# Kingdom Of Cambodia
## Nation Religion King


# Success in HIV / AIDS National Response

# And

# Challenges in The Future

## Cambodia Development Cooperation Forum

## 19-20 June 2007

**Success in HIV/AIDS National Response and Challenges in The Future**

## Epidemiology:

From a high of 3% in 1997, HIV prevalence and incidence has steadily declined to 1.9% in 2003.[1] The 2005 Cambodia Demographic and Health Survey included an HIV behavioural and sero-surveillance component. The CDHS indicated a national prevalence rate of 0.6% in people aged 15 to 49 years. The CDHS does not provide the definitive picture of the epidemic however. The 2006 HSS data, especially ANC, will need to be reconciled with the CDHS figures to provide an accurate picture of national adult prevalence. Cambodia's current estimates and projections will be revised at an expert's meeting to be held in Phnom Penh in June 2007.

Almost half of new infections are among married women (women were infected later in the epidemic and male AIDS mortality has surpassed incidence); One third of new infections occur from mothers to their new-born infants.

The 2005 STI Sentinel Surveillance (which included an HIV behavioural and sero-surveillance component for males-having-sex-with-males[2]) indicates a concentrated epidemic among MSM. The prevalence in Phnom Penh City was 8.7% and the aggregate figure for all 3 surveillance sites (Phnom Penh, Battambang and Siem Reap cities) was 5.1%. High rates of STI and low condom use, especially among MSM residing in rural areas were reported.

The prevalence of STI among direct sex workers and their clients (the sentinel "client" population in the SSS was police) has not significantly altered since the 2000 SSS.

Injecting drug users (IDU) are not currently included in the national surveillance system (however a drug use assessment is currently underway). However reports from local NGO's working with IDU and drug users indicate high HIV prevalence rates.[3]

Estimated number of people living with HIV (2003): 123,100 (57,500 women or 47.7%) and the estimated number of people with AIDS: 21,500 (17.5%)

In summary, Cambodia can be characterised as a country that has emerged from a generalised epidemic, is sustaining a concentrated epidemic while maintaining a significant treatment and impact mitigation burden.

## Coordination:

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[1] 2003 HSS
Prevalence (2003- latest data): 1.9% of all people aged 15 to 49 years
Direct Sex Workers: 21.4%
Indirect Sex Workers: 11.7%
Uniformed Services (Police): 2.5%
ANC Attendees: 2.1%
MSM: National - 5.1% Phnom Penh City - 8.7% (2005 STI Surveillance)

[2] MSM

[3] NGO Korsang: 42.86% of all IDU receiving VCT returned an HIV+ result (n=7). 2.38% of all ATS users receiving VCT returned an HIV+ result (n=84).

The national response (government, civil society, private sector) is coordinated by the National AIDS Authority (NAA) and its Secretariat. The NAA launched the government's costed national strategic plan (2006-2010) in February 2006 and HIV/AIDS is incorporated into the National Strategic Development Plan (2006-2010). A Policy Board provides overall policy direction, with a Technical Advisory Board and associated Technical Working Groups providing technical direction. The civil society response is coordinated through an umbrella body, the HIV/AIDS Coordinating Committee, which has a membership of approximately 90 NGOs. The Cambodia Network of People Living with HIV is coordinating the work of PLHIV networks and groups in all provinces of Cambodia and has recently established the Cambodian Community of Positive Women. The Ministry of Labour and Vocational Training has mandated HIV work-place training in private enterprises and a number of key industries (hotels, garment factories) have systematic training, which is supported by the Trade Union Federations. Development Partner work is coordinated through the Government/Donor Joint Technical Working Group on HIV/AIDS and through the Development Partners Forum on AIDS. The National Response is largely supported by DfID, USAID (through the NGO sector) and 4 successful rounds of the GFATM.

**Trends and Progress in the National Response:**

Cambodia has witnessed a significant decline in incidence and prevalence among brothel-based (direct) sex workers and their clients where reported correct and consistent condom is over 80%. However, men increasingly turn to "indirect" sex workers, non-regular partners and sweethearts for sex, with whom they are less likely to use a condom (confirmed by the 2005 National STI Sentinel Surveillance[4] and the PSI KAP).

