KINGDOM OF CAMBODIA

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The Sixth National Strategic Plan for a Comprehensive, Multi-sectoral Response to HIV/AIDS, 2024-2028

"Toward to Ending AIDS and Sustainability HIV Response, 2023-2028"

December 2023

The Sixth National Strategic Plan for a Comprehensive, Multi-sectoral Response to HIV/AIDS, 2024-2028

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List of Acronyms

ART	Antiretroviral therapy
ARV	Antiretroviral
BoCPCT	Boosted Continuum of Prevention to Care and Treatment
CBO	Community-based organizations
CDHS	Cambodia Demographic and Health Survey
CDP/CIP	Commune development plans/Commune investment plans
CLM	Community-led monitoring
CPA	Complimentary Package of Activities
CSDG	Cambodian Sustainable Development Goals
CSE	Comprehensive sexual education
CSO	Civil society organizations
DOSH	Department of Occupational Safety and Health
FEW	Female entertainment worker
FONPAM	Joint Forum of Networks of PLHIV and MARPs
FSW	Female sex worker
FTC	Fast-Track City
GBV	Gender-based violence
GDJ-TWG	Government and Donors Joint Technical Working Group
GF	The Global Fund
GDP	General Department of Prison
HACC	Health Action Coordinating Committee
HCV	Hepatitis C virus
HEF	Health Equity Fund
HIVST	HIV self-testing
HSP4	Fourth Health Sector Plan
HTC	HIV testing and counseling
IBBS	Integrated Biological and Behavioral Survey
KP	Key populations
MLVT	Ministry of Labor and Vocational Training
MMD	Multi-month dispensing
MMT	Methadone maintenance treatment
MoCFA	Ministry of Culture and Arts
MoEF	Ministry of Economy and Finance
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoInformation	Ministry of Information
MoI	Ministry of Interior
MoLVT	Ministry of Labor and Vocational Training
MoP	Ministry of Planning
MoPTC	Ministry of Post and Telecommunication
MoSVY	Ministry of Social Affairs, Veterans, and Youth Rehabilitation
MoT	Ministry of Tourism

MoWA	Ministry of Women Affairs
MPA	Minimum Package of Activities
MPWT	Ministry of Public Works and Transport
MSM	Men who have sex with men
MSW	Male sex worker
MTCT	Mother-to-child transmission
MTR	Midterm review
NAA	National AIDS Authority
NACD	National Authority for Combating Drugs
NCD	Non-communicable diseases
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NSP	National Strategic Plan
NSSF	National Social Security Fund
PAB	Policy Advisory Board
PAC	Provincial AIDS Committee
PDI	Peer driven intervention
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHD/PAS	Provincial Health Department/Provincial AIDS Secretariat
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child-transmission
PrEP	Pre-exposure prophylaxis
PSF	Patient Satisfaction Form
PWID	People who inject drugs
PWUD	People who use drugs
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SOP	Standard Operating Procedure
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
SWOT/TOWS	Strengths, weaknesses, opportunities, threats
TAB	Technical Advisory Board
TBPT	TB preventative therapy
TGW	Transgender women
OHCHR	Office of the United Nations High Commissioner for Human Rights
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
VCCT	Voluntary confidential counseling and testing
WNU	Women’s Network for Unity

Executive Summary

Cambodia's HIV response has made remarkable achievements. Prevalence has declined from 0.8% in 2010 to 0.5% in 2022 among adults ages 15 to 49 years. By the end of 2022, 86% of people living with HIV (PLHIV) were aware of their status, 99% of PLHIV who knew their status were accessing treatment, and 98% of PLHIV were virally suppressed. Compared to the baseline of 2010, there has been a 33% decline in new infections (from 2,000 to 1,400 in 2022) and a 30% decline in AIDS-related deaths (from 1,600 to 1,100 in 2022). These achievements have emerged from sound policy and strategic frameworks, and a legal framework that created an enabling environment for national HIV response as well as active engagement of CSOs in leading prevention efforts for key populations, providing care and support services for PLHIV, and closely working in partnership with government partners, and international organizations to strengthen community-led responses.

The draft Pentagonal Strategy Phase 1 for Growth, Employment, Equity, Efficiency, and Sustainability provides the Cambodia's socio-economic development agenda. Among the five pentagons, NSP VI contributes to the achievement of Pentagon 1 which is about human capacity development, in particular the improvement of people's health and well-being, and to a lesser extent, Pentagon 5 which is about building digital government and citizens.

Cambodia is committed to end AIDS as a public health threat, which aligns with SDG 3 i.e., ensuring healthy lives and promoting wellbeing for all at all ages. Two targets under SDG 3 are relevant: 3.3 end the epidemic of AIDS by 2030, and 3.8 achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Vision

The vision of the 2024-2028 National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS is that people in Cambodia live healthy and productive lives fully enjoying their human rights, free from HIV and AIDS and stigma and discrimination. This aligns with the vision of an "AIDS free Generation, with longer, healthier, and better life for PLHIV in Cambodia" as stated in the Strategic Plan for HIV and STI Prevention and Care in the Health Sector 2021-2025. It is consistent with the Global AIDS Strategy (2021-2026) aim of ending AIDS by reducing the inequalities that drive the epidemic.

Mission

Ensure a well-coordinated multi-sectoral HIV response which is inclusive, locally and community owned, people-centered, resilient and sustainable

Goal

A sustainable multisectoral HIV response that ensures AIDS is no longer a public health threat by 2028

Objectives and Strategies

Objective 1: Provide comprehensive and effective prevention, treatment, care and support through well-coordinated and holistic multi-sectoral approaches

Strategy 1.1 Expand differentiated HIV services in prevention, testing, treatment and care

The strategy focuses on health/medical focused interventions that will emphasize innovative and differentiated approaches such as combination HIV Prevention (virtual interventions, PrEP, etc.) HIVST, HIV Testing and Counseling (HTC) linked to counseling and treatment partner notification, STI treatment, expanding outreach coverage of KPs, and scaling up ART. This will enable different prevention and testing services to reach undiagnosed PLHIV, migrants, young people, detainees and those who have been released, and hidden/well-off MSM/TG who may be accessing HIV services in the private sector. At the same time, risks and vulnerabilities (e.g., Chemsex, increased online dating and sexual networking, high prevalence of STIs) can be effectively addressed. For treatment and care, ART retention will be optimized especially since there is a big cohort of PLHIV on treatment. In addition, prevention and treatment of co-morbidities in this group will be emphasized to reduce the burden on the individual and the health care system.

Strategy 1.2 Develop, integrate, and implement HIV prevention-related interventions from all stakeholders, especially in non-health sectors and at subnational level

This strategy is about fully engaging line ministries in non-health sectors that will provide information about HIV and HIV services to all individuals from adolescents to adults such as community members, migrants, and workers in the formal and non-formal sectors, in settings such as the school, workplace, at home, and in communities where they reside. This will give them the knowledge and skills to assess and protect risky interactions with the same or opposite sex that may put them at risk. The key HIV-related activities in non-health sectors will complement prevention efforts in the health sector by providing, reinforcing, and sustaining levels of knowledge about HIV. Behavior change can be encouraged so that consistent condom used and other safer practices can become the norm. The involvement of young people will be integral to the design and implementation of HIV-related interventions, particularly those targeting their peers.

Objective 2: Improve the social well-being of KPs and PLHIV and create a conducive environment for PLHIV's and KP's effective access to HIV, health, and other social and legal support services

Strategy 2.1 Accelerate the social protection coverage of PLHIV and KPs

The majority of PLHIV and KPs will be under the umbrella of the country's social protection system under this strategy. It aims to do this by addressing demand and supply side issues. On the demand side, awareness will be raised among KPs and PLHIV about the benefits of HEF and NSSF and ensure compliance of owners of entertainment establishments. On the supply side, registration will be strengthened and expanded, and social protection coverage can be increased through other schemes such as private insurance and the National Family Package Program.

Strategy 2.2 Improve the enabling and safe environment that promotes equitable access to HIV related services, health, and other social and legal support services

Key activities under Strategy 2.2 include raising awareness about SRHR, SOGIESC, and available social and legal services that KPs, PLHIV, and young people can access. Raising awareness about and reducing stigma and discrimination as well as GBV is also part of this strategy. On the other hand, local law enforcement, health care providers, and other frontline workers will be sensitized about ongoing HIV-related services, harm reduction interventions, and the importance of stigma-free services to foster greater access to HIV, health, social, and legal support services. A necessary complementary activity would be to advocate for the removal of legal and policy barriers thereby improving access to HIV related services.

Objective 3: Build institutional, community, and individual capacities to strengthen community led responses and improve integration of HIV in health and non-health sectors

Strategy 3.1 Enhance the capacities (soft and hard skills) of all stakeholders involved in the response including subnational entities and communities infected and affected by HIV, to mobilize resources design, implement, and monitor HIV-related interventions

Institutional capacities at the national and subnational levels will be built up in the areas of procurement of ARV and other HIV commodities; planning, budgeting, implementing, and monitoring HIV-related interventions in non-health sectors and in high-burden provinces; strengthening community-lead monitoring (CLM); and strengthening the organizational and institutional development of CSOs. At the individual level, trainings will be provided such as on SRHR, SOGIESC, and providing KP-friendly and stigma-free services.

Strategy 3.2 Strengthen/Accelerate the integration of HIV in the plans and programs of ministries

This strategy aims for further integration of HIV in all sectors. In the health sector, a common framework and guidelines are needed to push integration forward. However, KP-focused interventions should be maintained even as HIV services are meaningfully integrated in the general population system. In non-health sectors, HIV should become part of plans, programs,

and budgets of ministries. Integrating HIV into non-health sectors can raise awareness, help change behaviors, and address the social determinants that lead to infection.

Objective 4: Sustain the impact of the national HIV response by increasing local investments and strengthening the country system that governs, coordinates, and monitors the HIV response

Strategy 4.1 Increase domestically sourced investments of the HIV response

Cambodia's domestic funding for the HIV response from co-financing mechanisms has increased from US$1.6 million in 2015 to US$7 million in 2023. However, the national funding is largely for ARVs while the bulk of HIV funding comes from external sources, which have been declining. It is clear that Cambodia will be facing a lack of resources and the entry point will be the engagement of the line ministries to strengthen its support to the national HIV response including financial support for specific ministries to perform the HIV integration into their systems as deemed appropriate. The 2023 Optima analysis recommends additional spending of US$22 million from 2024 to 2030 for key prevention interventions in addition to the base spending of US3.3 million annually to reduce infections by 70% and to reach the target of 250 infections per year. In NSP V, the government has committed to finance 50% of all HIV expenditures.

Strategy 4.2 Strengthen the country system to improve the governance, coordination, and monitoring and promote greater ownership of the HIV response

This strategy aims to strengthen the country system so that the Policy Advisory Board (PAB) and the Technical Advisory Board (TAB) become fully functional, work closely with the Government and Donors Joint Technical Working Group (GDJ-TWG), give directions to the sub-working groups in charge of the strategies of NSP VI, and provide oversight to the national HIV response. Sub-working groups or technical working groups will also be strengthened by enhancing their capacities and reviewing their terms of references as well as membership.

