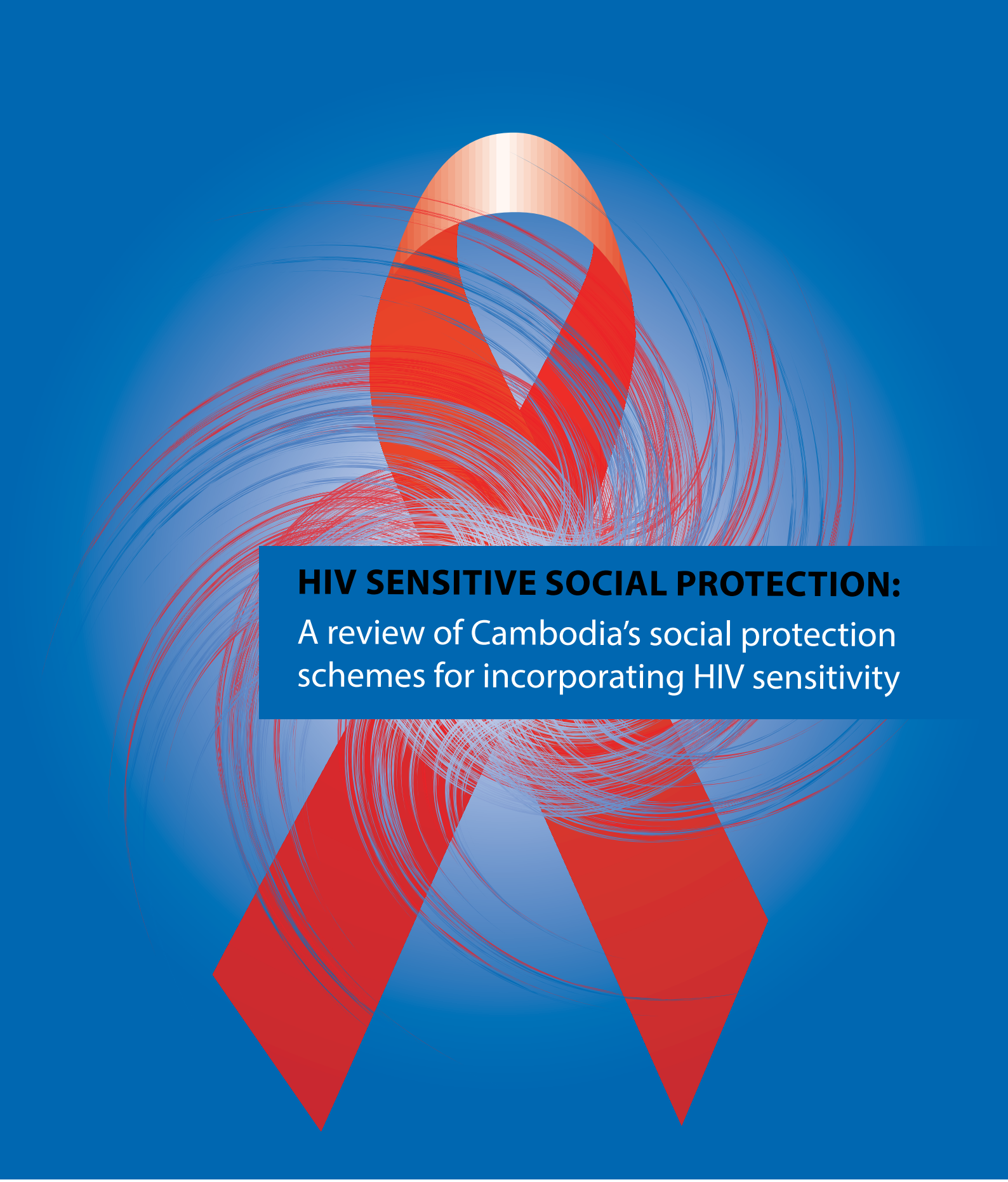


HIV SENSITIVE SOCIAL PROTECTION:

A review of Cambodia's social protection schemes for incorporating HIV sensitivity

CARD

NATIONAL AIDS AUTHORITY

UNAIDS

UNDP

Empowered lives.
Resilient nations.

