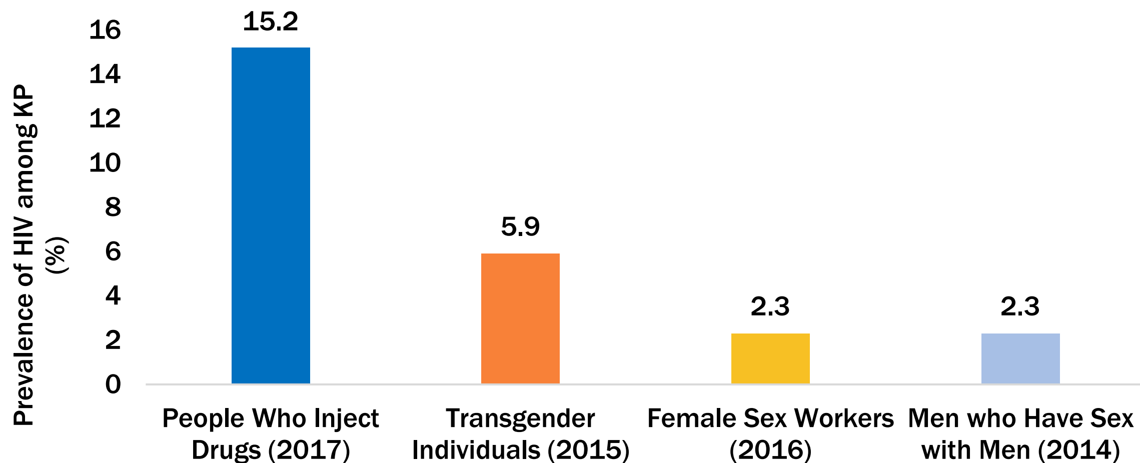
[3] Calculation of "ending AIDS target by 2030" using percentage reductions in Cambodia: new infections in 2010 baseline = 2,319 (based on AIDS Epidemic Model-Spectrum estimates from 2018). A 90% reduction from 2010 baseline = 231 new infections by 2030. However, the RGC announced in 2013 its intent for 2025 as the target year for achieving set strategies and objectives, including new HIV infections targets (UNAIDS, 2019).

[4] AIDS Epidemic Model-Spectrum estimates 880 new infections a year in 2018; about 2.4 new infections per day.



Source: AIDS Data Hub, n.d.

Program data and reports from the field, particularly from HIV testing and counseling during special events, has shown higher rates of infection among men who have sex with men and transgender people than would be expected from surveillance rates.[5] Risk behaviors for HIV among young people are also of particular concern, as they may mix risky sex with use of party drugs, alcohol, and reduced condom use. Additionally, KPs are often unwilling to disclose their status. Of those that do, they are difficult to track because the data is aggregated with the general population. Therefore, NCHADS and partners need to continuously assess the situation and adjust approaches, strategies, and activities.

Achieving epidemic elimination will not be possible without more robust and rapid progress in delivering evidence-based interventions that improve KPs' access to and uptake of HIV services across the cascade. Fundamental to that progress is the generation and use of KP-specific cascade data for both prevention and treatment. The NAA and NCHADS need to update the Key Populations Atlas from UNAIDS, bringing together country-specific data on a variety of indicators disaggregated by KP.

This requires the NAA to coordinate with key representatives from the health and non-health sectors to collect and use data from a variety of sources to identify strategies that are effective at reaching and engaging KPs at different points along the HIV cascade. This will allow targeted investments in programming to address gaps.

Sub-strategy 1.1: Engage all stakeholders to enhance prevention efforts.

HIV prevention in Cambodia is generally categorized into 1) prevention among KPs and 2) prevention among other populations. CSOs are responsible for reaching KPs. It is estimated that KPs, while making up an estimated 1.3% of the adult population ages 15-49 years, may account for 40% of all new infections, with the remaining 60% of new infections occurring "specific target groups within the general population" (NCHADS, 2017, pg. 7). Additionally, many of those labeled as KP may not self-identify this way, have overlapping and/or multiple

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[5] LINKAGES project staff. August 2019. Correspondence with Dr. Tia Phauly and Dr. Vic Salas, NSPV consultants. It was claimed that during special testing events over the past year, 10-30% of those tested (mainly men who have sex with men and transgender individuals) test positive. Most are being tested for the first time and are not the clients of CSOs implementing outreach activities.

risks, or are already reached by current outreach efforts. There is a need for significantly greater differentiation in prevention, outreach, and education services for the wide range of communities, populations, and sub-populations affected by HIV in the country.

Prevention among "non-key" populations (sometimes referred to as "low-risk" or "targeted general" populations) generally occurs through the public health system; health centers; health posts; operational districts and provincial hospitals, including the National Maternal and Child Health Center; and other government ministries, such as the Ministry of Education, Youth, and Sports. Many Cambodians seek care from private health practitioners; thus, all health providers must be involved in the HIV response, not just those in the public health sector.

Other ministries also have a role to play, such as the Ministry of Women's Affairs and the Ministry of Labor and Vocational Training. Although their roles are clear, they are not always well-coordinated or linked to services. To address greater risk of infection among young people, efforts to improve their basic HIV knowledge, motivate them to periodically check their status, and know where to access testing should be coordinated with efforts to improve prevention education through social media channels and influencers.

Sub-strategy 1.1.1 Engage health and non-health sector partners, private providers, CSOs, and NGOs in HIV prevention efforts

NAA advocates for and supports the increased involvement and participation of non-health sector partners—especially CSOs and NGOs working with private sector partners like entertainment facilities and private healthcare providers—to ensure increased access to evidence-based HIV testing and counseling and other prevention measures in various settings. With the evolving epidemic and fast-changing social media technology use among young people, it is imperative to revise and adapt current approaches to ensure effective coverage of all at risk groups and sub-groups. Efforts should be made to enable them to know their HIV status and where to get tested, and retain them with differentiated prevention services adapted to their needs. More detailed roles of the CSOs, NGOs, private providers, and non-health partners focused on prevention activities are presented in Table 3.

Table 3: National and Sub-National Coordinating Bodies and Other Stakeholders Involved in HIV Prevention[6]

3A. Ministries

Actor	Population Reached	Strategies for HIV Prevention
MOH, including NCHADS; National Maternal and Child Health Center; Department of Mental Health and Substance Abuse; operational districts and referral hospitals; and health centers	All populations, KPs, PLHIV	Expand access to HIV testing and counseling, voluntary confidential counseling and testing, and early start to treatment in health facilities, hospitals, antenatal care services, prisons, and rehabilitation centers Enhance implementation of health provider-initiated testing and counseling
Ministry of Education, Youth, and Sports, and youth groups	Youth and students in and out of school	Comprehensive sexuality and health education in schools, strengthening of youth networks, inclusion of HIV into curriculums, HIV training, and improving teachers' skills on sexual orientation, gender identity, and expression Reaching out-of-school youth to ensure their exposure to behavior change communication messages and health services
Ministry of Labor and Vocational Training	All workers and workplaces, mobile populations, entertainment places	Raise awareness about HIV and sexual health and reproductive rights in workplaces and the informal sector, with some KPs (i.e., karaoke and entertainment places) and migrant workers (pre-departure training package)
Ministry of Interior, Department of Local Administration	Commune and province officials	Provide guidelines for HIV integration in commune councils and use of commune budgets to support HIV activities as part of social services implementation
Ministry of Interior, General Department of Prisons	Prisoners	Collaborate with MOH/NCHADS to expand HIV services to prisons Allow continued access to care and treatment for HIV-positive inmates and to detect new cases of HIV
Ministry of Tourism	Tourist establishments	Promote access to and availability of condoms and HIV prevention messages at entertainment establishments, hotels, and guesthouses Include HIV/AIDS in regulation and licensing of entertainment parlors; support NCHADS and partners' efforts on HIV testing and counseling

[6] While this table identifies major stakeholders, it is not a complete list across all settings.

Actor	Population Reached	Strategies for HIV Prevention
Ministry of Social Affairs, Veterans, and Youth Rehabilitation	Rehabilitation and detention centers	Work with the Phnom Penh Municipality responsible for rehabilitation and detention centers (i.e., Prey Speu, "My Chance Center," and Kraing Thnoung) to facilitate better access for NCHADS and NGOs[7] to deliver HIV testing services and more streamlined care and treatment for HIV-positive detainees in rehabilitation centers
Ministry of Women's Affairs	Women and girls	Develop a national gender strategy that includes HIV prevention and treatment and addresses violence against women
Ministry of Information	General public	Raise HIV awareness through public advertising and public service announcements via government information and media channels
Ministry of Defense	Armed services	Raise HIV awareness among the uniformed services
MEF	All population groups	Allocate a greater share of resources to the HIV response—including resources for prevention—and ensure delivery of budgets
Ministry of Post and Telecommunication	General public	Disseminate messages through telecommunications (e.g., phones) and innovative communication channels

3B. National coordinating bodies and local authorities

Actor	Population Reached	Strategies for HIV Prevention
Major cities: Phnom Penh, Siem Reap, Poipet, Battambang, and Sihanouk Ville	KPs, other populations (such as those in detention), local authorities	Mobilize local resources (e.g., entertainment establishments) to support the continuum of prevention, care, and support effort for KPs Local authorities to provide support for the enabling environment necessary for prevention and to allow access for those in detention and/or rehabilitation facilities that are under the direction of local authorities
Local authorities, village leaders, Group of Champions	Targeted general populations	Build strong relationships with patients, respecting confidentiality, and with local authorities, through regular Health Centre Management committee meetings, awareness-raising, informal meetings (public forums), social networking, and discussions with Village Health Support Groups

[7] A formal letter of agreement between the Ministry of Social Affairs, Veterans, and Youth Rehabilitation and the MOH is required for NGOs to obtain access to detention centers.