Drug Use: Injecting drug use (predominately heroin, but also ATS) is emerging as a serious concern (estimated 1,750 IDU, especially among young people with poly-drug use behaviour observed (ATS, IDU and inhalants). Service coverage remains low, however foundations are being built to scale HIV prevention among IDU/DU with WHO technical support (NSP and OST guidelines and strengthening of coordinated action through the National Drugs and HIV Working Group coordinated by the National AIDS Authority and the National Authority to Combat Drugs). A national framework and costed operational plan is now under development. Harm Reduction is covering a significant number of IDU in Phnom Penh and Siem Riep.

MSM: A national MSM network (Bandanh Chaktomuk) has been created and strategies are being developed with community-based organisations and the health sector to scale-up targeted services/outreach to MSM. A national framework and costed operational plan for MSM will be developed in 2007 (under the guidance of the National MSM Technical Working Group).

OVC: A National OVC Task Force (established by government administrative order) has been established to guide the development of a national framework and costed operational plan for OVC functioning.

100% Condom Use Programme: Covers 22 provinces (98% -direct sex workers; 84% - indirect sex workers; 97% brothels provide condoms (22 million sold annually). The

[4] Direct sex workers and their clients (police) also reported low condom use in sweetheart relationships (25% and 39% respectively) and with casual partners (34% and 40% respectively)

"No.1 Plus" Condom targets MSM, along with peer outreach education - mainly in urban areas.

STI services: brothel-based sex workers access STI services in 22 Provinces (30 purpose STI clinics, including one clinic for MSM in Phnom Penh).
Revised standard operational procedures have been developed to better address indirect sex workers and their clients.

Spousal Transmission: Condom promotion programme among military couples; couples education integrated into some NGO reproductive health programmes; Targeted condom social marketing (OK condom) and mass media.

PMTCT Services: By December 2006, 60 facilities in 21 provinces were providing comprehensive PMTCT services; of a total of 48,010 first ANC attendees, at ANC clinics with PMTCT services, 33,251 (69.3%) were tested for HIV.

ART: 2006 has seen the rapid scale up of ART (20,131 people by December 2006, including 1,787 children – 80% of all in need of treatment[5]) and VCT (140 sites[6] throughout the country with 212,789 adults receiving services). In order to further scale-up testing services, Provider Initiated Testing & Counselling (PITC) has been approved as a policy by the MoH.

Home & Community-Based Care: By December 2006, 292 HCBC teams (17 provinces and Phnom Penh) were providing support to people living with HIV and a total of 516 Health Centres (54.8%) were linked to HCBC teams. At the end of December 2006, there were 640 active PLHIV groups operating in 14 provinces.

TB/HIV: At the end of 2006, 222 health centres in 8 provinces (of a total of 22 provinces) have intensified and strengthened collaboration with 3,746 TB patients referred for VCT and related services. The proportion of TB patients that have been detected as HIV positive varied from 10% to 25.3% across provinces.

Significant achievements have been made toward improved integration of HIV & AIDS, reproductive health, TB and ANC services.

HIV/AIDS related research: NCHADS has reinvigorated the National Working Group on Research and an inventory of research has been completed. A two year operational research agenda (bio-medical, behavioural, socio-economic etc. is under development).

The Ministry of Women's Affairs developed a national action plan to address spousal transmission.

The Ministry of Education is developing a National HIV/AIDS Strategy to consolidate prevention efforts with youth in and out-of-school.

The Ministry of National Defence has a peer education programme reaching the military in all 22 provinces of Cambodia. The programme is seen as a model for an effective sectoral response. A national strategic plan (2007-2011) is currently being costed.

[5] Proportion of adult patients still alive and on ART after 12 months varies from 80.4% to 90.1%. The level of drug resistance to first line regimens remains low: ≥ 80%

[6] There were a total of 12 VCT sites nationally in 2000.

