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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AJRM	Annual Joint Review Meeting
ANC	Ante Natal Care
ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
BB-EW	Brothel Based Entertainment Worker
BSS	Behavioral Sentinel Surveillance
CAC	Commune AIDS Committee
CBCA	Cambodian Business Coalition on HIV and AIDS
CBO	Community Based Organization
CCC	Country Coordination Committee
CDC	C«ambodia Development Council
CDHS	Cambodia Demographic Health Survey
CG	Consultative Group
CMDGs	Cambodia Millennium Development Goals
CoC	Continuum of Care
CoPCT	Continuum of Prevention to Care to Treatment
CPA	Comprehensive package of Activities
CPN+	Cambodian People Living with HIV network
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CUP	Condom Use Policy
DAC	District AIDS Committee
D&D	Decentralization and De-concentration
EW	Entertainment Worker
FTA	Functional Task Analysis
GDJTWG	Government-Donor Joint Technical Working Group on HIV and AIDS
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with or affected by HIV and AIDS
HACC	HIV and AIDS Coordinating Committee
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HRM	High Risk Male
HSS	HIV Sentinel Surveillance
IBBS	Integrated Bio-Behavioral Survey
ICRW	International Centre for Research on Women
IDU/DU	Injecting Drug User/Drug User
IEC	Information Education and Communication
LSE	Life Skills Education
MARP	Most-At-Risk Population
MARYP	Most-At-Risk Young People
MCH	Maternal and Child Health
MCHC	Maternal and Child Health Care
MDG	Millennium Development Goal

M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Research
MMP	Methadone Maintenance Program
MSM	Men who have Sex with Men
MSM/TG	Men who have sex with Men / Transgender
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoI	Ministry of Interior
MoLVT	Ministry of Labour and Vocational Training
MoSAVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoP	Ministry of Planning
MoWA	Ministry of Women's Affairs
NAA	National AIDS Authority
NASAs	National AIDS Spending Assessments
NBB-EW	Non-Brothel Based Entertainment Worker
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NCPI	National Composite Policy Index
NEC	National Ethics Committee
NGO	Non-Government Organization
NMCHC	National Maternal and Child Health Centre
NSDP	National Strategic Development Plan
NSP	Syringe Exchange Program
NSP II	Second National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS 2006-2010
NSP III	Third National Strategic Plan for a Comprehensive and Multisectoral National Response to HIV and AIDS
OD	Operational Health District
OI/ARV	Opportunistic Infection / Anti-Retroviral
OST	Opioid Substitution Treatment
OVC	Orphans and Vulnerable Children
PAC	Provincial AIDS Committee
PCWC	Provincial Committee for Women and Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RH	Reproductive Health
SOP	Standard Operating Procedure
SRA	Situational Response Analysis
SRH/FP	Sexual Reproductive Health/Family Planning
SSS	STI Sentinel Surveillance
STI	Sexually Transmissible Infection
SW	Sexual Worker
TB	Tuberculosis

TG	Transgender
TTI	Transfusion Transmitted Infection
TWG	Technical Working Group
VCCT	Voluntary Confidential Counseling and Testing
UA	Universal Access
UNAIDS	United Nations Joint Program on AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
USD	United States Dollar
WHO	World Health Organization

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Phnom Penh, 25th October 2010

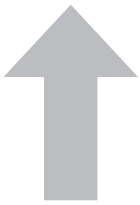
H.E. Dr. Nuth Sokhom
Senior Minister
Chair of NAA

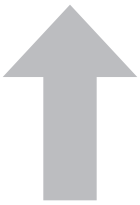
NSP III Summary

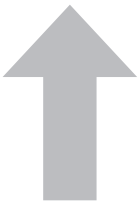
Goal #1: To reduce the number of new HIV infections through scaled targeted prevention.

Goal #2: To increase care and support to people living with and affected by HIV and AIDS

Goal #3: To alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society.



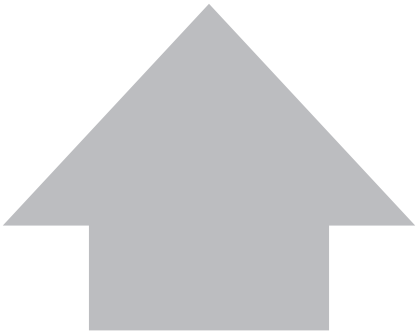




Strategy 1:
Increase coverage, quality and effectiveness of prevention interventions.

Strategy 2:
Increase coverage and quality of comprehensive and integrated treatment, care and support services addressing the needs of a concentrated epidemic.

Strategy 3:
Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS.



Strategy 4: Ensure effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub-national levels.

Strategy 5: Ensure a supportive legal and public policy environment for the national response to HIV and AIDS.

Strategy 6: Ensure availability and use of strategic information for decision-making through monitoring, evaluation and research.

Strategy 7: Ensure sustained, predictable financing and cost-effective resource allocation for the national response.

Goals

Implementation strategies

Cross-cutting strategies

Implementing Strategies

Strategy 1: Increase coverage, quality and effectiveness of prevention interventions.	Strategy 2: Increase coverage and quality of comprehensive and integrated treatment, care and support services addressing the needs of a concentrated epidemic.	Strategy 3: Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS.
Objective 1: Increase coverage and quality of prevention programmes for entertainment workers (EW). **Objective 2:** Increase coverage and quality of prevention programmes for men who have sex with men (MSM) and transgenders (TG). **Objective 3:** Increase coverage and quality of prevention programmes with injecting and non-injecting drug users (IDU/DU) **Objective 4:** Increase coverage and quality of prevention interventions with high risk males (HRM). **Objective 5:** Scale up and improve quality of Positive Health, Dignity and Prevention programmes with people living with HIV (PLHIV). **Objective 6:** Scale up provision of targeted, quality Prevention of Mother to Child Transmission (PMTCT) services in line with the four-pronged strategy. **Objective 7:** Increase coverage of quality prevention programs for young people aged 10-24 years, both in and out of school. **Objective 8:** Increase coverage of quality prevention programs for populations in prisons. **Objective 9:** Improve systems for biomedical prevention of HIV.	**Objective 1:** Expand coverage and improve quality of HIV treatment services. **Objective 2:** Improve quality and coverage of home and community based care services for PLHIV and their families. **Objective 3:** Ensure access to quality HIV testing and counselling services in the public and private sectors. **Objective 4:** Increase access to tailored services for most-at-risk populations (MARPs) and their sexual partners.	**Objective 1:** Ensure the needs of orphans and vulnerable children (OVC) affected by HIV and AIDS and their caregivers are met. **Objective 2:** Improve the social and economic status of PLHIV and their families, especially the most vulnerable. **Objective 3:** Expand and sustain community involvement in impact mitigation.

Cross-cutting Strategies

Strategy 4: Ensure effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub-national levels.	Strategy 5: Ensure a supportive legal and public policy environment for the national response to HIV and AIDS.	Strategy 6: Ensure availability and use of strategic information for decision-making through monitoring, evaluation and research.	Strategy 7: Ensure sustained, predictable financing and cost-effective resource allocation for the national response.
Objective 1: Integrate HIV work into the Royal Government's de-centralisation and de-concentration systems and the National Strategic Development Plan. **Objective 2:** Strengthen coordination and management architecture at the national and sub-national levels. **Objective 3:** Improve capacity of key ministries and relevant government institutions at the national and sub-national levels for delivery of targeted HIV programmes. **Objective 4:** Improve capacity and involvement of civil society institutions, especially organizations and community networks representing PHLIV and MARPs, in the national response. **Objective 5:** Improve capacity and involvement of private sector institutions for delivery of targeted and sustainable HIV programmes.	**Objective 1:** Intensify implementation and enforcement of the Law on Prevention and Control of HIV/AIDS. **Objective 2:** Engage stakeholders in development and implementation of legislation and policies to ensure an enabling environment for the national response. **Objective3:** Eliminate stigma and discrimination of people living with and affected by HIV and MARPs.	**Objective 1:** Strengthen the national multisectoral M&E, research and surveillance system. **Objective 2:** Obtain reliable evidence for HIV programming through monitoring, evaluation and research. **Objective 3:** Promote sharing and effective use of strategic information for decision-making.	**Objective 1:** Identify financial and human resources needed for the national response and resource gaps according to epidemiological trends and priorities. **Objective 2:** Intensify mobilization of financial and human resources and develop strategies to address identified resource gaps. **Objective 3:** Ensure cost effective and accountable allocation and use of financial resources across the NSP III according to priorities. **Objective 4:** Ensure an uninterrupted supply of key commodities for the national response.

1. Introduction

1.1 Background

In keeping with the principles of the Three Ones, Cambodia developed its first National Strategic Plan for the five-year period, 2001 to 2005. It was followed by a second five-year plan, the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS 2006-2010 (NSP II). The second plan included specific objectives and strategies for the first time, as well as an operational plan with broad activities to be implemented by stakeholders from government, civil society, the private sector and development partners.

Several developments in the early years of NSP II, including establishment of Universal Access targets, development of new strategies and operational plans for key sectors, and availability of revised HIV estimates and projections, made a revision necessary. To assess and respond to the new information and context, the Situational Response Analysis (SRA) was updated in 2007 and the NSP II was revised to enhance the national response to HIV for the remaining three years, 2008-2010.

In 2010, the last year of the NSP II period, a new Situation and Response Analysis was prepared[1] and the third National Strategic Plan (NSP III) was developed.

1.2 Methodology

The National AIDS Authority (NAA) led the process of developing the Situation and Response Analysis 2010 and the NSP III. A Core Group was convened to provide oversight and guidance throughout the process. Chaired by NAA, its 25 members were drawn from key ministries, technical assistance agencies, donors, private sector and civil society (including PLHIV networks and most at risk populations). Nearly all of the members also served on other Technical Working Groups (TWG).

A team of consultants was engaged by the National AIDS Authority (NAA) to review the response under NSP II (2006-2010) and update the epidemic situation, as well as develop and cost the NSP III for the period 2011-2015. Taking into consideration the findings and recommendations of the SRA, the consultants reviewed additional documents, in particular planning documents and sectoral and sub-population strategic plans and operational plans developed by ministries and TWGs.

A two-day National Consultation Meeting was held to review achievements, strengths, weaknesses, gaps under NSP-II and identify opportunities to strengthen the response and define priorities under NSP III. The consultant team worked with small groups of key stakeholders to define the focus of each strategy and develop key activities. Gender-related inputs were provided by NAA, with support from the International Center for Research on Women (ICRW).

Two rounds of Themed Group Meetings were held with relevant TWG members (including government, civil society and development partner representatives) to finalize objectives, activities and indicators for each

[1] NAA (2010) A Situation and Response Analysis of HIV and AIDS in Cambodia.

strategy. Core group meetings were held at key junctures to review progress. In addition, the Technical Advisory Board of the NAA met to prioritize key target groups for prevention interventions.

Lead by HACC the development of the NSP III enjoyed the wide participation of civil society around the country. Over 170 civil society organizations and community networks took part in community consultations held in Phnom Penh, Kampong Cham and Siem Reap. HACC then compiled recommendations and provided them to the NAA and to the team drafting the NSP III. HACC representatives also participated in the Themed Group Meetings.

The draft NSP III was presented and reviewed at a National Validation Meeting organized by the NAA on 22 June, 2010. The NSP III was then revised and finalized following the meeting, taking into account feedback and comments received from participants. The final versions were reviewed by the Core Group and endorsed by the NAA Secretariat prior to publication.

2. Situation and Response Analysis

High level political support has been the key to Cambodia's success under the second National Strategic Plan (NSP II). The epidemic is in decline and over 90% of eligible people living with HIV (PLHIV) receive treatment. Cambodia is one of the few countries in the world that has achieved its Millennium Development Goals related to human immunodeficiency virus (HIV). However, the gains made in reversing the epidemic trends will remain fragile as long as pockets of high prevalence persist among subpopulations of entertainment workers, men who have sex with men (MSM) and injecting drug users (IDU). The primary driver of Cambodia's HIV epidemic continues to be heterosexual transmission between entertainment workers and their clients and other sexual partners. Spousal transmission occurs when clients of entertainment workers infect their wives and subsequently, the infants born to infected mothers.

However, it is not possible to definitively assess progress in controlling the epidemic in Cambodia since the currently cited HIV prevalence estimates and projections showing an overall adult HIV prevalence of 0.7% in 2010 are based on biological data collected several years ago, in 2005 and 2006. Updated values for impact indicators will be available only after additional rounds of biological and behavioural surveillance which are planned in 2010.

Progress has been made in the prevention of HIV in several areas, including establishment of technical working groups (TWGs) and development of standard operating procedures (SOPs) for interventions with most-at-risk populations (MARPs). The introduction of the innovative four-pronged Linked Response approach for Prevention of Mother to Child Transmission (PMTCT) has increased the coverage and quality of services, as well as referral linkages. Coverage of screening of blood transfusion has reached 100% and condom and lubricant sales are expected to reach 2010 targets.

However, existing programs among key MARPs groups falls short of the extent of services required to achieve sufficient scale up and coverage to avert a "second wave" of the epidemic. Successful interventions among brothel based entertainment workers have been interrupted by the Law on Prevention of Human Trafficking and Sexual Exploitation, and Prakas 66 (100% condom use policy) has not yet been extended to non-brothel based entertainment establishments. Increased attention has been paid to HIV prevention among clients of entertainment workers (high risk males), but interventions need to be further scaled up and gender norms specifically addressed. MSM and transgenders (TG) are not adequately reached, largely due to stigma, discrimination and low capacity of civil society. Harm reduction for IDU continues at a very low level of coverage with services provided by only one non-governmental organization (NGO) and lack of understanding of the importance of harm reduction persists.

The greatest achievements and innovations under NSP II were in the area of scale up of care and treatment using the Continuum of Care (CoC) approach. Coverage of anti-retroviral treatment (ART) among eligible adults increased from 38% to over 90%. As the epidemic matures and with recently revised treatment guidelines for starting ART earlier in the course of the disease, the number of PLHIV eligible for treatment will continue to increase even as HIV incidence decreases. Maintaining high levels of coverage for ART over the long-term will require sustained and substantial commitment of financial and human resources.

Interventions for impact mitigation have been slow to expand. However, the recent inclusion of provisions for people living with HIV (PLHIV) and orphans and vulnerable children (OVC) in the new National Social Protection Strategy for the Poor and Vulnerable will effectively mainstream impact mitigation into the national

social protection system. Nevertheless, the social and economic support needs of PLHIV and their families will continue to require attention and the number of households requiring support is expected to increase over the medium term. Stigma and discrimination continue to affect the lives of PLHIV, MARPs and their families.