3C. CSOs, NGOs, KP networks, and the private sector

Actor	Population Reached	Strategies for HIV Prevention
Private sector (e.g., private health practitioners, pharmaceutical companies, pharmacies, etc.)	KPs and the general population	Provision of prevention information and services to clients; access to PrEP, HIV, and viral load testing; ARV medicines; continuing care for those who access care through private physicians; resource mobilization; and corporate social responsibility efforts linked to prevention
NGOs, community-based organizations (CBOs), KP networks, academic and faith-based organizations	KPs and target populations	Provision of prevention information and services to clients; access to PrEP, HIV, and viral load testing; continuing care for those who access care through private physicians; resource mobilization; corporate social responsibility efforts linked to prevention; messages and subtitles in karaoke production and centers
Entertainment facilities	KPs and target populations	Provision of prevention information and services to clients; access to PrEP and HIV testing; corporate social responsibility efforts linked to prevention; messages and subtitles in karaoke production and centers
CSOs, NGOs, and KP networks; informal groups of young people	KPs, vulnerable groups, youth groups, etc.	Expand outreach and testing services, reach KPs and the most vulnerable, and reduce stigma and discrimination Tailor messages and advertisements by social influencers to reach different KPs to encourage behavior change and the use of preventive measures

3D. Other national coordinating authorities

Actor	Population Reached	Strategies for HIV Prevention
National Authority for Combatting Drugs	People who use drugs; police and law enforcement	Adopt a public health approach to drug use and provide support for key harm reduction interventions

Sub-strategy 1.2: Ensure that NCHADS receives sufficient assistance to achieve 95-95-95 goals

Cambodia is one of only seven countries worldwide currently achieving high rates of viral suppression among all PLHIV (NAA and UNAIDS, 2018a). However, reaching elimination requires special efforts to identify and reach those who may be at higher risk of HIV, such as migrants and mobile populations, STI clinic clients, partners of PLHIV and KPs, and other targeted general populations, to know their HIV status, be enrolled and retained in the healthcare system, and practice HIV prevention consistently.

To do this, all HIV stakeholders must ensure that NCHADS receives sufficient resources and support. Human resources across program-implementing agencies, including government, CSOs, NGOs, and private providers, must be strengthened through a comprehensive capacity-

building plan. The MOH and NCHADS should join the NAA in strengthening the country's system to provide a dynamic, integrated, and sustainable response to HIV. This can be achieved by strengthening the links between Boosted Integrated Active Case Management, Partner Notification Tracing and Testing, and the Community Action Approach framework to create an enabling environment, social protection measures, integration in health and non-health sectors, and domestic resource mobilization.

Sub-strategy 1.2.1 Enable non-health sector partners, CSOs, and the private sector to mobilize

The NAA advocates for and supports non-health sector partners, CSOs, and the private sector (including entertainment facilities) to mobilize supportive policies and resources, build capacity, and coordinate their response to HIV.

NSP V aims to increase the involvement of the private sector in Cambodia's HIV response. Opportunities to support the response include resource mobilization via corporate social responsibility initiatives, provision of services via the introduction of PrEP, and improved adherence to ART and viral load testing guidelines and reporting requirements.

Sub-strategy 1.3: Strengthen CSOs to enable better support of prevention efforts

In Cambodia, CSOs are the backbone of the HIV response with regard to KP prevention efforts. It is unlikely that the government or private sector will be able to take on a significant portion of this work, even in the long term. Creating an enabling environment through community involvement and participation in decentralized planning, programming, and implementation is crucial to ensure that services are available for all population groups. This is also a necessary component in ensuring that services are designed in a manner that responds to needs and facilitates retention across the HIV care continuum.

The NAA will strongly support CSO representation in various forums and mechanisms for combating HIV, such as the Global Fund's Country Coordination Committee and technical and steering committees, as well as in policy discussions at all levels. The NAA will also advocate for increasing domestic resources for prevention, care, support, and community-strengthening systems in addition to treatment (see Strategy 4). In addition, it will support CSOs to implement critical prevention interventions with KPs and non-key populations and in entertainment facilities.

Strategy 2: Integrate HIV response activities into the health system, relevant ministries, and national coordinating bodies

Outcome: By 2023, an initial assessment and suggested framework for integration of HIV programming into the health system will be developed, with the full engagement of all partners.

Cambodia's HIV program was largely designed as a vertical program, heavily reliant on external funding, that focused on providing inputs to address identified system gaps in service delivery. The integration of HIV services into the health system is not only essential to ending AIDS as public health threat but will also yield broader health outcomes, including delivering health services in a sustainable, equitable, and effective way. It will foster a resilient and sustainable system for health, which is necessary for accelerating progress toward achieving universal health coverage targets.

In Cambodia, government facilities have been involved with ART treatment but not prevention, while CSOs have implemented various prevention services and testing strategies. The *Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector* describes integration of HIV using the Community Action Approach, adoption by primary healthcare structures such as village health support group volunteers and health centers, and eventual incorporation of HIV databases and annual HIV operational planning into the MOH's system (MOH, 2016). It also identifies plans to integrate HIV within the MOH's non-communicable disease departments. However, a recent rapid assessment of the Community Action Approach and Partner Notification Tracing and Testing approaches showed many areas for improved implementation and a need to clarify roles and responsibilities of key players (NCHADS, 2018). Furthermore, a recent case study on Cambodia and other countries shows trends toward HIV integration into health systems using analysis based the World Health Organization's framework for health systems (Wright et al., 2018). It describes HIV integration in Cambodia as "partly integrated" in terms of HIV policy and governance; service delivery and human resources; and strategic investments and efficiency; and "not integrated" at the commodity supply chain, strategic information, or health information system levels.

The NAA and the MOH should lead the integration of the HIV response into various elements of the health system, including those related to health sector reforms, improving efficiency and coordination, human resource development, and universal health coverage. Policy measure six in SCN 213 explicitly supports this integration (RGC, 2019b). The NAA, MOH, and MEF should discuss the implementation of SCN 213, absorb new healthcare worker salaries, and arrange for social contracting for CSOs to perform critical interventions, as outlined in Strategy 4.

Sub-strategy 2.1: Develop a common framework for integration of HIV into the health system

Over the next five years, efforts to integrate the HIV response into the health system should capitalize on existing resources and strengthen the country system to address the following areas:

1. Health management information systems
2. Procurement and supply chain management
3. Human resources for health
4. Integrated service delivery
5. Community systems and responses
6. Private sector engagement and public-private mix
7. Governance, leadership, and accountability
8. Health sector financing and financial management
9. Program implementation and management

While many of these core components are already being addressed, some—such as the integration of community systems and responses—are lagging, due to constraints posed by donor funding and the organization and limitations of other vertical systems that support integrated care at the community level. In the long term, integration requires a change in mindset, revised policies and institutional relationships, and changes in behaviors and resource use to address constraints in a more sustainable manner.

Sub-strategy 2.1.1 Work together to agree on a framework for HIV integration

The NAA will advocate with the MOH for the co-development of an Integration Framework for HIV in the Health System, based on an understanding of Resilient and Sustainable Systems for Health and the nine components mentioned above. The findings from this analysis, which requires involvement of the MOH, NCHADS, the NAA, and partners, will provide a roadmap of integration of the HIV response within the health system.

Sub-strategy 2.2: Ensure ministries and partners include HIV programming within their plans and programs

HIV is not an issue that the health sector alone can solve; there are various roles that other government ministries must fill. Ministries can adopt the following strategic steps to support integration:

1. Include HIV into strategic plans, three-year rolling investment plans, and annual budget plans. Strategic plans should be aligned with the health sector's goals in reducing new infections, knowing one's status, referral to services, reaching "95-95-95," and reducing stigma and discrimination. It is essential that the messages disseminated by all ministries are consistent, accurate, based on evidence, linked to services—especially HIV testing and treatment—and aim to reduce discrimination and stigma
2. Provide resources for HIV programming and assign focal person(s) to the NAA
3. Use the NAA's technical and policy advisory boards to revise policies and institutional relationships in order to change behaviors and resource use to address identified constraints in a more sustainable manner

The NAA should provide guidance and technical support to the relevant ministries, encourage scale-up, and, if paired with ministry focal point(s), act as a backstop/supporter.

Sub-strategy 2.2.1 Sub-strategy by ministry

Table 4: Sub-Strategy by Ministry

Ministry	Sub-Strategy
Ministry of Education, Youth, and Sports	NAA and partners will ensure that HIV education for young people is included in the ministry's strategic plan, three-year budget rolling plans, and annual plans, and resources are allocated to support implementation
Ministry of Social Affairs, Veterans, and Youth Rehabilitation	NAA and partners will ensure that HIV education for workers, migrants, and related social support is included in the ministry's strategic plan, three-year budget rolling plans, and annual plans, and resources are allocated to support implementation
Ministry of Labor and Vocational Training	NAA and partners will ensure that HIV education for KPs, formal and informal sector, and migrant workers is included in the ministry's strategic plan, three-year budget rolling plans, and annual plans, and resources are allocated to support implementation
Ministry of Women's Affairs	NAA and partners will ensure that HIV education for women is included in the Neary Rattanak Plan, three-year budget rolling plans, and annual plans, and resources are allocated to support implementation

Ministry	Sub-Strategy
Ministry of Interior	NAA and partners will urge the General Department of Prisons of the Ministry of Interior to allow NCHADS and NGOs better access to prisons to support HIV-positive inmates' access to care and treatment. The National Authority for Combating Drugs and the Department of Mental Health and Substance Abuse would be requested to intervene, as a proportion of inmates are also former (or current) people who use/inject drugs
Ministry of Interior and Commune Councils	NAA and partners will advocate to the Ministry of Interior and selected commune councils to use a portion of commune budgets to support HIV activities. In principle, the ministry supports the integration of HIV/AIDS activities into commune investment and development plans and requests guidance from the NAA to supplement commune planning tools
MEF	NAA and partners will advocate to and support the MEF to steadily increase resource allocation for the HIV response and ensure that the various types of resources allocated for HIV under SCN 213 and the national social protection policy framework are effectively implemented to serve vulnerable populations. These advocacy efforts should be undertaken at both the technical and management level
Ministry of Information	NAA and partners will advocate to and support the Ministry of Information to include educational messages on HIV in government information channels
Ministry of Tourism	NAA and partners will advocate to and support the Ministry of Tourism to ensure that the ministry supports the education and testing of entertainment workers in partnership with NCHADS. Eventually, this effort should be included in the ministry's strategic plan, three-year budget rolling plans, and annual plans, and resources should be allocated to support implementation

Sub-strategy 2.3: Coordinate with other authorities to include HIV interventions in policies and programs

Apart from the ministries noted above, coordination bodies such as the National Authority for Combating Drugs have roles and responsibilities related to HIV/AIDS policies and programs, since they are responsible for enforcement of drug laws, policies, and people who use drugs (a KP group). These entities have different perspectives on responses to drug use, drug demand reduction, harm reduction, and on how people who use/inject drugs can be reached. For example, a law enforcement approach is different from a public health or harm reduction approach; many people who inject drugs on ART have discontinued treatment and harm reduction services following a crackdown on illegal drugs. PLHIV and KPs who are detained in rehabilitation centers often do not have access to routine health services, ART, or methadone. The National Authority for Combatting Drugs allows CSOs to carry out harm reduction services (outreach and distribution of clean needles) in specified settings.