Implementation and coordination

The NAA will take the lead in coordinating the implementation NSP VI, consistent with its mandate to lead, advocate, coordinate, facilitate, mobilize resources, and monitor the national HIV response. Coordination and monitoring of the national response takes place through the Policy Advisory Board, Technical Advisory Board and sub-working groups whose membership comprise of stakeholders and chaired by the NAA. One of its key roles will be in coordinating the HIV response emanating from line ministries, development partners, and CSOs/CBOs that are expected to incorporate HIV in their strategic and action plans, programs, and budgets and follow through with their implementation. In addition, NAA needs to provide technical support, as needed, to stakeholders to ensure that the goal and outcomes of NSP VI are achieved.

Monitoring and Evaluation

The M&E plan of NSP VI will track and monitor its progress once implementation gets underway and allow for corrective action when needed. A monitoring and evaluation framework has been prepared, which will be monitored annually, potentially incorporated in the national consolidated HIV dashboard, and reported on at the annual meetings of the Policy Advisory Board. It will build on and/or complement indicators of the National AIDS Spending Assessment, the Stigma Index, SCN#213, CLM, and the Global AIDS Monitoring Report.

BACKGROUND

Cambodia's HIV response over the past two decades has been highly successful through the effective implementation of HIV programs guided by the National Strategic Plan for the Comprehensive and Multi-sectoral responses to HIV and AIDS and the HIV Strategic Plan in the health sector. This has led Cambodia to be one of the seven countries globally to achieve the 90-90-90 targets (that translates into 73% of all people living with HIV being virally suppressed) and has been a model for other countries in Asia and the Pacific region and beyond. By the end of 2022, 86% of people living with HIV (PLHIV) were aware of their status, 99% of PLHIV who knew their status were accessing treatment, and 98% of PLHIV on treatment were virally suppressed. Compared to the baseline of 2010, there has been a 33% decline in new infections (from 2,000 to 1,400 in 2022) and a 30% decline in AIDS-related deaths (from 1,600 to 1,100 in 2022). These achievements have emerged from sound policy and strategic frameworks, and a legal framework that created an enabling environment for national HIV response as well as active engagement of CSOs in leading prevention efforts for key populations, providing care and support services for PLHIV, and closely working in partnership with government partners, and international organizations to strengthen community-led responses.

Significant progress had been made in the multi-sectoral response to HIV, especially in integrating the response into non-health ministries such as education, labour, social affairs, and interior. A high-level agreement has been reached to integrate HIV activities in commune development plans and commune investment plans (CDP/CIP). Funds ranging from KHR40 million to KHR80 million have been allocated to capital and all provinces for capacity building and to undertake HIV-related activities. In terms of integrating HIV into the wider health system, costing, financing, and budgeting are, to a certain extent, already part of the MOH system, as, for instance, financing for prevention and community response have yet to be part of domestic HIV financing. HIV services are being made available at the health facilities. The counseling and finger prick testing are provided at health centre level, and at communities for key population, while confidential voluntary counseling and testing and confirmatory testing are conducted at VCCT sites, often co-located with ART clinics. For comprehensive ART and other HIV related health care services are mainly provided at the public provincial and district referral hospitals.

Despite the gains being made in nearly all fronts, the latest evidence showed that the pace of decline of new HIV infection is not fast enough to end AIDS by 2025, with a target of 250 new HIV infections per year. There is impressive decline in new infections among females but rising new infections among males. New infections among men who have sex with men, male sex workers, and transgender women are on the rise. In addition, increased proportion of new HIV infections among young people accounted for 43% of new HIV infections. The HIV prevalence among key populations remain high: 4.9% for female entertainment workers, 13.5% for transgender women, 5.5% for men who have sex with men,[1] and 15.2% for people who inject drugs.[2] Latest data show

[1] NCHADS. 2023. Integrated Biological and Behavioral Survey
[2] NCHADS. 2017. National Integrated Biological and Behavioral Survey and Population Size Estimation among People who Use and Inject Drugs in Cambodia

a 14% increase in HIV infections among young males between 2010 and 2022 which accounted for 42% of total male new HIV infections in 2022. Though Cambodia has achieved 90-90-90 targets since 2017, challenges remain to reach 95-95-95 by 2025, especially to close the first 95 gap. Inequalities in access to HIV prevention, testing and treatment services remain to be addressed, particularly among young key populations and children. In addition, challenges also remain in addressing HIV co-morbidities and co-infections, e.g., TB, viral hepatitis, STIs, NCDs, mental health, through ongoing efforts to improve coordination of different disease programs by strengthening screening and treatment of HIV and TB co-infection, STI prevention and treatment, HCV screening and treatment for PLHIV, and integration of mental health services and NCDs in some selected ART sites.

A major issue that needs to be tackled and directly impacts on sustainability is that the national HIV response has been largely funded by external donors which has declined over time. While there has been an increase of domestic commitment in the last few years, this has only been for treatment, and prevention interventions are almost entirely dependent on international financing. There is no commitment nor progress on social contracting to CSOs. There is a need for Cambodia to transition from an HIV response characterized by dependency to one that is sustainable and truly 'owned' by Cambodia and applying a people-centered human rights-based approach to improve access to services and address stigma, discrimination, and other inequalities that affect PLHIV and key populations.

Cambodia's current National Strategic Plan for the Comprehensive and Multi-Sectoral Response to HIV and AIDS 2019-2023 (NSP V) guides the country's HIV multi-sectoral response toward reaching Fast Track commitments and Ending AIDS target by 2025. NSP V will be completed at the end of 2023.

OBJECTIVE

The overall objective is to develop NSP VI 2024-2028, a national strategic plan consisting of vision, mission, goal, objectives, strategies, key interventions, and an M&E framework.

DEVELOPING NSP VI

The process of developing NSP VI occurred in two stages. The first was to come up with a situation analysis which involved the conduct of a light review of NSP V implementation, building on the completed mid-term reviews of the NSP V and the HIV Strategic Plan for the health sector.[3] These reviews provided information on the state of progress, challenges and lessons learned of the implementation of the strategic plans and sets of recommendations that guided the development of the NSP VI. The findings and recommendations of the situation analysis was presented to stakeholders for review and additional inputs last 19 October 2023.

[3] Please see the separate report on the situation analysis.

The second stage focused on the development of NSP VI, following the strategy change cycle. The strategy change cycle is a planning approach that is goal or purpose oriented widely used by the private and public sectors and not-for-profit organizations. The approach includes considering "context and developing and linking purposes, strategies, participation, and the coalitions of support needed" to create desired changes. It acknowledges "building capacity for ongoing implementation, learning, and change". [4] The original 10 steps of the cycle have been adapted for this exercise and collapsed to eight,[5] although the steps particularly relevant to crafting the NSP VI focused on the first seven steps.

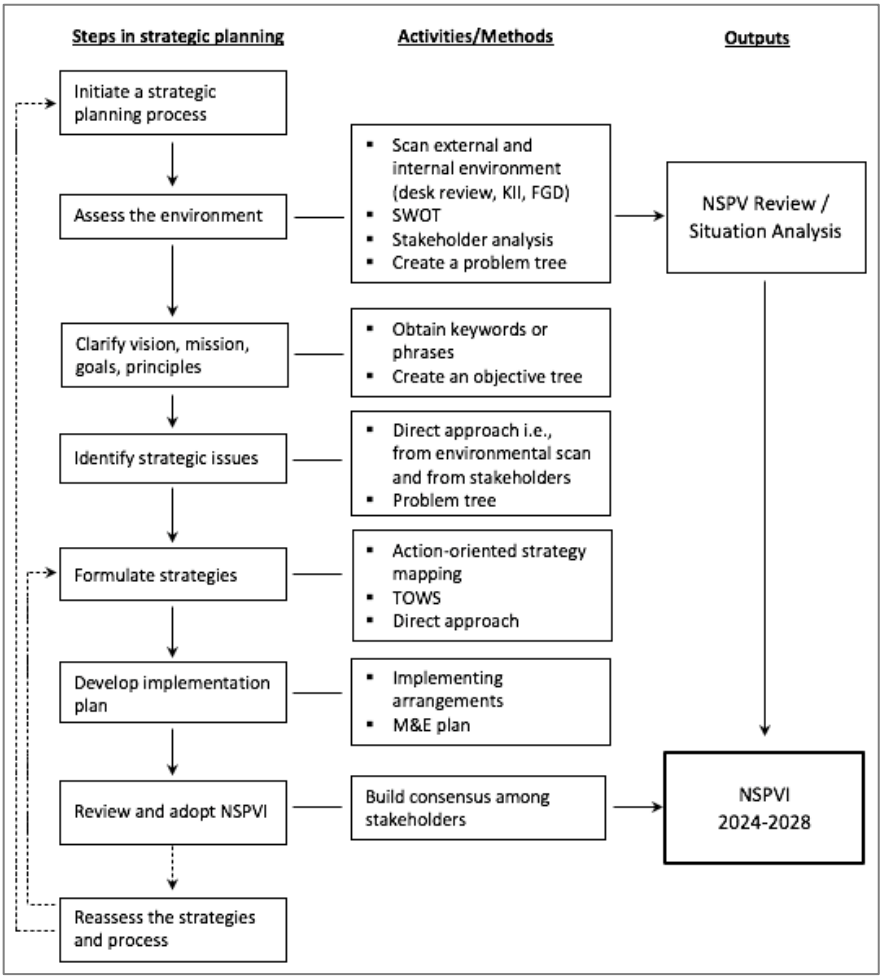
Twenty-one (21) key informants were interviewed and nine young KPs were engaged in a group discussion about their ideas regarding the vision, mission, goal, and strategies of NSP VI (Annex 1). Respondents were also asked about the strengths, weaknesses, opportunities and threats of the response (Annex 2). A desk review was carried out as well, including reports, assessments policies, standard operating procedures, strategic plans, guidelines, other related publications, and program data. Various reports were included such as the mid-term reviews of the NSP V and NSP of the health sector, the Optima analysis, surveillance reports, and accomplishment reports. Policy and strategy documents include, among others, the Pentagon Strategy Phase 1, National Strategic Development Plan 2019-2023, Strategic Plan for HIV and STI Prevention and Care in the Health Sector 2021-2025, and Global AIDS Strategy.

From the situation analysis which determined the progress, gaps, and lessons learned from the implementation of NSP V (Annex 3), a problem and objective tree as well as SWOT/TOWS were developed. The results combined with inputs from stakeholders produced the initial draft of NSP VI. The draft was presented to the Steering Committee for review and their inputs, and to a diverse group of stakeholders which provided additional inputs into the vision, mission, goal, and strategies. In drafting the final version of NSP VI, major activities for each strategy were identified, the details of which will be fleshed out during the preparation of the annual operational plan. The updated sustainability roadmap was also used to guide the sustainability component. The seventh round of NASA (2020-2022) being carried out by NAA with UNAIDS support will inform the potential financial gaps, assist in planning and mobilizing resources, and financing of the HIV response for NSP VI. The final NSP VI is aligned with the Pentagonal Strategy, contributing to the achievement of Pentagon 1 which is focused on human capital development. In particular, NSP VI will help address the improvement of people's health and wellbeing as well as contribute to the strengthening of social protection system. The final NSP VI was presented and validated in a workshop on 23 November 2023. Figure 1 diagrammatically illustrates the two-part process of developing the NSP VI.

