NATIONAL AIDS SPENDING ASSESSMENT FOR THE PERIOD 2016-2017 IN CAMBODIA

NATIONAL AIDS AUTHORITY (NAA)
September 2019

CAMBODIA'S SIXTH NATIONAL AIDS SPENDING ASSESSMENT (NASA VI), 2016-2017

ACKNOWLEDGEMENT

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KEY INDICATORS OF HIV AND AIDS SPENDING IN CAMBODIA, 2016-2017

HIV and AIDS Spending and Key Macro Indicators	2016	2017
HIV and AIDS spending - US$	$ 31,507,719	$ 34,447,888
GDP - US$ (Current US$)[1]	$ 20,016,747,754	$ 22,177,200,512
Health Spending - US$[2]	$ 1,207,000,000	No data
Health spending as a share of GDP - %	6%	No data
HIV and AIDS spending as a share of Health Spending[3] - %	0.03%	No data
HIV and AIDS spending per capita – US$	$ 2.00	$ 2.15
HIV and AIDS spending per PLHIV[4] - US$	$ 441	$ 487
HIV and AIDS Expenditure by Funding Sources	**2016**	**2017**
Public AIDS spending - US$	$ 7,913,080	$ 8,257,614
Private AIDS spending - US$	$ 54,694	$ 67,335
International AIDS spending - US$	$ 23,539,944	$ 26,122,939
Public AIDS spending - % over total AIDS spending	25%	24%
Private AIDS spending - % over total AIDS spending	0.17%	0.20%
International AIDS spending - % over total AIDS spending	75%	76%
HIV and AIDS Expenditure by Programmatic Area %	**2016**	**2017**
ASC.01 Prevention	19%	15%
ASC.02 Care and treatment	43%	46%
ASC.03 Orphans and vulnerable children (OVC)	0.5%	0.5%
ASC.04 Programme management and administration	34%	33%
ASC.05 Incentives for human resources	2%	3%
ASC.06 Social protection and social services	1%	1%
ASC.07 Enabling environment	0.3%	1.1%
ASC.08 HIV and AIDS-related research	0.1%	0.5%
HIV Expenditure by Beneficiary Population %	**2016**	**2017**
BP.01 People living with HIV	44%	47%
BP.02 Key populations	13%	7%
BP.03 Other key populations	6%	7%
BP.04 Specific "accessible" populations	0.3%	0.5%
BP.05 General population	1%	1%
BP.06 Non-targeted interventions	36%	37%

1 Source: https://databank.worldbank.org/indicator/NY.GDP.MKTP.CD/1ff4a498/Popular-Indicators

2 Source: Cambodia National Health Accounts 2012-2016: Health expenditure report, April 2019. Available at: https://iris.wpro.who.int/bitstream/handle/10665.1/14362/9789290618690-eng.pdf

3 NHA 2016 in Cambodia only captures Current Health Expenditure, while NASA 2016 tracked also capital expenditure. For the purpose of this report the total HIV spending in NASA was divided by the Current Health Spending.

4 Source: AEM analysis workbook

EXECUTIVE SUMMARY

HIV and AIDS spending in Cambodia was peaked at US$ 58.1 million in 2010 and has been in decline ever since. Lowest spending has seen in 2016 at US$ 31.5 million while 2017 showed a gradual increase with total HIV expenditures of US$ 34.5 million.

The share of public spending for the AIDS response in Cambodia has increased steadily from 4% in 2010 to 24% in 2017 but absolute amount stays relatively stable within the range of US$ 6 to 8 million annually between 2010 and 2017.

The country depends largely on international funding for the AIDS response. International funds cover 75% of overall AIDS spending in 2016 (US$ 23.5 million) and 76% in 2017 (US$ 26.1 million). The Global Fund to Fight AIDS, Tuberculosis and Malaria remains the largest financing source, providing 50% and 54% of total funds for AIDS response in Cambodia in 2016 and 2017. Government of the United States was the third biggest donor in 2016-2017. Although its contribution declined over the last six years – from US$ 13.9 million in 2011 to US$ 4.4 million in 2017, US Government is the main source of funding for the prevention interventions particularly for key populations.

Spending on Prevention shows a continuous decline since 2011 – from USD$ 14 million in 2011 to US$ 5 million in 2017, reduced to almost one-third over the period of six years. Steeper decline has seen in prevention spending for key populations with only US$ 2.5 million was spent in 2017 whilst the spending on prevention interventions for key populations was almost 4 times higher in 2011 with US$ 9.5 million.

Care and Treatment represents 43% and 46% of the total HIV expenditures in 2016 and 2017, followed by programme management and administration (34% in 2016 and 33% in 2017), and Prevention (19% in 2016 and 15% in 2017).

Majority of AIDS spending is implemented by public sector providers since 2012 and 65% of the AIDS response in Cambodia was implemented by public sector providers in 2017. Though the proportion of total spending implemented by private sector non-profit providers was only 35% in 2016 and 33% in 2017, they are the largest service delivery force for prevention interventions, representing 81% and 85% of total prevention spending in 2016 and 2017 respectively.

Domestic public funding starts playing a prominent role in the AIDS response, although a significant part of the Government spending captured by NASA relates to the shared health system cost.

Considering a shrinking funding envelope from the international sources, there is a dire need to - mobilize domestic sources from both public and private sectors; adopt innovative and integrated models with element of prioritization; optimize allocations to enhance greater efficiency gains for the effective and sustainable AIDS response.

1. INTRODUCTION

1.1 BACKGROUND

Cambodia's AIDS response over the past two decades has been highly successful and has led the country to be one of the early achievers[5] of the 90-90-90 targets in the global scale[6]. Impactful interventions have resulted in 62% decline in new HIV infections between 2010 and 2018. There are estimated 73,000 PLHIV in 2018 and of which, 82% know their HIV status, and 81% of estimated people living with HIV are receiving anti-retroviral therapy (ART) in Cambodia[7].

Cambodia's successful HIV programme are the outcomes of a sound policy and strategic framework that dates back to more than two decades. The national strategies and goals, complemented by Cambodia's legal framework, is overall conducive in creating an enabling environment for the AIDS response. These achievements, while led by the Cambodian government, have been heavily dependent on external financial and technical support. International investments contributed to 82% of financing for the AIDS response in 2015[8].

Assessment of AIDS spending that entails the analysis on the source of the financing and the distribution of the funds across different HIV services and beneficiaries, is crucial for the understanding of how the funds are used. National AIDS Spending Assessment (NASA) provides a framework and tools for undertaking a comprehensive analysis of actual HIV expenditures (health and non- health). It equips decision makers with strategic information that allow countries to mobilize resources and improve accountability mechanism for efficient and effective programme implementation. Between 2009-2015, Cambodia has conducted five rounds of NASA and this report summarizes the HIV expenditures for the period of 2016-2017.

1.2 OBJECTIVES

The overall goal of NASA is to monitor flow of funds that are used to finance the AIDS response. NASA VI objectives were to:

- Track AIDS expenditures, for the period of 2016-2017, from origin to the last point of service in the scope of financial sources (public, private or international), providers, beneficiaries (target groups) and inputs (production factors);
- Provide financial data that will inform the discussion around sustainability of the AIDS response in Cambodia.

NASA VI data collection included AIDS expenditures from several sources: domestic, international and private ones.

5 Achiever of 90-90-90 treatment target translates into 73% of all people living with HIV being virally suppressed

6 UNAIDS Global AIDS Update 2019 : Communities at the Centre (https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf)

7 http://aidsinfo.unaids.org/

8 NAA," Cambodia's Fifth National Aids Spending Assessment (NASA), 2014-15"

2. MEHTODOLOGY AND PROCESS

2.1 NASA FRAMEWORK

NASA measures spending for the final consumption of goods and services in the AIDS response by tracking the flow of spending from its origin to the final beneficiary, through six classifications – Financing Sources, Financing Agents, Providers of Services, AIDS Spending Categories, Beneficiary Populations and Production Factors.

NASA monitors actual expenditures (public, private and international) and those in the health sector and in other sectors (social mitigation, education, labor and justice) that make up the National AIDS Response.

As part of this methodology, NASA employs tables and double-entry matrices to represent the origin and destination of resources, thus avoiding double counting of expenses through the reconstruction of resource flows for all HIV transactions.

2.2 NASA CLASSIFICATION

The NASA classifies AIDS spending according to a standardized tool that is based on internationally agreed concepts and nomenclatures of sectoring, financing and production. Therefore, the tool allows the collection of pertinent and specific estimates that could easily be integrated into internationally comparative framework. In NASA, financial flows and expenses related to the AIDS response are organized in three dimensions - funding, service, and consumption and each dimension is further divided into two categories. The framework for the NASA system thus has six categories in total:

Funding

- **Financial Sources (FS)** are entities that provide funds to financial agents;
- **Financial Agents (FA)** are entities that collect financial resources to fund service provision programmes and to make decisions related to the programme.

Service Provision

- **Providers of Services (PS)** are entities that are engaged in the production, supply and provision of services related to HIV and AIDS;
- **Production factors (PF)** are the inputs used to supply goods and services;

Consumption

- **The AIDS Spending Categories (ASC)** are interventions and activities related to HIV and AIDS that are offered to the beneficiaries;
- **The Benefiting Populations (BP)** are direct beneficiaries of the interventions.

2.3 DATA COLLECTION AND PROCESSING

2.3.1 NASA Task Force

NASA VI exercise was led by the National AIDS Authority (NAA), with technical and financial assistance from UNAIDS and the USAID-financed Health Policy Plus Project (HP+). NAA established a NASA Steering Committee with participation from NAA, MoH, NCHADS, UNAIDS, HP+, PEPFAR and Civil Society representatives. NASA Steering Committee guided the overall process and validated the draft results.

2.3.2 Data Collection

The standard NASA data collection questionnaire was used to obtain information from 33 public,

private and international organizations and agencies. Data was collected between May – September 2018.

Most of the organizations were familiar with the data collection requirements, thus providing enough detail which allowed the NASA team to correctly assign codes to each of the provided amounts of expenditure. Whenever provided data required additional disaggregation, the team has contacted a respective institution/organization and discussed possible assumptions to achieve a necessary level of detail for NASA.

Another important task for the NASA team was to avoid double-counting of the same transaction flow. This was achieved by constantly reviewing all the entries and exclude possible duplication. NASA dataset contains an indicator which informs whether a certain amount of money is included or excluded from the total ("0" for excluded, "1" for included). At the stage of the data entry all transactions were marked as "1" indicating included. When the double counting of the same resource flow has been discovered, the indicator for this transaction was switched to "0" and thus excluded.

Generic rule for the inclusion of a transaction amount is that this amount has been provided by the organization closest to the level of service provision / consumption. For example, when the NASA team receives a completed data collection form from FHI360 and Cambodian Women for Peace and Development (CWPD), NASA dataset excluded the amount that FHI360 had transferred to CWPD and only included the expenditure of CWPD that had received through FHI360.

2.3.3 Data Processing

The data collected on expenditure were first launched in Excel® spreadsheets, checked and balanced. All information obtained or collected was checked in the greatest detail possible to ensure the validity of data sources and records. The data were then transferred to the NASA Resource Tracking Tool (RTT) (resource monitoring software), which is designed to facilitate data processing for NASA. The results form RTT were then exported to Excel® to produce tables and graphs for analysis.

2.3.4 Limitations of Assessment

- Limitations in data availability:
  - Some organizations did not report their expenditure on AIDS through NASA exercise and therefore not included in NASA VI;
  - Data from National Health Accounts (NHA) for 2016 and 2017 is not available at the time of analysis and report preparation. Hence, 2015 estimates were used for analysis and adjusted for inflation and there is a possibility that the data may not accurately reflect the actual health spending;
  - Out-of-pocket spending is not captured.
- Data quality and disaggregation of expenses:
  - Some data were reported aggregated (mainly for the AIDS Spending Categories, Beneficiary populations and Production factors);
  - Expenses for communication and behavior change are not disaggregated by age and sex;
  - Use of procurement data for HIV test kits cannot warrant the correct assignment according to AIDS Spending Category. For instance, by NASA categories, HIV testing is part of the prevention programmes (separately for each key population) and also part of care and treatment (provider-initiated testing and counselling), but the use of procurement data cannot accommodate such breakdowns;
  - It was not possible to disaggregate the consumption of ARV between first- and second-line treatment regimen. Data on ARV procurements (top-down) was used in the place of consumption (bottom-up);
  - Similar to the previous NASA rounds, it was challenging to separate expenditure between social protection programmes for orphans and vulnerable children (OVC) and social protection and social services for other

populations. When the details on the beneficiary populations were not available, NASA team has divided the expenditure (e.g. on food relief for OVCs and PLHIV and their families) in equal shares between these two programmes;

- There was no NASA conducted for the year 2013 and it is excluded from all the graphs and tables that provide time series of NASA results;
- Due to lack of costing data and detailed expenditure reports, some usage/ procurement of medicines was difficult to differentiate between OI and STI (e.g. Metronidazole, Ciprofloxacin, Clindamycin, etc.).

2.3.5 Key Assumptions

- **Calendar years.** The team analyzed 2016 and 2017 calendar years which corresponds to a fiscal year which begins on January 01 and ends on December 31. All the organizations provided data for the calendar years.

- **Exchange rates.** The results of the assessment are presented in US Dollars. When the data was reported in the local currency – Cambodian Riel – the following exchange rate has been applied to convert the amount into US Dollars:
  - In 2016 1 US Dollar = 4,050 KHR
  - In 2017 1 US Dollar = 4,050 KHR

- **Programme management and administration costs.** In NASA, AIDS Spending Category 04. represents "programme management and administration spending" that usually captures the efforts of national, regional or organizational level to strengthen coordination, policy and clinical guidelines, strategic information, monitoring and evaluation, drug supply systems etc. Most of this expenditure is considered non-targeted (BP.06 Non-targeted interventions in the classification of Beneficiary populations), implying that it benefits not just one specific population group. AIDS Spending Category 04 includes two sub-categories– ASC.04.01 Planning, Coordination and Programme management and ASC.04.02. Administration and transaction costs. From NASA III to NASA VI (except for NSASA V), the use of the ASC.04.02 was limited to transaction costs (bank charges for money transfer) and external audit. The code ASC.04.01 was broadly applied to many activities such as -coordination activities at the national and sub-national level, development of policies, guidelines as well as a related printing and dissemination cost, public communication and advertising, office costs and staff salaries of the NAA, part of the NCHADS costs and costs of other public or private organizations that do not provide services directly to the beneficiary populations (when such disaggregation was possible).

  The cost of running the service-providing facilities was assigned to a corresponding service-related ASC code, but not to ASC.04.01. For instance, the cost of running a drop-in center for PWID/PWUD was coded under ASC.01.10 Harm reduction Programmes for PWID/PWUD, and the cost of the ART clinic maintenance was assigned to the ASC.02.01.03 Antiretroviral therapy.

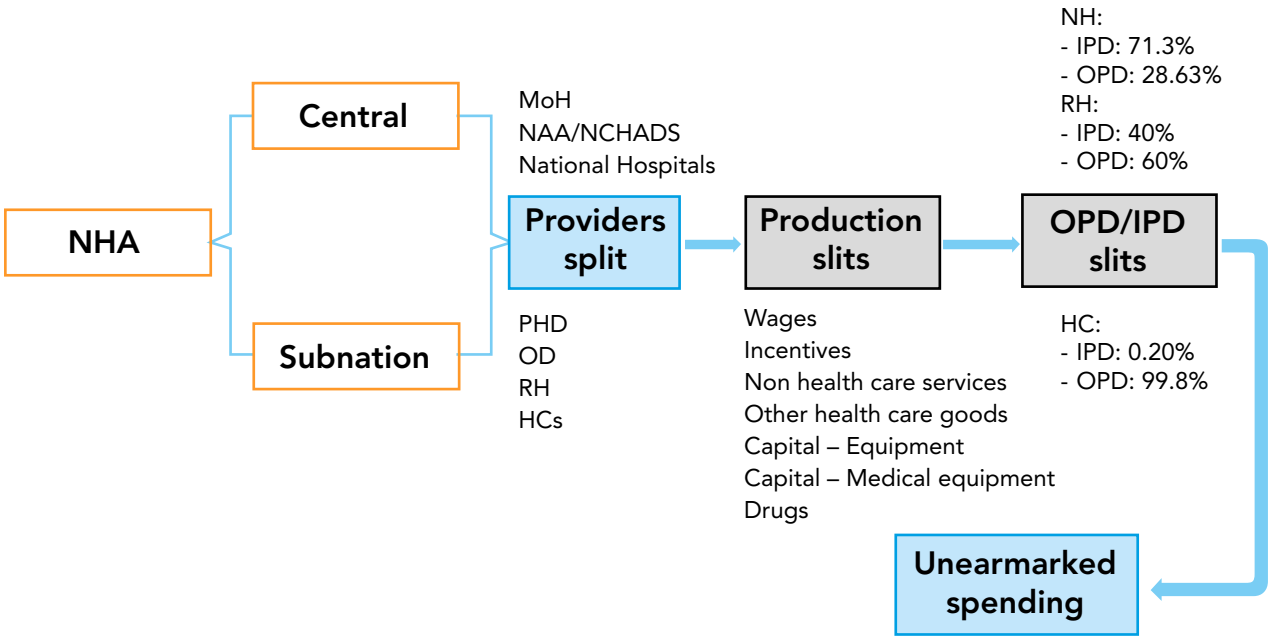
- **Coding of salaries.** According to a NASA Classification and Definitions, the coding of salaries depends on the functions performed by the staff. But in NASA V, the decision has been made to classify all staff-related expenditure under the AIDS Spending Category 05.01 Monetary incentives for human resources. In NASA VI, after the data verification, majority of the salaries have been re-assigned to specific function-related categories, while maintaining the appropriate coding of these expenses as a Production factor "PF.01.01 Labour income". For instance, expenditure on salaries for the NAA staff was classified as ASC.04.01 Planning coordination and Programme management; laboratory staff of NCHADS – as ASC.02.01.05 HIV-related laboratory monitoring; staff working in the ART clinics – either as ASC.02.01.98 Outpatient care services not broken down by intervention or directly as ASC.02.01.03 Antiretroviral therapy.