In settings such as prisons, detention facilities, and rehabilitation centers, the relevant ministries and their departments (i.e., Ministry of Social Affairs, Veterans, and Youth Rehabilitation; Ministry of Interior, General Department of Prisons; Department of Mental Health and Substance Abuse; provincial health departments) will collaborate with local authorities, prison authorities, and municipal governments to allow access to health services for detainees, including HIV prevention and treatment services. CSOs that implement HIV

services in detention centers will need to obtain memorandums of understanding with relevant authorities.

Other relevant coordination and multi-sectoral or multi-ministerial bodies are the Cambodian Human Rights Committee, the Supreme National Economic Council, and the National Social Protection Council. The Cambodian Human Rights Committee is a well-known supporter of lesbian, gay, bisexual, and transgender rights, and could also be involved in advocacy for access to health services as a human right. The Supreme National Economic Council is the prime policy level council that can support expanded fiscal space for HIV domestic financing, as mentioned in SCN 213 policy measure five (RGC, 2019b). The National Social Protection Council advises the Ministry of Planning and related agencies on social protection for poor and vulnerable groups.

Sub-strategy 2.3.1 Improve care and treatment for HIV-positive detainees

The NAA and partners will work with the National Authority for Combatting Drugs, the Department of Mental Health and Substance Abuse, the Ministry of Social Affairs, Veterans, and Youth Rehabilitation, and Phnom Penh Municipality to take more proactive roles in care and treatment of infected detainees in rehabilitation centers. These entities will regulate NCHADS and NGO visits to detainees. Eventually, proper access to ART and methadone (and other harm reduction services) for relevant detainees should be secured.

Sub-strategy 2.3.2 Include PLHIV in social protection mechanisms

The NAA and partners will engage with the National Social Protection Council for inclusion of PLHIV as a highly vulnerable group and ensure that social protection mechanisms cover (not explicitly exclude) HIV services and programs (see Strategy 3).

Strategy 3: Expand social protection coverage and improve access to health, social, and legal services for PLHIV and KPs

Outcome: 100% of PLHIV will be covered by a social protection mechanism by 2023 and be able to access a variety of health, social, and legal support services.

Cambodia's *National Social Protection Policy Framework 2016-2025* aims to build an effective and financially sustainable system that serves as a policy tool to reduce and prevent poverty, vulnerability, and inequality while boosting human development and economic growth (ILO, 2017). The framework aims to harmonize, integrate, and strengthen existing schemes and expand the social protection floor to respond to all contingencies throughout life. The envisioned system rests on two main pillars: social assistance and social insurance. The latter consists of employment injury insurance, social health insurance, and pensions. The *United Nations Development Assistance Framework 2019–2023, Cambodia* also commits support and expanded social protection for PLHIV (UNDP, 2019).

In Cambodia, the coverage provided by various social health protection mechanisms remains fragmented, though there have been major improvements in some mechanisms (Table 5). A senior MOH official announced that the HEF covers HIV services as of July 1, 2019, based on the new service packages that were finalized twelve months prior (Derriennic, 2019). To be effective, these efforts must engage CSOs that are well-connected to PLHIV and the poor.

Table 5: Coverage of Social Health Protection Mechanisms

Protection Scheme	Population Coverage	Services Covered	Financial Contribution
Government and donor subsidies	All service users	Immunization, tuberculosis, HIV/AIDS, malaria, other services in the minimum package of activities (MPA) or complementary package of activities (CPA); maternal and child health	Free services, subsidized services (pay user fees only), commune council social funds
HEF	Those using ID poor cards (including post-ID and on-demand ID-poor): approximately 3 million beneficiaries	MPA, CPA services + transport, food	Free services + support for food and transport
Reproductive health vouchers	Women of reproductive age, pregnant women	Reproductive and sexual health services, transport + cash transfers	Free services + support for transport and cash transfers for antenatal care with equity cards
Social health insurance, work injuries (National Social Security Fund)	1 million salaried workers	MPA, CPA, transport, maternity, disability benefits	Free services + ambulance support + other benefits (employer pays)
Voluntary health insurance	118,000 voluntary members	MPA, CPA services + transport	Free services, transport support
Private health Insurance	<5% of population	Limited benefits package (risk rated)	Reimbursements with ceiling
Pensions	Retired government staff, military, people living with disabilities	N/A	Government-subsidized
Others (NGO projects, Commune-Managed HEFs, etc.)	Site- or population-specific in project areas	Transport, food subsidies, MPA, CPA	Subsidized services, voluntary contributions

Source: Adapted from Ir, P., 2016.

Among the current social protection initiatives, the following are most relevant for HIV:

- ID-Poor/Equity cards issued by the Ministry of Planning and commune officials, including the so-called “Post ID-Poor” at health facilities and the On-Demand ID-Poor
- HEFs (MOH/MEF), which cover HIV services as of July 2019

- National Social Security Fund[8]
- Commune Council allocations and budgets for social services and Commune-Managed HEFs

Sub-strategy 3.1: Expand inclusion of HIV services in social protection scheme benefit packages

Coverage of HIV services by the HEF will rapidly support the expansion of social protection mechanisms for HIV. ART, HIV testing, viral load tests, and medicines for opportunistic infections are already free of cost in the public sector. The shift in coverage is a step to place HIV service provision on equal footing with the provision of other services covered by the HEF and indicates greater commitment toward mobilizing domestic resources for HIV. Findings from a 2018 study by HP+ showed that 18% of PLHIV have ID-poor cards (Bhavesh and Mony, forthcoming).

Sub-strategy 3.1.1 Ensure social health protection mechanisms include the poor

Expand all ID-poor mechanisms and other social health protection systems, such as the National Social Security Fund, to ensure that they include poor PLHIV. (On-Demand ID Poor will be implemented in 2019-2020 and scaled up to other provinces.) Raise awareness of expanded HEF coverage of HIV services with providers and NGOs working with PLHIV. NAA will strengthen its collaboration with institutions responsible for social protection (the Ministry of Planning and the National Social Protection Council) to ensure effective inclusion of poor KPs and PLHIV.

Sub-strategy 3.1.2 Support post-ID poor inclusion within the HEF

The NAA and partners will advocate to and support the MOH to effectively roll out post-ID poor inclusion within the HEF to capture all PLHIV who are eligible for HEF but who have not been identified by the Ministry of Planning.

Sub-strategy 3.1.3 Institute advocacy and monitoring mechanisms

Institute mechanisms for advocacy and monitoring of coverage and effectiveness of the various social protection mechanisms. These mechanisms should engage focal points of the NAA, relevant partners, and CSO representatives.

Sub-strategy 3.1.4 Ministry of Planning and the National Social Protection Council to provide a framework for inclusion

Provide a framework for people to request inclusion within HEF through on-demand ID Poor and to ensure that the standard ID-poor, post-ID poor, and other systems result in coverage for all PLHIV, including those who may be living alone, without family, or who are not part of a household, in accordance with SCN 213 policy measure two (RGC, 2019b).

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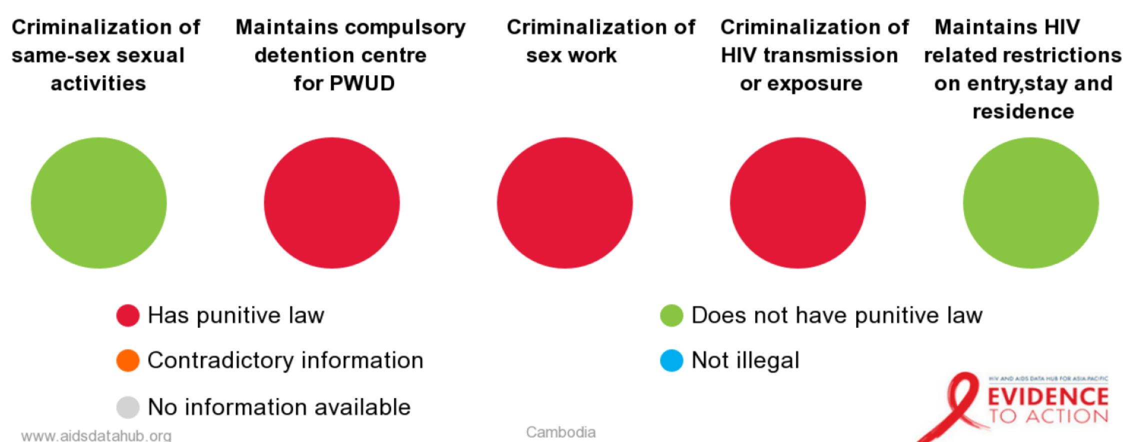
[8] This fund is paid solely by employers but is said not to cover HIV, as HIV services and drugs are currently provided free-of-charge.

Sub-strategy 3.2: Make legal and policy frameworks more inclusive

The preliminary findings of the Stigma Index 2.0 show that in general, stigma and HIV-related discrimination in Cambodia has declined over time. HIV status disclosure rates have increased and less than 6% of the 1,222 PLHIV who responded to the survey reported experiencing discrimination (Population Council, Unpublished). Cambodia is moving toward "zero discrimination," as seen in Figure 6. Same-sex activity is not considered criminal and there are no HIV-related restrictions on entry, stay, or residence.

Review of the NSP IV found several issues affecting people who inject drugs—especially during drug crackdown campaigns—including arrests, abuse, treatment disruption, and lack of access to these populations in detention facilities (NAA, Unpublished). Youth, especially those younger than 18 years who are KPs, have limited access to testing, counseling, or other prevention services, since consent from parents/guardians is required in health facilities. In this regard, the training that the NAA conducted for local authority, police, and healthcare workers in four provinces should be rolled out to other high-burden districts to create a better environment for uptake of critical health and non-health services.[9]

Figure 6: Getting to "Zero Discrimination" in Cambodia



Source: AIDS Data Hub, n.d.