**Additional Highlights:**

- Comprehensive policy audit and assessment undertaken through cooperation between UN Joint Team on HIV & AIDS, members of the NAA Technical Board and focal points in key line ministries. Recommendations to be presented to the NAA Policy Board.
- National M&E Framework and Guidelines developed by the National AIDS Authority.
- First National Assembly and Senate joint Forum on HIV & AIDS held. First Parliamentary Oversight visit on HIV & AIDS undertaken by Parliamentarians (Commission No. 8 for Health, Women and Social Affairs) and oversight report presented to the National Assembly.
- First Lady engaged as the APLF and National Champion on HIV & AIDS in Cambodia and a Leadership Awards programme initiated
- Media and HIV awards initiated with Cambodian Journalists Club
- "Turning the Tide" (5-part study - Cambodia's Response to HIV/AIDS) disseminated widely to national and international stakeholders (development partner community, missions, INGOs) and well received by key partners (DfID and USAID) and the NAA.
- A National MSM Working Group established, convened by the National AIDS Authority.
- Two National Consultations on Universal Access and one civil society consultation held, with comprehensive participation of government, community and civil society actors to agree on Universal Access indicators and targets for Cambodia. Cambodia presented process at PCB in Lusaka, Zambia.
- UN Joint Support Programme (2006-2010) developed and UNDP supporting TA to develop a costed operational plan for the UN-JSP to 2010. Plans underway to mobilise resources against the operational plan, once developed.
- Plans in the pipeline to do a technical needs assessment and technical needs plan for Cambodia, aligned with the Technical Division of Labour.

**Challenges in the National Response:**

**Sex Work** rapid increase in indirect sex work in bars, massage parlours, beer-gardens; not self identified as sex workers. Key challenge to reach this population[7] and their clients with appropriate information, commodities and services. Under-age sex workers, girls and boys, not reached - hidden and not registered in the 100% Condom Use Programme.

**Male sex** workers and trans-gendered populations are not afforded priority they warrant. MSM population - inadequately covered by appropriate targeted information and services in both urban and rural settings. Resources and capacity building required to take outreach to scale, with a focus on de-stigmatising MSM through interventions that address male sexual health needs, especially STI services.

[7] IDSW population estimated at 12,762 and DSW estimated at 2,977

**Drug Users**/IDU: harm reduction/outreach covers approximately 400 of the estimated 1,750 IDU. Resources and capacity building with NGOs necessary to scale efforts. Improved understanding of drug use behaviour (including use of ATS in sex-work settings) and prevalence of HIV/STI in the drug user (IDU, ATS) population required.

**Spousal Transmission**: Need to address condom use within primary relationships, and increase number and coverage of interventions targeting at-risk men and their female partners - sweet-hearts, indirect-sex workers. Key challenges - addressing gender stereotypes, developing specific services to address male sexual and reproductive health, couple counselling and developing programmes that address gender-based violence and emphasising broader development programmes that accrue social and economic assets to women.

**Adolescent Sexual & Reproductive Health**: While good progress has been made toward improved integration of HIV/STI into sexual and reproductive health programmes, more intensive work is required, including increased attention to adolescent SRH services. An improved evidence-base on youth sexual behaviour will be an essential precursor to scaling efforts.

**PMTCT**: With approximately 461,000 live births per year, it is estimated that about 9,700 pregnant women are HIV positive, that 20-30% of these women are eligible for ART and that without any intervention, annually, approximately 3,000 infants may be infected with HIV through vertical transmission. Despite government efforts to scale up services, in 2006, only 29,677 (6.4%) of the total annual number of pregnant women got an HIV test result and only 323 (3.3%) of HIV positive pregnant women received a complete course of ARV prophylaxis to reduce MTCT.

**Safe Blood**: HIV prevalence among blood donations has declined, but remains higher compared to that of the general population. Selection of voluntary donors among young students and monks is a successful strategy, but private sector transfusions and paid replacement donors remain challenges for the national blood transfusion services.

**Impact Mitigation & OVC**: Increased need for care, support and impact mitigation as more people with HIV become sick and join the ranks of those needing medical treatment, care and support. By 2010, it is projected that HIV/AIDS will account for more than 1 in 4 orphans in Cambodia (142,000), comprising 28% of the projected total orphans. More attention needs to be paid to integrating impact mitigation concerns into wider social and economic development programming.

**Coordination**: Increased efforts will be required in 2007-2008 to strengthen the core functions of the National AIDS Authority, especially in the areas of national coordination and sectoral planning, M&E framework development, resource tracking, strategic information gathering, sectoral planning and costing, advocacy and leadership development. Capacity remains weak in all these areas. DfID support has not to date been able to significantly address these shortcomings. Attention needs to be given to defining the functions and outputs of the Provincial AIDS Committees/Secretariats vis-à-vis the Ministry of Interior lead Decentralisation and Deconcentration process. A national policy/audit assessment was conducted by the National AIDS Authority in 2006. The challenge will be to operationalise the recommendations for policy updating and where necessary, policy development.