[4] Bryson, John. 2011. Strategic Planning for Planning and Non-profit Organizations. A Guide to Strengthening and Sustaining Organizational Achievement. Fourth Edition. Jossey-Bass A Wiley Imprint. San Francisco

[5] The two steps are clarifying organizational mandates and establishing the vision which has been combined with clarifying mission, goals, and values.

Figure 1. Process of developing the NSP VI



2024-2028 NATIONAL STRATEGIC PLAN

1. Guiding principles

The following principles guided the development of NSP VI and will guide its implementation: national and community leadership and ownership, alignment with SDGs and national policies, sustainable financing, multi-sector collaboration, people-centered approaches and equity, gender equality, civil society participation, evidenced-based interventions, accountability and transparency.

2. Vision, Mission, Goals, Objectives

a. Vision

People in Cambodia live healthy and productive lives fully enjoying their human rights, free from HIV and AIDS and stigma and discrimination

b. Mission

Ensure a well-coordinated multi-sectoral HIV response which is inclusive, locally and community owned, people-centered, resilient and sustainable

c. Goal

A multisectoral sustainable HIV response which ensures AIDS is no longer a public health threat by 2028

d. Objectives

The 2024-208 National Strategic Plan for a Comprehensive, Multi-sectoral Response to HIV/AIDS has four objectives, as follows:

- Provide comprehensive and effective prevention, treatment, care and support through well-coordinated and holistic multi-sectoral approaches
- Improve the social well-being of KPs and PLHIV and create a conducive environment for PLHIV's and KP's effective access to HIV, health and other social and legal support services
- Build institutional, community, and individual capacities to strengthen community led responses and improve integration of HIV in health and non-health sectors
- Sustain the impact of the national HIV response by increasing local investments and strengthening the country system that governs, coordinates, and monitors the HIV response

3. Strategies

Objective 1. Provide comprehensive and effective prevention, treatment, care and support through well-coordinated and holistic multi-sectoral approaches

Prevention, treatment, care and support services remain and will remain a key pillar in eliminating HIV and ending AIDS as a public health threat and in achieving the Global AIDS Strategy targets of 95 95 95. While treatment coverage is high and there is a strong commitment to close the gap in the first 95, prevention remains a challenge. There is increased proportion of new HIV infections among young people which accounted for 43% of new HIV infections. Low levels of knowledge about HIV, Chemsex, increased online dating and sexual networking, low condom use, and high prevalence of STIs further put young people at risk and make them vulnerable to acquisition of HIV. Prevention remains underfunded, hampering multisectoral efforts to stop new infections on one hand, and detect early and put people on treatment on the other. Prevention also focuses on case detection rather than increasing knowledge and risk perception and changing behaviors so that KPs and young people can protect themselves. The Optima report found that current coverage of physical, virtual, and nighttime outreach as well as PDI+ and HIVST is low relative to assumed saturation coverage (e.g., physical outreach coverage is 73% for MSM and TGW compared to an 85% saturation coverage, nighttime outreach 4% for

MSM and TGW versus 10% saturation rate). There is also a lack of HIV expertise in non-health sectors and the subnational level.

The first strategy of Objective 1 focuses on health/medical focused interventions that will emphasize innovative and differentiated approaches such as HIVST, HTC linked to counseling and treatment, PrEP, partner notification, STI treatment, expanding outreach coverage of KPs, and scaling up ART. This will enable different prevention and testing services to reach undiagnosed PLHIV, migrants, young people, detainees and those who have been released, and hidden/well-off MSM/TG who may be accessing HIV services in the private sector. For treatment and care, ART retention will be optimized especially since there is a big cohort of PLHIV on treatment. In addition, prevention and treatment of co-morbidities in this group will be emphasized to reduce the burden on the individual and the health care system.

Strategy 1.2 is about fully engaging line ministries in non-health sectors that will provide information about HIV and HIV services to individuals, including those who transition from adolescence to adulthood, in settings such as the school, workplace, at home, and in communities where they reside. This will give them the knowledge and skills to assess and protect risky interactions with the same or opposite sex that may put them at risk. The key activities in non-health sectors will complement prevention efforts in the health sector by providing, reinforcing, and sustaining levels of knowledge about HIV. Behavior change can be encouraged so that consistent condom use and other safer practices can become the norm. The involvement of young people will be integral to the design and implementation of HIV-related interventions.

Strategy 1.1 Expand differentiated HIV services in prevention, testing, treatment and care

Outcomes:

- Achievement of 95 95 95 targets
- Reduced new infections by 90% from the 2010 baseline
- Increased comprehensive HIV knowledge of young people

Activities

- Strengthen and expand targeted, cost efficient, innovative and differentiated HIV prevention, testing, treatment and care for KP and PLHIV, including engagement with private sector (including PMTCT).
- Establish HIV policy, strategies, and implementation framework to encourage and guide private clinics/sector in providing HIV services, to enhance the quality of the services, and improve reporting from private sector.
- Strengthen CSOs/CBOs key roles in implementing HIV services for KPs and PLHIV
- Improve the quality and effectiveness of HIV prevention outreach through nuanced and stratified approaches to ensure that prevention services can reach all sub-set of KP
- Advocate for the provision of harm reduction and HIV testing, prevention, care and treatment services in prisons and closed settings

- Improve HIV prevention among PWUDs and PWIDs such as by strengthening harm reduction outreach, promoting greater uptake in opioid substitution therapy (OST), and combining pharmacological treatments and behavior therapy
- Scale up provision of PrEP including PrEP innovations e.g., long-acting injectable Cabotegravir, Dapivirine vaginal ring, etc. through all channels including CBOs, boost demand, and encourage KP subgroups with high-risk behaviors to stay on PrEP consistently
- Expand access to and use of HIVST/HIV Testing and Services (HTS) that is linked to confirmatory voluntary confidential counseling and testing, treatment and care
- Strengthen collaboration and technical support from ART sites to NGO partners in delivering community-led prevention and testing services and ART treatment
- Improve STI diagnosis and treatment by identifying and treating persons with symptomatic and asymptomatic infections, using postexposure prophylaxis (PEP) as needed, counseling and following up of infected persons, and advocating for free treatment of all STI for KPs and PLHIV
- Prevent and treat co-morbidities and co-infections such as mental health, non-communicable diseases, TB, and HCV/HBV of PLHIV in all age groups
- Sustain and improve early treatment initiation (especially same-day treatment), coverage, and retention by ensuring access to treatment/medicines, offering motivational counseling, creating peer support, having non-judgmental/neutral staff etc.
- Strengthen adherence support for PLHIV on ART to ensure sustained viral suppression
- Develop SOPs, guidelines, and programs, including a referral system to health services and programs, for HIV management of a growing cohort of older and aging PLHIV

Strategy 1.2 Develop, integrate, and implement HIV prevention-related interventions from all stakeholders, especially in non-health sectors and at subnational level

Outcome:

- Prevention interventions designed, integrated, and effectively implemented by ministries and CSOs

Activities

- Strengthen and expand HIV prevention and HIV services awareness in the education, labor, telecommunications, entertainment/culture, tourism, and transportation/construction sectors through the engagement of government agencies (MoEYS, MoLVT, MoPTC, MoInformation, MoT, MoCFA, MoWA, MoI, MPWT), CSOs, and the private sector
- Identify innovative ways to expand and improve HIV education and awareness-raising activities in health programs for young people including but not limited to delivery of comprehensive sexual education (CSE)
- Involve adolescents and young people meaningfully in designing and implementing HIV programs, and in crafting policies and strategies
- Launch targeted campaigns to promote awareness and adoption of non-risky behavior particularly among KPs and PLHIV

Objective 2. Improve the social well-being of KPs and PLHIV and create a conducive environment for PLHIV's and KP's effective access to HIV, health and other social and legal support services

Cambodia's social protection system comprises of social assistance and social security, two pillars that aim to 'reduce and prevent poverty, vulnerability, and inequality'.[6] To date, coverage of KPs and PLHIV by the national social protection system has been limited. In 2023, there are 75,892 PLHIV and 160,763 non-PLHIV KP. There are 13,411 PLHIV who are registered in the ID Poor/HEF system, accounting for 20% of the 65,646 PLHIV on ART and 18% of the estimated total of PLHIV in 2023.[7] Poor families with an HIV positive member numbering 2,153 have received a monthly cash support, including 699 level 1 Equity Card and 1,454 level 2 Equity Card.[8] There are also 266 entertainment workers who have been registered under NSSF, since its roll-out in 2023, who can access HEF only. There is a plan to scale up registration of PLHIV in ART sites next year, which should narrow the gap in coverage. In 2023, some KPs have been included in the HEF coverage.[9] Strategy 2.1 aims to have the majority of PLHIV and KPs under the umbrella of the country's social protection system. It aims to do this by addressing demand and supply side issues. On the demand side, awareness will be raised among KPs and PLHIV about the benefits of HEF and NSSF and ensure compliance of owners of entertainment establishments. On the supply side, registration will be strengthened and expanded, and social protection coverage can be increased through other schemes such as private insurance and the National Family Package Program.

The 2019 Stigma Index reported that external stigma was experienced by a low proportion of men and women, but internalized stigma was very high. However, discriminatory experiences in communities, health facilities or workplace, recounted by young KPs and CBO representatives, require attention and redress by providing access to necessary social and legal services. A clear gap in the response is the limited social and legal services that PLHIV and KPs can access. While there are NGOs such as LICADHO and ADHOC whose work focus on human rights, they do not seem to have programs particular for KPs and PLHIV. However, these NGOs
investigate and respond to women and child rights, on issues such as sexual assault, domestic violence, rape, and human trafficking. Strategy 2.2 will address these gaps by raising awareness about SRHR, SOGIESC, and available social and legal services that KPs, PLHIV, and young people can access. Raising awareness about and reducing stigma and discrimination as well as GBV is also part of this strategy. On the other hand, local law enforcement, health care providers, and other frontline workers will be sensitized about ongoing HIV-related services, harm reduction interventions, and the importance of stigma-free services to foster greater access to HIV, health, social, and legal support services. A necessary complementary activity would be to advocate for the removal of legal and policy barriers thereby improving access to HIV related services.

Strategy 2.1 Accelerate the social protection coverage of PLHIV and KPs

[6] Royal Government of Cambodia. 2017. National Social Protection Policy Framework 2016-2025
[7] NCHADS data for the first quarter of 2023 as reported in Semester 1 Progress Report of NAA
[8] NAA 2023. Semester 1 Progress Report of NAA
[9] Interview with Director, Dept of Planning and Health Promotion, MoH

Outcome:

- PLHIV and KPs are covered by social protection services by 2028

Activities

- Strengthen and expand ID Poor registration, HEF, NSSF for PLHIV and KP, and their uses in accessing services
- Increase PLHIV's and KPs' demand for social protection benefits by mobilizing national, commune- and district-based agencies, CSOs and networks while ensuring confidentiality of HIV and KP status
- Reinforce compliance of entertainment establishment owners for NSSF registration and contribution
- Build stronger partnership of social protection actors with KP and PLHIV communities to
  - Increase coverage of KPs and PLHIVs with private health insurance programs
  - Increase awareness of social protection benefits among KPs and PLHIV
  - Include KPs and PLHIV in the National Family Package Program
- Establish a working 24-hour hotline that is well disseminated so that it is well known and can be readily accessed by PLHIV, KPs, and young people. The hotline can serve
  - as a source of information about HIV, health, social (e.g., social protection) and legal support services
  - as a means to obtain counseling such as for an HIV test or any mental health issue,
  - and to communicate and address any issue.