NAA has strengthened its coordination role during NSP II, but a recent Functional Task Analysis concluded that there is an urgent need to improve efficiency and strengthen capacity at all levels, including national, provincial and operational district. Civil society needs to take a greater role and community networks need to be strengthened. National AIDS Spending Assessments have been introduced during NSP II and conducted regularly to help define and forecast resource needs. These show that Cambodia's national response continues to rely heavily on external funds with very limited government contribution.

2.1 Opportunities for NSP III

To maintain the declining incidence and prevalence of HIV and avert a second wave of the epidemic, prevention efforts will need to be prioritized to achieve high coverage and high rates of correct and consistent condom use among the most-at-risk populations (MARPs). The priority groups are entertainment workers (EW), high risk males (clients of EW), MSM and transgenders, and drug users, especially those who inject. To further refine prevention among MARPs in NSP III, more attention should be given to addressing overlapping risks (i.e. IDU who buy or sell sex, MSM or EW who inject drugs, etc.). Youth interventions should be more targeted toward most at risk young people (MARYP) under NSP III. The growing numbers of PLHIV increase the need to expand services for Positive Health, Dignity and Prevention programs.

In a setting of high treatment coverage, the next step is to improve the quality of services. Improved outcomes require earlier access to HIV testing and treatment, especially among MARPs; improved monitoring of treatment failure and detection of drug resistance; expansion of linkages between HIV and tuberculosis (TB) programs; expansion and improvement of paediatric care and access to Early Infant Diagnosis; and cost-effective scale up of home-based care services.

More attention and resources are needed to provide an improved environment and support for OVC and for mitigating the socio-economic impact of HIV on households with PLHIV. Stigma and discrimination against PLHIV and MARPs needs to be addressed with more determination and with the goal of elimination.

The law and policy environment currently limits expansion and quality of MARPs interventions, especially for entertainment workers and IDU. While the HIV and AIDS law is robust, its enforcement and monitoring needs to be strengthened under NSP III to eliminate discrimination against PLHIV.

Improved surveillance, monitoring and evaluation are needed to track and shape the national response. Cambodia's surveillance system has provided a wealth of evidence to inform the national response. However, more effort is needed to regularly update information in a streamlined and cost-effective way, including routinely integrating behavioural and biological surveillance among key populations. Size estimates among MARPs need to be updated regularly for reliable reporting on indicators and program planning to increase coverage. In general, strategic information should be used more effectively at national and sub-national levels to inform policies and programmes.

The Functional Task Analysis (FTA) commissioned by NAA at the end of 2009 provides comprehensive recommendations for the strengthening of NAA's leadership and coordination role under NSP III. Key areas of focus are to increase technical and organizational capacities of NAA network to use effectively its administrative power both at the national and sub-national level in respect to Three Ones principle and basic principle of ownership, alignment and to align with the NSP III and to better strengthen management to eliminate any project or program that is not national priority that leads to non cost efficiency and to gain more meaningful participation of all stakeholders, including civil society.

A medium-term financing framework is needed to respond to changes in the funding environment and increase the contribution of domestic resources for the national response. As the HIV epidemic continues to decline, it is increasingly important to maximize the contribution of HIV programs to strengthening health systems in general. In addition, integrating programs into existing systems and structures wherever possible will reduce costs.

3. National Strategic Plan III: 2011–2015

3.1 Guiding Principles for the National Response to HIV and AIDS

Cambodia's national response to HIV and AIDS is built on key guiding principles. These apply to all strategies, objectives and activities in the National Strategic Plan.

Universal Access

Cambodia is committed to scale up to achieve Universal Access to key prevention, care and treatment and impact mitigation interventions and services. Since 2006, multi-stakeholder consultations and regular reviews to review progress towards comprehensive and integrated scaling-up of services have been carried out, and will continue under NSP III.

Evidence based and cost-effective

The NSP III prioritizes high impact interventions informed by epidemiological trends in Cambodia and the Asia-Pacific region, lessons learned in Cambodia and international best practice. Monitoring and evaluation plays a key role in the national response to assess the effectiveness and efficiency of strategies and interventions. Successful interventions will be scaled-up and increased attention will be placed on improving quality and cost-effectiveness of programmes through routine, continuous use of monitoring data and strengthened supervision systems.

In the setting of a concentrated and declining HIV epidemic, and as the global pool of HIV funding becomes smaller, HIV programs can become more efficient by being integrated into the broader health and social services where appropriate. In addition, NSP III will place increased focus on improving other health services as a result of HIV programmes.

Greater Involvement of People Living with or affected by HIV and AIDS (GIPA)

The experience, insights and efforts of people affected by HIV, including women, young people and marginalized populations (MARPS), are valuable resources in the national response and as members of decision-making bodies. Meaningful involvement of PLHIV is needed in all aspects of the national response, including in the design, implementation, monitoring and evaluation of HIV programmes. Community involvement also results in a sense of ownership and responsibility for HIV programmes and initiatives.

Rights-based

Respect for human rights underpins the Cambodian response to HIV and AIDS. HIV programmes interact with marginalized populations that suffer stigma and discrimination due to engaging in behaviours that are illegal and/or not accepted by society at large. NSP III is based on the rights (and empowerment) of individuals and communities to access stigma-free HIV prevention programmes, as well as care and treatment services without fear of harassment, violence or arrest. In addition, all services should be equally accessible to persons with disabilities.

Gender -equitable

Gender inequality and social marginalization are contributing factors to the vulnerability of most-at-risk populations in Cambodia to HIV. For many of these populations, HIV risk is generated within sexual relationships which are influenced by underlying gender norms. To more successfully reduce HIV over the

long term in Cambodia, the national response under NSP III will address the gender norms and inequalities that drive HIV risk. Gender-responsive approaches will be integrated into the activities that support the goals, objectives and strategies of the National Strategic Plan. Sex-disaggregated data will be used for monitoring and evaluation. Understanding of the links between gender, HIV and uptake of services will be built into trainings, programs and policies.

Multisectoral

HIV affects all aspects of society and as a result the response needs to be holistic and multi-dimensional. Cambodia's national response to HIV and AIDS is therefore multisectoral and involves strong and growing partnerships between the government and key government ministries, civil society and the private sector.

Linked to poverty and overall development planning

This National Strategic Plan addresses the inter-connectedness of the HIV epidemic and overall socio-economic development issues. Poverty is an important determinant that increases vulnerability to HIV infection, while being HIV positive may affect people's ability to earn an income, resulting in increased poverty. Cambodia's national response to HIV and AIDS integrated into the *National Strategic Development Plan (NSDP) 2006-2010 and will be integrated into next NSDP 2011-2013.*

HIV programs will be mainstreamed and integrated into existing systems and structures wherever possible to reduce the costs of vertical programming and increase sustainability. In addition, the contribution of HIV programs to overall health systems strengthening will be maximized and monitored.

3.2 Goals and Strategies

3.2.1. Overall Goals

The National Strategic Plan for HIV and AIDS contributes to the National Strategic Development Plan (NSDP) Update 2009-2013, which in turn supports the Royal Government's Rectangular Strategy for the development of Cambodia.

The NSDP is the single, overarching document outlining the Royal Government's priority goals and strategies to reduce poverty and to achieve the Cambodia Millennium Development Goals (CMDGs) and other socio-economic development goals for the benefit of all Cambodians. The NSDP gives highest priority to poverty reduction and progress towards CMDG targets by 2015, including Goal 6: "Halting and reversing the spread of HIV and AIDS, the incidence of malaria and other major diseases such as tuberculosis." Although the HIV epidemic is already is already in decline at the start of NSP III, continued efforts are needed to maintain the gains of the previous years and to further decrease transmission.

The overall goals of NSP III are:

1) To reduce the number of new HIV infections through scaled targeted prevention; and
2) To provide care and support to people living with and affected by HIV and AIDS; and
3) To alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society.

3.2.2. Strategies

The strategies of the National Strategic Plan (NSP III) include the three main intervention areas (prevention, care and treatment, and impact mitigation) that directly contribute to the overall goals, as well as four cross-cutting strategies that support the progress of the interventions.(See NSP III Summary for a graphic representation).

Strategy 1:	Increase coverage, quality and effectiveness of prevention interventions.
Strategy 2:	Increase coverage and quality of comprehensive and integrated treatment, care and support services addressing the needs of a concentrated epidemic.
Strategy 3:	Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS.
Strategy 4:	Ensure effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub-national levels.
Strategy 5:	Ensure a supportive legal and public policy environment for the national response to HIV and AIDS.
Strategy 6:	Ensure availability and use of strategic information for decision-making through monitoring, evaluation and research.
Strategy 7:	Ensure sustainable, predictable financing and cost-effective resource allocation for the national response.

3.3 Specific Objectives and Interventions, by Strategy

The National Strategic Plan III includes specific objectives for each of the seven strategies. Moreover, expected results and main activities are identified for each specific objective in a detailed framework in section 3.4. Descriptions in this section are complementary to activities included in the framework and they are not repeated in the text.

Strategy 1: Increase coverage, quality and effectiveness of prevention interventions.

The following description of the prevention strategy applies to all target groups. Additional approaches specific to individual target groups are outlined under each objective.

Prevention efforts among most-at-risk populations (MARPs) are the key to averting a second wave of the epidemic. In the current situation of a declining, concentrated epidemic, the highest priority groups are entertainment workers; men who have sex with men (MSM) and transgenders (TG); injecting drug users (IDU) and non-injecting drug users (DU); as well as mobile population including high risk men (HRM), defined as partners/clients of EW.

Prevention of spousal transmission is accomplished through interventions with mobile population, positive health, dignity and prevention programmes with people living with HIV (PLHIV), and reaching women of child-bearing age and their partners through prevention of mother-to-child transmission (PMTCT) programs.

Strategic focus:

- Provision of a full package of tailored Continuum to Prevention, Care and Treatment (CoPCT)

services, including behaviour change communications; access to prevention commodities; STI education and linkages to treatment; social and legal support; linkages to family planning and safe abortion services, as appropriate; access to HIV testing (VCCT, PICT and PMTCT); and linkages to care, treatment and support for those who are HIV positive.

- Identification of and provision of services to hard-to-reach sub-populations of each at-risk population.
- Expansion of availability of socially marketed condoms.
- Integration of HIV prevention programmes within mainstream delivery mechanisms for potentially vulnerable, but low risk populations .
- Inclusion of age-appropriate interventions for most-at-risk young people (MARYP) within prevention interventions for each target group.
- Attention to overlapping risks within prevention programs (e.g. drug and alcohol use among EWs, selling sex among IDU, etc.).

Specific links to other strategies within NSP-III:

- Monitoring and evaluation, as well as operations research to further identify sub-populations and develop tailored and effective interventions are included in Strategy 6.
- Regularly updated, reliable and agreed upon size estimations for each MARP group are included in Strategy 6.
- Strengthening the capacity and role of civil society and community (MARP) networks with a focus on active and meaningful community participation is included in Strategy 4.
- Ensuring provision of services within a supportive, gender-responsive and stigma-free environment, and access to services without fear of violence or arrest for all (including MARPs) is included in Strategy 5.
- Increasing uptake of HIV testing and tailored services for MARPs and their partners is included in Strategy 2.
- Ensuring an adequate supply of key commodities, including condoms, lubricants, needles, syringes, methadone, laboratory diagnostics, STI drugs and supplies for universal precautions and health care waste management is covered in Strategy 7.

Objective 1: Increase coverage and quality of prevention programmes for entertainment workers (EW).

The strategic focus of activities for HIV prevention among EW responds to changes in the landscape of the sex trade in Cambodia resulting from the implementation and enforcement of the 2008 Law on Suppression of Human Trafficking and Sexual Exploitation. The unclear of the implementation of this law does confuse the application of the 100% Condom Use Policy (CUP) and made it harder to reach women who engage in sex service.

The term “entertainment workers (EW)” refers to the groups previously described as brothel-based and non-brothel based entertainment workers in NSP II. This diverse population includes female sex workers working in illegal brothels, other freelance female sex workers working from a variety of venues (including street-based, casino-based, etc.) as well as women working in the entertainment industry (beer gardens, karaoke bars, etc.) with multiple concurrent partners (both paid and sweethearts[2]) who do not identify themselves as sex workers.

[2] ‘Sweethearts’ (in Khmer language Sangsar or Srey Sneih) are defined as persons in a non-commercial or semi-commercial, non-marital relationship involving a certain degree of affection and trust. Low risk sweethearts include students, factory workers, etc. High risk sweethearts include karaoke signers, waitresses, beer promotion girls, masseuses, hostesses, etc.

Interventions:

- Revision of Prakas 66 to expand 100% CUP to non-brothel entertainment establishments (applies to both female EW and MSM). Development of a guideline outlining the role of police, local authorities, health workers and communities to support implementation. (See Strategy 5 for complementary activities.)
- Scale up of comprehensive CoPCT services for EW according to national guidelines and SOPs.

Objective 2: Increase coverage and quality of prevention programmes for men who have sex with men (MSM) and transgenders (TG).

This target group includes both men who have sex with men (MSM) and transgenders (TG).[3] Sometimes referred to as "long hair MSM," transgenders are at higher risk for HIV than other (short hair) MSM due to higher risk sexual behaviours, greater gender-related stigma, discrimination and violence and less access to services. Male sex workers are also included among the broad label of "MSM."

Interventions:

- Scale up of a comprehensive package of CoPCT services according to national guidelines and SOPs.
- Implementation of operations research to identify needs and ways to reach the previously unknown population of "hidden MSM" to increase prevention coverage of this population.
- Provision of adequate supplies of lubricants in addition to condoms.
- Sensitization of health care providers to reduce stigma and increase access of MSM/TG to services. In addition, education of health care providers to increase their understanding of MSM and TG sexual identification and behaviours so that they can provide tailored services, including appropriate risk reduction counselling.

Objective 3: Increase coverage and quality of prevention programmes with injecting and non-injecting drug users.

The prevalence of HIV infection among IDU can increase rapidly since sharing needles and syringes is a very effective mode of transmission. However, non-injecting drug use is much more common in Cambodia compared to injecting drug use. Since drug use is associated with an increase in unprotected sex, both injecting and non-injecting drug users and their partners are at increased risk of sexual transmission of HIV.