Sub-strategy 3.2.1 Advocate for review of law on prevention and control of HIV/AIDS

The NAA and its partners will advocate with the Ministry of Justice to review the law on prevention and control of HIV/AIDS and consider revisions to make it more explicitly supportive of young KPs and youth access to all types of HIV services.

Sub-strategy 3.2.2 Engage and support the private health sector

The NAA will support the private health sector's expanded involvement in the HIV response (e.g., ARV medicines, viral load testing, pricing, distribution, self-testing, etc.) while NCHADS will better regulate the private health sector's adherence to HIV-related guidelines and

[9] The content of these trainings must include innovative approaches, such as sophisticated social media, virtual density mapping, Peer Driven Initiative (PDI+)/Snowball, and referral and networking to address gender-based violence, PrEP, and the link between Patient Management and Registration System and social protection for KPs and most-at-risk populations.

regulations, including reporting. This initiative is also related to Strategies 1 (multi-sectoral involvement) and 4 (domestic financing).

Sub-strategy 3.2.3 Advocate for an enabling environment at local levels

In collaboration with NCHADS and the MOH, the NAA will continue to advocate for an enabling environment for the HIV response by training police and local authorities in hotspot provinces to ensure better implementation of the Community Action Approach, government initiatives, and prevention among KPs.

Strategy 4: Increase government financing to 50% of all HIV expenditure by 2023 and allocate a share of the government budget to CSOs for delivery of critical HIV services

Outcome: Sustainable financing of the HIV response in Cambodia.

Current Financing of HIV

Domestic financing of the HIV response increased from USD 1.7 million in 2009 to USD 8.3 million in 2017, equal to 24% of total AIDS spending in the country (NAA, 2019). External assistance continues to finance the majority of the HIV response (76% in 2017), but domestic financing increased steadily over the past 10 years. Most government funding is used to finance salaries and purchase ARVs. Approximately 2% of current government expenditure goes toward prevention activities.

Estimated Resource Needs

Estimated resource needs for the HIV response between 2019 and 2023 were drawn from the 2018 HIV Transition Readiness Assessment, which was based on the HIV investment case from 2017 (UNAIDS, 2018). These estimates were updated for the NSP V and are presented in Table 5. Resource needs for PrEP were updated using the AIDS Epidemic Model with the estimated unit cost provided by FHI360 using the pilot of PrEP at Chuk Sor as a model (NCHADS, 2019; LINKAGES and NCHADS, 2017). Resource need projections were not broken down by sub-category.

Based on *National AIDS Spending Assessment* classifications, the prevention estimate includes behavior change communication, HIV testing services, condoms and lubricants, diagnostic tests used by communities, STI testing, and prevention of mother-to-child transmission. The care and treatment costs were broken down into various categories (ARVs, opportunistic infections, care and treatment, laboratory, and home-based care and nutrition). The prevention, care, and treatment estimate also include staff costs. Program management costs were classified into planning, coordination, monitoring and evaluation, and research and health information systems. Data on operational costs, utilities, supervision, and general health system expenditures in other ministries were obtained from *National AIDS Spending Assessments* V and VI. These costs were assumed to increase annually at the average rate of increase from 2014 to 2017. In addition, a recent analysis projected the cost of financing the HIV benefit package though the HEF (Bhavesh and Mony, Forthcoming). The HEF estimates were not adjusted for multi-month scripting due to challenges in modeling scale up. Further details on the methods are available in Annex 4.

Total resource needs are estimated to be USD 25.31 million in 2019, increasing to USD 27.23 million in 2023. The main driver is the cost of care and treatment, which is projected to

account for 39% of resource needs in 2023, followed by prevention (25%), program management (21%), and capacity building and transition (9%). The estimated total cost of ARVs is expected to decrease, from USD 6.44 million in 2019 to USD 5.78 million in 2023, reflecting lower ARV unit costs, anticipated reductions in the number of people on treatment, and fewer new infections expected after 2020. ARVs are projected to account for 55% of care and treatment costs in 2023. The estimated resource needs for PrEP increase from USD 0.22 million in 2019 to USD 2.83 million in 2023 because of an expected increase in coverage of KPs (from 30% in 2019 to 42% in 2023). The social protection costs (HEF benefit package) are estimated to increase from USD 0.38 million in 2019 to USD 2.02 million in 2023. The estimated resource requirements do not account for inflation. Annex 3 presents the detailed methodology used to prepare the financing estimates.

Table 6: Resource Needs by Cost Category, 2019-2023 (USD million)

Category	2019		2020		2021		2022		2023	
	USD	%	USD	%	USD	%	USD	%	USD	%
Prevention	3.50	13.8%	3.70	14.9%	3.80	14.8%	3.80	13.8%	3.90	14.3%
PrEP	0.22	0.9%	0.35	1.4%	1.15	4.5%	2.98	10.9%	2.83	10.4%
Care and treatment	11.70	46.2%	10.80	43.4%	10.80	42.2%	10.70	39.0%	10.50	38.6%
Program management	5.02	19.8%	5.13	20.6%	5.24	20.5%	5.35	19.5%	5.58	20.5%
Capacity building and transition	4.50	17.8%	4.10	16.5%	3.40	13.3%	3.00	10.9%	2.40	8.8%
Social protection	0.38	1.5%	0.80	3.2%	1.22	4.8%	1.62	5.9%	2.02	7.4%
Total resource needs	**25.31**	100.0%	**24.87**	100.0%	**25.60**	100.0%	**27.46**	100.0%	**27.23**	100.0%

Sources: UNAIDS, 2017; NAA and UNAIDS, 2018a; NAA, 2019; Authors estimates on PrEP

Estimated Future Funding and Financing Gap

Funding from the Global Fund in 2019 (USD 12.60 million) and 2020 (USD 11.90 million) was estimated using data for the 2018-2020 grant (Table 7) (Global Fund, 2019). It was then assumed to decrease by 5% to 10% per year until 2023 (by USD 9.40 million). There are two main reasons behind the decrease: First, under current allocation rules, funding would decrease because the number of PLHIV is stabilizing in Cambodia; it is likely that the Global Fund will divert resources to other countries with higher burdens. Second, since Cambodia reached lower-middle-income status in 2015, the allocation weight based on gross national income per capita will be reduced.

Support from PEPFAR is more difficult to predict because of ongoing changes in U.S. foreign policy and a shift in funding from HIV-related services to technical assistance and capacity building initiatives. PEPFAR funding is assumed to decline annually by 15% (the rate of decrease between 2016 and 2017) (PEPFAR, 2019). This equates to a reduction in funds from USD 8.32 million in 2019 to USD 4.21 million in 2023.

It is estimated that funding from the government will increase, from USD 4.39 million in 2019 to USD 13.62 million in 2023. This means that the government would finance about 50% of the HIV response starting in 2023—the NSP V target. It is expected that the government will increase its financing of ARVs per year, from USD 1.50 million in 2019 to USD 5 million in 2023 (NAA, 2019). The government would allocate 10% of the domestic HIV budget to CSOs for the delivery of critical HIV services in 2023 (USD 1.36 million) by increasing the allocation by USD 0.40 million per year. It will finance USD 0.25 million of other drugs and consumables in 2023 (Table 8).

Table 7: Estimated Funding and Financing Gap, 2019-2023 (USD million)

Category	2019	2020	2021	2022	2023
Total estimated resource needs	25.31	24.87	25.60	27.46	27.23
Government	4.39	5.90	8.29	11.95	13.62
Global Fund	12.60	11.90	11.30	10.40	9.40
PEPFAR	8.32	7.07	6.01	5.11	4.21
Financing gap	0.00	0.00	0.00	0.00	0.00

*PEPFAR estimation is based on total expenditure (PEPFAR admin cost and program cost)

Source: Author calculations

Table 8: Estimated Government Funding by Category, 2019-2023 (USD million)

Category	2019	2020	2021	2022	2023
ARV procurement	1.50	1.50	3.00	4.00	5.00
Social protection (HEF)	0.39	0.90	1.27	1.62	2.02
CSO support	0.00	0.40	0.80	1.20	1.36
Opportunistic infection drugs and commodities	0.93	0.90	0.63	0.40	0.25
Program costs & others	1.57	2.20	2.59	4.73	4.99
Total	**4.39**	**5.90**	**8.29**	**11.95**	**13.62**

Source: Authors' estimates

Sub-strategy 4.1: Increase the government's share of HIV financing to 50% by 2023

Sub-strategy 4.1.1: Leverage government financing to fund the HIV response

Cambodia's macroeconomic outlook remains favorable. Supported by robust economic growth—a projected GDP growth of at least 6% in real terms between 2019 and 2023—and enhanced revenue collection capacity, government revenues are expected to increase by 33% in real terms from 2017 to 2022 (IMF, 2019b). In 2018, Cambodia public debt was 28.64% of GDP—a 1.36 percentage point fall from 2017, when it was 30% of GDP (IMF, 2019a). If the health sector's share of government spending remains steady at the current rate, government spending could increase by 25% from 2017 to 2022. Increased fiscal space for health at the national level presents an opportunity to mobilize additional government financing. There is

also the potential to increase domestic financing for HIV at the subnational level by including HIV in community-level activities, such as follow-up and prevention in commune development and investment plans.

To this end, the following strategies are proposed:

- Set targets for increased government funding of HIV and develop a plan for transitioning from donor funding toward a sustainable HIV response, building on the UNAIDS *Transition Readiness Assessment* and *Sustainability Roadmap* (NAA and UNAIDS, 2018a and 2018b).
- Advocate for inclusion of HIV in routine budget planning at the national level. Strengthen program-based budgeting for HIV and leverage the social protection system to increase government financing for HIV.
- Build capacity of the NAA and the MOH to generate and present evidence, including a business case for increased government financing of ART, to inform budget negotiations and strengthen dialogue between health and finance authorities.
- Leverage subnational financing opportunities by working with the Ministry of Interior and MEF to allocate funds for HIV community activities in commune budgets, commune development plans, and commune investment plans.
- Support commune councils to use financial spending guidelines or standard operating procedures to finance HIV/AIDS activities at the commune level and leverage Global Fund innovation funding.
- Establish a task team of representatives from the MEF, MOH, NAA, and NCHADS to support integration of HIV resource needs into routine budgeting.
- Work with the Country Coordinating Committee during the new grant cycle to develop a plan for transition to government funding of key elements of the HIV response, such as ARV procurement and CSO-led activities.
- Leverage the tracking template developed to monitor implementation of SCN 213 and monitor resource allocation through National Health Accounts and *National AIDS Spending Assessments*.