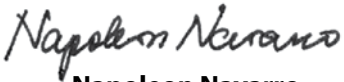
FOREWORD

Social protection is one of the pillars of the 5-year UN Development Assistance Framework in Cambodia. Social protection is needed to reduce people's vulnerability to socioeconomic risks and impoverishment and to enable the poor and vulnerable populations improve their livelihoods and productivity in the long term.

People living with HIV (PLHIV) are a vulnerable population group. The findings from the UNDP and National AIDS Authority study in 2010 on the socioeconomic impact of HIV at the household level in Cambodia clearly demonstrated disproportionate socioeconomic challenges faced by HIV-affected household as compared with non-affected household. One of the recommendations calls for social protection that addresses and mitigates such disproportionate socioeconomic impacts of the HIV-affected households.

As part of support for the effective implementation and governance of the National Social Protection Strategy with specific focus on one of the special vulnerable groups, UNDP Cambodia has embarked on an HIV-sensitive social protection initiative. It is very vital to ensure that national social protection strategies are inclusive of those affected by, highly vulnerable to, and living with HIV to demonstrate comprehensive HIV responses which directly contribute to alleviate the socioeconomic and human impact of AIDS on the individual, family, community and Society.

I hope this report will be a useful resource for incorporation of HIV sensitivity into existing social protection schemes in Cambodia. UNDP is committed to play facilitative role to ensure that social protection is possible and is available for people and households affected by HIV.



Napoleon Navarro
Country Director, a.i.
UNDP Cambodia

FOREWORD

This review of Cambodia's social protection schemes for incorporating HIV sensitivity marks a milestone in the maturation of the national dialogue to reduce poverty and protect the poor and vulnerable from shocks. It comes at a time of unprecedented commitment to social protection as we approach the mid-point of Phase I of the National Social Protection Strategy (NSPS). It builds on the significant recent data from the 2010 Socio-Economic Impact of HIV study and the 2010 Stigma Index for People Living with HIV study. By combining the objectives of the NSPS with the data on HIV impact, the review initiated the process of understanding how social protection in Cambodia can provide appropriate support to people living with HIV. The review extended the analysis to consider how social protection can work for people vulnerable to HIV transmission and marginalised key affected populations

Significant gains in the HIV response have been made, particularly in relation to access to treatment and reduction in HIV prevalence. Social protection mechanisms provide us with the opportunity to implement safety nets to ensure that people living with HIV do not fall below the poverty line, and ultimately address the socio and economic factors that increase vulnerability to HIV transmission.

This report shows that there are already social protection mechanisms in place which respond directly to the needs of individuals and households affected by HIV. But it challenges us to fully understand the wide reach of social protection and to increase the sophistication of our responses through nuance and refinement to further meet the needs of people living with HIV and key affected populations.

As we continue this dialogue, I would like to thank to all partners for their participation and invaluable contributions in preparing this report. The close cooperation between all stakeholders including government, civil society, development partners, networks of people living with HIV and networks of key affected populations is a key factor in Cambodia's successful response to HIV and AIDS and its welcome nascent social protection response.

FOREWORD

This report is a direct follow-up to the 2011 High-Level Technical Consultation on HIV-Sensitive Social Protection for Impact Mitigation in Asia and the Pacific hosted in Siem Reap, Cambodia.

Adopting the 5 key principles of HIV-sensitive social protection, the Consultation set the global precedence to bring together critical players, or social protection/national planning agencies, national AIDS authorities, and Civil Society Organisations, which some people refer to as "the Siem Reap model". This report is another major addition to the fledging field of HIV-sensitive social protection, as its analytical approaches and findings can inform and inspire concerned parties not just within Cambodia but across the world.

This report is also a timely contribution to the policy dialogue on the direction of social protection efforts in Cambodia, as it closely relates to the implementation of the National Social Protection Strategy for the Poor and Vulnerable (NSPS) developed in 2011.