- **ART drugs (consumption vs procurement).** General NASA rule guides the assessment team to estimate the cost of the consumed ART drugs by multiplying the cost of each regimen by number of patients that received that particular regimen that year, adjusting the figure by a patient drop-out rate etc. This usually provides the required level of detail to distinguish between adult and pediatric as well as first- and second-line regimes. While this was done in the NASA III and NASA IV, in the last two rounds of NASA – NASA V and NASA VI - it was decided to use procurement data to reflect ART spending.

- **Classification of Providers:** NGOs working inside public hospitals and clinics were considered as providers of services in the current and previous rounds of NASA exercise. Nevertheless, it is important to mention that according to the principles of the System of Health Accounts (SHA11), NGOs providing services inside public care setting are not considered as Provider of Services. The provider would be the public clinic or hospital since the provision of services is their mainstay (the NGO would in this case be a Production Factor, providing services for the public hospitals and clinics).

- **NHA HIV sub-analysis and NASA-NHA crosswalk.** Since the data from the National Health Accounts was not available for the year 2016 and 2017, NASA team has used NHA results and the calculation paths from the NASA V[9] (Figure 1). The attribution of the shared health systems cost to HIV had been discussed and agreed with the NHA team. Inflation rate of 3% was applied to calculate the estimates for 2016 and 2017. Detailed explanations are in Annex 1.

Figure 1. NHA Analysis Path for NASA VI



9 National AIDS Spending Assessment V for the years 2014-2015

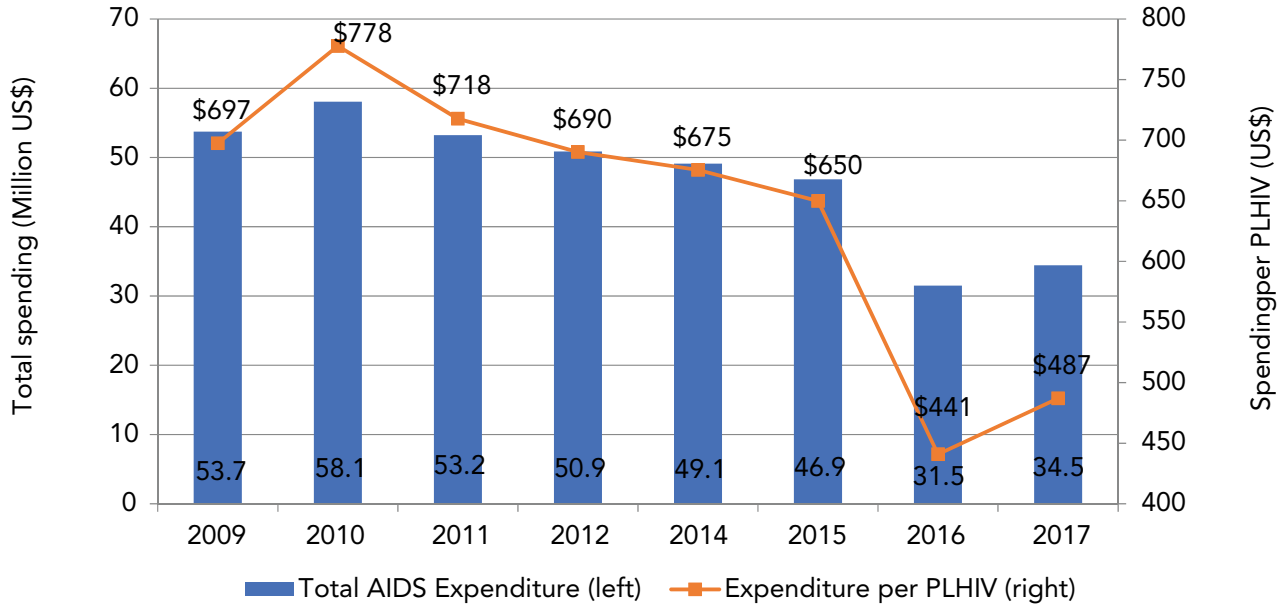
3. RESULTS OF NASA VI

3.1 TRENDS IN HIV EXPENDITURE

In Cambodia, the first case of HIV was reported in 1991 and by 1997 new HIV infections had rapidly increased to 16,000[10] and became one of the highest HIV burden countries in Asia and Pacific. The visionary AIDS response model of the Royal Government of Cambodia (RGC) has successfully turned down the epidemic and put Cambodia on the global map as one of the few countries that have achieved the status of "epidemic control" and the achiever of "90-90-90" targets[11]. The response model of RGC not only welcomes the financial and technical assistance of international donors and development partners but also works closely with civil society, key and vulnerable populations. Now the country is at the important juncture to main the success of AIDS response with the shrinking financial envelope.

The resources available from all sources for the implementation of the Cambodia AIDS response totaled US$ 31.5 million in 2016 and US$ 34.5 million in 2017, which is lower than the available resources of 2009 to 2015 (Figure 2).

Figure 2. Total HIV Expenditure Trends in 2009-2017



10 AEM-Spectrum Estimates 2018

11 Cambodia Fact Sheet 2017, http://aidsinfo.unaids.org/

A decreasing trend in international investments on AIDS has been evident at national, regional and global level in the past decade. The global economic crisis, new global health priorities, climate change, emerging public health emergencies, has impacted negatively on the international funding support for the AIDS response. As a consequence, many countries, including Cambodia, are grappling with a significant decline in donor support for the AIDS response.

In 2010 Cambodia spent a total of a US$ 58 million for the AIDS response[12] but the spending has reduced to almost US$ 47 million in 2015[13]. In 2016, the country has spent US$ 15 million less than the amount that had spent in the preceding year.

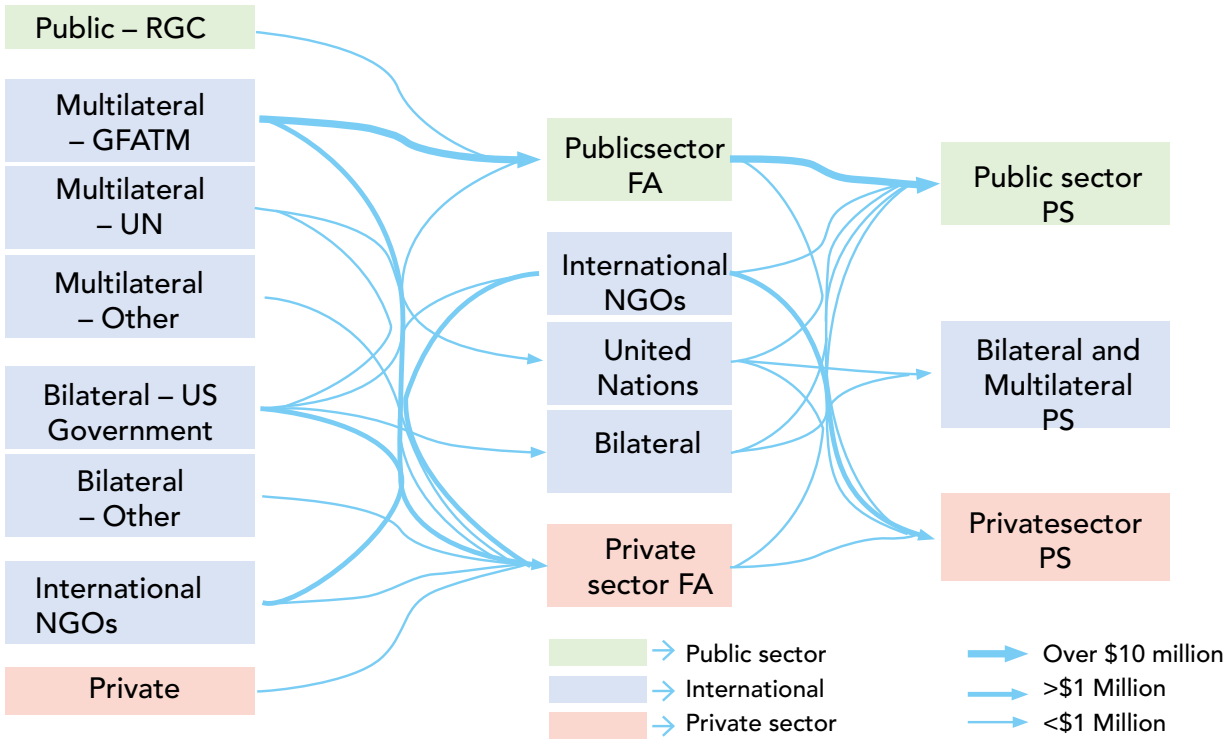
3.2 FINANCIAL FLOWS AND FUNDING MODALITIES

3.2.1 Funding Flows: From the Sources to Service Providers

National AIDS Spending Assessment methodology distinguishes three main roles that organizations and entities of various types may play in the AIDS response: Financing Source, Financing Agent and Provider of Services. One organization may be assigned with more than one role in a resource flow. Understanding the flow of funding helps the Government and the donors to adjust their allocations and to better focus their financing streams. Figure 3 graphically presents the map of the financial flows in Cambodia in 2016-2017.

In Cambodia, the biggest funder is The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Public sector Financing agents – Ministry of Health and its divisions – NCHADS in particular as one of the Principal Recipients of the GFATM grant, and NAA – manage the resources collected from various financing sources, transfer the money to the providers to buy or pay for the goods or/and services to be delivered to beneficiary populations. Public sector providers dominate service delivery in this funding flow with over US$ 10 million transferred annually in the recent years through this resource flow. The second largest funding flow also comes from The Global Fund, but it is managed and executed in the private non-profit sector, mainly by national NGOs.

Figure 3. Main Flow of Funding for the AIDS Response, 2016-2017



12 National AIDS Spending Assessment III for the years 2009-2010

13 National AIDS Spending Assessment V for the years 2014-2015

Even though US Government funding through PEPFAR has reduced its contribution as compared to the previous years, it still finances one of the largest transactions in the AIDS response in Cambodia, that is managed by US government agencies (CDC and USAID) and implemented by CDC, international and national NGOs, and others.

3.2.2 Financing Sources

3.2.2.1 Financing Sources – overall trends

Financing sources are the organizations, governments, corporations or private individuals where the resources for implementing HIV interventions originate. Over the years, the composition of the funding mechanisms of the national AIDS response in Cambodia has evolved, but the key contributors remain relatively unchanged.

International funding remains the key funding source for the AIDS response in Cambodia. Figure 4 shows the trend of total AIDS expenditure by financing source and it shows consistent trend on donor dependency. In 2017, total AIDS spending was US$ 34.5 million, 40% reduction from the amount of spending in 2010.

Figure 4. Total HIV and AIDS Expenditure, 2006-2017

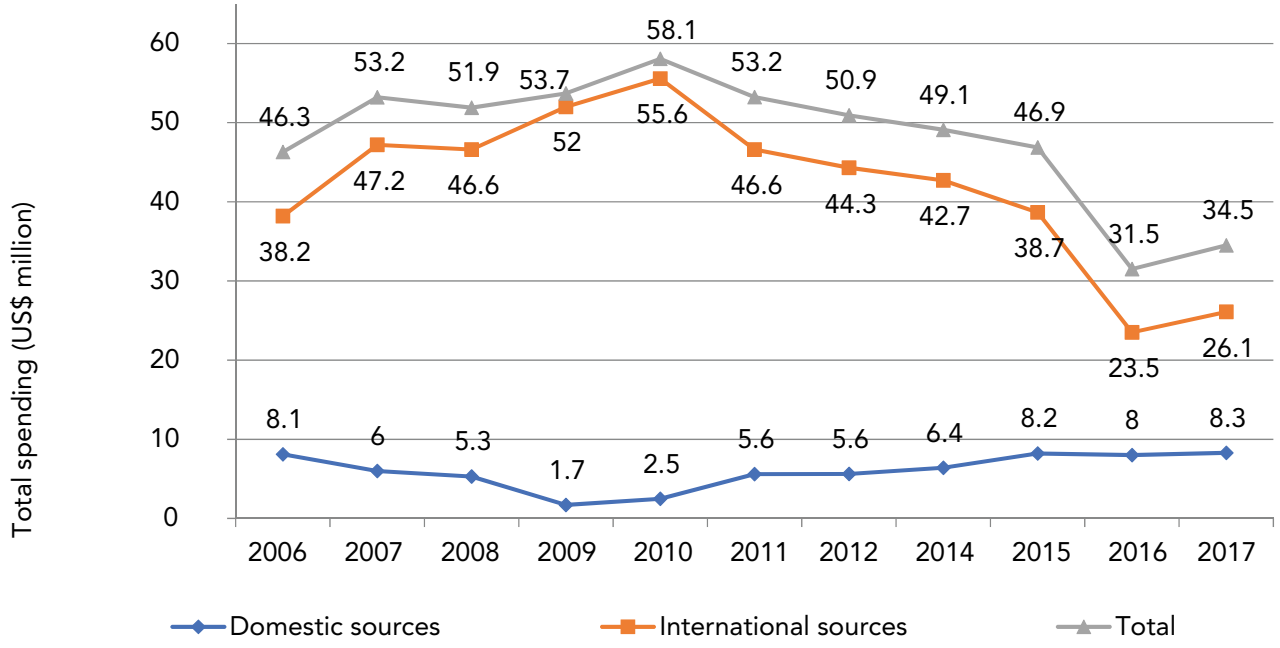


Figure 5. Total AIDS Spending by Financing Source, 2009-2017

Top largest Financing Sources	2009		2010		2011		2012		2014		2015		2016		2017	
	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%	$USD	%
The Global Fund	19,023,377	35%	22,711,245	39%	18,030,595	34%	20,027,132	39%	24,848,545	51%	19,276,367	41%	15,758,925	50%	18,732,595	54%
Bilateral Agencies	15,565,137	29%	15,662,525	27%	15,713,795	30%	15,872,474	31%	12,228,466	25%	14,047,855	30%	5,263,444	17%	4,641,631	13%
Royal Government of Cambodia	1,703,403	3%	2,436,832	4%	5,644,947	11%	5,671,862	11%	6,438,230	13%	8,188,161	17%	7,913,080	25%	8,257,614	24%
United Nations Agencies	7,547,437	14%	8,382,652	14%	7,128,857	13%	4,320,352	8%	2,309,481	5%	1,941,555	4%	925,220	3%	812,160	2%
International NGOs	9,119,295	17%	7,516,331	13%	3,736,224	7%	2,855,882	6%	2,409,038	5%	2,274,751	5%	1,543,413	5%	1,875,558	5%
Other Multilateral Organizations (excl. GF & UN)	612,307	1%	1,043,168	2%	1,745,621	3.3%	1,165,243	2.3%	860,173	2%	860,225	1.8%	48,941	0%	60,995	0.2%
Private Domestic	36,955	0.1%	51,540	0.1%	963,952	1.8%	956,837	1.9%	24,723	0.1%	262,750	0.6%	2,926	0.01%	2,709	0.01%
Private International	127,286	0.2%	255,175	0.4%	254,654	0.5%	57,619	0.1%	3,149	0.0%	12,745	0.0%	51,768	0.2%	64,626	0.2%
Total	**53,735,198**	**100%**	**58,059,469**	**100%**	**53,218,646**	**100%**	**50,927,401**	**100%**	**49,121,805**	**100%**	**46,864,409**	**100%**	**31,507,719**	**100%**	**34,447,888**	**100%**

Figure 5 displays the total spending disaggregated by financing sources, based on the findings from NASA III to NASA VI, that covered the period of 2009 to 2017.

