United States Department of State

Washington, D.C. 20520

FY 2015 Cambodia Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Cambodia.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

2015

Strategic Direction Summary

Cambodia

Country Operational Plan

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NOTE ON DATA: There are places in the SDS where data may not be consistent due to uses of modeled data, programmatic data and data available through surveys and surveillance. Throughout the SDS, the team has endeavored to be consistent in use of data to the extent possible and to note the data source so that it is clear why figures may not match.

GOAL STATEMENT

Cambodia has established itself as a global leader in the fight against HIV/AIDS, cutting adult infection rates in the general population by more than half in the past 14 years and providing HIV treatment to over 80% of eligible individuals since services were established in 2003. In the early 2000s, Cambodia achieved epidemic control nationally. Since 2013, Cambodia has had a goal of eliminating new HIV infections in the next decade and is on track to eventually reach this objective – effectively achieving the AIDS Free Generation. While there has been significant success, there are remaining areas of concern at the sub-national level where ART coverage is still low and within certain high-risk groups where high prevalence still exists.

The goal of the PEPFAR program in Cambodia is to provide targeted technical assistance (TA) in achieving the 90-90-90 goals within priority provinces to help Cambodia become the first AIDS Free Generation low-income country. At the same time, PEPFAR is working to ensure the long-term sustainability of the Cambodian HIV response. For the past decade, the response has been largely funded by external donors, primarily the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and PEPFAR. In recent years, donor funds have declined and are expected to continue to decline in the future. PEPFAR accounts for approximately 20-30% of funding for the HIV response, GFATM accounts for approximately 45-55% of the response and the government accounts for the remainder. The domestic spending has remained level for the past decade. In order to ensure continued success, Cambodia must focus its response and increase domestic resource allocation.

In order to ensure programmatic alignment with the global PEPFAR pivot, PEPFAR Cambodia is making a number of strategic shifts over the next 12-18 months as we focus on priority areas for highest impact and reduce funding in areas of lower priority. For example, PEPFAR will no longer provide the majority of funding for home and community-based care and support interventions as this will be transitioned to national and GFATM funding. PEPFAR will also no longer support social marketing of condoms as this role is being filled by a combination of private industry and national efforts. PEPFAR support for a broad-based blood safety program is being phased out as the national program gathers strength. These reductions will make room for additional work by PEPFAR needed to achieve the long-term sustainability of the HIV response as well as support related to the recent injection safety outbreak. In addition, several shifts in geographic focus are discussed in Section 3.0. These efficiencies should allow PEPFAR to scale down while continuing to make a strong impact.

In the COP 2015 implementation period, the PEPFAR program intends to further strengthen Cambodia in achieving a sustainable AIDS-free generation. This includes:

- Supporting the national government to appropriately lead, manage, implement and oversee the national program;
- Sustaining prevention efforts with key populations (KPs), while also looking towards new approaches to ensure the long-term strength of KPs prevention efforts as donor funding declines;
- Defining a solution to the long-term affordability of Cambodia's HIV response and advocating for increased government commitment of resources;
- Addressing emerging risks such as unsafe medical injection practices;
- Strengthening key information systems needed to assure transparency, accountability and to better use data to find remaining HIV cases; and

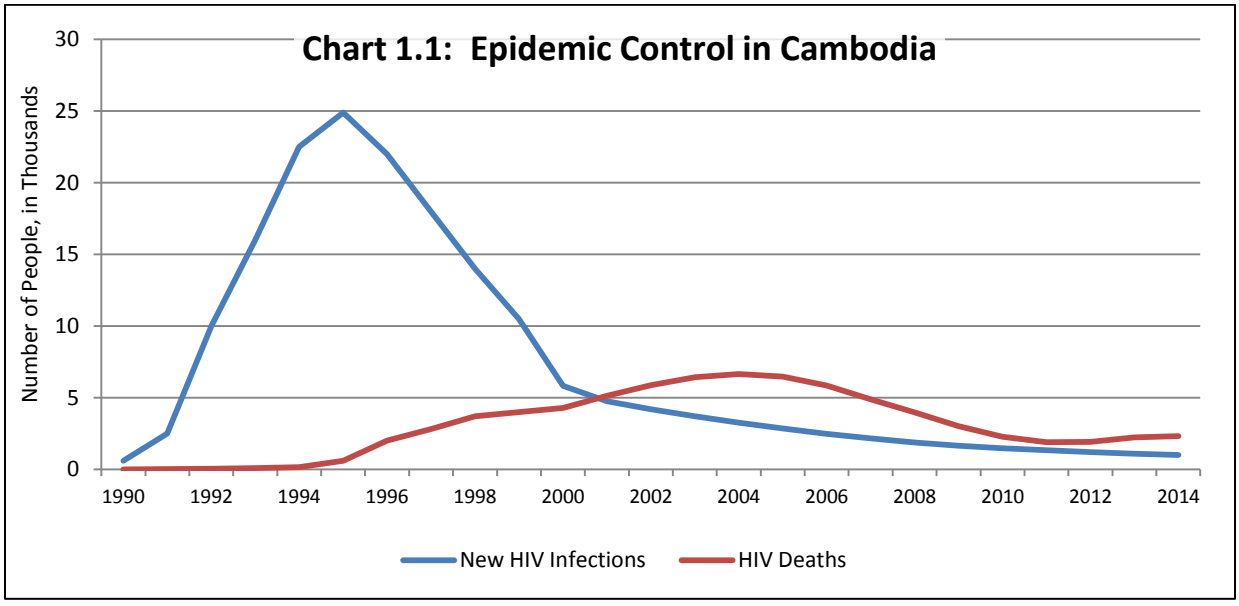
- Piloting new and innovative prevention, care and treatment approaches designed to support the achievement of 90-90-90 in priority provinces, improve Cambodia's long-term sustainable response to the epidemic and the achievement of zero new infections.

Against the backdrop of falling HIV budgets, a persistent concentration of HIV in high-risk groups, competing health and development priorities, and new evidence-based interventions for HIV prevention, the Cambodian government and its development partners must adapt to a changing resource and epidemiological context in order to further Cambodia's status as a leader in the global fight against HIV and ensure that it successfully achieves an AIDS-free generation. PEPFAR remains the leading bilateral partner in supporting Cambodia in this effort.

1.0 EPIDEMIC, RESPONSE, AND PROGRAM CONTEXT

1.1 SUMMARY STATISTICS, DISEASE BURDEN AND COUNTRY OR REGIONAL PROFILE

Cambodia's population is 14.7M and, as of 2014, 70,456 people (0.67%) were living with HIV[1]. Estimates suggest that HIV prevalence peaked at 1.7% in 1998 and has been declining ever since. Epidemic control[2] was reached in the early 2000s (see Chart 1.1). In 2014, it is estimated that among adults there were 2,783 AIDS-related deaths, and 694 new HIV-infections[3]. With targeted, effective interventions and high-levels of ART coverage among PLHIV, Cambodia is poised to become the first low-income country to achieve virtual elimination of HIV transmission within the next decade. This goal is defined in the Cambodia 3.0 strategy as an HIV-incidence of 3 per 100,000 people or less and a mother-to-child transmission rate of 2% or less.



Cambodia has achieved substantial progress in reducing the spread of HIV, with an overall reduction of 97% in the estimated annual new HIV-infections, from 24,348 in 1995 to

[1] AEM, 2014
[2] Defined as the point where the number of new HIV-infections has declined and falls below AIDS-related deaths.
[3] AEM, 2014

694 in 2014[4]. While the highest HIV prevalence persists among KPs, the highest number of new infections is among individuals with no identifiable risk. The populations with the highest prevalence include: 2.1% among men who have sex with men (MSM), 2.6% among female entertainment workers (FEW), 4.1% among transgender (TG), and 24.2% among people who inject drugs (PWID). However, none of these populations is particularly large; using the Asian Epidemic Model (AEM) there are an estimated 20,200 MSM, 34,000 FEW, 3,000 TG, and 1,355 PWID. Of the estimated 694 new adult HIV-infections in 2014 per AEM, this model suggests that heterosexual transmission is the driving force behind the epidemic, with around 58% of all new infections in males and females with no identifiable risks, 12% in FEW, 14% in their clients, and 13% in PWID. The recent cluster of at least 243 newly identified HIV-infections in Battambang province also suggests that there may be a proportion of new HIV-infections, as yet not fully quantified, resulting from use of unsafe injections and infusions by unlicensed medical practitioners. There is substantial geographic variation in the epidemiology of HIV in Cambodia, with HIV incidence likely largely concentrated in urban areas, particularly the large cities of Phnom Penh, Siem Reap, and Battambang (see Figure 1.4.2).

In 2011 the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS) launched Cambodia 3.0, which aims to achieve elimination of new infections by 2020. In addition, NCHADS is finalizing the *Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector 2015 – 2020* (Strategic Plan 2014-2020), which outlines three main strategies: 1) *Boosted Continuum of Prevention to Care and Treatment (CoPCT):* key population prevention and links to services, 2) *Boosted Continuum of Care (CoC):* retention and improvement of quality for patients in care, and 3) *Boosted Linked Response(LR):* elimination of new infections among children while addressing the needs of their mothers.

The first two phases of Cambodia's strategy have been effective; analysis of the Cambodian treatment cascade suggests that per AEM modelling, in 2014 Cambodia provided ART to 46,647 of an estimated 52,987 adult patients in need of ART (88%)[5]. Furthermore, approximately 85% of adults were retained in treatment at 12 months, and of the 40% of patients who received viral load testing 91% had a viral load that was suppressed at <1,000 copies/ ml[6].

However, Cambodia's Strategic Plan also identified important remaining challenges: the need to sustain structures, capacities, and services dedicated to HIV and STI, and the early diagnosis and treatment of TB/HIV co-infection; better access to services by vulnerable and KPs in a supportive legal and policy environment; stronger follow-up along the cascade; sharper epidemiological targeting and more effective interventions; and greater synergy within the health sector, and across other sectors.

The behavioral surveillance survey (BSS) conducted in 2013 reported that 68% of entertainment workers and 87% of MSM had undertaken an HIV test. The most recent data for PWID was the 2007 BSS in which 35.3% of PWID reported having had an HIV test. Such data suggest that there are still gaps in the continuum of response cascade. In addition, gaps in strategic information are a critical challenge, including: incidence estimates based on modeling, non-standardized methods for mapping and key population size estimations, infrequent data collection for KPs, lack of epidemic and response profiles, and inability to monitor linkages and the treatment cascade due to lack of unique identifier system. Addressing such challenges will

[4] Translating into a national prevalence of 0.7%.

[5] Data differs from that included in the table below as different sources are used. This information is from AEM modeling, where the table below includes programmatic data from NCHADS.

[6] NCHADS, 2012-2013

be critical for Cambodia to achieve an AIDS-free generation by 2020 as well as a sustainable national response.

Cambodia is currently a low-income country with a per capita GNI of $950[7]. It is rapidly approaching lower-middle income status with an economic growth forecast of 7.5% for 2015[8]. Government expenditures on health as a share of total government expenditures were 6.5% in 2012. Out-of-pocket expenditures are high at over 60% of all health expenditures. Additionally, spending on pharmaceuticals accounts for 40% of total health expenditures, double the spending on salaries and other staff costs[9]. These trends in health spending need to begin changing as donor resources decline.

Table 1.1.1: Key National Demographic and Epidemiological Data

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				*Source, Year*
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	14,676,591	100	2,274,245	15.5	2,143,730	14.6	5,280,838	36.0	4,977,778	33.9	Inter-censal survey 2013
Prevalence (%)		0.67		NA		NA		0.70		0.65	AEM, 2014 SPECTRUM 2014
AIDS Deaths (per year)	2,783		<30		<30		1,221		1,562		AEM, 2014 SPECTRUM 2014
PLHIV	70,456		2,500		2,500		37,099		33,356		AEM, 2014
Incidence Rate (Yr)		0.01		NA		NA		NA		NA	2013, UNAIDS 2014 GAP Report
New Infections (Yr)	694										AEM, 2014
Annual births	389,948	-									WPP, 2014
% >= 1 ANC visit	-	95%	-	-			-	-			HMIS, 2013
Pregnant women needing ARVs	707	-									PMTCT, 2014
Orphans (maternal, paternal, double)	23,855		NA		NA		NA		NA		2014, NCHADS HIV estimation report 2012
TB cases (Yr)	61,000		NA		NA		NA		NA		WHO, 2013
TB/HIV Co-infection	2,700	4.3%	NA	NA	NA	NA	NA	NA	NA	NA	HIV+ incid TB cases, HIV prev in incid TB WHO 2013
Males Circumcised	NA	NA			NA	NA			NA	NA	NA
Key Populations	-	-	-	-	-	-	-	-	-	-	-
Total MSM*	20,200	-									AEM, 2014
MSM HIV Prevalence	-	2.1									Bros Khmer 2010
Total FEW	34,422	-									AEM, 2014
FEW HIV Prevalence	-	2.6									2011 SSS

[7] World Bank, 2013
[8] World Bank
[9] National Health Accounts, 2013

Total PWID	1,355	-									AEM, 2014
PWID HIV Prevalence	-	24.1									2012 IBBS
Priority Pop Transgender	3,079	-	-	-	-	-	-	-	-	-	AEM, 2014
Priority Pop Prevalence Transgender	-	4.1	-	-	-	-	-	-	-	-	2012 IBBS

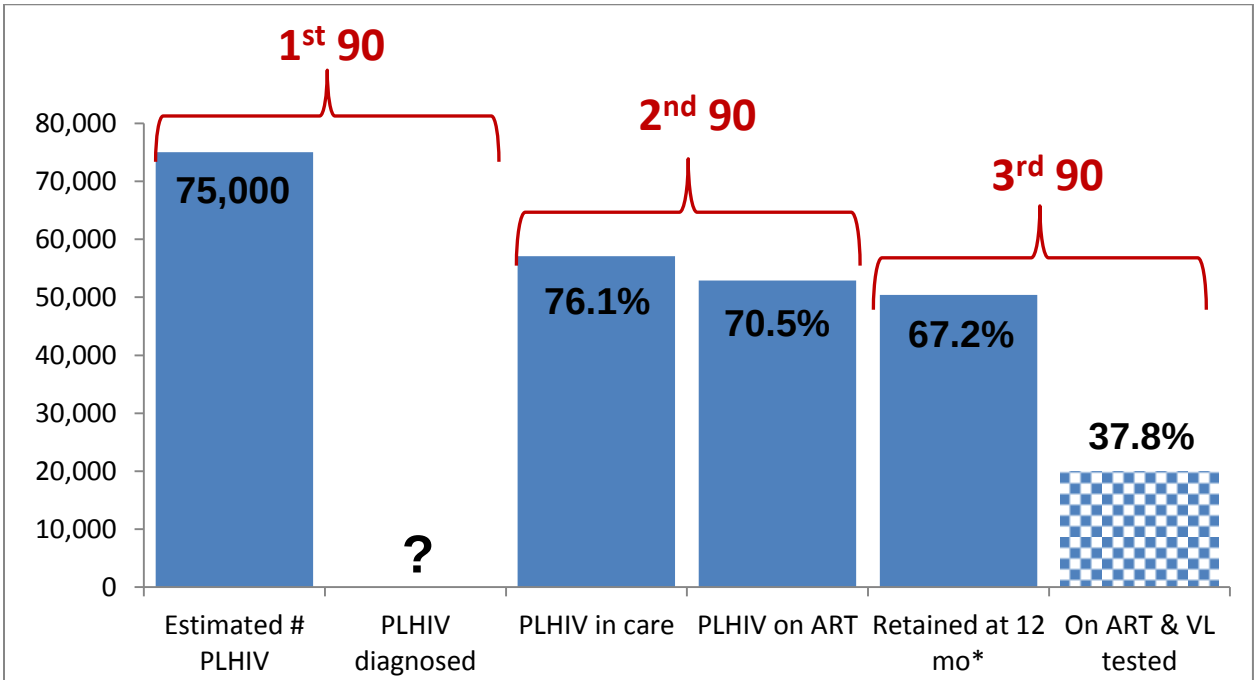
*Total MSM if calculated as 2.5% of adult male population 15 – 49 years old = 102,628

Table 1.1.2: Cascade of HIV diagnosis, care and treatment (12 months)

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	14,676,591	0.67	70,456	55,468	50,659	49,997	91%	582,145	5,277	4,187
Population less than 15 years	4,417,975	0.14	6,229	4,896	4,052	3,998	82%	7,194	325	323
Pregnant Women	389,948*	0.1%	662	666	607	-	-	219,936	244	689/433
MSM	20,200	*2.1*	*424*	NA	NA	NA	NA	17,361	NA	NA
FEW	34,422	*2.6*	*895*	NA	NA	NA	NA	23,120	NA	NA
PWID	1,355	*24.2*	*328*	NA	NA	NA	NA	NA	NA	NA
Priority Pop Transgender	3,079	*4.1*	*126*	NA	NA	NA	NA	1,525	NA	NA

Orange font if from AEM, 2014 (*italic Bros Khmer 2010 [MSM], 2011 SSS [FEW], 2012 IBBS [PWID, TG]*); Purple font if from M&E Table of Indicators and Targets used for 2020 Strategic Plan, 2014; Green if from NCHADS 2013 annual report; Light green if 2013 ART (http://www.nchads.org/DataMGT/2013%20q4/art.pdf); Retained on ART 12 months = # On ART – (# ART patients lost treatment + # ART patients died); Red if from Community Cascade PPT; Blue font if NCHADS 2013 pre-ART (http://www.nchads.org/DataMGT/2013%20q4/pre_art.pdf). In Care = pre-ART + ART; Black if Viral Load Data Analysis, 2012-2013 (viral suppression denominator is those receiving viral load test). Approximately 22,000 patients, or 40%, received viral load testing; Gray if from WPP, live births used as proxy for number of pregnant women.

Figure 1.1.1.3: National HIV Impact Cascade – Adult & Pediatric, 2014



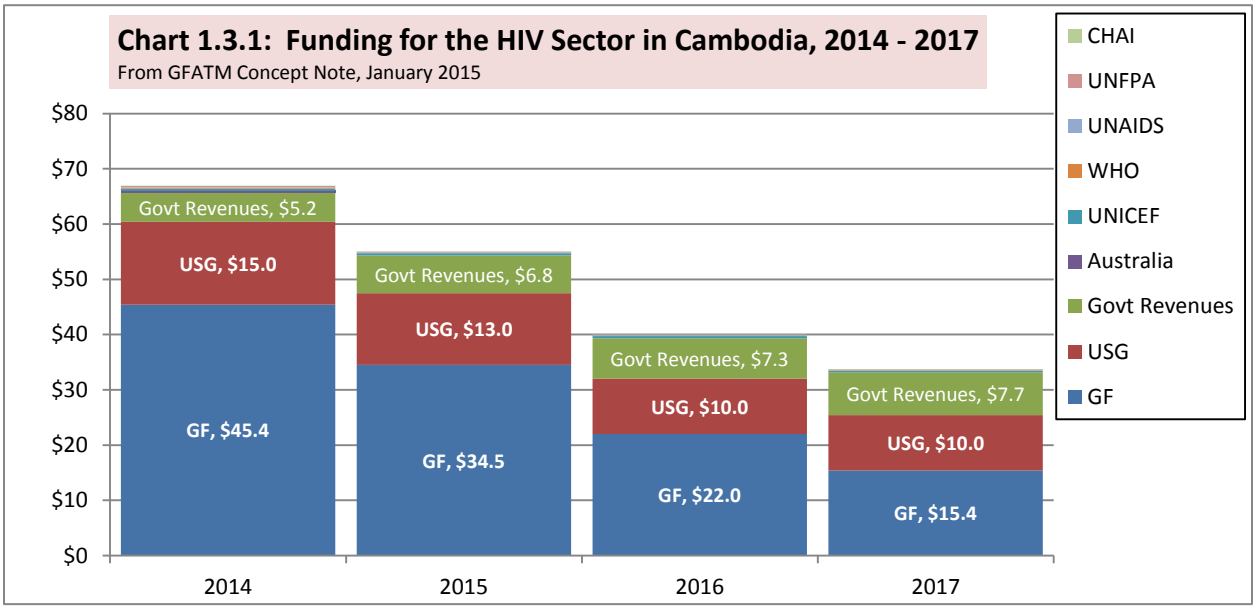
Source: PLHIV in care and on ART from NCHADS.
*Retention defined as new adults minus net gain in ART cohort, 2014

1.2 Investment Profile

The current HIV response in Cambodia is predominantly funded by external resources. The government started addressing HIV immediately in the early 1990s and funded the response. However, with the initiation of GFATM in the early 2000s, the government redirected domestic resources towards other health priorities. The USG has been funding HIV activities in Cambodia since the mid-1990s and came under the PEPFAR umbrella in 2006.

In response to the evolution of the HIV epidemic in Cambodia and to guidance provided by S/GAC, over the past three years PEPFAR has been transitioning out of direct service-delivery activities and focusing on providing TA to the Cambodian government and local non-governmental and civil society partners as they deliver prevention, clinical and non-clinical care, and ART services. The Cambodian government has always led the implementation of clinical care and treatment service, through the Cambodian public-health sector, so PEPFAR works in tandem with the existing local HIV care and treatment service delivery system. Until 2013, PEPFAR supported approximately 90% of the direct service delivery for prevention among key populations. The transition to a technical-assistance platform has required a moderate shift, primarily in prevention activities, to focus on enhancing the impact and reducing the cost of Cambodia's national response to HIV/AIDS.