One of the prominent features of the NSPS is its pronounced emphasis on special vulnerable groups, in addition to the poor, as the title indicates. Special vulnerable groups listed in the NSPS are those who are often stigmatized, marginalized and discriminated against and thus face additional socioeconomic challenges, including people living with HIV, persons with disabilities, the elderly and ethnic minorities.

This report highlights the importance of incorporating special needs and circumstances of people living with, affected by and vulnerable to HIV into existing general social protection schemes and policies. The underlying principle is certainly applicable to other vulnerable groups. It therefore offers one strategic approach to help transform the values and the spirit of the NSPS into effective action and lasting results.

The council of Agricultural and Rural Development wishes to extend our great support for this initiative and will remain committed to the joint effort of ensuring HIV incorporation in existing social protection schemes.

Ngy Chanphal

Secretary of State, Ministry of Interior
Vice - Chairman, Council for Agricultural and Rural Development
Chairman of Social Protection Coordination Unit

ACKNOWLEDGEMENTS

This report was commissioned by UNDP, written by Jo Kaybryn of Plurpol Consulting with consultation design and support from Amara Bou, UNDP Cambodia. Appreciation is extended to the National AIDS Authority (NAA), the Council for Agricultural and Rural Development (CARD), and the Joint United Nations Programme on HIV/AIDS (UNAIDS), for cooperation and support for this study.

Special appreciation is due to H.E. Dr Teng Kunthy, Secretary General of NAA, for his leadership and guidance in initiating and overseeing the review, and for expertly chairing the national consultative stakeholders' meeting. Grateful thanks are also extended to H.E Sim Khengkham, Vice-Chair of NAA, H.E Dr. Sim Kimsan, Director of Communication and Resources Mobilization Department of NAA, and Dr. Voeung Yanath, Deputy Director of Communication and Resource Mobilization Department of NAA, for their valuable facilitation with Technical Working Group on Impact Mitigation for the finalization and endorsement of this work.

The review process would not have been possible without the commitment of Marisa Foraci from UNDP Cambodia, Kazuyuki Uji from the UNDP Asia-Pacific Regional Centre and Kathy Keary from UNAIDS Cambodia. Special thanks for oversight goes to H.E. Mr Ngy Chanphal, Secretary of State, Ministry of Interior, Vice-Chairman of CARD and Chairman of the Social Protection Coordination Unit (SPCU); H.E. Dr Mean Chhi Vun, Director of the National Center for HIV/AIDS, Dermatology and STD Control (NCHADS); Sok Chanchhorvy, Democratic Governance Team Leader at UNDP Cambodia; and the Joint UN Team on HIV and AIDS in Cambodia, with particular thanks to Marie Odile Emond and Savina Ammassari of UNAIDS Cambodia.

The following key contributors are acknowledged with special thanks for their support and contributions: Nikki Ward from Plurpol Consulting, Juliette Rousselot from the Cambodian Center for Human Rights (CCHR), Silja Rajander from UN Women, Kasem Kolnary from Cambodian HIV/AIDS Education and Care (CHEC), Dr Ngauv Bora from NCHADS, Francesca De Ceglie and Dr Suntakna Meng Chhum from the World Food Programme (WFP), Anja Papenfuss from Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Leang Sopheak, Mak Sodaline, Phy Phat, Phin Aphikovith and Nur Yusyeila Yunus from UNDP, Les Ong from UNAIDS, Sok Kunthy, and all other government, civil society and development partner stakeholders who provided their full cooperation and participation in interviews conducted for the review process, the development of this report and the national consultative meeting held in Phnom Penh in December 2012. Complete lists of these important stakeholders are included in the appendices.