Figure 6 shows the highlight of the largest donors of the AIDS response in 2016 -2017. These financing sources combined represent 99% of the overall country's AIDS spending.

Figure 6. Top Largest Financing Sources of AIDS Response in Cambodia, 2016-2017

Top largest Financing Sources	2016	2017
The Global Fund to Fight AIDS, Tuberculosis and Malaria	15,758,925	18,732,595
Royal Government of Cambodia	7,913,080	8,257,614
US Government	5,144,851	4,407,615
AIDS Healthcare Foundation	1,031,634	1,175,482
UNAIDS Secretariat	813,001	770,406
Cambodian Red Cross	233,584	233,353
Government of France	26,321	137,451
Government of Sweden	83,488	96,088
European Commission	38,971	60,995
Caritas / Catholic Relief Services	33,577	43,145
UNFPA	88,442	25,498

3.2.2.2 Domestic Public Financing Sources

Although the AIDS Response in Cambodia continues to be predominantly funded by international sources, the Royal Government of Cambodia (RGC) remains committed to maintain its share of funding. Domestic funding remains the only source of funding that is growing regularly in absolute terms, although with relatively small increments. Stepping up the domestic resources is very crucial for the AIDS response considering the decline of funding from international donors (Global Fund and US Government in particular). In 2016-2017 domestic public spending was US$ 7.9 and 8.3 million respectively, representing 25% and 24% of the total HIV expenditure in Cambodia (Figure 5)[14].

3.2.2.3 International Financing Sources – The Global Fund

Support from the Global Fund continued to be significant over the last 8 years, reaching its highest – US$ 24.9 million – in 2014 (Figure 5). The Global Fund remains the largest financing source of the AIDS response in Cambodia and contributed US$ 15.8 million (50% of total AIDS spending) in 2016 and US$ 18.7 million (54% of total AIDS spending) in 2017 (Figure 5).

3.2.2.4 International Financing Source – Government of the United States of America[15]

Government of the United States of America continues to be the largest bilateral financer, and the third largest financing source after The Global Fund and the Royal Government of Cambodia. In 2016 its funding represented 16% of the total AIDS spending (US$ 5.1 million) and 13% (US$ 4.4 million) in 2017.

Traditionally, almost all US Government funding for HIV goes through either PEPFAR or The Global Fund. Overall PEPFAR expenditure has been declining over the years and it is reported in the PEPFAR Dashboard[16] as follow:

14 More details on the composition and use of the GFATM resources can be found in 3.4.2 HIV Expenditure from The Global Fund

15 More details on the composition and use of the US Government resources can be found in 3.4.3 HIV Expenditure from the Government of the United States

16 PEPFAR panorama spotlight: Dashboards-Cambodia. 2019; U.S. Government interagency. Accessed 15 September 2019

PEPFAR expenditure 2015-2018 (including salaries and allowances)

	2015	2016	2017	2018
Care and treatment	2,520,359	1,462,358	1,622,912	848,495
Testing	693,415	568,660	500,216	833,722
Prevention	1,822,224	1,867,989	1,430,960	532,119
Above site Program	2,271,171	2,102,346	2,346,377	2,145,711
Program management	2,620,350	2,347,285	2,365,627	2,003,040
Total	**9,927,519**	**8,348,638**	**8,266,092**	**6,363,087**

In NASA, the US Government's expenditure on HIV has been tracked using a bottom-up approach – based on the reports of the final implementors and that explains the difference between the PEPFAR's reported expenditure and NASA's actual spending.

3.2.2.5 International Financing Source – United Nations

UN invested over US$ 0.9 million and US$ 0.8 million in 2016 and 2017 representing 3% and 2% respectively of the overall AIDS spending.

NASA VI captured an HIV expenditure of International Labour Organization (ILO), Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO), United Nations Population Fund (UNFPA) and United Nations Development Fund for Women (UNIFEM). UNAIDS remains the largest UN contributor in Cambodia, spending US$ 813,001 in 2016, and US$ 770,406 in 2017, followed by UNFPA with the spending of US$ 88 thousand in 2016 and US$ 25.5 thousand in 2017. Over the period 2009-2017, there is a steady decline in funding from the United Nations (Figure 5), from US$ 7.6 million (14% of total AIDS spending) in 2009 to US$ 0.8 million (2% of total AIDS spending) in 2017.

3.2.2.6 Other Financing Sources

In 2016-2017 AIDS Healthcare Foundation (AHF) contributed over US$ 1 million annually (Figure 6)[17].

3.2.3 Financing Agents

Financing agents are the organizations or institutions that make decisions on how to spend the allocated money from financing sources. Key functions of the financing agents are to - decide what service or product to purchase, to select service providers that deliver services or products to the beneficiary populations[18]. In some cases, same organization may play multiple functions of financing source, financing agent and provider of services.

In 2016 and 2017, the largest financing agent was the Royal Government of Cambodia, represented by various ministries and entities. Non-governmental and civil society organizations, represented as private sector financing agents in NASA category, managed 22% and 20% of the overall AIDS spending respectively, followed by international financing agents that managed 10% and 9% of the spending in 2016 and 2017 (Figure 7).

17 Further analysis of the transactions of the AIDS Healthcare Foundation may reveal that some proportion of its contribution (or even all of it) may originate from one or more bilateral or multilateral financing Source.

18 The concept of a Financing Agent may vary depending on the perspective – e.g., for the US Government, financing agents for its PEPFAR funding is CDC or Department of Defense (DoD), while for the in-country HIV response these organizations will be mainly considered as financing sources. In this case, most likely financing agent for the majority of funds that directed to service delivery will be an organization, like FHI360, which facilitates the money flow to the actual service provision level.

Figure 7. Financing Agents for the AIDS response in Cambodia, 2016 - 2017

FINANCING AGENTS		2016		2017	
		US Dollars	%	US Dollars	%
FA.01 Public sector	FA.01.01.01.01 Ministry of Health	19,894,222	63%	23,040,116	67%
	FA.01.01.01.06 Ministry of Labour (or equivalent sector entity)	11,260	0.04%	11,460	0.03%
	FA.01.01.01.08 Other ministries (or equivalent sector entities)	21,270	0.07%	62,891	0.18%
	FA.01.01.01.10 National AIDS Coordinating Authority	1,400,733	4%	1,281,543	4%
	FA.01 Public sector Total	21,327,486	68%	24,396,010	71%
FA.02 Private sector	FA.02.05 Not-for-profit institutions (other than social insurance)	7,079,310	22%	6,985,897	20%
	FA.02 Private sector Total	7,079,310	22%	6,985,897	20%
FA.03 International purchasing organizations	FA.03.01.22 Government of United States	210,667	1%	198,113	1%
	FA.03.02.04 International Labour Organization (ILO)	4,786	0.02%	1,450	0.00%
	FA.03.02.07 UNAIDS Secretariat	813,001	3%	770,406	2%
	FA.03.02.09 United Nations Development Fund for Women (UNIFEM)	9,183	0.03%	6,583	0.02%
	FA.03.02.16 United Nations Population Fund (UNFPA)	88,442	0.28%	25,498	0.07%
	FA.03.02.19 World Health Organization (WHO)	-	-	8,222	0.02%
	FA.03.03.01 International HIV/AIDS Alliance	1,031,634	3%	1,175,482	3%
	FA.03.03.09 Caritas Internationalis / Catholic Relief Services	33,577	0.11%	29,377	0.09%
	FA.03.03.14 Family Health International	467,701	1%	560,258	2%
	FA.03.03.18 National and International Red Cross Societies	233,584	1%	233,353	1%
	FA.03.03.23 Population Services International	208,348	1%	57,238	0.17%
	FA.03 International purchasing organizations Total	3,100,924	10%	3,065,980	9%
Financing Agents TOTAL		**31,507,719**	**100%**	**34,447,888**	**100%**

3.2.3.1 Public Sector Financing Agents

As presented in the Figure 7 above, a majority of resources for the AIDS response in Cambodia was managed in the public sector. In 2016, over US$ 21.3 million representing 68% of the total spending, was managed by various public sector entities such as Ministry of Health, Ministry of Labour and Vocational

Training (MoLVT), Ministry of Women's Affairs (MoWA), National Center for HIV/AIDS, Dermatology and STDs (NCHADS), National AIDS Authority (NAA), National Maternal and Child Health Center (NMCHC). In 2017, the amount of spending managed by public entities totaled US$ 24.4 million, representing 71% of the country's spending on HIV.

The results of the previous spending assessment (NASA V) confirm the increasingly strong role of the RGC in managing both domestic public and international resources. The share of national AIDS spending managed in the public sector was 60% (US$ 29 million) in 2014 and 58% (US$ 27 million) in 2015.

A large part of the funds managed by various RGC ministries and institutions came from The Global Fund. GFATM funded 63% and 66% of total AIDS spending in 2016 and 2017 and it was managed by the Government entities such as - NCHADS as principal recipient of HIV grant and Ministry of Health as principle recipient of HSS grant.

In 2016, the amount of the domestic public resources for HIV managed in the public sector was US$ 7.9 million (37% of the overall publicly managed funding), and US$ 8.3 million in 2017 (34% of the publicly managed AIDS spending).

In the assessed years of NASA VI, RGC managed a relatively small amount of money from a bilateral source came from the US Government with US$ 14.5 thousand in 2016 and US$ 41.5 thousand in 2017. In both years the AIDS spending from the US Government channeled through the RGC comprised less than 1% of the overall funding managed in the public sector.

3.2.3.2 Private Sector Financing Agents

Private sector financing agents are represented by various non-governmental and civil society organizations. They receive contributions from domestic private and international sources of funding.

US$ 7.1 million (22% of the total AIDS spending) and US$ 7 million (20% of the total AIDS spending) respectively was managed by the national and international NGOs in 2016 and 2017. The majority of funds managed in the private sector, over 99% in both 2016 and 2017, came from the international financing sources, contributed by the Governments of France, Japan, Sweden, United States, The Global Fund, European Commission and others.

The largest share of the HIV expenditure managed in the private sector came from the US Government, US$ 4.2 million (60% of the total HIV funding managed by the private sector organizations) in 2016 and US$ 3.6 million (51% of the total HIV funding managed by the private sector organizations) in 2017. The next largest funding source for the private sector financing agents was The Global Fund. In 2016 and 2017, it channeled US$ 2.4 million and US$ 2.6 million through private sector financing agents of national and international NGOs. This represented 33% and 38% of the total amount managed by private funding agents in the corresponding years.

KHANA, one of the biggest non-governmental stakeholders in the AIDS response in Cambodia, is the largest private sector financing agent of both US Government and the Global Fund.

3.2.3.3 International Financing Agents

International financing agents comprised of various UN agencies, USAID / CDC and a number of international NGOs. All agents combined managed around US$ 3 million per annum (10% of the total AIDS spending in 2016 and 9% in 2017).

33% and 38% of resources managed by the international organizations in 2016 and 2017 had been provided by the AIDS Healthcare Foundation followed by Government of the United States. UNAIDS contributed and managed one quarter of the AIDS spending of international financing agents with contribution of US$ 0.8 million annually in 2016 and 2017.

3.2.4 Providers of Services

Most spending on HIV and AIDS in Cambodia are carried out by public sector providers, which absorbed 62% (US$ 19.7 million) in 2016 and 65% (US$ 22.3 million) in 2017 (Figure 8).

Figure 8. Providers of Services for the AIDS Response in Cambodia, 2016-2017

PROVIDERS OF SERVICES		2016		2017	
		US Dollars	% of total	US Dollars	% of total
PUBLIC SECTOR	Hospitals (Governmental)	3,395,514	11%	3,469,525	10%
	Ambulatory care (Governmental)	6,353,502	20%	7,786,871	23%
	Mental health and substance abuse facilities (Governmental)	57,978	<1%	47,309	<1%
	Laboratory and imaging facilities	1,715,765	5%	1,809,092	5%
	Blood banks (Governmental)	320,667	<1%	1,878,643	5%
	Research institutions (Governmental)	148,757	<1%	125,347	<1%
	National AIDS commission (NACs) or equivalent	1,460,979	5%	1,305,295	4%
	Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	6,116,876	19%	5,733,336	17%
	Departments inside the Ministry of Education or equivalent	28,128	<1%	25,498	<1%
	Departments inside the Ministry of Labour or equivalent	16,046	<1%	12,910	<1%
	Government entities	30,453	<1%	69,474	<1%
	Public Sector Providers TOTAL	19,644,666	62%	22,263,300	65%
PRIVATE SECTOR	Hospitals (Non-profit non faith-based)	256,823	1%	379,111	1%
	Civil society organizations (Non-profit non faith-based)	10,790,989	34%	10,995,278	32%
	Private Sector Providers TOTAL	11,047,812	35%	11,374,389	33%
Bilateral and multilateral agencies	Multilateral agencies TOTAL	815,241	3%	810,198	2%
TOTAL AIDS spending		**31,507,719**	**100%**	**34,447,888**	**100%**

3.2.4.1 Public Sector Service Providers

Public sector service providers consisted of a large number of public entities, namely hospitals, outpatient clinics (e.g. ART/VCCT sites), labs, blood banks, institutions such as National Centre for HIV/AIDS Dermatology and STDs (NCHADS) and National Maternal and Child Health Center (NMCHC).

In 2017, public service providers implemented 65% of HIV interventions and programmes (US$ 22.3 million) of which 35% (US$ 7.9 million) was RGC's own resources and 65% (US$ 14.4 million) came from various international financing sources, predominantly, The Global Fund.

This trend remains consistent across past several years. In 2014-2015, public sector providers implemented almost 60% of the response, although in the absolute figures the amount was higher than the amount in 2016-2017. In 2014 and 2015, public sector provider implemented US$ 29.2 million and US$ 27.1 million, respectively for the AIDS response.

RGC maintained and even increased its share in both funds availability and service delivery to buffer the overall funding decline from the international sources.

3.2.4.2 Private Sector Service Providers

Private sector service providers are represented by non-profit non-governmental and civil society organizations and private clinics[19].

Although the share of private sector providers in the AIDS response had dropped compared to the previous years, one third of all activities and programmes were still provided in the private sector. In 2014 and 2015, US$ 18 million per annum was provided through the private sectors, representing 37% and 38% of the overall AIDS response[20]. In 2016-2017, total amount was reduced around US$ 11 million per annum, representing 35% and 33% of the total HIV service delivery in 2016 and 2017.

Approximately 97% of private providers spending came from a variety of international financing sources - US$ 10.7 million in 2016 and US$ 11 million in 2017. The two largest financing sources for the private sector service providers were The Global Fund (US$ 4.7 million or 41% of all funding provided by private sector providers in 2017) and The Government of the United States (US$ 4.1 million or 36% of all funding provided by private sector providers in 2017). Funding came from the international NGOs was also managed and utilized in the private sector. In 2017, about US$ 1.9 million came from the international NGOs and was implemented by the private sector providers and that was equivalent to 16% of all private sector implementation.

3.2.4.3 Bilateral and Multilateral Agencies - Service Providers

Relatively small share of the AIDS spending was implemented directly by bilateral and multilateral partners. The amount implemented by these service providers was around US$ 0.8 million in both 2016 and 2017and the majority of the spending came from and was spent by UNAIDS.

3.3 PROGRAMMEMATIC DESCRIPTION OF HIV EXPENSES

Programmatic description of the spending on the AIDS response in Cambodia consists of two dimensions - AIDS Spending Categories and Production Factors. AIDS Spending Categories are classification of the activities, programmes and interventions that make part of the AIDS response in the country, while Production Factors are inputs to supply these activities, programmes and interventions.

3.3.1 Expenditure Per AIDS Spending Category

Classification of the AIDS Spending Categories includes health and non-health interventions and programmes for the AIDS response consolidated in eight major groups (Figure 9).

19 Only Sihanouk Hospital Center of HOPE is included under this code

20 National AIDS Spending Assessment V for the years 2014-2015, dataset. This data is not part of the NASA V report but is calculated from the NASA V dataset for the purposes of this analysis.