**Resourcing the Response**: Cambodia may well achieve the HIV/AIDS MDG goal as well as its Universal Access targets, however, this will depend on the continuing

commitment of development partners and the GFATM to resource priorities, for example the need to refocus the national response on prevention while at the same time, ensuring that long-term treatment, care and impact mitigation needs are sustained over the long-term. Development partner resources (DfID and USAID, the largest funders after the GFATM) are declining, with a strong perception (stimulated by the 2005 CDHS household prevalence data) that the epidemic is abating and national response therefore requires significantly less attention). The requirement to refocus the prevention agenda and the long-term requirements of treatment maintenance as more people need to convert to more expensive second-line regimens may be in jeopardy.

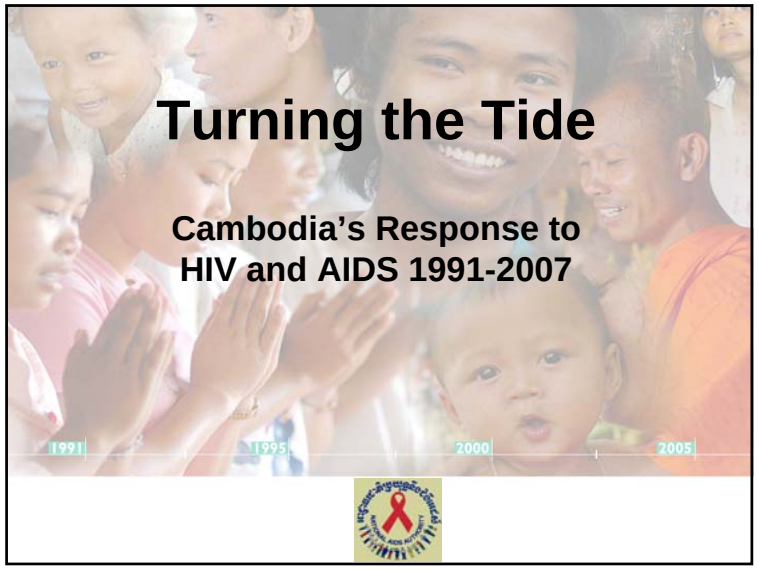
**Development Partner Harmonisation & Alignment around Country Priorities**: This remains a challenge for Cambodia. Development partner priorities are currently in flux – DfID and USAID are currently defining future priorities – these need to be clearly linked to the evolving trends of the epidemic and in line with the NSPII. The Development Partner Forum on AIDS and the Government Donor Joint Technical working Group on AIDS (under the Cambodian Development Co-operation Forum) are however making a difference and continuing efforts are being made by the UN Joint Team on AIDS to support national efforts to develop a solid evidence-base (readjusted estimates and projections, triaging strategic information to develop epidemic and response scenarios and a re-costing exercise for the National Strategic Plan, based on new prevalence data) for development partner decision-making.

## Cambodia's Universal Access Indicators and Targets – 2008 & 2010

| | INDICATOR | Baseline | Target 2008 | Target 2010 |
|---|---|---|---|---|
| 1 | Number of large organizations that have workplace policies and interventions. | 14 | 30 | 60 |
| 2 | Percentage of respondents who say that an HIV+ teacher who is not sick should be allowed to continue teaching. | 79% | 85% | 90% |
| 3 | Number of ministries that are actively implementing an HIV/AIDS plan, as per their sectoral strategy. | 6 | 9 | 18 |
| 4 | Percentage of households with OVC that receive minimum package of support. | GFATM R5 | 30% | 50% |
| 5 | Percentage of communes with at least one organisation providing care and support to households with OVC. | GFATM R5 | 50% | 100% |
| 6 | Percentage of provincial and commune development strategies that address HIV/AIDS. | 3% | 25% | 50% |
| 7 | Percentage of high risk men who report consistent condom use with commercial sexual partners. | 89% | 95% | 98% |
| 8 | Percentage of direct female sex workers who report consistent condom use. | 96% | 96% | 98% |
| 9 | Percentage of indirect female sex workers who report consistent condom use. | 82% | 90% | 98% |
| 10 | Percentage of IDUs who are exposed to HIV prevention interventions. | 15% | 40% | 80% |