ACRONYMS AND ABBREVIATIONS

AFH	Action for Health
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
BC	Bondanh Chaktomuk
BTC	Belgian Technical Cooperation
CARD	Council for Agricultural and Rural Development
CBHI	Community-based health insurance
CCHR	Cambodian Center for Human Rights
CHEC	Cambodian HIV/AIDS Education and Care
CLTS	Community-Led Total Sanitation
CPN+	Cambodian People living with HIV/AIDS Network
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HEF	Health Equity Fund
HIV	Human Immunodeficiency Virus
HIV-HH	HIV-affected household
IDPoor	Identification of Poor Households
ILO	International Labour Organization
LBGT	Lesbian, bisexual, gay and transgender
MEF	Ministry of Economy and Finance
MoE	Ministry of Environment
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
MoP	Ministry of Planning
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MRD	Ministry of Rural Development
MSM	Men who have sex with men
NA-HH	HIV non-affected household
NCHADS	National Center for HIV/AIDS, Dermatology and STD Control
NGO	Non-governmental organization
NSPS	National Social Protection Strategy
NSSF	National Social Security Fund
PALS	Productive Assets and Livelihood Support
PMTCT	Prevention of mother to child transmission
RGC	Royal Government of Cambodia
SECLO	Strengthening Economic Livelihood Opportunities for Low-Income and HIV-Positive Women
STI	Sexually transmitted infection
TVET	Technical and vocational education and training programme
UN Women	UN Entity for Gender Equality and the Empowerment of Women
UNAIDS	UN Joint Programme on HIV and AIDS
UNDP	UN Development Programme
UNICEF	UN Children's Fund
URC	University Research in Cambodia
USD	United States dollar
VCCT	Voluntary, confidential counselling and testing
VCT	Voluntary counselling and testing
WFP	World Food Programme
WNU	Women's Network for Unity

CONTENTS

CONTENTS

1 BACKGROUND

While Cambodia has successfully reduced the aggregate level of HIV infection through committed government leadership, effective policies, and strong civil society engagement, HIV is still directly affecting more than 60,000 households across the country.[1] Based on the national average household size of 4.7, this amounts to at least 280,000 individuals, or more than 2% of Cambodia's total population, who may belong to marginalized sections of society.[2]

Impact mitigation has emerged as a key component of national HIV response strategies across the region, as well as in Cambodia. In recent years, a major approach to impact mitigation, in the region and elsewhere in the world, has been the promotion of HIV-sensitive social protection. It is now generally considered best practice to include HIV-sensitive criteria in national social protection strategies, ensuring that the particular vulnerabilities of HIV-affected households are recognized and catered to, by integrating the needs of people who live with HIV and their households. This was recognized by participants in the high-level regional consultation organized by UNDP, UNICEF and the International Labour Organization (ILO), in partnership with the Royal Government of Cambodia (RGC), UNAIDS, and the Asia Pacific Network of People Living with HIV (APN+) in Siem Reap in April 2011.

As a direct follow up to the Socioeconomic Impact Study and the regional consultation, UNDP Cambodia and the National AIDS Authority (NAA) facilitated the engagement of a consultant to carry out a review of Cambodia's social protection schemes, with a view to incorporate HIV sensitivity in them. The review had a specific objective: to identify potential entry points to make schemes sensitive to the challenges and needs of people living with HIV and HIV-affected households, with particular consideration given to key affected populations. This exercise built on the mapping of existing social protection schemes already conducted by the Council for Agricultural and Rural Development (CARD), the national custodian agency of social protection, which had already expressed a strong commitment to addressing social protection in the context of HIV.

The findings of the review are intended to generate dialogue and guide discussions among relevant government agencies, UN, and key civil society stakeholders in a collective effort to integrate HIV into social protection efforts in Cambodia. There are a number of key mechanisms, including Technical Working Groups (TWG) and Task Forces whose members will be well-placed to continue the dialogue on HIV-sensitive social protection, and mobilize the Next Steps set out in the recommendations. The Interim TWG on Social Protection, the National Working Group on Impact Mitigation Interventions,