Strategy 2.2 Improve the enabling and safe environment that promotes equitable access to HIV related services, health, and other social and legal support services

Outcomes:

- PLHIV and KPs are accessing social (e.g., psychosocial support) and legal support services
- Improved legal and policy environments that promote access to HIV, health, social, and legal services
- Reduced stigma and discrimination
- Reduced all forms of gender-based violence

Activities

- Effectively implement the national S&D action plan by engaging relevant ministries, subnational authorities, (MoEYS, MoLVT, MoH, PAC, commune/sangkat) and communities in the following:
  - Strengthen the implementation of school health policy and workplace policy on HIV and AIDS
  - Raise awareness about HIV and SOGIESC among teachers and students to reduce S&D in schools
  - Sensitize health care providers on HIV and SOGIESC to enable the provision of youth-friendly and stigma-free services

- Strengthen Patient Satisfaction Form (PSF) and community-lead monitoring (CLM) implementation and use their results in, for instance, advocating for the reduction of S&D
- Partner with the health sector and the subnational level to address HIV, SRH and S&D at the local levels
- Encourage community initiatives that raise awareness about HIV, SOGIESC, and S&D
- Include PLHIV and KP representatives at PAC and communes/ sangkat level forums to address S&D
- Conduct S&D awareness raising/campaign through all forms of media targeting the general public

- Strengthen and strategically target efforts to improve the enabling environment to be implemented by NAA, MoI, MoT, MoLVT, MoH, and MoSVY which can help reduce stigma and discrimination and build a better enabling environment for PLHIV and KP to access services
- Work with MoI, MoJ, MoT, MoLVT, and MoSVY in partnership with CSOs towards the stuck down of sex work and drug use
- Reduce the arbitrary arrest of street-based sex workers and sending them to social affairs centers by seeking clarification on 'Public security', which is used as probable cause for apprehension
- Partner with the General Department of Prison to strengthen HIV service delivery and harm reduction interventions in prisons
- Implement fully the policy, strategy, and action plan on gender-based violence developed by MoWA and ensure the quality and accessibility of GBV services in partnership with other ministries and CSOs
- Ensure PLHIV and KP (including gay men, other MSM, and TGW) have access to GBV prevention and response services
- Adopt and effectively implement the addendum to the Law on Prevention and Control of HIV/AIDS that explicitly supports young KPs and youth in accessing HIV services
- Raise awareness about available social and legal services that KPs and PLHIV can access and enable and expand access to legal support by advocating and collaborating with the MoSVY, MoJ, CSOs/CBOs such as LICADHO and ADHOC, and potentially the private sector
- Raise awareness among KPs and PLHIV about their human rights such as the right to health and to live lives free from any form of discrimination including GBV and demand for legal and social support/services
- Encourage KPs and PLHIV to strongly engage in local organizations/associations/ networks and actively use CLM and PSF as mechanisms to solve S&D with concerned local authorities
- Improve legal literacy by raising awareness of and creating a 'help desk', among others, for PLHIV and KP through HACC, PLHIV and KP networks, and NGOs whose mandate include human and legal rights
- Sensitize local law enforcement about ongoing HIV-related services and harm reduction interventions, especially with PWIDs, PWUDs, and street-based sex workers to
  - sustain interactions with these KP groups and encourage their regular use of these services, and

- reduce cases of abuse and exploitation e.g., harassment, verbal abuse, bribes
- Advocate for the removal of legal and policy barriers that hinder access to HIV-related services of KPs, PLHIV, and young people

Objective 3. Build institutional, community, and individual capacities to strengthen community led responses and improve integration of HIV in health and non-health sectors

Integration of HIV into the health system and non-health sectors will remain one of the core strategies under the NSP VI. To a certain extent, HIV is being integrated into the health system such as in the MPA in health centers and CPA in referral hospital. Similarly, costing, financing, and budgeting are already integrated into the MOH system although prevention and community response is not yet included. Nevertheless, NAA took note of the slow progress of such integration over the last few years. It is therefore necessary to engage in strategic dialogues using existing mechanisms such as the Government and Donors Joint Technical Working Group (GDJ-TWG), Policy Advisory Board (PAB) and/or Technical Advisory Board (TAB) meetings to reinforce the need for the meaningful integration of HIV into the overall health system, and non-health sectors.

In the non-health sectors, the passage of SCN #213 has led NAA to plan and support the integration of HIV in commune development plans and investment plans (CDP/CIP). Several ministries have also initiated the integration of HIV. For instance, MoEYS has comprehensive sexuality education, including sexual and reproductive health, HIV, and drug use prevention in the curriculum. MoI has collaborated with NAA at the sub-national level to create a multi-sectoral committee whose role will be to facilitate HIV work of the city/commune/sangkat. MoI has delegated full authority to the province to enable them to carry out HIV-related work. However, non-health ministries have acknowledged their lack of expertise to integrate HIV into their plans and programs. Other concerns relating to integration of HIV include the absent or limited role of some stakeholders in the response, the respective roles of national and subnational stakeholders, the lack of clear plan about integration, and the lack of engagement of local CBOs in the integration of HIV by communes/sangkat. The private sector has not been engaged in the HIV response.

Strategy 3.1 will focus on building up the capacities at the national and subnational levels in the areas of procurement of ARV and other HIV commodities; planning, budgeting, implementing, and monitoring HIV-related interventions in non-health sectors and in high-burden provinces; strengthening CLM; and strengthening the organizational and institutional development of CSOs. At the individual level, trainings will be provided such as on SRHR, SOGIESC, and providing KP-friendly and stigma-free services. Strategy 3.2 aims for further integration of HIV in all sectors. In the health sector, a common framework and guidelines are needed to push integration forward. However, KP-focused interventions should be maintained even as HIV services are meaningfully integrated in the general population system. In non-health sectors, HIV should become part of plans, programs, and budgets of ministries. Integrating HIV into non-health sectors can raise awareness, help change behaviors, and address the social determinants that lead to infection.

Strategy 3.1 Enhance the capacities (soft and hard skills) of all stakeholders involved in the response including subnational entities and communities infected and affected by HIV, to mobilize resources, design, implement, and monitor HIV-related interventions

Outcome:

- National and subnational entities and communities are knowledgeable and skilled in mobilizing resources, developing, implementing, and monitoring HIV interventions
- Testing and treatment services effectively and efficiently delivered by community-led organizations
- Service delivery of HIV prevention effectively and efficiently delivered by community-, KP-, and women-led organizations
- Programs support achievement of societal enablers effectively and efficiently delivered by community-led organizations

Activities

- Regularly build the capacity of government and contract staff to procure ARV and other HIV commodities
- Work with MOH to secure longer term contracts for technical staff in key positions and their integration in MOH system and make positions permanent
- Build the capacity of key non-health sectors to plan, budget, implement, and monitor HIV-related interventions
- Build the capacity of high-burden provinces in planning, budgeting, managing, implementing, and monitoring HIV interventions, partnering with CSOs and communities as needed
- Provide orientation/training on SRHR and SOGIESC to KPs, PLHIV, adolescents and young people
- Train health care providers, outreach workers and other frontline workers to be KP/PLHIV friendly and have a neutral/non-judgmental attitude
- Strengthen and expand CLM to cover HIV high burden provinces
- Strengthen the organizational and institutional development, and knowledge and technical capacities of CSOs and community networks either through
  - investments (e.g., equipment, office, funding support) and/or
  - capacity building to enhance their roles in designing, delivering, and monitoring HIV-related services and societal enablers
- Enable the meaningful participation of local KP and PLHIV organizations and networks in the local response, including but not limited to allowing them to be members of local working groups, councils, and partnerships

Strategy 3.2 Strengthen/Accelerate the integration of HIV in the plans and programs of ministries

Outcome:

- HIV is integrated into the health system in the areas of
  - management information systems
  - procurement and supply chain management
  - human resources
  - community systems and responses
  - private sector engagement
  - governance, leadership, and accountability
- HIV is effectively integrated in strategic and action plans, programs, and budgets of ministries, subnational units, and CSOs

Activities

- Hold strategic dialogues using existing mechanisms such as the GDJ-TWG, PAB and/or TAB meetings to reinforce the need for the meaningful integration of HIV into the overall health system, and non-health sectors
- Develop and adopt a common framework and guidelines for integrating HIV into the health system
- Integrate HIV in strategic and action plans, programs, and budgets of ministries in the non-health sector (MoEYS, MoLVT, MoPTC, MoInformation, MoT, MoCFA, MoWA, MoI, MPWT) and CSOs/CBOs
- Develop a referral system of PLHIV and KPs in HIV programs to other health services and health programs e.g., TB, mental health etc.
- Integrate HIV prevention and testing services at the health center level in stages, aiming for a meaningful integration into the general population system i.e., the PHC Boosted Framework but maintaining the necessary interventions to continuously support KPs and PLHIV
- Shift from a national to local responses at Capital, provincial, district and commune/sangkat levels, guided by local HIV epidemiology, existing capacities at subnational levels, and the role of the national level in guiding and overseeing the response

Objective 4. Sustain the impact of the national HIV response by increasing local investments and strengthening the country system that governs, coordinates, and monitors the HIV response

Cambodia's domestic funding for the HIV response from co-financing mechanisms has increased from US$1.6 million in 2015 to US$7 million in 2023. In 2017, US$8.3 million out US$34.5 million was obtained from domestic sources. Funding for HIV allocated to capital and all provinces is also available, ranging from KHR40 million to KHR80 million which would need periodic review to make sure funds are well used, address real gaps in the local response, and invested in HIV interventions which provide impacts. However, the national funding is largely for ARVs while the bulk of HIV funding comes from external sources, which has been declining. In NSP V, the government has committed to finance 50% of all HIV expenditures. It is clear that Cambodia will be facing a lack of resources and the entry point will be the engagement of the line ministries to

strengthen its support to the national HIV response including financial support for specific ministries to perform the HIV integration into their systems as deemed appropriate. The Optima analysis recommends additional spending of US$2 million from 2024 to 2026 and US$4 million per year from 2027 to 2030 in addition to the annual base spending of US3.3 million from 2024 to 2030 for key prevention interventions to reduce infections by 70% and to reach the target of 250 infections per year. Another factor that has direct effect on the response is Cambodia's graduation from least developed country status, potentially losing access to low-cost ARVs.

Strategy 4.1 aims to sustain and stabilize the resources of the HIV response by exploring various options to increase investments from domestic sources, advocating to maintain access to Agreement on Trade-Related Aspects of Intellectual Property Rights, developing a policy on and piloting social contracting, expanding the coverage of NSSF and HEF, and maximizing the utilization of external funding. These activities will eventually lead to a nationally owned response. On the other hand, Strategy 4.2 will strengthen the country system so that the PAB and the TAB become fully functional, work closely with the GDJ-TWG, give directions to the sub-working groups in charge of the strategies of NSP VI, and provide oversight to the national HIV response. The PAB can be considered fully functional once it regularly reviews and monitors the progress of policy and strategy implementation using the HIV monitoring indicators/data from the National Consolidated HIV Dashboard, reviews the performance of line ministries, and finally issues resolutions (policy changes, etc.) while the TAB implements resolutions by getting technical guidance from PAB and Leadership of NAA with assistance of GDJ-TWG to identify ways/strategies to each PAB's recommended resolution and report back to PAB in its next meeting. As such, the TAB has to work with line ministries' technical team, NCHADS, PAC, CSOs and other stakeholders. Sub-working groups or technical working groups and the Provincial AIDS Committees will also be strengthened by enhancing their capacities and reviewing their terms of references as well as membership.