The USG remains by far the largest bilateral donor to the HIV/AIDS response in Cambodia, while the GFATM is the largest overall donor in the HIV sector on an annual basis, contributing over 40% of the overall resources for HIV (see chart 1.3.1). The national HIV/AIDS program uses GFATM resources to procure all ARV medications, support facility-level service delivery for the majority of individuals on treatment and in pre-ART care, and undertake a portion of the prevention activities related to HIV/AIDS. The PEPFAR program contributes significant assistance to the GFATM program through active engagement in the Country Coordinating Committee (CCC) and the technical working groups, support to develop and evaluate pilot programs prior to national scale-up, and assistance in ongoing monitoring of the national program.



In addition to the U.S. government and the GFATM, other donor organizations active in Cambodia in the HIV sector include WHO, UNICEF, UNFPA, DFAT[10] and CHAI. Together, these organizations account for approximately 2% of the funding for HIV. There are a number of donors that work in HSS, not specific to HIV, including DFAT, the Germans, KOICA[11], JICA[12], and the French. PEPFAR works in various capacities to ensure harmonization with these broader health related efforts.

Table 1.2.1: Investment Profile by Program Area

Table 1.2.1 Investment Profile by Program Area, 2012*

Program Area	Total Expenditure	% PEPFAR	% GFATM	% RGC	% Other
Care & Treatment	$11,046,415	6%	82%	9%	
Prevention	$14,608,119	40%	17%	24%	19%
Enabling Environment	$977,878	17%	13%	1%	69%

[10] The Australian Department of Foreign Affairs and Trade [formerly the Australian Agency for International Development (AusAID)]
[11] Korean International Cooperation Agency
[12] Japanese International Cooperation Agency

Social Protection, excluding OVC	$2,793,789	33%	2%	-	65%
OVC	$3,350,943	21%	17%	-	62%
Training	$1,094,317	27%	39%	-	34%
Program Management & Administration, including SI	$14,556,205	41%	42%	5%	12%
SI	$3,767,103	33%	60%	<1%	6%
Total	$52,194,769	28%	39%	10%	23%

* National AIDS Spending Assessment 2011-2012

Table 1.2.2: Procurement Profile for Key Commodities

Table 1.2.2 Procurement Profile for Key Commodities, 2015*

Commodity Category	Total Expenditure	% PEPFAR	% GFATM	% GRP	% Other
ARVs	$10,614,317	-	87%	13%	-
Rapid test kits	$822,718	-	100%		
Other drugs	$400,000	-	45%	45%	10%
Lab reagents	$1,218,400	8%	92%		
Condoms	$217,000	-	85%	15%	
Other commodities	$833,600		100%		
Total	$14,062,035	0.7%	88%	11%	0.3%

* GFATM Concept Note submission, January 2015

Table 1.2.3: Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$5,500,000	$1,300,000	4	$1,300,000	Improve social protection services; Strengthen interoperability between health information systems; Improve health financing
USAID TB	$5,000,000	$2,225,000	5	$1,440,000	Improve social protection services; Strengthen interoperability between health information systems; Strengthen supply chain systems; Improve health financing
USAID Malaria	$4,500,000	$510,000	1	$140,000	Strengthen supply chain systems
USAID FP	$5,000,000	$1,152,723	5	$1,440,000	Improve social protection services; Strengthen interoperability between health information systems; Strengthen supply chain systems; Improve health financing
Dept of Defense	$3,500,000	N/A	N/A	$250,000	Ensuring a safe blood supply (building 5 regional blood banks)
PEPFAR Central Initiatives					
Key Population					no new funds for this in COP 2015

Challenge Funds					
GFATM CCI	$120,000 (CDC) $441,770 (USAID)	$120,000 (CDC) $441,770 (USAID)	14263 (MOH) 17570 (Supply Chain)	$50,000 (MOH) $140,000 (Supply Chain)	strengthen capacity of CCC and in country mechanisms related to GFATM
SI Central Initiative	$250,000 (CDC) $250,000 (USAID)	$250,000 (CDC) $250,000 (USAID)	14263 (MOH) 14179 (Flagship) 16631 (HIPA)	$10,000 (MOH) $100,000 (Flagship) $30,000 (HIPA)	design, pilot, evaluate and support implementation of a national unique identifier system
Injection Safety PPP	$1,175,000	$175,000	TBD	$185,526	Exact amount from PPP is still being worked out. This is part of the BD PPP on injection safety.
TOTAL		**$6,274,493**		**$2,270,000**	Note: There are 5 USAID HSS mechanisms that receive a combination of PEPFAR, MCH, TB, Malaria, and FP funding.

1.3 National Sustainability Profile

Cambodia has achieved the goal of epidemic control nationally and in the majority of provinces (see Table 4.1.1). Priorities include maintaining epidemic control and strengthening the capacity of the Cambodian government to ensure a high-quality and efficient response. The SID confirms the view that the area's most critical to sustaining the national response include the elements under a domestic program and service delivery, health financing and strategic investments. These areas are critical to the long-term response for Cambodia, especially in light of declining donor funding. To ensure that Cambodia will be able to maintain and afford its own response in light of rapidly declining donor resources, these areas need to be addressed urgently.

For health financing, domestic resource generation and allocation is the highest priority and will require a long-term PEPFAR commitment. No other donor is addressing these issues for HIV. Economic tools have only recently been introduced to the national HIV/AIDS program. In 2014, PEPFAR supported, for the first time, the first costing of the new Strategic Plan 2014 – 2020 and WHO initiated an annual National Health Accounts (NHA) for the Ministry of Health. However, there is an incomplete picture of the costs of routine HIV service delivery or how the services are actually financed (i.e., financed through the hospitals or through the vertical program budget). According to the NHA, Cambodia is only financing 16.3% of its national HIV response and only 30% of the overall health budget is allocated to the sub-national level where the vast majority of health services are provided. Budget and expenditure tracking mechanisms are non-existent at district and hospital levels, and health facility budgets are not rationalized but instead are based on historic trends and negotiations. Over the last five years, the USG has been investing in a social health protection scheme for the poor, Health Equity Funds, which will reach nation-wide coverage by the end of 2015. The scheme is performance-based and the government is already contributing 40% to the pooled fund. The USG is advocating for PLHIV and some KPs to be covered under the HEF as a vulnerable population.

Under domestic programming and service delivery, the largest threat to sustainability is commodity security and supply chain. According to the NHA, about 60% of the health budget goes towards health commodities and drugs and is a source for corruption, according to a 2012 World Bank study. Since 2012, the national HIV program has experienced stock-outs of HIV rapid test kits and lab reagents resulting in poor performance under both PEPFAR and GFATM.

Poor stock management introduces technical inefficiencies for services delivery. Previously, 100% of ARVs were procured with GFATM resources. As a result of budget cuts under the new funding model, the Cambodian government has committed $3.7M over the next three years to ARVs, which represents approximately 10% of the required resources for ART.

1.4 ALIGNMENT OF PEPFAR INVESTMENTS GEOGRAPHICALLY TO DISEASE BURDEN

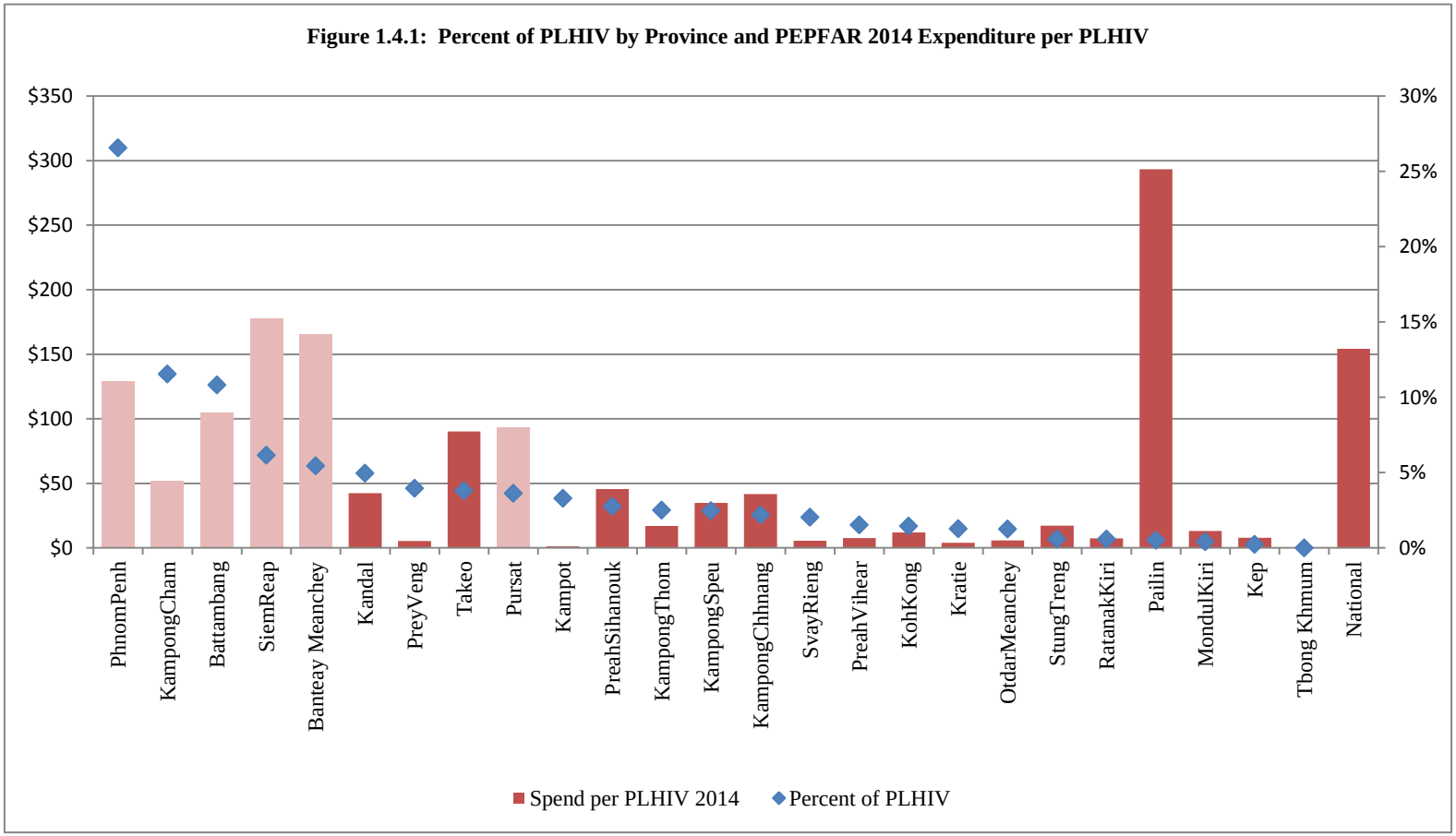
There were several key data points used to analyze the geographic alignment of PEPFAR investments in Cambodia, including 2014 expenditure analysis data by province, estimated numbers of PLHIV, FEWs, MSM and HIV prevalence by province, and outlier and yield data related to site performance.

With respect to 2014 expenditures by province, PEPFAR was already well aligned with the HIV-burden. Of the site-level expenditures, 93% were in the ten provinces considered to account for 80% of the HIV-burden (in terms of numbers of PLHIV) in Cambodia, see Figure 1.4.1. While these ten provinces have large estimated numbers of PLHIV, they have varying estimated levels of HIV prevalence, ranging from 0.07% in Prey Veng to 0.81% in Battambang. Additionally, the provinces also vary widely in terms of estimated numbers of KPs present, ranging from a few hundred FEW and MSM in Kampot to over 25,000 FEW and MSM in Phnom Penh (see maps in Figure 1.4.2). Finally, there were a number of sites within the PEPFAR program with very low numbers of individuals identified as HIV-positive within the past year, but with high related costs due to large number of individuals tested. These sites were scrutinized carefully for discontinuation.

The result of the analysis is that PEPFAR will focus efforts in six provinces: Banteay Meanchey, Battambang, Kampong Cham, Phnom Penh, Pursat, and Siem Reap (see Table 4.1.1(b)). These provinces are in the ten high-burden provinces in terms of PLHIV, and also include significant populations of key populations. Within these six provinces, four also have low coverage for both care and treatment of estimated PLHIV – between 40 and 72 percent estimated treatment coverage. Therefore, they are important locations for continued focus to support the achievement of the 90-90-90 goal.

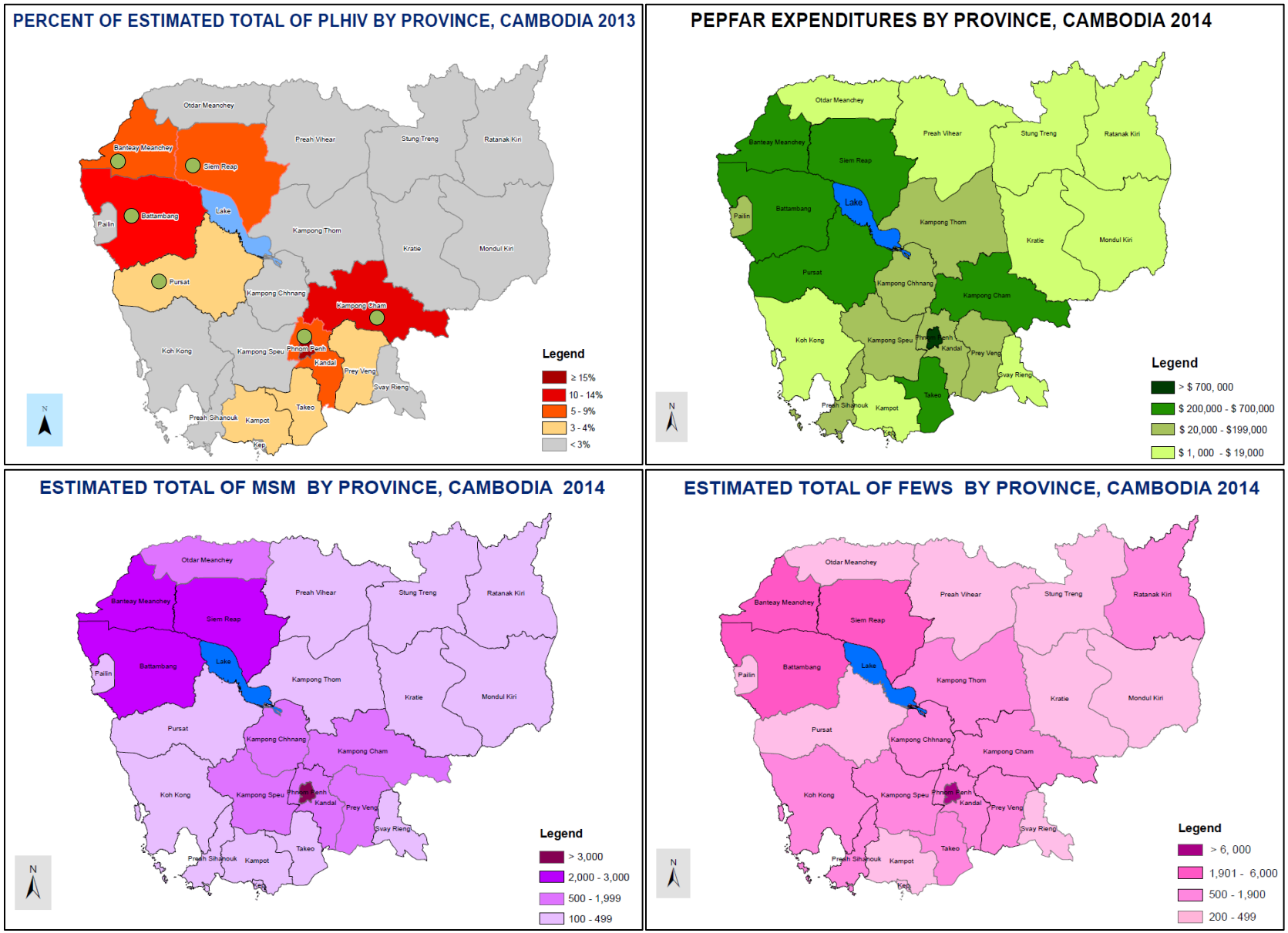
Over the next 12-24 months, PEPFAR will phase out support from six provinces where we have previously worked. These provinces are either outside of the ten high-burden provinces for PLHIV, have low estimated HIV prevalence and low numbers of KPs, or have high coverage of care and treatment. In addition, all of these provinces had low yield or high cost sites.

Figure 1.4.1: Percent of PLHIV by Sub-National Unit and PEPFAR 2014 Expenditure per PLHIV



Percent of PLHIV by province was estimated. The estimate used an average of PMTCT and ANC SS positivity, applied this to the adult population in each province from the 2013 Inter-Censal Population Survey to get ANC/PMTCT HIV-positive figures and added the number of high-risk group HIV-positive figures to it to come up with a total # PLHIV. If there are more people on ART in that province than the estimated number, the number currently on ART was used.

Figure 1.4.2: Estimated PLHIV by Province, Estimated MARPs by Province, and PEPFAR Expenditure by Province for 2014



1.5 STAKEHOLDER ENGAGEMENT

During COP 2015 planning, PEPFAR engaged with the host country government, GFATM, other health donors, civil society and the private sector through existing coordination structures such as the Country Coordinating Committee (CCC) and sub-TWGs on HIV prevention, care and treatment. Since COP development coincided with the development of the GFATM concept note, the PEPFAR team engaged with all relevant stakeholders throughout this intensive process to ensure that COP 2015 activities were aligned with the GFATM and other donors' programs. Separate COP 2015 stakeholder meetings were not held because the use of existing coordination mechanisms allowed for more cohesive, integrated HIV program planning for the country. The PEPFAR team will remain highly engaged in the CCC and other coordination mechanisms over the coming cycle to ensure that stakeholders are engaged in COP 2015 implementation.

During SID development, NCHADS and other partners were faced with competing priorities to meet GFATM deadlines and address an unexpected HIV outbreak in Battambang. Rather than overburden our stakeholders, the PEPFAR team drafted the SID before presenting the results to NCHADS and the health development partners. The SID was well-received by both NCHADS and other donors. This discussion laid the groundwork for future discussions about PEPFAR's transition as Cambodia closes in on its AIDS-free generation objective. In the next few months, the PEPFAR team will engage stakeholders to develop a plan to guide PEPFAR's role in virtual HIV elimination and eventual transition from Cambodia over the next decade.

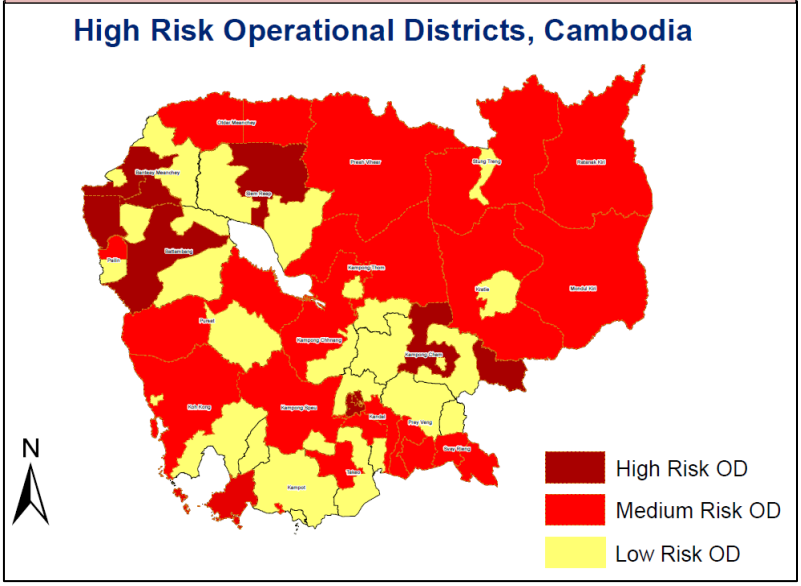
2.0 CORE, NEAR-CORE AND NON-CORE ACTIVITIES

PEPFAR reviewed current activities during a strategic retreat in February 2015. The team also discussed programmatic gaps that may hinder Cambodia from achieving an AIDS-free generation, along with the PEPFAR goals of epidemic control, 90-90-90 and a sustainable HIV response. All activities were then categorized as core, near-core and non-core. The team used a decision tree for categorization (see support document for final decision tree).

The result was a modest shift in focus to ensure that sustainability work was prioritized. These activities will contribute to achieving an AIDS-free generation, increasing epidemic control, increasing Cambodia's ability to achieve the 90-90-90 goals and increasing the sustainability of the HIV response. Near-core was a more difficult categorization as these activities may still contribute toward achieving key HIV outcomes, but may not be within the U.S. government's comparative advantage or have a compelling reason for the U.S. government to continue the work. The near-core activities are anticipated to be either transitioned or completed over the next 24 to 36 months. Near-core activities include several items to ensure programmatic quality as funding is transitioned from PEPFAR to GFATM and as the services are transitioned from NGO partners to the host government. Finally, those activities designated as non-core will be phased out over the coming twelve to eighteen months. There are no plans to fund non-core activities in COP 2015. For a listing of activities that fall into core, near-core and non-core, see Appendix A.

3.0 GEOGRAPHIC AND POPULATION PRIORITIZATION

Figure 3.0.1



PEPFAR has historically been aligned with the 32 priority operational districts identified by NCHADS as having the greatest HIV burden. PEPFAR-supported sites were identified through data analysis and negotiations with NCHADS and the GFATM, the only other major funding mechanism for HIV programs in Cambodia. Technical assistance in prevention, care and treatment had been geographically aligned to enhance the quality of GFATM-supported service delivery sites while PEPFAR maintained few direct service delivery sites to demonstrate and refine service delivery approaches and to scale up best practices to other sites.

At the same time that Cambodia has increased efforts to find every case in order to reach the virtual elimination goal, the available resources for the HIV program has started to decline rapidly. This dichotomy has necessitated refinements in the country's current prevention, care and treatment strategies and further prioritization of geographic locations and populations. NCHADS and its partners are currently refining the *CoPCT* strategy that will also impact the geographic focus of the national program in the near future. In the absence of the revised strategy, the PEPFAR team has analyzed available data to inform priority operational districts (ODs) for COP 2015 geographic focus.