1 UN (2011). The socioeconomic impact of HIV at the household level in Cambodia. Phnom Penh.

2 National Institute of Statistics (2009). General Population Census of Cambodia 2008. Phnom Penh..

and the National Orphans and Vulnerable Children Task Force are three of a number of collaborative groups with relevant expertise to move the HIV-sensitive social protection agenda forward. Progress towards increasing the sensitivity of social protection schemes needs to take place with the participation of expert inputs from networks of people living with HIV and networks of key affected populations (e.g. ART Users Association, Bondanh Chaktomuk, Cambodian Community of Women Living with HIV/AIDS, Cambodian People Living with HIV/AIDS Network, KORSANG and Women's Network for Unity) and human rights experts such as the Cambodian Center for Human Rights. Between them, these organizations can provide much-needed perspectives and experiences on the complex and diverse needs of people living HIV, households affected by HIV, key affected populations and marginalized people. An important part of the dialogue between HIV and social protection experts also needs to include learning and understanding each other's area of expertise. In order to mainstream HIV into social protection, HIV experts will need to become versed in social protection issues, and vice versa.

This review comes at a key phase in Cambodia's social protection response. The National Social Protection Strategy for the Poor and Vulnerable (NSPS), finalized in 2011, defines people living with HIV as part of the special vulnerable groups. Cambodia is in Phase 1 of its response to the NSPS (2011-2015) (RCG, 2012). This period has been designated as critical to pilot numerous initiatives and closely measure their impacts and effectiveness, with a view to expanding the most successful ones in Phase 2, from 2015. A Monitoring Framework for the NSPS was launched in December 2012 to track the progress on the following NSPS objectives:

a) The poor and vulnerable receive support including food, sanitation, water and shelter etc., to meet their basic needs in times of emergency and crisis.

b) Poor and vulnerable children and mothers benefit from social safety nets to reduce poverty and food insecurity, which enhance the development of human capital by improving nutrition, maternal and child health, promoting education, and eliminating child labour, especially its worst forms.

c) The working-age poor and vulnerable benefit from work opportunities providing secure income, food and livelihoods, while contributing to the creation of sustainable physical and social infrastructure assets.

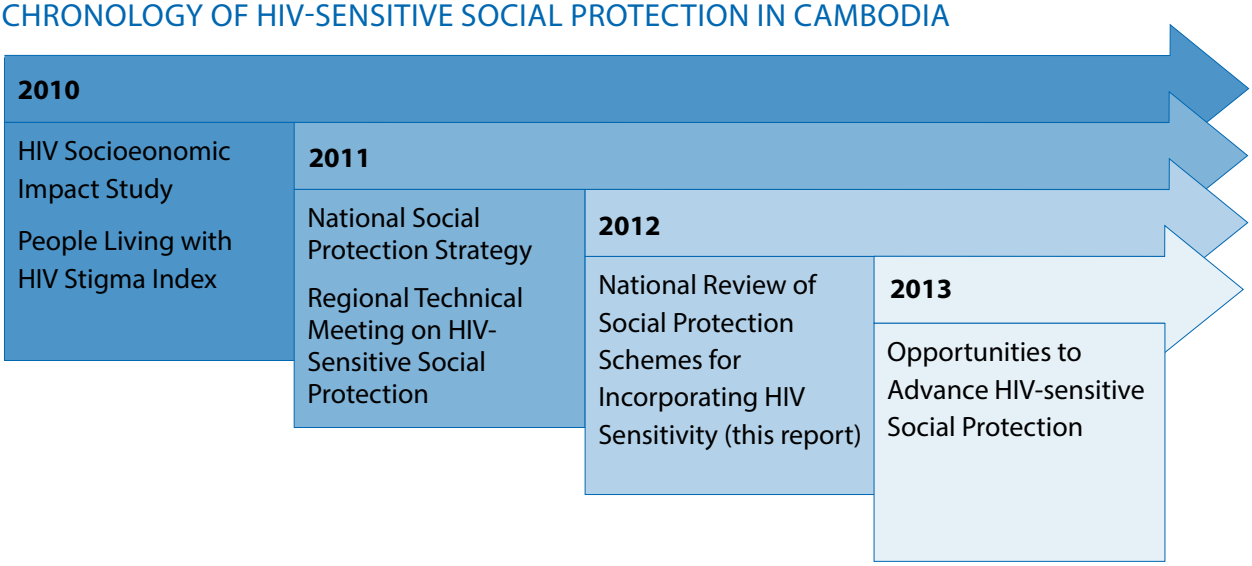
d) The poor and vulnerable have effective access to affordable quality health care and financial protection in case of illness.

e) Special vulnerable groups, including orphans, the elderly, single women with children, people living with disabilities, people living with HIV, patients of TB and other chronic illnesses etc., receive income, in-kind and psychosocial support, and adequate social care.