Sub-strategy 4.1.2: Increase government financing of HIV/AIDS by using social health contributions as a source of revenue

Recent social health protection reforms outlined in the *National Social Protection Policy Framework 2016-2025* present an opportunity to mobilize additional domestic financing for the HIV response (ILO, 2017). In July 2019, the government began reimbursing providers for services to poor HIV patients through the HEF, which is co-financed by the government and development partners. This is an important step towards expanding HEF benefits to all HIV patients, as outlined in SCN 213. In addition to increasing financial protection for PLHIV, this will also mobilize additional government funding for the HIV response (up to USD 2.02 million in 2023 as described above).

To this end, the following strategies are proposed:

- Expand social protection coverage of HIV interventions by including all PLHIV in the HEF, in addition to poor PLHIV.

- Raise awareness among poor HIV patients about their benefits under the HEF using commune councils, CSOs, and peer groups.
- Support the Payment Certification Agency in ensuring that health facilities are prepared to deliver and be reimbursed for providing services to poor HIV patients.
- Support the MOH with evidence and data to advocate with the MEF for inclusion of all PLHIV in the HEF.
- Establish a task team to engage with the planning and implementation of the *National Social Protection Policy Framework* to ensure inclusion and reimbursement of HIV-related services in the benefits package of the National Social Security Fund and future mechanisms to cover those working in the informal sector.

Sub-strategy 4.1.3: Explore the potential for private sector co-financing and engagement in service provision

Potential opportunities for domestic HIV financing are outlined in the HIV *Sustainability Roadmap* by exploring private sector co-financing and corporate social responsibility programs (NAA and UNAIDS, 2018b). Private sector co-financing would be separate from and in addition to the target of 50% government financing for HIV.

To this end, the following strategies are proposed:

- Review previously established social responsibility programs and co-financing platforms in Cambodia.
- Draw lessons learned from international experience, with a focus on the Asia region.
- Assess the feasibility of leveraging existing platforms or establishing a co-financing platform.
- Establish or identify an existing forum for dialogue with the private sector on HIV co-financing.
- Develop an operational strategy for co-financing with the private sector.
- Identify models and reimbursement mechanisms through which private healthcare providers can be contracted or encouraged to deliver HIV services, including viral load testing, PrEP, and self-testing.
- Conduct a study to determine if the current model for delivering prevention services is the most cost efficient.
- Design incentives and regulatory enforcement to ensure that private providers report treatment data to the national reporting system.
- Encourage private companies to contribute to the HIV response through their corporate social responsibility programs.

Sub-strategy 4.2: Allocate a share of the government health budget to CSOs

CSOs are essential to the HIV response in Cambodia. International NGOs generally play a technical support role, while national NGOs and community-based organizations provide prevention services and deliver care and support for PLHIV. Networks of KPs identify and communicate the needs and concerns of the community and advocate for an enabling

environment and protection of KPs' and PLHIV's rights. SCN 213 recognized that securing public financing for CSOs is vital to maintaining the success of the HIV response in Cambodia (RGC, 2019b).

Global Fund support to CSO activities during 2018-2020 is budgeted at USD 10.1 million, equal to almost one-quarter (24%) of the total Global Fund budget (USD 41.7 million) (Global Fund, 2019). This represents a reduction from the 2015-2017 grant. In 2018, PEPFAR started moving away from supporting service delivery through CSOs. This is expected to lead to a reduction in the number of CSOs and staff unless the government provides financing to CSOs through social contracting. If the government does not finance service delivery by CSOs, there is a risk that KPs will not be reached and ARV patient support will be reduced, which means that coverage and quality will be jeopardized.

International experience suggests that building a partnership between governments and CSOs through social contracting can contribute to achieving national goals related to the HIV response. SCN 213 has endorsed the important role that CSOs have played in Cambodia's HIV response. In addition to expanding the reach and quality of HIV services, such an approach can also generate cost savings and efficiencies, strengthen linkages and partnership with CSOs, and enable the government to exercise its stewardship role. Findings from the UNAIDS *Transition Readiness Assessment* suggests that there are CSOs that are willing to accept government funding to provide HIV interventions (NAA and UNAIDS, 2018a). There appears to be no specific legal or policy barriers that would prevent the MOH from funding CSOs. The MEF has indicated that the government would be open to contracting with CSOs and there is an existing mechanism in place at NCHADS for selecting and funding CSOs that can be built on to establish an effective and efficient contracting arrangement.

Sub-strategy 4.2.1: Create a supportive environment for social contracting

The following sub-strategies are proposed:

- Build understanding among RGC stakeholders about the vital role played by CSOs in delivering HIV prevention and support services.
- Review international and Cambodian experiences with social contracting with CSOs for delivery of HIV services.
- Develop a policy framework for contracting CSOs for relevant services.
- Establish mechanisms for coordination, partnership building, and support to CSOs.
- Build CSOs' financial management and business planning skills.
- Assist CSOs in resource mobilization during transition from donor to government funding.

Sub-strategy 4.2.2: Implement and monitor contracting mechanisms

The following sub-strategies are proposed:

- Develop a system for performance monitoring and accreditation of CSOs to deliver HIV services.
- Design and implement a contractual mechanism, including performance-based incentives.

- Establish a system to monitor implementation of social contracting that rewards performance and efficient delivery of HIV services, drawing on the Joint Monitoring Indicators.
- Consider feasibility of using the government budget to finance CSO contracted staff.
- Work with development partners to retain some funding for CSOs during the period of transition from donor to government funding.

4. Implementation

Implementation of the NSP V will require the coordination of multiple government ministries and partners to effectively engage in the HIV response, guided by their specific responsibilities linked to the four strategies detailed above. The NAA's primary roles will include coordination, facilitation, advocacy, and encouragement of the MOH to fully integrate HIV services into the health system. Similar efforts are needed to convince the MEF to provide more funding to the HIV response. The NAA will lead implementation of the NSP V, along with the partners presented in Table 8.

4.1 Implementation at the National Level

- The NAA is mandated to lead, advocate, coordinate, facilitate, mobilize resources, and monitor the HIV response in Cambodia. The NAA's actions will be guided by the NSP V vision, mission, goal, and strategies.
- To ensure achievement of the NSP V goal, the NAA should focus on transition/integration, domestic resource mobilization, and country ownership.
- During the government term and legislature, the NAA will engage different sectors to actively apply the RGC's Dynamic of Stakeholders Participation principle with the reforms guided by Public Financial Management Reforms, Decentralization and Deconcentration, and Public Administration Reforms.
- SCN 213
    - The NAA, MOH, and NCHADS will collaborate closely to ensure smooth integration of HIV services into the health system, as guided by SCN 213. This combined effort aims to make sure that the nine components of the Resilient and Sustainable Systems for Health are addressed, with tasks shifting based on priority needs, the emergence of new technologies, international best practices, and local context.
    - The NAA, MOH, MEF, National Social Protection Council, Ministry of Interior (Police and Local Administration), and the Ministry of Planning should collaborate closely to ensure the smooth integration of HIV activities in non-health sectors, as guided by SCN 213.
- Government ministries, development partners, CSOs, and the private sector should include HIV in their three-year rolling investment plans, annual budgets, and other plans to ensure effective contributions to the HIV response.
- Monthly Technical Advisory Board meetings should prioritize key issues that move stakeholders toward achieving the expected outcomes of the NSP V. This will require collaboration and coordination with key MOH and NCHADS Technical Working Groups (e.g., Boosted Integrated Active Case Management, Strategic Information, Logistic Management, etc.), other relevant sectors (e.g., MEF; Ministry of Planning; Ministry of Interior; Ministry of Labor and Vocational Training; Ministry of Education, Youth, and Sports; Ministry of Women's Affairs; etc.), key development partners (e.g., UNAIDS, PEPFAR, etc.), CSOs, KPs (e.g., Health Action Coordinating Committee, Forum of Networks of PLHIV and Most Affected Populations/Key Populations), and the private sector.

- Key issues from Technical Advisory Board meetings will be brought to the NAA Policy Advisory Board semester meeting for tracking, follow-up, and decision making.
- All stakeholders need to be informed and encouraged to apply key principles of the NSP V, especially the people-centered and equity approaches, with a focus on “no one left behind.”

4.2 Implementation at the Sub-National Level

At the provincial level, the Provincial AIDS Committee coordinates all HIV response activities (see Figure 7). The Provincial AIDS STI Program plays the main role for the HIV response at this level. With this in mind, the program should:

- Decentralize responsibilities to districts and communes to effectively address KPs, targeted populations, and PLHIV and make sure that “no one is left behind,” using Boosted Integrated Active Case Management, Partner Notification Tracing, and Testing and Community Action Approaches.
- Take a leading role in the Core Group and Provincial Group of Champions that coordinates with other Groups of Champions/operational districts.
- Police and local authorities in key districts with large KP groups should participate in the Group of Champions provincial meeting.
- Coordinate with relevant departments to build capacity for planning, budgeting, and implementation of the HIV response.
- Report to the Provincial HIV STI Program, Provincial Health Department, and the Provincial Governor chairing the Provincial AIDS Committee.

At the district level:

- The Core Group of Group of Champions/operational districts with an ART site at a referral health center works with its communes to implement the Identify, Reach—Intensify, and Retain approach. It works with rural operational districts that have no ART or voluntary confidential counseling and testing services to coordinate this approach, and reports their activities to the Groups of Champions at the provincial level.
- ART sites need to coordinate with 1) Health Centre and Commune Councils, 2) CSOs, and 3) volunteers (community ARV and ART delivery) to detect, treat, and retain PLHIV on treatment.
- Local authorities should build capacity and facilitate communes to plan, budget, and monitor the integration of HIV/AIDS at the commune level.