Strategy 4.1 Increase domestically sourced investments of the HIV response

Outcomes:

- Increased Financing of the HIV response from local sources
- Additional investments from 2024 to 2028 for key interventions to reduce new infections
- Low-cost access to ARVs, diagnostics and prevention commodities maintained after LDC graduation
- CSOs/CBOs have social contracts with the government to deliver HIV services
- Private sector provides HIV testing, treatment and care services in compliance with MoH guidelines and report to NCHADS
- Exit strategy for HIV/AIDS developed

Activities

- Explore funding options of the HIV response such as
  - Grant or loan financing, consistent with national policy on debts/loans
  - the private sector's corporate social responsibility
  - social contracting of CSOs/CBOs

- engaging in social enterprises
- through donations and contributions
- foundations, and
- other fundraising modalities such as from sin tax, airline levy, lottery proceeds, etc.

- Advocate and work with relevant ministries and partners to ensure that Cambodia access to Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) on ARVs and other commodities is maintained
- Develop a social contracting policy that can be applied in health and non-health sectors, adapting existing social contracting approaches in Cambodia and the Asian experience
- Develop an SOP that includes clear criteria on which CSOs can apply for government contracts and what steps to follow, and do a pilot with a CSO
- Continue to advocate with the highest level of senior policy and decision makers to implement SCN#213 effectively, particularly policy measures on:
  - allowing health centers and referral hospitals their own HIV/AIDS fund
  - social contracting of CSOs
  - financial support to implement commitments of ending AIDS
  - integrating the HIV response into the health system
- Develop an exit strategy, to include social contracting, in partnership with government, development partners, and CSOs
- Maximize utilization and optimize efficiency of external funding to accomplish planned interventions and avoid forfeiture of unspent funds
- Advocate with MoLVT and NSSF to include the coverage of HIV services and expand HEF to include private health care providers
- Advocate with the private sector to encourage their participation and mobilize their contribution in the HIV response
- Periodically review the efficient and effective allocation and utilization of domestic funding (e.g., FTC budget allocated to FTC provinces and to other provinces) to make sure funds are well used, address real gaps in the local response, and invested in HIV interventions which provide impacts
- Advocate for transparency on phase out plans and timelines from donors

Strategy 4.2 Strengthen the country system to improve the governance, coordination, and monitoring and promote greater ownership of the HIV response

Outcome:

- Advisory boards and working groups are fully functional in strategically and efficiently coordinating and monitoring the response
- PAC, commune councils, Group of Champions are functional and actively engaged in designing, implementing, and monitoring HIV interventions

Activities

- Improve strategic coordination among stakeholders by
  - proactively addressing emerging issues and gaps of the HIV response
  - building the technical and soft skills of key staff at the national and subnational levels

- using a digital platform for meetings and trainings
- using real time data to increase ownership and strengthen governance
- strengthening the high-level M&E system, and
- strengthening ownership and leadership of KPs and PLHIV

- Report periodically (e.g., every six months) on the extent of accomplishments of outcomes, indicators and targets and determine corrective action as needed
- Emphasize major priorities and issues of the HIV response as focus of discussions in meetings and following up to ensure implementation and resolution as well as sharing the responsibility to the response
- Implement and effectively utilize a national consolidated HIV dashboard (e.g., during PAB and TAB meetings) that includes health and non-health information, community-level interventions, stigma and discrimination, etc.
- Ensure that all relevant ministries will implement the resolutions issued by the Policy Advisory Board, through regular monitoring via TAB and PAB
- Review the functions and efficiency of existing TWGs. Support TWGs by providing
  - a clear term of reference,
  - a roadmap with clearly defined timeline,
  - having active members,
  - mobilizing resources for the use of WGs, and
  - building the technical and 'soft' skills of the TWG chair and the members Ensure that all relevant ministries will implement the resolutions issued by the Policy Advisory Board
- Improve ownership and governance of provincial level HIV responses
- Develop interoperability/linkages between and among existing databases on HIV and AIDS to strengthen people-centered data analysis and data use for both PLHIV and KP
- Strengthen the implementing and coordinating mechanism of the HIV response by
  - providing technical assistance so that the Policy Advisory Board and the Technical Advisory Board to become fully functional and sub-working groups are given technical support
  - reviewing the structure of PAB and TAB and adapting to the response as necessary
  - reviewing the terms of reference of PAB and TAB

IMPLEMENTATION

At the national level, the NAA will take the lead in coordinating the implementation of the NSP VI, consistent with its mandate to lead, advocate, coordinate, facilitate, mobilize resources, and monitor the national HIV response. Coordination and monitoring of the national response takes place through the Policy Advisory Board, Technical Advisory Board and sub-working groups of the NAA. The Boards and the sub-working groups have the primary role in ensuring that key milestones under each of the four strategies will be discussed and agreed upon among key stakeholders so that they will be used to guide the steady achievement of the ultimate goal of the NSP VI. One of the key roles will be coordinating the HIV response emanating from line ministries, development partners, and CSOs/CBOs that are expected to incorporate HIV in their

strategic and action plans, programs, and budgets and follow through with their implementation. Part of the coordinating role is to provide technical and coordination support to stakeholders to ensure that the goal and outcomes of NSP VI are achieved. Non-health ministries have acknowledged their lack of HIV expertise as well.

The NAA will also take the lead to ensure that SCN213 is effectively implemented. While the first and second directives (i.e., allocate a budget in the 5-year development plan and 3-year investment plan of commune/sangkat, allow all PLHIV to register into ID Poor /Equity Card system) are being implemented, the rest have made little headway. NAA should continue to advocate and work closely with MoI, MoEF, MoH, the Council of Ministers, and the Supreme National Economic Council so that the rest of the directives of SCN213 can be implemented as part of NSP VI.

At the subnational level, the Provincial AIDS Committee (PAC) coordinates all HIV response activities while the Provincial AIDS STI Program (PASP) has the main role for the local HIV response. The PAC should take the lead in the Core Group and Provincial Group of Champions that coordinates with other Groups of Champions in other operational districts; decentralize responsibilities to districts and communes so that the needs of KPs, PLHIV, and other targeted populations are effectively addressed; and coordinate with relevant departments to build capacity for planning, budgeting, and implementation of the response. At the commune level, commune councils and health centers should coordinate with CSOs to facilitate access to social protection of KPs and PLHIV. With HIV part of the minimum package of activities, health centers can coordinate and work with commune councils, police, and CSOs to address the needs of KPs and PLHIV and prevent new infections. KPs and PLHIV should be members of the commune councils.

Key factors that will impact on the success of the implementation of NSP VI are the coordination of the HIV response, the presence of accountability mechanisms to ensure that HIV messages, services, and commodities are available and accessible, and the governance of the response, particularly at subnational levels.

1. Coordination

The current coordination and management framework of the HIV response include the following structures.

Policy Advisory Board (PAB)

At the highest level, the PAB presides at the policy level, headed by NAA, with representatives from all ministries, the Provincial AIDS Committee as well as the Provincial Secretariat, and CSOs. It meets twice a year and is the forum where decisions are made regarding the roles and obligations of stakeholders vis-à-vis the response. The PAB also plays role in endorsing key or strategic documents such as the National AIDS Policy, the Strategic Plan, guidelines, etc. At the end of each meeting, a resolution (i.e., key action points) is made and announced to the members

for their respective action and follow-up. The PAB requires technical assistance so that it will become efficient and fully functional.

Technical Advisory Board (TAB)

The TAB was also created to provide necessary technical support to any key documents or discussions organized by NAA. It is also headed by NAA and quite similar in composition membership-wise to the PAB, but most members are of technical nature – as opposed to the policy nature for the PAB. The TAB meets on a quarterly basis. Like the PAB, the TAB needs technical assistance to make it fully functional to make robust and up-to-date technical guidance and recommendations.

Government and Donors Joint Technical Working Group

The Government and Donors Joint Technical Working Group (GDJ-TWG) was also formed to provide forum for government, civil society, donors and development partners to coordinate and monitor the implementation of the national and multi-sectoral plan responding to HIV/AIDS in a constructive and cooperative manner. Key focus areas for the GDJ-TWG included promote good governance, policy and strategy coherence across sectors; promote, facilitate and harmonize relevant multi-sectoral approaches; develop and promote shared accountability among GDJ-TWG and HIV/AIDS partners; etc. The GDJ-TWG is chaired by the NAA Chair and co-chaired by UNAIDS or USAID who take turns in assuming this role. It meets four times per year. A Secretariat led by the Secretary General is composed of GDJ-TWG active members with support from NAA staff.

Technical Working Groups

There are four TWGs responsible for monitoring and providing updates to the TAB on the progress of the response. These are the Prevention, Social and Legal Support, Sustainability, and M&E TWGs. The Care and Support TWG is based in NCHADS. The terms of reference and membership of the four TWGs should be reviewed so that they are aligned with each of the four strategies of NSP VI. The Chair and Co-Chair of the TWGs of NSP VI should come from key sectors based on the relevance of their mandates to the key functions of the working groups.