While Cambodia undertook an update to the AIDS Epidemic Model (AEM) exercise in 2014, this did not provide estimates of PLHIV or prevalence at a sub-national unit level. The PEPFAR team undertook to estimate PLHIV by province, using the method outlined in the attached support document. The provinces were then ranked based on the estimated numbers of PLHIV in each province. A comparison of these estimates with the number of people currently on ART reported by NCHADS as of February 5, 2015 showed that 13 (52%) of the 25 provinces in the country have already reached or exceeded 80% coverage of patients on ART. Ten provinces accounted for 80% of all PLHIV cases in the country (see table 4.1.1). The six priority provinces for PEPFAR in COP2015 (see table 3.0.2) account for 66% of all new HIV diagnosis and are within the ten provinces accounting for the highest burden of disease. Two of the provinces, Pursat and Kampong Cham, have the lowest percentage of PLHIV on ART of any of the ten high burden provinces, at 40 and 44%. These two provinces have low numbers of key populations, showing that the drivers of the epidemic here may be different and out outreach and testing strategies need to be adjusted to ensure we are finding the hidden positives.

Within the ten high burden provinces, there are an additional two provinces, Battambang and Banteay Meanchey, that fall below the 80% for PLHIV on ART. Battambang has 51% and Banteay Meanchey has 72%. Both of these provinces also have a high percentage of key

populations within the provinces. The focus of work in these two provinces needs to be across the entire cascade of reach, diagnose, treat and retain.

The provinces of Phnom Penh and Siem Reap are also prioritized for COP 2015, in spite of the fact that both provinces have reach over 80% of PLHIV on ART. There are several reasons for prioritizing work in these provinces. First, Phnom Penh accounted for 34% of all new HIV diagnosis in 2014. Second, these two provinces account for over 50% of all key populations in Cambodia. Third, these two provinces are the major urban centers for the country and continue to attract migrants from other locations, particularly key population migrants who are attracted to the more KP friendly environment found in these locations. Finally, PEPFAR undertakes demonstration projects in these two locations, for MARP friendly services, unique-identifier, community HIV testing and test and treat, which can then be rolled out nationally through NCHADS. In all six of the provinces where PEPFAR will focus in COP 2015, the scaling up of viral load testing (the third 90) will be prioritized.

Within the ten provinces that account for the highest burden of disease in Cambodia, the remaining four (Kandal, Prey Veng, Takao, and Kampot) were not prioritized for a number of reasons. All four provinces have reached over 80% of PLHIV on ART, have high numbers of PLHIV in care and have low percentages of key populations (less than 5% of the KP in any province). Outside of the ten high burden provinces, those provinces that had not reached 80% ART coverage accounted for very few cases, less than 7% of all PLHIV for the country, and were not prioritized for PEPFAR support. The six COP 2015 priority provinces– are already included in PEPFAR's current geographic coverage and accounted for 86.9% of PEPFAR's FY2014 expenditures.

Figure 3.0.2: Clinical Cascade in Six PEPFAR Priority Provinces, 2014

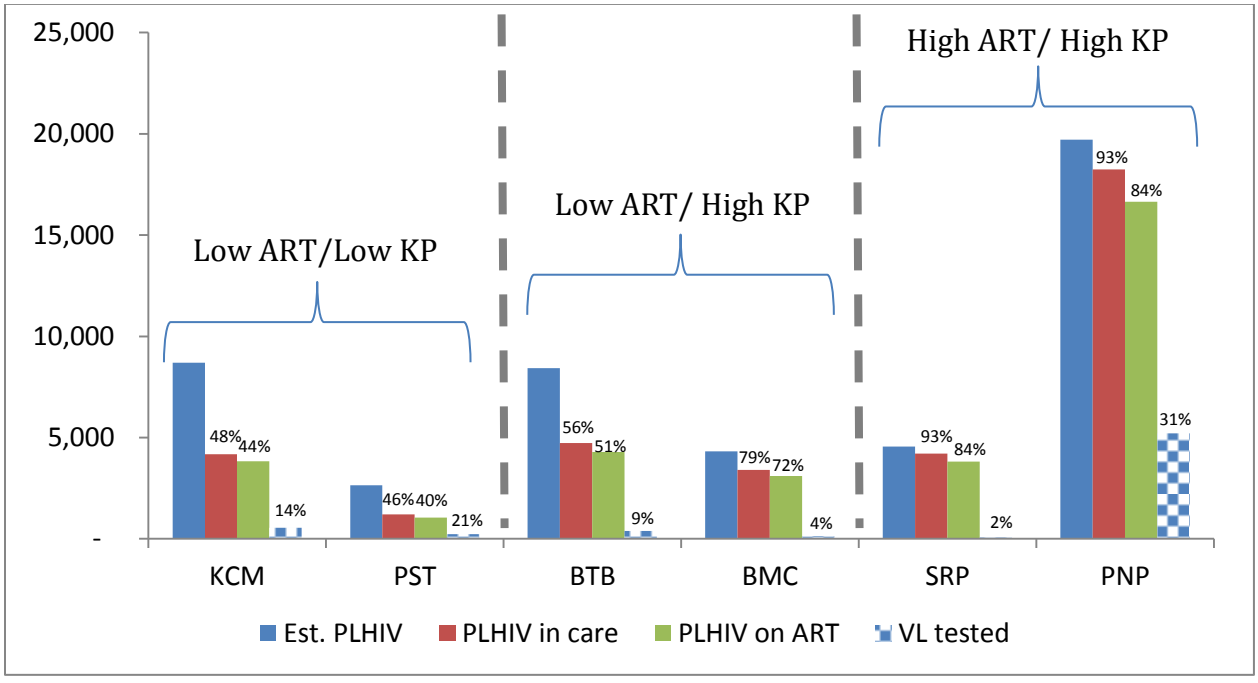


Table 3.0.3: Six PEPFAR Priority Provinces for COP 2015

SNU	PLHIV in province	PLHIV on ART	KP in province	Reach	Diagnose	Treat	Retain
PST	4% (2,652)	**40% (1,049)**	1% (821)	Strategic case finding, CBC pilot evaluation, improve data	ACM , **testing of priority populations** (e.g. TB/STI), partners of PLHIV, quality of services	ACM, quality of services	ACM, expand VL, quality of services
KCM	12% (8,701)	**44% (3,823)**	2% (1,628)	Strategic case finding, improve data	ACM , **testing of priority populations** (e.g., TB/STI), partners of PLHIV, quality of services	ACM, expand VL, quality of services	ACM, expand VL, quality of services
BTB	11% (8,422)	**51% (4,294)**	**10% (6,413)**	whole package, Injection safety	whole package	whole package	whole package
BMC	6% (4,327)	**72% (3,109)**	**7% (4,741)**	whole package	whole package	whole package	whole package
PNP	26% (19,703)	84% (16,643)	**41% (27,563)**	Improve targeted KP prevention	ACM, KP-friendly clinical services	Test & treat (KP), ACM, KP-friendly clinical services	ACM, KP-friendly clinical services
SRP	6% (4,551)	84% (3,810)	**11% (7,220)**	Improve targeted KP prevention (esp. MSM & TG)	ACM, KP-friendly clinical services	Test & treat (KP), ACM, KP-friendly clinical services	ACM, expand VL, KP-friendly clinical services

To further align PEPFAR's investments with high prevalence ODs, individual facility and community sites were analyzed based on:

- location within the six priority provinces;
- yield analysis related to ART, PMTCT, and HTC from FY2014; and
- outlier data related to expenditures.

Based on the analysis, PEPFAR will begin to phase out support to Pailin province over the next 24 months since Pailin has small numbers of KPs, a relatively low estimated prevalence, over 90% treatment coverage, and high cost compared to the average PEPFAR site (see figure 1.4.1). Six community prevention sites will also be phased out of PEPFAR support due to their low yields and location in non-priority provinces. Eleven community sites will be transitioned completely to the GFATM when the SAHACOM project ends in September of 2015. PEPFAR will work with NCHADS to revise its HIV testing strategy by moving away from universal screening toward targeted testing through stratifying individuals within KPs and target only those individuals found to be at higher risk. PEPFAR will work to refocus low yield sites in high prevalence provinces to increase HIV-positives identified. These sites will be reviewed again during the COP2016 process to determine whether yields have increased and if PEPFAR support should be continued.

In terms of population prioritization, there are four key, high-risk populations in Cambodia: FEW, MSM, TG women and PWID. Female entertainment workers (FEW) have been used as a focus for the epidemic modeling and outreach campaigns, due to the increased likelihood of undertaking paid sex work given their work environments. However, the need for improved stratification of those high-risk populations that are at elevated risk of contracting HIV

means an increased focus is on the female sex workers (FSWs) and not all FEWs. Please see Sections 1.0 and 4.2 related to epidemic information and activities of focus.

4.0 PROGRAM ACTIVITIES FOR EPIDEMIC CONTROL IN PRIORITY LOCATIONS AND POPULATIONS

4.1 TARGETS FOR PRIORITY LOCATIONS AND POPULATIONS

Cambodia has already reached virtual epidemic control. PEPFAR activities will focus on achieving the targets of 90-90-90 and virtual elimination of HIV. As noted in section 3.0, PEPFAR will focus on six of Cambodia's 25 provinces. These six focus provinces contain an estimated 64%[13] of Cambodia's PLHIV. Of these six focus provinces, three are estimated to have already achieved over 80% coverage of PLHIV on ART. A major focus will be on increasing case finding, entry into care, and treatment if eligible, especially in the three provinces that have not yet achieved over 80% coverage. In these three provinces, only 130 net new patients were added in 2014. In 2015, PEPFAR targets 758 new patients, with an additional 1,068 in 2016.

In 2017, there will be approximately 67,841 PLHIV[14] in Cambodia according to AEM/SPECTRUM projections. In order to achieve 80% ART coverage of PLHIV nationally, the national program would need to add a net gain of approximately 1,874 patients by 2017 from the 2014 baseline. The national Strategic Plan targets 51,032 adults and 3,339 children (total 54,370) on ART by 2017, which will be over 80% of PLHIV on ART. At the national level, the ART eligibility criteria are expected to increase to at least a CD4 count threshold of 500 cells/mm^3. Nationally, approximately 1,800 PLHIV already in care with a CD4 between 350 and 500 will become eligible for ART, as well as all new PLHIV identified with a CD4 < 500. The new guidelines are expected to be approved in 2015 and rolled out in 2016; therefore, the boost in new patients on ART will likely occur in 2016. In 2015, other boosted enhancements to the national program (such as decentralization of HIV testing, partner notification, tracing and testing, active case management, and focus on KPs with high and overlapping risk) are expected to increase the percent of PLHIV who know their status and are successfully linked into care and treatment.

Please note that Table 4.1.1(a) does not account for the declining number of PLHIV projected from 2014 to 2017. Provincial level estimates included multiple inputs, but were strongly influenced by the provincial level results of the 2010 ANC sentinel survey, which was not sufficiently powered for precise provincial level estimates. PMTCT programmatic data was used to triangulate the ANC survey data, and in some provinces PMTCT positivity was significantly different from the ANC survey data. For example, in Pursat province the estimated PLHIV using the ANC data (1.0% positivity) was 3,045, but only 1,096 using the PMTCT data (0.36% prevalence). Estimated treatment coverage would be either 48% (using the higher PLHIV estimate) or 80% using the lower estimate. A new ANC survey was completed in 2014 and provincial level PLHIV estimates will be revised based on the newest data.

PEPFAR activities will strengthen and improve HIV services in both community and facility platforms. Technical assistance will be provided to the MOH, implementing partners,

[13] 44,750/69,928

[14] 64,427 adults and 3,414 children

and PEPFAR focus sites to build capacity of programs and improve various facets of the clinical cascade and combination prevention, with emphasis on adopting the new treatment eligibility guidelines and improving viral load capabilities. Active case management, linkage and referral systems will also be a focus in 2015/16, especially with regard to KAPs receiving tests and linked to treatment and care services. Only two sites are considered DSD and are located in Phnom Penh. All other sites are TA.

Allocating PEPFAR resources required analysis of EA data combined with yield analysis and geographic priorities to designate needed activities. The ODs where PEPFAR will transition out of it are assumed to have essentially reached saturation with existing activities. Additionally, GFATM and other donors will continue operating in these areas. In 2015 one of PEPFAR's largest partners, SAHACOM Project, has started transitioning most of its community-based care and prevention for KAPs activities to GFATM. As a result of this change, it is expected that targets will drop. The geographic shift is not expected to impact national service delivery numbers since services will continue to be rendered under new funding. Additionally, some of the SAHACOM supported HIV testing sites were considered low-yield.

Data is limited with regard to KAPs in Cambodia. Prevalence estimates are only as far as the provincial level (one SNU). PEPFAR will develop surveillance activities to inform the overall program and map hotspots to better target interventions. This will also include supporting the MOH to develop/improve surveillance systems. PEPFAR will likewise work with the GFATM to ensure their partners are collecting and using data to inform programming.

Table 4.1.1: ART Targets in Priority Sub-national Units for Epidemic Control

Table 4.1.1(a) ART Targets in Priority Sub-national Units for Epidemic Control, National Program

SNU	Estimated Total PLHIV (2016)	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) *TX_CURR*	Newly initiated in FY 16 *TX_NEW*
PhnomPenh	18,234	17,850	N/A*	18,084	234
Battambang	7,794	4,634	1,601	5,162	528
Kampong Cham	5,274	2,756	1,463	3,132	376
SiemReap	4,212	4,021	N/A*	4,165	144
Banteay Meanchey	4,004	3,328	N/A*	3,529	201
Kandal	3,323	2,936	N/A*	3,013	77
Tbong Khmum	2,788	1,510	712	1,654	144
PreyVeng	2,630	2,420	N/A*	2,443	23
Takeo	2,609	2,501	N/A*	2,531	30
Pursat	2,454	1,177	786	1,436	259
Kampot	2,248	2,068	N/A*	2,172	104
PreahSihanouk	1,922	1,882	N/A*	1,892	10
Kampong Thom	1,804	938	505	1,019	80
Kampong Speu	1,726	1,504	N/A*	1,548	43
Kampong Chhnang	1,548	759	N/A*	856	97
SvayRieng	1,386	1,280	N/A*	1,327	47
PreahVihear	1,048	279	560	449	171
KohKong	1,006	870	N/A*	961	91
Kratie	901	459	262	543	84

Otdar Meanchey	864	332	359	469	137
Stung Treng	448	415	N/A*	432	17
RatanakKiri	391	No ART facility as of Dec. 2014			
Pailin	370	350	N/A*	367	0
MondulKiri	278	No ART facility as of Dec. 2014			
Kep	165	35	90	68	33
TOTAL	**69,408**	**54,304**	**6,339**	**57,250**	**2,946**

*N/A: not applicable because ART coverage >80% in 2014.

Table 4.1.1(b) ART Targets in Priority Sub-national Units for Epidemic Control, PEPFAR Program

SNU	Estimated Total PLHIV (2016)	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) *TX_CURR*	Newly initiated in FY 16 *TX_NEW*
PhnomPenh	18,234	1,679	N/A*	1,913	234
Battambang	7,794	4,634	1,601	5,162	528
Kampong Cham	5,274	2,135	1,463	2,416	281
SiemReap	4,212	3,614	N/A*	3,758	144
Banteay Meanchey	4,004	3,328	N/A*	3,529	201
Pursat	2,454	1,177	786	1,436	259
TOTAL	**41,972**	**16,567**	**3,850**	**18,214**	**1,647**

*N/A: not applicable because ART coverage >80% in 2014.
For Pursat, Battambang and Kampong Cham, will reach 1/3 of gap in FY 2016 and 2/3 of gap in FY 2017.

Table 4.1.2: Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16)

Table 4.1.2(a) Entry Streams for Newly Initiating ART Patients (FY 16), National Program

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	N/A	N/A	1,149
TB Patients not on ART	18,135	453	453
Pregnant Women (PMTCT_ARV)	333,832	653	653
FEW	22,298	446	446
MSM	12,240	122	122
TG	1,513	45	45
PWID	311	78	78
TOTAL	**388,329**	**1,797**	**2,946**

Table 4.1.2(b) Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16), PEPFAR Program

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	N/A	N/A	1,115
TB Patients not on ART	2,294	45	45
Pregnant Women (PMTCT_ARV)	32,655	350	350
Key Populations (FSW, MSM, TG, PWID)	27,492	137	137
TOTAL	**62,441**	**532**	**1,647**

Table 4.1.3: Not Applicable.

Table 4.1.4: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	**Population Size Est. in 6 Provinces**	**Population Size Estimate in focus ODs**	**Coverage Goal (in FY16)**	**FY16 Target**
FEW	28,411	25,774	*71.7%*	*18,472*
MSM	16,298	13,153	*71.3%*	*9,375*
TG	2,478	1,973	*83.8%*	*1,654*
PWID	1,199	1,086	*32.2%*	*350*
TOTAL	**48,386**	**41,986**	***71.1%***	***29,851***

Table 4.1.5: Not Applicable.

4.2 Program Area Summary: Priority Population Prevention

Cambodia's HIV epidemic is primarily driven by sexual transmission with the highest prevalence concentrated among four populations: FEW; MSM; TG women; and PWID (see Section 1.0). NCHADS has endorsed standardized packages of HIV prevention services tailored to the unique needs of each of the four key populations. PEPFAR's TA approach is largely dedicated to coaching implementers, financially supported by the GFATM, in delivery of these standardized prevention service packages to the respective key population beneficiaries, and strengthening the effectiveness and quality of these implementers' prevention approaches through demonstration and evaluation of innovative approaches. The limited direct service delivery performed under PEPFAR's prevention program introduces and tests new models for prevention programming with KPs, with an independent assessment process for determining effectiveness.

Given declines in both prevalence and resources for Cambodia's HIV/AIDS response, and recent challenges in identifying new HIV cases, NCHADS has adjusted strategies and guidelines of its 2012 *CoPCT* to better reach hidden and hard-to-reach KPs and maximize impact and efficiency of prevention programming by refining targeting, relevance, and frequency of services. The new sharpened approach stratifies the KPs into different levels of HIV-risk practices and factors, and prioritizes the set of prevention services that each will receive. For example, all TG and PWID are considered to be at the highest level of risk of HIV-infection; therefore, these populations will receive intensified services. Saturation of coverage in the operational districts and hot spots where TG and PWID are found would be part of this approach. In contrast, although FEWs are more numerous KPs in Cambodia, resources are saved by not delivering full packages of prevention and counseling and testing services to the roughly 29,000 women at lower risk. Rather, the sharpened approach would focus delivery of an intensified, streamlined set of prevention services to the estimated 5,000 FSWs having more than 7 clients per week and/or engaged in overlapping risk behaviors, such as drug use. Street-based and freelance FSWs would be prioritized, as would operational districts and entertainment establishments identified as hotspots of higher risk behaviors for this group.

The PEPFAR team considered this new approach together with the 2014 *Cambodia AIDS Epidemic Model* analysis and recent prevention program performance data during the core, near-core and non-core analysis. In the upcoming cycle, PEPFAR proposes to invest in the following interventions to preserve the epidemic control already achieved and to accelerate progress towards virtual elimination of new infections:

- Ongoing outcome analyses will be performed of the effectiveness of the NCHADS sharpened and prioritized approach, with findings used for further refinement of programming to increase identification, reach and retention of unserved KPs.
- Key populations experiencing gender based violence or human rights abuses will be linked to relevant health, legal, and social services providers. Enabling affected KPs to document these episodes to inform policymakers and law enforcement officials will be another component of this work.
- Related to this advocacy and legal work will be PEPFAR advice for completion of the national harm reduction strategy, which complements the GFATM work in PWID harm reduction.
- In connection with PEPFAR's transition strategy, we will advocate for increased overall domestic contribution to the national HIV/AIDS response and will partner with NCHADS and key stakeholders to develop strategies for the long-term sustainability of prevention work.
- PEPFAR will assist NCHADS and implementers to translate data from the upcoming integrated biological and behavioral survey (IBBS) into evidence based, focused, sustainable prevention services for this most numerous key population. One sustainability measure under consideration would shift select services such as family planning, HTC, and STI screening out of prevention outreach and into health facilities. Another potential strategy is use of inexpensive "mHealth" mobile technologies for key population risk screening and strategic behavior communications.
- Planned policy interventions include readying NCHADS leadership to adapt protocols in advance of World Health Organization (WHO) endorsement and issuance of guidelines for test and treat for KPs, with immediate ART initiation in new HIV-positive cases regardless of CD4 count.

4.3 Program Area Summary: Preventing Mother-to-Child Transmission

The Cambodia 3.0 strategy for the virtual elimination of new HIV infections includes the use of lifelong ART regardless of CD4 for pregnant and breastfeeding HIV-infected women as well as a case management approach to following pregnant women and their HIV-exposed infants (HEI) through testing at 6-8 weeks postpartum and prompt initiation of ART if an infant is found infected. The estimated number of new perinatal infections has been below 200 cases per year since 2011, and the most recent mother-to-child transmission rate is estimated to be 7%. While Cambodia is making significant strides towards its goal of virtual elimination of mother-to-child transmission and an AIDS-free generation, challenges remain.