Interventions:

- Increased coverage of a full package of prevention interventions among IDU and their partners, including needle and syringe exchange programs (NSP), promotion of safer sexual behaviours (and provision of condoms and lubricant), and opioid substitution treatment (OST).
- Advocacy for transition to community-based models of treatment which will allow drug users to access the full range of CoPCT services while undergoing rehabilitation and treatment.
- Advocacy to ensure the revised Drug Law's articles decriminalizing the provision of or access to health services for drug users is interpreted to include harm reduction services, such as needle and syringe exchange and opioid substitution treatment, and raise community and stakeholder understanding of the positive benefits of harm reduction.

[3] 'Transgenders are a diverse group, defined here as those who were born male but whose gender identity or behaviour does not fit traditional norms. While some may have undergone sex reassignment surgery or other cosmetic procedures or take hormones, many have not. The term "transgender" also applies to those who dress or otherwise behave like women.

- Inclusion of interventions to address overlapping risks since IDU who buy or sell sex can introduce more HIV into the sex trade, boosting the epidemic.
- Development and scale up of prevention programs targeting the growing population of non-injecting drug users and their partners.
- Development of gender-specific approaches to reach female IDU.

Objective 4: Increase coverage and quality of prevention interventions with mobile population including high risk males (HRM).

The mobile population[4] refers to group of population that have job away home for a short or long period of time such as fishermen, factory workers, casino workers, construction workers, mot-taxi driver etc. High Risk Males (HRM), defined as men who are clients and sweethearts of entertainment workers, have been identified as a separate target group for the first time in NSP III. Interventions among groups of men previously known to have increased likelihood of engaging in high risk behaviours, such as mobile and migrant men and uniformed servicemen (police and military), are included in this target group.

Mobile population and high risk men have multiple sexual partners and the distinction between commercial and sweetheart relationships is often blurred, with both men and women engaging in both concurrently. Men who engage in these behaviours also serve as a bridge for transmission of HIV to their wives since condoms are rarely used within marriage.

Interventions:

- Increased coverage of prevention interventions among mobile population including HRM. Male clients of entertainment workers follow predictable patterns and are accessible through a variety of communication channels, including interventions stated in the national strategy to prevent and control HIV transmission among EW their client and sweetheart such as outreach program, inter-personal communication, and IEC materials. Mass media interventions can also be utilized as appropriate to promote safer sexual behaviour.
- Development and inclusion of targeted messages to address male gender norms and increase male responsibility for family sexual and reproductive health with a focus on risk behaviours, such as excessive alcohol use, gender-based violence and multiple concurrent sexual partners.

Objective 5: Scale up and improve quality of positive health, dignity and prevention programmes with people living with HIV (PLHIV).

Interventions:

- Scale up of implementation of the national guidelines and SOP for HIV prevention among PLHIV.
- Integration of positive health, dignity and prevention into the comprehensive package of care and treatment services under Strategy 2.
- Development of targeted messages for MARPs and adolescents living with HIV.

Objective 6: Scale up provision of targeted, quality Prevention of Mother to Child Transmission (PMTCT) services in line with the four-pronged strategy.

[4] Mobile and Migrant Populations (MMP) were a separate target group under NSP II. Females in this group are covered under entertainment worker interventions and in workplace programmes (strategy 4).

Interventions:

- Scale up of a comprehensive package of services for PMTCT according to national guidelines.
- Increased focus on high-risk women and their partners, especially MARPs.
- Promotion of couples counselling and HIV testing for partners of high-risk women.
- Strengthening of linkages to sexual and reproductive health services and family planning.
- Strengthening of coordination between ANC and MCHC to ensure follow up as per guidelines for mother and infant health, early infant diagnosis and ARV treatment as needed.

Objective 7: Increase coverage of quality prevention programs for young people aged 10-24 years, both in and out of school.

In the setting of a concentrated epidemic, the main focus for youth interventions is targeted toward most at risk young people (MARYP), defined as those who are practicing high risk behaviours. There is little evidence of high risk sexual behaviours among the general population of young people in Cambodia and studies have shown that life skills education has little effect on HIV risk reduction[5]. Since 2009, MoEYS has moved from a vertical project-based approach to HIV education to an integrated Life Skills Education (LSE) curriculum.

Interventions:

- Development and implementation of interventions that are age-appropriate, gender-equitable, and accessible to disabilities to address the needs of young EWs, MSM/TG, IDU/DU and HRM; integrated into other MARPs programs.
- Focus on young people who are most likely to or already are engaging in behaviours that put them at risk for HIV transmission.
- Continued integration of age-appropriate, gender-equitable sexual and reproductive health and rights education into the Education Sector Support Program.
- Development of policy, legislation and strategies to provide an enabling environment for MARYP access to services of their needs.
- Participation of MARYP in HIV prevention forums and activities, including commune development planning.

Objective 8: Increase coverage of quality prevention programs for populations in prisons.

A high risk of HIV transmission exists in prisons worldwide due to the high prevalence of risk behaviours and high turnover among inmates. In addition, many inmates are drawn from most-at-risk populations, especially drug users, adding to the pool of HIV within the institution.

Interventions:

- Integration of HIV interventions for HIV/TB prevention, treatment, care into the Strategic Plan for Health in Detention (developed by MoH and MoI, with support from WHO, UNODC, and UNAIDS).
- Advocacy with prison department and local prison management to raise awareness of risks of HIV transmission within prisons and acceptance of programs for risk reduction.
- Provision of HIV/TB comprehensive services within prisons and strengthening of the referral networks to ensure continuity of health services for prisoners on release.

[5] Yankah, E and P. Aggleton (2008) Effect and Effectiveness of Life Skill Education for HIV prevention in Youth People. AIDS Education and Prevention, 20 (6), 465-485.

Objective 9: Improve systems for biomedical prevention of HIV.

This objective includes all biomedical interventions for prevention of HIV, including blood safety, universal precautions, post-exposure prophylaxis (PEP) and health care waste management.

Interventions:

- Continuation of blood safety program integrated into prevention of all transfusion transmitted infections (TTI).
- Improvement of infection control at both public and private clinics and institutions.
- Expand availability of PEP according to national guidelines especially for medical exposures.
- Consistent implementation of national guidelines for health care waste management.

Strategy 2: Increase coverage and quality of comprehensive and integrated treatment, care and support services addressing the needs of a concentrated epidemic.

The focus for NSP III will be to maintain the already achieved high levels of coverage in the face of increasing numbers of PLHIV who are eligible for treatment because of recommendations for earlier initiation of treatment and longer survival. In a setting of high coverage, the next step is to ensure equal access for all sub-populations (especially children and MARPs) and improve the quality of care, support and treatment services.

Strategic focus:

- Maintenance of existing coverage of adult treatment services with improvement of coverage of HIV testing and home-based care services.
- Improvement of early infant diagnosis and coverage of paediatric care services.
- Increased focus on quality improvement of care, treatment and support services.
- Improvement of linkages to prevention interventions to increase early testing and treatment among MARPs. This involves shifting from a CoC to a CoPCT model with tailored services for MARPs.

Specific links to other strategies within NSP-III:

- Inclusion of Positive Health, Dignity and Prevention for PLHIV into the CoC model is included in Strategy 1.
- Expansion of the role of civil society in implementation of the full spectrum of linked family-cantered and community-based care is included in Strategy 4.
- Improvement of other health services as a result of HIV programming is included in Strategy 4.
- Use of monitoring data for program planning and improvement is included in Strategy 6.
- Ensuring adequate supply of laboratory diagnostics and OI/ARV drugs is covered in Strategy 7.

Objective 1: Expand coverage and improve quality of HIV treatment services.

Coverage of HIV treatment increased dramatically over the course of NSP II using a Continuum of Care (CoC) approach. However, paediatric coverage remained low. As more PLHIV are maintained on treatment for longer periods, drug resistance and the need for more expensive second-line treatments can be expected to increase over the course of NSP III.

Interventions:

- Continue the CoC approach according to national protocols.
- Maintenance of high coverage levels for OI/ART among eligible adults, ensuring equally high rates of coverage for men and women.
- Expansion of the Continued Quality Improvement (CQI) initiative, which aims to enhance analysis and use of monitoring data at the service provider level for programme improvement, with involvement of PLHIV and other stakeholders in increasing satisfaction with services.
- Strengthening of linkages to TB/HIV using the 3 I's approach (isoniazid preventive therapy, infection control and intensified case finding).
- Strengthening of clinical and laboratory detection of treatment failure and treatment with second-line regimens when required.
- Expansion and improvement of paediatric care to increase coverage of ART among eligible children, including adherence to treatment for children and adolescents and linkages to nutritional supplementation, as needed.
- Improvement of linkages to CoC, including to prevention services (CoPCT), other treatment services, home based care and impact mitigation programs.

Objective 2: Improve quality and coverage of home and community based care services for PLHIV and their families.

Interventions:

- Expansion of coverage and quality of HBC services as needed to support the increasing number of PLHIV.
- Improvement of sustainability and cost effectiveness of home-based care services, possibly shifting from an NGO implementation model to community network service provision.
- Strengthening of linkages to facility-based services and impact mitigation activities.
- Expansion of the role of HBC to support adherence to HIV and TB treatment and implementation of Positive Prevention Health and Dignity programs with PLHIV in the community.

Objective 3: Ensure access to quality HIV testing and counselling services in the public and private sectors.

Many PLHIV, especially those among key MARP populations, are tested for HIV late and only after becoming symptomatic in the later stages of disease. Earlier HIV testing is needed to maintain coverage of HIV treatment in response to guidelines for earlier eligibility.

HIV testing and counselling is provided through both Voluntary Confidential Counselling and Testing (VCCT) and Provider-initiated Counselling and Testing (PICT).

Interventions:

- Expansion of access to HIV testing services through increasing the number of VCCT testing sites, integrated into the complimentary package of activities at OD level.
- Inclusion of PICT as a routine service for pregnant women, TB and STI patients.
- Consideration of point-of-care rapid testing to improve early access to treatment.
- Assurance of quality of counselling and testing services, including laboratory quality, in the public and private sectors.

Objective 4: Strengthen access to tailored services for most-at-risk populations (MARPs) and their sexual partners.

Although they are at the highest risk and have the highest likelihood of HIV infection, most-at-risk populations (MARPs) often do not access services due to real or perceived stigma, discrimination and other structural barriers. Tailored approaches are needed to provide appropriate counselling and treatment, and to increase utilization of services by MARPs.

Interventions:

- Sensitization of health care providers to reduce stigma and discrimination faced by MARPs when a ccessing services.
- Training of health care providers on MARPs-specific HIV risk reduction counselling (including self risk assessment) and STI/OI/ARV treatment.
- Integration of MARPs-specific approaches into existing systems and services wherever possible, including both public and private sector services.
- Consideration of rapid point-of-care HIV testing for earlier access to HIV treatment.
- Improvement of linkages from prevention to care and treatment for earlier testing and access to care, as well as improvement of linkages to MARPs
- networks and other CBO/NGOs serving MARPs communities.

Strategy 3: Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS.

The inclusion of provisions for PLHIV and OVC in the National Social Protection Strategy for the Poor and Vulnerable will effectively mainstream impact mitigation into the national social protection system under NSP III.

Strategic focus:

- Linkages between PLHIV, as well as OVC, to social protection interventions targeted for expansion in the National Social Protection Strategy for the Poor and Vulnerable, including community based health insurance; public works programmes; cash or in-kind transfers; food vouchers; subsidies and complimentary social welfare services.
- Prioritization of the most vulnerable PLHIV and OVC: women and girls living with and affected by HIV, and key marginalised populations and their families.

Links to other strategies:

- Reducing stigma and discrimination is included in Strategy 5
- Ensuring vulnerable children are protected through policy and legislation are included in Strategy 5
- Impact mitigation is closely linked to care and support services package for PLHIV, included under strategy 2.
- Establishing a harmonised M&E framework and monitoring mechanisms to collect, analyse and utilise data to inform policies, programs and advocacy efforts at national and sub-national levels is included in Strategy 6
- Improving capacity of civil society and PLHIV networks for service delivery and meaningful participation in the national response (including representation on TWGs) is included in Strategy 4.
- Regularly updated size estimations of OVC using appropriate methodology to support program planning and to monitor coverage of interventions are included in Strategy 6.

- Research to determine needs of those infected and affected by HIV is included in Strategy 6.
- Coordination with key ministries, particularly MoSAVY and MoWA, is included in Strategy 4.

Objective 1: Ensure the needs of orphans and vulnerable children (OVC) affected by HIV and AIDS and their caregivers are met.

OVC are defined as 1) children under 18 years of age who are living with HIV; children who have lost one or both parents due to AIDS; 3) children whose survival, well-being or development is threatened or negatively impacted by HIV; and 4) children living in affected families, and/or those families that have taken in children orphaned or displaced by HIV. Due to mainstreaming of OVC into national social protection programs, the needs of HIV affected children will often be addressed in programs affecting a broad range of vulnerable children in practice. However, the NSP only focuses on children who are vulnerable as a result of HIV to ensure their needs are met in the six areas of basic care: emotional, health, educational, economic, nutrition and social (includes legal support – including land title, family plan and inheritance).

Interventions:

- Provision of a comprehensive package of services, as described by the National Plan of Action for OVC, guidelines and SOPs, to all OVC and their households.
- Specifically address, through community-level programs, the needs of subgroups of OVC, including the reproductive health needs of older OVC, especially those living in institutions and orphanages; and female OVC who maybe at increased risk for early marriage, sexual violence, trafficking and sexual exploitation.
- Strengthening of the capacity of MOSAVY at all levels to better capture information on OVC and to plan and coordinate national and local responses.
- Strengthening of the capacity of CSOs and NGOs to implement the response.
- Linkage of OVC and their caregivers to existing social protection interventions, particularly community-based health insurance; public works programmes; cash or in-kind transfers; subsidies; complimentary social welfare services.
- Inclusion of social assistance programmes to households with vulnerable children in commune investment plans. Strengthening of the capacity of the members of the Commune Council in high HIV prevalence areas to fully understand and respond to OVC issues.
- Compliance with the provisions of the 2006 Policy on Alternative Care for Children and the Minimum Standards of Alternative Care for Children.

Objective 2: Improve the social and economic status of PLHIV and their families, especially the most vulnerable.

Populations with the highest prevalence of HIV -- drug users, entertainment workers, MSM and TG – are some of the most marginalized and vulnerable groups in society in terms of social and economic status. While there has been progress in advancing gender equality in Cambodia, young girls and women continue to be particularly vulnerable.

Interventions:

- Scale up of service provision to PLHIV and their families, including food, livelihood, psychological and spiritual support.
- Improvement of quality and impact of PLHIV support groups and networks. (Participation in support groups is already high.) Strengthening of OVC networks and support groups.
- Engagement and proactive participation from PLHIV to ensure a sustainable program.