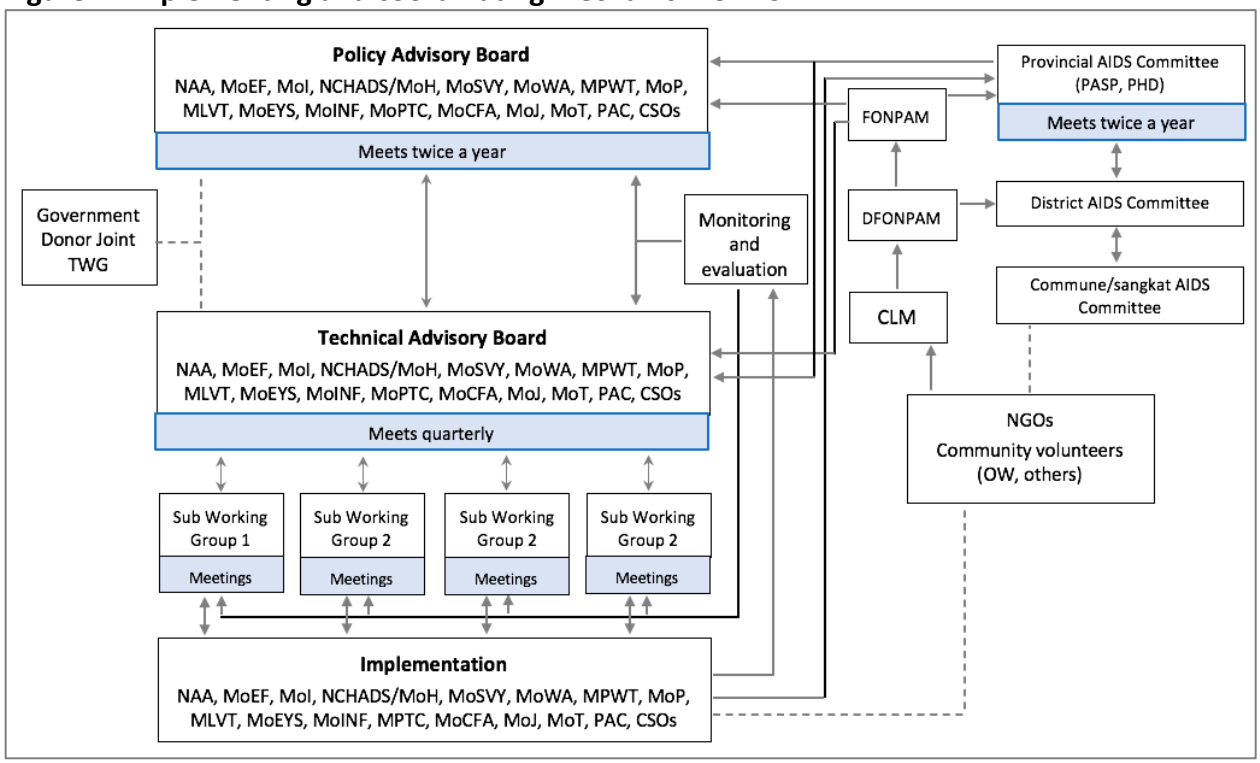
Subnational units

At the subnational level, the Provincial AIDS Committee provides guidance and oversight, governs, and coordinates the local HIV response. The limited governance at the subnational level point to their lack of familiarity with the HIV epidemiology in the province, and the lack of HIV expertise that would enable them to deliver the appropriate response. This may also point to the reliance on national bodies to provide directions and resources for the local responses. Going forward, subnational stakeholders should be trained and mentored so that they can govern the local HIV response effectively. They should be strongly encouraged to work in tandem with communities and support community-led responses.

The different structures of NSP VI's implementation, coordination, and monitoring and their relationship to each other are presented in Figure 2. The left-hand side of the diagram represents

the structures and the mechanisms at the national level, from the PAB, TAB, GDJ-TWG to the sub-working groups and the line ministries and CSOs that will craft policies and guidelines, and design and implement HIV related interventions. The right-hand side represent the decentralized HIV response, led by the PAC with corresponding units at the district and commune/sangkat levels. The M&E and CLM will track the performance of the response, providing updated data to the PAB, TAB, sub-working groups, and the PAC to enable evidenced based decisions.

Figure 2. Implementing and coordinating mechanism of NSP VI



2. Accountability

Accountability is being answerable for delivering results that were "determined through a clear and transparent assignment of responsibility, subject to the availability of resources and constraints posed by external factors".[10] Having accountability in place will help ensure that the roles of different stakeholders are executed as planned, contributing to the achievement of targets and outcomes of NSP VI. For NSP VI, line ministries are expected to identify key indicator(s) at the start of the year and at year's end, will be held accountable for its accomplishment or lack thereof.[11] The semi-annual meeting of the PAB, the aforesaid annual reporting on key indicators by line ministries, the quarterly meetings of the TAB, the semi-annual meeting of the PAC, and the meetings of the sub-working groups are expected to continue. These meetings (the blue boxes in Figure 2) will serve as the accountability mechanisms in the implementation of NSP VI as these are the venues where line ministries will report on the

[10] WHO. March 2015. WHO Accountability Framework
[11] Interview with NAA

progress made on their commitments to the HIV response. These meetings will also be the venue to deal with the challenges facing the HIV response and their resolution. This will be supported by internal periodic reviews among stakeholders, social audits, data from the monitoring and evaluation system and CLM, etc. that will provide evidence on the extent of accomplishments reported by involved stakeholders. Scorecards and 'seals of excellence' will document the performance of stakeholders and can be a basis for recognition or a signal to further improve. These will be explored, agreed on, and adopted by stakeholders for NSP VI.

MONITORING and EVALUATION

1. Proposed NSP VI monitoring and evaluation framework and indicators

Strategy 1.1 Expand differentiated HIV services in prevention, testing, treatment and care

Outcomes:

- Increased comprehensive HIV knowledge among young people between 15 to 24 years old
- Achievement of 95 95 95 targets
- Reduced new infections

Baseline:

- 86% of total estimated PLHIV know their status; 99% retained on treatment, and 98% of them achieved viral load suppression in 2023
- 1,400 estimated new infections in 2022
- 23% of young males and 26.5% of young females have comprehensive knowledge about HIV

Indicators	Responsible Ministries	Means of Verification
At least 95% of total estimated PLHIV know their status; at least 95% retained on treatment, and at least 98% of them achieved viral load suppression	Lead: NCHADS PHD Referral hospitals Health centers NAA CSOs/CBOs	▪ HIV infection estimates based on AEM-spectrum modelling ▪ ART programme data from NCHADS ART database
New infections reduced by 90% from 2010 baseline		
75% of young people have comprehensive knowledge about HIV	Lead: MoEYS NAA MoInformation MoCFA MPTC	CDHS

Strategy 1.2 Develop, integrate, and implement HIV prevention-related interventions from all stakeholders, especially in non-health sectors and at subnational level

Outcome:

- Prevention interventions developed and implemented by ministries and CSOs

Indicators	Responsible Ministries	Means of Verification
% of ministries and CSOs are implementing prevention interventions	Lead: NAA NCHADS MoEYS MoI MoSVY MoLVT MoT MoInformation MoCFA MPTC MPWT CSOs/CBOs	Accomplishment/ progress reports

Strategy 2.1 Accelerate the social protection coverage of PLHIV and KPs

Outcome:

- PLHIV and KPs are covered by social protection services

Indicators	Responsible Ministries	Means of Verification
95% of PLHIV and 50% of KPs are covered by social protection services by 2028	Lead: MoP NCHADS NAA MoH MoSVY MoLVT CSOs/CBOs	▪ Database records ▪ Accomplishment / progress reports

Strategy 2.2 Improve the enabling and safe environment that promotes equitable access to HIV related services, health, and other social and legal support services

Outcomes:

- PLHIV and KPs accessing social (e.g., psychosocial support) and legal support services
- Improved legal and policy environments that promote access to HIV, health, social, and legal services
- Reduced stigma and discrimination
- Reduced all forms of gender-based violence

Indicators	Responsible Ministries	Means of Verification
▪ _% of PLHIV and _% of KPs access social and legal services	Lead: NAA MoI	▪ Patient Satisfaction Feedback

▪ 90% of punitive laws and policies that deny or limit access to services changed/struck down ▪ % internal stigma among KPs and PLHIV ▪ % experienced stigma in community among KPs and PLHIV ▪ % experienced stigma in health care setting among KPs and PLHIV ▪ Less than 10% of women, girls, PLHIV and KPs experience gender-based violence	MoJ MosVY MoLVT MoT MoEYS MoInformation MoCFA MPTC MPWT CSOs/CBOs	▪ Community-lead monitoring (CLM) ▪ Stigma Index (future edition) ▪ IBBS reports for key populations ▪ Accomplishment/ progress reports

Strategy 3.1 Enhance the capacities (soft and hard skills) of all stakeholders involved in the response including subnational entities and communities infected and affected by HIV, to mobilize resources design, implement, and monitor HIV-related interventions

Outcomes:

- National and subnational entities and communities are knowledgeable and skilled in mobilizing resources, developing, implementing, and monitoring HIV interventions
- Testing and treatment services effectively and efficiently delivered by community-led organizations
- Service delivery of HIV prevention effectively and efficiently delivered by community-, KP-, and women-led organizations
- Programs support achievement of societal enablers effectively and efficiently delivered by community-led organizations

Indicators	Responsible Ministries	Means of Verification
▪ _ HIV interventions developed and implemented by subnational entities and communities ▪ 30% of testing and treatment delivered by community-led interventions ▪ 80% of HIV prevention services delivered by community-, KP-, and women-led organizations ▪ 60% of programs support the achievements of societal enablers to be delivered by community-led organizations	Lead: NAA NCHADS MoH MoI MoEYS MoWA MoSVY MoLVT MoT MoInformation MPTC MoCFA MPWT PHD	▪ Policies, SOPs that support and promote role of communities in the HIV response ▪ CLM ▪ Annual/ accomplishment/ progress reports

	Referral hospitals Health centers Provinces/districts/ communes CSO/CBO	

Strategy 3.2 Strengthen/ Accelerate the integration of HIV in the plans and programs of ministries

Outcome:

- HIV is integrated into the health system in the areas of
  - management information systems
  - procurement and supply chain management
  - human resources
  - community systems and responses
  - private sector engagement
  - governance, leadership, and accountability
- HIV is effectively integrated in strategic and action plans, programs, and budgets of ministries, subnational units, and CSOs

Indicators	Responsible Ministries	Means of Verification
▪ TBD ▪ % of ministries, subnational units and CSOs have incorporated HIV in strategic and action plans, programs, and budgets	Lead: NCHADS/MoH NAA MoI MoEYS MoWA MoSVY MoLVT MoT MoInformation MPTC MoCFA MPWT PHD Referral hospitals Health centers Provinces/districts/ communes	▪ Framework and guidelines for integrating HIV into health and non-health sectors ▪ Annual/ accomplishment/ progress reports

Strategy 4.1 Increase domestically sourced investments of the HIV response

Outcomes:

- Increased financing of the HIV response is from local sources

- Additional investments from 2024 to 2028 for key interventions intended to reduce new HIV infections
- CSOs/CBOs have social contracts with the government to deliver HIV services
- Private sector provides HIV testing, treatment and care services in compliance with MoH guidelines and report to NCHADS
- Low-cost access to ARVs, diagnostics and prevention commodities maintained after LDC graduation
- Exit strategy for HIV/AIDS developed

Indicators	Responsible Ministries	Means of Verification
▪ 50% of financing for the HIV response is from local sources ▪ At least US$14 million invested in key interventions to reduce new HIV infections from 2024 to 2028 ▪ 50% of CSOs/CBOs with social contracts ▪ Improved reporting from private sector facilities who deliver HIV services ▪ TBD ▪ TBD	Lead: NAA MoEF NCHADS MoH	▪ NASA ▪ Budget allocation reports ▪ Funding flow and resource tracking mechanisms at both sub-national and national levels

Strategy 4.2 Strengthen the country system to improve the governance, coordination, and monitoring and promote greater ownership of the HIV response

Outcomes:

- Advisory boards and working groups are fully functional in coordinating and monitoring the multi-sectoral response
- PAC, commune councils, Group of Champions are functional and actively engaged in designing, implementing, and monitoring HIV interventions

Indicators	Responsible Ministries	Means of Verification
▪ TBD ▪ More than 80% of PACs, 50% of commune councils, and 90% of Group of Champions actively designed, implemented, and monitored HIV interventions	Lead: NAA NCHADS MoH MoI MoEYS MoWA MoSVY MoLVT MoT MoInformation MPTC	▪ Accomplishment / progress reports ▪ Policies, SOPs that support and provide guidance to sub-national units on developing and implementing interventions

	MoCFA MPWT Provincial AIDS Committee	

In addition to the indicators of NSP VI, data from community-lead monitoring (CLM) as well as the S&D monitoring and reporting mechanism will provide evidence and inform the HIV response.

