National HIV/AIDS Monitoring and Evaluation Guidelines

January 2008

Foreword

The National HIV/AIDS Monitoring and Evaluation Guidelines aim to provide the framework for monitoring the progress and evaluating the outcomes of Cambodia's multi-sectoral response to the HIV/AIDS epidemic as outlined in the Revised National Strategic Plan 2006-2010 (NSP II).

In line with the Three Ones principle of *one monitoring and evaluation framework being applied in the national response to HIV/AIDS*, these guidelines are part of our efforts to establish and strengthen a comprehensive and integrated monitoring and evaluation system.

The Revised National Strategic Plan already includes an M&E Framework, which identifies a set of core indicators and targets for monitoring and evaluation of the national, multi-sectoral response to HIV/AIDS. Since then, further progress has been made in the form of a set of indicators and targets for Universal Access and the development of a comprehensive M&E guideline by the National Centre for Dermatology, HIV/AIDS and STDs (NCHADS). In addition, a set of revised indicators has been made available for the 2008 UNGASS reporting. These M&E Guidelines should be seen as a logical next step and an effort to incorporate previously developed monitoring and evaluation instruments.

Many of our partners in the national, multi-sectoral response to HIV/AIDS have made considerable progress in establishing strong monitoring and evaluation systems. Whilst these efforts are recognised and valued, there is also a need to link these systems and to bring together important information from various sources in one integrated and comprehensive national M&E system.

These National M&E Guidelines represent an important step in the process of establishing a national M&E system. However, further work needs to de done, not only in establishing the system itself, but also in terms of building the human capacity to maintain, strengthen and use the national M&E system.

These National M&E Guidelines were developed under the leadership of the National AIDS Authority and with considerable participation from committed M&E professionals from government, civil society and development partners. I would like to conclude by emphasizing that it is essential to adopt a similar approach to putting into practice these guidelines; a comprehensive national M&E system that is coordinated by the National AIDS Authority, with participation from and drawing on the important and valuable efforts of our partners in monitoring and evaluation of Cambodia's multi-sectoral response to the HIV/AIDS epidemic.

Acknowledgements

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The National AIDS Authority would like to express its appreciation to everyone who contributed to the development of these National HIV/ AIDS Monitoring and Evaluation Guidelines.

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Abbreviations

AIDS	Aquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ATS	Amphetamine Type Stimulants
BSS	Behavioural Sentinel Surveillance
CBO	Community Based Organisation
CCW	Cambodian Community of Women living with HIV/AIDS
CDHS	Cambodia Demographic and Health Survey
CENAT	National Centre for Tuberculosis and Leprosy Control
CMDG	Cambodia Millennium Development Goals
CPN+	Cambodian People Living With HIV/AIDS Network
CRIS	Country Response Information System
DAC	District AIDS Committee
FBO	Faith Based Organisation
GDJ-TWG	Government-Donors Joint Technical Working Group
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HACC	HIV/AIDS Coordinating Committee
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IDU	Injecting Drug Users
KHANA	Khmer HIV/AIDS NGO Alliance
M&E	Monitoring and Evaluation
M&E AG	Monitoring and Evaluation Advisory Group
M&E ASG	Monitoring and Evaluation Advisory Sub-Group
MER	Monitoring, Evaluation and Research
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MSM	Men who have Sex with Men
NAA	National AIDS Authority
NAA-CC	National AIDS Authority Coordination Committee
NAA-PB	National AIDS Authority Policy Board
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology, and STDs
NCMCH	National Centre for Maternal and Child Health
NGO	Non Governmental Organization
NIPH	National Institute of Public Health
NIS	National Institute of Statistics
NSDP	National Social Development Plan, 2006-2010
NSP II	National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS, 2006-2010
OD	Operational District
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAO	Provincial AIDS Office
PAS	Provincial AIDS Secretariat
PHD	Provincial Health Department
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission

PR	Principal Recipient of GFATM
ProTWGH	Provincial Technical Working Group for Health
RGC	Royal Government of Cambodia
SR	Sub-Recipient of GFATM
SSS	STI Sentinel Surveillance
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	Special Session of United Nations General Assembly
VCCT	Voluntary Confidential Counselling and Testing

I. Introduction

I.1 HIV and AIDS in Cambodia

The first HIV and AIDS cases were detected in Cambodia in 1991 and 1994, respectively. The epidemic peaked in 1997, when HIV prevalence was estimated to be 3% of the adult population aged 15 to 49 years. Since then, the prevalence of HIV in the adult population has been decreasing and is now estimated at 0.9%[1]. Furthermore, the incidence of HIV infections has been declining for most of the sentinel groups and mortality due to AIDS appears to have stabilized.

This illustrates the effectiveness of Cambodia's multi-sectoral and pragmatic response to the epidemic. Cambodia is one of the few developing countries that are on track to meet the Millennium Development Goal 6 – "*to have halted by 2015 and begun to reverse the spread of HIV/AIDS*".

Despite these successes there is no room for complacency, and Cambodia now faces the challenges of sustaining its successful response to the HIV epidemic and addressing new emerging risks.

(a) Every year there are people that get newly infected with HIV and will need care and treatment.

(b) There are also new areas of concern that need to be addressed, such as the increasing transmission of HIV within the family (i.e. from husband to wife and from mother to child), the spread of HIV into the rural areas, and the emergence of new most at risk populations (in particular men who have sex with men and drug users).

(c) Finally, strategies that focus on most at risk populations need to be complemented with interventions that address vulnerability and mitigate the long-term consequences of the epidemic.

I. 2 Cambodia's National Strategic Plan II

The National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS 2006-2010 (NSP II) was developed under leadership of the National AIDS Authority and aims to guide the national response to HIV/AIDS in Cambodia.

Almost two years into the implementation of the NSP II, it was felt necessary to update the NSP II to reflect the revised estimates and projections of HIV, the Universal Access targets, the costed strategies and operational plans that had been developed for some of the most-at-risk populations and key sectors and to reflect the 2007 update of the Situation Response Analysis which contains detailed recommendations for an enhanced response to HIV in Cambodia.

[1] Based on the Cambodia Demographic and Health Survey (CDHS) 2005 and the HIV Sentinel Surveillance (HSS) 2006, and estimated at an expert meeting in June 2007.

The National AIDS Authority led the process of developing the revised NSP II in partnership with a Core Group consisting of key partners from ministries, civil society, the private sector and development partners. The process was completed in November 2007 and implementation of the revised NSP II (covering the years 2008-2010) started in January 2008.

The national enhanced response to HIV/AIDS is part of the Royal Government's National Strategic Development Plan (NSDP) for 2006-2010, which aims to achieve "*efficiency and sustainability of social and economic development and poverty reduction in Cambodia*". NSDP is aligned with the Cambodia Millennium Development Goals (CMDGs) and targets.

The overall **goals** of NSP II are:

1) To further reduce the number of new HIV infections by taking to scale targeted prevention interventions;
2) To increase coverage and quality of care, treatment and support for people living with and affected by AIDS; and
3) To alleviate the socio-economic and human impact of AIDS on the individual, family, community, and society.

The **strategies** of revised NSP II are:

1) Increased coverage of effective prevention interventions and additional interventions developed.
2) Increased coverage of effective interventions for comprehensive care and support and additional interventions developed.
3) Increased coverage of effective interventions for impact mitigation and additional interventions developed.
4) Effective leadership by government and non-government sectors for implementation of the national response to HIV and AIDS, at central and local levels.
5) A supportive legal and public policy environment for the HIV and AIDS response.
6) Increased availability and use of information by policy makers and programme planners through monitoring, evaluation and research.
7) Increased, sustainable and efficiently allocated resources for the national response to HIV and AIDS.

Governance of the national response rests by legal sub-decree (Anukret 1009) with the National AIDS Authority. Membership of the National AIDS Authority includes representatives from 26 Ministries, the Cambodian Red Cross and 24 Provincial Governments.

Implementation of the activities included in NSP II relies on many implementing organizations from public sector, civil society partners (including national and international organizations), religious leaders and faith communities and private sector.

The National AIDS Authority is at the centre of the overall **coordination** of the national multi-sectoral response and coordinates the Government-Donor Joint

Technical Working Group (GDJ-TWG)[2] on HIV/AIDS, while the Ministry of Health (MoH) coordinates the health sector response.

The M&E Advisory Group provides advice to the National AIDS Authority concerning monitoring and evaluation of the national response as well as the national research agenda.

I. 3 Scaling-Up towards Universal Access

The Declaration of Commitment on HIV/AIDS made at the 2001 Special Session of the UN General Assembly (UNGASS) was an important milestone in the global response to HIV/AIDS. Since then the global AIDS response has steadily grown and gained considerable momentum and there is now a global commitment "*to develop and implement a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it*"

The Universal Access process, facilitated by UNAIDS, is driven by the countries themselves with support from multi- and bi-lateral agencies and donor organizations. The process aims "*to identify solutions to key obstacles that are blocking comprehensive and integrated scale-up of prevention, treatment, care and support services and to develop nationally agreed, targeted plans ('roadmaps') for building significantly greater coverage of services by 2010.*"

In Cambodia, the first national consultation meeting on scaling-up towards Universal Access was held in February 2006. The meeting resulted in a country report (presented at the regional consultation in Pattaya, 14-16 February 2006), which identified obstacles and recommended actions to overcome identified obstacles, and five-year targets for each of the recommended actions.

A second consultation meeting was held in November 2006 with the aim to improve understanding of Universal Access as a concept and its related indicators and targets and to refine and come up with common indicators and targets. The meeting resulted in a common set of 21 Universal Access indicators and agreed targets for each of the indicators (see annex 3).

[2] The GDJ-TWG has been established by the Royal Government of Cambodia (RGC) as a joint working group between the RGC and the development partners (bi- and multi-lateral donors and civil society). This Working Group has the role to provide strategic and technical guidance and coordination, and to assist the RGC to meet agreed targets as agreed in NSP II and confirmed in the Universal Access consultation in February 2006.

II. Rationale of National HIV/AIDS Monitoring and Evaluation Guidelines

The rapid scale-up of the global response to HIV/AIDS has been accompanied by a growing emphasis on measurable results. This has resulted in increasing demands on country-level monitoring and evaluation systems.

In Cambodia, monitoring and evaluation is recognised as a critical task and is an integral part of the national response to HIV/AIDS. This is reflected in the fact that NSP II identifies monitoring and evaluation as one of the strategic areas in the national response to HIV and AIDS. Furthermore, NSP II reiterates the Three Ones Principle and hence, is in support of one monitoring and evaluation framework being applied in the national response to HIV/AIDS.

The present National HIV/AIDS Monitoring and Evaluation Guidelines (in short, "the National M&E Guidelines") can be viewed as the logical next step and as an effort to provide guidance on how to monitor and evaluate Cambodia's multi-sectoral response to the HIV/AIDS epidemic.

II.1 Goals and Objectives of the National HIV/AIDS Monitoring and Evaluation Guidelines

In general terms, the purpose of any monitoring and evaluation system is to guide the process of collecting, analysing and presenting data, based on pre-defined indicators, in order to quantify the level of performance and achievement of a defined strategy and to inform the development of future strategies and interventions.

The **goal** of the National M&E Guidelines is to provide a coherent and integrated framework for monitoring progress and evaluating the outcomes of Cambodia's multi-sectoral response to the HIV/AIDS epidemic as outlined in NSP II.

The specific **objectives** of the National M&E Guidelines are:

1) To facilitate data collection and analysis needed to "tell the story" of the national, multi-sectoral response to HIV/AIDS as planned in the NSP II, through addressing both the course of the epidemic as well as the coverage of crucial services that are part of the national response.

2) To ensure the accountability of various sectors for the performance and achievements of the national, multi-sectoral response to HIV/AIDS in terms of immediate results and ultimate outcomes.

3) To provide a mechanism to bring together crucial information concerning all the elements of the multi-sectoral response and to make this information available to decision-makers (policy makers as well as programme planners).

Monitoring and evaluation of the national, multi-sectoral response requires the collection, analysis and reporting of a multitude of information:

- Information to assess progress made in the implementation of NSP II strategies and in achieving intended outcomes, including information generated through a comparison with baseline data.
- Information that will allow the identification of emerging trends and changes in the programme environment.
- Information required by managers for reporting nationally and internationally on achievements and progress made in the national response to HIV/AIDS.
- Information that will guide decision-makers in policy development and strategic planning.

II.2 Process of Developing the National HIV/AIDS Monitoring and Evaluation Guidelines

These National M&E Guidelines were developed under the leadership of the National AIDS Authority and the M&E Advisory Group (M&E AG).

The National M&E Guidelines were developed through a participatory process, which included consultation with relevant stakeholders. The process involved the following activities:

- Comprehensive and in-depth review of documents from Cambodia, other countries and international sources.
- Preparation of the draft outline structure of the National M&E Guidelines.
- Review of the draft outline structure by the M&E Advisory Sub-Group (M&E ASG), responsible for overseeing and guiding the development of the National M&E Guidelines.
- Development of a first draft of the National M&E Guidelines.
- Review of the draft National M&E Guidelines by the M&E Advisory Group.
- Development of a second draft of the National M&E Guidelines based on feedback received from the M&E Advisory Group.
- A workshop with participation of relevant stakeholders and with the aim to obtain stakeholders' agreement to the National M&E Guidelines as well as their feedback.
- Preparation of the final draft of the National M&E Guidelines.

II.3 Organization of the National HIV/AIDS Monitoring and Evaluation Guidelines

These guidelines for monitoring and evaluation of the national, multi-sectoral response to HIV/AIDS consist of five sections:

(i) The introduction (section I) with information on HIV/AIDS in Cambodia, the National Strategic Plan for 2006-2010, and on Universal Access.

(ii) Section II states the goals and objectives of the National M&E Guidelines and gives an overview of the participatory process that was followed to develop the guidelines.

(iii) Section III gives on overview of the key elements of the monitoring and evaluation of the National Strategic Plan 2006-2010.

(iv) The comprehensive National HIV/AIDS M&E System is discussed in section IV of these guidelines. This section provides a list of 54 core indicators and describes the data sources and data flow for each of these indicators. In addition, this section discusses issues such as:
- data storage, management and analysis,
- data use and dissemination,
- evaluation and research,
- M&E capacity building,
- M&E advocacy and communication, and
- Monitoring and evaluation of the monitoring function.

(v) The final section (section V) draws main conclusions, with emphasis on outstanding issues and recommendation on how to overcome these issues.

III. Monitoring and Evaluation Framework of NSP II

In close collaboration with the M&E Advisory Group, the National AIDS Authority is responsible for the coordination of overall monitoring and evaluation of the national, multi-sectoral response to HIV/AIDS in Cambodia as defined by the National Strategic Plan 2006-2010 (NSP II).

The many agencies involved in the implementation of the national response continue to monitor the implementation of their own activities and to evaluate their own specific programmes. At the same time, implementing partners are encouraged to share progress reports, service statistics, surveys reports, and other information, with the National AIDS Authority to allow this information to be used for monitoring and evaluation of the national, multi-sectoral response.

Key elements of the monitoring and evaluation of the revised NSP II are:

- The national operational plan 2008-2010; and
- The monitoring and evaluation framework.

The **national operational plan 2008-2010** identifies specific objectives and targets for each of the seven strategies included in NSP II. Furthermore, the operational plan identifies broad activities to be implemented for each of the specific objectives and the agencies involved in the implementation of these activities.

Based on the national operational plan, the National AIDS Authority and its implementing partners develop an annual operational plan that aims to guide the implementation of the national response each year.

The National AIDS Authority reports annually on the implementation of the annual operational plan. Data are collected by the National AIDS Authority from two main sources to prepare annual and quarterly reports:

- Ministries and other national-level government departments; and
- Provincial AIDS Secretariats (PAS), who are asked to submit quarterly reports to the National AIDS Authority.

The annual report also reports on a set of 54 indicators and targets that was developed as part of NSP II. As far as available, the **NSP II M&E framework** includes baseline values as well as targets that have been set for each of the indicators and to be achieved by the year 2010.

IV. A Comprehensive National HIV/AIDS Monitoring and Evaluation System

Since the inception of NSP II, there have been several developments that have contributed to a growing need for National HIV/AIDS M&E Guidelines:

(i) There is now common understanding of the need for national M&E guidelines, which not only deal with indicator definitions and methods of measurement, but also provide a description of how the national M&E system works and of what is needed to ensure its effective functioning.

(ii) Progress has been made through the definition of Universal Access indicators and targets and the production of specific guidelines that include detailed indicator definitions and explanations of measurement methods concerning this specific set of indicators.

(iii) Other guidelines have been produced, e.g. the M&E Guidelines of the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) and the UNGASS Guidelines for 2008 reporting.

There is now general agreement of the need for a single, comprehensive national HIV/AIDS M&E system that builds on the NSP II M&E framework and incorporates Universal Access indicators, UNGASS indicators and elements of the NCHADS M&E guidelines.

It is important to note that such a national M&E system is not intended in any way to replace existing systems that are used by implementing partners. Instead, it is intended to coherently link different existing systems and to operate in a complementary and mutually reinforcing fashion.

In other words, the comprehensive national M&E system aims to integrate information that is generated by existing systems, bringing together information from various partners and sectors and hence, facilitating the monitoring and evaluation of the national, multi-sectoral response to the HIV epidemic.

IV.1 M&E Resources and Arrangements

The national M&E system is managed by the National AIDS Authority, with technical guidance from the M&E Advisory Group. The Monitoring, Evaluation and Research (MER) department of the National AIDS Authority has been tasked with the day-to-day management of the M&E system.

Specific functions of the MER department are:

- The development, implementation and maintenance of the national M&E system;
- The collection, analysis and management of relevant data; and
- Reporting, dissemination and documentation.

The MER department is not directly involved with primary data collection. Instead, the unit works closely together with implementing partners, which are the primary source of the data needed for monitoring and evaluation of the national response. The multi-sectoral response includes organizations and agencies at national and sub-national levels, and includes government, civil society as well as the private sector (see figure IV.1).

National Level:

- ***Ministries*** generate their own specific HIV/AIDS related information and provide relevant pieces of information to the National AIDS Authority. It is recognised that while some ministries already have in place adequate information systems, others still need to develop and establish these systems.
  Currently, the MER Department is routinely collecting data from a limited number of ministries, but will gradually include additional ministries as HIV/AIDS is being mainstreamed into the work of government ministries and departments, and their monitoring systems become sufficiently strong to track activities, outputs and outcomes.

- The ***Ministry of Health (MoH)*** is mentioned separately here, given its key role in prevention and care and treatment interventions, especially through the National Centre for HIV/AIDS, Dermatology, and STDs (NCHADS) and the National Centre for Maternal and Child Health (NCMCH). The MoH National TB Programme (CENAT) plays an important role in TB/HIV activities along with NCHADS.
  The MoH is also responsible for the overall Health Information System (HIS) and is closely involved with the implementation of the Cambodia Demographic and Health Survey (CDHS), and functions as the Principal Recipient of HIV/AIDS funding from GFATM (Rounds 1, 2, 4 and 5).

- ***Civil society organizations*** are crucial partners in the information system and include national and international NGOs, community based organizations (CBOs), NGO/CBO networks and membership organizations (e.g. HIV/AIDS Coordination Committee - HACC), pagoda organizations and other faith based organizations (FBOs), and PLHA networks (e.g. Cambodian People Living With HIV/AIDS Network – CPN+, and Cambodian Community of Women living with HIV/AIDS – CCW).
  Many of these civil society organisations already report to line ministries, and some even report directly (through country offices) or indirectly (through Phnom Penh based networks and membership organizations) to the National AIDS Authority.

- ***Donor and technical assistance agencies*** often have their own monitoring and evaluation systems in place and generate useful information, which not always finds its way to the relevant ministries and the National AIDS Authority.
  The United Nations HIV/AIDS joint Support Programme 2006-2010 emphasizes the need to ensure that data collection by UN agencies is consistent with indicators used in the NSP II, UNGASS and CMDGs. In this way, UN collected data can easily feed into the national M&E system, consistent with the Three Ones principles.

It needs to be mentioned here that donor agencies are a crucial source of information on budget allocations and disbursements for HIV/AIDS.

Sub-National Levels:

- At provincial level we find a similar network of stakeholders with the ***Provincial AIDS Secretariat (PAS)*** in a central role and responsible for data collection at provincial level, for organizing data collection from lower levels (through District AIDS Committees and Commune Councils), and for reporting to the National AIDS Authority.
  The type of data collected by the PAS is mainly programme level data concerning the implementation of activities and the achievement of output level indicators and targets included in HIV/AIDS plans.

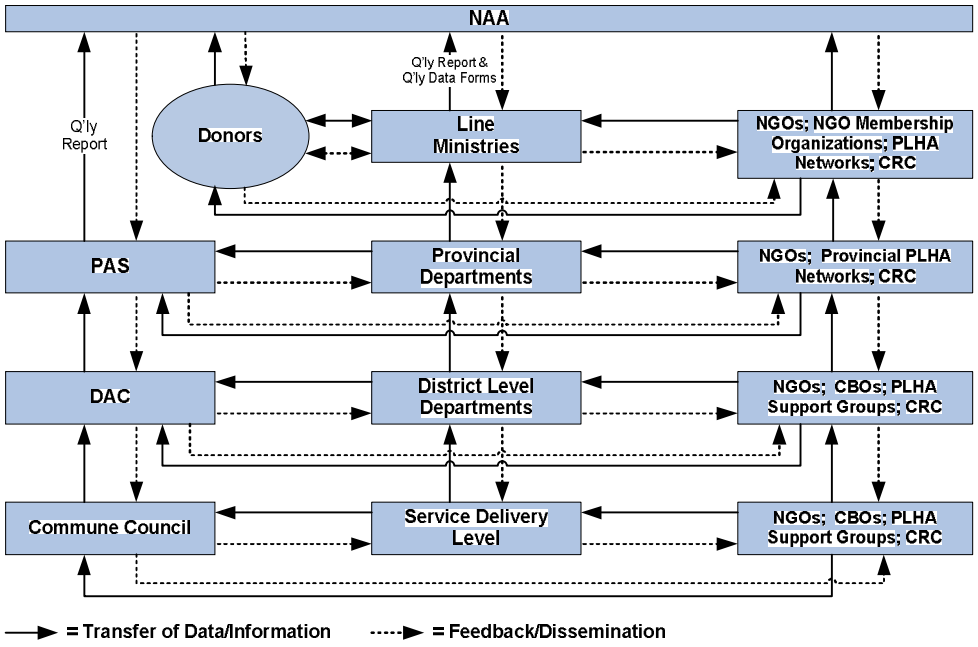
- Several key ***provincial departments*** generate their own HIV/AIDS specific information, usually for purposes of reporting to the respective national level line ministries. A copy of the reports that provincial departments submit to line ministries at national level should systematically be provided to the PAS.

- The ***provincial aids office (PAO)*** is part of the technical bureau of the Provincial Health Department (PHD). The PAO is a key stakeholder at provincial level, responsible for the implementation of prevention, and care and treatment interventions in the provinces.
  The PAO receives monthly reports from the health facilities that provide VCCT and OI/ART services, and prepares quarterly reports that are submitted to NCHADS. These reports need to be copied to the PAS.
  The PHD technical bureau is also responsible for the provision of PMTCT and TB/HIV services, as well as for the provincial level management of the MoH Health Information System.

- In most provinces, ***civil society organizations*** already liaise with each other and with relevant provincial departments. Within the health sector this is formalised in the form of regular meetings between the PHD and the NGOs working in health (the Provincial Technical Working Group for Health - ProTWGH).

Figure IV.1 shows the complexity of various existing and potential flows of data at national and sub-national levels as well as reporting channels from the sub-national to the national level. It demonstrates the challenges of collecting information from a large number of actors at national and sub-national levels and of avoiding reporting of the same information through different channels, i.e. double reporting, resulting in double counting.

Figure IV.1: Overview of existing and potential information flows in Cambodia



The most adequate and appropriate channel for data collection and reporting needs to be identified and defined for each indicator. The flow of data to measure different indicators differs depending on the source and type of data, the nature of institutional structures and linkages, and the data needs at various levels. For example:

(i) Routine monitoring data generated by the health centres (e.g. concerning TB/HIV services – indicator 2.11 in annexes 1 and 2) is transmitted through the Operational District to the Provincial Health Department and then to the central Ministry of Health and/or relevant national health programme. The latter compiles and cleans the data and transmits the data to the National AIDS Authority for storage in the national HIV/AIDS database, commonly referred to as CRIS - the Country Response Information System.

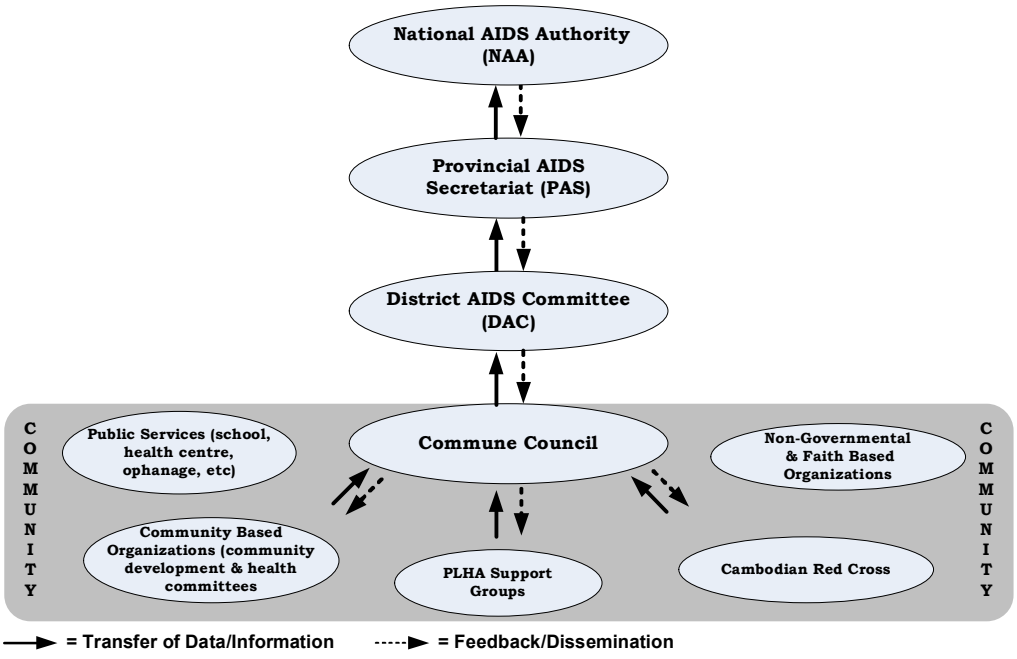
(ii) Similarly, monitoring data collected within the framework of the nation-wide HIV preventive education programme for students and out-of-school youths is obtained by the District Education Office from the schools and then channelled through the Provincial Education Office to the Ministry of Education, Youth and Sports (MoEYS). At ministry level, the data is compiled and cleaned and thereafter transmitted to the National AIDS Authority for central-level storage, processing and use.

(iii) Information needed by the National AIDS Authority to track specific input and output indicators[3], when not already adequately captured through existing sectoral monitoring systems, is gathered at decentralized levels and transmitted through a data flow channel involving the Commune

[3] Such as the number of specific most-at-risk populations exposed to prevention interventions; the number of people trained in HIV prevention; the number of OVC households who received support

Council, the District AIDS Committee (DAC) and the Provincial AIDS Secretariat (PAS). The PAS reports to the National AIDS Authority by means of quarterly reports[4]. This flow of data requires government and non-governmental organizations operating at decentralized levels to report selected data concerning mutually agreed indicators to one of these institutions depending on the level on which they operate.

Figure IV.2: Overview of existing and potential information flows from community to the National AIDS Authority



M&E resources and arrangements are not static and hence, information flows should be expected to change over time. In particular, information flows are likely to change due to concerted efforts to streamline and strengthen monitoring of the multi-sectoral response, to avoid duplication and unnecessary work, and to make the overall national M&E system more consistent and effective. Furthermore, existing indicators will need to be refined and indicators will need to be added or dropped to reflect changes in programme priorities and design and to address the growing need for comprehensive, appropriate and quality data for programming and policy making purposes. Finally, information management and reporting systems are likely to undergo modifications because of changes in institutional structures and procedures and as a result of an increasing capacity of the actors involved in monitoring and evaluation at various levels and across sectors.

These National M&E Guidelines reflect the current situation and clearly define the source of data as well as the flow of data from the source to the National AIDS Authority for 54 selected core indicators (section IV.3) which have officially been endorsed, and are already being used in Cambodia.

[4] Input and output indicators are numerous, varied and change quickly over time. They fall outside the category of 'core indicators', which includes mostly outcome and impact indicators, and are therefore not presented in these National M&E Guidelines.

IV.2 Indicator Selection and Definitions

The core indicators included in the National HIV/AIDS M&E Guidelines have been compiled from existing lists of indicators (Annexes 3 – 5):

- Universal Access indicators - 21 indicators
- Indicators for UNGASS 2008 reporting - 25 indicators
- Cambodia Millennium Development Goals (CMDG) – 7 HIV/AIDS related indicators.
- National Social Development Plan (NSDP) – 1 HIV/AIDS related indicator.

There is considerable overlap between these indicator lists, and careful review has resulted in a list of 54 core indicators for the monitoring and evaluation of the national, multi-sectoral response in Cambodia. Table IV.1 on the next page gives an overview of how these core indicators have been organised according to the NSP II strategies, as well as a summary overview of the types of indicators included.

A detailed overview of the core indicators, together with information concerning the source of data and a reference to the above-mentioned existing indicator lists can be found in Annex 1.

Annex 2 provides detailed information for each of the 54 core indicators, including:

- **Description** of the indicator;
- **Purpose** of the indicator;
- **Measurement**, including a description of the numerator, denominator, and the method of measurement;
- **Data source;**
- **Frequency of data collection;**
- **Strength and limitations** of the indicator; and
- **Further information,** including recommendations for further alignment and harmonization of M&E efforts in the future.

Table IV.1: Summary overview of core indicators, by NSP II strategy

NSP II Strategy	Number and Type of Indicators
Overall Impact Indicators	**3 indicators**, including: • HIV prevalence in the adult population and most at risk populations • HIV incidence in adult population
Strategy 1: Increased coverage of effective prevention interventions and additional interventions developed	**22 indicators**, including: • Condom use by various most at risk populations and young people • Prevention programmes for most at risk populations and in school • HIV/AIDS knowledge of young people and most at risk populations • Various other behaviour indicators • PMTCT
Strategy 2: Increased coverage of effective interventions for comprehensive care and support and additional interventions developed	**12 indicators,** including: • ART coverage and survival of PLHA on ART • VCCT coverage for adult population, pregnant women and most at risk populations • Various other indicators on coverage of Continuum of Care (COC), home based care support and PLHA support groups
Strategy 3: Increased coverage of effective interventions for impact mitigation and additional interventions developed	**7 Indicators**, including: • School attendance among OVCs • Coverage of external support for OVCs or households with OVCs
Strategy 4: Effective leadership by government and non-government sectors for implementation of the national response to HIV/AIDS at central and local levels	**5 indicators,** including: • Ministries implementing HIV/AIDS programmes and their level of participation in NAA • Existence of provincial and commune level development strategies and plans that address HIV/AIDS • Work place HIV/AIDS policies and interventions
Strategy 5: A supportive legal and public policy environment for the national response to HIV and AIDS	**1 indicator:** • National Composite Policy Index
Strategy 6: Increased availability and use of information by policy makers and programme planners through monitoring, evaluation and research	**3 indicators:** • Reports submitted to NAA • Quantity and quality of data in CRIS • Reports and publications prepared and issued by NAA
Strategy 7: Increased, sustainable and efficiently allocated resources for the national response to HIV/AIDS	**1 indicator:** • HIV/AIDS spending by categories and funding sources (National Funding Matrix)

IV.3 Data Sources and Frequency of Data Collection

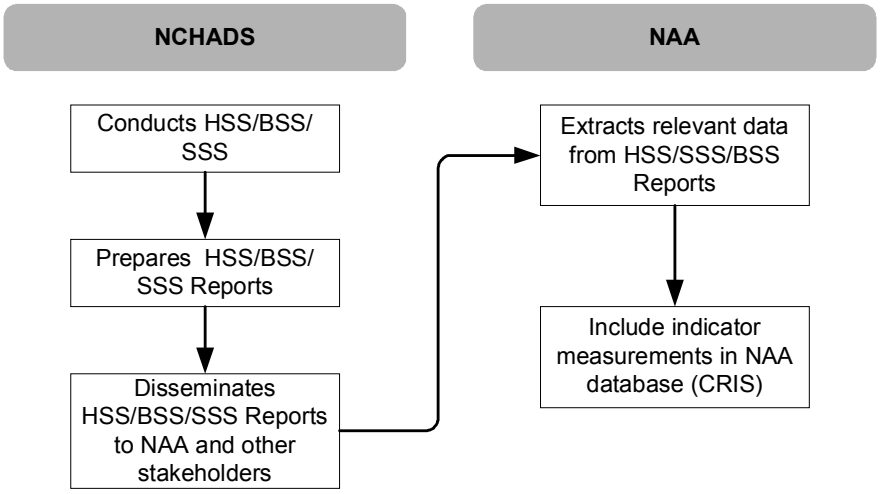
The data sources for each of the 54 core indicators have been identified (see annexes 1 and 2) and the flow of data from these sources to the National AIDS Authority is discussed below (sections IV.3.1 to IV.3.9).

IV.3.1 National Surveillance System

The national surveillance system is the responsibility of the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) and consists of three surveys that are repeated on a regular basis:

1) HIV Sentinel Surveillance (HSS):
   HSS has been conducted 11 times since 2002, with the last survey conducted in 2006. HSS is now conducted less frequently and is planned to be repeated every 2 to 3 years. The next HSS is planned for late 2008 or early 2009.

Figure IV.3: Data Flow – National Surveillance System



   HSS provides HIV prevalence data for pregnant women attending ANC as well as for most at risk populations such as direct and indirect female sex workers, military and police, and moto-taxi drivers. Future surveys should include different sentinel group as a result of changes in the epidemic and the emergence of new groups of people at particular risk of HIV infection (e.g., men who have sex with men and drug users).

2) Behavioural Sentinel Surveillance (BSS):
   BSS has been conducted 5 times since 1997, with the last survey taking place in 2007. BSS is repeated every 3 to 4 years and the results of the latest BSS are expected to be released by late 2007.

BSS provides data for most at risk populations on condom use and access to prevention programmes. Previous BSS focussed on direct and indirect female sex workers, military and police, and moto-taxi drivers. The latest BSS (2007) no longer includes the military and police, while men who have sex with men (MSM) were included as a new sentinel group. Future surveys are likely to include additional sentinel groups, such as injecting drug users (IDUs) and ATS users.

3) STI Sentinel Surveillance (SSS):
SSS has been conducted in 2001 and 2005 and is repeated every 3 to 4 years, with the next SSS planned for 2008 or 2009. SSS 2005 was the first surveillance study to include men who have sex with men.

NCHADS is also responsible for the preparation of surveillance reports and for the dissemination of these reports to the National AIDS Authority and other stakeholders.

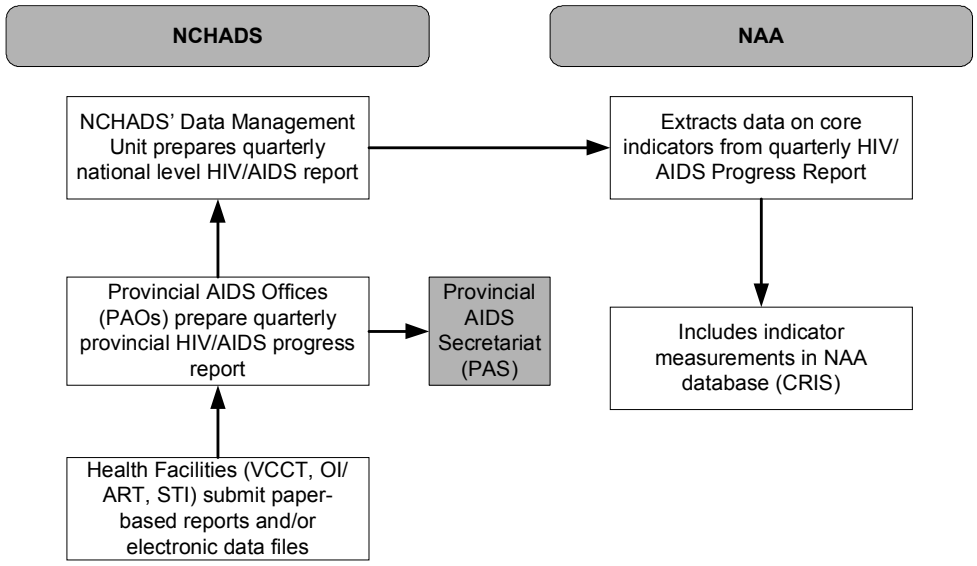
IV.3.2 NCHADS Routine Programme Monitoring

NCHADS collects routine programme data on VCCT, STI, OI/ART and home based care teams, through quarterly reports that are generated at facility level, compiled at provincial level by the Provincial AIDS Office, and verified, analysed and reported by NCHADS.

NCHADS routine programme monitoring was up-dated and standardized in 2005 and allows quarterly reporting in the form of paper-based reports as well as electronic data files.

Over the next few years an increasing number of facilities will switch to quarterly reporting in the form of electronic data files that can be easily transferred to and incorporated into provincial and national level databases, including CRIS at the National AIDS Authority

Figure IV.4: Data Flow – NCHADS Routine Programme Monitoring

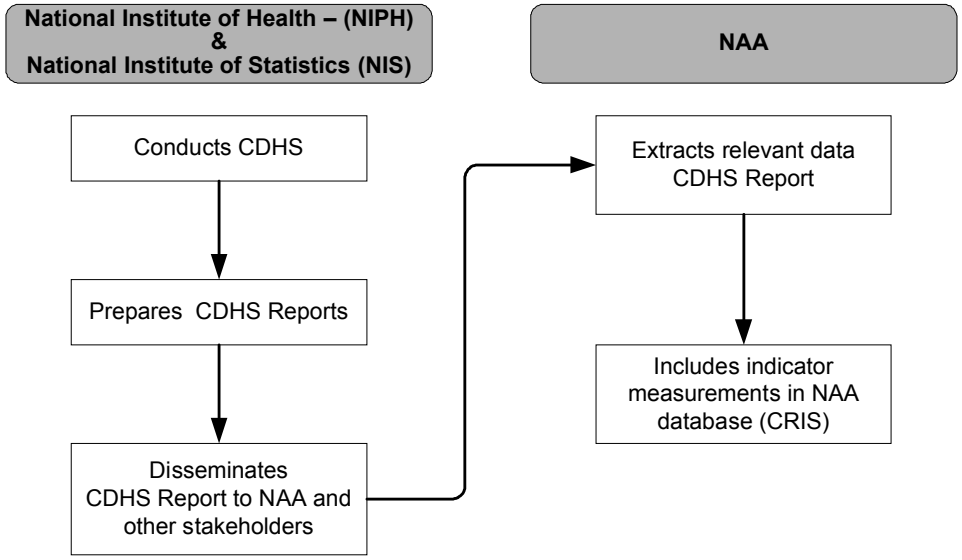


IV.3.3 Cambodia Demographic and Health Survey (CDHS)

The Cambodia Demographic and Health Survey (CDHS) is a population based survey, which includes a special module containing various questions regarding HIV/AIDS.

CDHS interviews a national representative sample of women and men aged 15 to 49 years. The previous CDHS (2000) already provides data on core HIV/AIDS knowledge and behaviour indicators at national level. CDHS 2005 also included sero-prevalence testing and hence, provides data on HIV prevalence among the adult population.