In 2013 NCHADS, with PEPFAR support, began rolling out a new decentralized model for point-of-care HIV testing and counseling (HTC) by fingerpick at the health center level in order to increase access to HIV testing among pregnant women and to reduce cost. Starting with PEPFAR supported sites, HTC trainings were rolled out for almost all of the ANC and maternity staff at health centers and referral hospitals (RHs) nationwide by the end of 2014. Several challenges arose with the new decentralized model. First, stock-outs of HIV test-kits and

supplies occurred due to delays with GFATM procurement, limiting HTC for pregnant women in some locations. PEPFAR is working to address this challenge through work with MOH, NCHADS, GFATM, and other partners to address the procurement and supply chain issues (see Section 6.3 for more details). Second, while initial testing is now offered at over 150 sites, confirmatory testing and entry into care and treatment are offered at 62 sites nationwide, therefore resulting in patients being lost along the cascade-of-service after initially testing positive. To address retention in the continuum of care for pregnant women and infants, PEPFAR assisted NCHADS and the National Maternal Child Health Center (NMCHC) to implement a case management approach for tracking HIV-infected pregnant women and HEI through the entire PMTCT cascade. The new streamlined *Community-Based Prevention, Care and Treatment* (CBPCT) model is expected to promote retention in care and help to recover those noted to be lost-to-follow-up; however, the effectiveness of this new streamlined model needs to be assessed.

PEPFAR will continue to provide TA at the central level with NCHADS on achieving the 90-90-90 targets for all PLHIV, including pregnant women, and maintaining high quality of care by continuing to work with the national program on guidelines development, standard operating procedures, training, monitoring, supervision, and strategic planning. In focus provinces and centers of excellence (COE), PEPFAR supports adult and pediatric treatment as well as PMTCT to initiate and demonstrate the new and innovative activities of Cambodia 3.0. The MOH and NCHADS must scale up and maintain these demonstrated successful and cost-efficient models at other sites nationwide using domestic and other funding sources. Because of the low prevalence (0.4%) of HIV among pregnant women in Cambodia, there are low- and no- yield sites; and PEPFAR will phase out support for one PMTCT site over the next two years. Long-term, PEPFAR is to gradually reduce the number of supported sites. With NCHADS and NMCHC, PEPFAR evaluated the site yield, location, and client characteristics of pregnant women testing positive for HIV in order to determine whether a targeted testing strategy could identify at least 90% of HIV-infected pregnant women. Preliminary results have been shared with the national programs.

HIV/FP integration was identified as a near-core activity for PEPFAR. Since over half of the HIV-infected pregnant women were already known positive, reducing un-intended pregnancy among PLHIV and preventing sexual transmission of HIV among partners, is an important objective for PMTCT and epidemic control. PEPFAR will work with NCHADS and NMCHC to pilot new, low-cost HIV/FP activities (such as on-site provision of FP in ART clinics) and national training materials; however, once established, PEPFAR will transition with this activity to NCHADS and NMCHC. The peer networks at ART treatment sites, working under the CBPCT model are an important component of the education, counseling and assessment for pregnancy and desire for family planning.

4.4 Program Area Summary: Biomedical Prevention

Blood Safety: PEPFAR has been working since 2010 to ensure a safe and adequate blood supply by providing TA to strengthen the Cambodian government's national strategy for blood safety to further build the National Blood Transfusion Center's (NBTC) effectiveness in directing and managing the national blood safety program and in sustaining a competent workforce in hospital laboratories and blood banks. While many of the broad blood safety activities have been categorized as non-core and will be completed or phased-out within the next

12 months, some activities focused on interventions most closely linked to HIV epidemic control and sustaining the progress made through USG investments in blood safety.

Interventions will include: strengthening serology testing through an improved testing algorithm to identify potential donors in the acute phase of HIV-infection to ensure early and accurate detection and reduce transmission through blood transfusion; referral and tracing of blood donors with high-risk status and/or HIV-reactive results to HTC programs for confirmatory testing and, where needed, referral to care and treatment services; assessing and improving quality management systems with the goal of attaining blood service-specific accreditation; training and the development of policies, guidelines and tools for blood donor education, pre-donation behavioral screening and selection; and improving donor counselling and care, including staff trained in transfusion-transmitted infections. Consolidated referral procedures will result in more of the population of known HIV status in treatment. High-risk populations who may not know their HIV status will be identified through the blood donor screening process. In addition to identifying infectious persons in the community, this testing algorithm will improve the safety of the blood supply.

Since both the GFATM and the US DoD have invested significant resources in constructing and equipping five new blood centers, PEPFAR will support a successful move to, and validation of, new NBTC facilities; assistance with strategies for staff management, recruitment, retention, including an adequate number of active MOH staff at NBTC for the new premises; training for equipment in the provincial sites; and forecasting and advocating for sufficient and sustainable supply of testing reagents, with efforts to develop a longer-term strategy through cost recovery and/or MOH support. These activities are near-core and are intended to be short-term.

Injection Safety: The 2014/2015 HIV outbreak in Roka commune, Battambang province highlighted the potential for unsafe medical injections to contribute to HIV-incidence in Cambodia. Since the outbreak was detected in December 2014, more than 243 individuals have been diagnosed with HIV – approximately 10% of those tested. The outbreak, centered among members of a rural community not believed to be at high-risk HIV exposure, has been epidemiologically-linked to unsafe medical injections.

Since over-exposure to medical injections has been documented as a potential HIV-risk factor in three DHS cycles[15], discussions are underway to launch a centrally-funded injection safety project in calendar year 2015. Via the PEPFAR/Becton-Dickinson (BD) public-private partnership (PPP), the intervention will focus on two specific areas of need: training for formal sector healthcare workers in safe injection practices and waste management, and an education/awareness campaign to reduce demand for injections in communities identified as reporting high-prevalence of exposure to medical injections. Under the PPP, medical injection experts will conduct assessments of current injection knowledge, attitudes and practices among licensed healthcare providers and develop a training course to improve safe and rational injection practices. Concurrently, a KAP survey among at-risk communities in provinces identified in DHS 2014 as having high-prevalence of medical injection use will be conducted. Communications strategies will be developed to address risks and misconceptions about medical injections, as well as non-injectable alternatives.

Additional areas of work that will be undertaken include: expansion of the pilot training project described above to additional sites; development of surveillance systems for medical transmission and integration into national system; implementation of methodology to identify

[15] In 2005, 2010 and 2014.

potential clusters, analyze data, and develop cultural acceptable interventions to increase HIV testing in high-risk areas; and development of strategies to pilot community outreach testing in areas identified. Expected outcomes include reduced use of injectable medicines and infusions in the target facilities, increased information-sharing by physicians and pharmacists with patients requesting injections when non-injectable alternatives are available; reduced demand for injectables and increased demand for non-injectable alternatives, reduced HIV incidence among individuals with no sexual or other behavioral risk factors for HIV, reduced bacterial infections and other adverse events associated with injections and infusions; community level behavior change resulting in declining overall and per-person prevalence of medical injections in subsequent DHS; national injection safety policy and regulation, and a national strategy to integrate auto-disable syringes and other injection safety technologies into national healthcare procurement streams, in accordance with WHO guidance.

4.5 Program Area Summary: HIV Testing and Counseling

Cambodia is closing in on achieving UNAIDS' goal of 90% of all people living with HIV knowing their status. The country has increased rates of HIV testing and counseling (HTC) in clinical settings in those ODs with high numbers of HIV-infected persons by making the routine offer of HIV diagnostic services the standard of care, and by introducing community-based rapid-test screening for HIV and syphilis in KPs. Ensuring early diagnosis of HIV and prompt entry into care and treatment are essential, yet challenges remain. The biggest hurdle faced by Cambodia's HTC programming is that fewer new HIV-positive cases are being identified. Having already achieved a high-level of estimated PLHIV identified and in care, Cambodia is now at a point of working towards identifying the most difficult to find cases.

HIV positivity rates among pregnant women tested are below the estimated prevalence captured through surveillance, yet the Cambodian MOH remains committed to universal HIV testing of pregnant women under its Cambodia 3.0 framework, which seeks virtual elimination of maternal to child transmission by 2020. Recently launched PEPFAR-supported mobile technology and risk-screening tools, focused on increasing the positivity rate of KPs tested for HIV, are expected to reduce unwarranted tests and inform NCHADS in adopting risk-screening in ANC settings. To increase detection of HIV-positive spouses/partners of HIV-positive pregnant women, during the upcoming year PEPFAR TA will help jump start the national HIV/AIDS program's new protocol for partner notification, tracing and testing that was finalized last year.

HIV positivity rates among KPs accepting HTC services are also lower than the estimated prevalence in each of those groups as found through recent IBBSs. For example, despite 24.8% positivity in PWID, the HTC caseload of PWID tested through PEPFAR had 3.4% positivity. The reasons for this gap are unclear. It is possible that certain KPs may access HTC on a self-referred basis to avoid discrimination, with their test results categorized as part of the general population. Other hypotheses to be verified include: current outreach approaches covering relatively low-risk KPs; individuals at higher-risk refrain from being tested or are not being reached by existing interventions; and prevalence is declining in KPs.

The national HIV program plans to reduce costs and improve outcomes of HTC services to KPs by focusing efforts on sub-groups at most elevated risk of HIV. Both the GFATM and PEPFAR's HTC approach will align with and support the national program's new approach. This new sharpened and prioritized approach for KPs is described in section 4.2 above.

Forty eight percent of MSM reached in 2014 by community-based rapid HTC services declined to be tested. Lack of privacy, confidentiality, and trust in peer provider testing skills are factors identified in a recent study of barriers experienced by MSM in accessing HIV-related outreach and clinical services. Planned adjustments to program modalities will mitigate these factors through improved privacy and confidentiality in test settings, and enhanced professionalism of HTC providers. A pilot to enhance MSM and TG-friendliness in select clinics run by non-governmental organizations in Phnom Penh with larger concentrations of MSM and TG is anticipated to improve HTC uptake by these groups, particularly hidden MSM of higher socioeconomic status and MSM and TG not connected to existing networks. Another approach will be to refine the frequency, timing and package of HIV services, including HTC, offered to street-based female and male sex workers and PWID to better meet the needs of these exceptionally hard-to-reach groups, as they are currently underserved and very likely to yield new positives.

The need for implementing a quality assurance program at HTC point-of-care testing sites was identified during a 2013 CDC assessment of Cambodia's active case management database that showed 3% discordant results between HIV screening at HTC sites and confirmatory diagnosis at referral laboratories. Another complicating factor is that only individuals screened reactive for HIV are referred for confirmatory testing and counseling. Individuals receiving erroneous negative screening results would have delayed correct diagnosis and potentially could continue transmitting HIV unknowingly. This has serious implications for achieving the goals of virtual elimination of new infections.

Recent SIMS monitoring of select facility and community-based rapid testing sites found that proper quality assurance training and proficiency testing are not being conducted. In response, PEPFAR will address quality assurance at the community level. PEPFAR TA to the national reference laboratory at NCHADS and to the National Institute of Public Health (NIPH) will revitalize their oversight role in proficiency testing and quality assurance at point-of-care testing services within facilities and communities. PEPFAR will work with NCHADS on the development of a national quality assurance program for HIV screening at HTC sites. Twenty high-burden sites will pilot training and implementation of quality assurance measures. NIPH will receive PEPFAR support for developing a proficiency testing (PT) program specific for HTC. NIPH and NCHADS will coordinate TA and retraining where problems are found.

The PEPFAR team used estimated provincial prevalence data and FY2014 site yield analysis to identify selected low yield sites for phase out and to adjust HTC program approaches to ensure a more robust output from the sites prioritized for retention in 2015. Community HTC in three low yield operational districts will be dropped after September 2015, and a total of six operational districts will be phased out over the next implementation cycle. PEPFAR will provide TA at national, sub-national and site levels to contribute to higher uptake of HTC for those individuals found to be at higher risk and HTC yield in the six provinces that will be retained.

4.6 Program Area Summary: Facility and Community-Based Care and Support

By the end of September 2014, 56,516 HIV-positive individuals (including 3,937 children) were diagnosed and enrolled in 62 HIV care and treatment sites across 23 of

Cambodia's 25 provinces, accounting for roughly 75% of all PLHIV[16]. At PEPFAR-supported sites, 15,569 adult patients were on ART. At the community level, PEPFAR supported 36,973 HIV-positive adults and children to receive community and clinic-based services at the end of FY 2014.

As can be seen in Table 1.4.1, the majority of funding for the national HIV/AIDS program's care and support services comes from the GFATM. The national HIV program relies on PEPFAR for to support TA in developing, monitoring, and strengthening program activities. PEPFAR has continued the transition of direct service delivery to the MOH. At the end of FY2015, there will be a planned reduction of 32 direct-service delivery sites for care and supports with the close-out of the SAHACOM project. Those activities are already in the process of being transitioned to the GFATM. There will also be a reduction of six low-yield community HTC sites and twelve low-burden care and treatment sites which will be phased-out in the next 12 months. PEPFAR expenditures will reduce in Takeo and Pailin provinces, which were identified by the expenditure analysis to have relatively high expenditures per PLHIV.

PEPFAR will continue to emphasize TA and capacity building across prevention and care at focus provinces and COEs and with sub-recipients under GFATM. PEPFAR's TA strategy is to assist NCHADS to initiate and demonstrate the new and innovative activities of Cambodia 3. NCHADS is expected to scale up and maintain these demonstrated successful and cost efficient models at other sites nationwide. For quality of service provision, scale up and sustaining of activities, PEPFAR will also support NCHADS, NIPH, and MOH to scale up, monitor and adjust the models.

Key interventions and illustrative activities for COP 2015 include:

- Active Case-Management System: PEPFAR will continue to work with NCHADS, UN agencies, civil society, and PLHIV to improve the counseling and referral process, from diagnosis of HIV-infection to entry into HIV care. PEPFAR will provide TA and training to scale up the active case-management system for tracking newly diagnosed patients, beginning with their initial positive HIV test through confirmatory HIV testing and enrollment in pre-ART and treatment initiation, if eligible. The active case-finding strategy will target partners and children of HIV-positive individuals, including regular partners and children of entertainment workers to identify PLHIV at an earlier stage in the disease. PEPFAR will assist NCHADS in developing standard, simple systems; training healthcare workers; monitoring; and follow-up.
- Maximum adherence, retention and viral suppression: Retaining patients in care will be improved by strengthening the package of services, improving counseling on the need for regular monitoring visits, training and mentoring providers, and ensuring better linkages between facility and community-based services. PEPFAR will also implement unique identifier systems to ensure patients are not lost between facility and community-based services. By the end of 2015, NCHADS is expected to adopt a higher CD4 threshold of 500 cells/mm3 for ART eligibility, and retention is expected to improve, as retention has been higher among patients on ART compared to pre-ART.

PEPFAR is evaluating the previous care and support model for cost effectiveness and advocated for cost efficiencies now included in the CBPCS model. The new CBPCS was developed and is being piloted in PEPFAR-supported sites and will be scaled up with GFATM resources in mid-2015. The new model will use community support volunteers (CSV) to target those PLHIV in critical need of support, particularly those who are newly enrolled in ART, those

[16] 56,516 adults and children (NCHADS quarterly report, quarter 3, 2014)/ 75,000 PLHIV (2013 Spectrum, UNAIDS)

who show poor adherence and are vulnerable to be lost-of-follow up. PEPFAR will continue to strengthen the capacity of the Cambodian Network of People Living with HIV (CPN+) at the provincial and community levels to strengthen care and support services and sustain relevant services after donor support phases out.

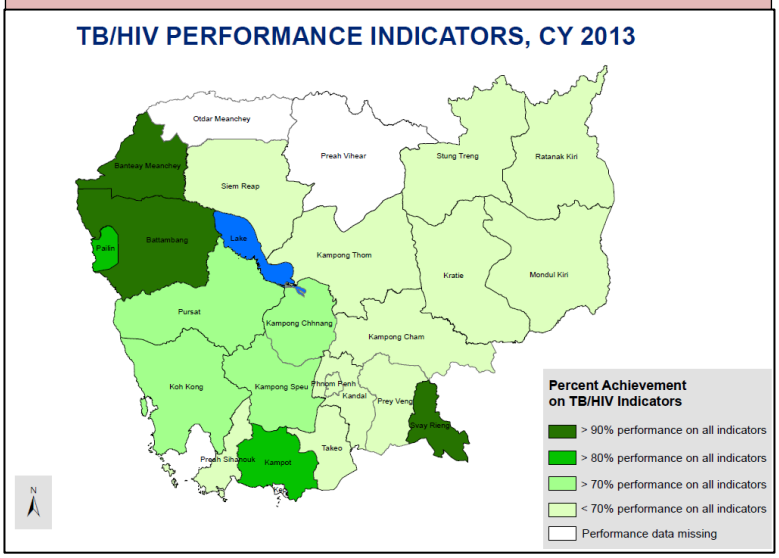
PEPFAR will also continue to strengthen implementation of the CoC and LR for PLHIV, particularly in areas related to: community-based care and linkage of PLHIV to pre-ART/ART services; support CSV on active case management; positive prevention and support to sero-discordant couples; FP/TB integration, referrals and strengthening of referral networks; and linkage of pregnant PLHIV to PMTCT/ANC and safe delivery.

For greater local ownership and sustainability of community care and support, PEPFAR will work with the NCHADS to integrate community-based care into the existing primary health care system through the Village Health Support Group system. In addition, PEPFAR will advocate for Health Centre Management Committees to integrate community-based HIV care services into the Commune Investment Plan and Commune Development Plan.

4.7 PROGRAM AREA SUMMARY: TB/HIV

Despite recent declines in TB prevalence, Cambodia remains one of the world's 22 high-burden TB countries with a prevalence of 764/100,000 in 2012, and HIV prevalence among TB patients was estimated to be 3.8% in 2012. The Cambodian national "Three I's" SOP objectives align closely with the 2011 WHO Intensified Case Finding (ICF)/ Isoniazid Preventive Therapy (IPT) guidelines. In 2012 with PEPFAR support, the national TB program (CENAT) established algorithms for TB testing of PLHIV with presumptive TB using Xpert® MTB/Rif testing as the initial diagnostic test and helped the national program to evaluate uptake of Xpert testing. Also, as mentioned in the HTC narrative, NCHADS decentralized HIV screening to the health center level in 2013 to provide greater access to point of care HTC for TB patients.

Figure 4.7.1



Nationally, Cambodia has achieved high performance on most TB/HIV performance indicators: in 2013, 83% of TB patients had known HIV status; 81% of PLHIV in care were screened for TB; 44% of eligible, newly-enrolled PLHIV were given IPT; and 90% of TB/HIV co-infected patients were given cotrimoxazole (CTX). PEPFAR TA supported sites have achieved high performance on TB/HIV performance indicators, however, some provinces were noted to have relatively poor performance. For example, in Phnom Penh (which contains 33% of all PLHIV on treatment), only 17% of eligible new PLHIV in care received IPT in 2013. Using lessons learned in the PEPFAR focus provinces, PEPFAR will support TB/HIV collaborative activities at the central level by providing TA to NCHADS and CENAT to monitor and supervise ICF and IPT

provision in the provinces with the highest number of PLHIV in care and lowest performance on TB/HIV indicators. Although the GFATM will fund additional Gene-Xpert machines and cartridges, one identified weakness for expansion of TB diagnosis with Xpert® MTB/ Rif testing is that the Gene-Xpert machines are not routinely calibrated or are not operational. PEPFAR will assist CENAT to maintain and fix these machines with transition to domestic funding within five years. To address a noted weakness in the TB/HIV monitoring systems, PEPFAR will help to track TB/HIV co-infected patients using an active case management approach to ensure that all co-infected patient are getting prompt TB treatment, ART and CTX prophylaxis. TB infection control (IC), while important, was deemed as a non-core activity for HIV epidemic control or achievement of the 90-90-90 targets. In 2013/14 PEPFAR assisted CENAT to write TB IC SOPs, assessment tools, and training curriculum; however, on-going support for TB IC activities will be transferred to domestic and USAID TB funding within two years.

During SIMS assessments, the lack of standard TB screening and documentation for HIV-infected children less than 15 years old in care was noted as a consistent finding. In 2015, PEPFAR will join the Pediatric HIV Technical Working Group to update the HIV care guidelines for children to include an agreed algorithm for TB screening and standard monitoring/ reporting tools for documentation of the TB screening.

4.8 Program Area Summary: Adult Treatment

Cambodia achieved HIV epidemic control in the early 2000s, and is estimated nationally to have 82% of eligible[17] PLHIV on ART. At the sub-national unit (SNU) level, half of Cambodia's 25 provinces have achieved over 85% ART coverage of all estimated adult PLHIV within the province. PEPFAR supports adult treatment sites in six of the ten provinces containing over 80% of all PLHIV.

Cambodia 3.0 includes the use of treatment as prevention (TasP) for sero-discordant couples and the provision of ART regardless of CD4 for some categories of PLHIV (including HIV-infected pregnant women, TB/HIV co-infected patients, and PLHIV with hepatitis B and chronic liver disease). The boosted adult treatment strategy contained some of the recommendation of the 2013 WHO consolidated treatment guidelines[18] but did not contain all of the treatment recommendations, such as expanded eligibility for ART at CD4 threshold of $\leq$ 500 cells/ mm^3. This deficiency led to a low score on the SID for "Quality Management" and will be addressed in 2015.

In 2015, PEPFAR will support NCHADS to update the national adult care and treatment guidelines to bring them in line with the newest WHO and international recommendations. Specifically, PEPFAR will fund an international consultant to work with NCHADS and the Adult Treatment TWG, which includes several PEPFAR members, to review recommended changes to the national treatment guidelines in line with the 2013 WHO consolidated guidelines. In 2014, PEPFAR contributed to the *Cambodia AEM* impact modeling and analysis to update the estimated number of adult PLHIV and to project cost based on several treatment scenarios[19] and to model the likely impact on numbers infected and numbers on treatment along with resource needs. Using the AEM projections and treatment scenarios, the national program will be able to make informed decisions on treatment eligibility scale-up. If the universal test and treatment

[17] CD4 count of 350 cells/ mm^3 is current national ART treatment eligibility guidelines.
[18] For example, adoption of once daily tenofovir-based first-line regimens.
[19] Including, ART at 500 CD4 threshold and ART regardless of CD4 level.