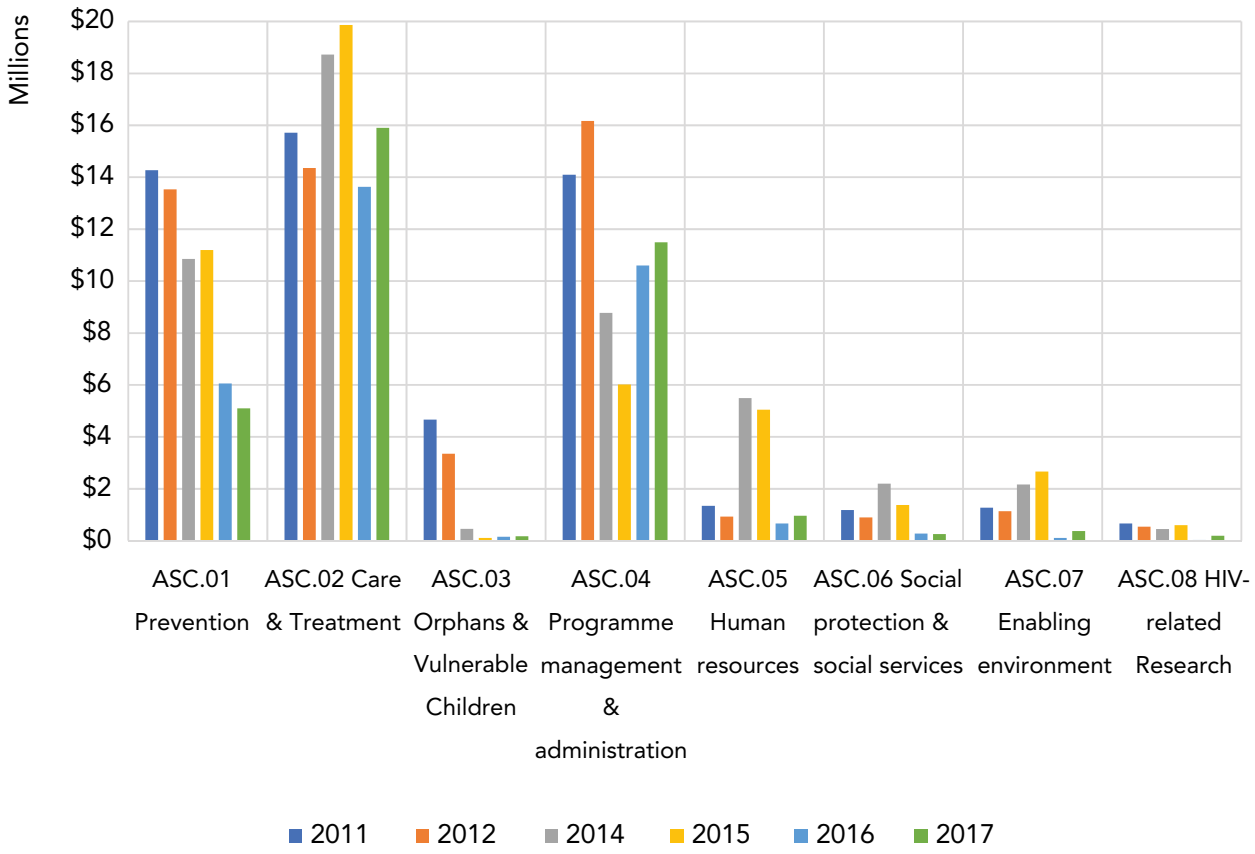
Figure 9. AIDS Spending Categories of the AIDS Response in Cambodia, 2011-2017[21]

AIDS SPENDING CATEGORIES	2011		2012		2014		2015		2016		2017	
	US Dollars	%	US Dollars	%	US Dollars	%	US Dollars	%	US Dollars	%	US Dollars	%
ASC.01 Prevention	14,272,159	27%	13,533,253	27%	10,850,297	22%	11,193,994	24%	6,051,378	19%	5,098,459	15%
ASC.02 Care and Treatment	15,716,094	30%	14,355,571	28%	18,722,478	38%	19,865,127	42%	13,631,573	43%	15,904,335	46%
ASC.03 Orphans and Vulnerable Children	4,666,336	9%	3,350,943	7%	455,887	0.9%	105,820	0.2%	152,277	0.5%	173,851	0.5%
ASC.04 Programme management and administration	14,100,083	26%	16,172,444	32%	8,776,940	19%	6,015,364	14%	10,596,276	34%	11,493,171	33%
ASC.05 Human resources	1,345,227	2.5%	932,088	2%	5,495,629	11.2%	5,047,118	10.8%	664,013	2.1%	960,853	2.8%
ASC.06 Social protection and social services	1,183,583	2.2%	898,745	2%	2,198,637	4.5%	1,378,475	2.9%	276,345	0.9%	255,068	0.7%
ASC.07 Enabling environment	1,273,239	2.4%	1,140,106	2%	2,170,532	4.4%	2,663,839	5.7%	107,435	0.3%	372,799	1.1%
ASC.08 HIV-related Research	661,926	1.2%	544,250	1%	451,405	0.9%	594,672	1.3%	28,422	0.1%	189,351	0.5%
TOTAL AIDS spending	**53,218,646**	**100%**	**50,927,401**	**100%**	**49,121,805**	**100%**	**46,864,409**	**100%**	**31,507,719**	**100%**	**34,447,888**	**100%**

21 NASA is not conducted for 2013

Figure 10 showed similar information on annual trends of expenditure within each broader AIDS Spending Category in graphic form.

Figure 10. Trends of HIV Expenditure across AIDS Spending Categories, 2011-2017



3.3.1.1 Expenditure on ASC.01 Prevention

In 2016 prevention activities absorbed 19% of the total AIDS spending, or US$ 6.1 million, however, in 2017 it was reduced to US$ 5.1 million, representing 15% of the total AIDS expenditure. As compared to prevention spending of US$ 14.3 million in 2011, the spending on prevention in 2017 was close to US$ 10 million less than 2011 prevention expenditure. However, it may possibly and partially be the case, that the overall efficiency improved significantly, and with "more for less" approach.

A detailed breakdown of the Prevention interventions (Figure 11) showed that the largest expenditure is directed to programmes aiming at prevention of HIV transmission among PLHIV and key populations.

Figure 11. Detailed Breakdown of ASC.01 Prevention, 2016-2017

ASC.01 PREVENTION AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of Prevention	US Dollars	% of Prevention
ASC.01.01 Communication for Social and behavioural change	19,401	0.3%	10,845	0.2%
ASC.01.02 Community mobilization	47,130	0.8%	49,422	1.0%
ASC.01.03 Voluntary counselling and testing	80,714	1.3%	99,783	2.0%
ASC.01.04 Prevention Programmes for vulnerable and accessible populations	110,174	1.8%	180,659	3.5%
ASC.01.05 Youth in-school	22,057	0.4%	26,615	0.5%
ASC.01.07 Prevention of HIV transmission aimed at PLHIV	541,968	9%	1,472,081	29%
ASC.01.08 Prevention Programmes for sex workers and their clients	1,503,854	25%	970,497	19%
ASC.01.09 Prevention Programmes for MSM	813,749	13%	858,988	17%
ASC.01.10 Harm reduction Programmes for IDUs	719,538	12%	534,865	10%
ASC.01.11 Prevention Programmes in the workplace	23,312	0.4%	47,826	0.9%
ASC.01.12 Condom social marketing	147,399	2.4%	57,238	1.1%
ASC.01.13 Male condom provision	65,536	1.1%	-	-
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	65,536	1.1%	-	-
ASC.01.17 Prevention of mother-to-child transmission	724,256	12%	299,709	6%
ASC.01.19 Blood safety	324,804	5%	450,003	9%
ASC.01.98 Prevention activities not broken down by type	841,953	14%	39,929	1%
TOTAL SPENDING on PREVENTION	**6,051,378**	**100%**	**5,098,459**	**100%**

In 2017 almost US$ 1.5 million has been spent for prevention among PLHIV (aiming at partners of PLHIV), which represented 29% of the total spending for Prevention. Second largest spending was for the programmes for sex workers and their clients with almost US$ 1 million (19% of Prevention), followed by prevention programmes for men who have sex with men where US$ 0.9 million was spent in 2017, representing 17% of the total prevention expenditure of 2017.

Harm reduction programmes for the people who inject drugs absorbed US$ 720 thousand in 2016 – 12% of spending on prevention, and US$ 535 thousand in 2017 – 10% of spending on HIV prevention.

Over US$ 325 thousand in 2016 and over US$ 450 thousand in 2017 was spent on blood safety programmes, benefiting the recipients of blood and blood components.

Expenditure on PMTCT activities has declined for more than 50% in just one year – from US$ 724,256 in 2016 to less than US$ 300,000 in 2017. It should be noted that the decision was made to analyze ARV spending based on the procurement data, the expenditure on the PMTCT-related ARVs for mothers in labor and their newborn children is tracked under ASC.02.01.03 Antiretroviral therapy as part of Care and Treatment.

In 2016, almost US$ 842 thousand was assigned under "ASC.01.98 Prevention not broken down by type" which translated to prevention among most-at-risk populations not disaggregated by type. This data came mainly from KHANA and PSI who could not provide detailed breakdown by key populations specific prevention Programmes.

Majority of prevention spending – 94% in 2016 and 97% in 2017 - came from the international sources of funding (Figure 12). The largest share was provided by bilateral organizations and the biggest donor was the US Government, contributing US$ 3.5 million in 2016 and US$ 2.5 million in 2017 for prevention interventions. The second largest contributor is The Global Fund, which provided US$ 1.6 million or 27% of prevention funds in 2016 and almost US$ 1.9 million or 37% of prevention spending in 2017. Out of the GFATM-originated spending on prevention, 48% (US$ 775,717) in 2016 and 57% (US$ 1,052,274) in 2017 was spent on the prevention among PWID, sex workers and their clients and men who have sex with men. Additionally, money from The Global Fund was spent on PMTCT activities, blood safety, workplace prevention, and programmes targeting prisoners, partners of PLHIV, health workers etc.

Figure 12. Financing Sources of ASC.01 Prevention, 2016-2017

FINANCING SOURCES for ASC.01 PREVENTION		2016		2017	
		US Dollars	% of ASC.01	US Dollars	% of ASC.01
International	Bilateral	3,603,871	60%	2,626,465	52%
	GFATM	1,613,261	27%	1,861,111	37%
	UN	56,758	0.94%	955	0.02%
	Other multilaterals (exc. GF & UN)	48,941	0.81%	60,995	1.20%
	International NGOs	379,001	6%	409,899	8%
	International TOTAL	5,701,833	94%	4,959,426	97%
Private TOTAL		51,768	0.86%	64,626	1.27%
Public TOTAL		297,777	5%	74,407	1%
TOTAL Prevention		**6,051,378**	**100%**	**5,098,459**	**100%**

Analysis of the service provision modalities of prevention component of the AIDS response in Cambodia revealed that 81% of spending in 2016 and 85% in 2017 was carried out by the private sector providers - non-governmental and civil society organizations, both national and international, followed by public sector providers which absorbed 19% in 2017 and 15% in 2017 (Figure 13)

Figure 13. Providers of Services for ASC.01 Prevention, 2016-2017

PROVIDERS OF SERVICES FOR ASC.01 PREVENTION		2016		2017	
		US Dollars	% of ASC.01	US Dollars	% of ASC.01
Public	PS.01.01.01 Hospitals	231,209	4%	151,874	3%
	PS.01.01.02 Ambulatory care	258,033	4%	320	0.01%
	PS.01.01.04 Mental health and substance abuse facilities	57,978	0.96%	47,309	1%
	PS.01.01.05 Laboratory and imaging facilities	256,313	4%	-	-
	PS.01.01.06 Blood banks	314,834	5%	449,683	9%
	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	30,170	0.50%	126,733	2%
	PS.01.01.14.99 Government entities n.e.c.	-	-	580	0.01%
	Public TOTAL	1,148,536	19%	776,498	15%
Private	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based) TOTAL	4,902,222	81%	4,321,586	85%
Bilateral and multilateral agencies	PS.03.02 Multilateral agencies TOTAL	620	0.01%	375	0.01%
TOTAL Prevention		**6,051,378**	**100%**	**5,098,459**	**100%**

3.3.1.2 Expenditure on ASC.02 Care and Treatment

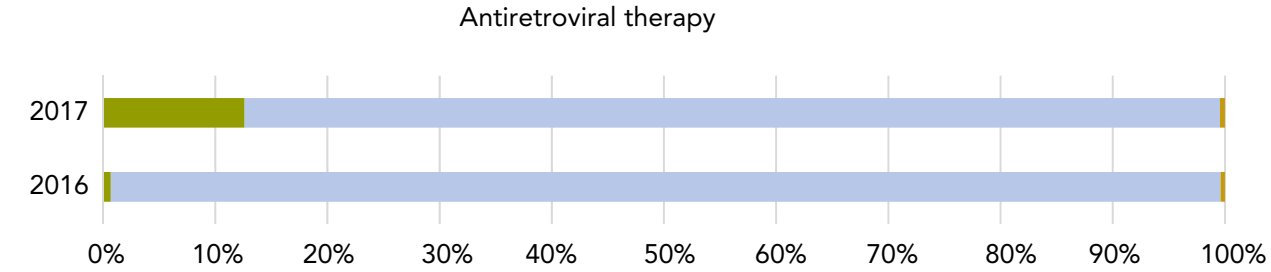
Care and Treatment takes the largest share of the AIDS expenditure (Figure 9). In 2016, US$ 13.6 million was spent on care and treatment equivalent to 43% of the overall spending. In 2017 the expenditure increased by almost US$ 1.5 million and totaled US$ 15.9 million, representing 46% of the AIDS spending in Cambodia. According to the results from the previous NASAs, spending on Care and Treatment peaked in 2015, when US$ 19.9 million have been directed to this programme.

Figure 14. Detailed Breakdown of ASC.02 Care and Treatment, 2016-2017

CARE and TREATMENT AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.02	US Dollars	% of ASC.02
ASC.02.01.01 Provider-initiated testing and counselling	10,392	0.1%	733,777	5%
ASC.02.01.02 OI outpatient prophylaxis and treatment	97,854	0.7%	371,870	2%
ASC.02.01.03 Antiretroviral therapy	5,826,861	43%	6,591,985	41%
ASC.02.01.05 Specific HIV-related laboratory monitoring	2,522,154	19%	2,505,789	16%
ASC.02.01.07 Psychological treatment and support services	15,806	0.1%	77,450	0.5%
ASC.02.01.09 Home-based care	658,201	5%	957,228	6%
ASC.02.01.98 Other Outpatient care services	1,894,187	14%	1,789,979	11%
ASC.02.02.01 Inpatient treatment of OIs	12,515	0.1%	31,641	0.2%
ASC.02.03 Patient transport and emergency rescue	31,727	0.2%	47,916	0.3%
ASC.02.98 Care and treatment services not broken down by type	2,561,877	19%	2,796,701	18%
CARE and TREATMENT TOTAL	**13,631,573**	**100%**	**15,904,335**	**100%**

As described in the Figure 14, Antiretroviral therapy remained the largest AIDS Spending Category of Treatment and Care with a spending of over US$ 5.8 million in 2016 and US$ 6.6 million in 2017. Spending on Antiretroviral therapy in 2017 translated to 41% of the spending on Care and Treatment or 19% of the total AIDS spending in Cambodia in 2017. Majority of ARV cost – 99% in 2016 and 87% in 2017 - is paid by The Global Fund, followed by the Royal Government of Cambodia that contributed less than 1% in 2016 and 13% in 2017. The rest of the ARV expenditure was covered by the AIDS Healthcare Foundation (Figure 15).

Figure 15. Financing sources of the ASC.02.01.03 Antiretroviral therapy

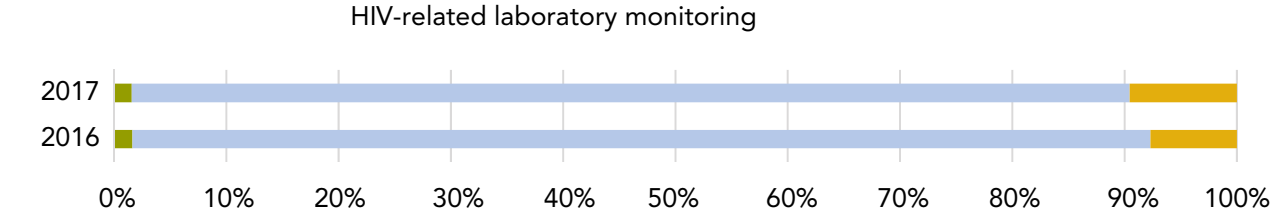


	2016	2017
RGC	39,647	831,209
GFATM	5,764,648	5,731,575
AHF	22,566	29,200

RGC GFATM AHF

Expenditure on HIV-related laboratory monitoring is closely linked to that of Antiretroviral therapy, and it was around US$ 2.5 million annually in 2016 and in 2017. It included the cost of the tests, reagents, materials, transportation of samples, wages of the lab specialists and the lab costs. As in ART funding, The Global Fund covered most of its cost – 91% in 2016 and 89% in 2017 (mainly reagents, materials, lab equipment and wages). AIDS Healthcare Foundation provided 8% and 10% of laboratory monitoring related costs in 2016 and 2017 (mostly wages and transportation cost) (Figure 16).