At the commune level:

- Health Centres should integrate HIV response activities into commune development and commune investment plans (SCN 213).
- Health Centres needs to play a coordinating role and work with commune councils, police, and CSOs to address the needs of KPs and PLHIV and to prevent new infections using differentiated service delivery, as stated in NCHADS’s strategic plan.
- Commune councils and health centers should coordinate with CSOs to support KPs’ and PLHIV’s access to social protection.

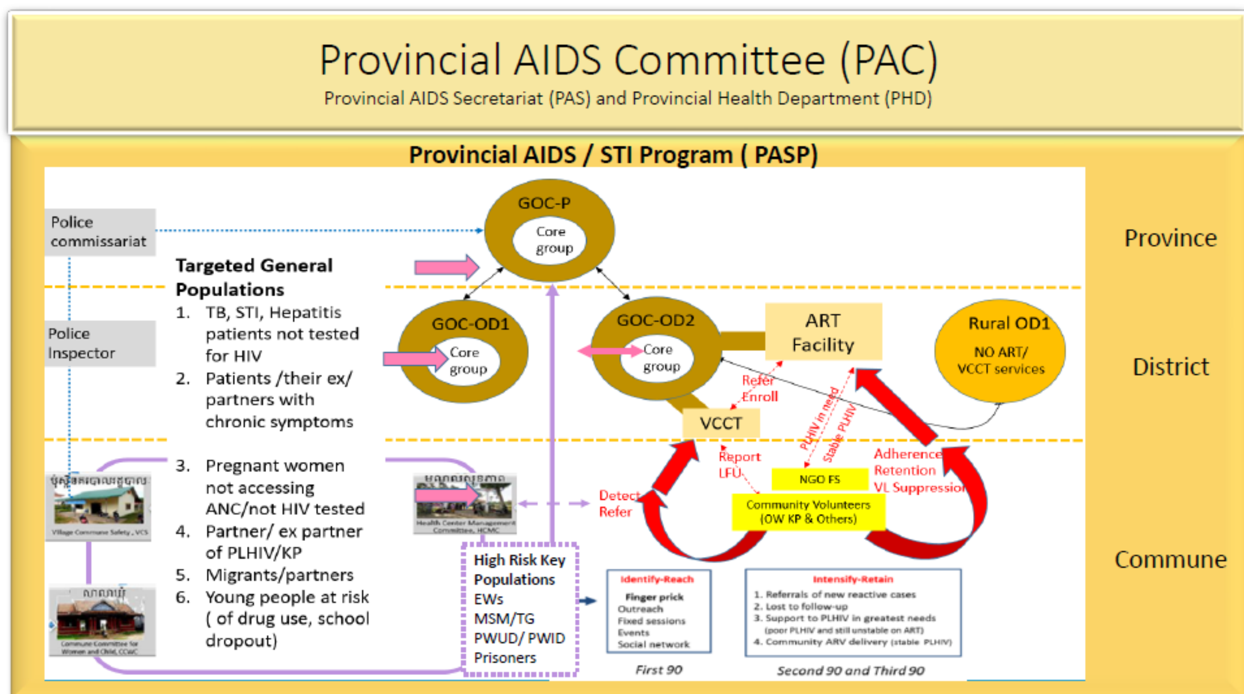
More detailed activities and outputs of the NAA and partners will be developed in a forthcoming operational plan.

Table 9: NSP V Implementation Framework and Partners

Strategies	Sub-Strategies	NAA Partners
Strategy 1: Deliver comprehensive prevention, care, treatment, and support through a multi-sectoral approach	1.1 Engage all stakeholders to enhance prevention efforts	NCHADS, MOH, Provincial Health Departments, Referral Hospitals Health Centers, Coordinating Bodies, NGOs/Community-Based Organizations, Private Sector
	1.2 Ensure that NCHADS receives sufficient assistance to achieve 95-95-95 targets	NCHADS, MOH, Referral Hospitals, Health Centres, Commune Councils, NGOs/Community-Based Organizations
	1.3 Strengthen CSOs to enable them to better support prevention efforts	MEF, MOH
Strategy 2: Integrate HIV response activities into the health system, relevant ministries, and national coordinating bodies	2.1 Develop a common framework for integration of HIV into the health system	NCHADS, MOH, Provincial Health Departments, Referral Hospitals/Health Centres, National Maternal and Child Health Center, National Center for Health Promotion, etc.
	2.2 Ensure that ministries and partners include HIV in their plans and programs	NCHADS; MOH; Ministry of Education, Youth, and Sports; Ministry of Social Affairs, Veterans, and Youth; Rehabilitation; Ministry of Women's Affairs; Ministry of Interior; MEF; Ministry of Labor and Vocational Training; Ministry of Information; Community Councils; Municipalities; CSOs; Private Sector
	2.3 Coordinate with other authorities to include HIV interventions in their policies and programs	NCHADS, National Authority for Combatting Drugs; Department of Mental Health and Substance Abuse; Ministry of Social Affairs, Veterans, and Youth Rehabilitation; Municipalities, Rehabilitation, and Detention Centers
Strategy 3: Expand social protection coverage and improve access to health, social, and legal services for PLHIV and KPs	3.1 Expand inclusion of HIV services in social protection benefit packages	Ministry of Planning, Supreme National Economic Council, MOH, NGOs/Community-Based Organizations, Commune Councils
	3.2 Make legal and policy frameworks more inclusive	Ministry of Justice, Development Partners, NGOs/Community-Based Organizations

Strategies	Sub-Strategies	NAA Partners
Strategy 4: Increase domestic financing to 50% of all HIV expenditures by 2023 and allocate a share of the government budget to CSOs for delivery of critical HIV services	4.1 Increase the government's share of HIV financing to 50% by 2023	NCHADS, MEF, MOH
	4.2 Allocate a share of the government health budget to CSOs	NCHADS, MEF, MOH, CSOs

Figure 7: Implementation Arrangements at the Sub-National Level



Source: NCHADS, 2017 and authors' descriptions

5. Monitoring and Evaluation

The NSP V monitoring framework is presented in Table 10. It will build on indicators that are already being collected regularly, such as the *National AIDS Spending Assessment*, the Global AIDS Monitoring Report, the Stigma Index, the Sor Chor Nor 213 implementation work plan, and the Joint Monitoring Indicators (Annex 5). The Planning, Monitoring, Evaluation, and Research Unit of the NAA and its partners will develop a detailed operational plan, monitoring plan, and indicators, which will be monitored yearly and reported on at the agency's annual policy board meetings. A midterm review is proposed for December 2021. In this elimination phase, granular strategic information (similar to the UNAIDS Key Populations Atlas) needs to be collected to address gaps, prioritize investments, and introduce innovative programming approaches to prevention, treatment, care, and support.

Table 10: Proposed NSP V Monitoring and Evaluation Framework and Indicators

Strategy 1: Deliver comprehensive prevention, care, treatment, and support through a multi-sectoral approach

Outcome: Moving toward ending AIDS with reduction of new infections from 880 in 2018 to 250 in 2025 (UNAIDS, 2018). 95% of all estimated PLHIV know their HIV status, 95% of those who know their status are on treatment, and 95% of those on treatment have a suppressed viral load

Baseline: Annual new infections as of 2018: 880

Sub-Strategies	Indicators of Achievement	Responsible Ministries	Means of Verification
1.1 National ministries, coordinating bodies, and other sectors—including CSOs and the private sector—enhance efforts at prevention for all populations, contributing to the reduction of new infections	1.1.1 Prevention initiatives incorporated into ministries, coordinating bodies, CSOs, and private sectors, etc. by 2021 and implemented by 2023 Joint Monitoring Indicators (see Annex 4)	NAA NCHADS MOH Provincial Health Departments Referral Hospitals and Health Centers NGOs/CBOs Private sector	Overall Memorandum of Understanding for Strategy 1 HIV infection estimates
1.2 The NAA and partners ensure that NCHADS will receive sufficient assistance from relevant stakeholders across sectors to achieve 95-95-95 targets	1.2.1 Coordination and facilitation assistance linked to education and prevention from other ministries will be received by NCHADS by 2020 Joint Monitoring Indicators (see Annex 4)	NAA NCHADS MOH Commune councils Referral Hospitals/Health Centres NGOs/CBOs	Circulars/policies/ regulations supporting NCHADS plan and implementation of prevention, care and treatment
1.3 All HIV partners strengthen capacity of CSOs to support comprehensive prevention, care, and support efforts led by NCHADS	To be developed	N/A	Documents, standard operating procedures, and circulars that support and promote the role of CSOs in the HIV response

Strategy 2: Integrate HIV response activities into the health system, relevant ministries, and national coordinating bodies

Outcome: By 2023, initial assessment and suggested framework for integration of HIV into the health system developed with full engagement of NAA, MOH, NCHADS, and partners, and recommendations are acted on

Sub-Strategies	Indicators of Achievement	Responsible Ministries	Means of Verification
2.1 Ensure that the MOH, NCHADS, and partners work together to assess HIV integration and adapt Resilient and Sustainable Systems for Health to guide this integration	To be developed	NAA NCHADS MOH Referral Hospitals/Health Centres	Overall Memorandum of Understanding for Strategy 2; health system review/ assessment Sub-strategy 2.1-Resilient and Sustainable Systems for Health framework
2.2 Ensure that relevant ministries and partners include HIV in their plans and programs and catalyze innovation from across all sectors to drive greater impact and value for money through synergy, harmonization, and alignment	2.2.1. HIV response reflected in ministries' strategic plans (and other plans) by 2020 and implemented by 2021. Program content is aligned with 95-95-95, prevention, reduction of stigma and discrimination, and referral to HIV testing and counseling services	NAA NCHADS MOH Ministry of Education, Youth, and Sports Ministry of Women's Affairs Ministry of Interior Commune councils Ministry of Social Affairs, Veterans, and Youth Rehabilitation Municipalities MEF Ministry of Information Ministry of Labor and Vocational Training Referral Hospital /Health Centres NGOs/CBOs Private sector Coordinating bodies	Standard operating procedures/ guidance/ Memorandum of Understanding on synergy, harmonization and alignment
2.3 Ensure close coordination with other national-level authorities, bodies, agencies, and commissions to include evidence-based HIV interventions in their policies and programs	2.3.1. HIV response reflected in the strategic plan of the National Authority for Combatting Drugs, Department of Mental Health and Substance Abuse, etc. by 2020 and implemented by 2021	NAA NCHADS National Authority for Combatting Drugs Department of Mental Health and Substance Abuse	Policy documents and program standard operating procedures

Strategy 3: Expand social protection coverage and improve access to health, social, and legal services for PLHIV and KPs

Outcome: 100% of PLHIV covered by a social protection mechanism by 2023; increased access to a variety of health, social, and legal support services

Baseline: In 2017, 18% of all PLHIV have an ID Poor card (Bhavesh and Mony, forthcoming).