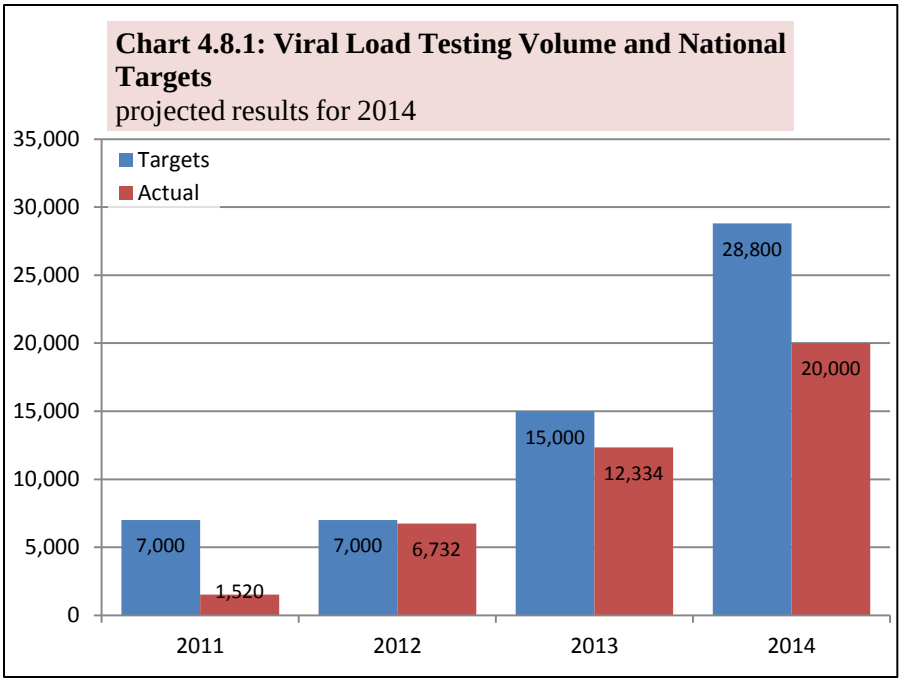
option is chosen, there will be an initial increase cost, but long-term reduction in the number of PLHIV and future cost.

PEPFAR made strategic decisions on the adult treatment program related to the number of PLHIV already in care and provincial-level per capita expenditure. In general, PEPFAR's provincial expenditures for adult treatment align well with the provincial estimates of percentage of PLHIV, and PEPFAR will continue to focus its TA in high-burden provinces that have not yet reached an estimated 90% of PLHIV in care (such as Battambang, Pursat, and Kampong Cham). PEPFAR will phase out of the province with relatively high expenditure per PLHIV on treatment and low number of PLHIV and low estimated prevalence (Pailin province) gradually transitioning financial support to the national program and GFATM. PEPFAR's TA model will pilot the "boosted" initiatives with MOH to set up and evaluate successful, low-cost models in COE and focus provinces. The training and implementation costs will be scaled-up with domestic and other donor resources, primarily the GFATM. Long-term, PEPFAR is beginning a process of gradual reduction in the number of supported sites. Multiple COEs and focus province sites are not necessary to achieve our PEPFAR strategy, which is to assist NCHADS to initiate and demonstrate the new and innovative activities of Cambodia 3.0 and enhance the quality of service provision. The MOH and NCHADS must scale-up and maintain these demonstrated successful and cost-efficient models at other sites nationwide. Although low volume ART sites in peripheral locations provide easier access to treatment for patients, PEPFAR will rely primarily on NCHADS and GFATM to sustain these sites.

PEPFAR will continue to support two DSD sites that are NGO managed facilities in the capital city specifically targeting KPs for diagnosis, care and treatment. Lessons learned from these sites (such as user-friendly services and a snowball method for recruitment of high-risk FSW and MSM) are expected to be transferred to NCHADS sites, where the majority of KPs seek treatment.

Also, PEPFAR's TA model will continue to work at the central level with NCHADS on achieving the 90-90-90 targets nationally and maintaining high quality of care by continue to work with the national program on guidelines development, SOPa, training, monitoring, and strategy planning. To continue progress on achieving 90% of PLHIV diagnosed and on ART, PEPFAR will continue to support the active case management approach (described in the HTC and Care narratives); partner notification, tracing, and testing; and expanded ART eligibility criteria mentioned above. With PEPFAR support, viral load (VL) testing launched in the public sector in 2011 and has since scaled up to

Chart 4.8.1: Viral Load Testing Volume and National Targets
projected results for 2014



approximately 2,000 tests/month, the maximum volume of the one Abbott m2000 machine at NCHADS (see Chart 4.8.1). In order to provide one annual VL test per PLHIV on treatment, a second machine was deployed in 2015 using GFATM resources and PEPFAR TA. In 2015, PEPFAR will work with NCHADS and other partners (UNICEF and CHAI) to improve and scale up transportation of VL, CD4, and infant polymerase chain reaction (PCR) specimens using a transport company, which is expected to be more efficient and less costly than the current ad hoc specimen transportation arrangements. This national specimen transportation system will address a consistent finding from the SIMS visits that transportation of specimens is a barrier to improved virologic testing of patients on ART. In addition, PEPFAR will work with NCHADS on prompt return of results to the sites by electronic transmission and entry into the clinical care databases. PEPFAR will also continue to provide TA to NCHADS on viral resistance testing for those who have documented treatment failure and clinical interpretation of the findings for second (and third) line regimen switches. In addition, the new CBPCS model is expected to enhance education for ART adherence and retention in care to maintain viral suppression among PLHIV on ART; however, the effectiveness of this new streamlined model will need to be assessed.

For maintaining quality of care and treatment, PEPFAR will continue to work at the national level and at COEs and focus province sites on continuous quality assurance (CQI) and clinical mentoring. The clinical mentoring uses CQI and other site performance indicators to target sites with a composite low performance score. The low performance sites (10 sites of 62 total) are paired with an experienced mentor who uses a standard tool (with some of the SIMS elements) to assess the weaknesses of the sites and set up an individualized site improvement plan. The site is then reassessed every six months for improvement and, if successful, graduates. National and provincial treatment program supervisors are invited to join the SIMS visits. So far, all of the assessed sites have a low percentage of red or yellow scores and none have required re-evaluation. Commodity shortages have been noted during SIMS visits for HIV testing supplies and lab reagents, but not for ARVs. In the SID, commodity security and supply chain are noted to be areas of weakness, and PEPFAR has identified this as a new program area of focus.

4.9 Program Area Summary: Pediatric Treatment

Cambodia is estimated to have approximately 83% of eligible HIV-positive children on ART and 79% of all estimated pediatric HIV-positive children (< 15 years old) on treatment by the end of 2014. Approximately half of all children on ART receive treatment within Phnom Penh and two provinces (Siem Reap and Battambang). PEPFAR supports pediatric treatment sites in five provinces, including the two highest burden provinces. Given the small number of pediatric HIV cases (estimated at 5,000) and concentration of pediatric cases in 32 treatment sites, specific pediatric SNU level estimates are difficult; therefore, the adult PLHIV proportion per province will be used as a proxy. Having already achieved epidemic control in the early 2000s, Cambodia's goal is the virtual elimination of new infections, in line with PEPFAR's AIDS-Free Generation goal. In 2013, there were less than 200 new HIV-infections among children. Given the success of the PMTCT program in reducing new perinatal infections (dropping below 200 cases per year since 2011), the cohort of HIV-infected children on ART is aging such that a growing percentage (46% of children <15 by the end of 2014) are age 11-15, and children older than 15 are graduating into adult treatment programs.

The Cambodia 3.0 strategy included the use of lifelong ART regardless of CD4 for pregnant and breastfeeding HIV-infected women as well as a case management approach to following pregnant women and their HIV-exposed infants (HEI) through testing at 6-8 weeks postpartum and prompt initiation of ART if an infant is found infected (see Section 4.3 on PMTCT).

In 2015, PEPFAR will work with NCHADS through the Adult and Pediatric Treatment TWG to optimize pediatric and adolescent treatment guidelines and regimens and bring the Cambodian national treatment guidelines in line with the current WHO consolidated guidelines. Given the large proportion of pediatric HIV cases moving into adolescence, writing specific guidance for adolescent care and treatment services will be an important component of the guidelines update. In SIMS visits, the lack of specific adolescent treatment services has been a noted deficiency at all sites assessed.

PEPFAR reviewed site yield and outlier data from our 2014 Annual Progress Report related to PMTCT and ART. For a discussion of the outcomes from this analysis, see narrative in Section 4.8: Adult Treatment. In addition to the shifts discussed there, PEPFAR will reduce DSD for pediatric HIV treatment by decreasing support to TA level of support for Angkor Hospital for Children. This site is expected to be a provider of TA to the national pediatric treatment TWG and clinical mentoring to low performing sites (described below). All other pediatric treatment sites are currently TA support sites.

PEPFAR will continue to work at the central level with NCHADS on achieving the 90-90-90 targets nationally and maintaining high quality of care by continuing to work with the national program on guidelines development, standard operating procedures, training, monitoring, and strategy development. To continue progress on achieving 90% of pediatric HIV-positive cases diagnosed and on ART, PEPFAR will continue to support the active case management approach (described in the HTC and Care narratives) and prioritize expansion of HIV DNA testing for all HIV-exposed infants and provider initiated testing and counseling in settings such as malnutrition wards; partner notification, tracing, and testing (which contains a component of HIV-testing of children for newly diagnosed PLHIV); and expanded ART eligibility criteria mentioned above. Additional information on viral load testing for all PLHIV, including children and adolescents, can be found in section 4.8 above.

For maintaining quality of care and treatment, PEPFAR will continue to work at the national level and at COEs and focus province sites on clinical mentoring. The clinical mentoring uses site performance indicators to target sites with a composite low performance score. The low performance sites (10 sites of 62 total) are paired with an experienced mentor who uses a standard tool (with some of the SIMS elements) to assess the weaknesses of the sites and set up an individualized site improvement plan. The site is then reassessed every six months for improvement and, if successful, graduates.

National and provincial treatment program supervisors are invited to join the SIMS visits. So far, all of the assessed sites have a low percentage of red or yellow scores and none have required re-evaluation. Commodity shortages have been noted during SIMS visits for HIV testing supplies and lab reagents, but not for ARVs. In the SID, commodity security and supply chain are noted to be areas of weakness, and PEPFAR has identified this as a new program area of focus.

5.0 PROGRAM ACTIVITIES TO SUSTAIN SUPPORT FOR OTHER LOCATIONS AND POPULATIONS

5.1 PACKAGE TO SUSTAIN SERVICES IN OTHER LOCATIONS AND POPULATIONS

As a result of yield analysis, there are five provinces will PEPFAR will be phasing out support. In four of these provinces, the support has only been for community HTC. In one province, the support has been for facility HTC, ART, PMTCT and community HTC. All of these locations have falling within the TA category, rather than the provision of direct service delivery. Therefore, PEPFAR has not been supporting procurement of ARVs, other drugs, or test kits, and has not provided funding staff salaries in any of these facilities. Discussions with NCHADS have indicated that facility based services will continue at these locations and PEPFAR does not need to provide any package to sustain services.

Table 5.1.1: Not Applicable

5.2 TRANSITION PLANS FOR REDIRECTING PEPFAR SUPPORT TO PRIORITY LOCATIONS AND POPULATIONS

Over the 12 to 18 months, PEPFAR support will phase out of non-health related services for PLHIV, broad based support for blood safety not specifically linked to HIV, and condom social marketing. Discussions have taken place with the government related to this shift and will continue as specific details are worked through.

6.0 PROGRAM SUPPORT NECESSARY TO ACHIEVE SUSTAINED EPIDEMIC CONTROL

6.1 LABORATORY STRENGTHENING

A priority of PEPFARs strategy is to support the development of a sustainable public-health laboratory system for HIV. The PEPFAR team performs a critical TA role in the national technical working group for laboratory systems, which has resulted in the development of the National Laboratory Strategic Plan (NLSP) 2015-2020. However, implementation of policies and guidelines outlined in the NLSP might be delayed as the national laboratory system remains weak. Most facilities are in poor condition and lack equipment, supplies, and human capacity to perform basic diagnostic tests. Stock-outs of essential laboratory supplies continue to occur as the procurement of laboratory equipment is not standardized and there is no system to regularly maintain equipment in public health laboratories. The lack of a comprehensive laboratory budget, the use of a push down procurement process which result in inadequate and erroneous delivery of reagents and consumables, and ineffective forecasting are ongoing challenges that contribute to stock-outs. In order to overcome those challenges, Cambodia's MOH, with assistance of PEPFAR, is focusing in laboratory quality management system improvements. Thirteen regional laboratories, along with the laboratories at NCHADS and the National Institute of Public Health (NIPH), are enrolled in the Strengthening Laboratory Management Through Accreditation (SLMTA) program. The National Institute of Public Health (NIPH) and NCHADS will receive additional resources in 2016 in preparation for ISO 15189 accreditation.

Results of site visits are regularly reviewed at national technical review meetings to inform national policies. PEPFAR will coordinate closely with NIPH, NCHADS, the National Blood Transfusion Services, and the Bureau of Medical Laboratory Services (BMLS) to implement laboratory strengthening activities. The most important common issues observed at site improvement monitoring system (SIMS) visits were related to equipment maintenance and procurement of reagents and consumables. The laboratories participating in the SLMTA program all have demonstrated improvements since enrollment and none had >50% red or yellow scores during a SIMS visit.

Another common challenge observed during regular SIMS assessments was lax compliance to biosafety standards and lack of waste management programs. Consistent with CDC and WHO guidelines, the PEPFAR team will support laboratory safety programs and the development of national guidelines. The USG will provide assistance for the development of national guidelines for a biosafety program.

A Laboratory Information Systems (LIS) supporting operations of clinical and public health laboratories that will streamline laboratory data collection, storage, analysis, reporting, and utilization of reagents and consumables in not fully operational yet. A pilot LIS has been introduced at NIPH, but continuous efforts and resources from PEPFAR are necessary for full national implementation.

With assistance from PEPFAR, NCHADS will collaborate with NIPH to maintain an external quality-assurance (EQA) system for CD4 and HIV-1 rapid tests using proficiency testing panels. The PEPFAR team will continue to support hematology and biochemistry testing by monitoring results of EQA programs and providing TA to focus laboratories.

Viral load testing is now available at all ART sites nationally. However, specimen collection and transport system haven't been well-organized, limiting access of viral load testing for ART-enrolled patients. Patient and specimen referral networks will be harmonized to elevate the number of tests and reduce costs. The GFATM has procured a second viral load instrument to be placed at NCHADS to accommodate the national demand of VL testing. ARV drug resistance genotyping has been available for suspected ART failure cases, but not widely implemented. The PEPFAR team will assist NCHADS to scale up HIV drug resistance testing and analysis capacity. Civil-society partners will strengthen treatment adherence counseling in community-based care programs to reduce the need for second-line treatment.

PEPFAR support focuses on improvement of quality laboratory services and includes:

- Training workshops with lectures conducted by US personnel, establishment and training a team of mentors, and regular site visits to supported laboratories for the implementation of laboratory quality management systems.
- Supporting the implementation of policies and guidelines outlined in the NLSP. Assisting the Bureau of Medical Laboratory Services to update the laboratory policy and the national strategic plan for 2015-2020. Providing training to hospital directors to understand and implement those policies and guidelines.
- Mentoring and assisting directors of national public health, provincial, and district level hospitals to prepare and implement activities outlined in the Cambodian Laboratory Strategic Plan.
- Strengthening capacity of the NIPH in its role as the national public health reference laboratory. Objectives of this TA are to improve management and technical systems to strengthen and sustain the national reference laboratory; implement and manage quality-assurance and laboratory-accreditation activities; and strengthen capacity in using laboratory information in public health practice.
- Supporting enrollment of public health laboratories in external quality assessment schemes for HIV, CD4, basic hematology and chemistry, and transfusion transmitted infections.
- Results of external quality control tests and SLMTA assessments will be reviewed by PEPFAR, NIPH, laboratory technical working group and other stakeholders.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support and strengthen capacity and quality of NCHADS for VL testing, HIV diagnosis using rapid tests, CD4 testing, and DNA polymerase chain-reaction testing for EID.	• Implement laboratory quality management systems. • Improve sample referral system and reporting.	• Earn ISO15189 accreditation by an international agency. • Reach 60% of VL testing in ART enrolled patients.	HLAB	HLAB $80,000	16688 (NCHADS)						X

	• Scale up VL testing towards PEPFAR 3.0										
Strengthen quality control systems and information in the public health laboratory system to improve patient care and inform public health policies, strategies, and guidelines.	• Support site visits, participation in EQA programs, and monitor performance of quality indicators. • Scale up implementation of LIS that can be integrated with other health care databases.	• Laboratories systematically achieve targets for quality indicators and fully implement quality management systems. • LIS is implemented and fully functional in 50% of public health laboratories.	HLAB	HLAB $80,000	16683 (NIPH)						
Mentor laboratory directors from provincial and district level hospitals enrolled in SLMTA to assist implementation activities outlined in the Cambodian Laboratory Strategic Plan; 2) and provide technical assistance to NCHADS and National Institute NIPH to develop HIV point-of-care quality control activities and systems to validate HIV diagnostic test kits	• Support implementation of NLSP by providing TA to BMLS staff and training to laboratory directors. • Design and launch a pilot program based on RTQII, to implement quality assurance for POC HIV tests at VCCT and HTC sites.	• Policies and guidelines of NLSP are fully implemented. • RTQII-based quality assurance program is fully implemented in focus provinces.	HLAB	HLAB $80,000	16683 (NIPH)						

6.2 STRATEGIC INFORMATION (SI)

Ensuring the availability of quality data to inform decision-making for Cambodia's HIV program is a core priority for PEPFAR. As part of the assessment of the continuum of service cascade, PEPFAR will focus its core SI activities on:

1. **Technical assistance in conducting and improving surveillance for priority key populations and pregnant women, including monitoring of sero-prevalence and behavioral indicators**. In alignment with their national strategy, NCHADS has planned: Finalization of the IBBS among priority KPs, including pregnant women and MSM, along with conducting new IBBS among entertainment workers and people who inject drugs. The direct financial support for these surveys will come from the GFATM.

2. **Technical assistance in conducting size estimation and GIS mapping of key affected populations**: FEW, MSM, TG, PWID and drug users. PEPFAR TA to NCHADS is to ensure method of size estimation is appropriate for each key affected population and support related work on the protocols (e.g., capture and recapture for MSM).

3. **Technical assistance for improving data availability, quality and use to improve the continuum of prevention, care and treatment and evidence-based program planning.** PEPFAR TA will support NCHADS to move to a comprehensive case

reporting system. Work will initially begin with NCHADS and community partners to collect detailed information (e.g., name, sex, age, residence, and modes of transmission) from VCCT, active case management, and partner notification tracing and testing programs, in order to reduce the de-duplication of clients who test HIV-positive multiple times, and allow for tracking of newly diagnosed HIV-infected patients into pre-ART services. HIV case reporting will also be strengthened through inclusion of CD4 count, HIV diagnosis and notification of death. PEPFAR TA will be used to assist NCHADS and partners to use this information for CQI at the facility, local, and national levels.

4. **Technical assistance in developing and implementing the national unique identifier system.** Currently National Maternal and Child Health Center data has been included into the health management information system (HMIS). PEPFAR TA will support the Department of Planning and Health Information of MOH and NCHADS to also integrate the current HIV database into the Patient Management Registration System (PMRS), which is a part of the MOH HMIS.