Figure 16. Financing Sources of the ASC.02.01.05 Specific HIV-related Laboratory Monitoring



	2016	2017
RGC	41,161	39,233
GFATM	2,286,996	2,227,475
AHF	193,997	239,081

RGC GFATM AHF

Care and Treatment expenditure assessment continues to suffer from a lack of details that allow further disaggregation. In 2017, almost US$ 1.8 million is coded under "ASC.02.01.98 Outpatient care services not broken down by intervention" and US$ 2.8 million is coded with even less details under "ASC.02.98 Care and Treatment services not broken down by intervention", and these combined was contributed to 29% of the Care and Treatment spending . A large part of this expenditure is a shared health systems cost attributed to HIV and calculated based on the data provided by the National Health Accounts.

It has been a challenge to correctly assign NASA codes based on the cost of the procured test-kits. NASA recognizes several types of HIV testing, depending on the type of Programme and intervention. For example, voluntary HIV screening for general population is assigned with the code under ASC.01 prevention whilst the testing of the donated blood and blood products is assigned under a different code and thus estimating the expenditure based on the procurement data did not provide enough detail to disaggregate and assign them correctly by type of Programme and interventions. If the procurement of test-kits falls under Care and Treatment component, the expenditure on HIV test-kits was assigned to ASC.02.01.01 Provider-initiated testing.

Figure 17. Financing Sources for ASC.02 Care and Treatment, 2016-2017

FINANCING SOURCES for CARE and TREATMENT	2016		2017	
	US Dollars	% of ASC.02	US Dollars	% of ASC.02
Royal Government of Cambodia	2,761,990	20%	3,968,153	25%
The Global Fund	10,374,691	76%	11,338,075	71%
Bilateral agencies	64,842	0.5%	119,835	0.8%
International NGOs	430,051	3%	478,272	3%
TOTAL Care and Treatment	**13,631,573**	**100%**	**15,904,335**	**100%**

Analysis of the Financing sources of the Care and Treatment programmes (Figure 17) demonstrates that most of the spending comes from the Global Fund – 76% in 2016 (US$ 10.4 million) and 71% in 2017 (US$ 11.3 million). Half of this amount – US$ 5.8 million in 2016 and US$ 5.7 million in 2017 - has been utilized for the provision of the antiretroviral therapy for PLHIV. A large portion of Global Fund-contribution on Care and Treatment went to HIV laboratory monitoring – US$ 2.3 million in 2016 and US$ 2.2 million in 2017. The remaining US$ 2.3 million in 2016 and US$ 3.4 million in 2017 is divided among activities such as home-based care, provider-initiated counselling and testing, patient transport, and other outpatient care services (case management, ART/VCCT clinics etc.).

A breakdown down by the Providers of Services for ASC.02 Care and Treatment showed that public sector ambulatory care providers (mainly ART/VCCT clinics) carried out the largest share of expenditure – US$ 6.1 million in 2016 and US$ 7.8 million in 2017. That represented almost half of the spending under this AIDS Spending Category (Figure 18). Similarly, public sector was the major service providers of treatment and care services in the earlier years and almost 80% of such services were provided in the public sector in 2014 and 2015 with corresponding spending of US$ 14.9 and US$ 15.4 million[22].

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Figure 18. Providers of Services of ASC.02 Care and Treatment, 2016-2017

PROVIDERS OF SERVICES FOR ASC.02 CARE and TREATMENT		2016		2017	
		US Dollars	% of ASC.02	US Dollars	% of ASC.02
Public	PS.01.01.01 Hospitals	2,518,686	18%	2,589,516	16%
	PS.01.01.02 Ambulatory care	6,095,468	45%	7,786,551	49%
	PS.01.01.05 Laboratory and imaging facilities	1,459,453	11%	1,808,742	11%
	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	181,481	1.3%	142,794	0.9%
	Public Total	10,255,088	75%	12,327,603	78%
Private	PS.02.01.01.01 Hospitals (Non-profit non faith-based)	256,823	2%	379,111	2%
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	3,119,662	23%	3,197,621	20%
	Private Total	3,376,485	25%	3,576,733	22%
TOTAL ASC.02 Care and Treatment		**13,631,573**	**100%**	**15,904,335**	**100%**

In NASA VI, private sector service provision is represented by Sihanouk Hospital, Center of Hope and 19 NGOs that reported having provided care and treatment services in the assessed years. Their engagement in service provision was spread across a number of service - ART provision, laboratory monitoring, OI diagnostics and treatment, providing case management for PLHIV, home-based care and others. Private sector organizations provided services that amounted to US$ 3.4 million in 2016 and US$ 3.6 million in 2017, representing 25% and 22% of the total service provision under ASC.02 Care and Treatment correspondingly.

3.3.1.3 Expenditure on ASC.03 Orphans and Vulnerable Children

Spending on Orphans and Vulnerable Children showed a continuous decline in the past 6 years. Highest spending was noted in 2011 with US$ 4.7 million or 9% of the overall AIDS spending. In 2017 the NASA team was able to trace US$ 173,851 directed to OVC programmes, which represents 0.5% of the total country's spending on HIV. The largest spending on OVC has been registered under "ASC.03.03 OVC family/home support, which refers to in-kind support such as bed nets, clothes, shoes, blankets, bedding, food (not an ART-related nutritional support), and other support (Figure 19).

The lack of data in the OVC-specific AIDS Spending Category may also be related to the fact that most of the collected data for the spending assessment did not provide a detailed disaggregation of expenditure by PLHIV and OVC. Thus, the interventions targeting OVC may be accounted for under ASC.02 Care and Treatment or ASC.06 Social Protection and Social Services.

Figure 19. ASC.03 Orphans and Vulnerable Children by Detailed AIDS Spending Category, 2016-2017

ASC.03 ORPHANS and VULNERABLE CHILDREN AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.03	US Dollars	% of ASC.03
ASC.03.01 OVC education	-	-	5,413	3%
ASC.03.02 OVC basic healthcare	-	-	1,550	0.9%
ASC.03.03 OVC family/home support	120,103	79%	121,054	70%
ASC.03.04 OVC community support	1,104	1%	1,191	0.7%
ASC.03.05 OVC Social services and administrative cost	4,039	3%	2,108	1.2%
ASC.03.98 Services for OVC not disaggregated by type	27,031	18%	42,535	24%
TOTAL ASC.03 Orphans and Vulnerable Children	**152,277**	**100%**	**173,851**	**100%**

Data indicated that international NGOs provided 100% of funding under ASC.03 Orphans and Vulnerable Children. The largest financing Sources for this category is The Red Cross. Similarly, all the services were provided by the non-governmental organizations.

Further analysis of the expenditure trends in the past NASAs revealed that OVC programmes suffered a major shift in resource availability and resource allocation modalities. Since 2012, some financing sources assumed to be discontinued, namely UNICEF and WFP, which together provided up to US$ 1.6 million (or 64% of the OVC expenditure) in 2011[23]. In the NASA VI, neither of them has submitted data for the analysis.

The Global Fund used to be a significant contributor of OVC programmes but the GFATM data for this NASA VI exercise did not contain OVC-specific budget execution lines for 2016 and 2017.

3.3.1.4 Expenditure on ASC.04 Programme Management and Administration Strengthening

The assessment team was able to assign spending on ASC.04 to various categories (Figure 20). Programme management and administration strengthening accounted for 33% of the AIDS spending in Cambodia, totaling US$ 11.5 million in 2017. This trend – representing one-third of the AIDS response – remains relatively consistent with the previous rounds of NASAs except for NASA V (years 2014 and 2015) in which the allocation approach has been modified[24].

Figure 20. ASC.04 Programme Management and Administration Strengthening by Detailed ASC, 2016-2017

ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION STRENGTHENING AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.04	US Dollars	% of ASC.04
ASC.04.01 Planning, coordination and Programme management	6,968,679	66%	6,938,118	60%
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	2,646,702	25%	2,164,576	19%
ASC.04.03 Monitoring and evaluation	187,714	2%	309,319	3%
ASC.04.04 Operations research	68,356	0.6%	780	0.01%
ASC.04.07 Drug supply systems	258,445	2%	337,561	3%
ASC.04.08 Information technology	171,683	2%	80,837	0.7%
ASC.04.10 Upgrading and construction of infrastructure	294,696	3%	1,661,978	14%
TOTAL ASC.04 Programme Management & Administration Strengthening	**10,596,276**	**100%**	**11,493,171**	**100%**

The largest spending was on "ASC.04.01 Planning, coordination and Programme management", which included a broad range of activities such as development of policies, laws, guidelines (including clinical protocols), standard operation procedures, coordination efforts of the AIDS response at the national (e.g. by the MoH, NCHADS or NAA), provincial and organizational levels (e.g. KHANA as an umbrella organization arranged and coordinated implementation of the Global Fund grant of their partner NGOs). In 2016 spending under ASC.04.01 was almost US$ 7 million which represented 66% of

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24 See explanation in Key Assumptions

Programme Management spending. In 2017 the expenditure decreased by US$ 30,000 from 2016 level and represented 60% of total Programme management spending.

"ASC.04.02 Administration and transaction costs associated with managing and disbursing funds" was assigned to transaction costs, bank charges and expenditure on outsourcing the external audit. However, based on the decision of the steering committee in 2016 and 2017, it also included a part of the shared health system's cost. Administration and transaction spending represented 25% of the total Programme management and administration strengthening spending in 2016 (US$ 2.7 million) and 19% (US$ 2.2 million) in 2017.

In 2017, a significant spending was noted under AIDS Spending Category dedicated for the upgrading and construction of the infrastructure – almost US$ 1.7 million (14% of the ASC.04) and it was spent on procurement of the laboratory and office equipment, construction and renovations.

A majority of spending on Programme management and administration strengthening comes from The Royal Government of Cambodia and The Global Fund (Figure 21).

In 2016 and 2017, RGC spent US$ 4.3 million and US$ 3.6 million under this category. It included staff salary and office maintenance cost of NAA, NCHADS, NMCHC as well as Provincial Health Departments etc. It also included an HIV-specific coordination within the shared health system's cost, provided by the National Health Accounts.

As for The Global Fund – its contribution to ASC.04 totaled US$ 3.5 million in 2016 and US$ 4.8 million in 2017. In the past few years GFATM's contribution for the country's Programme management and administration has been inconsistent, highest in 2012 with US$ 8.2 million which represented 50% of the total spending on ASC.04[25], while in 2015 it was as low as US$ 0.8 million, representing 14% of the total ASC.04 expenditure[26].

Figure 21. Financing Sources of ASC.04 Programme Management and Administration Strengthening, 2016-2017

FINANCING SOURCES for ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION STRENGTHENING		2016		2017	
		US Dollars	% of ASC.04	US Dollars	% of ASC.04
Public - Royal Government of Cambodia		4,319,290	41%	3,623,590	32%
International	Bilateral agencies	1,576,216	15%	1,786,154	16%
	The Global Fund	3,461,534	33%	4,813,680	42%
	UN	843,144	8%	800,588	7%
	International NGOs	393,166	4%	466,450	4%
Private		2,926	0.03%	2,709	0.02%
TOTAL ASC.04 Programme management		**10,596,276**	**100%**	**11,493,171**	**100%**

A breakdown of ASC.04 Programme Management and Administration Strengthening by Providers of Services (Figure 22) showed that 71% in 2016 and 69% in 2017 had been spent by various Government entities (MoH, NCHADS, NAA, NMCHC, as well as other ministries, Government entities and public hospitals), that play an important role as coordinating authorities carrying forward the AIDS response in Cambodia. Private sector AIDS response coordination efforts accounted for 21% of the ASC.04 spending in 2016 and 24% in 2017. Multilateral agencies absorbed 8% and 7% in the 2016 and 2017 correspondingly.

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Figure 22. Providers of Services of ASC.04 Programme Management and Administration Strengthening, 2016-2017

PROVIDERS OF SERVICES FOR ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION STRENGTHENING		2016		2017	
		US Dollars	% of ASC.04	US Dollars	% of ASC.04
Public	PS.01.01.01 Hospitals	246,165	2%	228,328	2%
	PS.01.01.05 Laboratory and imaging facilities	-	-	350	0%
	PS.01.01.06 Blood banks	5,833	0%	1,428,960	12%
	PS.01.01.13 Research institutions	148,757	1%	88,372	1%
	PS.01.01.14.01 National AIDS commission (NACs)	1,460,979	14%	1,305,295	11%
	PS.01.01.14.02 Departments inside the Ministry of Health	5,632,959	53%	4,875,403	42%
	PS.01.01.14.03 Departments inside the Ministry of Education	28,128	0.3%	25,498	0.2%
	PS.01.01.14.07 Departments inside the Ministry of Labour	10,186	0.1%	7,050	0.1%
	PS.01.01.14.99 Government entities	21,270	0.2%	23,187	0.2%
	Public TOTAL	7,554,277	71%	7,982,443	69%
Bilateral/ multilateral agencies	PS.03.02 Multilateral agencies TOTAL	807,315	8%	796,858	7%
Private	PS.02.01.01.15 Civil society organizations TOTAL	2,234,684	21%	2,713,869	24%
TOTAL ASC.04 Programme management and Administration Strengthening		**10,596,276**	**100%**	**11,493,171**	**100%**

3.3.1.5 Expenditure on ASC.05 Human Resources

In 2016 spending on ASC.05 Human Resources accounted for US$ 664,013, 2.1% of the total AIDS spending. In 2017 this amount increased to US$ 960,853, 2.8% of the AIDS response in Cambodia (Figure 9).

Due to the use of different methods in data processing and coding in NASA V, total amount under this category appeared to be much larger since most of salaries of the staff that implement AIDS response were assigned to Human resources[27]. In NASA III, NASA IV and NASA VI (except for the part of the non-earmarked shared health systems cost provided by the NHA team) salaries of the staff that implemented certain services are included under the relevant categories – e.g. salaries of staff providing Care and Treatment was coded under corresponding Care and Treatment category, staff of the NAA or NCHADS (or other relevant Government entities) coordinating AIDS response was coded under ASC.04.01 Planning, coordination and Programme management, staff working directly with key populations was assigned under respective prevention categories. The NASA Steering Committee decided that ASC.05 should include part of the shared health systems cost derived from the National Health Accounts and it was incorporated under ASC.05.01 Monetary incentives for human resources (Figure 23).

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Figure 23. ASC.05 Human Resources by Detailed AIDS Spending Category, 2016-2017

ASC.05 HUMAN RESOURCES AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.05	US Dollars	% of ASC.05
ASC.05.01 Monetary incentives for human resources	528,164	80%	543,533	57%
ASC.05.03 Training	135,849	20%	417,320	43%
TOTAL ASC.05 Human Resources	**664,013**	**100%**	**960,853**	**100%**

Royal Government of Cambodia bore most of the resources under ASC.05 – 80% in 2016 and 57% in 2017 (salary of health care staff as a part of a shared health systems cost), followed by The Global Fund with a share of 16% in 2016 and 35% in 2017 that supported various training activities (Figure 24). The US Government, as the bilateral agency, invested almost US$ 70 thousand for the training cost in 2017.

Figure 24. Financing Sources of ASC.05 Human Resources, 2016-2017

FINANCING SOURCES FOR ASC.05 HUMAN RESOURCES	2016		2017	
	US Dollars	% of ASC.05	US Dollars	% of ASC.05
Public - Royal Government of Cambodia	528,164	80%	543,533	57%
Bilateral agencies	15,781	2%	69,855	7%
The Global Fund	106,795	16%	333,110	35%
UN	11,070	2%	-	-
International NGOs	2,204	0.3%	14,354	1.5%
TOTAL ASC.05 Human Resources	**664,013**	**100%**	**960,853**	**100%**

Public sector providers were the main recipients and implementors of the activities under ASC.05 Human resources, 97% of all related funding in both 2016 and 2017, followed by civil society organizations, who delivered 3% and 2% of the activities correspondingly (Figure 25).

Figure 25. Providers of Services of ASC.05 Human Resources, 2016-2017

PROVIDERS OF SERVICES FOR ASC.05 HUMAN RESOURCES		2016		2017	
		US Dollars	% of ASC.05	US Dollars	% of ASC.05
Public	PS.01.01.01 Hospitals	399,454	60%	499,807	52%
	PS.01.01.13 Research institutions	-	-	36,975	4%
	PS.01.01.14.01 National AIDS commission (NACs)	-	-	-	-
	PS.01.01.14.02 Departments inside the Ministry of Health	243,845	37%	399,035	42%
	Public TOTAL	643,299	97%	935,818	97%
Bilateral and multilateral agencies	PS.03.02 Multilateral agencies TOTAL	2,240	0.3%	5,985	1%
Private	PS.02.01.01.15 Civil society organizations TOTAL	18,473	3%	19,050	2%
TOTAL ASC.05 HUMAN RESOURCES		**664,013**	**100%**	**960,853**	**100%**

3.3.1.6 Expenditure on ASC.06 Social Protection and Social Services

Spending on Social Protection and Social Services was less than US$ 0.3 million in 2016 and 2017. This money was spent on the activities to integrate PLHIV into the Health Equity Fund Benefit Packages in several provinces and social welfare support to PLHIV families to safeguard their basic needs (Figure 26).