| | | | | |
|---|---|---|---|---|
| 11 | Percentage of ATS users who are exposed to HIV prevention interventions. | n/a | 40% | 50% |
| 12 | Percentage of MSM who are exposed to HIV prevention interventions. | n/a | 60% | 90% |
| 13 | Number of OD with at least one PMTCT site offering the minimum package of PMTCT services. | 18 | 49 | 59 |
| 14 | Percentage of pregnant women attending ANC at PMTCT sites who received counselling and testing for HIV. | 53% | 70% | 80% |
| 15 | Percentage of pregnant women attending ANC services who receive testing and counselling. | 5% | 20% | 50% |
| 16 | Number of VCCT sites offering counselling and testing services. | 109 | 230 | 300 |
| 17 | Number of ODs with a full CoC package of services. | 22 | 34 | 34 |
| 18 | Number and percentage of PLHA on ART with access to CoC (OI and ART services). | 12,355 (49%) | 22,000 (80%) | 25,000 (95%) |
| 19 | Number and percentage of health centres with Home-Based Care Team support. | 350 | 452 | 471 |
| 20 | Number of health centres providing support to TB patients for HIV testing. | 150 | 350 | 470 |
| 21 | Number of condoms sold and distributed. | 21M | 27.4M | 29.4M |

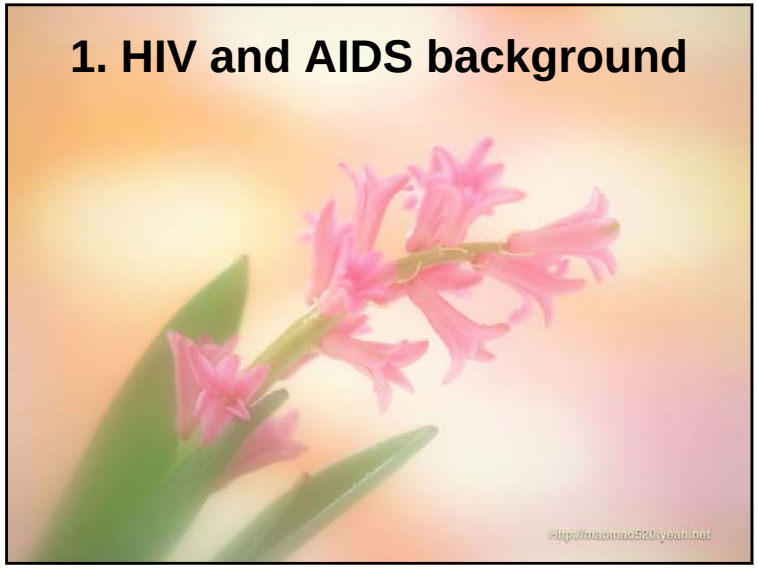
- Peer education program of the Ministry of National Defence is seen as a model for an effective sectoral response to HIV/AIDS. In spite of the development of its national strategic plan (2007-2011) and the costing, resourcing for the operationalization of the above plan would be a great concern.
- The development of a national OVC framework and costed operational plan is almost done but funds for the functioning of the above plan are short. Remarkable concerted efforts from the NAA and its development partners for the GFATM round 7 (2009-2013) requested $6004630. Fund required to respond to the need of OVC in 2008 seemed to be insufficient.
- Cambodia has requested the total amount of $43,045,121 to coordinate and implement the HIV/AIDS response in DU/IDU; MSM; Sex Worker outreach program; the OVC and the Continuum of Care from 2009-2013.
- National HIV/AIDS Strategy and national action plan of other line ministries will require sufficient fund to make them operationalized.



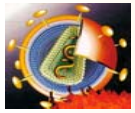

## The contents of the presentation

1. The background of HIV/AIDS in Cambodia
2. Factors contributing to the success in reducing the HIV epidemic in Cambodia
3. Conclusion
4. What is our next success