- Development and adjustment of strategies and approaches in response to new evidence as it becomes available. Two key research studies are underway at the time of NSP III preparation which will provide information on the socioeconomic impact of HIV and measure stigma.

Objective 3: Expand and sustain community involvement in impact mitigation.

Interventions:

- Strengthening of capacity and participation of PLHIV in social and development activities and .. meaningful involvement of PLHIV in impact mitigation interventions and decision making processes, especially those that relate to stigma and discrimination and including participation in pagoda-based committees.
- Mobilization of the broader community to provide support to HIV affected households and OVC.

Strategy 4: Ensure effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub-national levels.

To inform the development of NSP III, NAA commissioned a Functional Task Analysis (FTA)[6] to re-examine the structure of the national response to HIV and AIDS in light of the changing dynamics of the epidemic. The draft findings of this analysis are reflected in the focus of Strategy 4.

Strategic focus:

- Development of a coordinated national response to HIV and AIDS.
- Inclusion of all stakeholders, including government, civil society and development partners in all aspects of the national response.
- Harmonization and alignment of the functions, structures, policies, programmes and interventions of these bodies in relation to the HIV response.
- Strengthening and improvement of efficiency of technical and management capacity at all levels, including national, provincial and OD.
- Meaningful involvement of PLHIV at all levels, including in TWGs.
- Increase in the role of civil society in the national response and strengthening of networks.

Objective 1: Integrate HIV work into the Royal Government's decentralisation and de-concentration systems and the National Strategic Development Plan.

In a declining epidemic, integration of HIV work into other government systems will increase efficiency and cost-effectiveness of the national response. Policies and guidelines for the Royal Government's decentralization and de-concentration (D&D) system are still being defined. Therefore, the national strategy for integration of HIV work into the D&D will require flexibility and a phased approach to implementation.

Interventions:

- Strengthen NAA network at the national level to have effective integration of HIV into the National Strategic Development Plan (NSDP) and into the individual strategy and work plan of ministry and agency.

[6] NAA (S. Rushdy and K. Ley 2010). Functional Task Analysis for the Coordinated and Harmonized Response to HIV and AIDS in Cambodia.

- Strengthen NAA network at the sub-national level such as PAC, DAC and CAC network) to mainstream through the Royal Government's D&D process, most likely by integrating HIV and AIDS program into the provincial, district and commune development plan.

Objective 2: Strengthen coordination and management architecture at the national and sub-national levels.

Interventions:

- Strengthening of NAA core functions through capacity building and financing support to absolutely ensure all HIV and AIDS response in Cambodia is truely owned by the NAA, harminized and aligned to NSP III based on national and sub-national coordinating mechanism such as the policy borad, the technical board, the specific TWG, the GDJ-TWG, the PAC, DAC and CAC. by re-aligning and adjusting functions of existing structures, including the NAA Policy Board, Government Donor Joint Technical Working Group (GDJ-TWG), the NAA Technical Board and Technical Working Groups (TWGs) according to recommendations in the FTA.
- Reduce as maximum as possible the overlaping coordinating mechanism or abuse its individual mandate of coordinating mechanism
- Strengthening of the GDJ-TWG to be more effective in providing recommendation on priority setting, strategic and planning development, policy development, resource mobilization, progress monitoring and effectiveness of the national response
- Rationalisation of the TWGs with integration into seven groups aligned to the strategies of the NSP III, with consistent terms of reference, each including members from government, civil society, and development partners.
- Improvement of capacity of sub-national coordinating body through capacity building, motivation and financial support at least on effective coordination with respect to Three Ones Principle.

Objective 3: Improve capacity of key ministries and relevant government institutions at the national and sub-national levels for delivery of targeted HIV programmes.

This objective focuses primarily on government ministries with programs that are integral to the national HIV response strategies and activities. Programs should be well-targeted for maximum impact.

Interventions:

- Improvement of the capacity of key ministries and government institutions, as well as their active commitment and involvement in the national response.
- Maximization of the contribution of HIV programs to strengthening health systems in general. Vertical programming is harder to justify in a low prevalence epidemic and in an environment of reduced availability of funding. Several areas of health systems strengthening resulting from care and treatment were identified under NSP III, including paediatric care services, integrated laboratory services, ante-natal care (ANC) and mother and child health (MCH) services and management of opportunistic infections (OIs). Greater attention to and systematic monitoring of general health system strengthening is needed under NSP III.
- Mainstreaming and integration of HIV services into existing systems and structures wherever possible to reduce costs of vertical programming and increase sustainability. Examples include mainstreaming OVC services into national social protection systems; merging HIV life skills education into the general Education Sector Support Program; conducting HIV education as part of pre-departure training and orientation of documented migrant workers; and integrating the

HIV

and AIDS work plan into the national and sub-national development plan. Identification of additional opportunities for mainstreaming should be considered during annual reviews.

Objective 4: Improve capacity and involvement of civil society institutions, especially organizations and community networks representing PHLIV and MARPs, in the national response.

More meaningful participation of civil society is needed in the national response, including service organization and key affected population networks. Coordination and harmonization of the civil society response is included in Objective 2.

Interventions:

- Improvement of the technical capacity and organizational development of CSOs and networks.
- Strengthening of the coordination role and structure of service organization networks.
- Inclusion of civil society representatives in key national and sub-national forums including TWGs, the National Partnership Forum and the GDJ-TWG with meaningful involvement in the development of new laws, policies and programmes, and reviews of progress.
- Creation of an enabling environment for civil society participation and involvement, including reduction in administrative procedure but the civil society must ensure the capacity of its representative to response to the goal and objective of the TWG.
- Encouragement of human rights organizations to participate in raising awareness and understanding of the Law on Prevention and Control of HIV and AIDS, as well as monitoring of human rights throughout the national response.

Objective 5: Improve capacity and involvement of private sector institutions for delivery of targeted and sustainable HIV programmes.

Policies are in place to promote and support the private sector in implementation of HIV programmes in the workplace. A Prakas on Creating HIV and AIDS Committees in Enterprises and Establishments and Managing HIV and AIDS in the Workplace (Prakas 086) was issued in 2006 by the MoLVT stipulating that all private sector workplaces with 8 or more employees must have an HIV Committee and workplace HIV education programmes. In addition, the 100% Condom Use Policy (Prakas 066) should be revised to apply to all entertainment establishments (see Strategies 1 and 5). The Cambodian Business Coalition on HIV and AIDS (CBCA), formed in 2007, provides a forum for increasing the contribution of the private sector and coordinating its response.

Interventions:

- Strengthening of the enforcement and monitoring of implementation of relevant Prakas and guidelines.
- Improvement of capacity, involvement and financial commitment of private sector businesses, especially at high levels of management and owners.
- Improvement of capacity of the Cambodian Business Coalition to develop and implement a strategy to build corporate social responsibility for HIV in local businesses and with local agents of international companies for sustainability of HIV programmes.
- Prioritization of entertainment industry and infrastructure development (roads, bridges, irrigation, etc) companies, as well as garment factories, for implementation of workplace programmes for all workers.
- Addition of other health programs (i.e. RH, sanitation etc.) to increase interest of business owners in a setting of low HIV prevalence and a declining epidemic.

Strategy 5: Ensure a supportive legal and public policy environment for the national response to HIV and AIDS.

A supportive legal and public policy environment is needed to reduce HIV-related stigma and discrimination and support HIV program implementation.

Strategic focus:

- Implementation and enforcement of the provisions of the Law on the Prevention and Control of HIV and AIDS.
- Creation of policy to create an enabling environment for the national response to HIV and AIDS.
- Elimination of stigma and discrimination for people living with and affected by HIV and AIDS.

Objective 1: Intensify implementation and enforcement of the Law on Prevention and Control of HIV and AIDS.

While the HIV and AIDS law is robust, its enforcement and monitoring needs to be strengthened under NSP III to eliminate discrimination against PLHIV and respond to findings of the National Stigma Index Study.

Interventions:

- Promotion of awareness of the HIV and AIDS Law among policy makers, HIV programme implementers, health care providers, justice and law enforcement officials, and the general public.
- Improvement of systems to monitor the progress of the HIV and AIDS Law at national and sub-national levels, with engagement of PLHIV and MARPs.
- Alignment of all other laws and policies with the provisions of the HIV Law, particularly the Law on Suppression of Human Trafficking and Sexual Exploitation Law and the Drug Law.

Objective 2: Engage stakeholders in development and implementation of legislation and policies to ensure an enabling environment for the national response.

Interventions:

- Establishment of an enabling environment for prevention with MARPs, particularly in the area of entertainment work and harm reduction, including protection of human rights and access to prevention, care and treatment services without fear of harassment, arrest or punishment.
- Expansion of Prakas 66 to all entertainment establishments to build on and expand the success of implementation of the 100% Condom Use Policy (CUP).
- Development of supplemental policies and guidance to specifically support harm reduction activities under the revised Drug Law.
- Promotion of awareness of law enforcement agencies and other local authorities to ensure full understanding of the intent of laws, policies, sub-decrees and guidelines that impact HIV prevention and public health efforts and implementation of the Community-Police Partnership Programme of the Ministry of the Interior (MoI) Strategic Plan (2009-2013).
- Protection of vulnerable children through policy and legislation and creation of a supportive environment for a coordinated, effective response to children affected or made vulnerable by HIV and AIDS.
- Engagement of stakeholders in review of legislation and policies which create barriers to an effective national response.

- Assessment of the impact of enforcement of laws on vulnerability to HIV and AIDS or access to HIV services for MARPs, PLHIV and OVC of both sexes, with particular attention to the Law on Suppression of Human Trafficking and Sexual Exploitation and the Drug Law.

Objective 3: Eliminate stigma and discrimination of people living with and affected by HIV and MARPs.

Stigma and discrimination against PLHIV and MARPs will be addressed under NSP III with the goal of elimination. Members of MARPs groups who are HIV positive face double stigma. Self-stigma is an added dimension that needs to be addressed. The 2010 Stigma Index study provides an evidence base for development and prioritization of interventions.

Interventions:

- Orientation and sensitization of service providers in health, legal and social sectors to the needs of MSM, IDU and EW/SW, PLHIV and OVC to change attitudes and increase access to services.
- Particular attention to the specific needs of women and girls living with and affected by HIV, and key marginalised populations and their families.
- Development and implementation of culturally sound and evidence-based campaigns that combat stigma and discrimination against PLHIV and promote positive examples of living positive.
- Strengthening of interventions with community members/leaders in higher prevalence areas to reduce stigma and discrimination against MARPs, PLHIV and OVC.
- Development and implementation of workplace policies to address stigma and discrimination in the public and private sectors.

Strategy 6: Ensure availability and use of strategic information for decision-making through monitoring, evaluation and research.

In line with the Three Ones Principle, one single, integrated monitoring and evaluation framework is applied for tracking the epidemic and monitoring and evaluating the national, multi-sectoral response. The national M&E system is coordinated, overseen and monitored by the NAA.

Implementation of activities under Strategy 6 is based on the National HIV and AIDS M&E System Strengthening Plan, 2010-2015.[7] The plan prioritizes capacity building to increase staff skills, data quality and use of strategic information, as well as improving organizational structures for evaluation and research.

Strategic focus:

- Strengthening of one national multisectoral M&E system.
- Collection of high quality, relevant data.
- Effective use of information to guide and improve the national HIV and AIDS response.

Objective 1: Strengthen the national multisectoral M&E system.

The NAA coordinates efforts for improvement of the national multi-sectoral M&E system, in line with the National HIV M&E Strengthening Plan 2010-2015. In a well-functioning M&E system, key stakeholders work together to harmonize and align national M&E guideline without duplication of efforts and with clear roles and responsibilities.

[7] NAA (2010). National HIV/AIDS Monitoring and Evaluation System Strengthening Plan: 2010-2015.

Interventions:

- Improvement of coordination and linkages within a harmonized M&E system; horizontally between sector systems (NAA, MOEYS, NCHADS, PMTCT secretariat, MoSAVY, etc.) and vertically from sub-national to the national database.
- Strengthening of partnerships to advance the M&E agenda by regularly convening the national Monitoring, Evaluation and Research (MER) TWG.
- Improvement of capacity at all levels of the M&E system.
- Promotion of an enabling culture for M&E with mobilization of expertise and increased commitment to monitoring and evaluation.
- Coordination with surveillance teams during the planning phase to ensure surveys measure and report on key indicators for the HIV response.

Objective 2: Obtain reliable evidence for HIV programming through monitoring, evaluation and research.

Interventions:

- Harmonization of M&E efforts and improvement of data quality and availability.
- Disaggregation of M&E and surveillance data by sex wherever appropriate to evaluate gender equity.
- Undertake rigorous evaluation to demonstrate and improve the quality and cost effectiveness of HIV programming.
- Establishment of a coordinated national HIV and AIDS research agenda.
- Ensure all HIV-related research involving human subjects is subject to review by the National HIV and AIDS Ethics Committee (NEC) of NAA.
- Operations research to improve interventions especially HIV/TB interventions and other interventions with subgroups of EWs, subgroups of MSM and TG, mobile population, PLHIV (particularly adolescents and young people) and prevention and treatment programming for people within prisons.
- Integration of behavioural and biological surveillance (IBBS) to improve the utility of the information obtained and reduce the resources required for data collection and analysis. Ensure that key HIV indicators are measured with planned timing of surveys to meet National Strategic Planning needs.
- Size estimations conducted and updated regularly for all key target groups, including OVC, using appropriate methodologies. Involve MoI as appropriate to ensure that populations engaging in illegal behaviours are included (i.e. IDU, brothel-based EW).

Objective 3: Promote sharing and effective use of strategic information for decision-making.

A systematic approach to data sharing will allow more effective use of strategic information use at national and sub-national levels to inform policies and programmes.

Interventions:

- Strengthening of capacity of programme implementers, government policymakers and planners, and other stakeholders to utilize data for improvement of HIV programmes and advocacy for policy making.
- Review and analysis of monitoring and surveillance data, and triangulation of data from multiple sources for use in strategic planning and impact evaluation.
- Intensify dissemination of strategic information at gatherings (meetings, workshops, events) and through publications and up-to-date websites.

- Establishment of relationships with national media for accurate and timely dissemination of strategic information.
- Preparation and dissemination of regular reports for MDG, UNGASS and Universal Access through national consultations.
- Application of all relevant available data to inform annual and mid-term reviews of NSP III progress, including national priority setting, with the involvement of all stakeholders.

Strategy 7: Ensure sustained, predictable financing and cost-effective resource allocation for the national response.