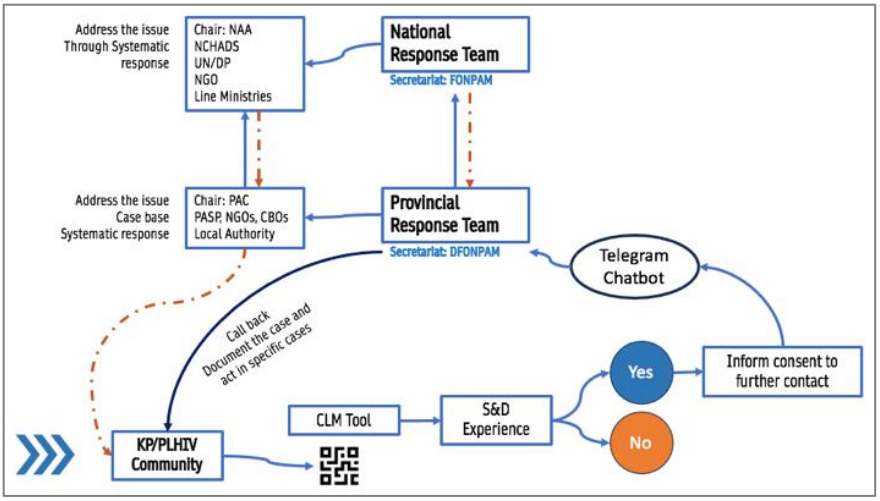
Community-Lead Monitoring (CLM)

CLM, implemented by Joint Forum of Networks of PLHIV and MARPs (FONPAM), District Joint Forum of Networks of PLHIV and MARPs (DFONPAM), collect data from community level and then data are automatically analyzed and presented in the CLM dashboard covering seven core indicators: prevention, PrEP, STI, care and treatment, GBV, social protection, and stigma and discrimination. A quarterly report covering the seven indicators is made by DFoNPAM and FoNPAM – who will then present and report to community, partners, and key relevant stakeholders. At each stage, CLM engages policy makers, service providers, and service users to ensure success in its operation. The CLM is currently being strengthened and promoted to be used as the national systematic mechanism for real monitoring and feedback sharing of key efforts involving all high-level government mechanisms (Provincial AIDS Committee, TAB, PAB, and national and subnational HIV mechanisms) as well as NGOs/CBOs and the community.

S&D Reporting and Response Mechanism

As shown in Figure 3, the upper half of the diagram has two levels of response, the national level and provincial level. The national level will be supported by the secretariat of FONPAM and the provincial level, by the secretariat of DFONPAM. The membership at the national level is represented by the NAA, NCHADS, UN, NGOs, and line ministries. That of the provincial level will be represented by PAC, PASP, NGOs, CBOs and local authorities. FONPAM and DFONPAM include memberships from the PLHIV and the key populations and they were created more than a decade ago with the support of UNAIDS. The lower part of the diagram describes how someone experiencing S&D will be assisted. In the event of an S&D against a KP or a PLHIV is uncovered through the CLM tool, the consent of the person in question will be obtained – and if she/he agrees, she/he needs to share their contact number that will be later contacted (through Telegram) for intervention and documentation of the case.

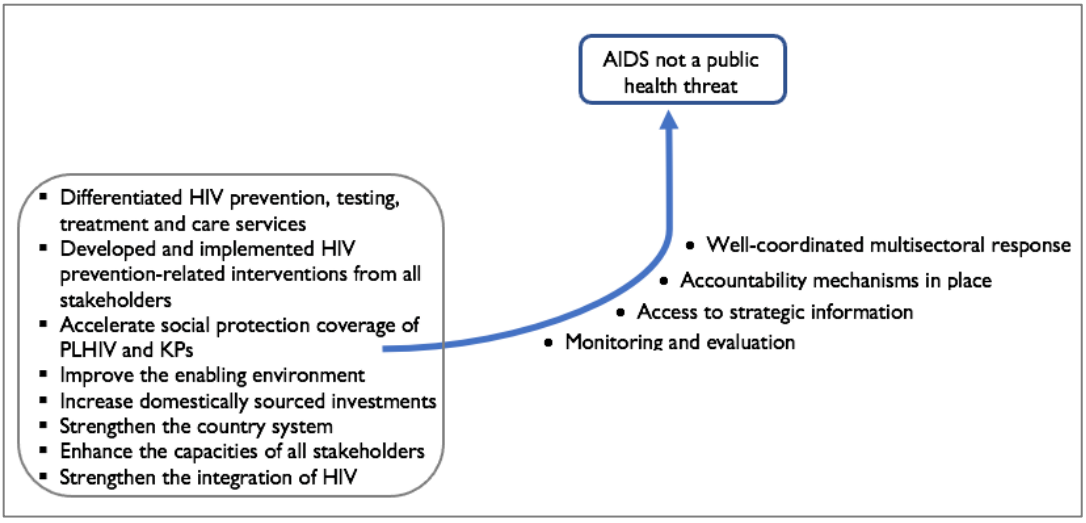
Figure 3. S&D Reporting and Response Mechanism



2. Theory of change

NSP VI's theory of change states that with the strategies in place that addresses issues of the current HIV epidemic, HIV and AIDS will no longer be a public health threat (Figure 2). The assumptions that underlie the implementation of the strategies include a well-coordinated response, having accountability mechanisms in place, access to up-to-date strategic information, and a well-functioning monitoring and evaluation system.

Figure 4. Theory of change of NSP VI



Another way of looking at the relationship between the strategies and the goals and outcomes is by using a results chain or outcome and impact orientation (OIO) model.[12] Each strategy which is action oriented, produces outputs which are then 'used' by 'actors' or stakeholders, leading to outcomes. For instance, the first strategy aims to 'expand differentiated HIV services in

[12] Espoused by Bread for the World, a German funding agency

prevention, treatment, and care' (Table 2). The outputs of this action statement can be increased knowledge about HIV, and awareness of availability/location of HIV commodities and services by KPs, PLHIV, and other population groups. The assumed next step in the results chain (use of output) is that commodities and services are being used and there is consistent condom use and risky behavior is reduced because of greater awareness, availability and accessibility of prevention commodities and services. All these would contribute to achievement of 95-95-95 targets, eventually reaching the impact of eliminating HIV and ending AIDS as public health threats (not shown). Using this approach clarifies the assumptions (i.e., greater awareness about HIV and services leads to behavior change like enrolling in PrEP or testing regularly) that are being made to reach the desired outcome(s). The assumptions give implementers notice that these should be paid attention so that the desired outcome(s) will be achieved or that a different set of conditions might be needed to achieve the outcome(s).

Table 1. Results chain of NSP VI

Strategies	Output	Use of output	Outcome
1.1 Expand differentiated HIV services in prevention, testing, treatment and care	▪ Increased comprehensive HIV knowledge among 75% of young people[13] ▪ Awareness about HIV services raised	▪ Access/use of differentiated services by KPs and PLHIV ▪ Consistent condom use ▪ Risky behaviors are protected through differentiated prevention options	Achievement of 95-95-95 targets
1.2 Obtain greater commitment to develop and implement HIV prevention-related interventions from all stakeholders, especially in non-health sectors and at subnational level	▪ Prevention interventions developed and implemented by ministries and CSOs		
2.1 Accelerate social protection coverage of PLHIV and KPs	▪ 95% of PLHIV and 50% of KPs are covered by social protection services by 2028	▪ PLHIV and KPs with Equity Cards NSSF, HEF access health services	
2.2 Improve the enabling environment that promotes access to HIV related services	▪ PLHIV and KPs are aware of social (e.g., psychosocial support) and legal support services ▪ Law enforcement/ frontline workers/	▪ Legal services used ▪ Number of arrests of street-based sex workers reduced ▪ Punitive policies relating to sex work	▪ PLHIV and KPs accessing social (e.g., psychosocial support) and legal support services ▪ Improved legal and policy environments

[13] 23.3% among females and 26.5% among males in the 15-24 age group. Source: National Institute of Statistics. Cambodia Demographic and Health Survey 2021-2022. Key Indicators Report

	establishments sensitized about HIV related issues	and drug use struck down	that promote access to HIV, health, social, and legal services ▪ Reduced stigma and discrimination ▪ Reduced all forms of gender-based violence
3.1 Enhance the capacities (Hard and Soft Skill) of all stakeholders involved in the response including subnational entities and communities, to mobilize resources and design and implement HIV-related interventions	▪ Completed wide range of trainings e.g., admin/finance, budgeting, planning, SOGIESC, SRHR, motivational counseling, etc.	▪ Service providers/ frontline workers offer services in a neutral/non-judgmental way ▪ Subnational entities and communities are knowledgeable and skilled in developing, budgeting, and implementing HIV interventions	▪ National and subnational entities and communities are knowledgeable and skilled in mobilizing resources, developing, implementing, and monitoring HIV interventions ▪ Testing and treatment services effectively and efficiently delivered by community-led organizations ▪ Service delivery of HIV prevention effectively and efficiently delivered by community-, KP-, and women-led organizations ▪ Programs support achievement of societal enablers effectively and efficiently delivered by community-led organizations
3.2 Strengthen/ Accelerate the integration of HIV in the plans and programs of ministries	▪ Framework and guidelines for integration developed	▪ Health and non-health sectors are applying framework and guidelines for integration	▪ HIV is meaningfully integrated into the health system ▪ HIV is effectively integrated in strategic and action plans, programs, and budgets of

			ministries, subnational units, and CSOs
4.1 Increase domestically sourced investments of the HIV response	▪ _% of financing for the HIV response is from local sources ▪ Additional investments of at least US$14 millions from 2024 to 2028 for key interventions intended to reduce new HIV infections ▪ CSOs/CBOs have social contracts with government to deliver HIV services ▪ Private sector provides HIV testing, treatment and care services and report to NCHADS ▪ Low-cost access to ARVS after LDC graduation maintained	▪ Continued supply of commodities and assured provision of HIV services ▪ Maintain key technical staff and outreach workers	▪ Achievement of 95-95-95 targets ▪ PLHIV and KPs accessing social (e.g., psychosocial support) and legal support services ▪ Improved legal and policy environments that promote access to HIV, health, social, and legal services ▪ Reduced stigma and discrimination ▪ Reduced all forms of gender-based violence ▪ National and subnational entities and communities are knowledgeable and skilled in mobilizing resources, developing, implementing, and monitoring HIV interventions ▪ Testing and treatment services effectively and efficiently delivered by community-led organizations ▪ Service delivery of HIV prevention effectively and efficiently delivered by community-, KP-, and women-led organizations ▪ Programs support achievement of societal enablers
4.2 Strengthen the country system to improve the governance, coordination, and monitoring and promote greater ownership of the HIV response	▪ Advisory boards and working groups are fully functional in coordinating and monitoring the response ▪ PAC, commune councils, Group of Champions are functional and actively engaged in designing and implementing HIV interventions	▪ Real time solutions to issues confronting the HIV response	

			effectively and efficiently delivered by community-led organizations

Annex 1. List of persons consulted for NSP VI

1. HE Dr. Tia Phalla, Vice Chair, National AIDS Authority
2. HE Dr. Ros Seilavath, Vice Chair, National AIDS Authority
3. HE Dr. Chhim Khin Dareth, Secretary General, National AIDS Authority
4. HE Dr. Sim Sophay, Vice Secretary General, National AIDS Authority
5. HE Dr. Tep Navuth, Head, PMER Unit, National AIDS Authority
6. Dr. Ly Vichearavouth, Director of Department of Planning & Health Information, MoH
7. HE Keo OUly, Ministry of Planning
8. Nhim Dalen, FHI 360-Epic
9. Choub Sok Chamreun, Executive Director, KHANA
10. Tim Vora, Executive Director, HACC
11. Dr. Veth Sreng, Program Manager, RHAC
12. Dr. Noy Prorphea, HIV Project Manager, CRS
13. Ms. Hul Sivantha, CHAI
14. Dr. Houy Sikheng, Executive Director, AHF
15. Dr. Sray Mony, Principal Advisor, LHSS
16. Ms. Patricia Ongpin, Country Director, UNAIDS
17. Dr. Khin Cho Win Htin, Strategic Information Adviser, UNAIDS
18. Mr. Ung Polin, Adviser-Services for All Implementation, UNAIDS
19. Dr. Deng Serongkea, Technical Officer, WHO
20. Mr. Phon Vutha, Youth Specialist, UNFPA
21. Ms. Bou Amara, Program Specialist, UNDP
22. Ms. Karen Peters, Regional Program Officer, UNODC
23. Young KPs, FGD participants