### 1.1. HIV and AIDS background

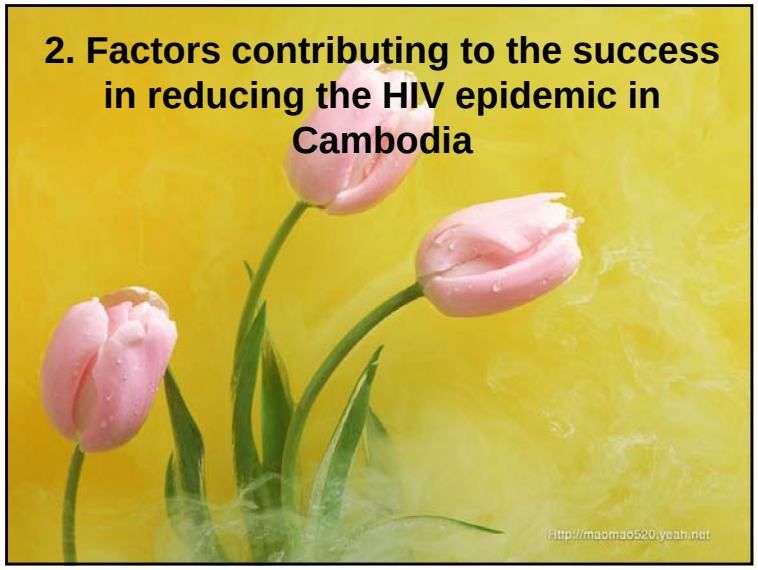


- HIV first detected in 1991

- AIDS case diagnosed in 1993

- Highest risk behaviour
  heterosexual sex

## 2. Factors contributing to the success in reducing the HIV epidemic in Cambodia




2.1. Surveillance system HSS, BSS, STI
2.2. Political commitment
2.3. Multisectoral responses
2.4. Well strategic and intervention development
2.5. Increasing coverage
2.6. Condom social marketing
2.7. Community participation
2.8. Religious participation
2.9. Increasing resources

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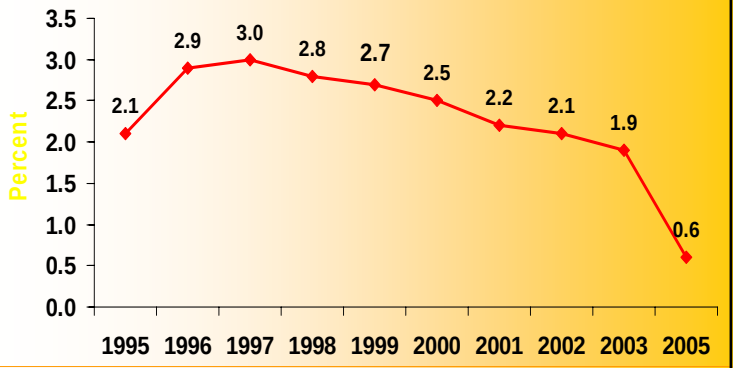
## 2.1. Surveillance system HSS, BSS, STI


2.1.1. The HSS has been set since the beginning of the epidemic

It tells us the scope trend of epidemic and used as information for intervention and evaluation

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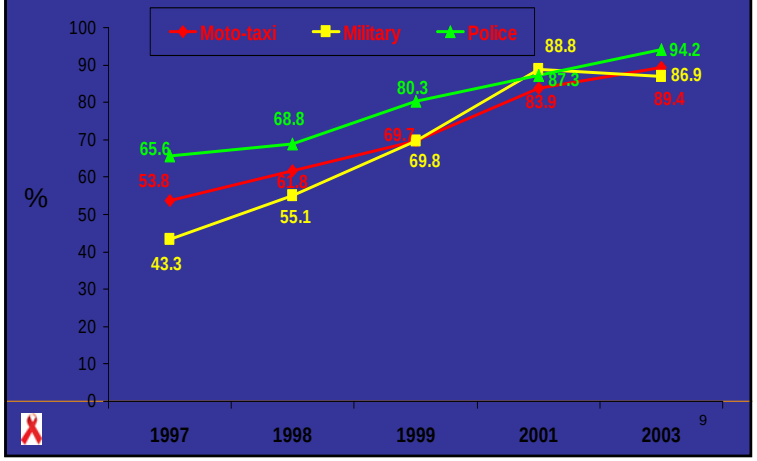
## 2.1.2. The BSS has been set since the beginning of the epidemic

### The consistent condom use with sex worker

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## The consistent condom use with clients


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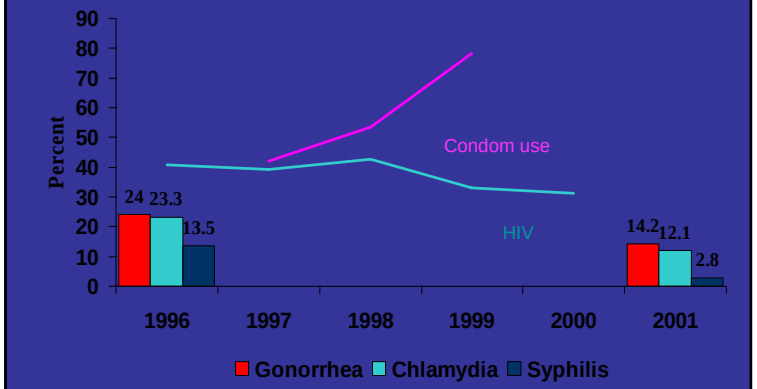
## 2.1.3. The SSS has been set since the beginning of the epidemic