Figure 26. ASC.06 Social Protection and Social Services by Detailed ASC, 2016-2017

ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.06	US Dollars	% of ASC.06
ASC.06.01 Social protection through monetary benefits	1,633	1%	-	-
ASC.06.02 Social protection through in-kind benefits	274,713	99%	255,068	100%
TOTAL ASC.06 Social Protection and Social Services	**276,345**	**100%**	**255,068**	**100%**

There was a declining funding on social protection programmes in recent year. US$ 2.2 million (4.5% of total AIDS spending) was spent in 2014 (Figure 9) whereas by 2017 the spending had dropped to US$ 255,068, only 0.7% of the total AIDS spending.

Most of the resources for the ASC.06 Social Protection and Social Services were mobilized through the Global Fund – 59% in 2016 and 56% in 2017. The remaining 41% and 44% came from the Red Cross (Figure 27)

All the activities under ASC.06 were implemented by the non-governmental civil society organizations.

Figure 27. Financing Sources of ASC.06 Social Protection and Social Services, 2016-2017

FINANCING SOURCES for ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES	2016		2017	
	US Dollars	% of ASC.06	US Dollars	% of ASC.06
The Global Fund	162,817	59%	141,801	56%
International NGOs	113,528	41%	113,268	44%
TOTAL ASC.06 Social Protection and Social Services	**276,345**	**100%**	**255,068**	**100%**

3.3.1.7 Expenditure on ASC.07 Enabling Environment

Overall spending on enabling environment was 0.7% and 1.1% of total AIDS spending in 2016 and 2017 (Figure 9). In the course of the last few years, it faced a dramatic decline in the resource availability. In 2014 spending on various enabling environment interventions and programmes was recorded at the level of US$ 2.2 million[28] whereas it had reduced to US$ 373 thousand in 2017.

The most funded ASC.07 activities in 2016 and 2017 were for the reduction of gender-based violence (ASC.07.05) (Figure 28). It showed a considerable increase from the spending in 2014 and 2015 that showed less than US$ 5,000 had spent on the same AIDS Spending Category[29].

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Figure 28. ASC.07 Enabling Environment by Detailed ASC, 2016-2017

ASC.07 ENABLING ENVIRONMENT AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.08	US Dollars	% of ASC.08
ASC.07.01 Advocacy	11,646	11%	25,531	7%
ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment	2,734	3%	24,378	7%
ASC.07.03 AIDS-specific institutional development			21	0.01%
ASC.07.04 AIDS-specific Programmes focused on women	9,183	9%	45,707	12%
ASC.07.05 Programmes to reduce gender-based violence	73,186	68%	219,463	59%
ASC.07.98 Enabling environment activities not broken down by type	10,685	10%	57,698	15%
Enabling Environment TOTAL	**107,435**	**100%**	**372,799**	**100%**

Enabling environment programmes were financed mostly from the international sources (87% in 2016 and 95% in 2017), mainly from the international NGOs, The Global Fund and The Government of the United States. Royal Government of Cambodia provided the remaining 13% for these activities in 2016 and 5% in 2017.

81% and 84% of service provision related to enabling environment in 2016 and 2017 were provided by the private sector through various civil society organizations (Figure 29). Ministry of Women Affairs is another active player in the service provision, implementing 9% and 12% correspondingly of the total ASC.07 Enabling Environment in 2016 and 2017. UNAIDS, coded under PS.03.02 Multilateral agencies, executed 5% and 2% of the Enabling environment projects in 2016 and 2017.

Figure 29. Providers of Services of ASC.07 Enabling Environment, 2016-2017

PROVIDERS OF SERVICES FOR ASC.07 ENABLING ENVIRONMENT		2016		2017	
		US Dollars	% of ASC.07	US Dollars	% of ASC.07
Public	PS.01.01.14.02 Departments inside the Ministry of Health	-	-	21	0.01%
	PS.01.01.14.07 Departments inside the Ministry of Labour	5,860	5%	5,860	2%
	PS.01.01.14.99 Government entities not elsewhere classified	9,183	9%	45,707	12%
	Public TOTAL	15,043	14%	51,588	14%
Private	PS.02.01.01.15 Civil society organizations TOTAL	87,325	81%	314,231	84%
Bilateral and multilateral agencies	PS.03.02 Multilateral agencies TOTAL	5,066	5%	6,980	2%
ASC.07 ENABLING ENVIRONMENT TOTAL		**107,435**	**100%**	**372,799**	**100%**

3.3.1.8 Expenditure on ASC.08 HIV-related Research

Less than 1% of the AIDS response in Cambodia was contributed to HIV-related research. In absolute numbers, the spending had peaked in 2011 at US$ 662 thousand[30] (Figure 9). In 2016-2017, it was spent on the Integrated Biological and Behavioral Surveillance Survey (IBBS) among PWID/PWUD and Entertainment workers (Figure 30). Financing source for the spending on HIV research is the Global Fund, both in 2016 and 2017. This activity was implemented by the public sector, NCHADS.

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Figure 30. ASC.08 HIV-related Research by Detailed ASC, 2016-2017

ASC.08 HIV-RELATED RESEARCH AIDS SPENDING CATEGORIES	2016		2017	
	US Dollars	% of ASC.08	US Dollars	% of ASC.08
ASC.08.01 Biomedical research	28,422	100%	22,060	12%
ASC.08.04 Social science research	-	-	167,291	88%
Grand Total	**28,422**	**100%**	**189,351**	**100%**

3.3.2 Expenditure Per Production Factors

A categorization of Production Factors in NASA provides a specific angle on the expenditure analysis focusing on the type of budgetary/economic items that were used to produce certain services, interventions and programmes. Production Factors classification in NASA has breakdowns on Current and Capital expenditure with further specification of particular codes.

Figure 31. Production Factors of the AIDS response in Cambodia, 2016-2017

PRODUCTION FACTORS		2016		2017	
		US Dollars	%	US Dollars	%
PF.01 Current expenditure	PF.01.01 Labour income	8,194,092	26%	7,384,228	21%
	PF.01.02 Supplies and services	20,929,792	66%	24,923,291	72%
	PF.01.98 Current expenditures not broken down by type	64,842	0.2%	119,835	0.3%
	PF.01 Current expenditure Total	29,188,726	93%	32,427,354	94%
PF.02 Capital expenditure	PF.02.01 Buildings	65,579	0.2%	54,530	0.2%
	PF.02.02 Equipment	2,253,414	7%	1,966,004	6%
	PF.02 Capital expenditure Total	2,318,993	7%	2,020,534	6%
Production Factors TOTAL		**31,507,719**	**100%**	**34,447,888**	**100%**

As shown in Figure 31, the majority of HIV-related activities in 2016-2017 were categorized under current expenditure, a part of which belonged to wages (26% and 21%), and the rest was for procuring services and supplies (66% and 72%).

Capital expenditure implies spending money on construction, renovation and purchasing of equipment and vehicles. NASA VI recorded such spending at 7% in 2016 and 6% in 2017 and that was used mainly on various equipment, particularly for laboratories.

Closer look into the Production Factors composition across programmatic areas showed similarities in the cost drivers. For Prevention spending in 2016 and 2017, current expenditure was 95% and 98% respectively and it was further broken down into labour income (15% and 17%), materials and supplies (79% and 81%). Capital expenditure was 5% and 2% respectively in 2016 and 2017. Care and Treatment spending in 2016-2017 was composed of 17% and 14% for Labour income, 42% and 40% for the ARVs, 0%[31] and 15% for the reagents, Travel and Transportation was 11% in both years, and capital expenditure of 11% and 0% respectively.

31 No expenditure on Reagents and Materials in 2016 may be explained in two ways. First – NASA VI is using cash accounting approach for tracking the spending on the items procured centrally. If there was no procurement that year, NASA will capture zero expenditure. Second explanation – when NASA team obtains the data from the bulk procurement of various supplies and there is little detail to disaggregate it into more specific categories, such expenditure goes to PF.01.02.01.98 Material supplies not disaggregated by type.

3.3.3 Expenditure Per Beneficiary Population

3.3.3.1 Total Expenses Per Beneficiary Population 2016-2017

NASA VI revealed that 44% in 2016, and 47% of the overall spending in 2017 was spent on people living with HIV (BP.01). A much smaller proportion of resources – 13% and 7% in the assessed years – benefited key affected populations (BP.02), and around 6% and 8% correspondingly was spent on programmes targeting other key and "accessible" populations (BP.03 + BP.04) (Figure 32)

Figure 32. AIDS Spending by Beneficiary Population, 2016-2017

BENEFICIARY POPULATIONS		2016		2017	
		US Dollars	% of Total	US Dollars	% of Total
BP.01 People living with HIV	BP.01.02 Children living with HIV	13,520	0.04%	11,449	0.03%
	BP.01.98 People living with HIV not disaggregated by age or gender	13,907,818	44%	16,191,145	47%
	BP.01 People living with HIV Total	13,921,338	44%	16,202,594	47%
BP.02 Key affected populations	BP.02.01 Injecting drug users (IDU) and their sexual partners	719,538	2%	560,248	2%
	BP.02.02.01 Female sex workers and their clients	1,503,854	5%	970,497	3%
	BP.02.03 Men who have sex with men (MSM)	559,075	2%	517,355	2%
	BP.02.04 Transgenders (TG)	254,674	0.8%	356,576	1%
	BP.02.98 "Key affected populations" not disaggregated by type	1,120,423	4%	97,167	0.3%
	BP.02 Key affected populations Total	4,157,565	13%	2,501,843	7%
BP.03 Other key populations	BP.03.01 Orphans and vulnerable children	152,277	0.5%	173,851	0.5%
	BP.03.02 Children born or to be born of HIV+ women	724,256	2%	299,709	0.9%
	BP.03.07 Prisoners	33,577	0.1%	97,135	0.3%
	BP.03.13 Partners of PLHIV	566,054	2%	1,472,081	4%
	BP.03.14 Recipients of blood and blood products	324,804	1.0%	450,003	1.3%
	BP.03 Other key populations Total	1,800,967	6%	2,492,780	7%
BP.04 Key "accessible" populations	BP.04.01 People attending STI clinics	51,483	0.2%	23,181	0.1%
	BP.04.03 High school students	22,057	0.1%	26,615	0.1%
	BP.04.04 University students	1,028	0.0%	768	0.002%
	BP.04.05 Health care workers	-	-	57,797	0.2%
	BP.04.10 Factory employees	23,312	0.1%	49,604	0.1%
	BP.04 Key "accessible" populations Total	97,879	0.3%	157,965	0.5%
BP.05 General population	BP.05.01.02 Female adult population	9,183	0.03%	48,120	0.1%
	BP.05.03.02 Young females	73,186	0.2%	219,463	0.6%
	BP.05.98 General population not broken down	158,890	0.5%	181,748	0.5%
	BP.05 General population Total	241,260	0.8%	449,331	1.3%
BP.06 Non-targeted interventions	BP.06 Non-targeted interventions	11,288,710	36%	12,643,375	37%
	BP.06 Non-targeted interventions Total	11,288,710	36%	12,643,375	37%
Beneficiary Populations TOTAL		**31,507,719**	**100%**	**34,447,888**	**100%**

Different financing sources provided different level of funding for the beneficiary populations (Figure 33 and Figure 34).

Figure 33. Financing Sources of Key Beneficiary Populations, 2016

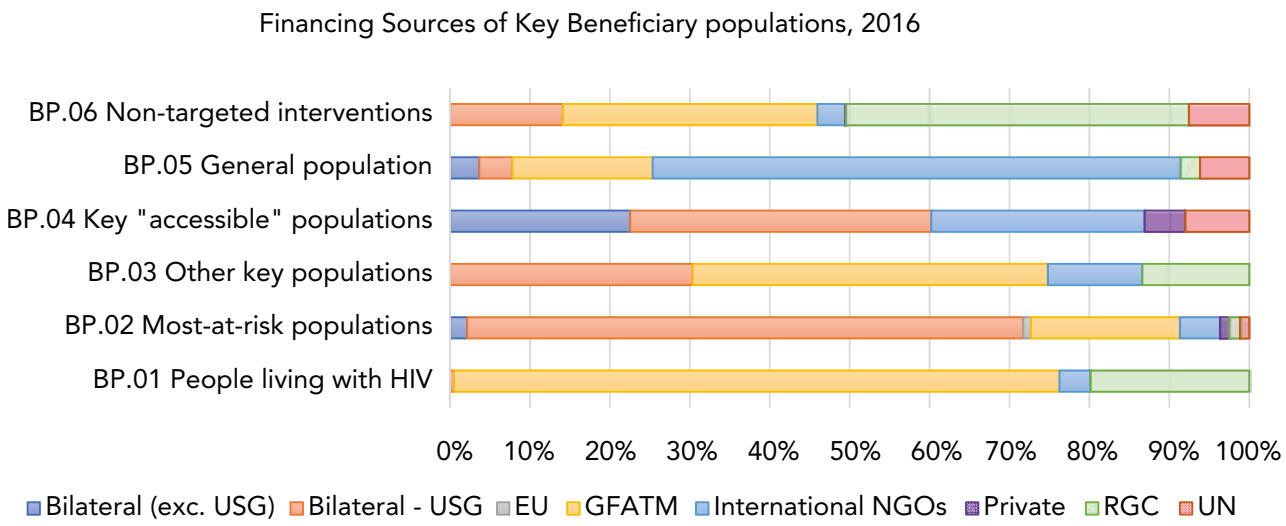
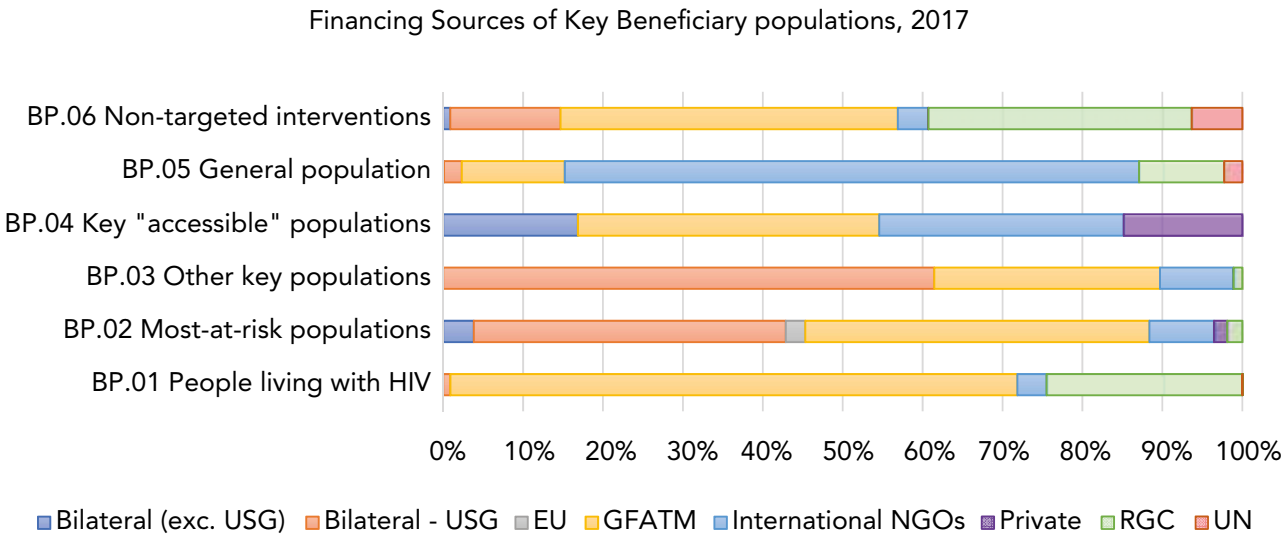


Figure 34. Financing Sources of Key Beneficiary Populations, 2017



The Global Fund remains the largest financer for BP.01 People living with HIV, providing 76% of the category in 2016 and 71% in 2017, followed by the Royal Government of Cambodia with 24% in 2016 and 20% in 2017.

Programmes aiming at key populations (BP.02 Most-at-risk populations) – PWID and their sexual partners, Sex Workers and their clients, MSM, transgender – were predominantly funded by the US Government through PEPFAR. In 2016, it funded 70% of all key populations programmes (or US$ 2.9 million) but in 2017, the share of USG funding to support prevention programmes for key populations had dropped significantly to 39% of the total key populations programme spending (just under US$ 1 million). The Global Fund's investment on key populations programmes increased both in absolute figures and as a share of total with US$ 0.8 million in 2016 and US$ 1.1 million in 2017. The increase, however, was not big enough to fill the gap from the withdrawal of the USG support.