As global resources for HIV stabilise or decline, it becomes increasingly important to allocate national resources more effectively. Improved long-term forecasting of funding commitments against the estimated costs of the national response will identify the funding gaps and will allow timely and adequate action to meet funding requirements.

Strategic focus:

- Prioritization of the response according to the drivers of the epidemic.
- Adoption of low cost, high impact interventions in line with regional recommendations.[8]

Objective 1: Identify financial and human resources needed for the national response and resource gaps according to epidemiological trends and priorities.

Interventions:

- Improvement of costing and financial planning for the national response with identification of human and financial resource gaps.
- Development and regular review of programme unit costs.

Objective 2: Intensify mobilization of financial and human resources and develop strategies to address identified resource gaps.

The national response will require increasing funding over the next five years. Strategies to increase domestic resource allocation to the national response are needed to reduce Cambodia's dependence on donor funding.

Interventions:

- Utilization of a combination of costing, resource tracking, M&E, research and strategic planning information to prioritize resource mobilization to fill gaps in priority response areas.
- Advocacy with development partners for harmonization of funding with national priorities and resource gaps.
- Advocacy and planning with Royal Government for increased domestic resource allocation to the national HIV response, integrated into sectoral plans and D&D plans where possible.

[8] Commission on AIDS in Asia (2008). Redefining AIDS in Asia: Crafting an effective response. New Delhi: Oxford University Press.

Objective 3: Ensure cost effective and accountable allocation and use of financial resources across the NSP III according to priorities.

Ensuring allocation of financial resources according to strategic priorities is essential for rational and effective use of resources. It will become increasingly important as the overall funding envelope contracts and difficult choices need to be made to sustain the momentum and gains made to date.

Interventions:

- Development of an effective resource tracking system.
- Determination and reporting of spending on the national response (National AIDS Spending Assessments) on a bi-annual basis. Further analysis of data collected to date in connection with cost projections would provide insights into strategies for funding the national response in the coming years.
- Unification and integration of resource allocation processes for HIV & AIDS under the GDJ TWG, including integration of the relevant Global Fund processes to harmonize resource allocation and accountability.

Objective 4: Ensure an uninterrupted supply of key commodities for the national response.

A continuous supply of key commodities is required to achieve the goals of the NSP III. Adequate resources, determination and forecasting of needs, timely procurement and functional supply chains are all essential to ensure the commodities are consistently available for end users.

Interventions:

- Support Strategy 1 with condoms, lubricants, HIV test kits, STI test kits and antibiotics, needles, syringes, methadone and supplies for universal precautions and waste management.
- Support Strategy 2 with first and second line ARV drugs and OI drugs.

3.4 Management of the National Strategic Plan

The overarching principle in management of the Strategic Plan is the Three Ones Principle of one national multisectoral strategy, one national coordination platform with a multisectoral mandate and one monitoring and evaluation framework. Stakeholders from government, civil society, the private sector and development partners will be involved in the management of the NSP III.

3.5 Governance and Coordination

Strong governance and coordination are crucial in ensuring harmonization and alignment of the multitude of stakeholders involved in the implementation of the National Strategic Plan.

Governance of the national response, (i.e. the provision of overall direction and leadership), rests by legal sub-decree with the National AIDS Authority. The sub-decree (Anukret 109) states that the mission of the National AIDS Authority is “to lead, prevent, and fight against the spread of the HIV and AIDS epidemic in the Kingdom of Cambodia under the supervision of the Royal Government of Cambodia”.

Coordination of the national response is crucial due to the multitude of different partners, each with their own mission and priorities. The National AIDS Authority is at the centre of the overall coordination of the national response, and carries out this task through its governance structures: NAA Policy Board, Government Donor Joint Technical Working Group (GDJ-TWG), NAA Technical Board, and Technical Working Groups (TWGs).

The National Strategic Plan recognises the need to further strengthen governance and coordination of the national response to HIV and AIDS. Drawing on analysis and recommendations from the 2010 Functional Task Analysis commissioned by NAA, the current structure of the NAA can be strengthened with harmonization and streamlining of the roles and responsibilities of the various governance and coordination bodies, and the relationships and linkages between them.

The Technical Policy Board will be modified to allow representatives from NGOs, community networks and development partners, as an observer to provide comments but no decision.

Technical Working Groups (TWGs) assist the National AIDS Authority in the coordination of components of the national response. These will be streamlined to seven TWGs, one for each of the strategy areas in the NSP III, with task forces for more specific areas as needed. Membership in the TWGs will be drawn from government, civil society and development partners.

Other important platforms for the overall direction and coordination of the national response are:

- **The Government-Donor Joint Technical Working Group on HIV and AIDS (GDJ-TWG)** was initiated and convened under the framework of the Cambodia Development Council (CDC) and the Consultative Group (CG). The GDJ-TWG on HIV and AIDS is a joint working group between the government and development partners (bilateral and multi-lateral donors and partners from civil society). The purpose of the GDJ-TWG on HIV and AIDS is "to promote the effective coordination and monitoring of the implementation of Cambodia's response to HIV and AIDS in a consultative and cooperative manner".
- The Country Coordinating Committee (CCC) provides governance for all programmes and activities in Cambodia that are supported by the GFATM.

To harmonize and coordinate the efforts of these two bodies, recommendations from the 2010 Functional Task Analysis include integration of all resource allocation functions for HIV & AIDS under the GDJ TWG, including the relevant Global Fund processes.

3.5.1. Implementation Arrangements

The implementation of the National Strategic Plan relies on many partner organisations (government, civil society and the private sector) that are implementing a wide range of activities (prevention, care and treatment, and impact mitigation) in different parts of the country (often in urban areas such as Phnom Penh and provincial capitals, but also in remote rural communities).

Implementing partners

The national response will be implemented by a multitude of organisations from government, civil society, the private sector and development partners.

For specific components of the national response, relevant organisations will collaborate through the

technical working groups for specific areas.
Individual organisations and specific technical working groups are responsible and accountable for implementation of components of the National Strategic Plan and for the achievement of agreed expected results and targets.

Decentralisation

In line with the government's decentralisation and deconcentration (D&D) strategy, decentralisation is an important part of implementing the national response. Where possible and appropriate, HIV and related social issues will be addressed through existing provincial, district and commune level planning processes. As outlined in Strategy 4, the HIV response will be integrated into the Social Development structures of the D&D. The capacity at sub-national level will be strengthened, through Provincial AIDS Committees (PAC) and Provincial AIDS Secretariat (PAS).

Priority Setting

Priority setting is a key task in the management of the National Strategic Plan and is expected to require increasing emphasis during the remaining three years under this Strategic Plan and beyond.

The priorities set in the current Strategic Plan will be reviewed regularly, as part of the monitoring and evaluation arrangement.

Priority setting will be guided by further improvements in the availability and use of strategic information. Moreover, an effective resource tracking system will be put in place to provide important information concerning the alignment of resource allocations to agreed priorities. The collection, storage and use of strategic information and the need for a resource tracking system are addressed by strategies 6 and 7 respectively.

Given its role in monitoring and evaluation as well as resource tracking, the National AIDS Authority will play a central role in priority setting. The National AIDS Authority will facilitate priority setting by supporting the relevant forums, such as the TWGs, the Technical Board and the GDJ-TWG on HIV and AIDS. Furthermore, the National Aids Authority will collect, analyse and provide the strategic programmatic and financial information that is needed to inform the priority setting process.

Final endorsement of recommended priorities lies with the National AIDS Authority.

Resource mobilization and tracking

The implementation of the National Strategic Plan will depend on whether sufficient resources will be made available by the government and development partners. Moreover, resource allocations will need to be aligned to the priority areas and programmes identified in the Strategic Plan.

The National AIDS Authority will strengthen a resource tracking system, which will provide crucial information on whether the existing allocation of funding is aligned with agreed national priorities. National AIDS Spending Assessments (NASAs), conducted every two years, are the core tool of the resource tracking system. Such a system will highlight areas where insufficient resources are being allocated (i.e. funding gaps).

Over the next three years, it will be important to advocate for increased domestic commitment to funding the national response to HIV and AIDS. Increased government funding will not only enhance the sustainability of HIV programmes, but will also result in a higher level of ownership.

Although the National AIDS Authority will not mobilise and receive funds on behalf of partner organisations, it can be instrumental in supporting partner organisations in mobilising resources and accessing external funding therefore all partners organizations must report regularly on fund received and expensed to NAA.

3.5.2 . Monitoring and Evaluation

In line with the Three Ones Principle, implementation of the National Strategic Plan will be monitored and evaluated through the national HIV and AIDS M&E framework and system, which is coordinated by the National AIDS Authority and with the support by the Monitoring, Evaluation and Research TWG.

Partners involved in the implementation of the National Strategic Plan will continue to operate their own systems for programme monitoring and evaluation. The national M&E system will bring together information that is generated by implementing partners and will facilitate the monitoring of progress made in implementing the National Strategic Plan and the evaluation of whether expected results and targets have been achieved.

Progress Monitoring

The National AIDS Authority will coordinate and facilitate the preparation of annual progress reports and annual operational plans, which will be discussed and finalised as part of the annual joint stakeholder review meeting.

The annual progress report will provide information on the progress made in implementing the annual operational plan. Based on programme monitoring data that is routinely collected by the National AIDS Authority from partner organisations, an assessment is made whether planned activities have been implemented and whether planned outputs and expected results have been achieved.

The annual progress report will also be based on the indicators and targets agreed in the M&E framework (see annex 1). Based on data collected by the National AIDS Authority and stored in the national database, an analysis will be made concerning the progress made in achieving the agreed targets for these core indicators.

Finally, the annual progress report will include an analysis of most recent surveillance data as well as data from other recent surveys in order to assess changing and emerging epidemiological trends.

Based on the results and findings of the assessments presented in the annual progress report, the National AIDS Authority, in close consultation with its partners, will prepare an operational plan for the coming year. This will be discussed, along with the annual progress report, with all stakeholders during the joint stakeholder review, with the aim of reaching consensus on:

- Progress made in the implementation of the national response as agreed in the current National Strategic Plan
- The direction and scope of future implementation of the response to HIV and AIDS.

Final Review and Impact Evaluation

A mid-term review of the National Strategic Plan should take place in early 2013. A final evaluation of the National Strategic Plan should take place in the second half of 2015. The final evaluation will assess whether expected results and targets have been achieved, through the analysis of available data to measure outcome and impact and a comparison with baselines values for these core indicators.
The final evaluation will not only assess effectiveness of individual programmes and of the overall national response, but will also take into consideration the quality and efficiency of programmes and interventions.

Research

Monitoring and evaluation of the National Strategic Plan will require data collected through research, including regular integrated behavioural and biological surveillance surveys (IBBS) and the population-based Cambodia Demographic Health Survey (CDHS).

Research also compliments monitoring and evaluation in building a knowledge base that will guide the national response. Thematic research will be needed in order to better understand underlying causes, dynamics and impacts of the epidemic, such as epidemiological trends, new and emerging areas of concern and a better understanding of vulnerability and long-term consequences of the epidemic.

Research priorities will be outlined in a multisectoral research agenda, which will be up-dated every other year.

4. National Strategic Plan III Framework

Strategy1. Increase coverage, quality and effectiveness of prevention interventions.

Objective 1: Increase coverage and quality of prevention programmes for entertainment workers (EW)	
Activities	**Indicators and Targets**
1. Strengthen the Condom Use Policy (Prakas 66) to ensure those condoms/lubricant are available in all entertainment establishments, without fear of arrest, closure or violence.	1.1.1 HIV prevalence among entertainment workers (EW) Target 2015: <8% 1.1.2 Consistent condom use by EW with clients/sweethearts Target 2015: EW condom use with client: 95% EW condom use with sweetheart: >80% 1.1.3 Condom use by EW with last client Target 2015: 99% 1.1.4 Percentage of EW reached with HIV prevention programmes in the last 12 months (data source: IBBS) Target 2015: 95% 1.1.5 Percentage of EW reached with prevention programmes in the last 12 months (data source: routine programme monitoring) Target 2015: 95% 1.1.6 Percentage of EW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission Target 2015: 80%
2. Ensure an enabling environment for EW sexual health by mobilizing key stakeholders, such as entertainment establishment owners, health care providers, community networks, local authorities, police (civil and anti-trafficking), etc.	
3. Implement national scale up of the SoP for Continuum of Prevention to Care and Treatment (CoPCT) for women entertainment workers in Cambodia, ensuring systematic quality across key provinces.	
4. Implement targeted behaviour change approaches for subgroups of EWs that emphasize risk reduction and promote safer sexual/risk reduction behaviours, accessible in all relevant environments.	
5. Promote increased access to, and systematic uptake of, critical health, social and legal services and products among EWs.	