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Source: NCHADS 2000-2002, Ryan et al 1998

## Shifts in New Infection Patterns

| *Infection route* | *1990* | *1995* | *2000* | *2005* |
|---|---|---|---|---|
| Males from sex workers | 79% | 61% | 15% | 20% |
| Males from wives | 0% | 1% | 6% | 9% |
| Females sex workers from male | 10% | 8% | 4% | 7% |
| Females from husbands | 10% | 26% | 48% | 19% |
| Children from mothers | 1% | 4% | 27% | 45% |
| *TOTAL New infections* | *2,895* | *38,822* | *10,553* | *4,014* |

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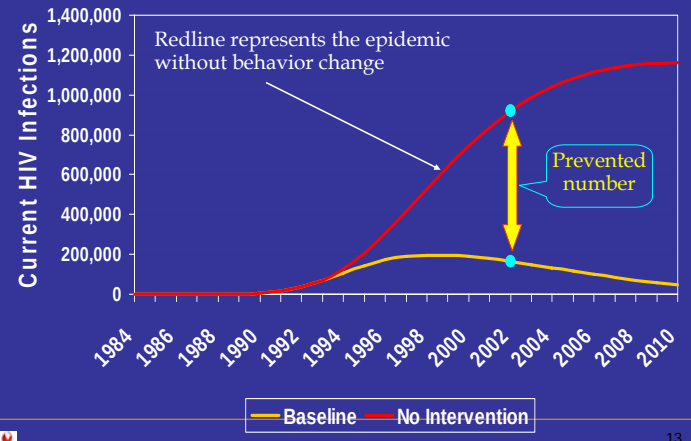
## Our effort so far leads to huge achievement for Cambodia

Prevention efforts and behavior change have averted over 600,000 infections

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## Sustainable success received so far within sex worke is important to put HIV epidemic under control.

If condom use among sex worker drop to 60% in 2002 the epidemic would be relapsed


## 2.2. The political comittment

King provides social support to PLWHA

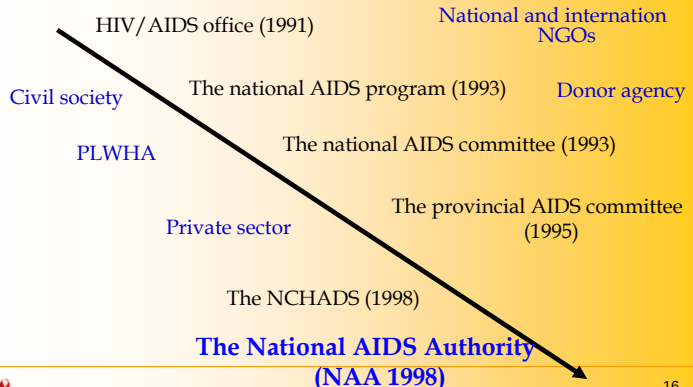
Samdech Hun Sen participated in the first national AIDS conference

