



GOING BEYOND HIV
EPIDEMIC CONTROL:
**CAMBODIA HIV
SUSTAINABILITY
ROADMAP**
2023-2029

Sustainability Technical Working Group / National AIDS Authority



Supported by:



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Preface

Cambodia HIV Sustainability Roadmap 2023-2029

1. There has been great progress in HIV and AIDS response in Cambodia where the latest estimate of the country cascade of testing and treatment are 86-99-98 in 2022. When new infections are not decreasing as expected, the fight against this epidemic remains a formidable challenge as the targets are moving.
2. Moreover, after more than 3 decades of the fight against AIDS, funds from development partners are shrinking. The RGC needs to take bold decisions as soon possible to increase domestic funding and to strengthen the country response system. If not, Cambodia will face a resurgence in HIV infections especially among young people and AIDS deaths, and very high future resource needs.
3. In this regard Cambodia has been embarking planning for a more sustainable response to HIV started in 2018 with the development of a Transition Readiness Assessment and an HIV Sustainability Roadmap. The risks and the mitigating actions which were defined in 2018 have been reviewed in 2022.
4. Ten risks have been updated from the review. Two overarching, fundamental risks were identified during the process of updating the Sustainability Roadmap, followed by three risks related to HIV service delivery, three risks related to CSOs and CBOs and two risks related to costs and financing.
5. At the end this document, an action plan with matrix has been developed to specify lead agency, timeline and measuring progress of these ten risks with 24 mitigating actions and precise steps for implementation of the proposed mitigating actions.
6. As we are transitioning towards sustaining AIDS response, I call on all stakeholders to acknowledge that sustainability is beyond funding and realize that the potential high cost of complacency and the importance of ensuring the sustainability of the AIDS response results through a people centered approach. We will never change the course of new infections if we are not stepping out of our comfort zone. Ending AIDS requires all us to build a strong leadership, to foster an inclusive partnership and to invest funding and time in addressing the needs of the vulnerable and those affected by HIV and AIDS.
7. With the above-mentioned spirit, the risks and mitigating actions in this roadmap will need to be deepened to find suitable alternatives to mitigate the risks in regular meeting of the Sustainability Working Group at National level and in Provincial/ Municipal AIDS Committee. Key Populations and PLHIV should be always invited to support the country system both at national and sub-national level to provide inputs in those meeting while applying the inequalities lens.
8. More importantly, the mitigation actions will be addressed in the National Policy to end AIDS in 2025 and a Sustainable Response program for 2024-2028 and brought into the upcoming National Strategic Plan for Comprehensive and Multi-sectoral response to HIV and AIDS 2024-2028.
9. I hope that our combined efforts in sustaining the response to HIV and AIDS will contribute a great deal to address not only this epidemic but other social issues where state capabilities are strengthened at national and sub-national through the intersection of authority, availability and acceptance to initiate change in our practices to solve those issues.



Phnom Penh,
Senior Minister, Chair of the National AIDS Authority

IENG MOULY

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
BCOC	Boosted Continuum of Care
B-CoPCT	Boosted Continuum of Prevention to Care and Treatment
CBO/CSO	Community-Based Organization / Civil Society Organization
DAC	District AIDS Committee
DOSH	Department of Occupational Safety and Health (Ministry of Labour and Vocational Training)
FEW	Female Entertainment Worker(s)
FHI360	Family Health International (NGO)
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IBBS	Integrated Bio-Behavioural Survey
HCP	Health Care Provider(s)
HTC	HIV Testing and Counseling
KHANA	Khmer HIV/AIDS NGO Alliance (NGO)
KP	Key Population(s)
LTFU	Loss/lost to follow-up (for HIV services)
MoEYS	Ministry of Education, Youth and Sport
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAA	National AIDS Authority
NCD	Non-communicable diseases
NCHADS	National Centre for HIV/AIDS, Dermatology and STD
NSP	National Strategic Plan (on HIV/AIDS)
PEP	Post-exposure prophylaxis
PLHIV	Person/people Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-exposure prophylaxis
PWID	People who Inject Drugs
PWUD	People who Use Drugs
SDG	Sustainable Development Goals
SCN213	Sor Chor Nor 213 (government policy document)
STI	Sexually Transmitted Infection(s)
STWG	Sustainability Technical Working Group
TB	Tuberculosis
TG	Transgender person(s)
TGW	Transgender woman/women
TRA	Transition Readiness Assessment
UNAIDS	Joint United Nations Program on HIV/AIDS
VCCT	Voluntary Confidential Counseling and Testing
VL	(HIV) Viral Load

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EXECUTIVE SUMMARY

BACKGROUND

The funding for Cambodia's HIV response has historically been dependent on international donor support. Gradually decreasing levels of external financial support have been observed in the past 10 years. Planning for a more sustainable response to HIV started in 2018 with a Transition Readiness Assessment and the development of an HIV Sustainability Roadmap. In 2022, the roadmap was reviewed and updated, resulting in the current document.

METHODOLOGY AND PROCESS

An inception report was prepared, followed by face-to-face or group-based interviews to understand the existing, evolving, emerging, and immediate risks towards sustainability of the Cambodian HIV response and to review the mitigating actions proposed in 2018. The consultant was tasked to focus particularly on the perspective of community-led services and KP communities/networks. The resulting Sustainability Roadmap Review report was shared with stakeholders and consequently updated and finalized. Building on this review report, during a consultative process, a common definition of sustainability in the Cambodian context was agreed, and a set of 10 newly defined risks and 24 mitigating actions were developed and discussed during a two-day workshop with key stakeholders in November 2022, which resulted in consensus and finalization of this document.

10 RISKS AND 24 MITIGATING ACTIONS

Two overarching risks were identified. First, in the context of declining external support, there is a **lack of a common long-term vision on sustainability**, and failure to establish a common implementation mechanism for the HIV response after 2029. Two mitigating actions were defined in order to address this risk. First, an unanimously agreed document should be developed that describes and outlines a common vision for a sustainable HIV response in Cambodia, including a definition of sustainability and roles and responsibilities of NCHADS/MOH, NAA, CSOs and other stakeholders. Secondly, findings of NSPV MTR and NSP MTR and the sustainability roadmap review should be utilized to define a long-term vision and roles of key stakeholders in the forthcoming NSPVI, next NSP and next GF grant.

The second overarching risk is that NCHADS and other key partners will not benefit from the ongoing capacity building by TA agencies due to rapid staff turnover, leading to knowledge and skills not becoming institutionalized. This could lead to a **loss of technical capacity to manage the HIV response effectively in the long term**. In terms of mitigation, advocacy for longer-term contracts should be conducted and agreed for funding by the government. Second, key technical posts should be integrated in the MOH system, making them permanent. This will ensure sustainability for key functions necessary in providing support to the HIV response.

Three risks related to HIV service delivery and the health system were identified. The first is that MOH takes over **ARV and other HIV commodity procurement**, without first establishing the necessary capacity of the national procurement mechanism, resulting in higher costs. Three mitigating actions were defined to address this risk. First, MOH should not take over ARV and other HIV commodity procurement until it is ready. Second, trust from donors should

be built on the procurement capability of MOH based on ongoing improvements. Third, the capacity of government and contract staff should be further built, particularly in the areas of forecasting, data management, and procurement.

The second risk related to HIV service delivery and the health system is that **key populations may not be covered by HEF/IDPoor** while losing the support they currently receive from CSOs/NGOs. This lack of support could lead them to drop out of HIV services, leading to a resurgent HIV epidemic. Two mitigating actions to address this risk are advocacy with the Ministry of Planning by NAA and KP networks to include KP in HEF/IDPoor, and second, increased short-term donor community support for these advocacy efforts.

Third, if AHF-supported posts supporting ART treatment are terminated, **Government health staff may be unable to absorb the workload**, which may lead in decreases in ART enrolment and adherence. Three mitigation actions to address this risk are to develop a transition plan (currently in process). Second, strengthen collaboration and technical support from government clinics to NGO partners. Third, the process of hand-over should be done gradually.

Three risks were identified related to CSOs and CBOs. The first risk is that **HIV services for key populations would be directly implemented by the health sector** after international donor support ends. This could lead to reduced access, quality and coverage of KP, leading to a resurgent HIV epidemic in KP and their partners. One mitigating action is to carefully document CSO-implemented interventions so that their effectiveness and essential function in the HIV response in Cambodia are clearly understood by key policy makers.

The second risk related to CSOs states that continued lack of urgency about the need to become more sustainable and self-reliant among CSOs results in **CSOs being unprepared to receive government support or not strong enough financially to continue providing services, leading to loss of coverage for HIV and social support services for KPs and PLHIV**. Three mitigating actions to deal with this risk were agreed: First, the next GF grants should focus on ensuring a sustained role for CSOs/CBOs in the HIV response in the long term. Second, CIP and CDP budgets should be mobilized for HIV outreach and related interventions at the commune- and district level, especially in the four fast-track provinces. And third, there is an opportunity to mobilize private sector contributions to the HIV response.

The third risk related to CSOs is that due to continued uncertainty about the future of CSO-led HIV services as well as the increased workload of outreach staff, key staff could leave CSOs to work elsewhere, leading to **lower quality CSO-implemented services and less willingness by government actors to consider social contracting in the medium to long term**. As a mitigating action, it would help if, as part of the Vision document (see Risk 1), NCHADS/ NAA would strongly commit to a vision in which it sees an important role for CSOs/CBOs in implementing HIV services for KP and PLHIV in the future (in line with SCN#213), including in the next GF grant. Secondly, the workload of community workers should be reduced, their working environment should be made more supportive, and they should receive appropriate compensation for reaching their targets.

Two risks related to costs and financing were defined. First, the government may **not be in a position to react fast enough to expand its budget to cover the funding gaps** that emerge

if international donor support ends in 2029. Five mitigating actions were defined to deal with this important risk. First, NAA and NCHADS/MOH need to continue advocating with MOEF to maintain financial support for the HIV response using government funds. Second, donor partners should, for as far possible, provide clear information about their funding phase-out plans so that there is sufficient time to prepare for transition. Third, the effective implementation of SCN#213, including its policy to implement social contracting, should be reinforced. Fourth, the forthcoming National Policy for Ending AIDS, NSPVI and next NSP for health should include measures towards financial sustainability of the HIV response. And fifth, HIV services need to be included in NSSF, and HEF should be expanded to include private health care providers.

The second risk related to costs and financing is that Cambodia could be potentially graduating from the Least Developed Country status (LDC) at or around the same time as donors leave, while TRIPS flexibility is not in place, **leading to much higher ARV and other commodity prices in the HIV response, leading to a much bigger funding gap** for the HIV response. The mitigating action to address this risk is for the NAA to advocate and work with relevant ministries and partners to ensure that Cambodia access to Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) on ARVs and other commodities is maintained.

CONCLUSIONS AND NEXT STEPS

In the medium to long term, increasing efforts towards greater sustainability is the only way for Cambodia to safeguard the successes of its HIV response achieved to date, and to prevent the country from having to face a future resurgence of the HIV epidemic. Maintaining (and eventually expanding) coverage of HIV prevention, testing and linkages to care services for key populations, keeping the number of new infections low, will ensure that much higher costs will not need to be made for lifelong ART provision in the future. Planning for a sustainable response to HIV and AIDS should be accorded priority to avert the risk of an earlier than anticipated significant decline in donor funding. All stakeholders that form the national HIV response should place a much stronger emphasis on preparing Cambodia for a sustainable HIV response, including ensuring active and sustained CSO/CBO engagement in the HIV response. For this to happen, a common vision and clear division of roles between NAA, NCHADS, CSOs and other stakeholders needs to be agreed upon, led by the Sustainability Technical Working Group. This Roadmap is a first step in that direction, but it needs far more detail in terms of defining the specific roles of different stakeholders, precise steps for implementation of the proposed mitigating actions, and who is responsible for implementing these actions. The risks and mitigating actions in this roadmap will need to be deepened, made more detailed, and they should be regularly revisited and updated. The upcoming design of the next Global Fund grant and the development of the next NSP lend excellent opportunities to strengthen these needed emphases and funding mechanisms for NCHADS, NAA and CSOs/CBOs.

1. BACKGROUND

The funding for Cambodia's HIV response has historically been dependent on international donor support, although in the past 10 years the Royal Government of Cambodia (RGC) has started to increase its funding support, especially for antiretroviral treatment (ART) and other health-sector related costs. In 2015, the Cambodian economy, having been 'low income' up until then, qualified as a 'lower-middle income country'. Since many international donors tie their support to the level of economic development of beneficiary countries, this has resulted in gradually decreasing levels of external financial support for Cambodia's HIV response. It will also have consequences for Cambodia's ability to buy ARV drugs and other supplies at a discount, as it currently is allowed under WTO rules, once it is no longer a 'least-developed country' (LDC).

In anticipation of further decreasing international donor support, senior policy makers in the National AIDS Authority (NAA) and the National Centre for HIV/AIDS, Dermatology and STD (NCHADS), have been planning for a more sustainable response to HIV. This is done in two main ways: finding avenues for increased national, provincial, and local financial support for HIV interventions, as well as integrating HIV into existing health systems and implementation mechanisms by looking for cost-savings and increased allocative and technical efficiency.

The impressive achievements of Cambodia's national HIV program, with continuously declining new infections, high ART coverage, and increasing rates of viral suppression, could be reversed unless the Royal Government of Cambodia (RGC) and other stakeholders take steps to identify and address transition and sustainability risks by designing and implementing actions to mitigate them. In recognition of the impending transition from a donor-dependent to a fully self-supported HIV program, the Sustainability Technical Working Group (STWG) (co-chaired by NAA and UNAIDS) was tasked to facilitate a coordinated approach to this transition. To guide this process, the STWG with technical support of UNAIDS initiated a Transition Readiness Assessment (TRA) and a subsequent Sustainability Roadmap. These documents were both published in December 2018¹. The TRA identified 13 risks that need to be mitigated to safeguard Cambodia's transition, and the roadmap suggested mitigating actions for all the identified risks to ensure sustainable HIV response. For each of the identified risks, a number of mitigating actions was proposed in the 2018 Sustainability Roadmap.

In July 2022, a review was conducted to assess the status and progress of all of these mitigating measures and whether their implementation is on track. The review also explored whether the identified risks are still relevant and whether any new risks (and proposed mitigating measures) should be added. The result of this process was the drafting of 10 new risks and 25 new mitigating actions in this updated Sustainability Roadmap document covering the period 2023-2029.

1 National AIDS Authority and UNAIDS. Towards ending AIDS in Cambodia: Transition Readiness Assessment. Phnom Penh: December 2018 and National AIDS Authority and UNAIDS. Towards ending AIDS in Cambodia: Sustainability Roadmap. Phnom Penh: December 2018. Both documents were authored by David Lowe.

2. METHODOLOGY AND PROCESS

Initially, an inception report was prepared with a comprehensive literature review, collecting data and information specifically on efforts, potential pathways and entry points to increase the sustainability of Cambodia's HIV response and key risks and opportunities (see below). The consultant then visited Cambodia to conduct face-to-face or group-based interviews to understand the existing, evolving, emerging, and immediate risks towards sustainability and to review the mitigating actions proposed in 2018. The consultant was tasked to focus particularly on the perspective of community-led services and KP communities/networks, including on community involvement and the all-important issue of pathways and funding for CSOs to deliver HIV services for key populations. A Sustainability Roadmap Review report was then shared for comments with stakeholders and consequently updated and finalized. Building on the Sustainability Roadmap review, during a consultative process, the creation of an agreed definition of sustainability in the Cambodian context took place, and a set of newly defined risks and mitigating actions were shared and discussed during a two-day workshop with key stakeholders for comments and inputs in November 2022, which resulted in consensus and finalization of this document.

3. REVIEW OF EXISTING POLICY DOCUMENTS AND RELATED STUDIES

Transitions from donor funding to domestic reliance for HIV responses: Recommendations for transitioning countries

A 2016 report that analyzed transition processes from donor-dependent to sustainable, country-supported HIV programs found that there was a lot of confusion about what transition entailed and how the transition process was supposed to happen. The authors state that it is important to develop a clear set of criteria for assessment of a country's transition preparedness. It is also clear that important donor organizations, such as GF and USAID, should make their plans and available transition schedules clear in advance, including the start and end dates and duration of transition. It is important that donors make well-coordinated decisions to support recipient countries in preparing for the transition. The authors note that successful transitions require sufficient time (at least 5, but preferably 10 years), but also a phased roadmap to achieve various specified financial and operational targets. Senior policy maker commitment and country ownership are also very important. Strong M&E efforts are needed to assess progress against the roadmap targets, as well as to track changes to the epidemic, issues affecting the HIV service cascade, access by key populations to essential services, and other important considerations. Transitions that promote and protect human rights are most likely to maintain and expand access to essential HIV services by key populations, especially via funding mechanisms for NGOs, which must be in place and working effectively to enable access to sufficient funds for key population service delivery programs. The authors also

mention the need for in-country capacity for advocacy based on data collection and analysis by NGOs or community-based networks representing each relevant key population. At the start of 'social contracting, NGOs need to possess the capacity to demonstrate specifically the level and types of activities they will undertake in the HIV prevention and treatment cascade to justify sustained government funding allocation².

SOR CHOR NOR #213

An important guiding policy document for Cambodia's HIV response is the *Sor Chor Nor #213* (SCN213) by the Council of Ministers³, published in February 2019. SCN213 instructs the NAA and relevant ministries to adopt six new policy measures, all of which are directly aimed at improving the sustainability of the HIV response. The NAA is assigned to collaborate with the Ministry of Interior (Mol) and the Ministry of Economy and Finance (MEF) to allocate a specific budget for the implementation of HIV interventions as part of the five-year development plans and three-year rolling investment plans of all communes/sangkats in the country, in other words, to use local budgets to support the HIV response. SCN213 designated PLHIV as a 'vulnerable group' that should be entitled to access equity cards to ensure free access to health care and social protection schemes. Furthermore, the MOH and the MEF are to cooperate to amend or develop rules and procedures for allowing health centres and referral hospitals to earmark their own funds for the HIV response. SCN213 acknowledges the important role of civil society organizations in the national HIV response and pledges financial support from the national budget for civil society-implemented interventions and services (depending on availability of national funding). MOH is tasked to continue to strengthen human resources, the procurement system, supply chain management and the health information system to allow for mainstreaming of HIV responses to be more effective and sustainable.

Strategic Plan for HIV and STI Prevention and Care in the Health Sector 2021-2025

NCHADS published the Strategic Plan for HIV and STI Prevention and Care in the Health Sector 2021-2025⁹ in March 2021. It feeds into the development of the Health Strategic Plan (HSP-4) currently being developed by the Ministry of Health, and is also aligned with the NSP V described below. Its vision is an AIDS-free generation, with a longer, healthier and better life for PLHIV in Cambodia. It has three goals, which are to ensure the highest quality of HIV and STI prevention, treatment and care services within the health sector for all in need, to end AIDS as a public health threat by 2025, and to achieve virtual elimination of mother-to-child transmission of HIV and syphilis by 2025. 6 strategies are proposed:

1. To reduce new HIV infections from 2300 (as of 2010) to less than 250 in 2025;
2. To increase coverage of the comprehensive package of HIV/STI prevention services for key populations and other vulnerable populations;
3. To improve case detection and retention across the treatment cascade in order to achieve the 95-95-95 targets;

2 Burrows, D., Oberth, G., Parsons, D., & McCallum, L. (2016). Transitions from donor funding to domestic reliance for HIV responses. Recommendations for transitioning countries. Nairobi: APM Global Health.

3 Cambodia Council of Ministers. 21 February 2019. Sor Chor Nor 213: Case on the Report on the results of the 2nd Policy Advisory Board meeting of the National AIDS Authority in 2018 and request for authorization from the Royal Government to introduce measures related to the HIV/AIDS Response." Phnom Penh; Council of Ministers.

4. To strengthen laboratory services in order to provide timely, quality, accessible and equitable services to PLHIV and key populations;
5. To strengthen HIV strategic information to effectively monitor the progress across the HIV prevention and treatment cascade;
6. To build sustainable and cost-effective systems for health through integration, and effective linkages between HIV/STI services, other health facilities and communities.

5th National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023)

The NAA issued the 5th National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023)⁴, abbreviated as NSP V, in 2019. This plan aims to complement the health-sector response to HIV, which is described and lined out in a separate strategy developed by the National Centre for HIV/AIDS, Dermatology and STD (NCHADS)⁵ (see above). Its vision is a Cambodia free of HIV/AIDS, with better health and well-being for all people. The NAA NSP V contains four main strategies, of which the final three are directly aiming to make the HIV response more sustainable:

1. Deliver comprehensive prevention, care, treatment and support through a multi-sectoral approach;
2. Integrate HIV response activities into the health system, relevant ministries, and national coordinating bodies, with as expected outcome the completion of a framework for integration of HIV into the health system, with full engagement of all partners;
3. Expand social protection coverage and improve access to social and legal services so that all PLHIV are covered with a social protection mechanism by 2023, enabling them to access a variety of health, social and legal support services;
4. Increase government financing to 50% of all HIV expenditures by 2023 (up from 24% in 2017), and allocate a share of the government budget to civil society organizations for delivery of critical HIV services.

Framework for the Integration of HIV/AIDS Services in Public Health Systems in Cambodia

In November 2020, the United States Agency for International Development (USAID), the President's Emergency Program for AIDS Relief (PEPFAR) and Health Policy Plus (HP+) published the Framework for the Integration of HIV/AIDS Services in Public Health Systems in Cambodia⁶. This framework identifies the collective priorities of the NAA, NCHADS, and their partners for integrating the HIV response into the strategic plans of the Ministry of Health (MOH) and other ministries, and proposes a Framework/Roadmap. Seven domains were identified:

1. Service delivery
2. Human resources for health
3. Procurement and supply management
4. Health management information systems
5. Governance, leadership and accountability
6. Health systems financing
7. Community participation, systems and response

4 The document can be downloaded here: <https://www.naaa.gov.kh/userfiles/image/download/160438975855.pdf>

5 Ministry of Health, March 2021. Strategic Plan for HIV and STI prevention and care in the health sector 2021-2025. Available from: <https://www.nchads.org/wp-content/uploads/2021/06/SPHIV-STIs-2021-2025-1.pdf>

6 Sharma, R., M. Srey, and B. Jain. 2020. Framework for the Integration of HIV/AIDS Services in Public Health Systems in Cambodia. Washington, DC: Palladium, Health Policy Plus.

Stakeholders interviewed for the development of the framework indicated that the integration of HIV services into health and other relevant government ministries' strategic plans is possible using a phased approach but will need a detailed operational plan which needs to be prepared by the NAA/NCHADS, with the help of development partners, across all seven domains. According to the report, the key role of the NAA is to garner support for integration efforts. It should take the lead in advocacy efforts to make the integration framework operational, per the suggested key domains. The authors recommended that NCHADS lead dissemination efforts regarding uptake of the integration framework with the MOH and key stakeholders, and they suggested NCHADS should advocate for incorporation of the framework into the MOH's next 10-year strategic plan, establishing technical working groups for each of the seven domains, to operationalize the integration framework, identifying focal points and champions for integration into different ministries and departments, and working toward making each domain functional and workable in Cambodia. Importantly, all of the key stakeholders interviewed unanimously felt that meaningful integration of HIV services into the health and other relevant government ministries is possible and will be effective in improving coverage and sustaining the HIV response.

The USAID/PEPFAR/HP+ report felt that engagement of the community is essential to maintain focus on community outreach activities and active case detection among key populations, track people living with HIV who are lost to follow-up, and retain them in the system of care and support services. In order to make the HIV response more efficient, CSO outreach workers should in many places cover a larger number health issues/diseases than just HIV in order to make investment of government resources in their services cost-effective: apart from HIV, TB, Malaria, maternal and child health, reproductive health and non-communicable diseases could also be covered under the community outreach program.

In order to pilot multisectoral responses at the commune- and provincial level, USAID/PEPFAR/HP+ suggest in their report that one province should be selected to pilot the provision of services in a fully integrated system and provide learning opportunities for scaling up the interventions by having better solutions and approaches. There were two options suggested for the phased integration:

- Identify a province and health facilities as a demonstration site for forging partnerships between public, private, and (especially) community sectors by developing new ways of working together, learning by doing, and generating visible results on the ground for the integrated services.
- Identify the services that need to be prioritized for integration and those that will remain vertical during the pilot phase. Most stakeholders suggested prioritizing governance, leadership, and accountability because the overall success of integration depends on this domain.

Capacity Assessment of National People Living with HIV and Key Population Networks in Cambodia

Also in November 2020, the Health Action Coordination Committee (HACC) and UNAIDS published the results of an assessment of the capacity of national PLHIV and Key Population networks in Cambodia⁷. National networks of people living with HIV (PLHIV)

⁷ Capacity Assessment of National People Living with HIV and Key Population Networks in Cambodia. Health Action Coordination Committee (HACC) and UNAIDS, Phnom Penh, November 2020.

and key populations (KP) in Cambodia comprise the Cambodian People Living with HIV Network (CPN+), ARV Users Association (AUA), National Female Entertainment Workers Network (EWNNet), Bandanh Chaktomuk (BC) representing men who have sex with men and transgender people and Cambodian Network of People Who Use Drugs (CNPUD). Significant gaps in capacity were found in each of the networks, with CPN+ and AUA relatively in better shape than the KP networks. A lack of capacity in advocacy and communication skills was found across all organizations studied. The KP networks were also found to lack capacity in financial management, human resource management, governance, data systems, and lack of understanding on social contracting mechanisms—each of which needs to be urgently addressed if social contracting for these networks will be taken into serious consideration. The authors noted that several network representatives were surprised at the concept of potential government funding for their networks, with only CPN+ having a clear understanding of and plan for working with social contracting at the OD and commune level. The authors state that social contracting may need to be considered differently for the PLHIV and KP networks. Since CPN+ already has contacts down to the commune level – due to previous funded work with PLHIV at a very large scale – the network’s representatives felt confident that social contracting funds that would be made available at the commune level will be able to be effectively accessed and used. AUA’s representatives did not express the same confidence but it appears likely that the network’s staffing, systems, policies and activities will allow AUA to achieve local funding in each OD where ART is provided. Substantial capacity building will be required for both networks but this should be able to be carried out by NAA, NCHADS, HACC and others involved in the social contracting process. For the KP networks, it is unlikely that commune-based payments will be effective except perhaps in large cities where key populations may congregate, the authors state. They suggest that it may therefore be more effective to provide training to the Executive Committees of the KP networks in ways to access, expend and report on social contracting funds at the national, rather than the district level.

Mid-Term Review of the 5th National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023) in Cambodia

In 2022, the NAA, with support from UNAIDS, conducted a mid-term review (MTR)⁸ of the implementation of the NSP V (described above). It found that overall, significant progress had been made in the health sector response to HIV in the first three years of the plan, despite the challenges posed by the Covid-19 pandemic. In terms of integrating the HIV response into the wider health sector and non-health ministries (Objective 2 of the strategy) the MTR found that the most important advocacy achievement of the NAA in recent years was the issuance of Sor Chor Nor 213 (SCN213) (see above) and the high-level agreement to integrate HIV activities in commune development plans and investment plans. However, in terms of integrating HIV into the wider health system, the MTR found that not much progress had been made since 2019. Costing, financing and budgeting are already integrated into the MOH system, and integration of HIV services in the overall health system is happening at the health centre level. The provision of ART and HIV related health care services is provided by (public) provincial and referral hospitals and 3 NGO clinics, and the supply of ARV drugs is operated through Central Medical Store (the MOH supply management system) with technical assistance and coordination by NCHADS. In terms of decentralizing the HIV response, following advocacy by the NAA, the MEF agreed to allocate approximately 20,000 USD to each of the four

8 Mid-Term Review of the 5th National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023) in Cambodia. Final draft submitted to the National AIDS Authority, 5 March 2022.

Fast Track Cities provinces to support the Provincial Health Departments (PHD) to conduct capacity building and supervision or the Provincial AIDS Committees/ Secretariats (PAC/ PAS) and district- and commune-level HIV activities. The NAA is working on the expansion of this initiative to eleven second-priority provinces in 2022—however, it is clear that funding is not nearly sufficient to cover the need. In terms of integrating HIV into relevant (non-health) ministries, the Ministry of Interior has been engaged to help push for the inclusion of key populations and PLHIV in the PAC as well as at the district level. The Ministry of Education, Youth and Sports (MOEYS) has integrated HIV in the MOEYS’s 5-year education sector strategic plan and a new curriculum for school-based sexuality education has been implemented which includes messages around HIV prevention and on drug use prevention. It has been integrated as part of the compulsory health education subject, although funding for printing of new text books and teaching guides, as well as funding for teacher training, are lacking. Indeed, most activities for non-health ministries remain fully dependent on international donor support. One under-served key population in Cambodia is people who use/inject drugs and prisoners/people in closed settings, however, efforts to engage the NACD have not been successful, and the Prison Department and Department of Social Affairs are also lagging behind in terms of their engagement in the HIV response. In terms of increasing PLHIV and KP access to social protection (objective 3 of the NSP V), the NAA, with support from partners, has successfully convinced/advocated with the Ministry of Planning that PLHIV are a vulnerable group who deserve access to the IDPoor (Equity Card). However, uptake among PLHIV remains low. Inclusion of vulnerable KP into IDPoor has been also advocated for, but progress has been slow with many challenges remaining on how to identify and register KP. In terms of increasing the central government financing to fund the HIV response (Objective 4 of the NSP V), whereas in 2017, 24% of HIV expenditure were raised from local budgets and resources, in 2020 this was 35%, although the way of measuring expenditures was different in 2017 and 2020; the 2017 NASA exercise was comprehensive and inclusive of both direct and indirect costs, whereas the 2020 expenditure measurement used a different methodology and only included direct costs or programme costs, making a direct comparison impossible. However, stakeholders were generally cautiously optimistic that Cambodia seems on track to reach the target of 50% local resources for the HIV response by 2023. At the same time, with decreasing foreign donor investment, the benchmark for government funding to reach 50% by 2023 is continuously being lowered. HIV has been included in routine budget planning at the national level, although this has so far only been for ARV drugs. Whereas MOI/MEF have allocated funds for HIV at the commune/district level, HIV is not yet part of provincial budgeting processes (this is being planned for). The MTR noted with concern that there seems little commitment or progress towards social contracting to CSO among senior decision makers in relevant sectors, especially MOH and MEF. It suggested that modalities for social contracting need to be developed, but also that most CSOs need to learn and understand the government’s administrative and financial systems and processes—increased investment in organizational and institutional CSOs is needed in this regard. The MTR concluded that there is a need for Cambodia to transition from an HIV response characterized by dependency to one that is sustainable and truly ‘owned’ by Cambodian actors. Furthermore, there is a need to apply a people-centered approach to address stigma, discrimination, access to services and other inequalities that affect PLHIV and key populations.

Mid-term review of the Strategic Plan for HIV and STI Prevention and Care in the Health Sector 2021-2025 (November 2022)

The MTR report noted that HIV C&T programs are progressively shifting from a well-resourced vertical program to integration with the wider health system, which is essential for long-term sustainability. However, the authors note that detailed planning for sustainable domestic financing of Cambodia's HIV response has not yet occurred, and they note that while funding levels have been fairly stable, there is a risk of an earlier than anticipated significant decline in donor funding. The authors point out that key population HIV prevention programming is the most vulnerable area as it is largely donor funded. Currently, there is an absence of planning within government to determine an appropriate funding modality (e.g., social contracting, etc.) for NGOs providing HIV services. The authors note that without much increased and improved prevention efforts aimed at key populations, Cambodia will not be able to reach the NSP target of reducing the number of new HIV infections to less than 250. The authors recommend to target prevention programs better to those most-at-risk while expanding coverage of existing prevention programs for KP. The authors state that maintenance of ending AIDS will require ongoing programming. For this to happen, a core package of services and activities needs to be defined, with flexibility to adapt, including scaling up or down, according to emerging needs. Broadly, this would include person-centred surveillance and monitoring activities; appropriately targeted HIV and STI prevention capability; meeting the life-long health service needs of PLHIV; effective governance of the HIV response; and maintenance of the effective partnership between government, health professionals and civil society that has served the HIV response so well over decades. The authors expect that the configuration of HIV services (e.g., vertical vs integration), is likely to evolve over time after the goal of ending AIDS as a public health threat has been reached. Integrating HIV programming into broader health systems has benefits and potential risks. A mix of vertical and integrated approaches to funding mechanisms and service delivery may be appropriate, particularly in transition. This would allow for targeted and incremental integration, with incorporation of lessons learned through phased implementation. Two recommendations were defined related to sustainability. First, planning for a financially sustainable response to HIV and AIDS should be accorded priority to avert the risk of an earlier than anticipated significant decline in donor funding. This should include an investment case study to maximize cost-effectiveness and allocative efficiency. Second, Priority should be given to developing a government-financed funding mechanism for CSOs/CBOs providing HIV care and treatment services and HIV key population HIV prevention services to fill the existing funding gap for delivery of services at scale and to ensure the long-term sustainability of prevention programming.

Legal and Regulatory Framework for Government Providing to CSO and Documentation of Practices of Royal Government of Cambodia providing Fund to CSO in Cambodia (draft)
In July 2020, Health Policy Plus conducted a legal and regulatory framework review related to the social contracting of CSOs in Cambodia⁹. HP+ concluded that there are no documented barriers that would prevent the government from funding CSOs working in HIV program. The review found existing examples where public funds were provided to CSOs working in non-health related sectors, including in education and labor dispute resolution. However, the study found that there was no standardized mechanism yet for social contracting that could also be used for CSOs working on HIV program. Two funding models for social contracting

9 HP+ (2020), Legal and Regulatory Framework for Government Providing to CSO and Documentation of Practices of Royal Government of Cambodia providing Fund to CSO in Cambodia (draft).

to CSOs working in HIV/AIDS were proposed (besides other funding modalities for CSOs), as follows:

- CSO selected without a bidding process, where the CSO is selected beforehand and is included and allocated funds in the annual budget proposal prepared by government ministries for implementing their proposed programs. This model was utilized by the RGC in providing funds to the Arbitration Council Foundation.
- CSO only selected after a bidding process. In this case, no CSOs are mentioned in the annual budget proposal prepared by government ministries. Once the budget is approved by the Ministry of Economy and Finance (MEF), the ministry selects a CSO who they feel is competent and has the required expertise.

In order to implement social contracting mechanisms in HIV program, the study recommended developing a standardized Standard Operating Procedures for the social contracting of CSOs working in HIV program. A scoping document towards informing the development of a draft SOP for social contracting was produced by HP+ in 2020¹⁰.

There are a number of social contracting experiences from Thailand, Malaysia, India, and Viet Nam could harbor lessons for Cambodia. For instance, The Thai National Health Security Office (NHSO) engaged in contractual arrangements with CSOs for what was called “Reach-Recruit-Test-Treat-Retain (RRTTR) services”. It was found that effective contracting is characterized by the following six factors¹¹, namely:

1. Engagement with partners in identifying annual targets of KPs together with capacity of the CSO to achieve these, clear budget allocations and terms and conditions and clear roles of each stakeholder;
2. A clear and transparent CSO selection process;
3. A pre-award assessment of each CSOs’ capacity to effectively implement the program;
4. Ensuring effective and timely payments from the NHSO to the CSOs, based on the achievement of pre-agreed benchmarks;
5. Strong monitoring and evaluation of CSOs’ performances and a continued focus on CSO capacity building;
6. The recruitment of a national project manager/coordinator tasked with managing social contracting and performance assessment.

10 HP+ (2020), Social contracting for civil society organizations providing HIV/AIDS Services in Cambodia. (draft)

11 Pudpong, N., Viriyathorn, S., Wanwong, Y., Witthayapipopsakul, W., Wangbanjongkun, W., Patcharanarumol, W., & Tangcharoensathien, V. (2021). Public contracting with civil society organizations for HIV/AIDS service provisions: A key strategy to ending AIDS in Thailand. *Journal of HIV/AIDS & Social Services*, 20(4), 285-301.

4. SUMMARY OF THE 2018 SUSTAINABILITY ROADMAP REVIEW REPORT

During stakeholder interviews held in July 2022, it became apparent that only a limited number of the mitigating actions proposed in 2018 have been partly implemented; the most important mitigating actions have all been postponed with no defined timeline. The main reason cited for the slow implementation of the previous roadmap was that Global Fund, USAID, PEPFAR and other donors have continued their support for Cambodia around 2022-2023 and have not announced or planned a cessation of funding as previously predicted. There was little sense of urgency among national key stakeholders to prepare for a sustainable HIV response, including among civil society organizations and KP networks who have yet to start finding alternative income sources and are hoping that the government will support them to continue implementing HIV services for KP through some mechanisms. It was found that some of the risks defined in 2018 were no longer relevant, and others needed updating. There were also some new risks that came out of the consultation process. The 13 risks and 23 mitigating actions of the 2018 Sustainability Roadmap were reviewed; for the findings of this aspect of the process kindly refer to the 2018 Sustainability Roadmap Review document¹².

One of the most important findings of the review and interview phase was that very few government stakeholders and almost none of the community stakeholders were actively preparing for a future without international donor support. There was a lack of urgency at all levels; the seriousness of the situation did not seem to be recognized. Many stakeholders are hoping that the GF and other donors can continue their support and stay on beyond 2029.

Stakeholders worried that despite significant progress in improving the quality and friendliness of HIV services in Cambodia in recent years, integration of HIV testing, treatment and support for KP in the government health system may be challenging, as not all government facilities are yet understanding, accepting and friendly to KP. Stakeholders were most worried about what would happen to prevention outreach, community-based HIV testing, and HIVST for KP after donors withdraw from Cambodia, realizing that CSOs and KP networks are key to reaching KPs, providing them with HIV related information and education, providing them with HIV screening tests and connecting them to HIV treatment services if found positive (or to PrEP services if found negative). In line with many other countries in the region, government funding for CSO implementation of key population HIV interventions remains far behind what is needed to maintain sufficient coverage and impact¹³.

12 NAA/UNAIDS (2022), Cambodia HIV Sustainability Roadmap Review, July-September 2022 (final draft, 14 Sept 2022).

13 Vannakit, R., Andreeva, V., Mills, S., Cassell, M. M., Jones, M. A., Murphy, E., ... & Phanuphak, N. (2020). Fast-tracking the end of HIV in the Asia Pacific region: domestic funding of key population-led and civil society organisations. *The Lancet HIV*, 7(5), e366-e372.

CSOs providing essential HIV services to KP that would otherwise not been reached by government health services will need strong support in the coming 7 years to change their dependence on international donor support, and become partly or wholly self-reliant. This should be an important focus in future national strategies, including in the next GF grant. Strategies that should be considered, and possibly piloted over the next period, could include:

- Social contracting, where the government contracts CSOs servicing KP to provide HIV prevention, testing or PLHIV support services¹⁴. This is particularly efficient and effective for the following service delivery areas:
 - HIV outreach (online and offline), including HIV prevention and promotion and delivery of community-led PrEP services
 - Provision of community-based HIV testing and HIVST
 - Support referrals to or between government services
 - Peer support for PLHIV, support for adherence/retention
 - Help to trace people who have become lost to follow-up
- Social enterprise, where part of the service provided by CSOs would no longer be free, and an income stream can be established from user fees or membership fees. Certain groups of KP might be willing to pay a fee for receiving 'premium service' (for example, getting tested at home, receiving PrEP at home, or being serviced quicker via a 'fast track' service), which then can become an income stream for the CSO;
- Organizing regular fundraising events;
- Income generation via the deployment of other businesses, such as shops or restaurants;
- Mobilizing support from the private sector/accessing funds related to corporate social responsibility.

In terms of remaining gaps in the current HIV response for KP, stakeholders mentioned the lack of interventions for PWID/PWUD as well as the need to design and implement interventions to address sexualized drug use (chemsex)¹⁵, particularly among MSM and TGW. Access to PrEP, especially for MSM and TGW, was also a worry as it was unclear to what extent PrEP provision could and would be integrated into the overall health system.

Another key finding of the review process was that the two key leading agencies in the national HIV response (NCHADS and NAA) envisioned approaches to a sustainable HIV response that were complementary, albeit from differing perspectives given their agency mandate and scope. In line with the Government's 'rectangular strategy' and the Sor Chor Nor 213 policy document, NAA is working for mobilization of the 'country system' with leading roles for commune, district and provincial development councils in managing and owning local HIV responses, based on local priorities, focusing initially on the four fast-track provinces. NCHADS (and other stakeholders) expressed the need for continued coordination, quality control and standardization at the national level, ensuring that interventions for key populations will continue to be prioritized when resources get scarcer, and ensuring that quality and access to HIV prevention, care and treatment for KP and PLHIV are maintained. The NAA and NCHADS visions on sustainability are mutually strengthening all stakeholders at all levels in the HIV response: NAA is tasked to work on the mobilization of the 'country system' with leading roles

14 "Social contracting in the response to HIV/AIDS refers to a legally binding agreement between the government / government entity (Party A) and a social/community organization (Party B), in which Party A agrees to pay Party B for services rendered as per Party A's request, at mutually agreed costs."

15 Defined as 'intentional drug-taking before or during casual and/or group sex to facilitate, initiate, prolong, sustain, and intensify pleasure'. Source: What is Chemsex? David Stuart. 2020. <https://www.davidstuart.org/what-is-chemsex>.

for commune-, district- and provincial development councils in managing the sub national HIV response, based on local priorities, and strengthening the enabling environment for HIV interventions for key populations. NCHADS provides technical assistance and guidance on programme implementation in the health sector as well as related to interventions for key population on HIV prevention and linkages to care. This includes maintaining or improving quality standards, and monitoring support from the central level, ensuring that KP/PLHIV interventions will continue to be prioritized and that quality and access to HIV services among KP/PLHIV are maintained and further improved.

It is important to note that NCHADS, NAA and key civil society organizations in Cambodia may, in a way, be victims of their own success. By achieving a reduction of the number of new HIV infections and AIDS-related deaths over the past decade, the idea has emerged that the HIV epidemic is under control, whereas in reality the HIV response needs to be sustained in order to prevent a resurgence of new HIV cases. At senior level in MOH, NCHADS and NAA there is concern about the decreasing levels of awareness about HIV among Cambodian teenagers and youth, the rise of Syphilis observed in some places and populations, and other warning signs indicative of the need to at least maintain and possibly increase levels of investment in HIV prevention, testing, care and support.

5. DEFINING SUSTAINABILITY IN THE CAMBODIAN CONTEXT

DEFINITION:

A sustainable HIV response in Cambodia maintains leadership, multisectoral partnership, and investment at all levels to ensure inclusive, local- and community-owned and people-centered HIV and related services that will provide continuing control of the HIV epidemic and resilience to socio-economic shocks and to other pandemics.

This definition was developed and agreed upon by all participants at the Sustainability workshop held on 16-17 November 2022. The definition recognizes that sustainability is beyond financial investments. Sustainability, by definition, is multi-faceted, and promoting sustainability needs to take epidemiological factors, political factors, structural factors, programmatic factors and human rights-related factors into consideration, besides financial factors¹⁶.

16 Gemma Oberth & Alan Whiteside (2016) What does sustainability mean in the HIV and AIDS response?, African Journal of AIDS Research, 15:1, 35-43, DOI: 10.2989/16085906.2016.1138976

6. TEN RISKS AND 24 MITIGATING ACTIONS TOWARDS A SUSTAINABLE HIV RESPONSE IN CAMBODIA

Two overarching, fundamental risks were identified during the process of updating the Sustainability Roadmap, followed by three risks related to HIV service delivery, three risks related to CSOs and CBOs and two risks related to costs and financing. Each of these ten risks will be discussed in this section, together with a total of 24 mitigating actions.

The first (overarching) risk is that in the context of declining external support, there is a **lack of a common long-term vision on sustainability**, and failure to establish a common implementation mechanism for the HIV response after 2029—a mechanism that clearly defines the respective roles of the health sector and a clear role for CSOs in the HIV response. Related to this, there is a risk that if NCHADS is not sufficiently supported with domestic resources, the HIV response for key populations becomes ‘decentralized and deconcentrated’ and loses its focus and quality, resulting in confusion, reduced efficiency, fragmentation and lower coverage—and ultimately, a resurging HIV epidemic.

Two mitigating actions were defined in order to address this risk. First, NAA, NCHADS, KP/PLHIV networks and other stakeholders should develop an unanimously agreed document describing and outlining their common vision for a sustainable HIV response in Cambodia, including a definition of sustainability and roles and responsibilities of NCHADS, NAA and other stakeholders. This updated Sustainability Roadmap document can be seen as the first step towards this aforementioned vision document. Secondly, findings of NSPV MTR and NSP MTR and sustainability roadmap review will help define long-term vision and roles of key stakeholders in the forthcoming NSPVI, NSP and in the forthcoming National policy to end AIDS by 2025 and HIV sustainability 2023-2028.

The second overarching risk is that NCHADS and other key partners will not benefit from the ongoing capacity building by TA agencies due to the rapid staff turnover that has been reported by key informants. As a result, knowledge and skills are often not institutionalized which may lead to a **loss of technical capacity to manage the HIV response effectively in the long term**. In addition, high-level technical posts in epidemic modeling, forecasting, data management, and research could be abolished after GF leaves. This, as well as the lack of institutionalization of knowledge and skills, would negatively impact NCHADS, and lead to disruption or discontinuation of technical support in all areas and supervision to the health sector response to HIV as well as to HIV interventions delivered by CSOs.

In terms of mitigation, as part of the vision document described above, advocacy for longer-term contracts should be conducted and agreed for funding by the government. Second, where possible, key technical posts should be integrated in the MOH system, making them permanent. This will ensure sustainability for key functions necessary in providing support to the HIV response.

The third risk (related to HIV service delivery and health system) is that MOH takes over ARV

and other HIV commodity procurement, without first establishing the necessary capacity of the national procurement mechanism, resulting in a shift to less efficient processes and higher costs. Capacity building efforts on procurement are currently led by CHAI, but—similar to Risk 2 above—high staff turnover causes a low level of institutionalization of these efforts.

Three mitigating actions were defined to address this risk. First, MOH should not take over ARV and other HIV commodity procurement until it has been independently verified that it is ready to do so, with sufficient oversight. Second, trust from donors should be built on the procurement capability of MOH by strengthening of procurement procedures and by connecting the procurement network with the international community in order to achieve lower-cost commodities. And third, the capacity of government staff and contract staff should be further built (with good pay to reduce turn-over), particularly in the areas of forecasting, data management, and procurement.

The fourth risk (related to HIV service delivery and health system) is that **key populations may not be covered by HEF/IDPoor** while losing the support they currently receive from CSOs/NGOs after donor support ends. This lack of socio-economic support could lead them to drop out of HIV services, leading to a resurgent HIV epidemic.

Two mitigating actions to address this risk are advocacy by NAA and KP networks to include KP in HEF/IDPoor with the Ministry of Planning, considering the risk of HIV and STI service discontinuation that may fuel a resurging HIV epidemic as arguments for why this is necessary. Second, the donor community should support advocacy with RGC to ensure KP access to HEF for those who need it.

The fifth risk (related to HIV service delivery and health system) is that if AHF-supported posts supporting ART treatment are terminated, **Government health staff may be unable to absorb the workload**, which may lead in decreases in ART enrolment and adherence in the medium to long term.

Three mitigation actions to address this risk are to develop a transition plan (which is currently in the process of being developed). Through this plan, AHF support will be taken over by NCHADS with transition of clients to NCHADS clinics. Second, collaboration and technical support from government clinics to NGO partners should be strengthened. Third, the process of hand-over should be done gradually; in other words, there should be a gradual increase in the number of government-funded health staff at locations where AHF is currently working; the process should be carefully planned.

The sixth risk is related to CSOs and CBOs. It is that **HIV services for key populations would be directly implemented by the health sector** after international donor support ends, because the Government cannot agree on or find a way to contract CSOs to reach them (or CSOs cannot adapt to/fulfill the requirements for receiving government funding in time). This could lead to reduced access, quality and coverage of KP, leading to a resurgent HIV epidemic in KP and their partners.

In terms of mitigating actions, one was defined. It is important that CSO-implemented interventions are well-documented, so that their effectiveness and essential function in the HIV response in Cambodia are clearly understood by key policy makers. Developing a clear 'investment case' for CSO-led HIV interventions can help do this—this should be part of the

next GF grants. At the same time, social contracting, as part of the SCN#213, should be implemented, and the capacity of CSOs to follow government rules and regulations when implementing government-funded activities should be strengthened (see below).

The seventh risk is also related to CSOs and CBOs. It states that continued lack of urgency about the need to become more sustainable and self-reliant among CSOs results in **CSOs being unprepared to receive government support or not strong enough financially to continue providing services, leading to loss of coverage for HIV and social support services for KPs and PLHIV** and, hence, re-emerging HIV epidemics. A smaller but related risk is that GF will not allow social enterprise models to be piloted during the next two GF grants because GF has so far always required for HIV services to be free—and according to Cambodian law, AIDS care should be free as well.

Three mitigating actions to deal with this risk are proposed: First, the next GF grants should focus on ensuring a continued role for CSOs/CBOs in the HIV response in the long term. New ways for financial sustainability of these CSOs/CBOs need to be found. CSOs/CBOs need to be prepared, capacity-wise, to be able to comply with government financial and administrative procedures and requirements. This could start by the MOEF subnational budget department to develop clear guidelines and training (possibly funded by the next GF grant) and a closer examination of capacity assessments already done for previous GF grants, and compare government requirements with current capacity.

Second, CIP and CDP budgets should be mobilized for HIV outreach and related interventions at the commune- and district level, especially in the four fast-track provinces and the 11 second-priority provinces. And third, there is an opportunity to mobilize private sector contributions to the HIV response, including through corporate social responsibility programs.

The eighth risk is the third one related to CSOs and CBOs. Due to continued uncertainty about the future of CSO-led HIV services as well as the increased workload of outreach staff, key staff could leave CSOs to work elsewhere, leading to **lower quality CSO-implemented services and less willingness by government actors to consider social contracting in the medium to long term.**

Although this risk is impossible to completely mitigate, it would help if, as part of the Vision document (see under Risk 1), NCHADS/NAA would strongly commit to a vision in which it sees an important role for CSOs/CBOs in implementing HIV services for KP and PLHIV in the future. The next GF grant needs to have a strong focus on the need for continued involvement of CSOs/CBOs in Cambodia's HIV response in the medium to long term, and measures for financial sustainability of CSO/CBOs should be piloted. Secondly, the workload of community workers should be reduced, and/or their working environment should be made more supportive, and they should receive appropriate compensation for reaching their targets.

The ninth risk is related to costs and financing. The government may **not be in a position to react fast enough to expand its budget to cover the funding gaps** that emerge if international donor support largely ends in 2029. Competing financial priorities and lack of urgency could restrict the ability of the RGC to prioritize HIV within the government budget—this could be exacerbated if new pandemics or new health crises occur in coming years. This would make it difficult for NCHADS/NAA to make the case to MEF and senior MOH leadership that

their success in controlling HIV in Cambodia requires continued government investment to sustain—this would lead to lower investment in HIV services and, in the medium to long term, lead to a resurgence of the HIV epidemic, especially among MSM and TG.

Five mitigating actions were defined to deal with this important risk. First, NAA and NCHADS/MOH need to continue advocating with MOEF to maintain financial support for the HIV response using government funds. It is important to have projections and forecasts for funding needs several years in advance, so this information can be used in a long-term advocacy push, also involving CSO/CBOs and KP and PLHIV networks. Second, donor partners should, for as far possible, provide clear information about their funding phase-out plans so that there is sufficient time to prepare for transition. Third, the effective implementation of SCN#213 (all policy measures), including social contracting (Policy Measure #4), will help alleviate this risk further. Fourth, the forthcoming National Policy for Ending AIDS, NSPVI and next NSP for health should include measures towards financial sustainability of the HIV response. And fifth, HIV services need to be included in NSSF, and the HEF scheme should be expanded to include private health care providers—in order to do so, strong advocacy efforts are required.

The tenth and final risk, also related to costs and financing, is that Cambodia could be potentially graduating from the Least Developed Country status (LDC) at or around the same time as donors leave, while TRIPS flexibility is not in place, **leading to much higher ARV and other commodity prices in the HIV response, leading to a much bigger funding gap** for the HIV response than would otherwise have been the case.

The mitigating action to address this risk is for the NAA to advocate and work with relevant ministries (Ministry of Commerce, Ministry of Foreign Affairs, Ministry of Health) and partners to ensure that Cambodia access to Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) on ARVs and other commodities is maintained.

7. LEAD AGENCY, TIMELINE AND MEASURING PROGRESS ON THE ROADMAP

In the table below, the risks and mitigating actions are summarized, a timeline is proposed, lead agency and partner agencies are proposed, and metrics for measuring progress are also shown.

TWO OVERARCHING RISKS

#	Risk	Mitigating actions	Lead agency	Time line	Metrics
1	Lack of agreed long term vision on sustainability with agreed roles for NAA, NCHADS, CSOs	Develop vision document (build on the updated Roadmap) Ensure MTR, Roadmap feed into GF proposal, NSPVI and NSP	NAA and MOH/ NCHADS (lead) STWG, MEF, MOI and stakeholders	18 months	Vision document 1. Drafted, 2. Discussed, 3. Reviewed, 4. Agreed, 5. Adopted STWG meets regularly to monitor progress
2	Lack of institutionalization of capacity building efforts in NCHADS and other agencies	Longer-term contracts for key staff. Integration of key posts in Govt system	MOH/NCHADS (lead) NAA, MEF, MOI and relevant stakeholders	24 months	%-age of technical staff at NCHADS on long-term contracts %-age of technical staff formally integrated in the MOH HR system

THREE RISKS RELATED TO HIV SERVICES AND THE HEALTH SYSTEM

#	Risk	Mitigating actions	Lead agency	Timeline	Metrics
3	MOH takes over ARV and other HIV commodity procurement, without first establishing the necessary capacity of the national procurement mechanism	MOH should only take over when it is ready Strengthen procurement processes and procedures Build capacity of MOH procurement staff, better pay	MOH/NCHADS (lead) CHAI UN agencies	36 months	Readiness assessment completed with satisfactory outcome.
4	Key populations may not be covered by HEF/IDPoor while losing the support they receive from CSOs/NGOs after donor support ends	Advocacy to include KP in HEF/IDPoor Donor support for advocacy efforts	NAA (lead) MOP, NSPC, MOH/NCHADS, KP networks, donors	24 months	KP considered and included in vulnerable population list entitled for HEF/IDPoor with specific criteria (not a barrier)
5	AHF support ends, government unable to absorb extra workload	Develop transition plan Strengthen collaboration between govt partners and NGO clinics Carefully plan a gradual handover	NCHADS (lead) AHF	24 months	%-age of AHF vs Government funded HIV treatment staff Adherence rate in AHF vs Government-funded sites

THREE RISKS RELATED TO CSO/CBOS

#	Risk	Mitigating actions	Lead agency	Time line	Metrics
6	HIV services for KP directly implemented by health sector	Document important role of CSOs in HIV response Push for implementation of SCN#213, which includes social contracting component	CSO and community networks (lead) NAA, MOH/ NCHADS, MoEF, UNAIDS	18 months	Documentation of CSO interventions defining their value added completed. SCN#213 component on social contracting implemented
7	CSOs not prepared for future without donor support, leading to loss of prevention and linkages to care programs for KP	Focus GF grants on preparing CSOs for sustainable future, including ability to receive government funds Mobilize CIP/ CDP budgets for HIV outreach and related interventions Mobilize private sector support	CSOs and community networks (lead) NAA, MOH/ NCHADS, MoEF, UNAIDS, local authorities, private sector	18 months	Include strong focus on strengthening CSOs in next GF proposal Ensure TA providers in Cambodia focus on strengthening CSO self-reliance Social contracting and social enterprise are in place # of private companies contributing to CSOs
8	Loss of qualified staff due to uncertainty about future of CSOs	Include need for CSO role in Vision document, AIDS policies, NSP etc Reduce workload of CSO staff, improve work environment	NAA, MOH/ NCHADS, CSO/CBOs (lead) MoEF, UNAIDS	24 months	Ensure Vision document includes strong commitment to supporting CSO service delivery Pilot new funding models for CSOs during next GF grant

TWO RISKS RELATED TO COSTS AND FINANCING

#	Risk	Mitigating actions	Lead agency	Time line	Metrics
9	Government cannot cover funding gaps soon enough	<p>Advocacy with MoEF for continued investment in HIV</p> <p>Donors to provide timely warning before leaving</p> <p>Implement SCN213</p> <p>Nat Policy, NSP VI and NSP to include measures to further sustainability</p> <p>Include HIV services in NSSF and expand HEF to private sector</p>	<p>NAA (lead)</p> <p>MOEF, MOH/ NCHADS, newly established RGC for national policy development (SCN927), Sustainability Working Group</p>	36 months	<p>Prepare investment case for MOEF and MOH for continued HIV investment</p> <p>Ensure further integration of HIV with other health concerns</p> <p>Progress report of SCN#213 implementation</p> <p>National Policy, NSPVI, NSP for health developed with strong sustainability focus</p> <p>HIV services included in NSSF, and HEF expanded to cover private sector</p>
10	No TRIPS flexibility in place when Cambodia loses LDC status	<p>advocate/work with MoC, MoFA, MOH and partners to ensure that Cambodia access to Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) on ARVs and other commodities</p>	<p>NAA, MoH/ NCHADS (lead)</p> <p>MoC, MoFA</p>	24 months	<p>Ensure the sustainability working group works towards TRIPS flexibility before the end of the next GF grant</p>

8. CONCLUSIONS AND NEXT STEPS

In the medium to long term, increasing efforts towards greater sustainability is the only way for Cambodia to safeguard the successes of its HIV response achieved to date, and to prevent the country from having to face a resurgence of the HIV epidemic. Maintaining (and eventually expanding) coverage of HIV prevention, testing and linkages to care services for key populations, keeping the number of new infections low, will ensure that much higher costs will not need to be made for lifelong ART provision in the future. Planning for a sustainable response to HIV and AIDS should be accorded priority to avert the risk of an earlier than anticipated significant decline in donor funding.

Therefore, moving forward, all stakeholders that form the national HIV response should place a much stronger emphasis on preparing Cambodia for a sustainable HIV response, including ensuring active and sustained CSO/CBO engagement in the HIV response. For this to happen, a common vision and clear division of roles between NAA, NCHADS, CSOs and other stakeholders needs to be agreed upon, led by the Sustainability Technical Working Group.

This Roadmap is a first step in that direction, but it needs far more detail in terms of defining the specific roles of different stakeholders, precise steps for implementation of the proposed mitigating actions, and who is responsible for implementing these actions. The risks and mitigating actions in this roadmap will need to be deepened, made more detailed, and they should be regularly revisited and updated.

The upcoming design of the next Global Fund grant and the development of the next NSP lend excellent opportunities to strengthen these needed emphases and funding mechanisms for NCHADS, NAA and CSOs/CBOs.

ANNEX 1: LIST OF PARTICIPANTS AT THE SUSTAINABILITY WORKSHOP ON 16-17 NOVEMBER 2022

Venue: Cambodiana Hotel

#	Name	Position/ Institutions
1	H.E Ieng Mouly	Chair of NAA
2	HE Dr. Tia Phalla	Vice Chair of NAA
3	HE Dr. Ros Seilavath	Vice Chair of NAA
4	H.E Dr Suth Thang Phann	Chief of Cabinet of NAA
5	HE Dr Chhim Khin Dareth	Secretary General of NAA
6	H.E Dr Sim Sophay	Deputy Secretary General, NAA
7	H.E Dr Tep Navuth	Director of PMER department, NAA
8	Dr Ly Chanravuth	Deputy Director, PMER Department, NAA
9	Sauth Phearum	Officer, NAA
10	Pen Sereyvong	Officer, NAA
11	Tan Sokhey	M&E TA, NAA
12	Kim Teng	NAA
13	But Sreyna	NAA
14	H.E Lo Veasnakiry	Secretary of State, MOH
15	H.E Dr Lon Chanraksmeay	Deputy Director General, MOH
16	So Nary	Chief Office, DBF/MOH
17	H.E Keo Chakriya	Secretary of State, MEF
18	Bik Lak	Deputy Secretariat, MEF
19	Chhun Bunnary	Chief Office, MEF
20	Chhun Sokha	Officer, MOEF
21	Kim Sopheak	Assistant, MEF
22	H.E Lay Onry	Deputy Director General, MOI
23	Tren Maren	Deputy Chief Office, MOI
24	Lay Chanthou	Officer, MOI
25	Maun Chansarak	Department Director, MOP
26	Sar Chivorn	Deputy Department Director, MOP
27	Chin Narong	Focal Point, MOEYS
28	Dr Ouk Vichea	Director, NCHADS
29	Dr Samreth Sovannarith	Deputy Director, NCHADS
30	Dr Ngauv Bora	Deputy Director, NCHADS
31	Dr Tep Samnang	Chief of BCC Unit, NCHADS
32	Youk Pheaktra	Officer, Ministry of Civil Services
33	Virak Kruey	Officer, GS-NSPC
34	Pen Norakvuth	NSSF

#	Name	Position/ Institutions
35	Phang Malika	NSSF
36	Sok Sovanseilatat	NSSF
37	Dr Ly Vanthy	Deputy Director, USCDC
38	Dr. Sok Bunna	Program Management Specialist, USAID
39	Dr Hy Chhaily	PEPFAR Coordinator, USCDC
40	Seng Sopheap	Country Representative, FHI360
41	Steve Wignall	Project Director, EpiC/FHI360
42	Nhim Dalen	Strategic Information Technical Adviser, EpiC/FHI360
43	Nicholas Edwards	Chief of Party, LHSS
44	Dr Srey Mony	Principle Adviser, LHSS
45	Dr Khun Sokrin	Consultant, LHSS
46	Ms. Patricia Ongpin	Country Director, UNAIDS
47	Dr Khin Cho Win Htin	Strategic Information Adviser, UNAIDS
48	Ung Polin	Strategic Intervention Adviser, UNAIDS
49	Chheav Aphyra	Senior Program Officer, CRS
50	Ann Piseth	M&E Officer, RHAC
51	Dork Pagna	Executive Director, MHSS
52	Chhorn Sona	Program Coordinator, MHSS
53	Choub Sok Chamreun	Executive Director, KHANA
54	Seng Por Sourn	Project Manager, KHANA
55	Kem Vichet	Program Manager, MHC
56	Pov Pheakdey	Excom member, Bandanh Chaktomuk
57	Nov Dane	DFoNPAM representative
58	Path Mariya	DFoNPAM representative
59	Chhorn Ann	Program Manager, CWPD
60	Un Chenda	Program Manager, KORSANG
61	Tith Vanny	CNPUD Representative
62	Tith Chantha	Assistant, CPN+
63	Khem Sophy	Program Coordinator, Mith Samlanh
64	Chhan Sothy	Medical Coordinator, Mith Samlanh
65	Yun Phearun	Executive Director, Chhouk Sar Association
66	Heng Chheangkim	Program Manager, AUA
67	Kavin Yi	Manager, CHAI
68	Huy Angtola	Associate, CHAI
69	Tim Vora	Executive Director, HACC
70	Khun Rathana	HACC
71	Jan W. de Lind van Wijngaarden	Consultant