Objective 2: Increase coverage and quality of prevention programmes for men who have sex with men (MSM) and transgenders (TG)

Activities	Indicators and Targets
1. Strengthen the Condom Use Policy (Prakas 66) to ensure availability of condoms/ lubricant in all entertainment establishments targeting MSM/TG, without fear of arrest, closure or violence. 2. Build an enabling environment for MSM/TG programmes by mobilizing key stakeholders, such as entertainment establishment owners, health care providers, community networks, local authorities, police, etc. 3. Implement national scale up of the MSM/TG National Guidelines for the Continuum of Prevention to Care and Treatment (CoPCT) ensuring systematic quality across key provinces. 4. Implement targeted behaviour change approaches for subgroups of MSM and TG that emphasize risk reduction and promote safer sexual/risk reduction behaviours, accessible in all relevant environments. 5. Intensify MSM/TG demand for, access to, and uptake of, health, social, and legal services and products.	1.2.1 HIV prevalence among men who have sex with men (MSM) Targets 2015: • MSM: 3% • Transgender: 6% 1.2.2 Consistent condom use by men who have sex with men (MSM) in the last month. Targets 2015: • MSM: 60% • Transgender: 60% 1.2.3 Condom use by MSM last time they had anal sex with male partner Targets 2015: • MSM: 95% • Transgender: 95% 1.2.4 Percentage of MSM reached with HIV prevention programmes (data source: IBBS) Targets 2015: • MSM: 90% • Transgender: 90% 1.2.5 Percentage of MSM reached with prevention programmes (data source: routine programme monitoring) Targets 2015: • MSM: 90% • Transgender: 90% 1.2.6 Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission Targets 2015: • MSM: 80% • Transgender: 80%

Objective 3: Increase coverage and quality of prevention programmes with injecting and non-injecting substance users (IDU/DU)

Activities	Indicators and Targets
1. Strengthen legislation, policy and strategies to address barriers which prevent the efficient and effective delivery of HIV prevention with IDU/DU. 2. Build an enabling environment for HIV prevention with IDU/DU and their partners by mobilizing key stakeholders, including, health care providers, community networks, local authorities, police, etc. 3. Implement national scale up of HIV prevention with IDU/DU and their partners, informed by guidelines and SoPs, including for needle and syringe exchange programmes, opioid substitution therapy, and community-based drug dependence treatment. 4. Implement targeted behaviour change approaches for subgroups of male and female IDU/DU that emphasize risk reduction and promote safer sexual/risk reduction behaviours, accessible in all relevant environments.	1.3.1 HIV prevalence among injecting drug users (IDU) and drug users (DU) Targets 2015: *IDU* <15% *DU (Non-IDU)* Male <0.6% Female <0.6% 1.3.2 Condom use by IDU and DU at last sex with regular partner, non-regular partner and commercial partner Targets 2015: *IDU with* regular partner Male: 60% non-regular partner Male: 80% commercial partner Male: 90% *DU with* regular partner Male: 60%, Female: 90% non-regular partner Male: 90%, Female: 80% commercial partner Male: 95%, Female: 90% 1.3.3 Percentage of IDU and DU reached with HIV prevention programmes (data source: IBBS) Targets 2015: *IDU* 85% *DU (Non-IDU)* Male 85% Female 80% 1.3.4 Percentage of IDU and DU reached with HIV prevention programmes (data source: routine programme monitoring) Targets 2015: IDU 85% *DU (Non-IDU)* Male 85% Female 80%

Objective 3: Increase coverage and quality of prevention programmes with injecting and non-injecting substance users (IDU/DU)

Activities	Indicators and Targets
5. Intensify IDU/DU demand for, access to, and uptake of, health, social and legal services and products (including rehabilitation and re-integration).	1.3.5 Percentage of IDU and DU who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: Targets 2015: *IDU* 80% *DU (Non-IDU)* Male 80% Female 80% 1.3.6 Percentage of IDU report using a sterile needle and syringe in the last month Targets 2015: 80%

Objective 4: Increase coverage and quality of prevention interventions with mobile population including high-risk male

Activities	Indicators and Targets
1. Expand and scale up HIV prevention programming for mobile population as prioritized in the national HIV and AIDS operational plan for mobile population.	1.4.1 Percentage of men and women aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months (higher risk sex) Targets 2015: • All: 3% • Male: 5% • Female: 0.17%
2. Implement targeted and mass media behaviour change communication interventions to promote safer sexual behaviour, address negative gender values, and promote male responsibility for positive health.	1.4.2 Condom use (at last sex) by men and women aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months. Targets 2015: • All: 60% • Male: 60% • Female: 20%
3. Establish and scale up MMP (including high risk male) demand for, access to, and uptake of sexual health products and services.	1.4.3 Condom use by high risk men (proxy: moto-taxi drivers) Target 2015: 95%

Objective 5: Scale up and improve quality of positive health, dignity and prevention programmes with people living with HIV (PLHIV)

Activities	Indicators and Targets
1. Scale up national implementation of the SoP for HIV prevention with PLHIV.	
2. Ensure Positive Health, Dignity and Prevention work is integrated at all levels of the continuum of care at health facilities and in community-based efforts, including availability/accessibility of condoms/lubricant and other FP methods.	
3. Intensify PLHIV demand for, access to, and uptake of health products and services.	

Objective 6: Scale up provision of targeted, quality Prevention of Mother to Child Transmission (PMTCT) services in line with the four-pronged strategy

Activities	Indicators and Targets
1. Scale up the provision of quality, comprehensive PMTCT services, using the Linked Response approach, to reach pregnant women, their partners and their infants, particularly high risk groups, integrated into the full package of ANC services.	1.6.1 Percentage of pregnant women tested for HIV and received their result Target 2015: 75% 1.6.2 Percentage of HIV-infected pregnant women who received antiretroviral prophylaxis/treatment to reduce risk of mother-to-child transmission Target 2015: 75%
2. Strengthen community awareness and understanding of PMTCT (4 prongs) to increase demand for PMTCT and other related antenatal, family planning, sexual and reproductive health, voluntary confidential counselling and testing services (through targeted social mobilization and communication interventions) with a focus on high risk groups.	1.6.3 Percentage of infants born to HIV-infected mothers who received an HIV test within 12 months of birth Target 2015: 70% 1.6.4 Percentage of HIV-infected women who report using at least one modern contraception method Target 2015: 50%

Objective 6: Scale up provision of targeted, quality Prevention of Mother to Child Transmission (PMTCT) services in line with the four-pronged strategy

Activities	Indicators and Targets
3. Ensure all (known) HIV-infected pregnant women and their HIV-exposed infants receive OI/ARV treatment or prophylaxis, breastfeeding education, and follow up as per national protocols to reduce mother-to-child transmission of HIV.	1.6.5 Percentage of male partners of HIV-infected/high risk pregnant women tested for HIV and received results Target 2015: • Male partners of HIV-infected pregnant women 50% • Male partners of high risk pregnant women 30% 1.6.6 Percentage of infants born to HIV-infected mothers who are not infected Target 2015: 83.7%
4. Strengthen PMTCT programme planning, management, coordination, implementation and supervision at all levels in order to reach PMTCT targets by 2015.	

Objective 5: Scale up and improve quality of positive health, dignity and prevention programmes with people living with HIV (PLHIV)

Activities	Indicators and Targets
1. Implement evidence-informed, gender-equitable, comprehensive prevention programmes for young people most at risk and especially vulnerable and ensure that all MARP programming is effectively addressing needs of most at risk young people (MARYP).	1.7.1 Condom use at last sex by young people aged 15-24 Targets 2015: • Male: 90% • Female: 90% 1.7.2 Percentage of young men and women aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission Targets 2015: • All: 60% • Male: 60% • Female: 60%
2. Strengthen legislative measures, policy instruments and strategies to improve efficient and effective delivery of HIV prevention with MARYP.	
3. Expand gender-equitable, age-relevant sexual and reproductive health and rights education and skills to reduce young people's risk and vulnerability to HIV, accessible in all relevant environments.	

Objective 5: Scale up and improve quality of positive health, dignity and prevention programmes with people living with HIV (PLHIV)

Activities	Indicators and Targets
4. Increase MARYP demand for, access to, and uptake of, health, legal and social services and products.	1.7.3 Percentage of schools that provide life-skills based HIV education in the last academic year Target 2015: 60% 1.7.4 Percentage of young people aged 15 to 24 who had sexual intercourse before the age of 15: Targets 2015: • All: 0.5% • Male: 0.2% • Female: 0.7%
5. Ensure active participation of young women and men, especially vulnerable and marginalized, in HIV prevention forums and activities.	

Objective 8: Increased coverage of quality prevention programmes for populations within prisons

Activities	Indicators and Targets
1. Advocate with Department of Prisons to raise awareness of HIV risk and vulnerability within prisons and build support for provision of HIV services for prisoners.	1.8.1 Percentage of prisoners who received HIV counseling and testing Targets 2015: • Male: 50% • Female: 50% 1.8.2 Percentage of prisoners with advanced HIV infection (CD4 ≤350) receiving ART Target 2015: • Male: 80% • Female: 80% 1.8.3 Percentage of prisoners enrolled in HIV care who were screened for TB Targets 2015: • Male: 80% • Female: 80%
2. Strengthen policy and strategies to address barriers which prevent the efficient and effective delivery of HIV prevention in prisons.	
3. Scale up HIV/TB prevention, treatment and care efforts informed by the national SoP.	
4. Implement targeted behaviour change approaches for subgroups of prisoners that emphasize and promote safer sexual and risk reduction behaviours.	
5. Ensure the sustainable availability and accessibility of HIV prevention commodities within prison settings.	
6. Strengthen the health referral network of HIV/TB services, particularly for those who have been released from prison.	

Objective 9: Improve systems for biomedical prevention of HIV	
Activities	**Indicators and Targets**
1. Ensure full coverage of universal precautions and infection control SoP in all health care settings, including training and in-service training for health care professionals and the provision of appropriate equipment and supplies (e.g. Post-exposure prophylaxis [PEP]).	1.9.1 Percentage of donated blood units screened for HIV in a quality assured manner: Target 2015: 100% 1.9.2 Percentage of voluntary blood donors Targets 2015: 60% • Male: 60% • Female: 60% 1.9.3 Percentage of transfusions using blood components Target 2015: 40%
2. Implement PEP in all health care settings for medical exposures.	
3. Improve waste management practices and implementation at all health care settings.	
4. Continue to expand voluntary recruitment and retention of blood donors.	
5. Ensure systematic and quality-assured HIV screening of all donated blood.	
6. Promote the rational use of blood and blood components/products.	

Strategy 2: Increase coverage and quality of comprehensive and integrated treatment, care and support addressing the needs of a concentrated epidemic.

Objective 1: Expand coverage and improve quality of HIV treatment services.	
Activities	**Indicators and Targets**
1. Expand the coverage and quality of adult and paediatric OI/ART and other facility based care with earlier initiation of treatment.	2.1.1 Percentage of adults and children with advanced HIV infection (CD4 ≤350) receiving antiretroviral therapy (ART) Targets 2015: All (adults & children): 95% 2.1.2 Percentage of adults and children on ART alive at 12, 24, 36 and 48 months after initiation of treatment. Targets 2015: >85% at 12 months M/F/adult/children 80% at 24 months M/F/adult/children 75% at 36 months M/F/adult/children 75% at 48 months M/F/adult/children
2. Train additional staff and further strengthen capacity of staff involved in facility-based care.	
3. Guarantee adequate management and availability of supplies and drugs.	
4. Strengthen quality of the CoC through scaling up the continuous quality improvement (CQI) approach.	
5. Improve adherence, detection of treatment failure and appropriate use of second line treatment regimens.	
6. Strengthen linkages and referral between facility-based services (e.g., VCCT, OI/ART, PMTCT, TB, STI and reproductive health.	

Objective 2: Improve quality and coverage of home and community based care services for PLHIV and their families.

Activities	Indicators and Targets
1. Expand the coverage of home-based care (HBC).	2.2.1 Percentage of PLHIV supported by HBC services Targets 2015: • All: 70% • Male: 70% • Female: 70% 2.2.2 Number and percentage of health centers with Home Based Care Team Support Targets 2015: 85%
2. Train additional community support volunteers, staff for and further strengthen capacity of home-based care teams.	
3. Strengthen the role of HBC to support positive prevention (including adherence to ART), and links to TB and SRH services.	
4. Develop cost effective approaches and strategies to sustain home based care in the medium to long term.	
5. Enhance the quality of service provision and involve all stakeholders in the process.	
6. Strengthen linkages (for referral and follow up) between facility-based and home-based care.	

Objective 3: Ensure access to quality HIV testing and counseling services in the public and private sectors.

Activities	Indicators and Targets
1. Increase the number of licensed VCCT sites.	2.3.1 Percentage of women and men aged 15 to 49 who received an HIV test in the last 12 months and who know the result Targets 2015: • All: 7% • Male: 10% • Female: 6% 2.3.2 Percentage of estimated HIV positive incident TB case who received treatment for TB and HIV Targets 2015:
2. Train additional staff and further strengthen capacity of staff involved in VCCT.	
3. Guarantee adequate management and availability of test kits supplies.	
4. Ensure the quality of Counseling and testing services, including Early Infant Diagnosis services (PCR).	

Objective 3: Ensure access to quality HIV testing and counseling services in the public and private sectors.

Activities	Indicators and Targets
5. Expand routine PICT for pregnant women, TB and STI patients and strengthen linkages from prevention to care and treatment.	• Male: 85% • Female: 85%
6. Integrate VCCT into comprehensive package of activities (CPA).	

Objective 4: Strengthen access to tailored services for MARPs and their sexual partners.

Activities	Indicators and Targets
1. Improve early access to and quality of HIV testing, care and treatment, SRH/FP and STI services for most-at-risk populations (MARPs) and their partners.	2.4.1 Percentage of most-at-risk populations who received an HIV test in the last 12 months and know the result Targets 2015: EW: 80% MSM: 75% Transgender: 75% IDU: 60% DU (non-IDU): 60% Male: 60% Female: 60% HRM (moto-taxi drivers): 40%
2. Expand linkages to NGO/CBOs that support MARPs to ensure continuum of prevention to care, treatment and support.	

Strategy 3: Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS.

Objective 1: Ensure needs of orphans and vulnerable children affected by HIV and AIDS and their caregivers are met

Activities	Indicators and Targets
1. Expand the provision of quality care and support to supplement the household's ability to care for HIV-affected children.	3.1.1 Current school attendance among orphans and among non-orphans aged 10-14 Targets 2015: All: Orphan 85%; Non-Orphan 95% Male: Orphan 85%; Non-Orphan 95% Female: Orphan 85%; Non-Orphan 95%
2. Link OVC and their caregivers to existing social protection programmes (including in-kind/cash interventions) and appropriate local networks to assist in accessing essential services and meeting their basic needs.	3.1.2 Number and percentage of OVC/OVC households whose received at least 3 of the following types of support: • health care assistance • education assistance • food/cash transfers • economic • psychosocial • other (legal/protection/shelter) Targets 2015: • Male: 60% • Female: 60%
3. Improve coordination, linkages and referral among social, health, education and community based services at the local level, with particular attention to gender-based vulnerabilities.	
4. Provide vulnerable children in need of alternative care with access to safe, appropriate alternative care options.	

Objective 2: Improve social and economic status of PLHIV and their families, especially the most vulnerable.

Activities	Indicators and Targets
1. Provide food support to those PLHIV and their families that lack food security.	3.2.1 Percentage of PLHIV who are supported by PLHIV support groups Targets 2015: 70% • All: 70% • Male: 70% • Female: 70%
2. Advocate for and expand evidence-informed sustainable livelihood and income generation interventions for PLHIV and their families.	
3. Provide good quality emotional and spiritual support to PLHIV and their families.	
4. Link PLHIV and their families to existing social safety net/social protection programmes to ensure they are able to access essential services and meet their basic needs.	
5. Strengthen the quality and impact of PLHIV support and self-help groups and networks.	

Objective 3: Expand and sustain community involvement in impact mitigation.

Activities	Indicators and Targets
1. Mobilize communities to provide support to households with OVC.	3.3.1 Percentage of communes with at least one organization providing care and support the household with OVC Target 2015: 85%
2. Increase the visibility and meaningful participation of PLHIV in impact mitigation interventions and decision-making.	
3. Establish and/or strengthen community systems that mitigate the impact of HIV at sub-national and local levels.	