Samdech Tep Vong at the Candle Light Memorial Day

Chum Tev Bun Rany Hun Sen at the World AIDS Day

## 2.3. The infrastructure for multisectoral response

From health sector to multi-sectoral rsponse

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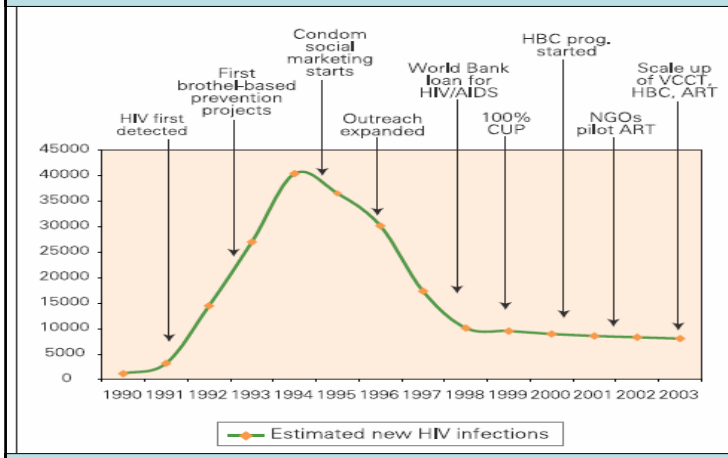
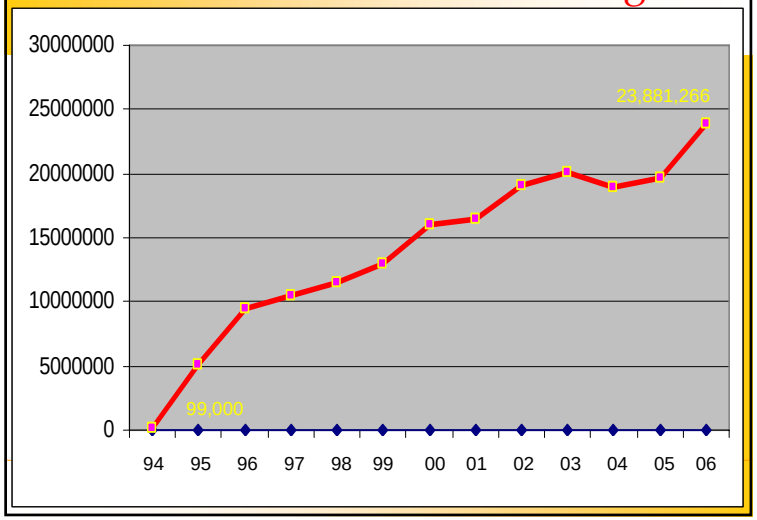
## 2.4. Well strategic and intervention development




## 5. Increasing coverage

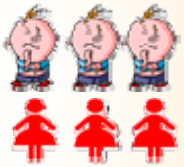
## 2.5. Condom social marketing




## 2.6. Community participation and religious support

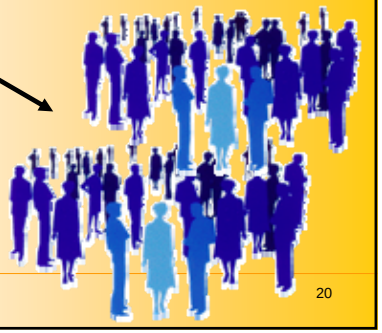
1. Community always participate in HIV/AIDS education and help to spread information
2. Buddhism actively participate in prevention care and impact mitigation

## 2.7.1. increasing human resource



Cambodia's response was initially led by a small group of dedicated individuals, driven by a conviction that HIV posed a serious threat, long before it was visible or properly researched.

And leading to many HIV/AIDS activist including PLWHA



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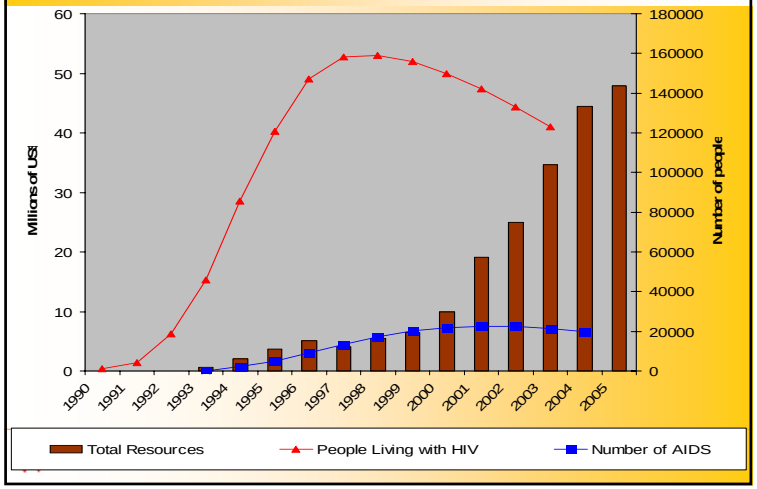
## 2.7.2. increasing financial resource




## 3. Conclusion

The success achieve so far lead by two key factors

Necessary factor + Sufficient factor

The political commitment

- The surveillance system HSS, BSS, STI
- Multisectoral responses
- Well strategic and intervention development
- Increasing coverage
- Condom social marketing
- Community participation
- Religious participation
- Increasing resources

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Therefore this success

Does not happen by chance

Does not happen by its nature

But all efforts are from Development Partners and Government under the

High Leadership of

Samdech Hun Sen The Prime Minister

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