Sub-Strategies	Indicators of Achievement	Responsible Ministries	Means of Verification
3.1 Expand coverage of social protection mechanisms, enabling access to health and other social services related to HIV	3.1.1 75% of PLHIV have free access to services through provision of ID Poor or Equity card system by 2023 3.1.2 Other established Social Protection mechanisms cover PLHIV Joint Monitoring Indicators (see Annex 4)	NAA Ministry of Planning Supreme National Economic Council MOH NGOs/CBOs	Overall Memorandum of Understanding for Strategy 3 - Stigma index/legal literary and accessibility surveys Sub-strategy 3.1 – Program records from Ministry of Planning, Supreme National Economic Council, and NGOs/CBOs
3.2 Create a legal and policy framework that is more inclusive for access to services for all KPs and lesbian, gay, bisexual, and transgender people, especially young people	3.2.1 Relevant laws or policies revised by 2023 to promote access to all forms of services, including HIV education, with a focus on young people and KPs	NAA Ministry of Justice Development partners NGOs/CBOs	Laws, policy, regulations, circulars

Strategy 4: Increase domestic financing to 50% of all HIV expenditures by 2023 and allocate a share of the government budget to CSOs for delivery of critical HIV services

Outcome: Sustainable financing for the HIV response in Cambodia

Baseline: In 2017, 24% of HIV spending is domestically funded (NAA, 2019)

Sub-Strategies	Indicators of Achievement	Responsible Ministries	Means of Verification
4.1 Increase government financing to 50% by 2023	4.1.1 50% of HIV response financed by the government by 2023 Joint Monitoring Indicators (see Annex 4)	NAA NCHADS MEF	Overall Memorandum of Understanding for Strategy 4

Sub-Strategies	Indicators of Achievement	Responsible Ministries	Means of Verification
4.2 Allocate a share of the government health budget to CSOs	4.2.1 Contracting mechanism for NGOs established and implemented 4.2.2 Government provides domestic resources to CSOs to deliver critical HIV services	NAA NCHADS MEF NGOs/CBOs	Documents/ standard operating procedures/ Memorandum of Understanding for social contracting

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National AIDS Authority ARV Financing in Cambodia: Recommendation from the National AIDS Authority.

Annex 1. Sor Chor Nor 213 (Unofficial Translation)

Kingdom of Cambodia
Nation Religion King

Council of Ministers

No: 213 សជណ.សស

Date: Thursday, 2nd (Buddhist Calendar)
Phnom Penh, Date 21st February 2019

Permanent Deputy Prime Minister, Minister in charge of Council of Ministers

To

- Samdach Krala horm Deputy Prime Minster, Minister of Interior
- H.E. Akeak Bandith Saphea Char, Deputy Prime Minister, Minister of Economy and Finance and Chair of Supreme National Economic Council
- H.E. Senior Minister, Minister of Planning
- H.E. Senior Minister, Chair of National AIDS Authority
- H.E. Minister of Health

Objective: Case on the Report on the results of the 2nd Policy Advisory Board Meeting of the National AIDS Authority in 2018 and a request for authorization from the Royal Government to introduce measures related to HIV/AIDS response.

References: - Letter number 328 អ.ជ.ប.ជ.អ dated 14 December 2018 from NAA

Highest approval inscription of Samdach Aka Moha Sena Padey Decho Hun Sen, Prime Minister of Kingdom of Cambodia dated 13th February 2019.

Referring to the above objective and references, the Council of Ministers is very pleased to inform Samdach, Your Excellency, that the Royal Government agreed with NAA to introduce the below measures in relation to HIV/AIDS response:

1. The National AIDS Authority collaborates with the Ministry of Interior and the Ministry of Economy and Finance to allocate a specific budget package for the implementation of HIV/AIDS integration in the 5-year development plan and three-year rolling investment plan of Commune/Sangkat.
2. The Ministry of Health and the Ministry of Planning shall determine that people living with HIV/AIDS are vulnerable groups who are eligible for the Equity Card that ensures access to health care and social protection schemes.
3. The Ministry of Health and the Ministry of Economy and Finance cooperate to amend, develop rules and procedures for allowing health centers and referral hospitals to have its own fund for response to HIV/AIDS.

4. The Council of Ministers, Ministry of Interior, Ministry of Economy and Finance, Ministry of Health and National AIDS Authority shall acknowledge the important role of Civil Society Organizations in responding to HIV / AIDS and shall continue to support continued participation through providing fund from the Royal Government of Cambodia according to the availability of the National Budget.

5. The Supreme National Economic Council should study the fiscal space to ensure the implementation of the commitments of the Royal Government to eliminate HIV and AIDS by 2025.

6. The Ministry of Health shall continue to strengthen human resources, procurement system, supply chain management, and health information system that allow a mainstreaming of HIV/AIDS response to be more effective and sustainable.

Receiving this circular, the National AIDS Authority shall lead the meetings with relevant ministries, institutions and stakeholders for developing detailed implementation of this circular.

With the above description please Samdach, Your Excellency be informed and take action.

-Signed & Stamped-

Minister in charge of Council of Ministers Secretary of States

Soy Sokha

CC:
Cabinet of Samdach Aka Moha Sena Padey Decho, Prime Minister
Cabinet of H.E. Kate Kosal Bandith, Permanent Deputy Prime Minister
Chronicles-document

Annex 2. Outputs from the NSP V Visioning Workshop

Strategic Direction Groups and Members	Strategic Activities/Objectives and Outcomes
Prevention, Care and Treatment Group *Members: NAA, NCHADS, UNAIDS, KHANA, Catholic Relief Services, AIDS Healthcare Foundation, PSI, Cambodian Health Education & Care, Provincial Health Department Battambang* *Presenter: KHANA*	Increase HIV awareness raising through modern information and communication technology Increase ownership of the HIV response at the community level Create community level volunteer networks for HIV/AIDS Strengthen the capacity of village health support groups responsible for taking care of PLHIV Community ART delivery, increase ART sites
Social Protection Group *Members: NAA, Ministry of Interior, National Social Protection Council, UNAIDS, UNWOMEN, Ministry of Women's Affairs, Ministry of Social Affairs, Veterans, and Youth Rehabilitation, Provincial Health Department Banteay Meanchey* *Presenter: UNAIDS*	Provide All PLHIV with equity card (Ministry of Planning) and HEF (MOH) so that they can have access to other social support: Ministry of Planning: Pre-ID (at community level) MOH: Post-ID + HEF Ministry of Social Affairs, Veterans, and Youth Rehabilitation: improved access to ID Poor and to other services (e.g., Cash Transfer, livelihood program, etc.) Issuance of equity card for PLHIV will be fair and transparent. Confidentiality must be observed NAA will request National Social Security Fund support to provide reimbursements for HIV benefits provided to PLHIV National Social Protection Council, Payment Certification Agency, and National Social Security Fund: cooperating with NAA and CSOs to take part in social protection mechanisms, facilitation at the policy level, and monitoring Explore and maximize the use of commune budget packages and other social services to support the HIV response

Strategic Direction Groups and Members	Strategic Activities/Objectives and Outcomes
Domestic Financing Group *Members: NAA, MEF, HP+, USAID, Health Action Coordinating Committee* *Presenter: Dr. Phalla,* *Co-Presenter: Tim Vora*	Dr. Phalla explained epidemic trends and the resources available; the investment case may need to be revised. Spending patterns also need to be analyzed, as a large proportion is put into non-specific activities that are difficult to justify to MEF. A new SCN 213 was issued on 21 February 2019 with 6 important points (RGC, 2019b): External budget for Provincial Health Department in Siem Reap 0.5 million USD per year; 0.25 million USD for Provincial Health Department Battambang per year → We should consider integration as we will no longer receive external support All networks (KPs) to be strengthened and funded (SCN #4 refers); consider automatic acceptance of network proposals Allocate 3-5% of future grants for KPs networks ID Poor card, equity card should be made available for all PLHIV PLHIV should be allowed to take certain job opportunities in formal sector, leading to automatic access to National Social Security Fund PLHIV to create an informal workers' association to facilitate access to the social support scheme under the National Social Security Fund. Cambodia Network of People Living with HIV and AIDS and Association of ARV Users in Cambodia would comprise the core association. MOH has approved the health benefit package (includes 39 services) but not fully implemented it due to budget access; no clear budget commitment from the MEF SCN #4: National budget to support CSOs; the Ministry of Education has provided 2 million USD to NGOs Study how best to support CSOs: which priority areas should be covered? Should it be on prevention only? Need to determine the actual needs Support the community: CSOs could also act as watchdogs to monitor and provide feedback on the quality and coverage of HIV/AIDS services Amending provisions in the "red book"—that is to refer to the SCN #3—to allow PLHIV access to various social services, such as antenatal care, water, and sanitation
Integration Group *Members: NAA, MOH, HP+, USAID, UNAIDS* *Presenter: HP+*	"Integration" was discussed for the health and the non-health sectors/ministries, and at the commune level, in view of decentralization efforts. Detailed integration framework and strategies are continued to be discussed in health sector strategic plans for HIV and AIDS, led by NCHADS

Annex 3. Methods Used to Prepare Financing Estimates

Resource Needs

Estimated resource needs for the HIV response between 2019 and 2023 were drawn from the 2018 HIV *Transition Readiness Assessment*, which was based on the HIV investment case from 2017 (UNAIDS, 2018). These estimates were updated for the NSP V.