Strategy 4: Ensure effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub-national levels.

Objective 1: Integrate HIV work into the Royal Government's decentralisation and de-concentration systems and the National Strategic Development Plan.

Activities	Indicators and Targets
1. Ensure HIV plans (with related social issues) are mainstreamed into social development plans at provincial and commune level within MOI led decentralization and deconcentration (D&D) process.	4.1.1 Percentage of provincial development strategies that address HIV and AIDS Target 2015: 100% 4.1.2 Percentage of commune development plans that address HIV and AIDS Target 2015: 100%
2. Mobilise financial and technical resources to support development and implementation of plans, including HIV and AIDS interventions, at sub-national levels.	
3. Ensure partnerships between HIV stakeholders and Commune Councils for the effective planning and implementation of HIV work within Commune Investment Plans.	
4. Coordinate with MoP and key ministries to strengthen integration of HIV across all relevant components of next National Strategic Development Plan (2014-2018).	

Objective 2: Strengthen coordination and management architecture at the national and sub-national levels.

Activities	Indicators and Targets
1. Strengthen the management architecture of the NAA Secretariat to improve performance of its core functions for leadership coordination and management of the national response.	
2. Strengthen capacity of D&D management mechanisms and structures for coordinating HIV work and mainstreaming HIV into social development service delivery.	

Objective 2: Strengthen coordination and management architecture at the national and sub-national levels.

Activities	Indicators and Targets
3. Rationalize the structure and improve capacity of the Technical Working Groups (TWG) and task forces to support the national response according to the strategies of NSP III.	
4. Strengthen the strategic direction and coordination function of Government Donor Joint TWG, with focus on addressing strategic issues and ensure linkages with GFATM oversight and proposal development structures.	
5. Increase the effectiveness of national and sub-national coordination structures in particular Provincial AIDS Committees (PAC).	

Objective 3: Improve capacity of key ministries and relevant government institutions at the national and sub-national levels for delivery of targeted HIV programmes.

Activities	Indicators and Targets
1. Strengthen capacity, systems and plans of key ministries and government authorities at national and sub-national levels that have a primary role in implementing targeted evidence-informed interventions of the national response.	4.3.1 Number of key line ministries implementing an HIV and AIDS programme Target 2015: 100%
2. Strengthen priority health services through increased integration of HIV service delivery.	
3. Mainstream broad-based HIV programs and activities into key ministry non-HIV policies and workplans where appropriate.	
4. Engage key line ministries in the work and decision-making processes of the Policy Board and National Technical Partnership Board with particular emphasis on national strategic planning, implementation of HIV-related legal instruments, and financing the response.	
5. Ensure that all ministries have an appropriate of HIV workplace policy which is resourced and implemented.	

Objective 4: Improve capacity and involvement of civil society institutions, especially organizations and community networks representing PLHIV and MARPs, in the national response.

Activities	Indicators and Targets
1. Improve the involvement of civil society, service organizations and affected population networks in policy dialogue and decision-making, through active participation in key national and sub-national forums.	4.4.1 Increased involvement of civil society in strategic planning
2. Strengthen capacity of civil society (especially organizations and networks representing PLHIV and MARPs) to play a larger role in working towards UA and implementing the national response.	
3. Harmonize and strengthen networks with clear representation by all civil society stakeholders involved in the national response.	

Objective 5: Improve capacity and involvement of private sector institutions for delivery of targeted and sustainable HIV programmes.

Activities	Indicators and Targets
1. Strengthen relevant ministries and their partners to improve enforcement and monitoring of relevant Prakas and guidelines to ensure effective delivery of HIV prevention programmes to key populations in high risk environments.	4.5.1 Number of large organizations that have workplace policies and interventions in place Target 2015: 250
2. Strengthen the work of the Cambodia Business Coalition on AIDS to promote corporate social responsibility among local businesses, advocate, share information and engage key and relevant private sector entities in workplace-based HIV prevention programmes, including bench-marking and monitoring effectiveness of programmes.	

Strategy 5: Ensure supportive legal and public policy environment for the national response to HIV and AIDS.

Objective 1: Intensify implementation and enforcement of the Law on Prevention and Control of HIV and AIDS.	
Activities	**Indicators and Targets**
1. Intensify public understanding and awareness of the Law on Prevention and Control of HIV and AIDS through mass and focused communications, and integration into community-based HIV education messages.	5.1.1 National Composite Policy Index (NCPI) Part B
2. Orient justice and law enforcement officials on the guidance for implementation of the Law on Prevention and Control of HIV and AIDS.	
3. Work with key line ministries to oversee the implementation and development of a system to intensify monitoring and enforcement of the provisions of the Law on the Prevention and Control of HIV and AIDS.	
4. Review the implementation progress of the Law on the Prevention and Control of HIV and AIDS, amend it as needed, and ensure its clauses are adequately reflected in other legislation related to HIV and AIDS.	
5. Facilitate oversight visits by parliamentarians and parliamentary/public hearings to monitor and promote the implementation of the Law on the Prevention and Control of HIV and AIDS.	

Objective 2: Engage stakeholders in development and implementation of legislation and policies to ensure an enabling environment for the national response.

Activities	Indicators and Targets
1. Undertake a comprehensive national policy audit ensuring the full participation of civil society, especially PLHIV and, MARPs and their partners, as well as advocates for OVC.	
2. Work with relevant ministries and other stakeholders, including PLHIV, MARPs and advocates of OVC, to prevent and mitigate the negative consequences of laws and policies and assess their impact on effectiveness of the national response to HIV.	

Objective 3: Reduce as much as possible stigma and discrimination against MARPs and people living with and affected by HIV.

Activities	Indicators and Targets
1. Use appropriate communication approaches to reinforce positive perceptions, attitudes and behaviours toward PLHIV, MARPs and OVC in line with national communication and advocacy strategy and plan.	5.3.1 Percentage of men and women (aged 15-49) who express accepting attitudes towards those living with HIV and AIDS Targets 2015: • Male: 80% • Female: 80%
2. Sensitize and mobilize senior officials, law makers, opinion leaders, private sector and faith-based organizations to reinvigorate the fight against stigma and discrimination at institutional and community levels.	
3. Sensitize and train service providers in health, legal and social sectors on approaches to eliminate stigma and discrimination against MARPs and people living with and affected by HIV.	
4. Enhance introduction and implementation of workplace policies addressing stigma and discrimination in public and private sectors.	

Strategy 6: Ensure availability and use of strategic information for decision-making through monitoring, evaluation and research.

Objective 1: Strengthen the national multi-sectoral HIV M&E system.

Activities	Indicators and Targets
1. Strengthen organizational structures with M&E functions through investment in basic infrastructure, equipment and human resources.	6.1.1 National HIV and AIDS report is regularly published on annual basis. Target 2015: 5 annual national reports.
2. Build institutional and human capacity for M&E through formal and on-the-job training.	
3. Develop and strengthen partnerships to plan, coordinate and manage the national M&E, research and surveillance systems.	
4. Develop and/or update multi-year and annual costed M&E plans consistent with the National M&E Guidelines and based on M&E system strengthening assessments.	
5. Conduct advocacy and communication to enhance the understanding of and commitment to strengthening M&E.	

Objective 2: Obtain reliable evidence for HIV programming through monitoring, evaluation and research.

Activities	Indicators and Targets
1. Produce comprehensive and high quality routine programme monitoring data by harmonizing M&E efforts including alignment of indicators, indicator definitions, data collection tools, data management and reporting procedures.	

Objective 2: Obtain reliable evidence for HIV programming through monitoring, evaluation and research.	
Activities	**Indicators and Targets**
2. Produce timely and high quality data from surveys and integrated behavioural and biological surveillance (IBBS) and other recurrent studies.	
3. Produce sound evidence to inform programme and policy decision making through HIV evaluation and national research agenda.	
4. Regularly conduct update and improve population size estimations.	
5. Maintain and expand comprehensive national HIV database.	
6. Establish effective system for supervision and data auditing.	

Objective 3: Promote sharing and effective use of strategic information for decision-making.	
Activities	**Indicators and Targets**
1. Improve the dissemination of information through a combination of channels (including national media), at gatherings and through publications and up-to-date websites.	
2. Encourage use of data in TWGs and for program planning at all levels.	
3. Conduct Annual Joint Review Meetings (AJRM) to assess progress, draw lessons and adjust strategies and to develop operational NSP implementation plan for subsequent year.	
4. Conduct workshops, conferences and symposia on key issues to foster analysis and interpretation of data, integration and of data from multiple sources, updates of HIV estimates and projections, and to exchange of information and experiences.	

Strategy 7: Ensure sustained, predictable financing and cost-effective resource allocation for the national response.

Objective 1: Identify financial and human resources needed for the national response and resource gaps according to epidemiological trends and priorities.	
Activities	**Indicators and Targets**
1. Determine the cost of all HIV and AIDS interventions planned and prioritised on a multi-year and on a yearly basis.	
2. Establish and monitor commitments and pledges to support national response and to address financial and human resource gaps by order of priority.	
3. Identify financial resource gaps to 2015 based on new prevalence estimates and projections.	
4. Assess human resource capacity gaps at national and provincial level including financial resources needed for addressing capacity gaps.	
5. Build capacity within NAA Secretariat to cost national sectoral and key population plans including putting in place a mechanism to review unit costs on a regular basis.	

Objective 2: Intensify mobilization of financial and human resources and develop strategies to address identified resource gaps.

Activities	Indicators and Targets
1. Use strategic, costing and resource tracking information to advocate for sustained funding of the national response to prevent a resurgence in the epidemic and to formulate funding proposals to address priority gaps.	7.2.1 Domestic and international spending by categories and financing sources Targets 2015: Total amount: • Domestic: 20% • International: 80%
2. Review funding priorities regularly together with all stakeholders and notably as part of joint annual NSP progress review meetings by using M&E, research and costing data.	
3. Design and explore realistic modalities for harmonizing and aligning development partners' support to financing identified priority gaps and key priority needs.	
4. Develop a roadmap for increasing domestic resource allocations to the national response.	
5. Integrate HIV and AIDS interventions into sectoral development and decentralization plans to strengthen sustainability of initiatives.	
6. Key coordination bodies (TWGs), ministries and civil society organizations, in particular PLHIV and MARPs networks, develop/review their capacity building plan and take steps to implement and monitor them.	

Objective 3: Ensure cost effective and accountable allocation and use of financial resources across the NSP III according to priorities.

Activities	Indicators and Targets
1. Strengthen national HIV and AIDS financial resource tracking system and lead National AIDS Spending Assessments every two years.	7.3.1 Number of National AIDS Spending Assessments conducted Target 2015: 3 (cumulative)
2. Develop strategies to attract and retain good quality staff at NAA and key line ministries.	
3. Ensure resources are efficiently and effectively allocated to national response priorities through readjustments decided by annual reviews and prioritizations informed by strategic information.	

Objective 4: Ensure uninterrupted supply of key commodities for the national response.

Activities	Indicators and Targets
1. Undertake a systematic analysis of condom, lubricant and other essential HIV prevention and Continuum of Care commodity requirements and ensure that appropriate commodity plans are developed and resources mobilized to fill gaps.	7.4.1 Number of condoms distributed and sold Target 2015: 24.5 million 7.4.2 Number of lubricant sachets distributed and sold Target 2015: 1.3 million
2. Ensure that a commodities forecasting and tracking system is developed for HIV prevention and the Continuum of Care, implemented and systematically updated/ reviewed every quarter.	

ANNEX 1. MONITORING AND EVALUATION FRAMEWORK

Progress in implementing the revised National Strategic Plan will be measured against core indicators and agreed targets as defined in the M&E Framework that is presented in this annex.

Many of the indicators are drawn from the National HIV/AIDS Monitoring and Evaluation Guidelines which defines 54 core indicators for the monitoring and evaluation of the national, multi-sectoral response to HIV and AIDS. These core indicators were compiled for the revised NSP II based on existing indicator lists from the original NSP II, Universal Access indicators, Indicators for UNGASS 2008 reporting, Cambodia Millennium Development Goals and the National Social Development Plan 2006-2010.

Gender disaggregated reporting is included wherever appropriate.

Monitoring and Evaluation Framework of the NSP3

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
	General indicators			
0.1	HIV prevalence in adult population	HSS/CDHS [9]	0.7%[10] (2010)	n/a
0.2	HIV prevalence in most at risk populations: BB-EW	HSS	14.7% (2006)	8%
	NBB-EW	HSS	11.7% (2003)	8%
	All EW	HSS	N/A	8%
	MSM in Phnom Penh	SSS	5.1% [11]	3%
	Transgender in Phnom Penh	SSS	17% (2005)	6%
	IDU DU (Male and Female)	DU Survey	24.4% 1.1% (2007)	<15% <0.6%

[9] NCHADS, HIV Estimates and Projections for Cambodia, 2007.
[10] This estimate will be updated per 2010 HSS.
[11] The 2005 SSS found prevalence for Phnom Penh based MSM (including TG) to be 8.7% compared to 0.8% in the Provinces. NCHADS has previously reported 5.1% as a combined figure for all MSM, although they caution this is not a rigorous estimation of national prevalence for MSM.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
0.3	HIV incidence in adult population	HSS/CDHS [12]	630[13] (2010)	n/a
Strategy 1: Increase coverage, quality and effectiveness of prevention interventions				
1.1	Consistent condom use with clients:[14] BB-EW - clients - sweethearts	BSS	94% 52% (2007)	95% >80%
	NBB-EW - clients - sweethearts	BSS	83% 54% (2007)	95% 95%
	All EW - clients - sweethearts	BSS	N/A	95% 85%
1.2	Condom use with last client:[15] BB-EW NBB-EW All EW	BSS	99% 94%[16] (2007) N/A	99% 99% 99%
1.3	Consistent Condom use by men who have sex with men (MSM) in the last month:[17] MSM Transgender	BSS	44% 42% (2007)	60% 60%
1.4	Condom use by men who have sex with men (MSM) last time they had anal sex with a male partner[18] MSM Transgender	BSS	83% 94% (2007)	95% 95%

[12] Ibid.
[13] This estimate will be updated per 2010 HSS.
[14] The recall period for condom use differs for each respondent group and study. For BB-ESW in the 2007 BSS, recall period for clients was 1 week and for sweethearts was 1 month. For BB-ESW in the 2003 BSS, recall period for both clients and sweethearts was 1 week. For NBB-ESW in the 2007 BSS, recall period for both clients and sweethearts was 3 months. For NBB-ESW in the 2003 BSS, recall period for "regular clients" was 1 month and for sweethearts was 1 week.
[15] This is UNGASS indicator #18 and uses the question "did you use a condom with your most recent client".
[16] In BSS 2007 broken down: 88%, 96% and 95% for beer garden workers, beer promoters and karaoke workers respectively.
[17] This indicators uses results from the BSS on MSM and Transgender regarding condom use during penetrative sex with male partners only. The denominator is all MSM and TG surveyed, including those who reported no penetrative sex in the last month.
[18] This is UNGSS indicator # 19, and includes regular and non regular male partners, paid and unpaid. In UNGASS MSM and TG are not disaggregated, in the 2009 UNGASS report 86.5% was reported but the denominator did not use a specific recall period as required by the indicator.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
1.5	Condom use at last sex by injecting drug users (Male IDU) with: Regular partner Non-regular partner Commercial partner	DU Survey	 40.2% 68.0% 81.4% (2007)	 60% 80% 90%
1.6	Condom use at last sex by non-injecting drug users (non-IDU) M/F with: Regular partner Non-regular partner Commercial partner	DU Survey	 52.9% 80.5% 88.4% (2007 Male baseline only)	M/F 60/90% 90/80% 95/90%
1.7	Percentage of men and women aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months (higher risk sex)[19]			
	All (adult aged 15-49)	CDHS	3% (2005)	3%
	Male	CDHS	6% (2005)	5%
	Female	CDHS	0.17% (2005)	0.17%
1.8	Condom (at last sex) use by men and women aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months (higher risk sex – more than one partner)[20]			
	All (adult aged 15-49)	CDHS	40% (2005)	60%
	Male	CDHS	40.9% (2005)	5%
	Female	CDHS	n/a	-
1.9	Condom use by high risk men: Moto-taxi drivers Condom use at last sex with FSW Condom use at last sex with sweetheart	BSS	 95.2% 71.7% (2007)	 95% 80%

[19] This is UNGASS indicator # 16. The baseline data differs from that shown in the 2005 CDHS because the weighted results are shown here, as required in UNGASS reporting. Note that the female result is based on 29 respondents.