5. **Technical assistance in conducting key studies on the NCHADS research agenda**. PEPFAR TA will be used to support key studies on the NCHADS research agenda developed by the Strategic Information Technical Working Group. Through participation in the SI TWG, PEPFAR staff will also support the review and updating of the national research agenda.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Surveillance studies											
STI, BSS, HSS, IBBS – financial support of these activities were budgeted under the Concept Note of the new funding model of GFATM, expecting to get the award around July 2015 and will last until 2017. PEPFAR team will pay a major role in providing TA to the National HIV Program to conduct these surveillance studies based on its individual schedule.	• Completed IBBS among MSM and ANC	• Conducted IBBS among PWID/PWUD and EW	HVSI $10,000	HVSI $4,000	NCHADS Coag	1.3 – Epi and health data, 1.5 – Key population 10- Allocative Efficiency 13.3.Opportunities for Civil Society Engagement 15.2- Planning and coordination	X	X		X	
Site estimation and mapping of key affected population											
Size estimation and mapping - With WHO, UNAIDS and relevant partners, PEPFAR will provide technical support to conduct and use size estimations and mapping of high-risk groups (FEW, MSM, TG, IDU and DU) to better target prevention and HTC interventions.	• Annual size estimation and mapping of FEW, MSM, TG, IDU and DU conducted annually	• Annual size estimation and mapping of FEW, MSM, TG, IDU and DU conducted annually	HVSI $180,000	HVSI $672,000	NCHADS Coag and Flagship	1.5 – Key population 10- Allocative Efficiency 13.3.Opportunities for Civil Society Engagement 15.2- Planning and	X	X		X	

						coordination					
Improve data availability, quality and use to improve the continuum of cascade services											
1. HIV Case report system – PEPFAR will provide technical and financial support to NCHADS to update the patient record to include counselling and testing data as well as care	• A comprehensive HIV case report has been revised and used	• A comprehensive HIV case report has been revised and used	HVCT& HTXS $5,000	HVCT& HTXS $30,000	NCHADS Coag	3-Performance data 10.1. Allocative Efficiency	X	X	X	X	X
2. Active Case Management – PEPFAR will join financial support with GFATM and provide technical support to NCHADS to roll out Active Case Management CMCA/ ACM/ HIV case reporting/ linkages to care and treatment; Partner Notification Tracing Testing and targeted PITC for high HIV risk groups. These activities will expand the coverage to at least the high-risk operational districts.	• 2/3 of NCHADS priority ODs have ACM	• All 32 NCHADS priority ODs have ACM	HVSI & HTXS $5,000	HVSI & HTXS $10,000	NCHADS Coag and Flagship	3-Performance data 10- Allocative Efficiency 15.2- Planning and coordination	X	X	X	X	
3. Continue Quality Improvement (CQI) - PEPFAR will work with UNAIDS and WHO to continue technical and financial support to NCHADS to expand CQI program of adult and children.	• Data of adult and children from 38 ART sites collected, interpreted and used.	• Data of adult and children from 45 ART sites collected, interpreted and used.	HVSI & HTXS $50,000	HVSI & HTXS $54,000	NCHADS Coag	3-Performance data 10- Allocative Efficiency 15.2- Planning and coordination			X		X
4.Community strengthening - PEPFAR will continue to provide technical and financial support to NCHADS to improve quality of new community-based care model to most effectively provide outreach and support to PLHA and increase treatment adherence.	• Demonstrate effectiveness of new community-based care model and provide report to NCHADS	• Model has been expanded to at least 10 other sites besides Flagship consortium IPs coverage through financial support from GFATM and other partners	HVCT& HTXS $15,000	HVCT& HTXS $700,000	Flagship/HIV I&E	3-Performance data10- Allocative Efficiency 13.3.Opportunities for Civil Society Engagement 15.2- Planning and coordination	X	X	X	X	X
Develop and implement national unique identifier system											

Patient Management Registration System (PMRS) – PEPFAR will provide both technical and financial support to NCHADS and Department of Planning and Health Information of MOH to establish a Unique Identifier System (UIS). The "PLHA and KPss' identity" system will be integrated into the MOH Health Management Information System.	• Report from a feasibility study is completed	• All PEPFAR supported facilities have implemented PMRS	HVSI & HTXS $10,000	HVSI & HTXS $154,000	MOH Coag. and HIPA	3-Performance data 10- Allocative Efficiency 13.3. Opportunities for Civil Society Engagement 15.2- Planning and coordination	X	X	X	X	X
Conduct key studies											
See item 1 under HSS log frame for studies related to costing and financing models.	•	•									

6.3 HEALTH SYSTEM STRENGTHENING (HSS)

While Cambodia has achieved significant results in HIV epidemic control and has a further goal of virtual elimination of new infections, this achievement has been largely funded by external resources. In light of significant reductions in donor funding, Cambodia must now shift its focus to sustainability. The challenge is to maintain life-long care and treatment services for PLHIV which are predominately government run but operated vertically from the rest of the health system. Besides long-term financing, strengthening and integrating systems are a high-priority for sustaining the gains made in Cambodia.

Under the new funding model, GFATM reduced Cambodia's funding by 50% and PEPFAR has embarked on a transition plan, which includes a gradual budget decline. As Cambodia approaches middle-income status, the country is under added pressure to increase its domestic contribution to supporting the HIV response, which at present is only 11%. The SID indicated that financing was the weakest area to sustaining the HIV response in Cambodia. PEPFAR will focus on building the evidence base to inform policy makers and donors about the fiscal space required to increase and improve allocation of domestic resources to finance the National HIV Program. This entails examining the current financial landscape to determine how various elements of the response are being financed, explore financial mechanisms already in place which could be utilized in the HIV sector, and costing out services to obtain a better picture of actual budget requirements. In parallel, PEPFAR will pilot innovative financing through the Health Equity Fund (HEF) for the poor for transport payments for PLHIV to reduce management cost and to pave the way for inclusion of PLHIV as a vulnerable population under the HEF funded by the pooled donors, of which the government is already contributing 40%. This

evidence will form the base for PEPFAR's health diplomacy to help steer the host country's economic transition over the next five years.

Perhaps one of the reasons for Cambodia's success was the establishment of vertical services to scale, solely managed and monitored by the National HIV/AIDS Program. However, as the country enters an era of sustainability, the efficiency of this approach is of concern and requires more "smart integration". PEPFAR will work with NCHADS and other national programs to assess the present situation and provide TA on integrating HIV services into mainstream health services without disrupting quality. For example, all health centers in Cambodia provide HIV testing as a part of the routine ANC package; however this adds additional 1000+ sites throughout the country for NCHADS to monitor, dramatically increasing the management burden on a national program whose staff is reducing. Integrating the service delivery, monitoring, quality improvement, and supply chain into the existing MCH and health center systems would ensure longer-term provision of this service.

According to the SID, another hurdle to obtain sustainability is the Commodity Security and Supply Chain system (score: 4.0). Poor planning and stock-outs have resulted in a lower number of Cambodians tested for HIV and create inefficiencies in service delivery. The ability of the National HIV/AIDS program to achieve an AIDS-free generation depends on solving procurement and supply chain management concerns. The issues reach far beyond NCHADS as the majority of drugs and medical supplies in Cambodia are stored and distributed through a central body and dispensing regulation is not enforced across both public and private facilities. PEPFAR will leverage GFATM support to modernize the existing automated logistics and supply chain management system to become web-based and link to the MOH web-based Health Information System. PEPFAR will also improve and strengthen the drug forecasting, ordering, tracking, and distribution mechanisms and bottlenecks in the drug and health commodities delivery systems in Cambodia.

Sites in Cambodia lost points in the SIMS as a result of the lack of patient tracking information. Because Cambodia does not have a unique identifier and a computer-based system to track individuals across different HIV preventative and clinical services, interoperability between the various HIV service delivery points does not exist making it difficult to follow individuals along the continuum of care. Various pilots have been tested over the past few years. PEPFAR intends to conduct an assessment of these models to bring NCHADS and development partners to consensus on identifying a unique identifier for HIV and roll-out that model over the next two years. The Health Information Policy and Advocacy project will build from the HIV UIC model to develop a comprehensive patient tracking system for the entire public health sector. This will allow for patient-level monitoring of referrals, services, and outcomes across the health areas, including those linked to HIV such as Family Planning, Maternal Child Health, TB, and non-communicable disease. PEPFAR will also support the integration of HIV data with other disease reporting systems in collaboration with the Department of Planning and Health Information and other donors.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Develop innovative financing approaches that increase and improve allocation of domestic resources for HIV programming. Build the evidence base to inform policy makers and donors regarding the fiscal space to increase and improve allocation of domestic resources to finance the HIV response.	• Costing of the National HIV/STI Strategy for the Health Sector completed with central funds. • Pilot of health equity funds to pay transport benefit to PLHIV initiated. • Strategic direction formularized based on high level participation in finance working group to explore USG support to revenue generation in health, and development of the Strategic Plan 2014-2020 and the corresponding pooled donor strategic plan. PLHIV are included as a vulnerable population in both strategies.	• Evaluation including cost effectiveness of the pilot of the new care and treatment model using health equity funds to disperse transport. • Assessment of the financial landscape for HIV completed including recommendations for financing mechanism for HIV services (ART and facility HCT). • Costing of ART and HCT services completed and benefit package and/or program budget initiated. • Design of pilot of financing mechanism most likely HEF initiated through the pooled donors.	HSS $100,000 in FY2013 reprogrammed funds	HSS $650,000	SHP SAHACOM Health Financing & Governance Project	Health Financing and Strategic Investments overall scored the lowest on the SID: DRM: Resource Generation 11 DRM: Resource Commitments 3 Allocative Efficiency 3 Technical Efficiency 5.8	X	X	X		X
Strengthen integration and mainstreaming of HIV-related services into wider health or community platforms. (coordination with USAID/MCH team)	• Assessment designed of each area: (ANC, FP/RH, STI, TB) to determine how well it is integrated and plan developed for mainstreaming within each area. • MOH Community Health Policy finalized. (USAID MCH funds and GFATM).	• Integration assessment completed. • HIV indicators for PMTCT, FP, and STI are included in the main HMIS. • HCT is fully integrated in ANC including monitoring components such as supervision and quality improvement.	$100,000 USAID MCH funds HSS $100,000 PEPFAR funds	HSS $473,000	Flagship in partnership with MCH partners	Allocative Efficiency 3 Technical Efficiency 5.8	X	X			
Provide technical assistance to NCHADS and the MOH to modernize the LMIS system and improve efficiency of the supply chain system.	• Joint donor partner and MOH assessment completed outlining options for modernizing the LMIS system. Based on the assessment, consensus is reached regarding the options forward.	• Plan for strengthening the LMIS is finalized. Design of LMIS including software of the updated system focused on HIV, TB, and Malaria commodities is completed and pilot designed.	HSS $360,313	HSS $140,000	TBD Supply Chain	Commodity Security and Supply Chain: 4.0	X				X

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Strengthen interoperability between different HIV services within a facility. Develop a system for a unique identifier code.	• UIC pilot among key populations completed. Inter-agency assessment of various UIC approaches completed with the MOH and consensus reached regarding which UIC will be utilized for HIV sector.	• Based on the 2015 UIC assessment, the UIC for PLHIV and key populations is rolled out. Assessment completed of the HIS at various HIV delivery points and plan developed on how to link them. Roll-out of the plan initiated in 2016.	SI $200,000	HSS $230,000	HIPA	UIC and strong HIS is essential to monitoring the maintenance of epidemic control	X	X	X		X

7.0 STAFFING PLAN

PEPFAR has always been small and focused working across multiple program areas. Over the past two years, the team has reviewed and adjusted positions that were either difficult to fill or more narrowly focused. The result is a number of critical shifts that has set the team up well to address the program shifts and the core/near-core/non-core decisions. Some changes include:

- Adjusting the Strategic Information Advisor position scope to spend approximately 50% effort on capacity building with the national HIV program and changing the hiring mechanism to a CDC direct-hire position. This position is filled full-time starting in July 2015 after a three year vacancy. The skills in this position will help meet the refocus within PEPFAR on data analysis and use, ensure support to the national program in measuring progress towards eliminating new HIV infections, and building sustainability.
- Modifying the previous HIV Prevention Advisor position to support PEPFAR in context of broader HSS. Going forward, a critical area where PEPFAR must engage is in ensuring long-term sustainability. This includes working on innovative new ideas for sustaining the HIV KPs prevention work that has been previously supported almost exclusively by donor funding. This remodeled position, and a new non-PEPFAR funded local-hire position, will have a key role in this work.
- Hiring a new USAID Monitoring and Evaluation Advisor for health. This position will work part-time to support USAID in their ability to meet the SIMS requirements as well as working with the SI Advisor to support PEPFARs focus on data analysis and use.

With COP 2015, the percentage of funding towards PEPFARs cost of doing business has increased. As programs transition to local partners, including government and NGOs, the extramural funding to these partners has declined while the TA needs provided by PEPFAR staff has remained steady or, in some cases, increased to help with the program transition. As a result, the relative proportion of funding that goes to PEPFAR staff has, and will likely continue, to increase as the nature of the program changes in this way. The TA provided by PEPFAR staff will likely decline at a more gradual rate than the funding provided to partners.

A large portion of staff time is dedicated to providing TA to the national program. Staff leverage technical expertise a variety of areas to encourage innovation and adoption of best practices. PEPFAR staff actively participate on national TWGs, assistance with the development and revision of national HIV guidelines and SOPs, the provision of technical guidance and direction through active involvement in program decisions, including suggesting and encouraging approaches to accelerate progress. All TA is delivered with the intention of improving service delivery quality, improving quality and reach of prevention efforts, and ensuring data analysis and use, all of which are essential to achieving and sustaining an AIDS-free generation. For CDC, all funding to government partners is coupled with intensive technical support by CDC staff. Significant staff time is spent with the national program and in the field, co-facilitating training workshops, undertaking joint monitoring and supervision visits with national staff to sub-national sites, providing hands-on coaching and mentoring of laboratory staff, and building management capacity and oversight through participation on government procurement and human resource selection committees for supplies and personnel funded by PEPFAR resources.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Strengthen referral networks between community and health facilities. • Improve the quality of facility-based care and treatment services • Improve viral suppression at facilities. • Improve the quality of pediatric care and treatment services and ensure transition of adolescents to adult services. • Develop and pilot a Unique Identification Code System for community and facility services to track patients through the cascade. • Develop and demonstrate refined approaches to improve uptake and improve targeting of community-based testing and outreach • Strengthen referral system for reactive cases in KPss to confirmatory HIV testing/enrollment in Care/Tx • Develop and support implementation of strategies for long-term sustainability of prevention work. • Strengthen integration and mainstreaming of HIV-related services into wider health or community platforms. • Strengthen interoperability between different HIV services within a facility. • Strengthen targeting approach of prevention interventions to increase identification, reach, and retention of unserved key populations	• Support two Centers of Excellence to demonstrate the new community-based care model • Support GFATM implementers to collect and use data to improve the effectiveness of prevention interventions. • Evaluate characteristics of USAID-supported ART sites that could be mainstreamed into public ART sites to make them more MARP-friendly	N/A – no non-core activities are being funded in COP 2015
Sub-national level	• Build capacity of focus provinces and ART sites to implement the 2013 National Boosted CoC strategy • Strengthen capacity of focus provinces and sites to improve quality of care and treatment services and to implement and monitor	• Priority investments to ensure USG investments (DOD and GFATM) are successful: training for purchased equipment in the provincial sites – including use, maintenance and cleaning	N/A – no non-core activities are being funded in COP 2015

	national ART activities • Develop and pilot system to use the Health Equity Fund system to direct financial and technical resources for quality HIV service delivery • Quality Assurance of lab testing • Pilot community outreach strategy for testing in an area identified as a potential PWID cluster • Technical experts to mentor Cambodian laboratory directors from provincial and district level hospitals • Conduct and use size estimations and mapping of high-risk groups to better target prevention and HTC interventions. • Improve quality of pediatric HIV services by improving national leadership and health care provider's capacity • Establish interoperability between HIV and health information systems • Provide technical assistance to NCHADS and the MOH to modernize the LMIS system and improve efficiency of the supply chain system • Strengthen targeting approach of prevention interventions to increase identification, reach, and retention of unserved key populations		
National level	• Support national program roll-out of "test and treat." • Evaluate efficacy of CoPCT model • Maintain viral suppression of PLHIV on ART and monitoring for ARV drug-resistance • Build capacity of NCHADS to implement nationally the 2013 CoC strategy • Strengthen national capacity to implement and monitor national ART activities and improve quality of care and treatment services. • Technical assistance to assess and improve quality management systems • Develop and support implementation of strategies for long-term sustainability of prevention work. • Strengthen interoperability between different HIV services within a facility mainstreaming	• Improve quality of new community-based care model • Evaluate effectiveness of key populations prevention models to identify and enroll patients in HIV care and treatment. • Training and the development of policies, guidelines and tools for blood donor education, pre-donation behavioral screening and selection. • Support NCHADS to develop policies on pre-exposure prophylaxis for select key populations. • Evaluate characteristics of USAID-supported ART sites that could be mainstreamed into public ART sites to make them more MARP-friendly	N/A – no non-core activities are being funded in COP 2015

	of HIV-related services into wider health or community platforms. • Establish interoperability between HIV and health information systems • Provide technical assistance to NCHADS and the MOH to modernize the LMIS system and improve efficiency of the supply chain system • Strengthen targeting approach of prevention interventions to increase identification, reach, and retention of unserved key populations		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC	• Strengthen referral system for reactive cases in KPss to confirmatory HIV testing/enrollment in Care/Tx • Develop and demonstrate refined approaches to improve uptake and improve targeting of community-based testing and outreach • Quality Assurance of lab testing • CMCA/ ACM/ HIV case reporting/ linkages to care and treatment; Partner Notification Tracing Testing and targeted PITC for high HIV risk groups • Strengthening serology testing strategy through an improved and validated viral testing algorithm to increases the chance of identifying a person in acute phase of HIV infection (Biomedical)		N/A – no non-core activities are being funded in COP 2015
PMTCT	• Establish guidelines and standard operating plans to implement life-long ART • Improve efficiency of PMTCT interventions.		N/A – no non-core activities are being funded in COP 2015
Priority Populations Prevention	• TA support to national roll-out of "test and treat" program • Strengthen targeting approach of prevention interventions • Develop and support implementation of strategies for long-term sustainability of prevention work.	• Support development of national PrEP policy • Evaluation of prevention models	N/A – no non-core activities are being funded in COP 2015
Biomedical Prevention			
Injection Safety	• Pilot community outreach strategy for testing		N/A – no non-core activities are being funded in

	in an area identified as a potential cluster • Develop surveillance for medical transmission and integrate into national system • Develop and implement methodology to identify potential clusters, analyze data, develop cultural acceptable way to interventions to increase testing, community mobilization for testing in high-risk areas		COP 2015
Blood Safety	• Technical assistance to assess and improve quality management systems with the goal of attaining blood service-specific accreditation • Training for purchased equipment in the provincial sites – including use, maintenance and cleaning. • Forecasting and advocating for sufficient and sustainable supply of testing reagents, longer term strategy is through cost recovery and/or MOH support • Assistance with strategies for staff management, recruitment, retention, including an adequate number of active MOH staff at NBTC for the new premises	• Training and the development of policies, guidelines and tools for blood donor education, pre-donation behavioral screening and selection • Improving recruitment and retention of voluntary blood donors and donor care • Improving donor counselling and care, including staff trained in TTI.	N/A – no non-core activities are being funded in COP 2015
Adult Care and Treatment	• Strengthen referral networks between community and health facilities • Develop and pilot a Unique Identification Code System for community and facility services • Evaluate efficacy of CoPCT model • Improve the quality of facility-based care and treatment services	• Support two Centers of Excellence to demonstrate the new community-based care model. • Technical, financial support to NCHADS to improve quality of new community-based care model	N/A – no non-core activities are being funded in COP 2015
Pediatric Care and Treatment	• Improve the quality of pediatric care and treatment services and ensure transition of adolescents to adult services.	• Strengthen capacity of MOH (NMCHC and NCHADS) to cooperate, lead, implement, and monitor PMTCT activities	N/A – no non-core activities are being funded in COP 2015
TB/HIV	• Improve and strengthen TB/HIV integration of activities		N/A – no non-core activities are being funded in COP 2015
LAB	• Technical experts to mentor Cambodian laboratory directors from provincial and district level hospitals to assist implementation activities outlined in the Cambodian Laboratory Strategic Plan • Site visits to monitor implementation of quality assurance activities and good laboratory practices.		N/A – no non-core activities are being funded in COP 2015

	• Strengthen sample referral, confirmation of diagnostic tests, and evaluation of new methodologies. • Forecasting and advocating for sufficient and sustainable supply of testing reagents, longer term strategy is through cost recovery and/or MOH support (Biomedical) • Support and strengthen capacity and quality of the national HIV laboratory for viral-load testing, HIV diagnosis using rapid tests, CD4 testing, and DNA polymerase chain-reaction testing for early infant diagnosis. • Strengthen quality control systems and information in the public health laboratory system to improve patient care and inform public health policies, strategies, and guidelines		
Program/system support	• Build capacity of NCHADS to implement nationally the 2013 CoC strategy (Adult Care/Tx) • Strengthen national, provincial, and site capacity to implement and monitor national ART activities (Adult Care/Tx) • Develop and pilot system to use the Health Equity Fund system to direct financial and technical resources for quality HIV service delivery targeted to vulnerable PLHA and at-risk populations • Training for purchased equipment in the provincial sites – including use, maintenance and cleaning (Biomedical). • Assistance with strategies for staff management, recruitment, retention, including an adequate number of active MOH staff at NBTC for the new premises (Biomedical) • Develop innovative financing approaches that increase domestic resources for HIV programming. • Strengthen integration and mainstreaming of HIV-related services into wider health or community platforms. • Strengthen interoperability between different HIV services within a facility. Develop a		N/A – no non-core activities are being funded in COP 2015

	system for a unique identifier code. • Provide technical assistance to NCHADS and the MOH to modernize the LMIS system and improve efficiency of the supply chain system		
Strategic Information	• Establish interoperability between HIV and health information systems. • Under Continuous Quality Improvement program (CQI), enhance national capacity to collect, report, analyze, and use data for program planning and monitoring • Strengthen data quality and use of information for monitoring, supervising and planning TB/HIV activities. • Technical support to conduct and use size estimations and mapping of high-risk groups to better target prevention and HTC interventions. • Technical support to National HIV Program for STI surveillance survey, BSS, HSS, IBBS • CMCA/ ACM/ HIV case reporting/ linkages to care and treatment; Partner Notification Tracing Testing and targeted PITC for high HIV risk groups • Support NCHADS/DPHI to improve the quality of electronic patient record systems and the national unique identifier system to track individuals		N/A – no non-core activities are being funded in COP 2015

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Adult Care/Treatment: • TA to link clients to non-health services, including economic livelihoods and social protection programs • TA to establish village savings and loan groups for PLHIV self-help groups	end of project	$0	$0	1	2015	
Blood Safety • Support for establishment of National Donor Association to engage on recruitment of donors, donor referral information and promoting healthy lifestyles • Support for development of mechanisms for blood service insurance coverage and recipient support and blood system financing model		$0	$0	2		

• Support for the development and implementation of national blood service standards and regulations • Assistance with a clinical governance framework for ordering and management of blood transfusions • Support of a national and provincial donor information management system • Support for national community education campaigns to address community concerns and fears related to blood donation • Support for the establishment of emergency preparedness plans • Support for the establishment of hospital transfusion committees and hospital based protocols for blood ordering and management of blood transfusions						
Prevention: Key Populations • Assess effectiveness of "sweetheart" BCC campaign in increasing condom use. • Condom social marketing		$0	$0	1		
Strategic Information • Build capacity for local research institution • Review and refine the national HIV research agenda	Shift in USG SI approach	$0	$0	1	2015	Work related to the national HIV research agenda may be supported through TA from PEPFAR staff, primarily the SI Advisor.
Totals		$0	$0			

APPENDIX B

B.1 PLANNED SPENDING IN 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$US0	**$US 13,000,000**	**$US13,000,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$229,085
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$2,333,095
IDUP	Injecting and Non-Injecting Drug Use	$108,972
HMBL	Blood Safety	$260,024
HMIN	Injection Safety	$190,865
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$817,316
HBHC	Adult Care and Support	$1,096,930
PDCS	Pediatric Care and Support	$136,303
HKID	Orphans and Vulnerable Children	$0
HTXS	Adult Treatment	$1,146,985
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$146,982
HVTB	TB/HIV Care	$255,529
HLAB	Lab	$243,283
HVSI	Strategic Information	$1,410,288
OHSS	Health Systems Strengthening	$1,707,077
HVMS	Management and Operations	$2,917,266
TOTAL		**$13,000,000**

B.2 RESOURCE PROJECTIONS

A number of data sources were used in calculating resource needs for COP 2015. The first step was to come to agreement on activities that would be included in core and near-core. The team agreed that non-core activities would not be funded in COP 2015. The second step was to come up with a template for budgeting for each core and near-core activity. As PEPFAR is a targeted assistance country without large scale service delivery activities, the PBAC tool was not useful in budget setting. However, the team did look at the categories included in the PBAC tool, which align with the categories included in Expenditure Analysis. From these tools, we selected a subset that we thought would be useful in being able to explain and articulate activities. The budget template therefore included activities with costs by the following categories: 1) training; 2) construction/renovation; 3) equipment/furniture; 4) travel/transportation; 5) other investment; 6) personnel; 7) other supplies; and 8) other recurrent cost. In addition, each implementing mechanism was budgeted as a whole for certain costs that were difficult to break out by activity, including: 1) program management (including overhead); 2) vehicles; and 3) strategic information.