Figure IV.5: Data Flow – Cambodia Demographic and Health Survey (CDHS)



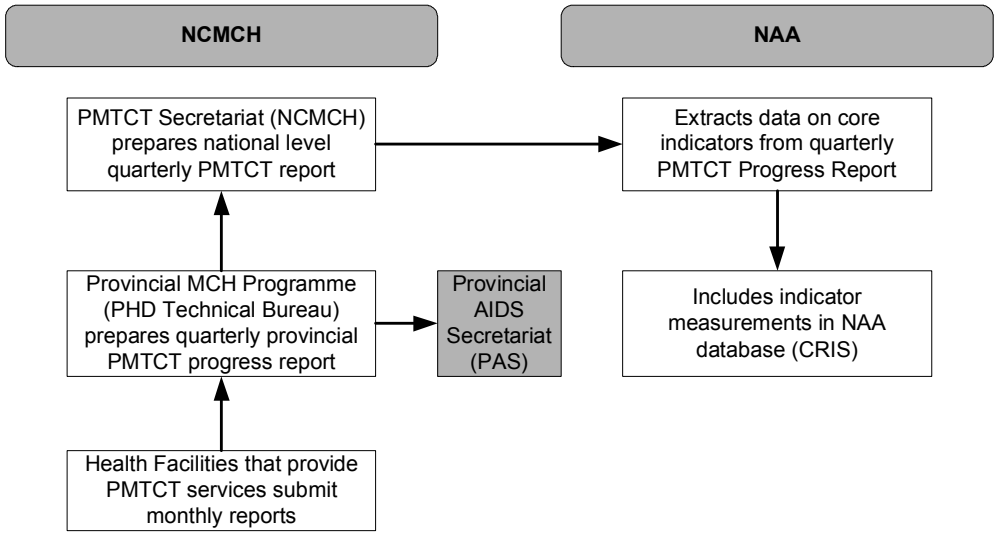
CDHS is conducted by the National Institute of Public Health of the Ministry of Health and the National Institute of Statistics of the Ministry of Planning and is repeated every 5 years.

IV.3.4 National Centre for Maternal and Child Health (NCMCH)

The National Centre for Maternal and Child Health is responsible for Prevention of Mother to Child Transmission (PMTCT) services and thus, for the collection and reporting of routine PMTCT programme data.

Health facilities that provide PMTCT services are required to submit monthly reports to the provincial level Mother and Child Health (MCH) programme under the responsibility of the technical bureau of the Provincial Health Department (PHD). Provincial reports are compiled by the PHD and submitted on a quarterly basis to the PMTCT Secretariat at the national-level NCMCH.

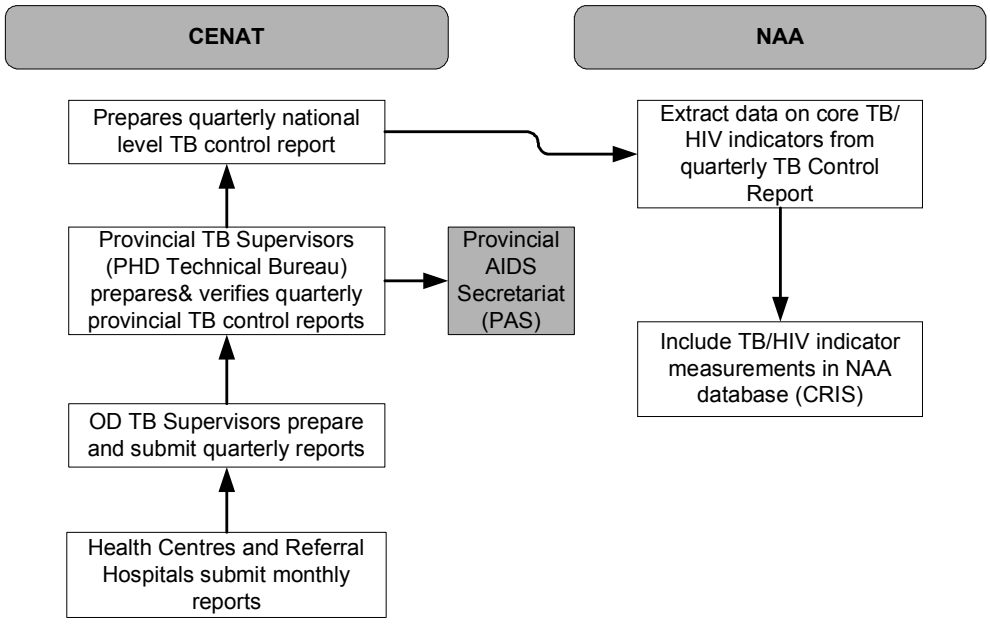
Figure IV.6: Data Flow – National Centre for Maternal and Child Health (NCMCH)



IV.3.5 National Centre for Tuberculosis and Leprosy Control (CENAT)

The routine recording and reporting system of the National TB Programme provides data on core TB/HIV indicators. Information is collected at health facility level and reported through Operational District (OD) and provincial level to the National Centre for TB and Leprosy Control (CENAT) at the national level.

Figure IV.7: Data Flow – National Centre for TB and Leprosy Control (CENAT) – Data on TB/HIV

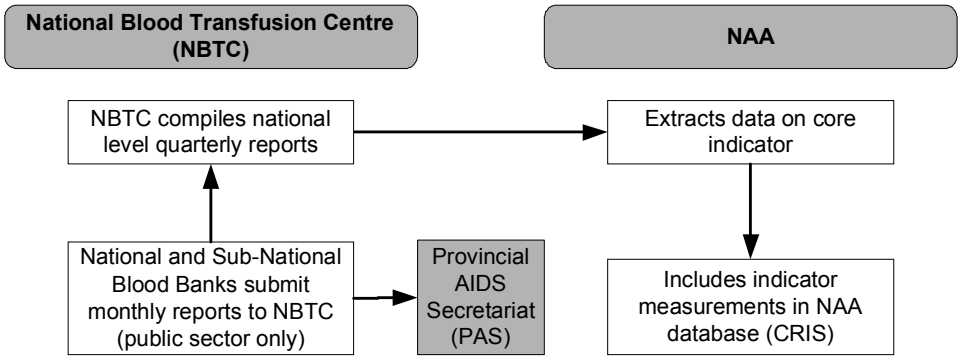


Although health facilities report on a monthly basis, Operational District, provincial, and national level TB control reports are prepared and submitted on a quarterly basis.

IV.3.6 National Blood Transfusion Centre

The National Blood Transfusion Centre (NBTC) collects data on the screening of donated blood units from all blood banks in public sector health facilities.

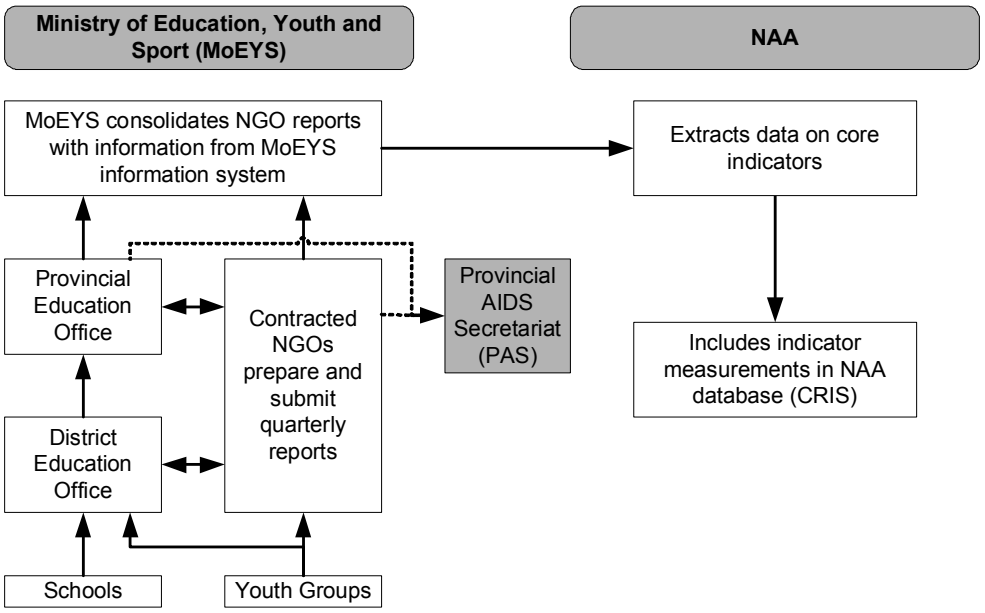
Figure IV.8: Data Flow – National Blood Transfusion Centre (NBTC)



IV.3.7 Ministry of Education, Youth and Sport (MoEYS)

The Ministry of Education, Youth and Sport (MoEYS) has contracted the implementation of the Life Skills for HIV/AIDS Education Programme in 14 provinces to NGOs. These NGOs have developed and are implementing a comprehensive M&E framework, which allows them to prepare quarterly reports to be submitted to the MoEYS.

Figure IV.9: Data Flow – Ministry of Education, Youth and Sport (MoEYS)



The information from NGO quarterly reports is consolidated with the MoEYS monitoring and evaluation information, which is collected and reported by the district and provincial level education offices. Furthermore, MoEYS conducts regular field visits with aim to monitor on-going programmes, using both qualitative and quantitative data collection methods.

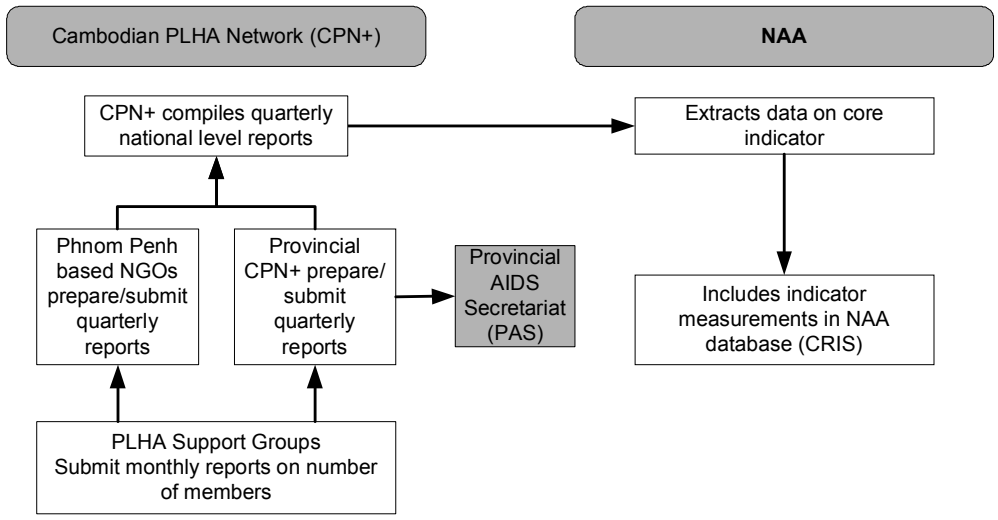
IV.3.8 Civil Society

Civil society organizations report various types of data and information to a range of different institutions, in particular line ministries and donors. The most consistent reporting effort by NGOs, CBOs and other civil society organizations is currently taking place under initiatives sponsored by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The Principal Recipients' monitoring system is an important sub-component of the national M&E system, and aims to track input and output indicators as well as outcome and impact indicators. Data generated in this way should therefore be transmitted regularly and in an aggregate format to the National AIDS Authority for inclusion in the national database (CRIS).

The only core indicator that is currently reported by a civil society organisation is the number of PLHA that are member of a PLHA support group (indicator 2.9 in annexes 1 and 2). This indicator is reported by the Cambodian PLHA Network (CPN+) and information is received through 2 different channels:

- In provinces that have a provincial PLHA network (provincial CPN+), PLHA support groups report on a monthly basis to the provincial CPN+. Data are compiled at provincial level and reported to CPN+ in Phnom Penh on a quarterly basis.
- In Phnom Penh, CPN+ received quarterly reports from NGOs that organise and support 1 or more PLHA support groups.

Figure IV.10: Data Flow – Cambodian PLHA Network (CPN+)



IV.3.9 OVC / Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY)

Currently, data are not available for most of the indicators concerning orphans and vulnerable children (OVC). Given its mandate, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) will play a key role in the future collection of data concerning OVC and hence, will be the main source of data for these indicators.

The only core indicator that can currently be reported by MoSVY is the number of OVC with access to shelter or alternative care. However, orphanages are the only type of alternative care for which data are available. Data are collected through the annual census of children living in orphanages that are registered with MoSVY. The results of the annual census are reported in the annual Alternative Care Report.

IV.4 Data Storage, Management and Analysis

IV.4.1 Data storage and management

When data on the 54 core indicators reach the National AIDS Authority through the channels described in the previous sections, they are stored in the Country Response Information System (CRIS) database.

CRIS was originally developed by UNAIDS with the aim to assist countries with biennial UNGASS reporting and has been established at the National AIDS Authority in August 2005 to store and to manage HIV/AIDS related data.

CRIS is a flexible information management system that has been configured to fit national HIV/AIDS data storage needs. Data are derived from different sources and entered into CRIS with the aim to measure and analyse indicators such as UNGASS, Universal Access, NSP II and other national indicators. In this way, CRIS enables the National AIDS Authority to monitor the national, multi-sectoral response and to prepare reports on progress toward the achievement of common objectives and agreed to targets.

IV4.2 Data processing and analysis

CRIS functions as a data warehousing and collection system for all kinds of HIV/AIDS indicator data. It is a browser-based programme that allows users to enter and process indicator data. Information in CRIS is easily stored and retrieved by using a configuration which has been adapted to the needs of Cambodia.

The National AIDS Authority uses CRIS as a repository of indicator data obtained from different sectors as well as to generate tables, graphs, thematic maps or other types of analyses of indicators through external software tools such as Excel. These types of data analyses are important to monitor the national, multi-sectoral response to HIV/AIDS and to produce comprehensive reports on the HIV epidemic and on the national, multi-sectoral response.

IV.4.3 Ensuring data quality

Data exchange between CRIS and other database systems is possible and future versions of CRIS will further simplify importing and exporting data into/from CRIS and will enhance the electronic transfer of data.

The transfer of data from line ministries and other organizations to the National AIDS Authority is not only easier in an electronic format, but it also reduces the risk of errors involved with manual data entry.

There is a need to ensure the quality of data, including completeness and accuracy. To ensure good quality data, audits and supervision are required and these are the responsibility of data providers such as line ministries and other government departments as well as of the National AIDS Authority.

IV.5 Data Use and Dissemination

IV.5.1 National AIDS Authority Reporting

The National AIDS Authority reports annually on progress made in the national, multi-sectoral response to HIV/AIDS. The annual report is submitted to the National AIDS Authority's Policy Board and to the Royal Government of Cambodia, and is shared with development partners and various implementing agencies. The annual report is not published until after the annual joint review (see IV.5.2)

The annual report includes three different levels of reporting:

(i) The annual report gives details on the progress made in implementing activities and producing the outputs included in the annual operational plan.

(ii) Since the annual operational plan is based on the five-year operational plan, the annual report also reports on progress made in the implementation of the five-year operational plan and in achieving the specific objectives of NSP II.

(iii) Finally, the annual report states the progress that was made during the previous year in achieving the targets that were set for the indicators included in the NSP II M&E framework.

The National AIDS Authority gathers the information necessary for the preparation of the annual report through quarterly activity reports submitted by line ministries and other government departments and Provincial AIDS Secretariats, and quarterly data collection forms submitted by several line ministries and other government departments. Additional information is collected from and/or reported by various stakeholders through various, increasingly institutionalized channels of data transfer.

IV.5.2 Joint Annual Stakeholder Review

Each year the National AIDS Authority organises a joint stakeholder review. The purpose of this joint review is to:

- Review progress made in the implementation of the national; response, with special focus on lessons learned and existing gaps;

- Assess changing situations and emerging epidemiological trends; and
- Develop a joint annual operational plan for the next year to guide the implementation of the NSP II.

The joint annual stakeholder review is held under the leadership of the National AIDS Authority and with the assistance of the M&E Advisory Group.

IV.5.3 Special Reports

The National AIDS Authority coordinates the preparation of special country reports, which contribute to global progress reports such as:

- The biennial UNGASS report concerning HIV/AIDS around the world; and
- Universal Access progress reports, which assess progress against interim (2008) and final targets (2010) that have been set by countries to achieve Universal Access to prevention, treatment and care.

The National AIDS Authority also coordinates the HIV/AIDS reporting as part of regular CMDG progress reports.

IV.5.4 Dissemination

It is important that data generated through the National M&E System are made available to and used by all relevant stakeholders for programme planning and decision making. This is done in a number of ways.

- The National AIDS Authority disseminates information through routine as well as *ad-hoc* reports and other publications.
- The National AIDS Authority has a website, which is used to post the latest data on core indicators and to provide easy access to this data, not only for its members but also for other stakeholders.

IV.5.5 Use of Data by Other Stakeholders

While it is realised that stakeholders such as government institutions, civil society, donors and implementing agencies have their own M&E and reporting requirements, they are encouraged to use as much as possible the data and reports generated by the National M&E System.

It is important therefore, that stakeholders are aware of and have easy access to the data generated by the National M&E System. Furthermore, the system needs to be flexible enough to respond to stakeholders' specific data needs.

IV.6 Evaluation and Research

In the context of the present guidelines, evaluation is defined as the periodic assessment of the relevance, efficiency, effectiveness, impact and sustainability of the national, multi-sectoral response to HIV/AIDS. It involves systematic

collection of information in order to determine whether intended results have been achieved and to inform future decision-making.

Evaluation is more than the analysis of data that have been systematically collected overtime and for a number of core impact and outcome indicators. Evaluation studies are necessary to generate additional quantitative and qualitative data, which help to measure results and to assess the relevance, quality, efficiency and sustainability of interventions.

Evaluation research provides the information that is needed to endow interventions with an evidence-based approach. This and other types of research are carried out by the various stakeholders. In order to streamline research efforts in the health sector, NCHADS has taken the initiative to establish an HIV/AIDS related research agenda with the aim to ensure that research meets programmatic needs and that research findings translate back into action.

IV.6.1 Baseline

Baseline data are of critical importance for evaluating the outcome or impact of interventions and one way to accurately measure progress over time. The assessment whether intended objectives and targets were achieved requires a comparison of the situation before and after interventions.

Alternatively, an experimental design can be adopted involving the construction of control groups to facilitate the comparison of programme participants with non-participants (comparison of with and without). Control groups should be representative and resemble the participants as much as possible on relevant characteristics.

Baseline data are available for most of the outcome and impact indicators included in the M&E Framework of the NSP II. Although some of the indicators lack baseline data, measurement at regular, carefully chosen time intervals also provides useful and important information concerning existing and emerging trends.

IV.6.2 Annual Reviews

The joint stakeholder review organised by the National AIDS Authority each year in collaboration with the M&E Advisory Group aims to:

- Review progress made in implementation of the national, multi-sectoral response;
- Assess changing patterns in the epidemic and emerging issues; and
- Develop a joint annual (costed) operational plan for the next year.

The focus of the annual review is on the analysis of input and output indicators as well as the analysis of indicators that assess progress made in increasing the access to and the up-take of key services in the areas of prevention, care and treatment, and impact mitigation.

Moreover, annual reviews take into account data from recent surveys, including data from the latest CDHS and sentinel surveillance surveys, as well as data provided by updated estimates and projections.

IV.6.3 Mid-Term Reviews and Evaluations

Following international best practices, it was originally planned to review the National Operational Plan 2006 – 2010 (NSP II) during the second or third quarter of 2008 or, half-way through its implementation period.

However, given the extensive review of the NSP II conducted during the last quarter of 2007 and resulting the Revised NSP II, it is no longer believed to be necessary to conduct a mid-term review.

The original timing of a mid-term review was based on the logic that half-way through the implementation of the NSP II sufficient time would have passed to allow a thorough assessment of whether implementation is on track to achieve intended objectives and targets, while sufficient time would still have been left to make the necessary adjustments based on lessons learned and changed circumstances.

In comparison with annual reviews, the mid-term evaluation would have focussed more on core outcome and impact indicators with the aim to assess progress made in achieving objectives and targets (effectiveness) and to identify changes in epidemiological trends that require readjustment of strategies and targets. The mid-term review would have consisted predominantly of an in-depth review and analysis of data from secondary sources such as documents and databases.

The mid-term evaluation would also have included the collection and analysis of qualitative data in areas of service delivery, implementation and management. Qualitative data facilitate in-depth and detailed examination of selected issues through a careful description of programme situations, interactions and observed behaviours. On-going monitoring and the annual reviews should also make use of qualitative data collection and analysis.

IV.6.4 Final Review and Impact Evaluations

A final evaluation of the current phase of the national response to HIV, within the framework of the Revised National Operational Plan 2006 – 2010 (NSP II), will take place after its completion.

The main focus of the final evaluation of NSP II is to assess whether intended objectives and targets have been achieved. This involves analysis of already available data to measure outcome and impact indicators and a comparison with baseline values for these indicators. Additional information is needed to derive conclusions about the programmes' impact and efficiency by isolating as much as possible programme influences. The main aim is to determine to which extent programme goals and objectives have been attained and to draw

lessons for the future for fine-tuning and adjusting interventions and to increase their efficiency and effectiveness.

The final evaluation of the NSP II will focus on results and impact as well as on the contributions of different interventions to the achievement of these results.

IV.6.5 Thematic Research

Evaluation depends on data collected through research. This is illustrated by the fact that many of the core indicators included in these guidelines are measured by way of surveillance surveys that are repeated every 2 to 4 years, and the large population-based Demographic and Health Survey conducted every five years.

In addition to these regular features on the research agenda there is a need for specialised, *ad-hoc*, thematic research in order to better understand the underlying causes, dynamics and impacts of the epidemic and to obtain information which informs policy making and programming:

- Epidemiological trends need to be studied and understood.
- New areas of concern need to be examined in order to be able to adjust interventions and effectively address these emerging concerns. For example, the increasing transmission of HIV within the family (from husband to wife and from mother to child), the spread of HIV into the rural areas, and the emergence of new high risk groups such as men who have sex with men and drug users are current issues which require careful attention.
- The conventional focus on risk groups needs to be complemented by better understanding of vulnerability and the long-term consequences of the epidemic.

The research agenda for 2008/09 was developed by NCHADS and defines the research priorities in HIV/AIDS prevention, care and treatment, and socio-economic impact mitigation. NCHADS has a research unit which was created in 2003 and is supported by a HIV/AIDS related Research Steering Committee. The Steering Committee was established in 2004 by the Ministry of Health and is composed of NCHADS, other MoH departments and programmes, and other organizations active in HIV/AIDS research.

IV.7 M&E Capacity Building

The establishment of a National M&E System inevitably calls for the strengthening of the institutional and human capacity for effective monitoring and evaluation of the national, multi-sectoral response to HIV and AIDS.

The capacity building needs of the National AIDS Authority's partners show considerable variation. While some partners have already managed to put in place relatively strong M&E systems and to strengthen the M&E capacity of their staff, others are still in need of considerable capacity building inputs.

IV.7.1 Capacity Development Strategy and Tools

It is crucial that M&E staff have a basic understanding of M&E concepts and master basic M&E skills. The minimum qualifications required for the recruitment of M&E staff to work on HIV issues are as follows:

- Postgraduate degree in social science, health or related field
- Experience with monitoring, evaluation and/or research
- Familiarity with database design and management
- Experience with data analysis and reporting
- Knowledge of HIV/AIDS programming and planning
- Strong conceptual and analytical skills
- Solid computer skills including spreadsheet applications
- Experience in team building and delivering training
- Good communication and presentation skills (written and verbal)

The National AIDS Authority aims to improve M&E knowledge and skills of its own staff and that of government and non-government institutions at centralised and decentralised levels. Although formal training through both short- and long-term training courses is an important tool in building knowledge and skills, an effective M&E capacity development strategy should include a combination of different strategies:

- Access to ***formal training*** should be expanded in the form of standard short-term courses that are offered by local training institutes as well as in the form of tailor-made training courses. These courses are usually developed and delivered by specialised external trainers. This type of training has much potential and can be further expanded through the utilization of existing, in-country resources.
  Although more costly and therefore not always in the realm of possibilities, long-term formal training can be very useful and should be promoted. Furthermore, it usually represents a considerable incentive to staff. A growing number of long term training opportunities are now available in-country and are offered on a part-time basis.

- ***On-the-job training and coaching*** are approaches which should be more systematically applied. Apart from on-the-job training by existing contracted staff and technical assistance, coaching by supervisors and colleagues (within and outside the workplace) is a valuable capacity building tool.

- Recruitment of ***contracted staff*** with good M&E knowledge and skills should as much as possible be undertaken not only to increase the M&E capacity, but also to enhance knowledge and skills transfers in the workplace. Such transfers are much facilitated through the hiring of local contracted staff due to the absence of language barriers. It allows capacity development to take place in the form of on-the-job training, tailor-made training courses developed and delivered by contracted staff, and coaching of permanent staff on an ongoing basis in their day-to-day tasks.

- ***Technical assistance*** (both national and international) can be employed to meet specific capacity building needs. It is important to ensure that all

technical assistance in the area of M&E includes the transfer of skills and hence, contributes to strengthening of the M&E capacity.

IV.7.2 Capacity Building Plan

An important role of the National AIDS Authority is to ensure that M&E capacity is built and constantly upgraded within the context of the national, multi-sectoral response to HIV/AIDS. Efforts have to target those institutions and individuals that lack capacity and are therefore ill equipped to fulfil their M&E tasks and to contribute in a meaningful way to the operations of the National M&E System.

M&E capacity assessments should be undertaken, where needed, to evaluate the need for capacity building. Capacity assessments should determine the need for general and specialized formal training and to establish the appropriate mix of different capacity building strategies and interventions.

The findings of M&E capacity assessments are to be used to develop a capacity building plan, which aims to achieve measurable results and to build M&E capacity in a coherent manner, over time and by pursuing well defined objectives and targets.

Toward this aim a comprehensive national M&E Capacity Building Plan needs to be developed. M&E training should be reflected as a key activity among other strategies and activities set out in Annual Operational Plans developed to guide implementation of the NSP II.

IV.8 M&E Advocacy and Communication

The importance of monitoring and evaluation needs to be advocated together with the need to share and communicate the data, reports and other outputs of a comprehensive national HIV/AIDS M&E system.

IV.8.1 Development of an M&E and reporting culture

Effective monitoring and evaluation of the national response depends on the systematic collection and reporting of the required data. This does not only require strong coordination of M&E efforts, but also sufficient understanding of and commitment to monitoring and evaluation among the majority of the stakeholders.

The development of such an M&E and reporting culture requires the government, donors and civil society to invest in building the necessary M&E capacity and to set aside sufficient resources to implement a comprehensive M&E system. It is normally recommended that any programme or plan should foresee an allocation of at least 10 to 15% of overall resources to monitoring and evaluation.

Communication and advocacy initiatives are also a useful means to increase political will and commitment for the strengthening of monitoring and evaluation functions and to enhance resource allocation.

IV.8.2 Advocacy for the M&E coordinating role of NAA

The present National M&E Guidelines aim to stress the importance of monitoring and evaluation as well as to clarify the role of the various stakeholders in monitoring and evaluation of the national, multi-sectoral response to HIV/AIDS. They do not intend in any way to replace existing systems or to undermine M&E efforts which are already on track. Instead, the M&E system propagated in these guidelines provides a crucial instrument to strengthen what already exists and to identify what is yet to be developed in the field of monitoring and evaluation. The overall aim of these National M&E Guidelines is to foster an alignment and harmonization of efforts.

Given the fact that the National AIDS Authority is (by legal decree) at the centre of the overall coordination of the national response, it is best positioned to coordinate the monitoring and evaluation of the national, multi-sectoral response.

IV.8.3 Strengthening coordination and information sharing

The coordination function is important and needs further strengthening in order to make sure that data from various sources can feed into the national M&E system and be stored in one central database (CRIS) where they can be used for more wide-ranging and advanced analyses.

Improved coordination needs to include efforts to promote that stakeholder organisations place more emphasis on M&E as part of their work and are able to contribute relevant and accurate information needed for monitoring and evaluation of the national, multi-sectoral response to HIV and AIDS.

Moreover, there is a need to ensure that instruments used to collect data are consistent with the indicators included in the National M&E Guidelines. This will avoid confusion regarding the interpretation of collected data and will ensure that data can easily be included in the comprehensive and integrated national M&E system.

IV.9 Monitoring and Evaluation of the M&E Function

Given the fact that monitoring and evaluation is one of the strategies included in NSP II, it is necessary to assess progress made in the implementation of this strategy. In other words, it is necessary to monitor and evaluate the M&E function.

The National M&E Guidelines include three indicators for monitoring and evaluation of the M&E function. In addition to these core indicators, other indicators will be specified in annual operational plans, such as specific input

and output indicators and results to be achieved in the course of each year. The annual review and reporting process will include an assessment of whether M&E activities were implemented according to plan and whether specific M&E targets in the form of outputs and milestones were achieved.

V. Conclusions

These National M&E Guidelines provide a detailed description of the national M&E system for the multi-sectoral response to HIV/AIDS and of what is needed to ensure its effective functioning.

In line with the Three Ones Principle, the National M&E Guidelines support the principle of one monitoring and evaluation system being applied in the national, multi-sectoral response to HIV/AIDS. The National AIDS Authority is best positioned to coordinate such a comprehensive and integrated M&E system.

The comprehensive national M&E system does not replace existing M&E systems that are used by implementing partners. Instead, it aims to facilitate the monitoring and evaluation of the national, multi-sectoral response by linking existing M&E systems and bringing together data and information from various partners and sectors.

An important part of the National M&E Guidelines is the proposed list of 54 core indicators, together with their data sources and a detailed description of the data flow from the source to the national M&E system. As indicated in the relevant sections of these guidelines, some of the indicators require further clarification of definitions and methods of measurement, while other indicators lack a source of data and hence, are not measured at the moment.

It follows that the list of indicators included in Annex 1 and described in detail in Annex 2, should be regarded as *a work in progress* and as dynamic rather than constant and unchanging. As a matter of fact, the use and measurement of these indicators as well as future strategic and programmatic changes in the national, multi-sectoral response may result in the retirement of certain indicators and the inclusion of other more relevant and adequate indicators.

Another area where further efforts are recommended is M&E capacity building. In order to implement these National M&E Guidelines and to manage and maintain the national M&E system, both the National AIDS Authority as well as several of its partner organization will need to strengthen their institutional and human resource capacity for effective monitoring and evaluation.

Annex 1: Core HIV/AIDS Indicators

No.	Indicator	Indicator Type	Data Source	Reference
0.1	HIV prevalence in adult population	Impact	HSS CDHS	NSP II CMDG NSDP
0.2	HIV prevalence in most at risk populations	Impact	HSS	UNGASS
0.3	HIV incidence in adult population	Impact	HSS	NSP II
Strategy 1: Increased coverage of effective prevention interventions and additional interventions developed				
1.1	Condom use by female sex workers, disaggregated by direct and indirect sex workers	Outcome	BSS	NSP II UA UNGASS CMDG
1.2	Condom use by high risk men, disaggregated by military/police and moto-taxi drivers	Outcome	BSS	UA
1.3	Condom use by male sex workers	Outcome	SSS	UNGASS
1.4	Condom use by men who have sex with men (MSM)	Outcome	SSS	NSP II UNGASS
1.5	Condom use by injecting drug users (IDUs)	Outcome	Drug User Survey	UNGASS
1.6	Proportion of adults that had multiple sexual partners (higher risk sex)	Outcome	CDHS	UNGASS
1.7	Condom use by adults that had multiple sexual partners (higher risk sex)	Outcome	CDHS	UNGASS
1.8	Condom use by young people, disaggregated by sex	Outcome	CDHS	CMDG
1.9	Condom use by married women who identified themselves at risk	Outcome	-	CMDG
1.10	Number of condoms distributed and sold	Output / Coverage	PSI MoH (HIS)	UA
1.11	Percentage of most at risk populations reached with HIV prevention programmes	Coverage	BSS (excluding MSM, IDUs and ATS)	UA UNGASS
1.12	Percentage of schools that provided life-skills based HIV education in the last academic year	Coverage	MoEYS	UNGASS
1.13	Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Outcome	CDHS	NSP II UNGASS
1.14	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Outcome	BSS*	UNGASS
1.15	Percentage of injecting drug users (IDU) report using a sterile needle and syringe at last injection	Outcome	Drug User Survey	NSP II UNGASS
1.16	Percentage of young people aged 15 to 24 who have had sexual intercourse before the age of 15	Outcome	CDHS	UNGASS

1.17	Percentage adults who say that an HIV positive female teacher who is not sick should be allowed to continue teaching	Outcome	BSS CDHS	UA
1.18	Percentage of pregnant women attending ante-natal care at PMTCT sites who received HIV counselling and testing	Outcome	NCMCH	UA
1.19	Percentage of pregnant women attending ante-natal care services who received HIV counselling and testing	Outcome	NCHADS	UA
1.20	Percentage of infants born to HIV infected mothers who received PMTCT and who are HIV positive at age 18 months.	Impact	NCMCH / NCHADS Modelling by UNAIDS	NSP II UNGASS
1.21	Percentage of HIV infected pregnant women who received a complete course of antiretroviral prophylaxis to reduce risk of mother-to-child transmission	Outcome	NCMCH	NSP II CMDG UNGASS
1.22	Number of Operational Districts (ODs) with at least one centre providing PMTCT services	Output/ Coverage	NCMCH	UA
Strategy 2: Increased coverage of effective interventions for comprehensive care and support and additional interventions developed				
2.1	Survival of adults and children on antiretroviral therapy (ART) 12 month after initiation	Impact	NCHADS Monitoring System	NSP II UNGASS
2.2	Percentage of adult and children with advanced HIV infection receiving antiretroviral therapy (ART)	Outcome	NCHADS Monitoring System	NSP II UA UNGASS CMDG
2.3	Percentage of women and men aged 15 to 49 who received an HIV test in the last 12 months ad who know the result	Outcome	NCHADS Monitoring System	UNGASS NSP II
2.4	Percentage of most at risk populations who received an HIV test in the last 12 months and know the result	Outcome	BSS (after adaptations)	UNGASS
2.5	Number of licensed sites offering counselling and testing services (VCCT sites)	Output	NCHADS	UA
2.6	Percentage of PLHA who receive comprehensive care	Outcome	Still under discussion!	NSP II
2.7	Number of Operational Districts with a full package of continuum of care (CoC) services	Output	NCHADS	UA
2.8	Number and percentage of health centres with Home Based Care Team support	Output	NCHADS	UA
2.9	Percentage and number of PLHA who are associated with PLHA support groups (disaggregated by gender)	Outcome	CPN+	NSP II
2.10	Number of health centres providing support to TB patients enabling them to go for HIV testing	Output	CENAT	UA
2.11	Percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV	Outcome	NCHADS / CENAT	UNGASS
2.12	Percentage of donated blood units screened for HIV in a quality assured manner	Outcome	NBTC	UNGASS

Strategy 3: Increased coverage of effective interventions for impact mitigation and additional interventions developed				
3.1	Percentage of adults aged 15 to 49 willing to look after family member with HIV	Outcome	CDHS	NSP II
3.2	Percentage OVC aged 6 to 14 attending school (disaggregated by gender)	Outcome	-	NSP II
3.3	Current school attendance among orphans and among non-orphans aged 10 to 14	Outcome	CDHS	UNGASS
3.4	Percentage and number of OVC with access to shelter or alternative care	Outcome	MoSVY	NSP II
3.5	Percentage of households with OVC that received minimum package of support	Outcome	-	UA
3.6	Percentage of OVCs aged 0-17 whose households received free basic external support in caring for the child	Outcome	-	UNGASS
3.7	Percentage of communes with at least one organization providing care and support to households with OVC aged 0 to 17	Outcome	PAS (through DAC and Commune Councils*	UA
Strategy 4: Effective leadership by government and non-government sectors for implementation of the response to HIV/AIDS, at central and local levels				
4.1	Number of line ministries implementing an HIV/AIDS programme	Outcome	NAA	NSP II UA
4.2	Percentage of provincial development strategies that address HIV/AIDS	Outcome	NAA	NSP II
4.3	Percentage of commune development plans that address HIV/AIDS	Outcome	NAA	UA
4.4	Percentage of line ministries participating in at least 10 NAA Technical Board meetings each year	Outcome	NAA	NSP II
4.5	Number of large organizations that have workplace policies and interventions in place	Outcome	Work place survey – Ministry of Labour*	UA
Strategy 5: A supportive legal and public policy environment for the HIV/AIDS response				
5.1	National Composite Policy Index (NCPI)		NAA	NSPII / UNGASS
Strategy 6: Increased availability of information for policy makers and programme planners through monitoring, evaluation and research				
6.1	Reports/data received by NAA	Outcome	NAA	
6.2	Quantity and quality of data in CRIS	Outcome	NAA	
6.3	Reports and publications by NAA	Outcome	NAA	
Strategy 7: Increased, sustainable and equitably allocated resources for the national response				
7.1	Domestic and international spending by categories and financing sources	Input	NAA (NASA)	UNGASS

* Indicates that although the source of data is known, data are currently not available (indicator 4.5), adjustments of data collection tools are needed (indicator 1.14), or data collection needs to be established and capacity built (indicator 3.7)

Annex 2: Detailed Description of Core HIV/AIDS Indicators

Indicator 0.1 *HIV prevalence in adult population*	
Description	Percentage of the adult population aged 15 to 49 years who are HIV infected.
Purpose	To assess the impact of the national response to HIV/AIDS in terms of a reduced HIV prevalence in the general population.
Measurement	Numerator**:** The total number of adults aged 15 to 49 years who tested positive for HIV. Denominator: The total number of adults aged 15 to 49 years who were tested for HIV. Method of Measurement: Dried blood drop samples were collected from a sample of women and men aged 15 to 49. The samples were tested by the National Institute of Public Health (NIPH), according to an agreed HIV testing algorithm. Alternatively, this indicator is estimated by modelling with available data, and using the HIV prevalence among ANC women aged 15 to 49 years as collected by the HIV Sentinel Surveillance (HSS)
Data Source	Cambodia Demographic and Health Survey (CDHS), 2005 HIV Sentinel Surveillance (HSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS)
Frequency of Data Collection	CDHS is conducted every 5 years Previous CDHS: 2000 (did not measure this indicator) Next CDHS: 2010 (planned) HSS is conducted every 2-3 years Previous HSS: 1992, 1994-2000, 2002, 2003, 2006 Next HSS: 2008 (planned)
Strengths and Limitations	**As measured through CDHS**: Strengths: • CDHS is a large population based survey Limitations: • CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS. • There are concerns that CDHS can under-estimate the HIV prevalence in concentrated epidemics. **As measured through HSS:**

Limitations:

- Estimated based on modelling of HIV prevalence among ANC women aged 15 to 49, and not a direct measurement of HIV prevalence in the general population.
- There are concerns that this can result in an over-estimation of HIV prevalence in the general adult population.

Further Information

This indicator is included in various indicator lists:

- NSP II
- Cambodia Millennium Development Goals (CMDGs)
- National Social Development Plan (NSDP)

Indicator 0.2
HIV prevalence in most at risk populations

Description

Percentage of most at risk populations who are HIV infected, disaggregated by most at risk population groups.

Purpose

To assess progress in reducing HIV prevalence among most at risk population groups and hence, to assess the impact of the national response to HIV/AIDS.

Measurement

Numerator**:**
The total number of a most at risk population group that tested positive for HIV

Denominator:
The total number of a most at risk population group that was tested for HIV

The following most at risk population groups are distinguished:
- Direct female sex workers (brothel-based)
- Indirect female sex workers (women working as beer promoters or in karaoke establishments)
- Policemen (high risk men)
- Pregnant women attending ante-natal care (ANC) clinics

The most recent HIV Sentinel Surveillance survey (HSS 2006) includes 2 sentinel groups:
- Direct female sex workers (brothel-based)
- Pregnant women attending ante-natal care (ANC) clinics

Method of Measurement:
As part of the HIV Sentinel Surveillance (HSS), blood samples are taken from individuals in selected sentinel groups, which are tested for HIV antibodies.

Data Source

HIV Sentinel Surveillance (HSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS)

Frequency of Data Collection

HSS is conducted every 2-3 years

Previous HSS: 1992, 1994-2000, 2002, 2003, 2006

Next HSS: 2008 (planned)

Strengths and Limitations

Strengths:
- Data are collected every 2 to 3 years

Limitations:
- In theory, assessing progress in reducing the number of new infections is best done through monitoring changes in incidence. Incidence data are not available, but can be estimated based on the HIV prevalence in persons newly initiated to behaviours that put them at risk of getting infected. It is noted that it is not desirable to restrict this analysis just to the young people in certain most at risk

populations.

- No data available for certain most at risk populations, such as injecting drug users (IDUs). However, the HIV prevalence survey among drug users planned to be conducted later this year (2007) will provide prevalence data for this most at risk population. HIV prevalence data are available from the 2005 STI Sentinel Surveillance (SSS)

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of most at risk populations who are HIV infected.

Indicator 0.3
HIV incidence in adult population

Description

The number of new HIV infections among adults aged 15 to 49.

Purpose

To assess progress made in reducing the number of new infections.

HIV incidence is becoming a more appropriate indicator to assess the impact of the national response to HIV/AIDS, now HIV prevalence is unlikely to decrease as more people are able to benefit from antiretroviral therapy (ART).

Measurement

Numerator**:**
n/a

Denominator:
n/a

The number of newly infected adults aged 15 to 49.

Method of Measurement:
This indicator is measured in two different ways, both using data collected as part of HSS

- Incidence testing of HIV positive specimen collected from ante-natal care attendees as part of the HIV Sentinel Surveillance (BED-CEIA test).
- Alternatively, HIV prevalence among ANC women aged 15-24 years provides a proxy indicator for HIV incidence among the general population.

Data Source

HIV Sentinel Surveillance (HSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS)

Frequency of Data Collection

HSS is conducted every 2-3 years

Previous HSS: 1992, 1994-2000, 2002, 2003, 2006

Next HSS: 2008 (planned)

Note: Incidence testing of HIV positive specimen was included for the first time in HSS 2006.

Strengths and Limitations

Strengths:

- HIV incidence is becoming a more appropriate indicator to assess the impact of the national response to HIV/AIDS now HIV prevalence is unlikely to decrease as more people are able to benefit from antiretroviral therapy (ART).

Limitations:

- BED-CEIA validations are still on-going, but US-CDC recommends that it can be used to estimate HIV-1 incidence in cross-sectional sero-surveys.

Further Information

This indicator is included in various indicators lists:

- NSP II: HIV incidence in adult population 15-49 (disaggregated by gender).
- UNGASS: Percentage of young people aged 15-24 who are HIV infected. However, the UNGASS guidelines define this indicator as measured for ante-natal clinic attendees aged 15 to 24 years.
- CMDGs: HIV prevalence rate among pregnant women, 15 to 24 years visiting ante-natal care clinics

Indicator 1.1
Condom use by female sex workers, disaggregated by direct and indirect sex workers

Description

Percentage of female sex workers who report consistent use of condoms with clients, disaggregated by direct and indirect sex workers.

Purpose

To assess progress in preventing exposure to HIV among female sex workers through unprotected sex with clients.

Measurement

Numerator**:**

- Direct sex workers: The number of brothel-based female sex workers who reported consistent condom use with clients during the past week.
- Indirect sex workers: The number of non-brothel based female sex workers (beer garden, beer promotion and karaoke workers, etc.) who reported consistent condom use with clients during the past 3 months.

Denominator:

- Direct sex workers: The number of brothel-based female sex workers interviewed.
- Indirect sex workers: The number of non brothel-based female sex workers (beer garden, beer promotion and karaoke workers, etc.) interviewed.

Method of Measurement:

Respondents are asked the following question:

- Direct sex workers: This past week, how often did/do you use condoms with your clients?
- Indirect sex workers: In the past three months, how often did you use condoms when you had/have sex for money or gifts?

Data Source

Behavioural Surveillance Survey (BSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs

Frequency of Data Collection

BSS is conducted every 3-4 years

Previous BSS: 1997, 1998, 1999, 2001, 2003

Next BSS: 2007 (data available by early 2008)

Strengths and Limitations

Strengths:

- Data are collected every 3 to 4 years using the same survey methodology, which facilitates the analysis of trends over time.

Limitations:

- The use of a recall period of 1 week for direct sex workers and 3 months for indirect sex workers is subject to a recall bias. It is often preferred to ask whether a condom was used with the most recent client. The latter may overestimate the level of consistent condom use, but the trend in condom use with

most recent client will still reflect the trend in consistent condom use.

Further Information

This indicator is included in various indicator lists:

- NSP II: Percentage of commercial sex workers report always using condoms with clients (disaggregated by direct and indirect sex workers.
- Universal Access: Percentage of direct / indirect female sex workers who report consistent condom use.
- CMDG: Condom use rate among commercial sex workers during last commercial intercourse (%).
- UNGASS: Percentage of female and male sex workers reporting the use of a condom during their last sexual intercourse.

The recall period used in the BSS is one week prior to the survey for direct commercial sex workers, and 3 months prior to the survey for indirect sex workers.

It should be noted that BSS also includes questions concerning condom use with most recent client, but this indicator is not reported in the BSS report.

Indicator 1.2
Condom use by high-risk men, disaggregated by military/police and moto-taxi drivers

Description

Percentage of high-risk men who report consistent condom use with commercial sex workers during the last three months.

Purpose

To assess progress in preventing exposure to HIV among high-risk men through unprotected sex with commercial sex workers.

Measurement

Numerator**:**
Number of high-risk men (disaggregated by military/police and moto-taxi drivers) who reported consistent condom use in the past three months with commercial sex workers

Denominator:
Number of high-risk men (disaggregated by military/police and moto-taxi drivers interviewed

Method of Measurement:
Respondents are asked the following question:
In the past three months, how often did you use a condom when you had/have sex with commercial sex workers?

Note: The most recent Behavioural Surveillance Survey (BSS 2007) no longer includes military, police and moto-taxi driver.

Data Source

Behavioural Surveillance Survey (BSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs

Frequency of Data Collection

BSS is conducted every 3-4 years

Previous BSS: 1997, 1998, 1999, 2001, 2003

Next BSS: 2007 (data available by early 2008)

Strengths and Limitations

Strengths:

- Data are collected every 3 to 4 years using the same survey methodology, which facilitates the analysis of trends over time.

Limitations:

- The use of a recall period of 3 months is subject to a recall bias. It is often preferred to ask whether a condom was used in most recent sexual act. The latter may overestimate the level of consistent condom use, but the trend in condom use in most recent sexual act will still reflect the trend in consistent condom use.

Further Information

This indicator is included in the list of Universal Access indicators:

- Percentage of high-risk men who report consistent condom use.

The recall period used in the BSS is 3 months prior to the survey.

It should be noted that BSS also includes questions concerning condom use in most recent sexual act with a commercial sex worker, but this indicator is not reported in the BSS report.

Indicator 1.3
Condom use by male sex workers

Description	Percentage of male sex workers who report consistent condom use during the past month
Purpose	To assess progress in preventing exposure to HIV among male sex workers through unprotected sex with clients
Measurement	Numerator**:** The number of men who reported to have been paid for sex by male and/or female clients, and who reported consistent condom use with clients during the past month Denominator: The total number of men who reported to have been paid by a man and/or women included in the survey Method of Measurement: The MSM module of the 2005 STI Surveillance Survey includes the following questions: • In the past one month have you been paid by a woman for sex? • In the past one month did you receive money for sex with a man? • In the past one month, how often did you use condoms when selling sex to women? • In the past one month, how often did you use condoms when being paid for anal sex with a man? The MSM module of the 2007 Behavioural Surveillance Survey includes the following questions: • In the last year, have any female clients paid you to have sex? • In the last year, have you had any guests/clients who you served sexually? • In the last month, with all of these female clients who you served sexually, how often did you use a condom? • In the last month, how often did you use a condom when you had anal sex with those male clients
Data Source	STI Prevalence Survey (SSS) 2005, conducted by the National Centre for HIV/AIDS, Dermatology and STIs
Frequency of Data Collection	SSS is conducted every 3-4 years Previous SSS: 2001 (did not include an MSM Module), 2005 Next SSS: 2008 (planned) BSS is conducted every 3-4 years Previous BSS: 1997, 1998, 1999, 2001, 2003 (did not include and MSM Module) Next BSS: 2007 (data available by early 2008)

Strengths and Limitations

Strengths:

- Data are collected every 3 to 4 years using the same survey methodology, which facilitates the analysis of trends over time.

Limitations:

- SSS 2005 and BSS 2007 did not sample male sex workers. However, the questionnaire includes filters that identify male sex workers. Caution is needed concerning how representative the sub-sample of male sex workers is for all male sex workers.
- The use of a recall period of 1 month is subject to a recall bias. It is often preferred to ask whether a condom was used with most recent client. The latter may overestimate the level of consistent condom use, but the trend in condom use with most recent client will still reflect the trend in consistent condom use.

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of female and male sex workers reporting the use of a condom during their last sexual intercourse.

The recall period used in SSS and BSS is one month prior to the survey.

Indicator 1.4
Condom use by men who have sex with men (MSM)

Description

Percentage of MSM who report consistent condom use while having sex with a male partner during the past month.

Purpose

To assess progress in preventing exposure to HIV among MSM through unprotected sex with a male partner

Measurement

Numerator**:**
The number of MSM who reported consistent condom use with male partners during the last month

Denominator:
The number of MSM interviewed

Method of Measurement:
The MSM module of the 2005 STI Surveillance Survey includes the following questions:

- In the past one month, how often did you use condoms when having anal sex with your male sweetheart?
- In the past one month, how often did you use condoms when paying for anal sex with a man?
- In the past one month, how often did you use condoms when being paid for anal sex with a man?

The MSM module of the 2007 Behavioural Surveillance Survey includes the following questions:

- In the last month, how often did you use a condom when you had anal sex with a man without payment?
- In the last month, how often did you use a condom when you had anal sex when buying sex from a man?
- In the last month, how often did you use a condom when you had anal sex with a male client?

Data Source

STI Prevalence Survey (SSS) 2005, conducted by the National Centre for HIV/AIDS, Dermatology and STIs

MSM have been included as a sentinel group in the 2007 BSS.

Frequency of Data Collection

SSS is conducted every 3-4 years
Previous SSS: 2001, 2005 (including a MSM module)
Next SSS: 2008 (planned)

BSS is conducted every 3-4 years
Previous BSS: 1997, 1998, 1999, 2001, 2003 (did not include and MSM Module)
Next BSS: 2007 (data available by early 2008)

Strengths and Limitations

Strengths:

- Data are collected every 3 to 4 years using the same survey methodology, which facilitates the analysis of trends over time.

Limitations:

- The use of a recall period of 1 month is subject to a recall

bias. It is often preferred to ask whether a condom was used in most recent sexual act. The latter may overestimate the level of consistent condom use, but the trend in condom use in most recent sexual act will still reflect the trend in consistent condom use.

Further Information

This indicator is included in various indicator lists:

- NSP II: Percentage MSM report use of a condom at last sex with a male partner.
- UNGASS: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.

Indicator 1.5
Condom use by injecting drug users (IDUs)

Description

Percentage of IDUs who report the use of a condom the last time they had sexual intercourse, disaggregated by regular partner, non regular partners and commercial sexual partner

Purpose

To assess progress in preventing exposure to HIV among IDU through unprotected sex.

Measurement

Numerator**:**
The number of IDUs who reported consistent condom use during the last sexual intercourse with regular partner, non-regular partner and commercial sexual partner.

Denominator:
The number of IDUs interviewed

Method of Measurement:
The HIV prevalence and behavioural survey among drug users (2007) includes the following questions for IDUs:

- The last time you had sex with a regular partner; did you and your partner use a condom?
- The last time you had sex with a non-regular partner; did you and your partner use a condom?
- The last time you had sex with a commercial partner; did you and your partner use a condom?

Data Source

The HIV prevalence and behavioural survey among drug users was conducted in 2007, by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS). Data will become available by the second quarter of 2008.

Frequency of Data Collection

Although IDUs could be included as a sentinel group in future BSS, NCHADS seems to prefer to regularly repeat HIV prevalence and behavioural survey among drug users

Frequency of the HIV prevalence and behavioural survey among drug users needs to be decided.

Strengths and Limitations

Strengths:

- The HIV prevalence and behavioural survey among drug users conducted in 2007 was the first time such a survey is conducted among drug users

Limitations:

- The sample size of the HIV prevalence and behavioural survey among drug users was calculated for the purpose of HIV testing. It remains to be seen (based on reported confidence intervals) whether the sample of IDUs is large enough for the assessment of condom use among IDUs.
- The cost effectiveness of conducting a separate survey among drugs users (as opposed to including IDUs as a sentinel group in future BSS) needs to be looked at.

Further

This indicator is included in the list of UNGASS indicators:

Information

- Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.

Indicator 1.6
Proportion of adults that had sex with multiple partners

Description

Percentage of adults aged 15 to 49 who have had sexual intercourse with more than one partner in the last 12 months, disaggregated by sex.

Purpose

To assess progress made in promoting risk avoiding behaviour.

Measurement

Numerator**:**
The number of women or men aged 15 to 49 who report to have had sexual intercourse with more than 1 partner during the last 12 months.

Denominator:
The total number of women or men aged 15 to 49 interviewed.

Method of Measurement:
A sample of women and men aged 15 to 49 are asked the following question:

- Apart from this person (i.e. the last person the respondent had sexual intercourse with), have you had sexual intercourse with any other person in the last 12 months?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2000

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:

- Measured through a large population based survey (CDHS), that is repeated every 5 years.

Limitations:

- If people reduce the number of sexual partners but still had sex with more than 1 sexual partner, this change will not be captured by this indicator even though this may have a significant impact on the spread of HIV.
- CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS).

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.

Indicator 1.7
Condom use by adults that had sex with multiple partners

Description

Percentage of adults aged 15 to 49 with more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse, disaggregated by sex.

Purpose

To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners.

Measurement

Numerator**:**
The number of women or men aged 15 to 49 who report to have had more than 1 sexual partner during the last 12 months who also report the use of a condom the last time they had sex

Denominator:
The total number of women or men aged 15 to 49 who report to have had more than 1 sexual partner during the last 12 months (Indicator 1.6)

Method of Measurement:
A sample of women and men aged 15 to 49 are asked the following question:

- Apart from this person (i.e. the last person the respondent had sexual intercourse with), have you had sexual intercourse with any other person in the last 12 months?

In addition, the respondent is asked:

- The last time you had sexual intercourse with this person was condom used?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2000

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:

- Measured through a large population based survey (CDHS), that is repeated every 5 years.

Limitations:

- The broader significance if this indicator depends on the extent to which people engage in multiple sexual relationships. Thus, levels and trends should be interpreted carefully using this data.
- This indicator does not report on the level of consistent condom use. It should be noted, however, that CDHS 2005 included questions concerning consistent condom use.

- CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS).

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Indicator 1.8
Condom use by young people, disaggregated by sex

Description

The percentage of young people, aged 15-24, reporting the use of a condom during sexual intercourse with a non-regular sexual partner.

Purpose

To assess progress in preventing exposure to HIV among young people through unprotected sex.

Measurement

Numerator**:**
The number of young people aged 15-24 (disaggregated by sex) who had higher risk sexual intercourse in the past 12 months, who reported using a condom at last higher risk sexual intercourse.

Denominator:
The number of young people aged 15-24 (disaggregated by sex) interviewed, who had higher risk sexual intercourse during the last 12 months.

Higher risk sexual intercourse is defined as sexual intercourse with a non-marital, non-cohabiting partner.

Method of Measurement:
A sample of women and men aged 15-24 years were asked the following questions:

- When was the last time you had sexual intercourse?
- If during the last 12 months, was a condom used the last time you had sexual intercourse?
- What was your relationship to this person with whom you had sexual intercourse?
- If boyfriend / girlfriend were you living together as if married?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2000 (did not measure this indicator)

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:

- Based on a large population based survey (CDHS), which is repeated every 5 years

Limitations:

- CDHS 2005 reports on this indicator for young men only. Due to the small number of young women engaged in higher risk sexual activity in the past 12 months (less than 1%), CDHS 2005 was not able to report condom use at last higher risk sexual intercourse for young women.

- This indicator was not measured in CDHS 2000 and the next CDHS will take place in 5 years. It should be noted that it is

under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS.

Further Information

This indicator in included in the list of HIV/Indicators of CMDG:

- Young people, 15-24 years, reporting use of condom during sexual intercourse with non regular sexual partner (%).

Indicator 1.9
Condom use by married women who identify themselves at risk

Description

The percentage of married women who identify themselves as at risk reporting consistent condom use

Purpose

To assess progress in preventing exposure to HIV among women who identify themselves as at risk through unprotected sex.

Measurement

Numerator**:**
The number of women who identify themselves as at risk who reported consistent condom use.

Denominator:
The total number of women who identify themselves as at risk.

Method of Measurement:
The CMDG Report appears to suggest that this indicator is measured by CDHS 2000, which is not correct.

CDHS 2000 reports the percentage of women who reported use of condom during last sex, among women (disaggregated by marital status) who know of HIV/AIDS, who have had sexual intercourse and who know about condoms.

CDHS 2005 reports the percentage of women who had higher-risk sexual intercourse in the past 12 months, among women aged 15 to 49 who had sexual intercourse in the past 12 months. Higher risk intercourse is defined as sexual intercourse with a non-marital, non-cohabiting partner. However, the number of women reporting higher risk sexual intercourse was only 0.1% (or 10 women) and hence, too small to give a reliable estimate of condom use among this group

Data Source

Not Available

Frequency of Data Collection

-

Strengths and Limitations

Strengths:
-

Limitations:
- No data are currently available for this indicator.

Further Information

This indicator is included in the list of Cambodia Millennium Development Goals:
- Proportion of condom use reported by married women who identified themselves at risk.

Indicator 1.10
Number of condoms distributed and sold

Description

The total number of condoms sold and distributed through social marketing, the commercial sector and the public sector.

Purpose

To monitor the number of condoms sold and distributed, which gives an indication of how widely available condoms are.

Measurement

Numerator**:**
n/a

Denominator:
n/a

Method of Measurement:
The aggregate of:

- The total number of male condoms distributed through social marketing by PSI (PSI Cambodia sales figures).
- The total number of male condoms provided free of charge through the public sector (figures reported by Operational Districts and Health Centres).
- The estimated number of condoms sold in the commercial sector (based on the estimated market share of the commercial sector as reported by the PSI's 2002 Distribution Survey).

Data Source

Combination of the following sources:

- PSI Cambodia sales figures (number of condoms distributed by PSI)
- MoH Health Information System (number of condoms distributed by the public sector)
- PSI Cambodia Distribution Survey, 2002 (estimated market share of the commercial sector)

Frequency of Data Collection

PSI Cambodia sales figures and MoH Health Information System data are available annually.

PSI Cambodia Distribution Survey has not been repeated since 2002

Strengths and Limitations

Strengths:

- Data are collected and available on an annual basis.

Limitations:

- The sale of condoms in the private sector is most likely underestimated
- PSI sales figures reflect the number of condoms distributed and is believed to somewhat overestimate the actual sale of condoms through social marketing.

Further Information

This indicator is included in the list of Universal Access indicators:

- Number of condoms sold and distributed

Indicator 1.11
Percentage of most at risk populations reached with HIV prevention programmes

Description

Percentage of most at risk populations that is reached with HIV prevention programmes, disaggregated by direct and indirect female sex workers, military and police, moto-taxi drivers, men who have sex with men (MSM), injecting drug users (IDUs), and ATS users.

Purpose

To assess progress in implementing HIV prevention programmes for specific most at risk populations.

Measurement

Numerator**:**
The number of people of a specific most at risk population that reported to have received HIV/AIDS education and/or information in the past 6 months.

Denominator:
The total number of people of a specific most at risk population group interviewed.

Specific most at risk populations:
- Direct sex workers
- Indirect sex workers
- Military and police (high risk men)
- Moto-taxi drivers (high risk men)
- Men who have sex with men (MSM)
- Injecting drug users (IDUs)
- ATS users

The previous BSS (2003) included direct and indirect female sex workers and high risk men (military and police, and moto-taxi drivers.

BSS 2007 included direct and indirect female sex workers, moto-taxi drivers, and men who have sex with men (MSM)

Method of Measurement:
In the Behavioural Surveillance Survey (BSS), respondents are asked the following question:
- Have you received HIV/AIDS education and/or information in the past 6 months?
  BSS 2007 includes the same question, but the recall period has been reduced to 3 months.

The same question was included in the HIV prevalence and behavioural survey among drug users, which was conducted in 2007.

Data Source

Behavioural Surveillance Survey (BSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs

The HIV prevalence and behavioural survey among drug users (data will become available by the second quarter of 2008).

Frequency of Data Collection

BSS is conducted every 3-4 years

Previous BSS: 1997, 1998, 1999, 2001, 2003

Next BSS: 2007 (data available by early 2008)

Not clear when next HIV and behavioural survey among drug users will be conducted.

Strengths and Limitations

Strengths:

- Data are collected every 3 to 4 years using the same survey methodology, which facilitates the analysis of trends over time.

Limitations:

- The previous BSS did not include MSM, and drugs users. It should be noted that the 2007 BSS included MSM for the first time and that the first HIV prevalence and behavioural survey among drug users was conducted in 2007.
- BSS focuses only on HIV/AIDS education and information interventions and may exclude other prevention interventions.

Further Information

This indicator is included in various indicator lists:

- UNGASS: Percentage of most at risk populations reached with HIV prevention programmes.
- Universal Access:
  - Percentage of MSM who are exposed to HIV prevention programmes.
  - Percentage of IDUs who are exposed to HIV prevention programmes.
  - Percentage of ATS users who are exposed to HIV prevention interventions.

Indicator 1.12
Percentage of schools that provided life-skills based HIV education in the last academic year

Description	Percentage of schools that provided life-skills based HIV education in the last academic year, disaggregated by primary and secondary schools.
Purpose	To assess progress towards implementation of life skills based HIV education in schools
Measurement	Numerator**:** The number of primary and secondary schools that provided life-skills based HIV education in the last academic year Denominator: The total number of primary and secondary schools Method of Measurement: The Ministry of Education, Youth and Sports (MoEYS) reports on a quarterly basis to the National AIDS Authority (NAA) the number of primary and secondary schools with teachers trained on HIV and life skills education, where HIV and life skills education was taught.
Data Source	Ministry of Education, Youth and Sports (MoEYS) reporting to the National AIDS Authority (NAA)
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Data are available and reported to NAA on a quarterly basis Limitations: • Aggregation of quarterly reports may result in an over-estimation of this indicator as measured on an annual basis.
Further Information	This indicator is included in the list of UNGASS indicators: • Percentage of schools that provided life skills-based HIV education in the last academic year.

Indicator 1.13
Knowledge about HIV Prevention among young people

Description

Percentage of young women and men aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Purpose

To assess progress towards wide-spread knowledge of the essential fact about HIV and HIV transmission.

Measurement

Numerator**:**
The number of young women and men aged 15 to 24 with comprehensive knowledge about HIV/AIDS

Denominator:
The total number of young women and men aged 15 to 24 interviewed

Comprehensive knowledge of HIV/AIDS means:

- Knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV; and
- Knowing that a healthy looking person can have HIV; and
- Rejecting the two most common local misconceptions about HIV transmission or prevention, i.e. HIV can be transmitted by mosquito bites and HIV can be transmitted by sharing food with an HIV positive person.

Method of Measurement:
A sample of women and men aged 15-24 years were asked the following questions:

- Can people reduce their chances of getting the AIDS virus by having sex with just one sex partner who is not infected and who has no other partners?
- Can people reduce their chances of getting the AIDS virus by using a condom every time they have sex?
- Can people get the AIDS virus from mosquito bites?
- Can people get the AIDS virus by sharing food with a person who has AIDS?
- Is it possible for a healthy-looking person to have the AIDS virus?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2000

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:

- Data collected through a large population based survey (CDHS), which is repeated every 5 years

Limitations:

- Reporting on comprehensive knowledge will under-estimate the percentage of young women and men that can correctly identify ways of preventing the sexual transmission of HIV (as illustrated by the findings of CDHS 2005).
- CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS.

Further Information

This indicator is included in various indicator lists:

- NSP II: Young people (15-24) who report knowledge of HIV transmission and prevention:
  - Heard of HIV
  - Condoms prevent HIV transmission
  - Healthy looking person can have HIV
  - HIV can be transmitted during pregnancy
- UNGASS: Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Indicator 1.14
Knowledge about HIV Prevention among most at risk populations

Description

Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Purpose

To assess progress towards building knowledge of the essential facts about HIV and HIV transmission among most at risk populations.

Measurement

Numerator**:**
The number of respondents from a specific most at risk population with comprehensive knowledge about HIV and HIV transmission.

Denominator:
The total number of respondents from a specific most at risk population interviewed.

Comprehensive knowledge of HIV and HIV transmission means:

- Knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV; and
- Knowing that a healthy looking person can have HIV; and
- Rejecting the two most common local misconceptions about HIV transmission or prevention, i.e. HIV can be transmitted by mosquito bites and HIV can be transmitted by sharing food with an HIV positive person.

Method of Measurement:
Respondents of each specific most at risk populations are asked the following questions:

- Can people reduce the risk of HIV transmission by having sex with only one faithful uninfected partner?
- Can people reduce the risk of HIV transmission by using a condom every time they have sex?
- Can people get HIV from mosquito bites?
- Can people get HIV by sharing food with a person who is HIV infected?
- Is it possible for a healthy-looking person to have HIV?

Data Source

Not Available

Could be included in the Behavioural Surveillance Survey (BSS), which includes the following most at risk populations (BSS 2007):

- Direct female sex workers
- Indirect female sex workers
- Moto-taxi drivers (high risk men)
- Men who have sex with men (MSM)

Frequency of Data Collection

BSS is conducted every 3-4 years

Previous BSS: 1997, 1998, 1999, 2001, 2003

Next BSS: 2007 (data available by late 2007)

Strengths and Limitations

Strengths:

-

Limitations:

- No data are currently available for this indicator.

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of most-at-risk populations who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission.

Indicator 1.15
Use of sterile needles and syringes by injecting drug users (IDUs)

Description

Percentage of injecting drug users who report using a sterile needle and syringe at last injection.

Purpose

To assess progress in promoting risk avoiding behaviour and in preventing injecting drug use associated HIV transmission.

Measurement

Numerator**:**
The number of injecting drug users who report using a sterile needle and syringe during the last injection.

Denominator:
The total number of injecting drug users interviewed.

Method of Measurement:
Injecting drugs users are asked the following question:

- Think about the last time you injected drugs. Did you use a needle or syringe that had previously been used by someone else?

Data Source

The HIV prevalence and behavioural survey among drug users was conducted in 2007, by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS). Data will become available by the second quarter of 2008.

Frequency of Data Collection

Although IDUs could be included as a sentinel group in future BSS, NCHADS seems to prefer to regularly repeat HIV prevalence and behavioural survey among drug users

Frequency of the HIV prevalence and behavioural survey among drug users needs to be decided.

Strengths and Limitations

Strengths:

- The HIV prevalence and behavioural survey among drug users was conducted for the first time in 2007.

Limitations:

- The sample size of the HIV prevalence and behavioural survey among drug users was calculated for the purpose of HIV testing. It remains to be seen (based on reported confidence intervals) whether the sample of IDUs is large enough for the assessment of use of safe needles and syringes by IDUs.
- The cost effectiveness of conducting a separate survey among drugs users (as opposed to including IDUs as a sentinel group in future BSS) needs to be looked at.

Further Information

This indicator is included in various indicator lists:

- NSP II: Percentage of IDUs who report using a sterile needle and syringe at last injection.

UNGASS: Percentage of IDUs reporting the use of sterile injecting equipment the last time they injected.

Indicator 1.16
Proportion of young people who have had sex before the age of 15

Description

Percentage of young people aged 15 to 24, who have had sexual intercourse before the age of 15, disaggregated by sex.

Purpose

To assess progress in increasing the age at which young women and men aged 15 to 24 have sex for the first time.

Measurement

Numerator**:**
The number of young women or men aged 15 to 24, who report to have had first sexual intercourse before the age of 15.

Denominator:
The total number of young women or men aged 15 to 24 interviewed.

Method of Measurement:
A sample of women and men aged 15-24 years were asked the following questions:

- Did you ever have sexual intercourse?
- If yes, how old were you when you had sexual intercourse for the very first time?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2005

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:

- Measured through a large population based survey (CDHS), that is repeated every 5 years.

Limitations:

- Given the relatively low number of young people who have sex before the 15 in Cambodia (0.9% for women and 0.3% for men), it may be better to opt for a different indicator: The percentage of young people aged 18 to 24 years who have had sexual intercourse before the age 18.
- Only individuals entering this age group (i.e. those aged under 15 at the beginning of the period for which trends are to be assessed) will influence this indicator. Therefore, if this indicator is assessed every 5 years it may be better to look at the age group 15 to 19.
- Young people's response to the survey question may be biased, deliberately misreporting the age at which they first had sex.

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

Indicator 1.17
Accepting attitudes towards those living with HIV/AIDS

Description

Percentage of the adult population who say that an HIV positive female teacher who is not sick should be allowed to continue teaching.

Purpose

To assess progress in promoting accepting attitudes and in reducing stigma towards people living with HIV/AIDS.

Measurement

Numerator**:**
The number of adults aged 15 to 24 who answer that an HIV positive female teacher who is not sick should be allowed to continue teaching

Denominator:
The total number of adults 15 to 24 interviewed

Method of Measurement:
A sample consisting of 16,579 women and 6,674 men was asked the following question:
In your opinion, if a female teacher has the AIDS virus but is not sick, should be allowed to continue teaching in the school.

Alternatively, this indicator is also measured for most at risk populations (direct and indirect female sex workers, military and police, and moto-taxi drivers) as part of the Behavioural Surveillance Survey (BSS).
Each of these most at risk populations interviewed is asked the following question:
If a female teacher has HIV/AIDS virus but is not sick, should she be allowed to continue teaching in school?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2000 (measured a different indicator: respondents who think that a person with HIV/AIDS should be allowed working)

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:
- Measured through a large population based survey (CDHS), that is repeated every 5 years.

Limitations:
- CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS).

Further Information

This indicator is included in the list of Universal Access indicators:
- Percentage of respondents who say that an HIV positive teacher who is not sick should be allowed to continue teaching.

Indicator 1.18
Pregnant women attending ante-natal care services at PMTCT sites who received an HIV test

Description

The percentage of pregnant women attending ante-natal care services at PMTCT sites who received HIV counselling and testing.

Purpose

To assess progress made in promoting HIV counselling and testing for pregnant women.

More specifically, this indicator allows assessment of progress made in the up-take of HIV testing at PMTCT sites.

Measurement

Numerator**:**
The number of pregnant women who attended ante-natal care services at a PMTCT site, who received counselling and testing in the last reporting period

Denominator:
The total number of pregnant women who attended at least 1 ante-natal care consultation at a PMTCT site in the last reporting period

Method of Measurement:
Both the numerator and the denominator are collected from patient registers at the PMTCT service.

Data Source

National Center for Maternal and Child Health – Quarterly reports

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:
- Accurate data are collected and reported on a quarterly basis.

Limitations:
- This indicator is limited to pregnant women who attend ante-natal care services at a PMTCT site, which excludes the majority of the women who attend ante-natal care at health facilities that do not provide PMTCT.

Further Information

This indicator is included in the list of Universal Access indicators:
- Percentage of pregnant women attending ANC at PMTCT sites who received counselling and testing for HIV.

It is recommended that this indicator be reconsidered as it mostly provides an assessment of the up-take of counselling and testing at PMTCT sites. Although important for PMTCT programmatic purposes, this indicator may be less relevant as an indicator for the assessment of Universal Access. It is suggested that a more appropriate indicator would be "the percentage of pregnant women who received counselling and testing and know their result".

It follows that indicators 1.18 and 1.19 could be replaced by one revised indicator: “the percentage of pregnant women who received counselling and testing and know their result”.

Indicator 1.19
Pregnant women attending ante-natal care services who received an HIV test

Description

Percentage of pregnant women attending ante-natal care services who received HIV counselling and testing.

Purpose

To assess progress made in promoting and providing access to HIV counselling and testing for pregnant women that attend ante-natal care services.

Measurement

Numerator**:**
The number of pregnant women attending ante-natal care who received HIV counselling and testing in the last reporting period

Denominator:
The total number of pregnant women who attended at least 1 ante-natal care consultation in the last reporting period.

Method of Measurement:
The numerator is collected from patient registers at VCCT sites. Currently, it is registered at the VCCT site whether or not a women is pregnant, but not whether she has attended ante-natal care. As a result, the numerator is presently not available as defined here.
However, NCHADS is in the process of changing registration forms, which will include whether a pregnant women was referred by an PMTCT site or by an ante-natal care service

The denominator is collected from patient registers at the ante-natal care services and as reported by the MoH Health Information System (HIS).

Data Source

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) – VCCT quarterly reports.

MoH Health Information System (HIS)

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:
- As soon as patient registration at VCCT sites has been revised, accurate data would be available and reported on a quarterly basis.

Limitations:
- This indicator is currently not reported as defined here.

Further Information

This indicator is included in the list of Universal Access indicators:
- Percentage of pregnant women attending ANC services who receive testing and counselling.

It is recommended that this indicator be reconsidered as it mostly provides an assessment of the up-take of Provider

Initiated Counselling and Testing (PICT). Although important for programmatic purposes, this indicator may be less relevant as an indicator for the assessment of Universal Access. It is suggested that a more appropriate indicator would be "the percentage of pregnant women who received counselling and testing and know their result".

It follows that indicators 1.18 and 1.19 could be replaced by one revised indicator: "the percentage of pregnant women who received counselling and testing and know their result".

Indicator 1.20
HIV infants born to HIV infected mothers who received PMTCT

Description

The percentage of babies born to HIV infected women who received PMTCT and who are HIV positive at age 18 months.

Purpose

To assess progress made towards eliminating mother to child transmission of HIV.

Measurement

Numerator**:**
The number of babies born to HIV infected women who received PMTCT who are known to be HIV positive at age 18 months.

Denominator:
The total number of babies born to HIV infected women who received PMTCT.

Method of Measurement:
The measurement of this indicator is being piloted at the moment, with the introduction of a new register and report at OI/ART sites (HIV exposed register and report)

Alternatively, this indicator is modelled by UNAIDS, using data on the coverage of PMTCT services.

Data Source

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

Frequency of Data Collection

Annual (retrospective cohort analysis)

Strengths and Limitations

Strengths:

- When measured in the future, this indicator provides important information concerning the clinical outcomes of PMTCT services

Limitations:

- Measurement of this indicator requires a retrospective cohort analysis for data for which is currently not available.

Further Information

This indicator in included in various indicator lists:

- NSP II: Percentage of babies born to HIV infected women who received PMTCT who are HIV positive at age 18 months.
- UNGASS: Percentage of infants born to HIV infected mothers who are infected.

Indicator 1.21
HIV infected pregnant women who received PMTCT services

Description	Percentage of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission
Purpose	To assess progress made in preventing mother-to-child transmission of HIV.
Measurement	Numerator**:** The number of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission during the last 12 months. Denominator: The total number of pregnant women that tested HIV positive in the past 12 months. Method of Measurement: Data for measurement of the numerator and the denominator is collected at PMTCT sites. Data for measurement of the denominator is collected at VCCT sites.
Data Source	National Centre for Maternal and Child Health (NCMCH) – PMTCT quarterly reporting National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) – VCCT quarterly reporting
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Accurate data are collected and reported on a quarterly basis Limitations: -
Further Information	This indicator in included in various indicator lists: • NSP II: Percentage of HIV positive pregnant women who receive PMTCT prophylaxis according to national standards. • UNGASS: Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission. • CMDG: HIV infected pregnant women attending ante-natal care, receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission (%).

Indicator 1.22
Number of Operational Districts with PMTCT services

Description	Number of Operational Districts (ODs) with at least one centre providing PMTCT services
Purpose	To assess progress in providing increased access to PMTCT services.
Measurement	Numerator**:** n/a Denominator: n/a The total number of Operational Districts with at least one facility/centre that provides PMTCT services. Method of Measurement: An overview of all facilities with PMTCT services that report to the National Centre for Maternal and Child Health, allows counting the number of Operational Districts with PMTCT services.
Data Source	National Centre for Maternal and Child Health (NCMCH) – PMTCT quarterly reporting.
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Accurate information is available and reported on a quarterly basis Limitations: -
Further Information	This indicator is included in the list of Universal Access indicators: • Number of Operational Districts with at least one PMTCT site offering the minimum package of PMTCT services.

Indicator 2.1
Survival of adults and children on antiretroviral therapy (ART) 12 months after initiation

Description

Percentage of adults and children who are known to be alive 12 months after initiation of antiretroviral therapy.

Purpose

To assess the effectiveness of antiretroviral therapy that is provided.

Measurement

Numerator**:**
The number of patients (adults and children under 15 years of age) on antiretroviral therapy who are known to be alive 12 months after initiation. Patients who were lost to follow-up during the first 12 months after initiation of antiretroviral therapy are excluded from the numerator.

Denominator:
The total number of patients (adults and children) who started antiretroviral therapy in a specific year.
Patients who died, stopped antiretroviral therapy, or were lost to follow-up are included in the denominator.
Patients who were transferred to a different ART site are excluded from the denominator

Method of Measurement:
Retrospective cohort analysis using data from the electronic patients databases at ART sites.

Data Source

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

Frequency of Data Collection

Annual (retrospective cohort analysis)

Strengths and Limitations

Strengths:

- Electronic database has been developed and is in the process of being introduced

Limitations:

- At the moment, only a limited number OI/ART sites are able to report ART cohort data. However, the electronic database is being introduced at a growing number of OI/ART sites. As a result, all OI/ART sites will be able to report ART cohort data in the future.

Further Information

This indicator is included in various indicator lists:

- NSP II: Survival of people on ART 12 months after initiation.
- UNGASS: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART.

Indicator 2.2
Adults and children with advanced HIV infection receiving antiretroviral therapy (ART)

Description	Percentage of adults and children under the age of 15 with advanced HIV infection receiving antiretroviral therapy, disaggregated by sex.
Purpose	To assess progress towards providing antiretroviral therapy to all people with advanced HIV infection (i.e. all people in need of antiretroviral therapy).
Measurement	Numerator**:** The number of active patients on antiretroviral therapy at the end of the reporting period, disaggregated by sex and by age (< 15 years and ≥ years). Denominator: Estimated number of people living with HIV/AIDS with advanced HIV infection (with AIDS), disaggregated by sex and by age (< 15 years and ≥ years). The denominator is generated based on mathematical models using HIV prevalence data from HIV Sentinel Surveillance (HSS). The need or eligibility for antiretroviral therapy follows the NCHADS/MoH definitions for diagnosis of advanced HIV (including AIDS) for adults and children. Method of Measurement: The numerator (the number of active patients) is collected from patient registers at OI/ART sites. Estimation of the denominator requires HIV prevalence data from the HIV Sentinel Surveillance (HSS).
Data Source	National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) – OI/ART quarterly reports
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Accurate data are available and reported on a quarterly basis Limitations: • The denominator is an estimate, based on prevalence data collected through surveys such as the HIV Sentinel Surveillance (HSS).
Further Information	This indicator in included in various indicator lists: • NSP II: Percentage of eligible HIV/AIDS patients on ART. • UNGASS: Percentage and children with advanced HIV infection receiving ART • CMDG: People with advanced HIV infection receiving antiretroviral combination therapy

- Number and percentage of PLHA on ART with access to COC (OI/and ART)

Indicator 2.3
Adults who received an HIV test in the last 12 months and who know the result

Description

Percentage of women and men aged 15 to 49, who received an HIV test in the last 12 months and know the result.

Purpose

To assess progress made in promoting and in providing access to HIV testing and counselling.

Measurement

Numerator**:**
The number of women and men aged 15 to 49, who reported to have been tested in the last 12 months preceding the survey and who know thetest results.

Denominator:
Total survey respondents aged 15 to 49, disaggregated by sex.

Method of Measurement:
CDHS 2005 asked the following questions:

- I don't want to know the result, but have you ever been tested to see if you have the AIDS virus?
- I don't want to know the result, but did you get the results of the test?

Alternatively, this indicator can be collected from patient registers at VCCT sites. In this case, the denominator will based on the total population aged 15-49 derived from the most recent population estimates published by the National Institute of Statistics.

Data Source

Cambodia Demographic and Health Survey (CDHS) 2005

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) – VCCT quarterly reports

Frequency of Data Collection

CDHS is conducted every 5 years
Previous CDHS: 2005 (did not include measurement of this indicator)
Next CDHS: 2010

VCCT reports are prepared quarterly

Strengths and Limitations

As measured through CDHS:
Strengths:

- Based on a large population based survey (CDHS), which is repeated every 5 years

Limitations:

- CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the previous CDHS.
- CDHS 2000 did not measure this indicator as respondents that had been tested for HIV were not asked whether they knew their result.

As measured based on VCCT reports:

Strengths:

- Accurate data are available reported through the quarterly VCCT reports

Limitations:

- VCCT reports do not distinguish people getting tested more than once in the same year and hence, there is a possibility of over-reporting.

Further Information

This indicator in included in various indicator lists:

- NSP II: Percentage of adults 15-49 who received HIV test at licensed VCT service in the past 12 months.
- UNGASS: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result.

Indicator 2.4
Most at risk populations who received an HIV test in the last 12 months and know their result

Description

Percentage of most at risk population groups who received an HIV test in the last 12 months and know the result, disaggregated by direct and indirect female sex workers and high risk men (military/police and moto-taxi drivers).

Purpose

To assess progress made in promoting and in providing access to HIV testing and counselling among most at risk populations

Measurement

Numerator**:**
The number of a specific most at risk population who received an HIV test in the last 12 months and know the result.

Denominator:
The total number of respondents from a specific most at risk population group interviewed (sample size)

The following most at risk population groups are distinguished:

- Direct female sex workers
- Indirect female sex workers
- Military and police (high risk men)
- Moto-taxi drivers (high risk men)
- Men who have sex with men (MSM)
- Injecting drug users (IDU)

Notes:

- The most recent Behavioural Surveillance Survey (BSS 2007) no longer includes military, police and moto-taxi drivers. Instead, men who have sex with men have been included for the first time in BSS 2007.
- The HIV prevalence and behavioural survey among drug users (planned for 2007), includes this indicator for IDUs.

Method of Measurement:
BSS 2007: Respondents from specific most at risk population groups are asked the following questions:

- In the past 12 months, have you ever had an HIV test?
- Last time you got tested did you receive the result of the test you took?

The HIV prevalence and behavioural survey among drug users includes the following questions:

- I don't want to know the result, but have you ever had an HIV test?
- Please do not tell me the result, but did you find out the result of your test?

Data Source

Behavioural Surveillance Survey (BSS), conducted by the National Centre for HIV/AIDS, Dermatology and STIs.

The HIV prevalence and behavioural survey among drug users was conducted in 2007, by the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS). Data will become available by the second quarter of 2008.

Frequency of Data Collection

BSS is conducted every 3-4 years
Previous BSS: 1997, 1998, 1999, 2001, 2003
Next BSS: 2007 (data will be available by early 2008)

Although IDUs could be included as a sentinel group in future BSS, NCHADS seems to prefer to regularly repeat HIV prevalence and behavioural survey among drug users

Frequency of the HIV prevalence and behavioural survey among drug users needs to be decided.

Strengths and Limitations

Concerning BSS:
Strengths:

- If revised, BSS would provide a measurement of this indicator every 3-4 years.

Limitations:

- Previous BSS included different sentinel groups: included police, military and moto-taxi drivers, and did not include MSM.

Concerning the HIV prevalence and behavioural survey among drug users planned for 2007:
Strengths:

- This was the first time such a survey was conducted among drug users

Limitations:

- The sample size of the HIV prevalence and behavioural survey among drug users was calculated for the purpose of HIV testing. It remains to be seen (based on reported confidence intervals) whether the sample of IDUs is large enough for the assessment of condom use among IDUs.
- The cost effectiveness of conducting a separate survey among drugs users (as opposed to including IDUs as a sentinel group in future BSS) needs to be looked at.

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of most-at-risk populations that received an HIV test in the last 12 months and who know their result.

Indicator 2.5
Number of sites that offer HIV counselling and testing

Description

The number of licensed sites offering counselling and testing services (VCCT sites) in the public and non-profit sectors.

Purpose

To assess progress in providing increased access to counselling and testing services.

Measurement

Numerator**:**
n/a

Denominator:
n/a

The total number of VCCT sites operated by MoH and sites operated by non-profit agencies with MoH licence.

Method of Measurement:
The number of licensed VCCT sites is equal to the number of sites that are expected to report to NCHADS on a quarterly basis.

Data Source

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) – VCCT quarterly reports.

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:

- Accurate information is available and reported on a quarterly basis.

Limitations:
-

Further Information

This indicator is included in the list of Universal Access indicators:

- Number of VCCT sites offering counselling and testing services.

Indicator 2.6 ***PLHA that receive comprehensive care***	
Description	This indicator is still under discussion and awaiting a clear definition of what is included in comprehensive care.
Purpose	
Measurement	Numerator**:** Denominator: Method of Measurement:
Data Source	Not measured
Frequency of Data Collection	
Strengths and Limitations	Strengths: • Limitations: • This indicator currently lacks a clear definition, in particular it needs to be defined what is meant with "comprehensive care"
Further Information	This indicator is included in the list of NSP II indicators: • Percentage of PLHA who receive comprehensive care.

Indicator 2.7
Number of Operational Districts with full continuum of care (COC)

Description

The number of Operational Districts (ODs) with full package of continuum of care.

Purpose

To assess progress made in providing increased access to continuum of care.

Measurement

Numerator**:**
n/a

Denominator:
n/a

The total number of Operational Districts with at least the following services:

- VCCT
- OI/ART
- Laboratory support
- Home based care
- PLHA support group
- MMM
- CoC coordinating committee

Method of Measurement:
Information about which of the above services is available in each of the Operational Districts is available at and maintained by the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS).

Data Source

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:

- Accurate data are available at reported on a quarterly basis

Limitations:
-

Further Information

This indicator is included in the list of Universal Access indicators:

- Number of Operational Districts with a full Continuum of Care package of services.

Indicator 2.8
Health Centres with home based care

Description	Number of Health Centres with home based care teams support.
Purpose	To assess progress made in providing increased coverage of and access to home based care for PLHA.
Measurement	Numerator**:** n/a Denominator: n/a The number of Health Centres (966 in total) that have at least 1 active home based care team. Method of Measurement: The number health centres with home based care support for PLHA is equal to the number of health centres that are expected to report to NCHADS on a quarterly basis.
Data Source	National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) – Home based care report.
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Accurate data are available and reported on a quarterly basis Limitations: -
Further Information	This indicator is included in the list of Universal Access indicators: • Number and percentage of health centres with home based care team support.

Indicator 2.9
PLHA associated with PLHA support groups

Description	The percentage of PLHA who are associated with PLHA support groups, disaggregated by sex
Purpose	To assess progress made in the coverage of and access to PLHA support groups.
Measurement	Numerator**:** The number of PLHA who are associated with PLHA support groups, disaggregated by sex Denominator: The total number of PLHA, disaggregated by sex Method of Measurement: Support groups report the number of PLHAs that are a member through NGO and provincial PLHA networks to the Phnom Penh based Cambodian People Living with HIV/AIDS Network (CPN+).
Data Source	Cambodian People Living with HIV/AIDS Network (CPN+)
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • This indicator is reported by a wide network of PLHA support group (> 600) on a quarterly basis Limitations: • The quarterly report cover support groups in Phnom Penh and 13 additional provinces. However, no reports are available at the moment for Kg Chhnang, Kg Speu, Kratie, Rattanakiri, Stung Treng, Mondolkiri, Preah Vihear, Odar Meanchey, Pailin and Kep. • There are some concerns regarding the accuracy of the quarterly reports. PLHAs that newly joined support groups are included, but it is not clear whether the reports account for support group members that moved, stopped participating, or died.
Further Information	This indicator is included in the list of NSP II indicators: • Number and percentage of PLHA who are associated with PLHA support groups (disaggregated by gender).

Indicator 2.10
Health Centres that provide support to TB patients for HIV testing

Description

The number of health centres that provide support to TB patients enabling them to go for HIV testing

Purpose

To assess progress made in TB/HIV collaborative activities aimed at increasing the number of and proportion of TB patients tested for HIV.

Measurement

Numerator**:**
n/a

Denominator:
n/a

The number of health centres that provide any type of support for TB patients to get tested for HIV, e.g. transportation to VCCT sites or financial support to cover travel costs to VCCT sites.

Method of Measurement:
The National TB Programme's recording and reporting (R&R) system, which generates quarterly activity reports from health centres, Operational Districts and provinces.

Data Source

National Centre for Tuberculosis and Leprosy Control (CENAT).

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:
- Data are available and reported on a quarterly basis

Limitations:
- This indicator looks at whether TB patients are referred for HIV counselling and testing, but not whether TB patients are actually tested and know the result of the test.

Further Information

This indicator is included in the list of Universal Access indicators:
- Number of health centres providing support to TB patients for HIV testing.

VCCT sites record the number of TB patients that get tested for HIV and hence, it is recommended to replace this indicator with *"percentage of newly detected TB patients who have been tested for HIV and know their result"* The numerator (the number of TB patients that get tested) is available at VCCT sites, while the denominator (the total number of new TB cases) is available from the National TB Programme.

Indicator 2.11
HIV incident Tuberculosis cases that received treatment for TB and HIV

Description

The percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV.

Purpose

To assess progress made in TB/HIV collaboration and in detecting Tuberculosis in people living with HIV.

The strategy is to screen all PLHA prior to starting ART.

Measurement

Numerator**:**
The number of adults with advanced HIV infection (with AIDS) who are currently receiving antiretroviral therapy and who were started on TB treatment within the reporting period.

Denominator:
The estimated number of incident TB cases in people living with HIV (WHO estimate).

Method of Measurement:
The numerator can be collected from patient registers at OI/ARV sites.

The estimated number of incident TB cases in people living with HIV is calculated by WHO and available at http://www.who.int/tb/country/en and was estimated at 2,586 for the year 2005. It should be noted that the estimate provided by WHO is considered to be unreliable and inaccurate by local technical sources.

Data Source

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:
-

Limitations:
- The denominator is based on a WHO estimate, which is regarded as unreliable and inaccurate by local technical sources.

Further Information

This indicator is included in the list of UNGASS indicators:
- Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.

Given the fact that the denominator is regarded as inaccurate and the fact that the national strategy is to screen all PLHA prior to starting ART, the following indicator was recommended as more useful: *"Percentage of PLHA that started ART and was screened for TB who were started on TB treatment during the reporting period"*

Indicator 2.12
Donated blood units screened for HIV

Description

The percentage of donated blood units screened for HIV in a quality assured manner.

Purpose

To assess progress made in ensuring a safe blood supply.

Measurement

Numerator**:**
The number of donated blood units screened for HIV in a blood bank or blood screening laboratory during the last 12 months

Denominator:
The total number of blood units donated during the last 12 months.

The denominator includes all possible blood donors:

- Voluntary blood donors
- Replacement (family) blood donors
- Paid donors
- Patients who provide their own blood to be stored and re-infused, if needed, during surgery (autologous donors).

Method of Measurement:
This information is routinely collected from all blood banks at public health facilities in the country by the National Blood Transfusion Centre.

Data Source

National Blood Transfusion Centre (NBTC)

Frequency of Data Collection

Monthly

Strengths and Limitations

Strengths:

- Data are routinely collected and reported by the National Blood Transfusion Centre on a monthly basis

Limitations:

- Monthly reports on the number of blood units collected and tested are limited to public health facilities.
- Presently only two blood banks (at the NBTC and in Battambang Provincial Hospital) participate in an external quality assurance scheme. Plans are under way, however, to establish an external quality assurance that includes all 22 blood banks in the country.
- Specialist at the NBTC and WHO country office are of the opinion that this indicator is of limited use only and that there are more appropriate and accurate blood safety indicators (see below)

Further Information

This indicator is included in the list of UNGASS indicators:

- Percentage of donated blood units screened for HIV in a quality assured manner.

Specialist at the NBTC recommended two additional indicators

that are likely to provide a more accurate indication of blood safety:

- The percentage of donors that are paid donors.
  A relatively large number of paid donors means an increased chance of HIV positive blood units getting into the blood supply at blood banks (i.e. blood units that test HIV negative during the window period).
- The percentage of donated blood units that tested HIV positive
  This indicator gives an indication of how safe the blood supply is and of the risk of HIV positive blood getting into the blood supply at blood banks.

Indicator 3.1
Willingness to look after an HIV infected family member

Description

Percentage of adults aged 15 to 49 who are willing to look after a family member with HIV.

Purpose

To assess progress made in promoting accepting attitudes and in reducing stigma towards people living with HIV/AIDS.

To assess progress made in promoting care for people living with HIV/AIDS in the family setting.

Measurement

Numerator**:**
The number of adults aged 15 to 49 who report to be willing to look after a family member with HIV.

Denominator:
The total number of adults aged 15 to 49 interviewed.

Method of Measurement:
A sample of adults aged 15 to 49 was asked the following question:
If a relative of yours became sick with the virus that causes AIDS, would you be willing to care for him or her in your own household.

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS: 2005

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:
- Measured through a large population based survey (CDHS), that is repeated every 5 years.

Limitations:
- CDHS is conducted only once every 5 years. It should be noted that it is under consideration to repeat the HIV/AIDS component 2.5 years after the last CDHS).

Further Information

This indicator is included in the list of NSP II indicators:
- Percentage of adults (15-49) willing to look after family member with HIV.

Indicator 3.2
School attendance by orphaned and vulnerable children (OVCs) aged 6 to 14

Description

The percentage of orphaned and vulnerable children (OVCs) aged 6 to 14 who are currently attending school, disaggregated by gender.

Purpose

To assess progress made in promoting and supporting school attendance by OVCs.

Measurement

Numerator:
The number of OVCs aged 6 to 14 that are attending school

Denominator:
The total number of OVCs or (in case of a survey) the total number of OVCs included in the survey (sample).

Method of Measurement:
Not measured at the moment.

Data Source

Not Available.

Given the questions included in the CDHS 2005 questionnaire, secondary analysis of the CDHS dataset may be able to provide data on school attendance of single and double orphans aged 6 to 14 years.

Frequency of Data Collection

-

Strengths and Limitations

Strengths:
-

Limitations:
-

Further Information

This indicator is included in the list of NSP II indicators:

- Percentage of OVC (6-14) attending school (disaggregated by gender).

Given the fact that CDHS 2005 dataset may include data that would allow calculation of this indicator, the possibility of conducting secondary analysis of the CDHS data set on children at risk should be considered and investigated.

Indicator 3.3
Current school attendance by survival status of the parents

Description

The percentage of orphans and non-orphans aged 10 to 14 who are currently attending school

Purpose

To assess progress made towards preventing or reducing the relative disadvantage in school attendance among orphans in comparison with non-orphans

Measurement

Numerator**:**
Orphans: The number of orphans aged 10-14 years who are currently attending school
Non-orphans: The number of non-orphans aged 10-14 who are currently attending school

Denominator:
Orphans: The total number of orphans interviewed.
Non-orphans: The total number of non-orphans interviewed.

Method of Measurement:
For every child living in the household, an adult household member is asked the following questions:

- Is the child's natural mother alive? If yes, does the child's natural mother live in this household?
- Is the child's natural father alive? If yes, does the child's natural father live in this household?
- Did the child attend school at any time during the present school year?

Data Source

Cambodia Demographic and Health Survey (CDHS), 2005

Frequency of Data Collection

CDHS is conducted every 5 years

Previous CDHS:

Next CDHS: 2010 (planned)

Strengths and Limitations

Strengths:

- Measured through a large population based survey (CDHS), that is repeated every 5 years.

Limitations:

- CDHS is conducted only once every 5 years.
- CDHS reports on the school attendance of double orphans only. However, secondary analysis of the CDHS data set should be able to provide data on single orphans.

Further Information

This indicator is included in the list of UNGASS indicators:

- Current school attendance among orphans and non-orphans aged 10-14.

Indicator 3.4
Orphaned and vulnerable children (OVCs) with access to shelter or alternative care

Description

Percentage and number of orphaned and vulnerable children (OVCs) with access to shelter or alternative care

Purpose

To assess progress made in providing shelter or alternative care to orphaned and vulnerable children.

Measurement

Numerator**:**
The number of OVCs with access to shelter or alternative care

Denominator:
The total number of OVCs or (in case of a survey) the total number of OVCs included in the survey (sample size)

Alternative care is defined as:

- Residential care: Orphanages, recovery shelters and protection centres
- Non-residential care: Community and family based care (foster families, kinship care); Pagoda based care; Group home based care

Method of Measurement:
It appears that the only data available is from the annual census of children living in orphanages (residential care only) that are registered with the Ministry of Social Affairs, Veterans and Youth rehabilitation (MoSVY). The findings of the annual census are reported in the MoSVY Alternative Care Report.

The MoSVY is in the process of piloting data collection on other forms of alternative care (i.e. non residential care)

Data Source

Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) – Alternative Care Report

Frequency of Data Collection

Annual

Strengths and Limitations

Strengths:

- MoSVY conducts the annual census of children living in orphanages and publishes the results on an annual basis.
- The number of orphanages registered at MoSVY and hence, included in the annual census has increased considerably.

Limitations:

- The data collected by MoSVY is limited to residential care only and does not include children that are covered by other (non-residential) forms of care.
- The denominator is based on OVCs children, while not all OVCs are in need of alternative care.

Further Information

This indicator is included in the list of NSP II indicators:

- Percentage and number of OVC with access to shelter and alternative care

Indicator 3.5
Households with orphaned and vulnerable children (OVCs) receiving minimum package of support

Description

Percentage of households with orphaned and vulnerable children (OVCs) that received minimum package of support.

Purpose

To assess progress made in providing support to households that are caring for orphaned and vulnerable children aged 0 to 17.

Measurement

Numerator**:**
The number of households with OVCs aged 0 to 17 that received the minimum package of support.

Denominator:
The total number of households with OVCs aged 0 to 17 or (in case of a survey) the total number of households with OVCs aged 0 to 17 included in the survey (sample size).

Definition of minimum package of support (one of six support components):

- Food support
- Health care
- School support
- Emotional/psychological support
- Shelter
- Right protection

Method of Measurement:
This indicator is currently not measured.

Data Source

Not Available

Frequency of Data Collection

-

Strengths and Limitations

Strengths:
-

Limitations:

- No data are currently available for this indicator

Further Information

This indicator is included in the list of Universal Access indicators:

- Percentage of households with OVC that receive minimum package of support.

The potential exist to use the Commune Councils to collect data for this indicator and to report the data through the District AIDS Committees and the Provincial AIDS Secretariats. However, this would require considerable efforts to train the Commune Councils in how to collect this data.

Indicator 3.6
OVCs whose households received free basic external support in caring for the child

Description Percentage of OVCs aged 0 to 17 whose households received free basic external support in caring for the child.

Purpose To assess progress made in providing support to households that are caring for orphaned and vulnerable children aged 0 to 17.

Measurement

Numerator**:**
The number of OVCs aged 0 to 17 who live in a household that received at least one of the four types of support for each child.

Denominator:
The total number of OVCs aged 0 to 17 or (in case of a survey) the total number of OVCs aged 0 to 17 who live in households that were interviewed.

External support is defined as free help coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization.

The four types of support are:
- Medical support (including medical care and/or medical care supplies)
- School related assistance (including school fees)
- Emotional/psychological support (including counselling from a trained counsellor and/or emotional/spiritual support or companionship)
- Other social support, including socio-economic support (e.g. clothing, extra food, financial support, shelter) and /or instrumental support (e.g. help with household work, training for caregivers, childcare, legal services).

Method of Measurement:
Through a survey, which ask the head of the household the following four questions to be answered for each OVC aged 0 to 17 living in the household:
- Has this household received medical support within the last 12 months?
- Has this household received school-related assistance within the last 12 months?
- Has this household received emotional/psychological support within the last 3 months?
- Has this household received other social support, including socio-economic and/or instrumental support, within the last three months.

Data Source This indicator is not measured.

Usually measured through a population based survey

Frequency of -

Data Collection

Strengths and Limitations

Strengths:
-

Limitations:
- No data are currently available for this indicator

Further Information

This indicator is included in the list of UNGASS indicators:
- Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.

The potential exist to use the Commune Councils to collect data for this indicator and to report the data through the District AIDS Committees and the Provincial AIDS Secretariats. However, this would require considerable efforts to train the Commune Councils in how to collect this data.

Indicator 3.7
Communes with access to support and care to households with OVCs

Description

Percentage of communes with at least one organization providing care and support to households with OVCs aged 0 to 17.

Purpose

To assess progress made in providing support to households that are caring for orphaned and vulnerable children aged 0 to 17.

Measurement

Numerator**:**
The number of communes with at least one organization providing care and support to households with OVCs aged 0 to 17

Denominator:
The total number of communes (1,627 nation-wide)

Method of Measurement:
A mapping exercise was conducted in 2007, which reports on the percentage of communes with at least one organization providing care and support to households with OVCs. Care and support was defined as:

- Strengthening families to support OVC – Food security and nutrition, income security through income generation activities, psychological support and succession planning (including identifying kinship and foster care)
- Ensuring access to essential services – Education, HIV/AIDS services, health care
- Mobilise and support community based responses – Anti-stigma and discrimination, OVC support groups, child clubs/play groups

Data Source

Mapping the Response: Protecting, Caring for and Supporting Orphans and Vulnerable Children in Cambodia; Save the Children Australia and the National and Multi-Sectoral Orphans and Vulnerable Children Taskforce.

Frequency of Data Collection

Not clear whether and how often the mapping exercise will be repeated.

Strengths and Limitations

Strengths:

- The mapping exercise is based on data collected through literature/desk review, consultation and interviews with key informants and validated through a national workshop.

Limitations:

- It is not clear if and when the mapping exercise will be repeated.

Further Information

This indicator is included in the list of Universal Access indicators:

- Percentage of communes with at least one organization providing care and support to households with OVCs.

The potential exist to use the Commune Councils to collect data for this indicator and to report the data through the District AIDS Committees and the Provincial AIDS Secretariats. However, this would require considerable efforts to train the Commune Councils in how to collect this data.

Indicator 4.1
Line ministries implementing HIV/AIDS programmes

Description	The number of line ministries and secretariats that are actively implementing and HIV/AIDS plan as part of their sectoral strategy.
Purpose	To assess progress made in promoting line ministries to have HIV/AIDS activities integrated into their sectoral strategies. This provides an indication of the extent of the multi sectoral coverage of the national response to HIV/AIDS.
Measurement	Numerator**:** The number of ministries and secretariats that are actively implementing HIV/AIDS activities as part of their sectoral strategy. Denominator: The total number of ministries and secretariats as members of NAA. Method of Measurement: Information is collected through line ministries' quarterly activity reports to the National AIDS Authority (NAA).
Data Source	Quarterly activity reports by line ministries to NAA
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Data are available on a quarterly basis Limitations: -
Further Information	This indicator is included in the list of Universal Access and NSP II indicators: • Number of line ministries implementing and HIV/AIDS programme.

Indicator 4.2
Provincial development strategies that address HIV/AIDS

Description

The percentage of provincial development strategies that address HIV/AIDS.

Purpose

To assess the provincial level response to HIV/AIDS

Measurement

Numerator**:**
The number of provincial development strategies that address HIV/AIDS

Denominator:
The total number of provincial development strategies (24)

Method of Measurement:
Information is collected through Provincial AIDS Secretariat's (PAS) quarterly activity reports to the National AIDS Authority (NAA).

Data Source

Quarterly activity reports by Provincial AIDS Secretariats (PAS) to NAA.

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:
- Data are available on a quarterly basis

Limitations:
-

Further Information

This indicator is included in the list of Universal Access and NSP II indicators:
- NSP II: Number of provincial development strategies that address HIV/AIDS.
- Universal Access: Percentage of provincial and commune development strategies that address HIV/AIDS.

Indicator 4.3
Commune development plans that address HIV/AIDS

Description	Percentage of commune development plans that address HIV/AIDS.
Purpose	To assess the commune level response to HIV/AIDS
Measurement	Numerator**:** The number of commune development plans that address HIV/AIDS Denominator: The total number of commune development plans Method of Measurement: Information is collected through Provincial AIDS Secretariat's (PAS) quarterly activity reports to the National AIDS Authority (NAA).
Data Source	Quarterly activity reports by Provincial AIDS Secretariats to NAA.
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Data are available on a quarterly basis Limitations: -
Further Information	This indicator is included in the list of Universal Access indicators: • Percentage of commune development strategies that address HIV/AIDS.

Indicator 4.4
Participation of ministries in NAA Technical Board meetings

Description	The percentage of all ministries and secretariats that are member of the National AIDS Authority (NAA) and participated in at least 10 NAA Technical Board meetings in the last year.
Purpose	To assess participation of line ministries and secretariats in NAA Technical Board meetings
Measurement	Numerator**:** The number of ministries and secretariats that are member of the National AIDS Authority (NAA) and participated in at least 10 NAA Technical Board meetings in the last year. Denominator: The total number of ministries (26) and secretariats (3) that are member of the National AIDS Authority. Method of Measurement: Information on attendance is available from meeting minutes of the NAA Technical Board meetings.
Data Source	Minutes of the NAA Technical Board meetings
Frequency of Data Collection	Minutes are available for each NAA Technical Board meeting (monthly), but indicator is calculated annually.
Strengths and Limitations	Strengths: • Data are available from meeting minutes Limitations: -
Further Information	This indicator is included in the list of NSP II indicators: • Percentage of ministries participating in at least ten NAA Technical Board meetings each year.

Indicator 4.5
Organizations with workplace HIV/AIDS policies and interventions

Description

Number of large organizations that have workplace HIV/AIDS policies and interventions in place.

Purpose

To assess progress made in implementation of workplace policies and interventions in support of HIV/AIDS prevention in support of providing care for staff living with HIV/AIDS.

As the private sector develops, it is crucial that employers take adequate and appropriate measures to reduce HIV infections in employees and protect the rights of employees living with HIV.

Measurement

Numerator**:**
n/a

Denominator:
n/a

Number of large organizations/employers that have developed HIV/AIDS workplace policies and are implementing HIV/AIDS interventions.

"Large organizations" has been defined as organizations that employ more than 100 people.

Method of Measurement:
At present there is no systematic measurement of this indicator and available information from programme reports is incomplete (does not cover all large organizations).

Alternatively, data could be collected by way of surveys that include only a sample of large organizations.

Data Source

Ministry of Labour and Vocational Training; Employee organizations; Cambodian Labour Union; Implementing partners, such as ILO, CARE, FHI.

Frequency of Data Collection

Quarterly

Strengths and Limitations

Strengths:
•

Limitations:
•

Further Information

This indicator is included in the list of Universal Access indicators:
- Number of large organizations that have workplace policies and interventions.

Indicator 5.1
National Composite Policy Index (NCPI)

Description	National Composite Policy Index (NCPI)
Purpose	To assess progress made in the development and implementation of national level HIV and AIDS policies and strategies.
Measurement	Numerator**:** n/a Denominator: n/a Method of Measurement: Measured by way of the National Composite Policy Index (NCPI) questionnaire (see Appendix 7 of the Guidelines on Construction of Core Indicators, UNGASS 2008 reporting). The NCPI covers the following broad areas of policy, strategy and programme implementation: • Part A: - Strategic Plan - Political Support - Prevention - Treatment, care and support - Monitoring and evaluation • Part B: - Human rights - Civil society involvement - Prevention - Treatment, care and support
Data Source	Various sources, including government and civil society organizations
Frequency of Data Collection	Every two years, as part of UNGASS reporting
Strengths and Limitations	Strengths: • The National Composite Policy Index questionnaire is completed every two years as part of UNGASS reporting Limitations: -
Further Information	This indicator in included in the NSP II and UNGASS indicator lists.

Indicator 6.1 *Reports/data received by the National AIDS Authority*	
Description	The number and percentage of quarterly reports and data collection forms received by the National AIDS Authority.
Purpose	To assess progress made in regular reporting by line ministries and secretariats and by Provincial AIDS Secretariats (PAS).
Measurement	Numerator**:** The number of quarterly reports and data collection forms received from line ministries and secretariats and from Provincial AIDS Secretariats. Denominator: The total number of quarterly reports and data collection forms to be received from line ministries and secretariats and from Provincial AIDS Secretariats. Method of Measurement: The number of reports and data collection reforms received is recorded in administrative files that are maintained by the National AIDS Authority.
Data Source	National AIDS Authority
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Data are available from administrative files that are maintained by the National AIDS Authority. Limitations: -
Further Information	Additional indicators for monitoring and evaluation of the M&E function will be specified in annual operational plans, such as specific input and output indicators and results to be achieved in the course of each year.

Indicator 6.2
Quantity and quality of data in CRIS

Description	The number and percentage of indicators for which good quality data are stored in the Country Response Information System (CRIS).
Purpose	To assess progress made in management of CRIS, i.e. in ensuring the quality of data stored in CRIS and in keeping data stored in CRIS up-to-date.
Measurement	Numerator**:** The number of indicators for which quality data are stored in CRIS. Denominator: The total number of indicators stored in CRIS. Method of Measurement: For each of the indicators stored in CRIS it is determined at least once per year whether: • The quality of the data stored has been adequately verified; and • The data are up-to-date (i.e. most recent data available has been stored in CRIS).
Data Source	National AIDS Authority
Frequency of Data Collection	Annual
Strengths and Limitations	Strengths: • This indicator can be measured by the National AIDS Authority. Limitations: • Data verification procedures and tools still need to be developed and defined. • Measurement of this indicator may be time consuming and hence, add to the already considerable workload of the Monitoring and Evaluation Unit of the National AIDS Authority.
Further Information	Additional indicators for monitoring and evaluation of the M&E function will be specified in annual operational plans, such as specific input and output indicators and results to be achieved in the course of each year.

Indicator 6.3
Reports and publications by the National AIDS Authority

Description	The number of reports and publications by the National AIDS Authority that use data/information provided by the national M&E system.
Purpose	To assess progress made in dissemination and use of data gathered by the national M&E system and stored in CRIS.
Measurement	Numerator**:** n/a Denominator: n/a Method of Measurement: The number of reports and publications is recorded in administrative files that are maintained by the National AIDS Authority.
Data Source	National AIDS Authority
Frequency of Data Collection	Quarterly
Strengths and Limitations	Strengths: • Data are available from administrative files that are maintained by the National AIDS Authority. Limitations: -
Further Information	Additional indicators for monitoring and evaluation of the M&E function will be specified in annual operational plans, such as specific input and output indicators and results to be achieved in the course of each year.

Indicator 7.1
HIV/AIDS spending

Description

Domestic and international AIDS spending by categories and financing sources.

Purpose

To collect accurate and consistent data on how funds are spent at the national level and the source of these funds.

Measurement

Numerator**:**
n/a

Denominator:
n/a

Method of Measurement:
AIDS spending is measured through the National AIDS Spending Assessment, which results in the information needed to complete the National Funding Matrix (see Appendix 6 of the Guidelines on Construction of Core Indicators, UNGASS 2008 reporting). The National Funding Matrix includes actual expenditures disaggregated by eight AIDS Spending Categories (APCs) and by funding source.

The eight APCs are:
- Prevention
- Care and treatment
- Orphaned and vulnerable children (OVCs)
- Programme management and administration strengthening
- Incentives for human resources
- Social protection and social services (excluding orphans and vulnerable children
- Enabling environment and community development
- Research (excluding operations research, which is included under programme management)

Each of these APCs is sub-divided into multiple sub-categories

Three main funding sources are distinguished:
- Domestic public
- Domestic private
- International

Each of the above funding sources includes multiple sub-categories

Data Source

Various sources, including government, donors and non-governmental organizations.

Frequency of Data Collection

Every two years, as part as UNGASS reporting

Strengths and Limitations

Strengths:
- The National AIDS Spending Assessment is conducted ate least every two years as part of UNGASS reporting

Limitations:

-

Further Information

This indicator in included in the UNGASS indicator list:

- Domestic and international AIDS spending by categories and financing sources

Annex 3: Universal Access Indicator

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

Annex 4: Indicators for UNGASS 2008 Reporting

Core Indicators for the Implementation of the Declaration of Commitment on HIV AIDS2008 Reporting[5]

Indicators	Data Collection Frequency	Measurement Tool
National Indicators		
National Commitment and Action		
1. Domestic and international AIDS spending by categories and financial sources	Ad hoc based on country request and financing, by calendar or fiscal year	National AIDS Spending Assessment or financial resource flow survey
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Every 2 years	Desk review and key informant interviews
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services to orphans and vulnerable children, and education)		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Annual	Programme monitoring
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Annual	Programme monitoring and estimates
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Annual	Programme monitoring and estimates
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Annual	Programme monitoring
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Every 4-5 years	Population-based survey
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Every 4-5 years	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Every 4-5 years	Behavioural surveys
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	Every 4-5 years	Population based-survey
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Every 4-5 years	School-based survey
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10-14	Every 4-5 years	Population-based survey
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Every 4-5 years	Population-based survey

[5] Guidelines on construction of core indicators, 2008 reporting; Pages 21-22

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Every 2 years	Behavioural surveys
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Every 4-5 years	Population-based survey
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Every 4-5 years	Population-based survey
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Every 4-5 years	Behavioural surveys
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Every 2 years	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Every 2 years	Behavioural surveys
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Every 2 years	Behavioural surveys
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Every 2 years	Behavioural surveys

Impact

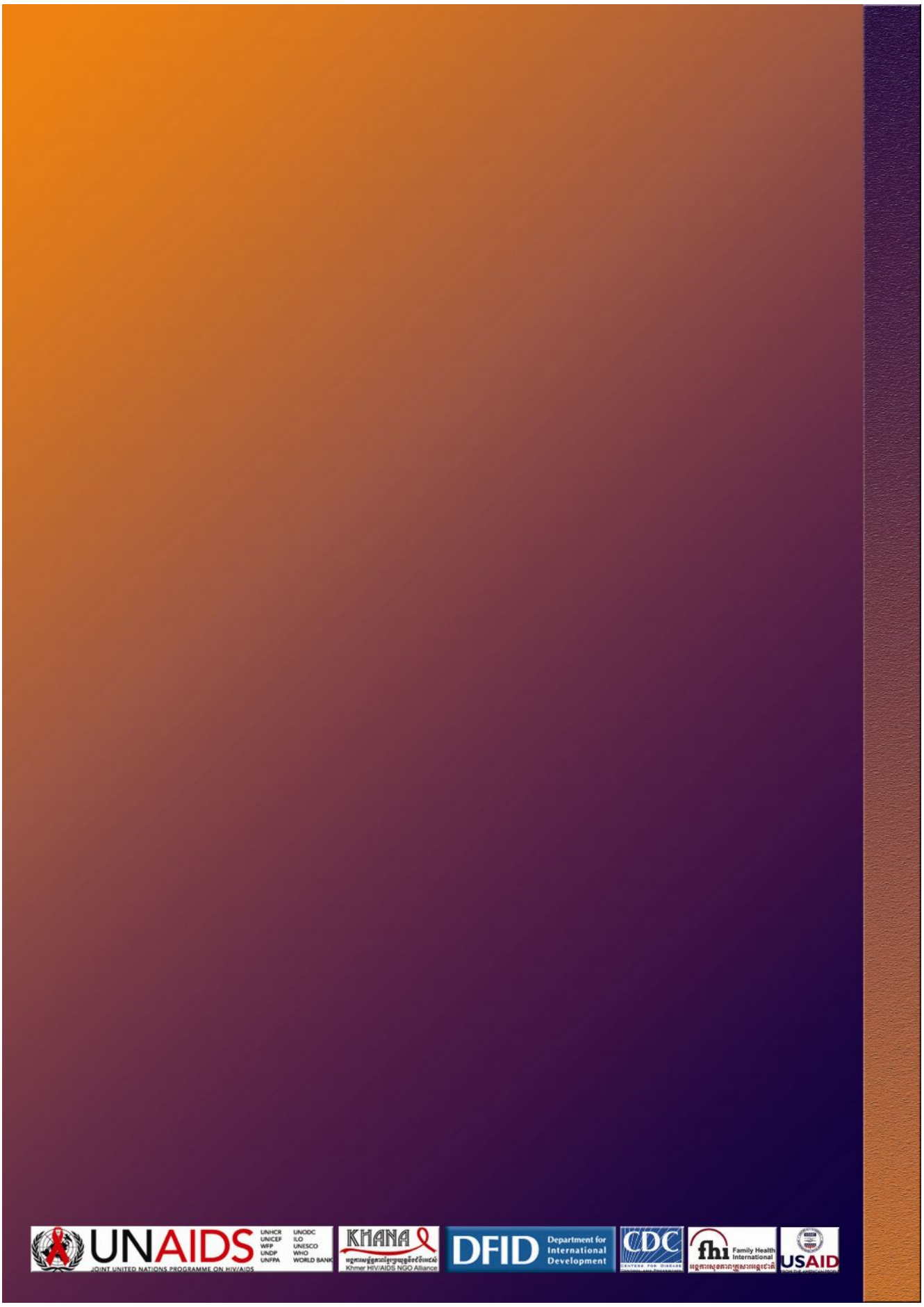
22. Percentage of young women and men aged 15-24 who are HIV infected	Annual	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	Annual	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Every 2 years	Programme monitoring
25. Percentage of infants born to HIV-infected mothers who are infected	(Modelled at UNAIDS Headquarters, based on programme coverage)	Treatment protocols and efficacy studies

Annex 5: HIV/AIDS Indicators in Cambodia Millennium Development Goals (CMDGs)

Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases[6]

Global MDG 6	CMDG 6
Target 7: Have halted by 2015 and begun to reverse the spread of HIV AIDS	**Overall target 11:** Decreasing the spread of HIV/AIDS
Indicator 18: HIV prevalence rate among 15-24 years old pregnant women	**Indicator 6.1:** HIV prevalence rate among adults aged 15-49
	Indicator 6.2: HIV prevalence rate among pregnant women aged 15-24 visiting ANC
Indicator 19: Condom use rate of the contraceptive prevalence rate	**Indicator 6.3:** Condom use rate among commercial sex workers during last commercial sexual intercourse
	Indicator 6.4: Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular partner
	Indicator 6.5: Proportion of condom use reported by married women who identified themselves at risk
Indicator 20: Number of children orphaned by AIDS	**Indicator 6.6:** Percentage of HIV infected pregnant women attending ANC receiving a complete course of anti-retroviral prophylaxis to reduce the risk of MTCT
	Indicator 6.7: Percentage of people with advanced HIV infection receiving antiretroviral combination therapy

[6] Cambodia Millennium Development Goals (CMDG) Report 2003; page 51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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
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KHANA
Khmer HIV/AIDS NGO Alliance
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