Annex 2. Guide questions for NSP VI development

Key informant interviews

1. What are the strengths and weaknesses of the multisectoral HIV response?
2. What opportunities are available to make the multisectoral HIV response more effective?
3. What are the threats facing the multisectoral HIV response?
4. How do you see the domestic funding landscape for national HIV response?
5. What major outcome or situation (i.e., vision) do you see in 2028, after implementing NSP VI? What kind of change is being aimed for by 2028 after NSP VI?
6. What should be the mission of NSP VI?
7. What should be the values or guiding principles of NSP VI? How should NSP VI interventions be carried out?
8. What should be the goal of NSP VI?
9. What strategic direction (strategies) should be the focus of NSP VI?

Guide questions (FGD)

1. What HIV related interventions would be appropriate for you and young people? What kind of HIV related interventions would make you access/participate HIV commodities and services?
2. What can be done differently in NSP VI for a more effective HIV response?
3. What role should digital/online technology and social media play in NSP VI?
4. In what ways can you and KPs or young people participate or increase your participation in the HIV response?
5. What are the strengths and weaknesses of the multisectoral HIV response?
6. What opportunities are available to make the multisectoral HIV response more effective?
7. What are the threats facing the multisectoral HIV response?
8. How do you see the domestic funding landscape for national HIV response?
9. What major outcome or situation (i.e., vision) do you see in 2028, after implementing NSP VI? What kind of change is being aimed for by 2028 after NSP VI?
10. What should be the mission of NSP VI?
11. What should be the values or guiding principles of NSP VI? How should NSP VI interventions be carried out?
12. What should be the goal of NSP VI?
13. What strategic direction (strategies) should be the focus of NSP VI?

Annex 3. Achievements, gaps, and lessons learned from NSP V implementation

Achievements and gaps in implementing NSP V

Strategy 1. Delivery of comprehensive prevention, care, treatment and support through a multi-sectoral approach	
Achievements	**Gaps**
▪ Prevention of HIV has made great strides o 82,967 KPs reached in Q2 2023 compared to 69,255 KPs in Q3 2022 o Average of 45% of KPs reached were tested for HIV in 2022 o PrEP services increased from 2 to 29 sites between 2019 and 2023 o As of June 2023, PrEP retention rate was at 53% ▪ HIVST is available in 19 provinces in 2022 ▪ Cascade of treatment at 86-99-98 ▪ ART sites increased from 32 to 72 sites between 2005 and 2023 ▪ Awareness raising about HIV is being carried out in schools by integrating CSE including HIV in the curriculum, in workplaces, and for work-bound migrants to other countries ▪ Prevention of gender-based violence ▪ At the subnational level o multi-sectoral committee whose role will be to facilitate HIV work of the city/commune/ sangkat o HIV is being integrated in commune/sangkat plans	▪ Prevention and multi-sectoral activities have been reduced due to declining funding ▪ Awareness raising activities for general population is almost non-existent ▪ CSE/SRH including HIV is now integrated in the school curriculum but the roll out has been slow as there are limited funds to print textbooks and to train educators ▪ No prevention activities targeting out-of-school youth ▪ Difficulty in creating demand for HIVST and PrEP, especially for young KPs ▪ Challenge to reach migrants, some of whom may be undocumented ▪ Reaching 10,000-12,000 undiagnosed PLHIV ▪ Outreach workers face sub-optimal conditions and experience frequent turnover ▪ Outreach work has not reached saturation coverage ▪ HIV prevention among PWUDs and PWIDs is limited ▪ Little HIV prevention and treatment services in closed settings
Strategy 2. Integrate AIDS response activities into the health system, relevant ministries, and national coordinating bodies	
Achievements	**Gaps**
▪ Integration of HIV in the health system is progressing well o ART, PrEP, and most of VCCT sites are integrated or co-located in referral hospitals o HIV is part of MPA at health centers and CPA at referral hospitals	▪ Lack/limited engagement of relevant/key non-health ministries in HIV: MPTC, MoInformation, Ministry of Culture and Fine Arts, Drug Control agency, Prison Authority, Ministry of Tourism, Ministry of Public Works and Transport ▪ No clear plan about integration including the lack of clear roles of stakeholders at

○ HIV and syphilis screening are regularly carried out in health centers for pregnant women ○ Costing, financing, and budgeting are already integrated into the MOH system ○ There are efforts to integrate HIV with mental health and substance abuse and NCD ▪ In non-health sectors ○ HIV is being integrated in CIP/CDP of commune/sangkat per SCN #213 ○ MoEYS has integrated CSE including HIV and drug use prevention in the health education curriculum ○ MoI collaborated with NAA to create a multi-sectoral committee (AIDS Committee) whose role will be to facilitate HIV work at sub-national level (provincial, district, city/commune/ sangkat ○ MLVT has a committee that guides HIV prevention-related activities in workplace settings and for migrants ○ MOWA has developed a policy, strategy and national action plan to prevent and respond to gender-based violence (GBV) considering female key populations (EW, female people who inject drugs) – not clearly linked with HIV ○ MPTC integrated and disseminated HIV related messages through mobile phones and bulletin (websites)	national and subnational levels, and no HIV expertise of relevant ministries for HIV integration ▪ Limited capacity at subnational to plan and implement HIV interventions ▪ PLHIV/KPs/CBOs not fully aware nor engaged at the efforts of commune/ sangkat to integrate HIV ▪ Lack of budget to print textbooks based on curriculum integrating CSE for students and to train teachers (MoEYS) ▪ Violence against TGW and MSM does not appear to be included in definition of GBV by MoWA
Strategy 3. Expand social protection coverage and improve access to social and legal services	
Achievements	**Gaps**
▪ MoP/NAA/NCHADS with joint support of UNDP and UNAIDS developed ID Poor registration system for individual PLHIV at ART sites which started in 8 ART sites in December 2022 ▪ Of 65,646 PLHIV on ART, 13,411 are registered with ID Poor/HEF and 4,832 received Equity Cards as of Q1 2023	▪ Expansion in the coverage of social protection among PLHIV is slow due to factors such as ○ Family based design of ID Poor/HEF ○ KPs/PLHIV are fearful/unwilling to disclose their status ○ KPs/PLHIV hide identities ○ Lack of legal documents

▪ 2,153 poor families with a member living with HIV received a monthly cash support, including 699 level 1 Equity Card and 1,454 level 2 Equity Card ▪ 266 NSSF cards have been distributed to KPs; KPs and their employers have started making $5-$10 per month towards their NSSF ▪ Three social programs that benefit PLHIV: the HEF, support for PLHIV in poor households, and coverage for entertainment workers ▪ Advocacy for inclusion and enrolment of KP in HEF is ongoing	○ Mobile (KPs) ○ Lack of compliance of entertainment establishments so limited NSSF coverage among FEW ▪ S&D is still experienced by KPs and PLHIV according to informants from CBOs e.g., ○ not receiving good care despite having Equity Card ○ stigma is problem in communities and health care settings ○ sex workers being picked up and arrested/sent to social affairs centers ▪ No information if KPs have access to social and legal services
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	
Achievements	**Gaps**
▪ Funding from local sources is increasing, especially for ARV ▪ In 2017, 24% of HIV expenditure were raised from local budgets and resources but may be higher as hospitals draw on own resources ▪ Funding for HIV in all provinces have been allocated, ranging from KHR40 million to KHR80 million ▪ KHR223 million for 59 communes/ sangkat with HIV action plans in 2023 ▪ Government contribution not only funding; also have multi-sector engagement and participation ▪ Sustainability analysis of HIV response found positive trends between 2015 and 2021 ▪ Sustainability Roadmap identified 10 risks with appropriate mitigating measures	▪ Bulk of funding goes to care and treatment ▪ Prevention is underfunded, largely reliant on external sources; spending on prevention in 2010 was $14.3 M and $5.1M in 2017 ▪ If 2022 spending is maintained, projected to result in 1,400 annual new infections (Optima analysis) ▪ Issues around current funding: ○ Cambodia will soon graduate from LDC with implications to TRIPS and acquisition of ARV ○ Need to diversify sources e.g., private sector CSR ○ Need for an exit strategy as donor commitments wind down ○ Need to proactively plan to raise investments even if donor participation is still forthcoming ▪ Social contracting: discussions have been held since 2019 but little progress made ▪ Challenges to social contracting ○ Community expertise not fully recognized and undervalued

	○ KPs/PLHIV not recognizing that they possess knowledge, understanding, experience, and connections with their peers and communities ○ Sustainability dialogue is pioneering so face resistance/challenges ○ Prevention is not perceived as priority compared to treatment ○ CSOs require capacitation to meet implementation and reporting requirements ○ Need to build trust between govt and KP organizations ○ Need an SOP to identify and describe the processes of social contracting ○ Need for common understanding about social contracting

Lessons learned from implementing NSP V shared by stakeholders

- There are not enough young people are participating in the response (i.e., in designing and implementing programs or in crafting policies) despite the increasing infections among them
- There is a need to have sustained comprehensive sexual education (CSE); while available in high school, this is no longer provided after high school
- Some stakeholders are not fully aware about HIV and how to integrate this in their plans and programs. They would need orientation, training, and coaching/mentoring.
- Need to advocate at subnational level so that there is improved collegial relationship among subnational units and CSOs/CBOs and communities which will in turn improve coordination. For instance, CBOs can connect well with NAA but find it challenging to do at provincial level.
- KPs and PLHIV can proactively prepare requirements so that they can apply for ID Poor. This is being done by a community-based organization, a practice which can be adopted and replicated in many communities.
- Need to offer mobile methadone as treatment otherwise PWIDs everyday travelling to obtain it find it as a disincentive and/or they go back to using heroin
- Need to translate key documents into actions e.g., Sustainability Roadmap
- Having a national strategic plan and disseminating it is not enough and should translate these to concrete actions by stakeholders. For instance, meeting on NSPs should focus on progress, gaps, challenges, and solutions
- Problems and how they are resolved need be documented and shared. Cambodia is seen as a leader in managing HIV.
- It should be recognized that in organizations, there are technical and political groups, and may be distinct from each other, which should be taken into account in implementing the NSP.
- At the higher level, conversations must be held with those who hold power which can facilitate the implementation of the NSP.

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