BP.03 Other key populations includes OVCs, children born or to be born from HIV+ mothers (beneficiary of all PMTCT interventions), sero-discordant couples, prisoners and recipients of blood and blood products, and it was financed mainly by the US Government (US$ 0.5 million in 2016 and US$ 1.5 million in 2017) and GFATM (US$ 0.8 million in 2016 and US$ 0.7 million in 2017). Contribution from iNGOs (such as Caritas/CRS, Red Cross, International Planned Parenthood Federation) and the Royal Government of Cambodia was US$ 0.2 million each in 2016. However, in 2017, only US$ 27 thousand came from RGC, while iNGOs support for programmes for BP.03 Other key populations have slightly increased as compared to 2016.

Programmes benefiting "BP.04 Key accessible populations" that were reached through schools, universities, clinics, and workplace HIV programmes were funded by - various bilateral sources (including US Government) with a total of US$ 60 thousand, US$ 26 thousand from iNGOs, and US$ 7 thousand from the UN agencies in 2016. No such expenditure has been tracked under the GFATM contribution in 2016 but it provided almost US$ 60 thousand for prevention programmes aimed at people who attend STI clinics in 2017. In 2017, about US$ 50,000 from various iNGOs benefited "Key "accessible populations" and US$ 23,500 was spent by private companies and organisations on workplace prevention.

Majority of funding aiming at "BP.05 General population" in 2016 came from iNGOs – US$ 160,000; followed by US$ 42,000 from GFATM; US$ 15,000 from the UN agencies; US$ 10,000 from the USG; US$ 9,000 from other bilateral donors such as Governments of France, Japan and Sweden; and US$ 6,000 from the RGC. In 2017, the amount funded by iNGOs for HIV-related programmes for general population was US$ 323,000; followed by GFATM – almost US$ 58,000; RGC – US$ 48,000; UN and USG – US$ 10,000 each.

Non-targeted interventions – those in the area of coordination, policy development, programme management, capacity strengthening etc. – were funded by the RGC (US$ 4.9 million in 2016 and US$ 4.2 million in 2017); GFATM (US$ 3.6 million in 2016 and US$ 5.3 million in 2017); USG (US$ 1.6 million in 2016 and US$ 1.8 million in 2017). International NGOs provided US$ 0.4 and US$ 0.5 million in 2016 and 2017, while contribution from the UN agencies for the non-targeted interventions was recorded around US$ 0.9 million in 2016 and US$ 0.8 million in 2017. Additional US$ 110,000 for this category came from the French Government in 2017.

Most of the programmes across various Beneficiary Populations were implemented either by public or private non-profit providers (Figure 35 and Figure 36)

Figure 35. Service Providers for Key Beneficiary Populations, 2016

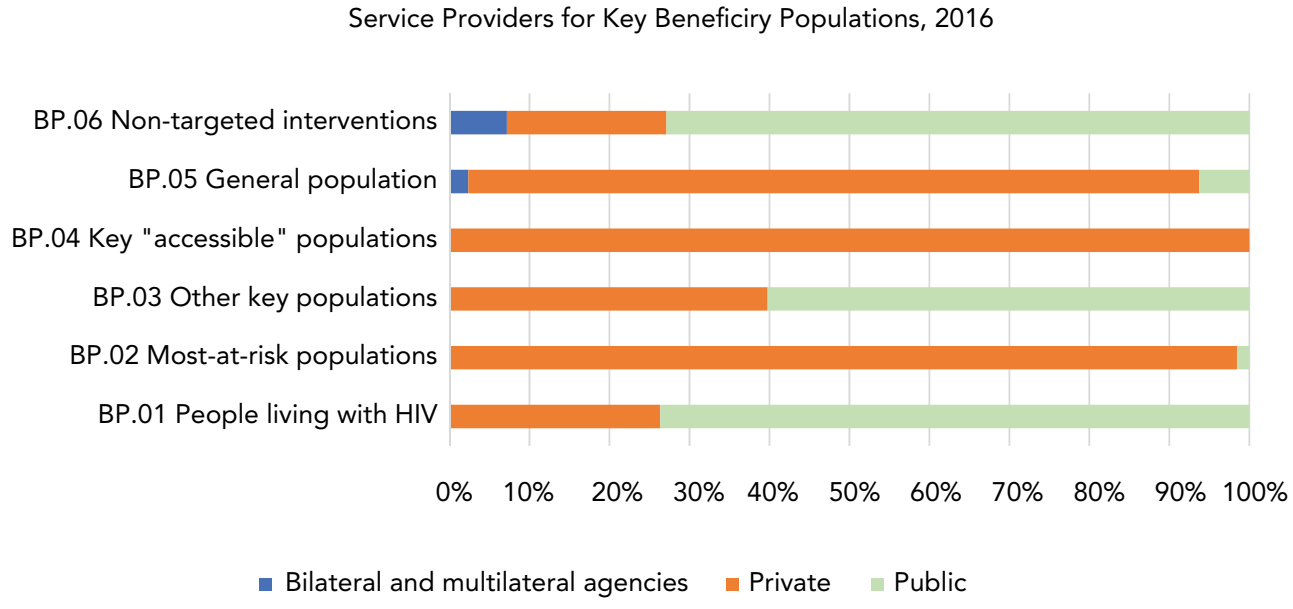
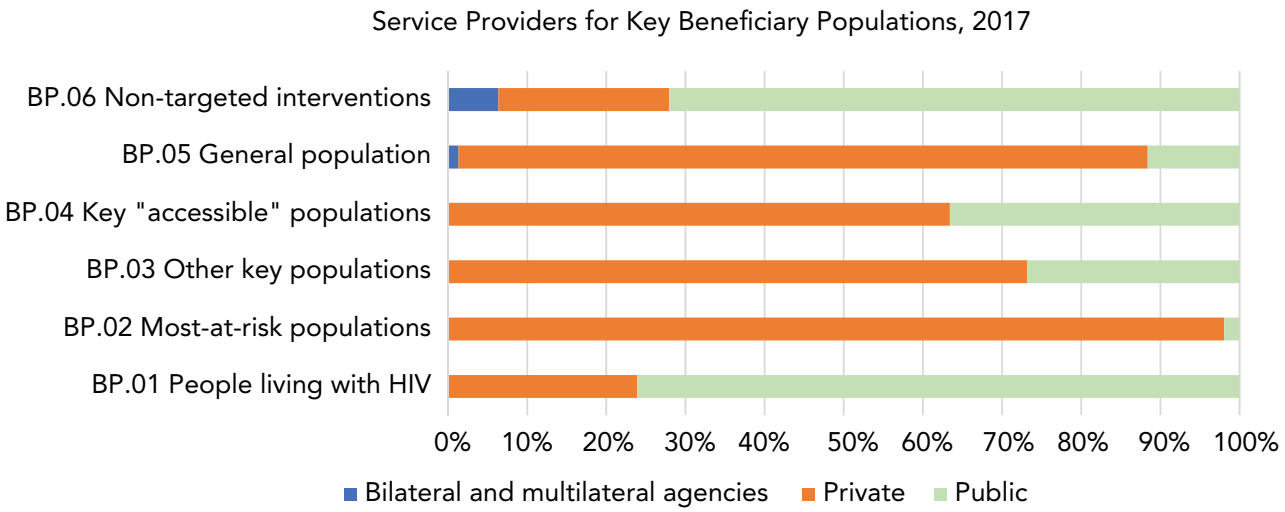


Figure 36. Service Providers for Key Beneficiary Populations, 2017



Public sector providers were key in the implementation of programmes aiming at PLHIV, representing 74% (US$ 10.3 million) of total service provision for PLHIV in 2016, and 76% (US$ 12.3 million) in 2017. Correspondingly, 26% and 24% of services for PLHIV had been delivered by private non-profit providers.

Services for key populations (BP.02 Most-at-risk populations) were provided mainly (98% in both years) in the private sector, through NGOs. Only 2% of these crucial services was provided in the public sector.

Key providers for BP.03 "Other key populations" in 2016 were public, whose share was at 60%, while in 2017 73% of the services for these populations were delivered by private non-profit providers, leaving only 27% for public service provision.

In 2016, all service provision for BP.04 "Key accessible populations" was in the private sector, but in 2017 public providers implemented 27% of these services and programmes.

Ninety-one per cent of services for general population in 2016 and 87% in 2017 was provided by private sector providers; 6% in 2016 and 12% in 2017 – by public sector providers; 2% in 2016 and 1% in 2017 – by bilateral and multilateral organizations.

Public sector providers dominated implementation of non-targeted interventions – 73% in 2016 and 72% in 2017, followed by private providers, whose share of the non-targeted, policy level, interventions were 20% in 2016 and 22% in 2017. Bilateral and multilateral organizations provided 7% and 6% of non-targeted intervention in 2016 and 2017 respectively.

3.4 ANALYSIS OF AIDS SPENDING BY KEY FINANCERS IN 2016-2017

3.4.1 Description of the Domestic Public Spending in Cambodia

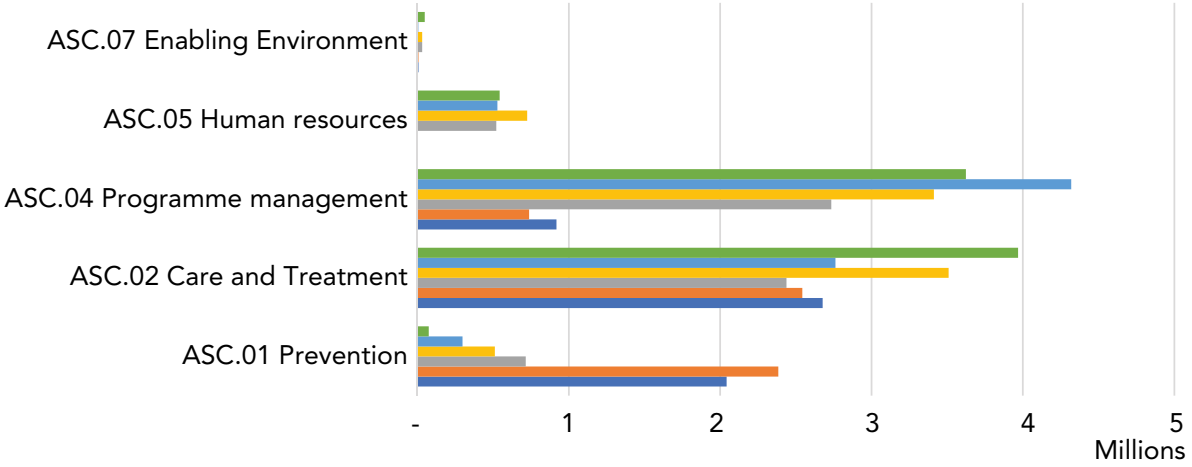
Royal Government of Cambodia mobilized US$ 7.9 million in 2016 and US$ 8.3 million in 2017. As a Financing Source, RGC has two types of funding that is a) resources earmarked for HIV within the National HIV Strategic Plan, and b) a non-earmarked funding that goes to the overall health system functioning in Cambodia. To track an HIV earmarked spending, NASA team obtained budget execution reports from MoH, NAA, NCHADS etc.

To calculate the HIV share in the overall health systems spending, NASA team used various assumptions and proxies applied to the figures in the consolidated health expenditure reports available in the National Health Accounts. Based on the NHA data, non-HIV-earmarked shared health systems spending in Cambodia represented 17% and 16% of the total estimated AIDS spending in Cambodia in 2016-2017. Within the domestic public allocation for HIV, it represented 66% of total domestic public source each year.

Figure 37 shows the breakdown of domestic public spending by AIDS Spending Categories that was financed by the Government, in the six years of NASA exercise– 2011-2012, 2014-2015 and 2016-2017.

Coordination and Programme management function received most of the Government resources representing 55% and 44% of the total RGC AIDS spending in 2016 and 2017.

Figure 37. Domestic Public Spending on HIV by AIDS Spending Categories



	ASC.01 Prevention	ASC.02 Care and Treatment	ASC.04 Programme management	ASC.05 Human resources	ASC.07 Enabling Environment
2017	74,407	3,968,153	3,623,590	543,533	47,931
2016	297,777	2,761,990	4,319,290	528,164	5,860
2015	511,700	3,508,973	3,411,791	724,634	31,063
2014	715,679	2,437,681	2,733,904	520,366	30,600
2012	2,384,270	2,542,984	737,049		7,560
2011	2,042,206	2,676,809	918,372		7,560

2017 2016 2015 2014 2012 2011

ASC.02 Care and Treatment is the second largest programme in the RGC funding portfolio with US$ 2.76 million in 2016 and almost US$ 4 million in 2017 (35% and 48% of RGC AIDS spending).

Prevention allocation in the Government funds for HIV is much smaller with US$ 300 thousand in 2016 (4% of total RGC share) and US$ 75 thousand (1% of total RGC share) in 2017. In NASA V Government's spending benefiting key populations totaled at US$ 716 thousand in 2014 and US$ 512 thousand in 2015. The decline in prevention funding by the public sources is a cause for concern particularly when the country is running the last mile towards ending AIDS as a public health threat in Cambodia.

Since the coding of beneficiary populations is largely dependent on a particular AIDS Spending Category, the biggest allocation went to BP.06 Non-targeted interventions[32] - 61% of the total domestic public spending in 2016, and 50% in 2017. The second largest beneficiary group for the RGC funding was People living with HIV, a beneficiary population of Treatment and Care programmes. In 2016 the share of domestic public expenditure that benefited PLHIV was at the level of 35%, and 48% in 2017. In 2016 3% of the public funding availed by the RGC was directed to PMTCT programmes, benefiting children born or to be born from HIV+ mothers (in NASA – BP.03.02), although no such funding was reported in 2017[33].

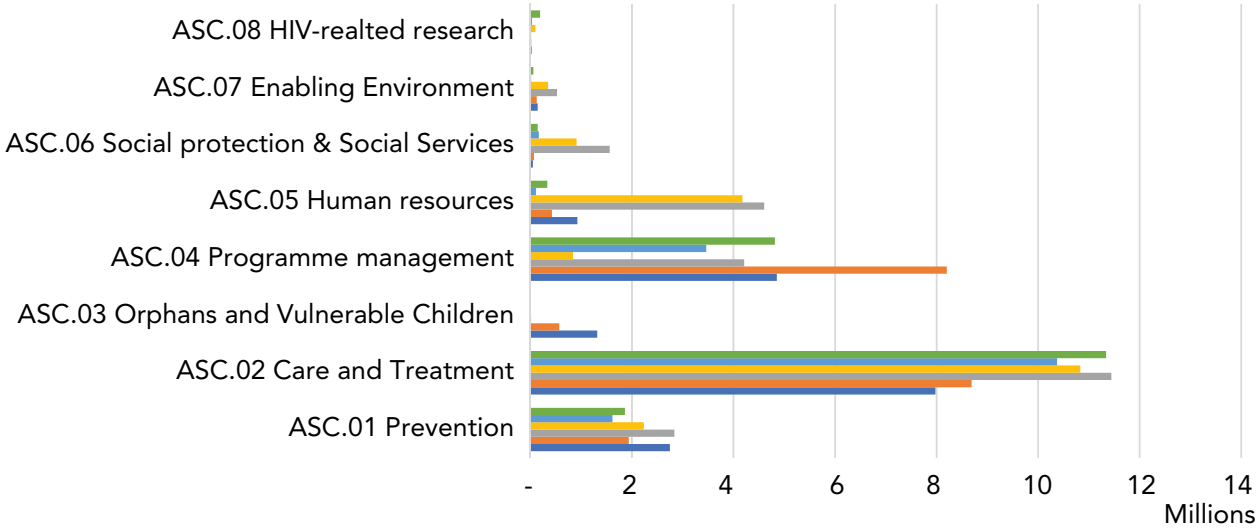
32 This BP code is used, among others, for all policy and coordination level activities, where all population groups of the HIV Response benefit from its implementation.

33 As mentioned in the previous sections of this report, it was impossible to separate cost of PMTCT-related ARVs from the rest of the ARV drugs, so 100% of ARVs, including those purchased with public funding is captured under ASC.02.01.03 Antiretroviral therapy, and not under ASC.01.17.98 PMTCT

3.4.2 HIV Expenditure from the Global Fund

The Global Fund accounted for 50% and 54% of the total HIV expenditure in Cambodia in 2016 and 2017 with a contribution of US$ 15.8 and US$ 18.7 million correspondingly.

Figure 38. GFATM Spending on HIV by AIDS Spending Categories



	ASC.01 Prevention	ASC.02 Care and Treatment	ASC.03 Orphans and Vulnerable Children	ASC.04 Programme management	ASC.05 Human resources	ASC.06 Social protection & Social Services	ASC.07 Enabling Environment	ASC.08 HIV-realted research
2017	1,861,111	11,338,075		4,813,680	333,110	141,801	55,467	189,351
2016	1,613,261	10,374,691		3,461,534	106,795	162,817	11,405	28,422
2015	2,235,156	10,829,254	5,100	839,887	4,174,003	908,240	346,499	96,889
2014	2,834,832	11,440,132	12,646	4,210,842	4,604,467	1,561,978	525,525	12,106
2012	1,937,565	8,689,154	565,872	8,201,023	425,399	69,604	22,476	16,038
2011	2,746,968	7,976,430	1,314,067	4,851,966	926,328	48,287	143,481	23,069

2017 2016 2015 2014 2012 2011

Figure 38 showed the GFATM resource allocation and predominant amount of funding was for Care and Treatment services (66% and 61% of the total Global Fund allocation), followed by Prevention (10% of the total GF allocation annually) and Programme Management (22% and 26% of the total GF allocation).

In 2016 and 2017, the highest share of spending by the Global Fund, spending on Care and Treatment, was recorded under ASC.02.01.03 Antiretroviral therapy (accounted for 37% and 31% of the total Global Fund allocation) and ASC.02.01.05 HIV Laboratory monitoring (15% and 12% correspondingly).

Prevention expenditure from The Global Fund was directed to focused prevention (among PWID/PWUD, FSW and MSM and their partners/clients), that totaled US$ 776 thousand in 2016 and US$ 1.05 million in 2017 (5% and 6% of the total Global Fund spending on HIV), followed by programmes for prevention of mother-to-child transmission with US$ 441 thousand and US$ 254 thousand (3% and 1% of total Global Fund spending on HIV in 2016 and 2017); and blood safety programmes (US$ 277 thousand and US$ 381 thousand or 2% of total Global Fund spending HIV annually).

In 2016-2017, US$ 1.5 million (10% of total Global Funding spending on HIV) and US$ 2 million (10% of total Global Funding spending on HIV) were spent on ASC.04.01 Programme management and coordination. The Global Fund also contributed US$

1.6 million and US$ 1 million, 10% and 6% of the Global Funding spending on HIV in 2016 and 2017, for the ASC.04.02 Administration and transaction costs associated with managing and disbursing funds.

The remaining 2% (US$ 0.3 million) in 2016 and 4% (US$ 0.7 million) in 2017 of the total GFATM-originated spending is distributed between ASC.05.03 Training, ASC.06 Social protection and Social service, ASC.07. Enabling Environment and ASC.08 HIV-related research.

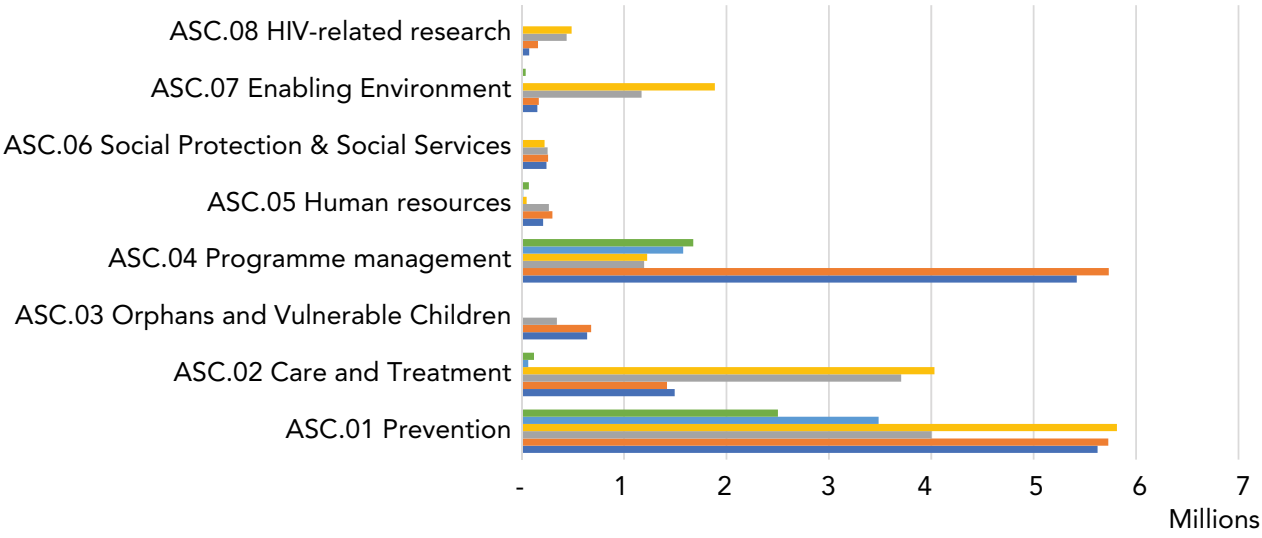
Analysis by Beneficiary population showed that 67% and 61% of GFATM resources in 2016 and 2017 were spent on programmes benefiting PLHIV; 23% and 28% - for the non-targeted interventions (such as Trainings, policy development, coordination and administration of funds); 5% and 6% - for Key populations. The remaining share (5% in 2016 and 4% in 2017) of GFATM funds was distributed to other key and vulnerable populations such as prisoners, partners of PLHIV, recipients of blood and blood products, children born or to be born from HIV+ mothers etc.

3.4.3 HIV Expenditure from the Government of the United States

US Government represented 16% and 13% (US$ 5.2 million and US$ 4.4 million) of the total AIDS spending in Cambodia in 2016-2017. Figure 39 shows how it was distributed across main AIDS Spending Categories of NASA.

The United States Government (USG) funding portfolio was concentrated mainly on prevention which amounted to US$ 3.5 million in 2016 and US$ 2.5 million in 2017 (68% and 57% of the total USG expenditure on HIV in the years of assessment). Prevention programmes funded by the USG was focused mainly on prevention interventions for PWID/PWUD, FSWs, and MSM.

Figure 39. Spending on HIV from the US Government by AIDS Spending Categories



	ASC.01 Prevention	ASC.02 Care and Treatment	ASC.03 Orphans and Vulnerable Children	ASC.04 Programme management	ASC.05 Human resources	ASC.06 Social Protection & Social Services	ASC.07 Enabling Environment	ASC.08 HIV-related research
2017	2,503,358	119,835		1,675,245	69,855		39,321	
2016	3,485,279	64,842		1,576,216	15,781		2,734	
2015	5,813,152	4,030,416		1,225,588	47,879	223,964	1,886,502	487,748
2014	4,002,887	3,705,647	344,581	1,194,816	266,003	253,233	1,170,294	439,299
2012	5,729,948	1,418,817	677,470	5,734,561	299,473	257,020	167,301	158,929
2011	5,623,741	1,493,444	639,162	5,420,465	208,046	242,650	153,164	73,903

2017 2016 2015 2014 2012 2011

Second largest USG-funded activity was provided for ASC.04 Programme management and Administration Strengthening and 31% and 38% of USG spending went to this ASC in 2016 and 2017. Almost all of it was spent within ASC.04.01 Policy, coordination and Programme management. A remaining share went to support Care and Treatment, Human resources and Enabling environment programmes.

Analysis of populations which benefited from USG contribution to AIDS response in Cambodia revealed that in 2016 and 2017, 56% and 22% was focused on key populations; 31% and 40% of AIDS spending of the USG went for the non-targeted policy-level interventions; and 10% and 33% correspondingly was used to implement programmes specifically benefiting partners of PLHIV.

Considering that funding decline from USG resources, there is an urgent need of strategies and solutions to provide continued and quality assured support for the focused prevention programmes particularly for key populations.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

1. The results of the National AIDS Spending Assessment show a continuous decline of HIV expenditure in Cambodia over the years, peaked in 2010 with US$58.1 million and reaching its lowest point in 2016 - US$ 31.5 million. In 2017, although the overall estimated country's spending on HIV has slightly increased to US$ 34.5 million, it is unlikely that this trend continues in the following years. RGC, The Global Fund and US Government are the biggest funding sources of the AIDS response in Cambodia.

2. Cambodia relies heavily on the international funding that comprises 75% in 2016 and 76% in 2017 of the total expenditure on HIV. According to NASA findings, funding from external donors has significantly reduced in recent years.

3. RGC has been consistently increasing its contribution in the past years, from US$ 2.5 million in 2010 to US$ 8.3 million in 2017. Considering the diminishing resources from the international community of donors, domestic spending has stepped up in 2016 and 2017, representing 25% and 24% of total spending correspondingly.

4. NASA has proven to be essential in understanding the funding landscape of various funding sources and their roles in the AIDS response, especially in light of anticipated gradual decline in donor support. While the majority of RGC spending is channeled to care and treatment programmes followed by AIDS response coordination and Programme management, the support from the US Government was concentrated on prevention programmes, especially for key populations. GFATM remains the largest funder of the care and treatment programme in Cambodia and the country is still much dependent on the Global Fund's support that provided 100% of funding for ARV drugs in 2016 and 87% in 2017.

5. Continued funding on key populations prevention programme is of crucial importance to maintain the success of epidemic decline in Cambodia. However, due to re-focusing or withdrawal of funding from international donors, there was a significant decline in funding support for the prevention programmes. USG share in focused prevention was 70% in 2016 and declined to 40% in 2017. The expenditure on prevention programmes benefiting PWID, FEW, MSM and transgender was US$4.9 million in 2015 and it had reduced to US$ 4.2 million in 2016 and further declined to US$ 2.5 million in 2017. More than ever, domestic leadership, ownership and commitments are needed to step up the funding for the sustainability of prevention interventions.

6. NASA findings show a steep decline in resources available for social protection and social services. Funding from two largest sources – WFP and UNICEF - has been either withdrawn or significantly decreased and less than 1% of total HIV resources was spent on social protection services in 2016. NASA VI dataset does not have data on the use of Health Equity Fund by PLHIV, although such analysis should be part of the spending assessment.

8. Another layer of analysis that is missing in NASA VI (as well as in previous exercises) is the out-of-pocket spending related to HIV. During NASA VI exercise, it was not possible to collect the data on out of pocket spending mainly due to the lack of sources of data. Similar challenge exists also for the National Health Accounts exercise.

9. There are methodological and data interpretation issues in NASA VI that require further attention

and possible modification or alignment. Across different NASA rounds, differences in interpretation and coding of the data, such as salaries, programme management and transaction costs etc., may have an impact on the NASA results, affecting its compatibility across years. Consistency and comparability across all NASA rounds should be considered seriously, starting from the preparation phase of all NASA rounds. For instance, NASA V used different methodologies to assign expenditure for key populations as well as salaries and thus making it difficult to compare the results with other rounds of NASA.

10. Shared health system cost associated with HIV represents a significant part of NASA, representing 17% (or US$ 5.3 million) of the total estimated HIV expenditure in 2016 and 16% (or US$ 5.4 million) in 2017. This includes a share of health care budgets executed at OD and PHD levels, referral hospitals, health centers etc. Concerted efforts are required to harmonize NASA and NHA exercise in the area of planning, data collection, interpretation and validation.

4.2 RECOMMENDATIONS

1. In the face of continuously diminishing international resource availability for Cambodian AIDS response, an adequate domestic funding boost is urgently required. A rapid pace of the economic development resulted in higher GDP and more resources available for health and social sectors. National and international partners in Cambodia have collected and developed a good evidence, the Sustainability Roadmap, that can be used as basis for sustainability of AIDS response through innovations, synergies, and efficiency gains.

2. Besides committing to scaling-up ART programmes, the Government needs to boost its support for prevention programmes, particularly for key populations. It is both a political and an operational-level quest and it requires high-level advocacy to affirm political will to mobilize budget revenues for HIV. Establishment of social-contract mechanisms between Government and CSOs as well as building the capacity of public service providers and community are also essential in maintaining and improving the services for key and vulnerable populations.

3. Cambodia is well publicized as one of the achievers of 90-90-90 treatment targets in global scale[34]. To understand whether the spending levels are sufficient for the path towards ending the AIDS epidemic, a comparison analysis with the resource needs estimates will be critical to understand the resource needs envelope. Resource needs estimates need to be developed in line with committed targets towards ending AIDS coupled with innovative and differentiated services delivery models that are impactful in Cambodia context.

4. Efforts to scale-up and maintain antiretroviral programme – a high-impact and resource-consuming intervention – needs to be continuously monitored and evaluated along with the expenditure tracking. High-quality and detailed expenditure data will help understand the cost drivers of the programme and it will in turn support the formulation of effective strategies and operational planning. Additionally, monitoring of drugs cost is essential for the analysis of whether the chosen procurement scheme manages to maintain procurement prices at their lowest or most optimal levels. Collecting a more detailed data on running the ART sites could inform policy makers on the challenges as well as optimization options (decisions on staffing, office maintenance options, equipment requirements, lab services etc), especially during scale-up.

5. Resource tracking efforts should continue, and the NASA team should seek for a greater level of expenditure detail that will allow for a more in-depth analysis, especially for the high-impact interventions such as those aiming at key populations, as well as care and treatment. It is recommended that service providers keep their records on the expenditure for these programmes

34 https://www.aidsdatahub.org/sites/default/files/UNAIDS-2019-global-AIDS-update_2019.pdf

as detailed as possible, so that a more rigorous and comprehensive analysis by beneficiaries and services provided may be made possible.

6. Synergies with NHA should be explored, and NASA and NHA teams should unite their efforts to produce a better HIV sub-account and to improve the quality of NASA. It is recommended to align the schedules for data collection between the teams, agree on the data collection and interpretation beforehand to complement both exercises in the future.

7. Utilization of the National AIDS Spending Assessment classifications should be unified for the future exercises to ensure time series compatibility. NASA Steering Committee, with the technical guidance from UNAIDS, should agree on the application of the NASA classification for the future exercises and prepare an explanatory/guidance note for the NASA team.

ANNEX 1.

Calculation path for HIV/AIDS sub-account in the National Health Accounts is based on a disease split introduced in the NHA. It then uses the account codes and service provision splits to extract health-related AIDS spending for NASA:

- NHA account code was retrieved from the main expenditure subaccount numbers: 6000, 6100, 6200, 6300, 6400, 6500 and 2100:
  - 6000: for all types of purchases and supplies at/to health facilities (PHD, OD, RH and HCs as well as at the national level);
  - 6100 and 6200: for all kinds of services provided by health facilities;
  - 6300 for tax payment;
  - 6400 to 6500 for staff salary and allowances;
  - 2100 for kinds of tangible purchases and procurements at all facilities setting.
- HIV/AIDS split by providers and Outpatient (OPD) and Inpatient (IPD) services:
  - National hospitals: IPD: 71.3% and OPD 28.63%;
  - Referral and provincial hospitals: IPD 40% and OPD 60%;
  - Health centers or former district hospitals: IPD: 0.2% and 99.8%.
- Economic categories used for splitting:
  - All cost related to employees;
  - Incentive, wages and salaries;
  - Non health care services;
  - Health care goods and commodities;
  - Drugs;
  - Capital investment such as equipment and infrastructure.
- HIV/AIDS split by categories from health information system:
  - Inpatient section:
    - Urethral discharge;
    - Vaginal discharge;
    - Genital ulcer;
    - Genital warts;
    - AIDS Symptoms.
  - Outpatient section:
    - Urethral discharge;
    - Vaginal discharge;
    - Genital ulcer;
    - Genital warts;
    - VCCT;
    - Pre-ART and ART;
    - STI consultation.

These are the step undertaken to calculate HIV/AIDS sub-account in the NHA for NASA:

Step 1: Total expenditure by all providers from NHA

Step 2: Classify the expenditure by cost category

Step 3: Classify expenditure by services (OPD or IPD) and proportion

Step 4: Calculation formula: A x C or B x C (where A = B in case of detail expenditure)

Step 5: Get the proxy estimation of expenditure for 2016 and 2017:

- Using 2015 expenditure by each expenditure;
- Multiply by the Inflation rate of 3%.

Summary table of Cross-Walk NASA/NHA:

Expenditure in NHA group by Production factors, in US$	2014	2015	2016	2017
Wages	2,352,297	2,403,261	2,475,358	2,549,619
Non-wage labour income	501,809	512,681	528,061	543,903
Other drugs and pharmaceuticals (excl. ARV)	303,979	310,565	319,882	329,478
Material supplies not disaggregated by type	209,705	214,249	220,676	227,296
Services not disaggregated by type	1,629,696	1,665,005	1,714,955	1,766,403
Laboratory and other medical equipment	172,142	175,872	181,148	186,582
Grand Total	**5,169,628**	**5,281,631**	**5,440,080**	**5,603,282**