[20] This is UNGASS Indicator #17. The baseline data differs from that shown in the 2005 CDHS because the weighted results are shown here, as required in UNGASS reporting. The female result has been excluded, as the weighted number was very low at 2.5.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
1.10	Condom use at last sex by young people 15-24			
	Male	CDHS	88%	90%
	Female	CDHS	n/a	-
1.11	Percentage of most at risk populations reached with HIV prevention programmes[21]	BSS	93.8% (2007)	95%
	BBS-EW	Routine Monitoring	n/a	95%
	NBB-EW	BSS	90.6% (2007)	95%
		Routine Monitoring	n/a	95%
	All EW	BSS	n/a	95%
		Routine Monitoring	96%[22]	95%
	MSM Transgender	BSS	79% 83%[23] (2007)	90% 90%
		Routine Monitoring	73%[24]	90%
	IDU	DU Survey	n/a	85%
		Routine Monitoring	n/a[25]	85%
	DU (Non IDU) Male Female	DU Survey	n/a	 85% 80%
	Male Female	Routine Monitoring	n/a[26]	85% 80%
1.12	Percentage of schools that provided life-skills based HIV education in the last academic year	MoEYS	34.1% (2008/9)	60%

[21] This is UNGASS indicator #9, and is a composite indicator. The results here do not strictly match the definition in UNGASS. This is measured through BSS which asks if respondents have received HIV/AIDS education or information in the past 6 months (2003) and past 3 months (2007). The IDU/DU survey did not have a recall period.

[22] This percent does not represent national figures, but rather 12,596 reached out of estimated 13,156 EW based on GFATM program implemented by 3 SRs, however there is a total estimated 36,713 EWs in Cambodia (NCHADS, December 2009).

[23] This baseline will need to be updated in late 2010 when the Bros Khmer study data is available, and the target confirmed then also.

[24] This percent does not represent national figures, bur rather 11, 921 reached out of an 16,400 estimated MSM in three provinces in Cambodia (FHI, 2009). Based on GFATM program data. National estimates for total MSM are 14,652, however, it is deemed this is an underestimate in light of difficulty identifying and FHIs estimates. No national estimates available on number reached.

[25] This data is not disaggregated nationally by DU/IDU but rather all DU. Current IDU estimates are 2045 (DU Survey 2007), but this is deemed as gross overestimation and more realistic figures are considered around 1000 IDU.

[26] Estimate of total DU is 13,000. Based on program data, coverage of both IDU/DU is 42.8%.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
1.13	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			
	All	CDHS	47.4% (2005)	60%
	Male	CDHS	45.2% (2005)	60%
	Female	CDHS	50.1% (2005)	60%
1.14	Percentage of most at populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission:			
	BB-EW	BSS	n/a	80%
	NBB-EW	BSS	n/a	80%
	MSM	MSM survey	n/a (2010)	80%
	Transgender	MSM survey	n/a (2010)	80%
	IDU	DU Survey	n/a	80%
	DU Male Female	DU Survey	 n/a n/a	 80% 80%
1.15	Percentage of injecting drug users who used a sterile needle and syringe at last injection:	DU Survey	64.7% 2007[27]	80%
1.16	Percentage of young people aged 15 to 24 who have had sexual intercourse before the age of 15[28]:	CDHS		
	All		0.6% (2005)	0.5%
	Male	CDHS	0.3% (2005)	0.2%
	Female	CDHS	0.9% (2005)	0.7%

[27] This has been calculated specifically by recalculating from raw data from related indicator "% who used non-sterile syringes/ needles last time injected", however, it is not included in official survey report. NCHADS.

[28] This is UNGASS indicator #15. The result for "all" has been weighted to account for the larger female data set. The targets for 2015 will need updating when the CDHS 2010 is available.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
1.17	Percentage of pregnant women tested for HIV and received their result	NMCHC	42% (2009)	75%
1.18	Percentage of HIV-infected pregnant women who received antiretroviral prophylaxis to reduce risk of mother-to-child transmission	NMCHC	32.3% (2009)	75%
1.19	Percentage of infants born to HIV-infected mothers who received a HIV test within 12 months of birth	NMCHC	39% (2009)	70%
1.20	Percentage of HIV-infected women who report using at least one modern contra-ception method	NMCHC	n/a	50%
1.21	Percentage of male partners of HIV-infected/high risk pregnant women tested for HIV and received results Male partner of HIV infected pregnant women	NMCHC	n/a	50%
	Male partners of High Risk Pregnant Women		n/a	30%
1.22	Percentage of infants born to HIV-infected mothers who are not infected	NMCHC/ UNAIDS	n/a	83.7%
1.23	Percentage of prisoners who received HIV counselling and testing[29] Male Female		n/a n/a	50% 50%
1.24	Percentage of prisoners with advanced HIV infection receiving ART Male Female		n/a n/a	80% 80%
1.25	Percentage of prisoners enrolled in HIV care who were screened for TB Male Female		n/a n/a	80% 80%

[29] The denominator for this indicator is not confirmed. The Prison Assessment reports 10,263 inmates in 2008, but a more recent figure from official sources is needed as LICARDO is reporting 13,454 in 2010.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
1.26	Percentage of estimated HIV positive incident TB case that received treatment for TB and HIV[30] Male Female	CENAT	 4.8% (2009)	 85% 85%
1.27	Percentage of donated blood units screened for HIV in a quality assured manner	NBTC	100%	100%
1.28	Percentage of voluntary blood donors	NBTC	50%	60%
1.29	Percentage of transfusions using blood components	NBTC	15%	40%
Strategy 2: Increase the coverage and quality of comprehensive and integrated treatment, care and support while addressing the needs of a concentrated epidemic				
2.1	Number and percentage of adult and children with advanced HIV infection receiving antiretroviral therapy (ART)[31] All	NCHADS	All: 37,315 (92.2%) (2009)	95%
	Adults (15+) Male Female	NCHADS	Adults: 33,677 (95.8%) (2009) n/a n/a	95%
	Children (<15) Male Female	NCHADS	Children: 3,638 (68.2%) (2009) n/a n/a	95%

[30] This is UNGASS indicator #6, the denominator for the 2009 reporting was estimated by WHO.

[31] The 2009 baseline data is based on a CD4 count of ≤250, however, on January 1 2010 the eligibility for ART was changed to a CD4 count of ≤350. New baseline data and 2015 targets based on the new CD4 count eligibility will be available towards the end of 2010.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
2.2	Percentage of adults and children on ART alive at 12, 24, 36 and 48 months after initiation of treatment[32] All % at 12 months	NCHADS	87.4% (2009)	>85%
	Male/Female % at 12 months % at 24 months % at 36 months % at 48 months		n/a n/a n/a n/a (2009)	>85% 80% 75% 75%
	Adults (15+) % at 12 months % at 24 months % at 36 months % at 48 months		86.7% 77.7% 72% 70.3% (2009)	>85% 80% 75% 75%
	Children (<15) % at 12 months % at 24 months % at 36 months % at 48 months	NCHADS	93.9% (2009)	>85% 80% 75% 75%
2.3	Number of PLHIV supported by active[33] self-help groups (SHG)	NCHADS (CPN+)	32,252 June, 2010	49,780
2.4	Number and percentage of health centers with active SHGs	NCHADS	771 79.9%	965 98%

[32] This is UNGASS indicator #24. The targets for 2015 will be amended when NCHADS releases targets towards the end of 2010.
[33] "Äctive" refers to actively providing community-based prevention, case and support (CBPCS) services to PLHIV according to the National SOP.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
2.5	Percentage of women and men aged 15 to 49 who received an HIV test in the last 12 months and who know the result [34]	CDHS		
	All		4.1% (2005)	7%
	Male	CDHS	5.1% (2005)	10%
	Female	CDHS	3.2% (2005)	6%
2.6	Percentage of most at risk populations who received an HIV test in the last 12 months and know the results:[35]	BSS		
	BB-EW		68.1% (2007)	80%
	NBB-EW	BSS	51.8% (2007)	80%
	All EW	BSS	n/a	80%
	MSM[36]	BSS	53.6% (2007)	75%
	Transgender	BSS	64.7% (2007)	75%
	IDU	DU Survey	35.3% (2007)	60%
	DU[37]	DU Survey	38.2% (2007)	60%
	HRM (Moto-taxi drivers)	BSS	19.8% (2007)	40%

[34] This is UNGASS indicator #7. The baseline data is from the 2010 UNGASS report that weighted the male and female CDHS data.

[35] This is UNGASS indicator #8. The baseline data for the IDU and the DU does not strictly speaking confirm with this indicator, the question used was "have you ever had an HIV test". This should be kept in mind when comparing future data on this indicator.

[36] TThe baseline for MSM is different to that shown in the UNGASS 2010 report because the UNGASS report combined data for MSM and Transgender. The baseline for MSM and Transgender was calculated by UNAIDS using the results presented in the BSS 2007.

[37] The baseline data used here was calculated by UNAIDS from data in the DU survey. Of 358 non-IDU surveyed, 137 had ever been tested and knew their results.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
Strategy 3: Increased coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS				
3.1	Current school attendance among orphans and among non-orphans aged 10 to 14 All	CDHS	Orphans V's non Orphans 76.1% vs 91.6% (2005)	85% vs 95%
	Male	CDHS	74.1% vs 92.5% (2005)	85% vs 95%
	Female	CDHS	78.1% vs 90.8% (2005)	85% vs 95%
3.2	Number and percentage of OVC whose household received at least 3 of the following types of support[38] - health care assistance - education assistance - food/cash transfers - economic - psychosocial - other (legal/protection/shelter) Male Female	MoSVY	 n/a n/a	 60% 60%
3.3	Number and percentage of PLHIV who are supported by PLHIV support groups	CPN+	36,893 63.7% (2009)	70%
3.4	Percentage of communes with at least one organization providing care and support to households with OVC	HACC	78% (2009)	85%

[38] The number of OVC households have to be confirmed.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
Strategy 4: Effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub national levels				
4.1	Percentage of provincial development strategies that address HIV/AIDS	NAA	100% (2009)	100%
4.2	Percentage of commune development plans that address HIV/AIDS	NAA	3% (no date available)	100%
4.3	Number of key line ministries implementing an HIV/AIDS programme[39]	NAA	29% (2009)	100%
4.4	Increased involvement of civil society in strategic planning	UNGASS/NCPI Part B	-	-
4.5	Number of large organizations that have workplace policies and interventions in place	NAA/MLVT	80 (2009)	250
Strategy 5: A supportive legal and public policy environment for the national response to HIV and AIDS				
5.1	National Composite Policy Index Part B (NCPI)[40]	NAA	n/a	n/a
5.2	Percentage of men and women (aged 15-49) who express accepting attitudes towards those living with HIV/AIDS[41] Male Female	CDHS (2005)	 32% 36.2%	 80% 80%

[39] The baseline refers to all ministries, the key ministries have yet to be identified, but have been set at approximately ten.
[40] This is a composite qualitative indicator and cannot easily be synthesized quantitatively. The indicator is measured every two years to prepare the UNGASS Country Progress Report.
[41] This is a composite indicator, compiled from four questions asked in the CDHS. The 2015 targets were set before the baselines were known so this will need to be revised when the CDHS 2010 data is available.

No	Indicator	Data Source	Baseline Value and Year NSP3	Targets 2015
Strategy 6: Ensure the availability and the use of strategic information for decision-making through HIV monitoring and evaluation including impact evaluation and research				
6.1	Progress made in strengthening the M&E system (assessed through the M&E System Strengthening tool)[42]	NAA	n/a (2010)	
Strategy 7: Ensure sustained, predictable financing and cost-effective resource allocation for the national response				
7.1	Domestic and international spending by categories and financing sources Total - Domestic - International	NASA	USD 51.8M (2008) 10% 90%	 20% 80%
7.2	Number of National AIDS Spending Assessments conducted	NAA	-	3[43]
7.3	Number of condoms distributed and sold[44]	PSI	18,181,437 (2009)	24.5 million
7.4	Number of lubricants distributed and sold	PSI	795,280 (2009)	1.3 million

[42] This is a composite qualitative indicator and cannot easily be synthesized quantitatively. The indicator is measured every 2-3 years by using the M&E System Strengthening Tool of GFATM.
[43] This is a cumulative indicator form the beginning of the NSP3 period. .
[44] This indicator is for socially marketed condoms. The market share of socially marketed condoms has been predicted to decrease because of PSI's new marketing strategy which is aiming to increase market space for private sector condoms.

ANNEX 2. BIBLIOGRAPHY

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