In addition to the budget tool, activity managers used information from the 2014 expenditure data, to the extent possible, to help guide reasonable allocations. The 2014 expenditure analysis data was not granular enough to provide all the needed information, as it was not necessarily specific to site level cost for partners. So activity managers used the information and made adjustments to best articulate the inputs for activity. The interagency then reviewed the proposed activity budgets, along with the overall implementing mechanism budgets and allocation to program areas and budget codes.

The activity budget setting was an iterative process with activity managers putting together reasonable figures that were reviewed and agreed to by the interagency. At agency discretion, the activity budgets were then shared with the implementing partner for review, discussion and agreement. Where there was not agreement, the implementing partner worked with the activity manager to adjust as needed, based on additional information.

One of the confounding factors as we put together resource needs and budget projections is the timeframe for when COP 2015 will be implemented. The different funding accounts have varying timeframes for availability for obligation and expenditures. The Special Notification requirements for Cambodia can at times delay the availability of funds for obligation. The GAP funding arrives prior to the COP being submitted and is expected to be obligated within one year. The GHP-USAID funds usually arrive next, often in late September, and are available for obligation into HQ field support mechanisms or an in-country bilateral agreement with the Cambodian government between 5 and 7 months after COP approval. The GHP-State funds are typically the final allocation to be available. Historically, GHP-State funding does not become available for obligation until at least February following COP submission (at least 7 months after COP approval). Given the different timeframes for availability of funding, it has been difficult for the team to come up with a set timeframe for the Cambodia COP "implementation period."

Following the initial allocation based on activities, the current monthly burn-rate and pipeline was reviewed to ensure mechanisms would not be building up pipeline and that new allocations were sufficient to cover anticipated monthly expenditures for the implementation period.

APPENDIX C

C.1 ACRONYMS LIST

AIDS	Acquired Immune Deficiency Syndrome
AIHA	American International Health Alliance
ART	Anti-retroviral therapy
CENAT	National Center for Tuberculosis and Leprosy Control
CCC	Country Coordinating Committee
CD4	Cluster of Differentiation 4 (a type of white blood cell)
CDC	Centers for Disease Control and Prevention (USG)
CHAI	Clinton Health Access Initiative
CoAg	Cooperative Agreement
COP	Country Operational Plan
CoPCT	Continuum of Prevention to Care to Treatment
CQI	Continuous Quality Improvement
DFAT	Australian Department of Foreign Affairs and Trade
DNA	Deoxyribonucleic acid
FP	Family planning
FY	Fiscal year
G2G	Government to government (funding)
GAP	Global AIDS Program (funding account through HHS/CDC)
HEF	Health Equity Funds
HSS	Health systems strengthening
HIV	Human immunodeficiency virus
HIPA	Health Information, Policy and Advocacy
IBBS	Integrated Biological and Behavioral Survey
IPT	isoniazide preventive therapy
IT	Information technology
M&E	Monitoring and evaluation
M&O	Management and Operations
MOH	Ministry of Health (Cambodian)
MTCT	Mother-to-Child Transmission
NASA	National AIDS Spending Assessment
NCHADS	National Center for HIV/AIDS, Dermatology, and STDs
NGO	Non-governmental organization
NIPH	National Institute of Public Health
NMCHC	National Center for Maternal and Child Health
OI	Opportunistic Infection
PCR	polymerase chain reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
POC	Point of Care
RGC	Royal Government of Cambodia
S/GAC	Office of the Global AIDS Coordinator (Department of State)
SHP	Social Health Protection
SI	Strategic Information
SOP	standard operating procedures
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
TA	Technical assistance
TB	Tuberculosis
TBD	To be determined
UIC	unique identifier code
UIS	Unique Identifier System
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Cambodia COP15 Targets by Province: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military Cambodia	-	-	-	-	-
Banteay Meanchey	11,377	340	4,269	341	3,638
Battambang	16,194	406	5,356	448	5,162
Kampong Cham	18,311	312	2,684	281	2,416
Kampong Chhnang	-	-	-	-	-
Kampong Speu	-	-	-	-	-
Kampong Thom	-	-	-	-	-
Kampot	-	-	-	-	-
Kandal	-	-	-	-	-
Kep	-	-	-	-	-
Koh Kong	-	-	-	-	-
Kracheh	-	-	-	-	-
MondolKiri	-	-	-	-	-
Oddar Meanchey	-	-	-	-	-
Pailin	-	-	-	-	-
Phnom Penh	42,426	259	2,126	234	1,913
Preah Sihanouk	-	-	-	-	-
Preah Vihear	-	-	-	-	-
Prey Veng	-	-	-	-	-
Pursat	3,597	63	1,293	199	1,282
Ratanakiri	-	-	-	-	-
Siem Reap	23,236	160	4,176	144	3,758
Stung Treng	-	-	-	-	-
Svay Rieng	-	-	-	-	-
Takéo	-	-	-	-	-
Tbong Khmum	-	-	-	-	-
Total	**115,141**	**1,540**	**19,904**	**1,647**	**18,169**

Cambodia COP15 Targets by Province: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military Cambodia	-	-	-
Banteay Meanchey	-	2,852	-
Battambang	-	3,925	-
Kampong Cham	-	1,068	-
Kampong Chhnang	-	-	-
Kampong Speu	-	-	-
Kampong Thom	-	-	-
Kampot	-	-	-
Kandal	-	-	-
Kep	-	-	-
Koh Kong	-	-	-
Kracheh	-	-	-
MondolKiri	-	-	-
Oddar Meanchey	-	-	-
Pailin	-	-	-
Phnom Penh	-	17,814	-
Preah Sihanouk	-	-	-
Preah Vihear	-	-	-
Prey Veng	-	-	-
Pursat	-	930	-
Ratanakiri	-	-	-
Siem Reap	-	3,262	-
Stung Treng	-	-	-
Svay Rieng	-	-	-
Takéo	-	-	-
Tbong Khmum	-	-	-
Total	**-**	**29,851**	**-**

Cambodia COP15 Targets by Province: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
_Military Cambodia	-	-
Banteay Meanchey	3,166	67
Battambang	4,098	112
Kampong Cham	6,952	45
Kampong Chhnang	-	-
Kampong Speu	-	-
Kampong Thom	-	-
Kampot	-	-
Kandal	-	-
Kep	-	-
Koh Kong	-	-
Kracheh	-	-
MondolKiri	-	-
Oddar Meanchey	-	-
Pailin	-	-
Phnom Penh	11,402	43
Preah Sihanouk	-	-
Preah Vihear	-	-
Prey Veng	-	-
Pursat	1,014	25
Ratanakiri	-	-
Siem Reap	6,023	58
Stung Treng	-	-
Svay Rieng	-	-
Takéo	-	-
Tbong Khmum	-	-
Total	**32,655**	**350**

Cambodia COP15 Targets by Province: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
_Military Cambodia	-	-
Banteay Meanchey	1,453	58
Battambang	841	33
Kampong Cham	94	-
Kampong Chhnang	-	-
Kampong Speu	-	-
Kampong Thom	-	-
Kampot	-	-
Kandal	-	-
Kep	-	-
Koh Kong	-	-
Kracheh	-	-
MondolKiri	-	-
Oddar Meanchey	-	-
Pailin	-	-
Phnom Penh	-	-
Preah Sihanouk	-	-
Preah Vihear	-	-
Prey Veng	-	-
Pursat	321	14
Ratanakiri	-	-
Siem Reap	-	-
Stung Treng	-	-
Svay Rieng	-	-
Takéo	-	-
Tbong Khmum	-	-
Total	**2,709**	**105**

HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) **(sustainable and requires no additional investment at this time)**
Light Green Score (13-16.9 pts) **(approaching sustainability and requires little or no investment)**
Yellow Score (7-12.9 pts) **(emerging sustainability and needs some investment)**
Red Score (0-6.9 pts) **(unsustainable and requires significant investment)**

Sustainability Analysis for Epidemic Control: CAMBODIA

Epidemic Type: Concentrated
Income Level: Low
PEPFAR Categorization: Targeted Assistance
COP 15 Planning Level:

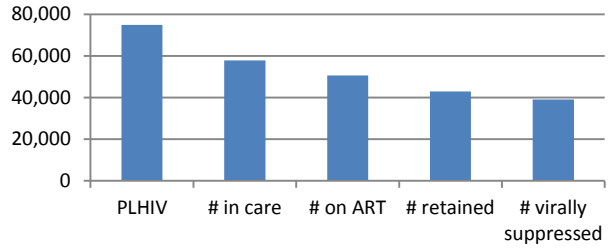
SUSTAINABILITY DOMAINS and ELEMENTS

UNSUSTAINED → SUSTAINED

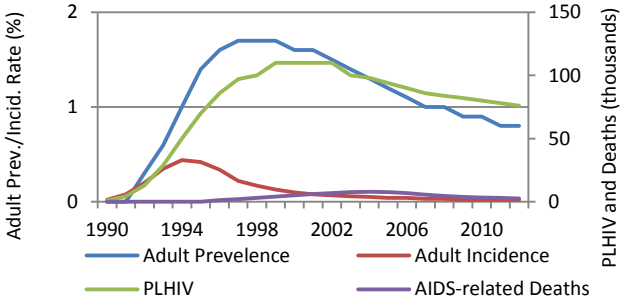
	Score
Institutionalized Data Availability	
1. Epidemiological and Health Data	10.9
2. Financial/Expenditure Data	9.0
3. Performance Data	17.0
Domestic Program and Service Delivery	
4. Access and Demand	16.2
5. Human Resources for Health	7.0
6. Commodity Security and Supply Chain	4.0
7. Quality Management	12.4
Health Financing and Strategic Investments	
8. DRM: Resource Generation	11.0
9. DRM: Resource Commitments	3.0
10. Allocative Efficiency	3.0
11. Technical Efficiency	5.8
Accountability and Transparency	
12. Public Access to Information	5.0
13. Oversight and Stewardship	7.0
Enabling Environment	
14. Policies, Laws, and Regulations	16.0
15. Planning and Coordination	19.0

CONTEXTUAL DATA

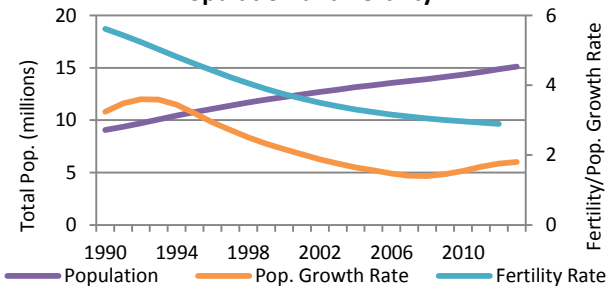
Care and Treatment Cascade



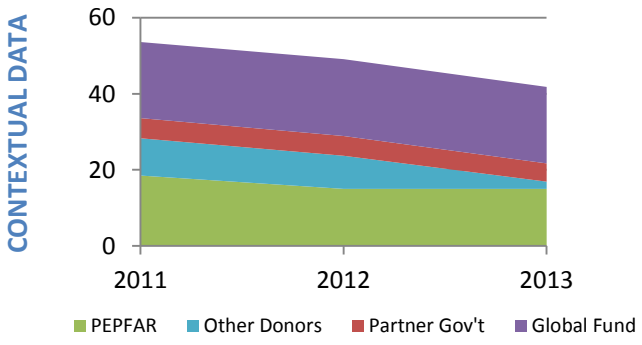
Epidemiological Data



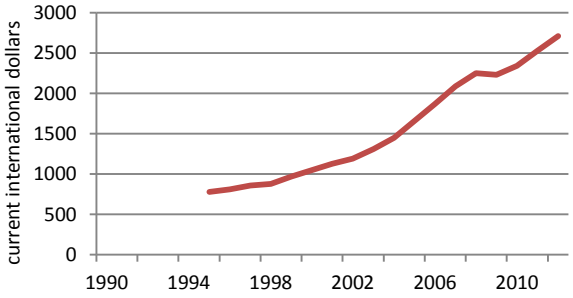
Population and Fertility



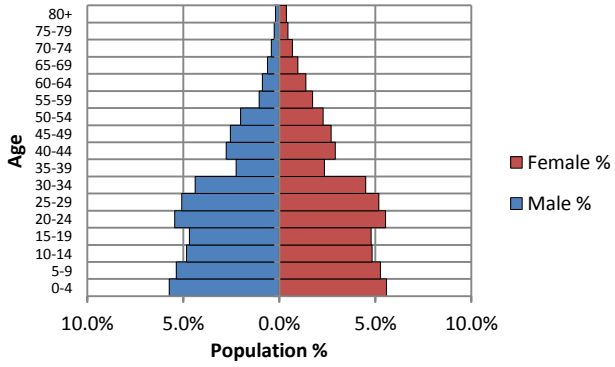
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.			**Source of data**	**Notes/Comments**
Q1. **Who leads**: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?	◉ A. Host Country Government/other domestic institution ○ B. External agency with host country government ○ C. External agency, organization or institution ○ D. Not conducted	4.5	In country documented source, such as minutes of planning meeting, report, or memo: Study protocols	
Q2. **Who finances**: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?	○ A. 80-100% of the total cost of latest survey was financed by Host Country Government ○ B. 60-79% of the total cost of latest survey financed by Host Country Government ○ C. 40-59% of the total cost of latest survey financed by Host Country Government ○ D. 20-39% of the total cost of latest survey financed by Host Country Government ◉ E. 10-19% of the total cost of latest survey financed by Host Country Government ○ F. 0-9% of the total cost of latest survey financed by Host Country Government	1	In country budget with sources of funding from most recent DHS HIV/AIDS Section, AIS, key population surveys, or other population-based survey 2014 DHS was 11% funded by RGC with the remaining funded by donors	
Q3. **Comprehensiveness of Prevalence and Incidence Data**: Does Host Country Government collect HIV prevalence and or incidence data?	○ No, the government does not collect HIV prevalence or incidence data ◉ Yes, the government collects (check all that apply): ☐ A. HIV prevalence ☑ Collected by age ☐ Collected for children ☑ Collected by sex ☑ Collected by key population ☐ Sub-national data ☑ Collected every 3 years ☑ Data analyzed for trends ☑ Data made publicly available ☐ B. HIV incidence ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed for trends ☐ Data made publicly available	0.6	Most recent country prevelance and incidence reports (provide citation): 2005 incidence survey 2014 - MSM, ANC 2012 - IDU 2011/2015 - FSW	Most recent incidence information is from 2005, which was felt to be too long ago to still be likely to be accurate with the current epidemic.
Q4. **Comprehensiveness of Viral Load Data**: Does Host Country Government collect viral load data?	○ No, the government does not collect viral load data ◉ Yes, the government collects viral load data (check all that apply): ☑ Collected by age ☑ Collected for children ☑ Collected by sex ☐ Collected by key population ☑ Sub-national data ☑ Collected every 3 years ☑ Data analyzed to understand trends	2.8	In country source such as government report: Viral Load Database	
Q5. **Key Populations**: Does the Host Country Government conduct size estimation studies for key populations?	○ No, the host country government does not conduct size estimation studies for key populations ◉ Yes, the government conducts key population size estimates (check all that apply): ☑ Men who have sex with men (MSM) ☑ Female sex workers ☑ Transgender ☑ People who inject drugs (PWID) ☐ Government finances at least 50% of the size estimation studies ☑ Government leads and manages the size estimation studies	2	In country source such as government report: See question 3	
	Epidemiological and Health Data Score:	10.9		

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.			**Source of data**	**Notes/Comments**
Q1. **Expenditure Tracking**: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	○ No, it does not have a national HIV/AIDS expenditure tracking system ◉ Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): ☑ A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening ☐ C. Collected sub-nationally ☐ D. Collected annually ☑ E. Data is made publicly available	3	In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: NASA 2011/12	
Q2. **Quality of Expenditure Tracking**: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others: _____	○ No, they are not using any international standards for tracking expenditures ◉ Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.	5	in country citations for latest NHA, NASA, government expenditure tracking report, global fund new funding model for country NHA 2014 NASA 2011/2012	
Q3. **Transparency of Expenditure Data:** Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?	○ No, they do not make expenditure data available to the public Yes, check the one that applies: ○ A. Annually ○ B. Bi-annually ◉ C. Every three or more years	1	In country source of latest expenditure data made available to the public: NASA 2011/2012	
Q4. **Economic Studies:** Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?	◉ No, they are not conducting special health economic studies for HIV/AIDS ○ Yes, check all that apply: ☐ A. Costing studies or analyses ☐ B. Cost-effectiveness studies or analyses ☐ C. Efficiency studies or analyses ☐ D. Cost-benefit studies or analyses	0	In country reports:	AEM, NASA - paid for by UNAIDS NHA - paid for by WHO Costing of health sector HIV strategic plan - paid for by USG All were done with full participation of the host government, but not funded by them.
	Financial/Expenditure Data Score:	**9**		

3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.			**Source of data**	**Notes/Comments**
Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?	○ No, the government does not have an HIV/AIDS service delivery data collection system ◉ Yes, service delivery data are collected/reported for (check all that apply): ☑ A. For HIV Testing ☑ B. For PMTCT ☑ C. For Adult Care and Support ☑ D. For Adult Treatment ☑ E. For Pediatric Care and Support ☑ F. For Pediatric Treatment ☐ G. For AIDS-related mortality	6	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: NCHADS website (www.nchads.org) HMIS website	
Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?	○ No, the government does not routinely analyze service delivery data to measure performance ◉ Yes, service delivery data are being analyzed to measure (check all that apply): ☑ A. Continuum of care cascade, including testing, care, treatment, retention and adherence ☑ B. Results against targets ☑ C. Coverage ☑ D. Site specific yield for HIV testing (HTC and or PMTCT) ☑ E. AIDS-related death rates	5	For each check, in-country source of latest data: NCHADS website (www.nchads.org) HMIS website	
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	○ No ◉ Yes, service delivery data are being: (check all that apply): ☑ A. Collected at least quarterly ☑ B. Collected by age ☑ C. Collected by sex ☑ D. Collected from all clinical sites ☐ E. Collected from all community sites ☐ F. Data quality checks are conducted at least once a year	4	In country source, such as the latest HMIS report or presentation on HIV/AIDS services NCHADS website (www.nchads.org)	

Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	○No, they do not make program performance data available to the public Yes, check the one that applies: ◉ A. At least annually ○ B. Bi-annually ○ C. Every three or more years	2	In country source of where HIV/AIDS service delivery data are available to public, such as a website: NCHADS website (www.nchads.org)	
	Performance Data Score:	**17**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIVAIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.			**Source of data**	**Notes/Comments**
Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?	○ This information is not available Check the one answer that best describes the current situation: ● A. More than 80% of facilities in high prevalence/burden locations are providing ART. ○ B. 50-79% of facilities in high prevalence/burden locations are providing ART. ○ C. 21-49% of facilities in high prevalence/burden locations are providing ART. ○ D. 20% or less of facilities in high prevalence/burden locations are providing ART.	Q1 Score: 4	In country source, i.e., SIMS, readiness assessments: health facility listing ART Report from NCHADS (Q1, Q2, Q3 FY2014)	There are 62 ART sites nationwide, located in the high-burden operational districts. Not all health facilities provide ART as it is a concentrated epidemic and that would not be cost-efficient.
Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?	○ This information is not available Check the one answer that best describes the current situation: ● A. More than 80% of facilities in high prevalence/burden locations are providing Option B+. ○ B. 50-79% of facilities in high prevalence/burden locations are providing Option B+. ○ C. 21-49% of facilities in high prevalence/burden locations are providing Option B+. ○ D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.	Q2 Score: 3	In country source, i.e., readiness assessments: ART report from NCHADS FY2013	ART is provided at 62 sites nationwide, located in high-burden operational districts. PMTCT (option B+) is offered at all of these ART sites. Not all facilities that offer HIV testing for pregnant women or delivery services provide option B+.
Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ This information is not available Check the one answer that best describes the current situation: ● A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites	Q3 Score: 3	In country source, i.e. MOH report: ART report from NCHADS FY2013	
Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites ● B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites	Q4 Score: 2	In country source, i.e., report on Key Populations. Global Fund Principle Recipient Technical Review Team June 2014	While Cambodia looks positive when responding directly to these questions, the questions do not necessarily reflect full access to care and treatment for some key populations - particularly hidden populations.
Q5. Uptake of services: What percent of PLHIV are currently receiving ART? 70%	○ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of PLHIV are currently receiving ART ● B. 50-79% of PLHIV are currently receiving ART ○ C. 20-49% of PLHIV are currently receiving ART ○ D. Less than 20% of PLHIV are currently receiving ART	Q5 Score 3	In country source, i.e. government annual HIV/AIDS report: UNAIDS estimate for number of PLHIV from 2013 (denominator) NCHADS Annual Report 2013 70% includes all estimated PLHIV, not estimated PLHIV in need	80% of eligible PLHIV as the national guidelines is CD4<350.

Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	Check the one answer that best describes the current situation: ○ No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations. ● Yes, there are efforts by the government (check all that apply): ☐ educates PLHIV about their legal rights in terms of access to HIV services ☐ educates key populations about their legal rights in terms of access to ☑ National policy exists for de-stigmatization in the context of HIV/AIDS ☑ national law exists regarding health care privacy and confidentiality protections ☐ government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	Q6 Score 1.2	In country source, i.e., government strategy/plan/SOP, HIV/AIDS Human Rights assessment report: see Domain E questions 1 and 2.	education efforts are done by NGOs.
	Access and Demand Score	**16.2**		

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Source of data**	**Notes/Comments**
Q1. **HRH Sufficiency**: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?	Check the one answer that best describes the current situation: ● This information is not available ○ A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand ○ B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply) ☐ HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand ☐ HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites	Q1 Score: 0		Not all sites are staffed by government workers. Some, particulary community-based service sites, are staffed and provided by NGOs.
Q2. **HRH Transition**: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	Check the one answer that best describes the current situation: ● A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date ○ C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date. ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	Q2 Score: 0	In country PEPFAR HRH transition plan and documentation:	There is an inventory of healthcare workers. There are some salary supplements received under the GF grants, however these will be phasing out over the next 1 to 3 years. The govt has a plan to increase all civil service salaries over the next 1 to 5 years. As part of all new GF grants being awarded this year, a condition presendent is being included that a transition plan for all PBF payments to be phased out from GF will be developed by December 2015.
Q3. **HRH Financial reform:** Has financial reform been undertaken in the last 5 years to address government financing of health workers?	Check the one answer that best describes the current situation: ○ A. No financial reform has been undertaken in the last 5 years to address government financing of health workers ● B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply): ☑ Wage reform to increase salaries and or benefits of health workers ☑ Increase in budget allocation for salaries for health workers	Q3 Score: 2	In country source, i.e. report on HRH reform or civil service reform: Finance law for 2015, Ministry of Economy and Finance	while civil service wage reform is underway, the base salary for civil servants is still very low, and for doctors and other health care professionals it is also low. Even proposed increases are insufficient to maitain the best trained and ensure no corruption.

Q4. **Pre-Service**: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	Check the one answer that best describes the current situation: ○ A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE ● B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☐ content updated for all HIV/AIDS services ☐ updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ updated curriculum is problem based/competency based ☐ updated curriculum includes practicums at high volume clinical/ social services sites ☐ institutions that track students after graduation	Q4 Score: 1	country team knowledge	
Q5. **In-Service**: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?	Check the one answer that best describes the current situation: ○ A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training. ○ B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented. ○ C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date. ● D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.	Q5 Score: 0	Country Team Knowledge; SIMS Inservice Training CEE country team knowledge	
Q6. **HRIS**: Does the government have a functional Human Resource Information System (HRIS) for the health sector?	Check the one answer that best describes the current situation: ○ A. No, there is no HRIS ● B. Yes, the government does have a HRIS (check all that apply) ☑ The HRIS is primarily funded by host country institutions ☐ There is a national interoperability strategy for the HRIS ☐ The government produces HR data from the HRIS at least annually ☑ The government uses data from the HRIS for HR planning and management	Q6 Score: 1	national HRIS document or other country team knowledge WHO information on the MOH staffing database.	Database is maintained by Dept of Personnel. Was developed with support from WHO and VSO. Validation is performed through support by HSSP2 - a joint govt and pooled donor funding mechanism.
Q7. **Domestic funding for HRH**: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?	Check the one answer that best describes the current situation: ○ This information is not known ○ A. Less than 20% ○ B. 20-49% ● C. 50-79% ○ D. 80% or more	Q7 Score: 3	In country source, i.e. HRH report, HRIS data: NHA 2013, Appendix 6	facility staff are funded by government with salary supplement from GF community staff are funded by NGOs which are primarily external resources Per the NHA, domestic resources account for 72%, but 75% of those funds are out-of-pocket spending and only 25% from the government.
	Human Resources for Health Score	**7**		

6. **Commodity Security and Supply Chain:** The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Source of data**	**Notes/Comments**
Q1. **ARV domestic financing**: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ● A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q1 Score: 0	Data from NASA, NHA, or Supply Chain management IM: Global Fund HIV concept note, submitted January 2015	GF has historically funded all ARV. In 2015, the govt agreed to contribute $1M of the total need of $13M for the year.
Q2. **Test Kit domestic financing:** What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ● A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q2 Score: 0	Same as above Global Fund HIV concept note, submitted January 2015	GF procures 100% of test kits.

Q3. **Condom domestic financing**: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ● A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q3 Score: 0	In country source, i.e., NHA, MOH, Condom assessment report: Global Fund HIV concept note, submitted January 2015	Govt contributing $5M (?) in 2015
Q4. **Supply Chain Plan:** Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	○ A. No, there is no plan or thoroughly annually reviewed supply chain SOP ● B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) ☐ Human resources ☐ Training ☐ Warehousing ☐ Distribution ☐ Reverse Logistics ☐ Waste management ☐ Information system ☐ Procurement ☐ Forecasting ☐ Supply planning and supervision	Q4 Score: 1	National supply chain plan/SOP: draft Health Sector Plan III - 2016 to 2020	Not specific to HIV
Q5. **Stock:** Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?	● A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time ○ B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time ☐ Both public and (if they exist in the country) private storage facilities at central level ☐ Both public and (if they exist in the country) private storage facilities at intermediate level	Q5 Score: 0	In country source, i.e., supply chain assessment report, LMIS data: GF Principle Recipient Technical Review Team, June 2014	
Q6. **Assessment**: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment? (If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)	○ A. No assessment has been conducted nor do they have a system to oversee the supply chain ○ B. Yes, an assessment was conducted but they received below 80% ● C. No assessment was conducted, but they have a system to oversee the supply chain that reviews: ☑ Commodity requirements ☑ Commodity consumption ☑ Coordinates procurements ☑ Delivery schedules ○ D. Yes, an assessment was conducted and they received a score that was 80% or higher	Q6 Score: 3	In country Assessment Report:	The logistics related to HIV have been assessed in various reports (including a WHO assessment conducted in 2013, a GF assessment conducted in 2013 and a JSI assessment conducted in 2013) but none are a national supply chain assement and non provided a score. There is a Central Medical Store under the MOH, but there is a parallel system for HIV managed through NCHADS. NCHADS has a Logistics and Supply TWG that meets regularly.
	Commodity Security and Supply Chain Score	**4**		

7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.			**Source of data**	**Notes/Comments**
Q1. **Existence of System**: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?	○ A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH ● Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply): ☑ Routinely reviews national HIV/AIDS performance and clinical outcome data ☐ Routinely reviews district/regional HIV/AIDS performance and clinical outcome data ☐ Prioritizes areas for improvement	Q1 Score: 2	CQI SOP, 2012 SOP for clinical mentoring	
Q2. **Strategy:** Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?	○ No, there is no HIV/AIDS-related QM/Q strategy ○ B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years) ○ C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements ● D. Yes, there is a current HIV/AIDS program specific QM/QI strategy	Q2 Score: 4	CQI SOP for Continuum of Care 2012, QI Clinical Mentoring SOP 2014	

Q3. **Guidelines:** Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?	○A. No, the national practice does not follow current WHO guidelines for PMTCT or ART ●B. Yes, the national practice does follow current WHO guidelines for: ☑ PMTCT (option B+) ☐ Adult ART ☑ Pediatric ART ☐ Adolescent ART ☑ Test and treat for specific populations	Q3 Score: 2.4	Current government SOP/technical guidelines for PMTCT and ART: NCHADS website SOPs (www.nchads.org)	There is test and treat for pregnant HIV+, TB and Hep patients. Adult ART guidelines is still CD4<350, though WHO officially changed to 500.
Q4. **QI Data use**: Does the host country government monitor and use data for HIV/AIDS quality improvement?	○A. No, there is no monitoring for HIV/AIDS quality improvement ●B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes: ☐ All sites ☑ Use of data to determine quality of program or services ☑ Making recommendations and action plan for mid-course corrections	Q4 Score: 4	NCHADS Quarterly Report Q3 CY2014 (www.nchads.org) GF Principle Recipient Technical Review Team, June 2014	
Q5. **Post-transition:** Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?	●A. No, there is no quality monitoring at sites post-transition ○B. Yes, there is quality monitoring at transition sites. Monitoring includes: ☐ All transition sites ☐ Review of service outcomes ☐ Client feedback on changes in quality ☐ Quality improvement action plan ○C. PEPFAR/other donors have never supported direct service delivery in the country	Q5 Score: 0	In country sources, i.e., post-transition report or documentation:	
		Quality Management Score	**12.4**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.			**Source of data**	**Notes/Comments**
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	○ A. No, there is no budget line item for HIV/AIDS in the national budget ○ B. Yes, there is an HIV/AIDS budget line item under the Health budget ○ C. Yes, there is an HIV/AIDS program-based budget across ministries ◉ D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 6	In country source, i.e. national budget, budget summary or report for 2014: Finance law for 2015, MOEF	
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	○ A. No ◉ B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program ○ C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	In country source, i.e. national budget, budget summary or report for 2014:	Most recent I could find online was from 2008.
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	○ Yes ◉ No	Q3 Score: 0	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/selection/scorecards	
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic revenue excludes external grants)	Check the appropriate box for your country's income category: FOR LOW INCOME ○ A. More than 16.4% (i.e. surpasses category mean) ◉ B. 14.8%-16.4%, (i.e. 90-100% of category mean) ○ C. Less than 14.8%, (less than 90% of category mean) FOR LOW MIDDLE INCOME ○ D. More than 22.3% (i.e. surpasses category mean) ○ E. 20.1-22.3% (i.e. 90-100% of category mean) ○ F. Less than 20.1% (less than 90% of category mean) FOR UPPER MIDDLE INCOME ○ G. More than 27.8% (i.e. surpasses category mean) ○ H. 25.0%-27.8% (i.e. 90-100% of category mean) ○ I. Less than 25.0% (less than 90% of category mean)	Q4 Score: 2	OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics Public Forum on Financial Law for Management 2015 (MEF) December 2014	
Score for Domestic Resource Mobilization: Resource Generation:		11		

9. **Domestic Resource Mobilization: Resource Commitments:** Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.			**Source of data**	**Notes/Comments**
Q1. Benchmarks for health spending: **African countries:** Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? **Non-African countries:** Is government health expenditure at least 3 percent of GDP?	○ A. Yes ◉ B. No	Q1 Score: 0	OGAC-provided data sheet (follows tab E) Original sources: WHO and World Bank	MEF 2013 - 1.25%

Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	○A. Less than 10% ◉B. 10-24% ○C. 25-49% ○D. 50-74% ○E. 75% or Greater	Q2 Score: 2	NASA or NHA data: NHA 2012 - 16.3%	
Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	○A. None or information is not available ◉B. 1-9% ○10-24% ○25-49% ○50-74% ○75% or Greater	Q3 Score: 1	In country source, i.e., NASA data, national expenditure analysis report: NASA IV	The NASA IV (in 2012) showed public sector spending in prevention was 16% of total but was for blood safety, HTC for general population and PMTCT. This has likely shifted some as other resources have declined, but the large portion of key population spending is still from other donors.
Score for Domestic Resource Mobilization: Resource Commitments:		**3**		

10**. Allocative Efficiency:** The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).			**Source of data**	**Notes/Comments**
Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	◉A. No, data are not used annually ○B. Yes, data are used annually. Check all that apply: ☐Epidemiological data are used ☐Health/service delivery data are used ☐Financial data are used ☐There is integrated analysis across data streams ☐Multiple data streams are used to model scenarios	Q1 Score: 0	In country documentation of strategic plan or annual planning:	
Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	○A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites ○B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◉C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ○D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ○E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	Q2 Score: 3	In country government source, i.e., presentation, GIS data, planning document: according to NCHADS Q3, FY2014 reports, 28 of 62 ART facities yield 80% of the ART patients	There are a total of 61 ART facilities. 28 of these sites yield 80% of the ART patients.
Q3.Data driven reprogramming: Do host country government policies/systems allow for reprograming investments based on new or updated program data during the government funding cycle?	◉A. No, there is no system for funding cycle reprogramming ○B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used ○C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0	In country source: policy/SOP:	For domestic resources, there is not a system for reprogramming (use or lose). GF resources do allow for reprogramming.
Allocative Efficiency Score:		**3**		

11. **Technical Efficiency:** Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.			**Source of data**	**Notes/Comments**
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	○ A. No ◉ B. Yes (check all that apply): ☐ Annually ☑ For HIV Testing ☑ For Care and Support ☑ For ART ☑ For PMTCT ☐ For VMMC ☐ For OVC Service Package ☑ For Key population Interventions	Q1 Score: 4.25	In country source, i.e., government document, report or presentation: GF HIV concept note, submitted Jan 2015	
Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?	Check all that apply: ☐ Using findings from cost-effectiveness or efficiency studies to modify operations or interventions ☑ Streamlining management to reduce overhead costs ☐ Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling ☐ Improving procurement competition ☐ Integration of HIV/AIDS into national or subnational insurance schemes (private or public) ☑ Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact ☑ Geographic targeting in high burden/high yield sites to increase impact ☐ Analysis of expenditure data to establish appropriate range of unit costs	Q2 Score: 1.5	GF HIV Concept Note, January 2015 Cambodia 3.0 Strategy 2012	
Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?	◉ A. No ○ B. Yes	Q3 Score: 0	In country source, i.e., national HIV/AIDS expenditure report:	
Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?	Check boxes that apply: ☑ They are not paying for any ARVs ☑ They are not paying for any test kits ☐ They are paying no more than 5% above the international benchmark price for first line ARVs ☐ They are paying no more than 5% above the international benchmark price for test kits	Q4 Score: 0	http://apps.who.int/hiv/amds/price/hdd/Default.aspx	
Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2 years ago: $ 97.33 Current unit cost: $ 109.91	◉ A. No ○ B. Yes	0	WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/	Cambodia is switching from D4T to tenofovir.
		Technical Efficiency Score: 5.75		

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.			**Source of data**	**Notes/Comments**
Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)	○ A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) ○ B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) ○ C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) ○ D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) ◉ E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) ○ F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget	Q1 Score: 1.0	OGAC-provided data sheet (follows tab E) Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org) OBI score = 15	
Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?	○ A. No, the national HIV/AIDS program progress report or presentation of results is not made public ◉ B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): ☑ On Website ☐ Through any type of media ☑ Disseminate print report or presentation of results	Q2 Score: 4.0	In country source, i.e., last annual national HIV/AIDS progress report or presentation: NCHADS 2013 annual report (http://www.nchads.org/index.php?lang=en)	
Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?	◉ A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically ○ B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply: ☐ On website ☐ Through any type of media ☐ Disseminate print report	Q3 Score: 0.0	In country source, i.e., last HIV/AIDS audit report:	
		Public Access to Information Score: 5		

13. **Oversight and Stewardship**: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.			**Source of data**	**Notes/Comments**
Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.	○ A. PEFA assessment never conducted, or data unavailable ○ B. PEFA was conducted and score was below C ◉ C. PEFA was conducted and score was C ○ D. PEFA was conducted and score was B ○ E. PEFA was conducted and score was A	Q1 Score: 1.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	

Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment. Actual scores are ____	Check A or B; if B checked, select appropriate disaggregates: ○ A. PEFA assessment never conducted, or data unavailable ○ B. PEFA was conducted and score was C or higher for: ☐ (i) Completeness of the financial statements ☐ (ii) Timeliness of submission of the financial statements ☐ (iii) Accounting standards used	Q2 Score: 0.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	Was conducted by score was below C. Which answer do we select?
Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. No, there are no formal channels or opportunities ○ B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback ◉ C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☐ In joint annual program reviews ☐ For policy development ☑ As members of technical working groups ☐ Involvement on evaluation teams ☐ Giving feedback through social media ☐ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	Q3 Score: 3.0	In country source, i.e., reports indicating CSO engagement, policies or SOPs: Role and Contribution of Civil Society in the National Response to HIV/AIDS, July 2012 - http://www.hacccambodia.org/pub_report	
Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society? If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?	○ A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role ◉ B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government ○ C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight	Q4 Score: 3.0	OGAC-provided data sheet (follows tab E) Data derived from Civicus Enabling Environment Index (civicus.org/eei/)	
		Oversight and Stewardship Score:	**7**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. **Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Source of data**	**Notes/Comments**
Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?	○ A. No, there are no such laws or policies ◉ B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): ☐ Criminalization of HIV transmission ☐ HIV testing disclosure policies or age requirements ☐ Non-disclosure of HIV status laws ☐ Anti-homosexuality laws ☑ Anti-prostitution legislation ☑ Laws that criminalize drug use, methadone use or needle exchange	Q1 Score: 4.0	In country source, i.e., name of law or policy: The law on the prevention and control of HIV/AIDS, enacted by Cambodian National Assembly, 14 June 2002	The anti-trafficking in persons law and snagkat/commune safety policy are obsticles; misinterpretation and discriminatory misapplication of the above law/policy pose barriers to HIV service access
Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated? (note: full score of six points possible without checking all boxes)	○ A. No, there are no such policies or laws ◉ B. Yes, there are such policies and laws. Check all that apply: ☑ For people living with HIV ☑ For men who have sex with men ☑ For transgendered persons ☑ For sex workers ☑ For people who inject drugs ☑ For children orphaned or affected by HIV/AIDS ☑ For young girls and women vulnerable to HIV ☑ For survivors of gender-based violence	Q2 Score: 6.0	In country source, i.e., the name of laws and policies: The law on the prevention and control of HIV/AIDS, enacted by Cambodian National Assembly, 14 June 2002; Ministry of Labour and Vocational Training No: 194 KB/PR.K Prakas on Working Conditions, Occupational Safety and Health Rules of Entertainment Service Enterprises, Establishment and Companies, August 2014.	
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	○ A. No, there are no special provisions or advantages for CSOs ◉ B. Yes, there are special provisions and advantages for CSOs. Check all that apply: ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☐ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 2.0	In country source, name of legislation: http://www.icnl.org/research/monitor/cambodia.html Law on Taxation (2004) article 9, provides tax-exempt status for NGOs if they are organizations with either religious, charitable, scientific, literary or educational purposes.	A pending regulatory initiative, the Cambodian Development Cooperation and Partnership Strategy (DCPS) 2014 - 2018, restricts CSOs to work that is only in support of service delivery and peoples' welfare.
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	○ A. No ◉ B. Yes, there are. Check all below that are included: ☑ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 4.0	In country source, name of legislation or policy: Law No. NS/RKM/0701/015 "Law on the Prevention and Control of HIV/AIDS," enacted 14 June 2002 by the Cambodian National Assembly. Prakas No. 095 NAA/SN "Prakas on the Working Process and the Division of	
		Policies, Laws, and Regulations Score: 16		

15. **Planning and Coordination:** Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			**Source of data**	**Notes/Comments**
Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. No, there is no national strategy for HIV/AIDS ◉ B. Yes, there is a national strategy. Check all that apply: ☑ It is multiyear ☑ It is costed ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy	Q1 Score: 4.0	In country source, name of current strategy: Strategic Plan For HIV/AIDS and STI Prevention and Control in the Health Sector in Cambodia 2014-2020	
Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?	○ A. No data-driven prioritization approach was used ○ B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources ◉ C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources	Q2 Score: 4	In country source, i.e., data analysis government used: Asian HIV Epidemic Modeling with cost projections; key population size estimations and HIV or STI IBBS; NASA analyses; costing analysis of NSP IV	
Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?	○ A. No or there is no CCM ○ B. Yes, with conditions ◉ C. Yes	Q3 Score: 2	Global Fund Eligibility List 2014	
Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?	○ A. No, it does not track or map all HIV/AIDS activities ◉ B. the host country government coordinates all HIV/AIDS activities. Check all that apply: ☑ Of Civil Society Organizations ☐ Of private sector ☑ Of donor implementing partners ☑ Activities are tracked or mapped ☑ Duplications and gaps are addressed ☑ Joint operational plans are developed that include key activities of all implementing agencies	Q4 Score: 5.0	In country source, i.e., Coordination data or reports: Actual oversight and coordination from National HIP Program as PR for GF HIV grant (until July 2015); coordination via natinal and provincial health department oversight and technical bodies; reporting of implementers into NCHADS quarterly reporting	
Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	○ A. No ◉ B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: ☑ In advocacy ☑ In programmatic decision-making ☑ In technical decision-making ☑ In service delivery	Q5 Score: 4.0	In country source for each checked: lists of local and international organizations engaged in HIV-related activiteis under National Strategic and Annual Operating Plans or through donor workplans; NGO/CSOs working on RGC, NCHADS, NAA technical working groups	
		Planning and Coordination Score: 19		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN