HIV AND AIDS DATA HUB FOR ASIA-PACIFIC

EVIDENCE TO ACTION

Cambodia

Country Review December 2011

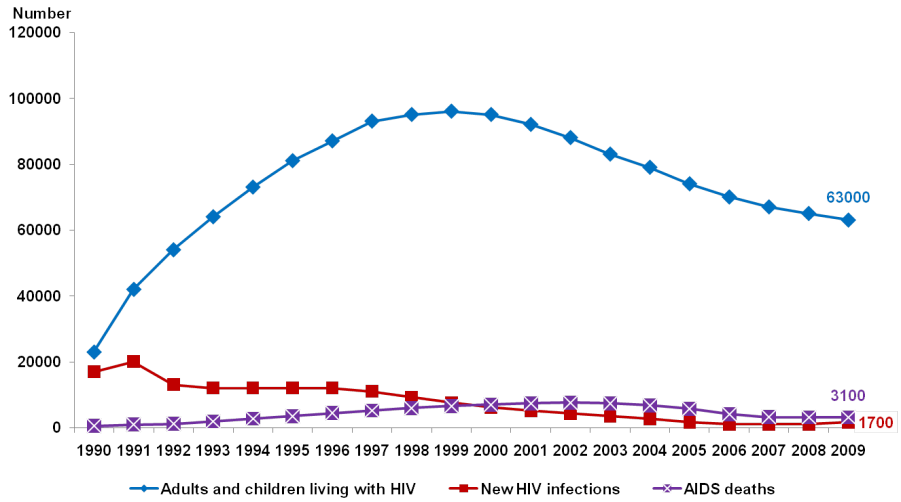
CAMBODIA AT A GLANCE

Total population (in thousands)	15,053 (2010)[1]
Annual population growth rate	1.7% (2010-2015)[1]
Population aged 15-49 (thousands)	8,273 (2008)[2]
Percentage of population in urban areas	20% (2010)[3]
Crude birth rate (births per 1,000 population)	24.7 (2008)[4]
Under-5 mortality rate (per 1,000 live births)	89 (2008)[5]
Human development index (HDI) - Rank/Value	124/0.494 (2010)[6]
Life expectancy at birth (years)	62.2 (2010)[6]
Ratio of girls to boys in primary and secondary education (%)	89.7 (2007)[4]
Adult literacy rate	77% (2005–2008)[6]
GDP per capita	1,914 (2009)[4]
Per capita total health expenditure (Int.$)	108 (2007)[5]

HIV Prevalence & Epidemiological Status

HIV was first detected in 1991 during serological screening of donated blood. Cambodia appears to be experiencing relative success in the fight against HIV. After peaking at approximately 3.3% in 1997-98, HIV prevalence among the adult population aged 15-49 years declined to 1.2% [0.8% - 1.6%] in 2001 and more recently estimated to be 0.5% [0.4% – 0.8%] in 2009.[7] According to National Centre for HIV & AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) officials, the declines could be attributed to increased condom use among, and health service provision for people living with HIV. By the end of 2009, an estimated 63,000 [42,000 – 90,000] adults and children were living with HIV of which an estimated 35,000 [23,000 – 52,000] were women 15 years and older.[7] This represents the most recent figure in a steady decline in the estimated number of people living with HIV, which is expected to continue in coming years (Fig. 1).

Figure 1: Estimated number of adults and children living with HIV, new infections and AIDS deaths, 1990-2009

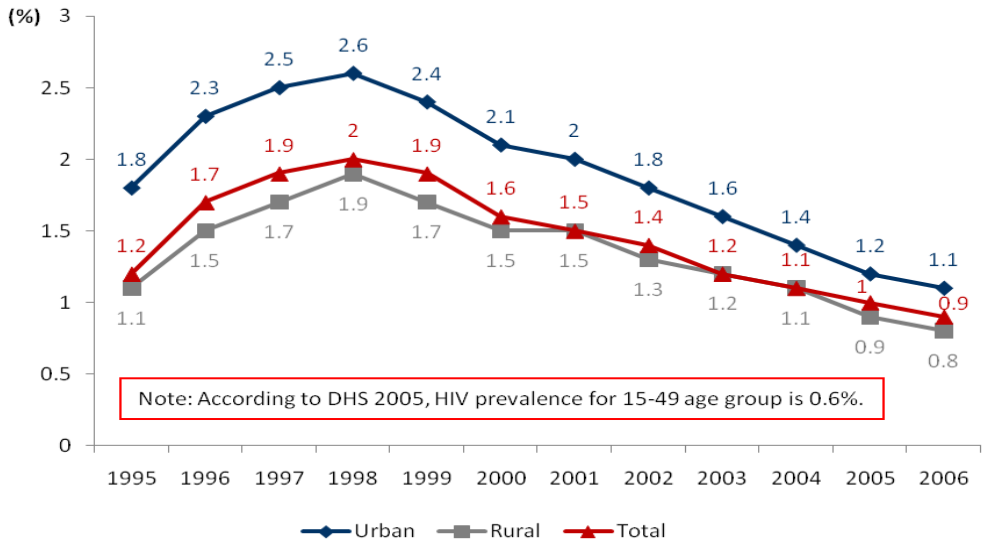


Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

There also has been a shift in the age composition of HIV infections. In general, women are infected at younger ages, peaking between the ages of 20-24, than men, peaking between the ages of 25-29. Yet, the peak of male infections shifted to 30-34 year olds by 2005. Because the majority of male infections occurred in the mid 1990s, the peak age increased almost linearly over the last five years. The shift among women peaked at the 25-29 age group in 2005. Overall, the level of infection in both men and women will fall, but women's levels will fall more gradually.[8]

Figure 2 shows the estimated trends in HIV infection among the general population from 1995 to 2006. HIV prevalence in urban sectors is much higher than in rural ones. HIV infections peaked in 1998-1999, followed by a sharp decline, which was more pronounced in urban areas than in rural areas.

Figure 2: Estimated HIV prevalence among the general population aged 15-49 by residence



Source: Prepared by www.aidsdatahub.org based on NCHADS, National Institute of Public Health, FHI/USAID, CDC, WHO, UNAIDS, East-West Center. Consensus workshop on HIV estimation for Cambodia, June 28, 2006

Surveillance systems:

A national monitoring and evaluation (M&E) system is in place, linking M&E systems of government partners, civil society and development partners. It captures data on a variety of core indicators, including the Universal Access indicators, Cambodia Millennium Development Goals and the indicators for UNGASS reporting. This data is stored in the Country Response Information System database at the National AIDS Authority.[9]

- HIV Sentinel Surveillance (HSS): 1st round of HSS was conducted in 1994 and as of 2006, the country had carried out 10 rounds[10]
- Sexually Transmitted Infections (STI) Sentinel Surveillance, 2005
- Behavioural Sentinel Surveillance (BSS): The first round of BSS was conducted in 1997, followed by seven rounds as of 2010.[10; 11]
- Drug User Survey, 2007
- Cambodian Demographic Health Survey (DHS), 2005
- Internationally supported studies and surveys

Who is at risk of HIV in Cambodia?

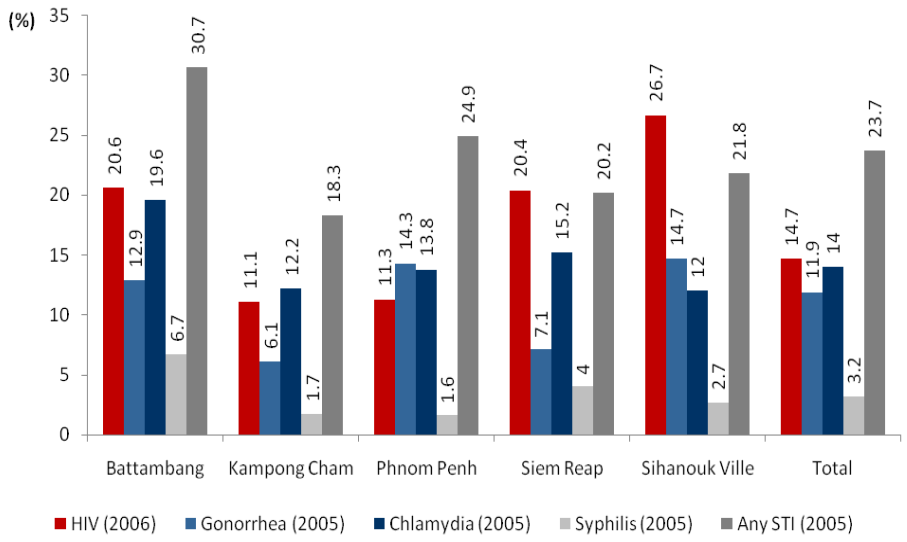
HIV transmission in Cambodia occurs primarily through sexual intercourse. Under the baseline modelling scenario, HIV prevalence was particularly high among female sex workers (FSWs) in the capital city, Phnom Penh, and some major provinces in the early 1990s.[8] Since then, most of the infected cases occurred via heterosexual transmission between FSWs and their clients. In turn, clients of sex workers transmitted the virus to their wives or girlfriends. In addition, one-third of new infections occurred from mothers to children through vertical transmission.

Female sex workers

HIV prevalence has declined among FSWs. In 2006, HIV prevalence among direct FSWs was estimated at 14.7%, down from 23.4% in 2003.[12] A comparison of HIV prevalence in different age groups shows that 2.9% of young FSWs (below the age of 25) were estimated to be HIV positive, compared to 14.4% of FSWs aged 25 and older.[13] In 2006, data showed that HIV prevalence among direct FSWs was as high as 26%, 27% and 31% in the provinces of Kampong Speu, Sihanoukville and Banteay Meanchey, respectively.[13] Prevalence was higher than 20% in 6 of the 20 provinces and municipalities surveyed.

The most recent Sexually Transmitted Infections (STI) Survey (2005) found that STI prevalence among FSWs was also high: nearly a quarter (24%) of FSWs surveyed had at least one STI (Fig. 3).[14]

Figure 3: HIV (2006) and STI (2005) prevalence among entertainment establishment-based sex workers (direct sex workers), various sites



Source: Prepared by www.aidsdatahub.org based on HSS 2006; STI Sentinel Survey 2005

No significant decline in STI prevalence was observed between 2000 and 2005.[14] FSWs who had been selling sex for 12 months or less were significantly more likely to carry an STI than those who had been selling sex for more than a year. The 2005 STI Survey also revealed that, among FSW who reported ever having an STI: 88% sought care from medical facilities—especially public clinics (64%); and 47% continued to have sex during their last STI episode. Due to the availability of outreach programmes, direct sex workers show a greater propensity to seek STI treatment at medical facilities over time.

In the DHS 2005, men were asked about commercial sex.[15] Overall, 6% of men had engaged in paid sex in the last 12 months. The highest percentages were reported by men in Phnom Penh (15%) and in Krong Preah Sihanouk/Kaoh Kong (10%) and among those with higher levels of education. Men between the ages of 20 and 29 were most likely to report having paid for sex than other age groups. Thirteen percent of men in both urban and wealthiest groups reported having paid for sex. A separate survey conducted among ten population groups (n=3,848) in 4 provinces found that the percentage of men who patronized sex workers in the last 12 months ranged from 20 to 50% in high-mobility occupation groups (whereas in other population groups it ranged from 5 to 10%).[16]

Moto-taxi drivers have been identified as a target group by NCHADS, and have been included as a sample population in BSS since 1997. Data from 2010 (n = 1010) reveals that 34.1% of moto-taxi drivers had had sex with a FSW in the past year, down from 40% in 2007.[17] Additionally, a high proportion (34.4%) of moto-taxi drivers reported having multiple sexual partners in the past year, down from 47% in 2007.[17]

A 2005 study among male clients of brothel-based sex workers in 3 provinces, (Battambang, Bantey Meanchey, and Siem Reap) found high rates of HIV among all participants in the study: 9.2% had a positive test result.[18] Almost 60% visited FSWs one month before the survey, and 75% reported condom use with sex workers. However, consistent condom use with their girlfriends was substantially lower at 14%. Indeed, this differentiated behaviour should be a key consideration of intervention programmes, particularly in the context of prevalence of STIs (15.8 %). These clients are considered at higher risk of HIV exposure and could transmit HIV from a key affected population (e.g. FSWs) to a population at lower risk such as their wives, and girlfriends.[18]

Men who have sex with men

Men who have sex with men (MSM) were first included as a sentinel group in STI Sentinel Surveillance (SSS) in 2005. This SSS found that HIV prevalence was highest among men who have sex with men (MSM) in Phnom Penh: 8.7% against 0.8 % in the two provincial towns included in the study (Battambang and Siem Reap).[19] Prevalence was 7.9% among transgender groups and 2% among non-transgender MSM. HIV prevalence was especially high among transgender groups in Phnom Penh, which was estimated to be 17% (4.5% among non-transgenders).[19]

Important sexual networking exists among MSM, the sex worker population, and the general population (female partners of MSM). The SSS found that 5.4% and 2.8% of MSM in Phnom Penh and other provinces, respectively, were currently married. Another 4.3% and 1.2% in Phnom Penh and other provinces were divorced or widowed.[14] More recently, according to the BSS 2007, 36% of MSM and 60% of transgenders (also called “long hair MSM”) reported ever having sold sex.[11] The percentage of MSM who sold sex to a woman in the last year was 18% among short hair and 3% among long hair MSM. Further, 50% and 6% of short and long hair MSM bought sex with a FSW in the last year, and 66% of short hair and 7% of long hair MSM had sex with a woman in the last year.

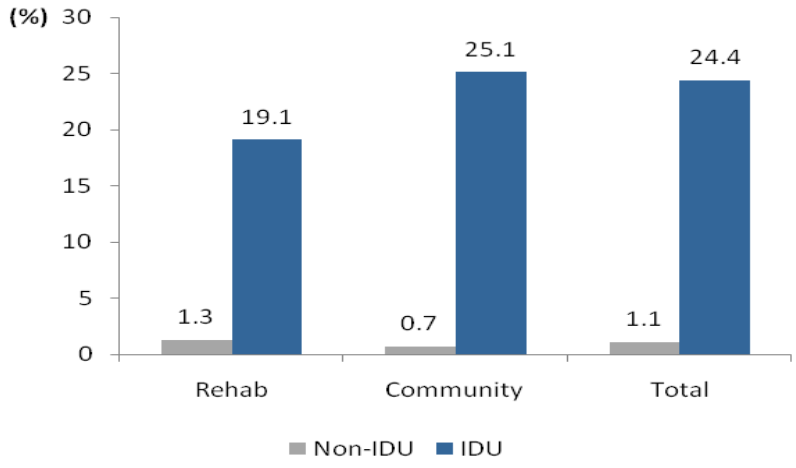
MSM at a glance

HIV prevalence (2005) [19]	• 8.7% in Phnom Penh • 0.8% in Battambang and Siem Reap • 7.9% among transgender MSM • 2% among non-transgender MSM • 17% among transgender MSM in Phnom Penh • 4.5% among non-transgender MSM in Phnom Penh
Selected behaviors (2007)[11]	• 45% of transgender MSM and 29% of non-transgender MSM had unprotected sex in the past month. • 86.5% used a condom with last male partner.[9]
National response[11]	• 66% of transgender MSM and 57% of non-transgender MSM have had an HIV test in the past year. MSM are formally organized. • 96% of MSM have been reached by HIV education. • There is a specific program line for MSM in the national HIV plan. • Programmes for MSM received 3% of total prevention funding in 2008 (US$ 635,516).[20]

Injecting drug users

In 2005, Cambodia had an estimated 1,750 injecting drug users (IDUs).[21] A 2007 cross-sectional study carried out by NCHADS, which surveyed 528 drug users (including 170 IDUs), found that HIV prevalence was 24.4% (19.1% among those sampled in a rehab centre and 25.1% among those surveyed within the community) (Fig. 4).[22] The same study found that 36% of IDUs reported that they shared needles and syringes the last time they injected drugs, 50% had shared material used for injecting drugs in the past month and 26% of IDU had injected drugs which had been dissolved in someone else's blood in the past month.[22] Meanwhile, a high percentage (about 64%) of IDUs reported having sex with brothel- or street-based FSWs.[22]

Figure 4: HIV prevalence among drug users in four provinces, 2007



Source: Prepared by www.aidsdatahub.org based on Surveillance Unit, National Centre of HIV/AIDS, Dermatology and STD

VULNERABILITY, KNOWLEDGE & RISK BEHAVIOURS

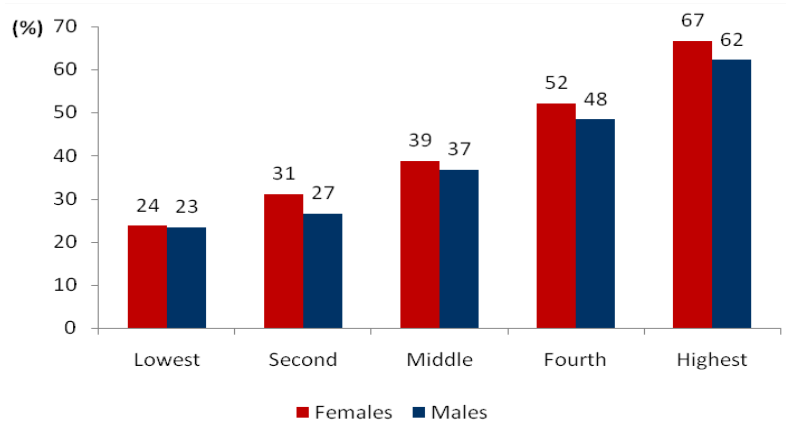
Vulnerability factors
Cambodia has a concentrated HIV epidemic and continues to have the following vulnerability:
•Condom use is low among men in casual sex.
•Condom use is low among sex workers in non-commercial sex.
•The *Law on the Suppression of Human Trafficking and Sexual Exploitation (2008)* is causing many FSWs to evade prevention services, including the successful 100% Condom Use Program, for fear of prosecution.[23; 24; 25]
•Fear of spousal violence prevents many women from accessing counselling and testing services in antenatal clinics (ANC).[26]
•Sexual violence among sex workers: In a survey carried out in Phnom Penh in 2004 among a probability sample of more than 1,000 sex workers, over 90% of sex workers reported being raped at least once a year; the majority of these rapes were perpetrated by clients during the past year but one-third were gang-raped by police and another third by gangsters.[27]

Knowledge of HIV and AIDS

The Cambodia DHS 2005, found that most young people aged 15 to 24 could correctly identify the two most readily accepted ways to prevent sexual transmission of HIV (91% of males; 89% of females).[15] However, the DHS also found that less than half (48%) of all young people had comprehensive knowledge of HIV – that is, were able to both correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions about HIV transmission (specifically: 50% for females (15-24) and 45.2% for males (15-24).[15]

The DHS 2005 also identified that comprehensive HIV knowledge among adults (15-49) was 44% among females and 41% among males.[15] This knowledge varied widely across wealth quintiles, from 24% and 23% among females and males, respectively, in the lowest quintile to 67% among females and 62% among males, in the highest quintile (Fig. 5).[15]

Figure 5: Percentage of adults (aged 15-49) with comprehensive HIV knowledge, by wealth quintile, 2005



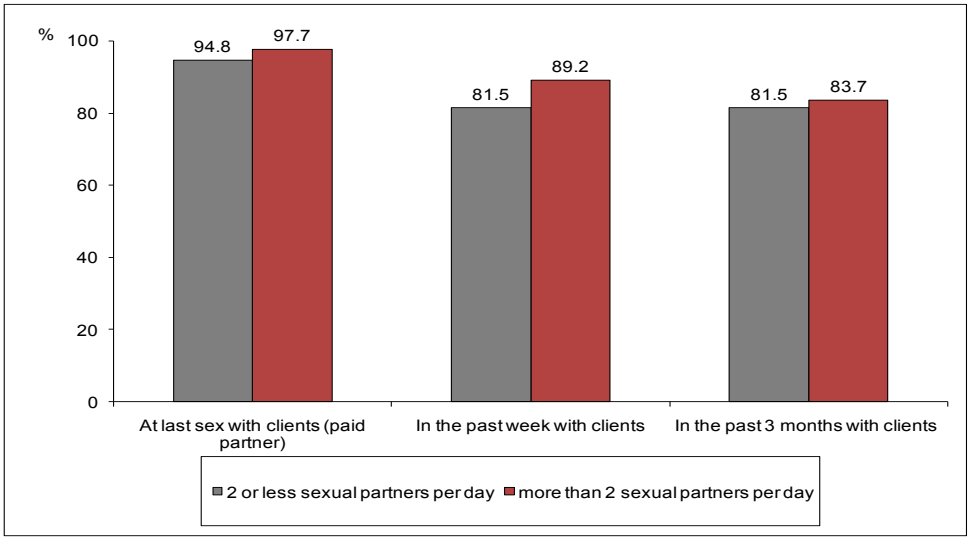
Source: Prepared by www.aidsdatahub.org based on Cambodia Demographic and Health Survey (DHS), 2005

While comprehensive knowledge among key affected populations has not yet been assessed in Cambodia, the aforementioned 2007 study among IDUs and Non-IDUs, found that 71% and 77% of IDUs in rehabilitation centres and in communities, respectively, knew that using used needles can cause HIV infection.[2]

Condom use

The 100% Condom Use Programme (CUP) was piloted in 1998 and has since expanded nationwide. It promotes consistent condom use for all types of FSWs and their clients and reportedly contributed to the decline in HIV prevalence in Cambodia. According to the most recent BSS (2010) an overwhelming majority (94.8%) of female entertainment workers FEWs with an average of two or less partners per day reported the use of a condom with their most recent client (paid partner), compared to 97.7% of those with an average of more than two partners per day (Fig. 6). It should be noted that the average number of FEWs in the same establishment with 2 or less sexual partners per day (50 respondents) was much higher than those with more than 2 sexual partners per day (7 respondents).[17]

Figure 6: Percentage of condom use with clients (paid partners) at last sex, in the past week and in past 3 months among female entertainment workers, 2010

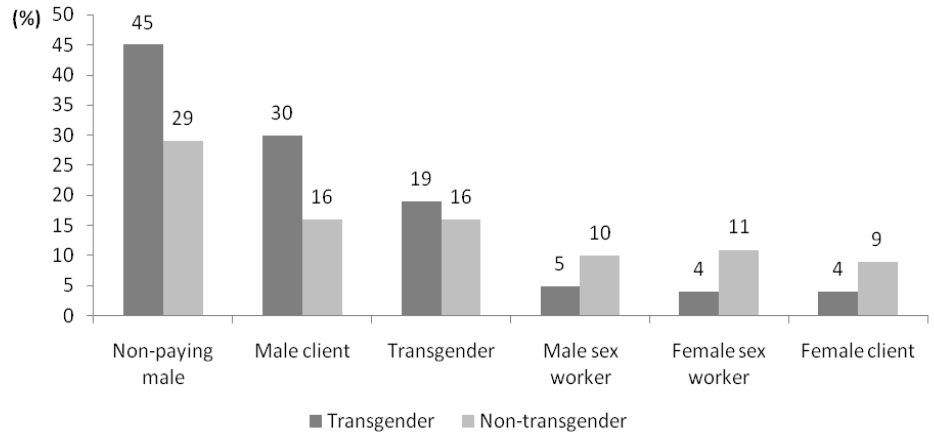


Source: Prepared by www.aidsdatahub.org based on National Centre for HIV/AIDS, Dermatology and STDs, Behavioral Surveillance Survey, BSS, 2010

The Tracking Results Continuously (TRaC) survey conducted by Populations Services International (PSI) in 2009, found that condom use among indirect FSWs varies depending on the type of partner.[9] Ninety-seven percent used a condom at last sex with a client, compared to only 63% who used a condom at last sex with a sweetheart.

According to the BSS 2007, 87% of MSM reported the use of a condom during the last time they had anal sex. Condom use is highest among younger MSM (aged 15-24) with 89% reporting condom use during most recent anal sex, against 82% for the age group 25 and older.[28] Figure 7 shows that – as was the case among FSWs – unprotected sex among MSM is more common with a non-paying partner as compared to with a client or sex worker.

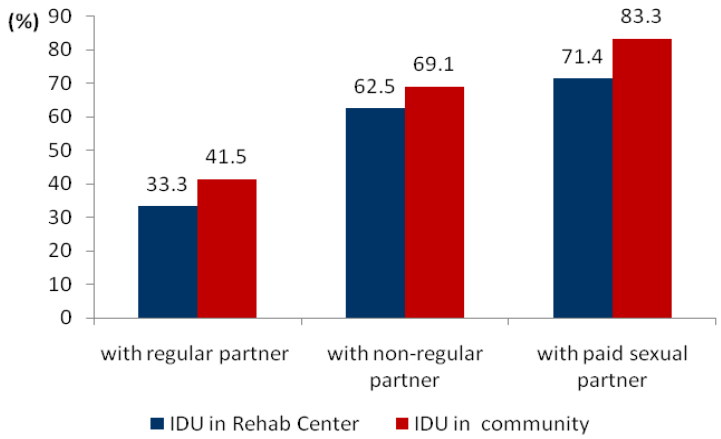
Figure 7: Percentage of MSM reporting unprotected sex in the past month by partner type, 2007



Source: Prepared by www.aidsdatahub.org based on National Center of HIV/AIDS, Dermatology and STD, Behavioral Sentinel Surveillance, 2007

The same trends in condom use by partner type observed among FSWs and MSM were noted in the abovementioned cross-sectional survey among drug users. The survey found that IDUs reported using a condom at last sex most frequently with a paid partner than with non-regular and – to a greater extent – regular partners (Fig. 8).[22]

Figure 8: Percent of IDUs in four provinces reporting condom use at last sex with various types of partners, 2007



Source: Prepared by www.aidsdatahub.org based on Cambodia, Surveillance Unit, National Center for HIV/AIDS, Dermatology and STD (Power Point Presentation of cross-sectional study of 518 IDU and Non-IDU in 4 Provinces), 2007

HOW MIGHT HIV AFFECT CAMBODIA IN THE FUTURE?

A number of studies analyzing the poverty impact of HIV & AIDS in Cambodia reveal that significant numbers of non-poor households are being pushed into poverty as a result of HIV. It is estimated that poverty reduction in Cambodia may be slowed down by up to 60% every year between 2003 and 2015 in the absence of antiretrovirals (ARV).[29] Moreover, HIV has lowered life expectancy by 3 years in Cambodia.[30]

A study on the impact of HIV & AIDS on poverty in Cambodia using a simulation model showed that HIV and AIDS-related expenditures and income effects caused households with people living with HIV (PLHIV) to decrease consumption expenditure by between 46% and 54%. The primary impact for PLHIV is household debt. All households with PLHIV, other than those in the highest consumption quintile (Q5), will fall below the (overall) poverty line. Households in the poorest three quintiles will also fall below the food poverty line[1] after the income and expenditure effects are considered. Households in the third, fourth, and fifth quintiles with PLHIV will become newly poor. Households in the poorest two quintiles, which were already below the poverty line, will fall deeper into poverty, and households in the third and fourth quintiles will be newly poor. These findings are independent of ARV use. The small difference between households with PLHIV using ARVs and not using ARVs is because PLHIV using ARVs are able to remain economically active and contribute to household income longer than those not using ARVs.

A 2003-2004 study sampling 1000 households in three Cambodian provinces also explored the effects of HIV and AIDS on household economics and the social wellbeing of children in HIV-affected families.[31] Once again, results showed that HIV and AIDS contribute to increased vulnerability to poverty and increased burdens on families and children. HIV-affected households incurred larger expenditures on medical care and funerals, had lower income, and were more likely to sell off assets, borrow money from family members, take out loans, and ration medical care for food.

NATIONAL RESPONSE

Law and policy related issues

Legal issues relating to HIV and AIDS in Cambodia include the following:

- The *Law on the Prevention and Control of HIV/AIDS (2002):*[32] Provides for a wide range of activities by Ministries and by civil society. It includes human rights and the involvement of people living with HIV in its guiding principles, emphasizing issues including non-discrimination, confidentiality, voluntary HIV testing, freedom of movement and abode, and the prohibition of HIV screening for employment or education. Specifically, the Law imposes fines of up to one million Riels (or US$ 24,000) and a penalty of imprisonment for one to six months for discrimination based on perceived or suspected HIV/AIDS status of an individual or his/her family members (article 52).

[1] Less than the most basic food needs (2,100 calories per capita) can be met with household expenditure available for consumption

• *The Law on the Suppression of Human Trafficking and Sexual Exploitation (2008)* criminalizes sex for money, public soliciting for prostitution and many forms of financial transactions connected to sex work.[25] The law has been criticized for conflating sex work and trafficking[25] and for improper implementation leading to illegal detentions and physical abuses.[33]

• Sex between men is not criminalized but it is highly stigmatized.[34; 35]

Notwithstanding the existence of legislation, there is often a disconnect between the law and conflicting policies, as well as a lack of coordination among government bodies and weak law enforcement. Despite whatever type of legal environment that exists, police and local authorities have been known to take punitive or more restrictive actions against sex workers based on outdated or unrelated laws and policies. Each of these issues acts as a barrier to HIV intervention programme implementation by making key affected populations hidden for fear of being apprehended and by hampering their health-seeking behaviour.

Governance

Factors contributing to this success are political commitment, a strong response from civil society and a wide range of activities by the Ministry of Health, including the 100% condom use programme (CUP). Many national policies and strategies have been developed to address HIV and AIDS. Government departments have been encouraged to fund HIV prevention activities from their regular budgets.

To coordinate a multi-sectoral approach involving ministries beyond the Ministry of Health, the government established the National AIDS Committee in 1993, which was succeeded by the National AIDS Authority (NAA) in 1999. The NAA is comprised of 26 line Ministries, the Cambodian Red Cross and 24 provinces and with responsibility for formulating and monitoring the national response to HIV and AIDS.

Over the years, the Royal Government of Cambodia has undertaken several initiatives and actions to prevent and control the spread of HIV & AIDS, among which include:

• Adoption of the law on prevention and protection of HIV/AIDS in 2002

• Development and adoption of the National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS for 2001–2005, which focused on determinants of behaviours at the individual level and on changing aspects of the country's socio-economic, legal and political environments

• Updating of 2005 situation and response analysis (SRA) to inform the development of the second National Strategic Plan for a Multi-sectoral Response to HIV/AIDS for 2006-2010, reflecting the new HIV prevalence estimates and projections as well as changing circumstances and priorities

• In September 2010, the NAA released the third National Strategic Plan for a Multi-sectoral Response to HIV/AIDS for 2011-2015.

• Completion of extensive evidence-based and strategic planning of interventions with MSM and IDUs

• Design of better informed and more substantive interventions to mitigate the impact of the epidemic, in particular to improve the situation of orphans and vulnerable children

• Development of new policies and revision of existing policies to better reflect the challenges that are arising in the national response to HIV

• Greater recognition of the multi-sectoral involvement in the national response, resulting in much stronger relationships and coordination between government and non-government sectors. With the assistance of bi- and multi-lateral partners, the role and involvement civil society organizations have been strengthened and expanded

• Fulfilment of the target set by the global '3 by 5' initiative

• Launching, successful implementation and scale-up of the 100% CUP

HIV Prevention Programmes

According to the 2007 BSS, HIV education programmes had reached 96% of MSM, 94% of brothel-based (direct) FSWs and 91% of non-brothel based (indirect) FSWs in the 6 months preceding the survey.[11] In terms of age, younger FSWs (<25 years) were somewhat less likely to be exposed to HIV and AIDS education.[11] The 2009 TRaC Survey found lower levels of coverage – in that 75% of women working in entertainment establishments had been exposed to HIV programs in the last 6 months. The program included at least one of the following: peer education, family planning, HIV testing and counselling and STI services.[9]

While prevention coverage among IDUs has not been surveyed, the NCHADS cross-sectional study found the following:[22]

• 19% of IDUs in the rehabilitation centre and 54% of IDUs in the community believe that they can get ART if needed;

• 29% of IDUs in the rehabilitation centre and 41% of IDUs in the community know that there is health facility providing ART; and

• 43% of IDUs in the rehabilitation centre and 54% of IDUs in the community know about voluntary confidential counselling and testing services;

Moreover, in 2009, 51 syringes/needles were estimated to have been distributed per IDU by needle and syringe exchange programme.[36]

During the school year 2008-2009, 34.1% of all schools in Cambodia provided life skills-based education – 40.6% of all primary schools and 5.2% of all secondary schools.[9]

HIV testing is variable among population groups:

- According to the 2010 BSS, nearly two-thirds (63.7%) of FEWs with 2 or less partners per day and 81.5% of FEWs with more than 2 partners had had an HIV test in the past year. Compared to 74.2% of brothel-based FSWs in the previous BSS (2007, this figure was even lower among non-brothel-based FSW: 41.1%, 67.1% and 50.4% of beer garden workers, beer promoters and karaoke workers, respectively).[17]

- Among moto-taxi drivers, HIV testing was low: 26% had an HIV test in the past year and 95.9% among those tested received the results (2010 BSS).[17]

- According to the 2007 BSS, 57% of short hair MSM (n=388) and 66% of long hair MSM (n= 341) had an HIV test in the past year. Of those, 94% (short hair) and 98% (long hair) received the results of their tests.[17]

- 35.3% of IDUs were tested in the last 12 months and knew the result.[37]

- According to the 2010 Universal Access report, 153,884 pregnant women were tested for HIV and 146,453 received their results.[36]

- As of December 2009, a total of 26,278 individuals (10,604 males and 4,367 females) aged 15 years and older had received HIV testing and counselling and know their results.[36]

- In 2005, 4% of sexually active young women and men aged 15-24 received an HIV test in the last 12 months and knew their results (233 males, 115 females, n=348).[15]

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

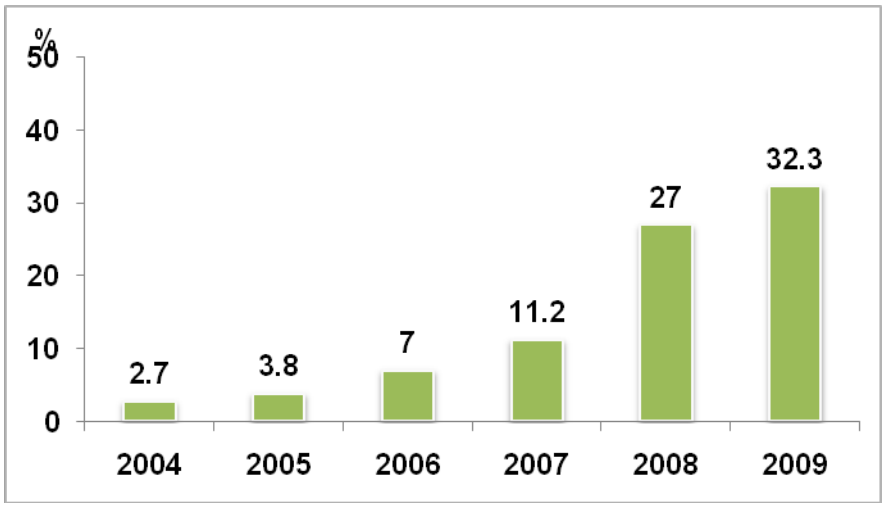
The number of facilities that provide ART increased from 30 in 2005 to 52 in 2009 (in 20 of 24 provinces).[9] At the same time, 29 facilities were providing paediatric ART.[9]

Cambodia far exceeded the global ART coverage target of 30% as shown by the continuing increases in proportions of adults and children with advanced HIV infection who were receiving ARVs. According to the Towards Universal Access: Progress Report 2010, the estimated ART coverage was 94% of adults, similar to 94.9% in 2008 and up from 82.6% in 2007.[36]

As of December 2010, a total of 246 VCT sites were in operation (up from 197 in 2007); at least 200 offered prevention of mother-to-child transmission (PMTCT) services.[10] The percentage of HIV-positive pregnant women who received ART to reduce mother-to-child transmission had increased from 1.2% in 2003 to 32.3% in 2009 (Fig. 9).[38] HSS 2006 data showed that HIV prevalence declined among pregnant women attending ANC: from an estimated 2.1% in 2000 to 1.6% in 2003 to 1.1% in 2006 (n=12,464).[39] Since then, in 2009, HIV prevalence had been estimated to be 0.7% among women who were tested for HIV at a government ANC clinic.[9] HIV prevalence among pregnant women who attended provincial capital/urban ANCs had been consistently higher than among those who attended remaining district/rural ANCs (1.4% vs. 1.1% in 2006). Notably, this prevalence remained as high as 2.1% in Pailin province.[39]

A 2007 hospital-based quantitative and cross-sectional survey at the National Maternal and Child Health Center in Phnom Penh (n=599) found that the prevalence of HIV testing among women who delivered at the hospital was 76%.[40] The survey also found that the main barriers to HIV testing among the sample were: the perceived need to obtain a partner's permission to be tested; the lack of knowledge about HIV prevention; and treatment and the lack of access to ANC services.[40]

Figure 9: Percentage of HIV+ pregnant women who received ART to reduce the risk of mother-to-child transmission, 2004-2009



Source: Prepared by www.aidsdatahub.org based on PMTCT Program of the NMCHC, 2003-2009, as cited by UNGASS 2010

The estimated vertical transmission declined from 30.5% of all births to HIV-positive women in 2001 to 11.4% in 2007.[29] A 2007 retrospective cohort study assessed mortality both pre-ART and during ART among 1,168 HIV infected children (aged 0-14) enrolled in HIV-programs in Cambodia.[41] The study found that HIV infected children experienced a high mortality and loss-to-follow-up rates before starting ART. Specifically, by the end of the observation period, 14.5% patients not on ART had died compared to 5.5% of those under treatment. Moreover, 22% who did not start ART were lost-to-follow-up compared to 2% on ART.

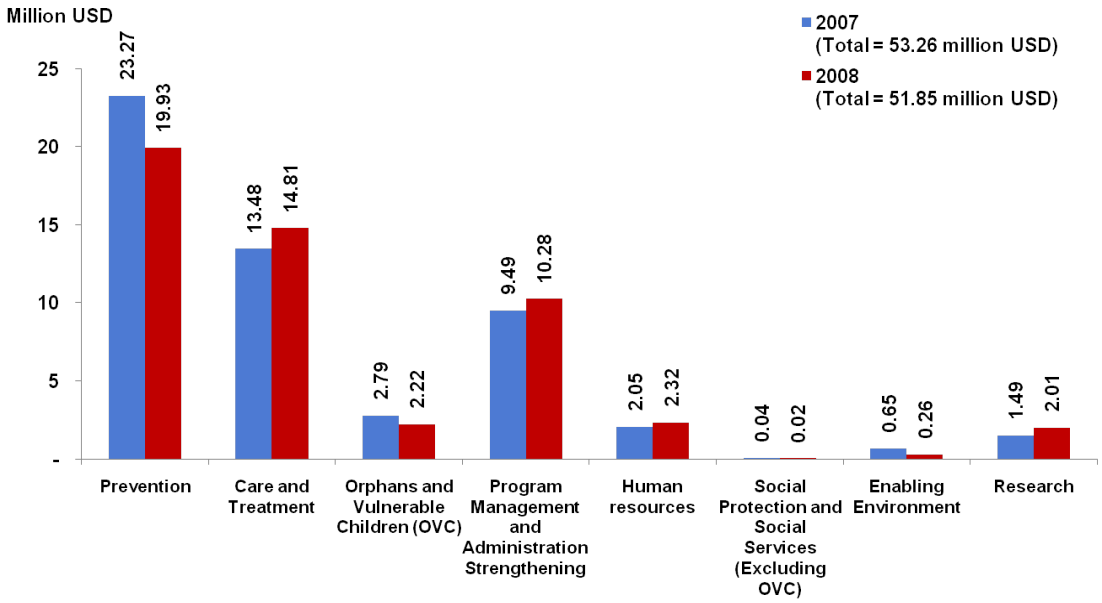
ECONOMICS OF AIDS

An estimated total of US$ 51.8 million was available for the national response to HIV in 2008 (down from US$ 53.3 in 2007, yet higher than the US$ 46.3 million that was spent in 2006).[7] Development partners and the Global Fund were the primary sources of AIDS funds (83% of total AIDS spending). This reflects Cambodia's high reliance on funding support from the donor sector to deliver HIV & AIDS services. Bilateral agencies and the Global Fund were the primary contributors to total AIDS funding (contributing 62% of the total in 2006, 78% in 2007 and 77% in 2008).

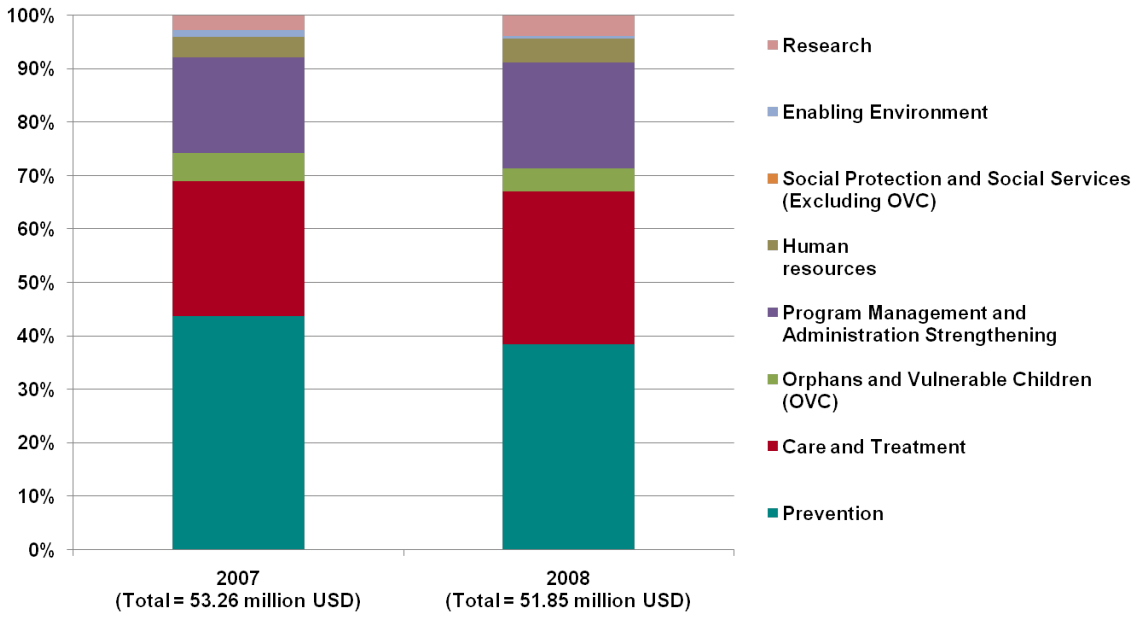
In 2008, prevention continued to be the largest spending category (44%), followed by care and treatment (29%), and program management and administration strengthening (18%) (Fig. 10, a-b).[7] The percentage of funding allocated for prevention programmes targeting key affected populations in 2008 was highest for female sex workers and their clients (6% of the prevention sub-total, although dropping from 12% in 2007). Harm-reduction programmes for IDUs and programmes for MSM each received 3% of total prevention funding.[7]

Figures 10a and 10b: (a) Amount and (b) Percent distribution of total HIV expenditures by major spending category, 2007 and 2008

(a)



(b)



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

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