Operational costs

Data on operational costs, utilities, supervision, and general health system expenditure (not allocated by disease) were obtained from *National AIDS Spending Assessments* V and VI, and included ministries such as the Ministry of Women's Affairs; the Ministry of Education, Youth, and Sports; the Ministry of Labor and Vocational Training; and the Ministry of Interior (HFG et al, 2017; NAA, Unpublished). These costs were assumed to increase annually at the average rate of increase from 2014 to 2017. These costs were not allocated to PrEP or ARVs.

Prevention

Prevention costs were broken down into three categories (HIV testing and counseling, behavior change communication, and prevention of mother-to-child transmission) using the 2017 proportions presented in the latest *National AIDS Spending Assessment* (NAA, 2019). HIV testing and counseling includes voluntary confidential counseling and testing, STI, and prevention for KPs. Behavior change communication accounted for 4%, testing services accounted for 80%, and prevention of mother-to-child transmission and other health-related prevention accounted for the remainder. The PrEP costs were estimated based on the AIDS Epidemic Model with a base coverage of 4% in 2019, increasing to 50% in 2023 (NCHADS, 2019). The PrEP estimates include ARV cost, laboratory testing, quarterly visits, and program costs. The total cost per person per year is USD 113.60 (ARV = USD 43.60; lab test = USD 62.00; and program cost = USD 9.00).

Care and treatment

Costs of care and treatment were broken down into four categories (ARVs; home-based care and nutrition; health service delivery, including inpatient and outpatient care; and laboratory). Annual treatment costs follow the trend reflected in the final investment case scenario presented in the *Transition Readiness Assessment* (NAA and UNAIDS, 2018a). Based on *National AIDS Spending Assessment* expenditure in 2017, the following proportions were used to calculate the cost: ARV: 55%; health service delivery (opportunistic infection, in-patient care, outpatient care, and other): 23%; laboratory: 16%; and home-based care: 6% (NAA, 2019).

Program management

Program management costs were broken down into two categories: 1) planning, coordination, and monitoring and evaluation, and 2) research and health information systems, using the *National AIDS Spending Assessment* 2017 proportions. Current levels of program management are adequate to ensure successful implementation of the responses. This section includes the estimated cost for relevant ministries, planning, coordination, monitoring and evaluation, research, and health information systems. The cost breakdown used the proportion of the *National AIDS Spending Assessment* VI is: planning, coordination, and

monitoring and evaluation: 60%; operational costs, research, and health information systems: 40% (NAA, 2019).

Social protection

NCHADS and HP+ estimated the cost of financing the HIV benefit package though the HEF (Bhavesh and Mony, Forthcoming). The estimated costs were calculated by level of the health system. The costs of different HIV benefits included in the HEF package, ART services, Inpatient department services for PLHIV, and administration were divided by the total estimated number of PLHIV to obtain a unit cost of USD 35.40 per person. The estimated number of PLHIV on ART in Cambodia is 58,957 in 2019 and will be 57,214 in 2023 (NCHADS and UNAIDS, 2019). The coverage of PLHIV by HEF was estimated to increase from 18% in 2019 to 100% in 2023. The interpolation method was used to estimate coverage between 2019 and 2023. The HEF estimates were not adjusted for multi-month scripting, due to challenges in modeling scale up.

Estimated ART Coverage and Cost, 2019-2023

Item	2019	2020	2021	2022	2023
Estimated number of PLHIV on ART	58,957	58,637	58,200	57,727	57,214
Coverage	18%	38.5%	59%	79.5%	100%
Number of PLHIV to be covered	10,612	22,575	34,338	45,893	57,214
Total estimated cost	375,584	798,971	1,215,273	1,624,220	2,024,888

Source: NCHADS, 2019 and authors' estimates

Capacity building and transition

Estimates for health systems strengthening costs included estimates from the HIV investment case and some PEPFAR-supported investment in capacity building and transition (UNAIDS, 2017b).

Financing Sources

The estimates of government funding were calculated based on the government's target contribution for 2023 (50% of all HIV expenditures) (Derriennic, 2019). Estimates for 2019 were extrapolated from 2017 data and scaled up through 2023 (NAA, Unpublished). Funding from the Global Fund in 2019 and 2020 was estimated using data from the 2018-2020 grant and 2021-2023 estimates were taken from the *Transition Readiness Assessment* (Global Fund, 2019; NAA and UNAIDS, 2018a). PEPFAR support was more difficult to predict because of annual strategic planning processes and a shift in funding from HIV-related services to technical assistance and capacity building. PEPFAR funding was assumed to decline 12% annually (the rate of decrease between 2016 and 2017) (NAA, Unpublished).

Annex 4. Joint Monitoring Indicators, 2019-2023

Outcome (2019-2023)	Output (2019-2020)	Output Indicators with Baseline and Target (2019-2020)	Definition
AIDS eliminated as a public health threat by 2025 with 95-95-95 targets achieved	92-92-92 targets achieved	92% of all PLHIV should know their HIV status (baseline 2018: 82%) 100% of PLHIV who know their status are on treatment (baseline 2018: 99%) 100% of PLHIV on treatment have suppressed viral load (baseline 2018: 95%)	N/A
	PLHIV are covered under social protection programs	80% of PLHIV on ART are enrolled in social protection programs (baseline 2018: 18%)	Social protection programs include HEF, the National Social Security Fund, and other government programs
	Increased domestic financing for the HIV response	35% of overall HIV expenditure will be financed domestically by 2020 (baseline 2015: 17%)	Domestic financing includes central government, provincial, and local government funding

Source: RGC, 2019a

Annex 5: NSP V Development Contributors

No	Full Name	Position	Institution
1.	H.E. Dr. Tia Phalla	Vice Chair	NAA
2	H.E. Dr. Teng Kunthy	Vice Chair	NAA
3	H.E. Dr. Ros Seilavath	Vice Chair	NAA
4	H.E. Dr. Chea Por	Vice Chair	NAA
5	H.E. Dr. Hor Bunleng	Vice Chair	NAA
6	H.E. Chhim Khindareth	Secretary General	NAA
7	H.E. Dr. Chhea Setthi	Deputy Secretary General	NAA
8	H.E. Sorn Piseth	Director Admin and Finance	NAA
9	Dr. Tep Navuth	Director, Planning, Monitoring, Evaluation and Research Unit	NAA
10	Dr. Hout Sereyrath	Director, Communication and Resource Mobilization	NAA
11	Dr. Voeung Yanath	Director, Prevention, Care and Support	NAA
12	Dr. Ly Chanravuth	Deputy Director	NAA
13	Dr. Sou Sophy	Deputy Director	NAA
14	Mr. Cheng Tha	Chief Officer	NAA
15	Dr. Sim Sophay	Deputy Director	NAA
16	Mr. Kim Sanh	Advisor	Ministry of Education, Youth, and Sports
17	Mr. Finh Rithipol	Deputy Director	Ministry of Economy and Finance
18	Dr. Leng Monipheap	Director	Ministry of Women's Affairs
19	Dr. Ly Penh Sun	Director	NCHADS
20	Dr. Lan Vanseng	Deputy Director	NCHADS
21	Dr. Sou Sanith	Deputy Director	Provincial Health Department Battambang
22	Dr. Kros Sarath	Director	Provincial Health Department Siem Reap
23	Dr. Keo Sopheaktra	Director	Provincial Health Department B. Meanchey
24	Dr. Sok Bunna	Project Management Specialist for HIV/AIDS;	USAID

No	Full Name	Position	Institution
25	Mr. Robert Stanley	Health Finance and HIV/AIDS Technical Advisor	USAID
26	Ms. Vladanka Andreeva	Country Director	UNAIDS Cambodia
27	Dr. Khin Cho WIN HTIN	Strategic Information Advisor	UNAIDS Cambodia
28	Mr. Ung Polin	Community Support Advisor	UNAIDS Cambodia
29	Ms. Raylynn Benn	Program Officer	UNAIDS Cambodia
30	Mr. Yann Derriennic	Chief of Party and Country Director	HP+ (USAID)
31	Mr. Bhavesh Jain	HIV and Health Financing Advisor	HP+ (USAID)
32	Dr. Srey Mony	HIV and Health Policy Advisor	HP+ (USAID)
33	Mr. Vichet Am	Program Officer and Grant Manager	HP+ (USAID
34	Dr. Steve Wignall	Chief of Party	LINKAGES (USAID)
35	Ms. Seng Sopheap	Country Representative	LINKAGES (USAID)
36	Mr. Phal Sophath	Project Officer	LINKAGES (USAID)
37	Mr. Andrew McCracken	Country Director	Clinton Health Access Initiative
38	Ms. Sivantha Hul	Senior Associate	Clinton Health Access Initiative
39	Dr. Deng Serongkea	Technical Officer	World Health Organization
40	Mr. Tim Vora	Executive Director	Health Action Coordinating Committee
41	Mr. Choub Sokchamroeun	Executive Director	KHANA
42	Mr. Phorng Chanthorn	Senior Advocacy Officer	KHANA
43	Dr. Sok Pun	Deputy Head of Program	Catholic Relief Services
44	Dr. Noy Prorphea	HIV Project Manager	Catholic Relief Services
45	Dr. Vith Sreng	Program Manager	Reproductive Health Association of Cambodia
46	Mr. Sorn Sothearith	Executive Director	Cambodia Network of People Living with HIV and AIDS
47	Mr. Seom Sophal	Program Officer	Cambodia Network of People Living with HIV and AIDS
48	Mr. Chhorn Ann	Program Manager	Cambodia Women for Peace and Development

No	Full Name	Position	Institution
49	Mr. Taing Phoeuk	Executive Director	KORSANG
50	Ms. Pich Polet	Executive Director	Women's Network for Unity
51	Ms. Keo Tha	Program Officer	Joint Forum of National Networks of PLHIV and Most-at-Risk Populations
52	Ms. Han Sienghorn	Executive Director	Association of ARV Users in Cambodia
53	Dr. Vic Salas	Consultant, NSP V	HP+ (USAID) and UNAIDS
54	Dr. Tia Phauly	Consultant, NSP V	HP+ (USAID) and UNAIDS
55	Mr. Choeun Chhunna	Consultant, NSP V	-
56	Mr. Henrik Axelson	Costing and Financing Consultant, NSP V	HP+ (USAID)
57	Dr Kimlee Khieu	Costing and Financing Consultant, NSP V	HP+ (USAID)