The assessment of the socioeconomic impact of HIV at the household level in Cambodia, led by UNDP and NAA, provided an important body of evidence from which impact mitigation strategies could be developed. HIV-sensitive social protection can mitigate the socioeconomic impact of HIV on people living with HIV and their households. Additional recent evidence includes the People Living with HIV Stigma Index (CPN+, 2012), which also provides data on access to services by people living with HIV.

This review contributes to the implementation of Cambodia's NSPS, by highlighting current and potential relevance to the specific vulnerable group, people living with and affected by HIV, as articulated in Objective 5 of the strategy. The review looks at the relevance of mechanisms to this group across all five of the strategy's objectives.

CHRONOLOGY OF HIV-SENSITIVE SOCIAL PROTECTION IN CAMBODIA



Impetus for HIV-sensitive social protection comes from the 2011 regional High Level Technical Consultation on HIV-Sensitive Social Protection for Impact Mitigation, hosted in Siem Reap, Cambodia. An important result of the consultation was unanimous agreement on five key principles that were distilled from the presentations and country group work, and which the consultation participants believed should be the basis for planning and implementing HIV-sensitive social protection in the Asia-Pacific region (UNDP, 2011). The participants decided that instead of recommendations, the key principles will have more practical value in terms of developing and implementing policies and programmes.

1.1. THE FIVE PRINCIPLES OF HIV-SENSITIVE SOCIAL PROTECTION ADOPTED AT THE SIEM REAP MEETING:

1.1.1. **Aim for HIV-sensitive social protection rather than HIV-specific social protection:** For reasons of sustainability, coverage, involvement of multiple sectors and opportunities for mainstreaming HIV into national and decentralized development plans.

1.1.2. **Involve multiple sectors and partners:** HIV-sensitive social protection requires the involvement of different ministries, the private sector, civil society and communities. Their involvement and partnership is required at every stage - from planning to implementation. This is also important for sustainability.

1.1.3. **Engage affected individuals, networks and communities, especially key populations:** Design of HIV-sensitive social protection programmes should be inclusive and participatory to ensure the interventions address the specific needs and concerns of the affected people.

1.1.4. **Protect and enhance human rights:** While implementing HIV-sensitive social protection schemes, special attention must be paid to ensuring the human rights of the participants are not violated, rather, they are enhanced. Issues of concern are mandatory testing, disclosure of beneficiary details, breach of confidentiality and involuntary confinement.

1.1.5. **Take into account sustainability:** As in the case of antiretroviral therapy (ART), HIV-sensitive social protection requires long-term political and financial commitment, hence sustainability should be an integral part of the planning process.

This review covers the five principles and is part of the effort to translate them into practical policy options and actions.

1.2. PURPOSE OF THE REVIEW

This report reviews government social protection schemes in Cambodia to identify potential areas where the unique needs and circumstances of people living with HIV, HIV-affected households and key populations affected by HIV, can be incorporated.

1.3. OBJECTIVES OF THE REVIEW

1.3.1. To identify potential entry points to integrate/strengthen HIV-sensitive provisions.

1.3.2. To identify legal, operational, social and financial barriers faced by people affected by HIV in accessing government social protection schemes.

1.3.3. To make recommendations on: (1) how best to promote HIV-sensitive social protection and (2) how tangible progress can be achieved in the coming years to guarantee that all the main social protection schemes and efforts adequately cater to the needs of people living with HIV, and their households.

1.3.4. To identify gaps and issues requiring further attention and research.

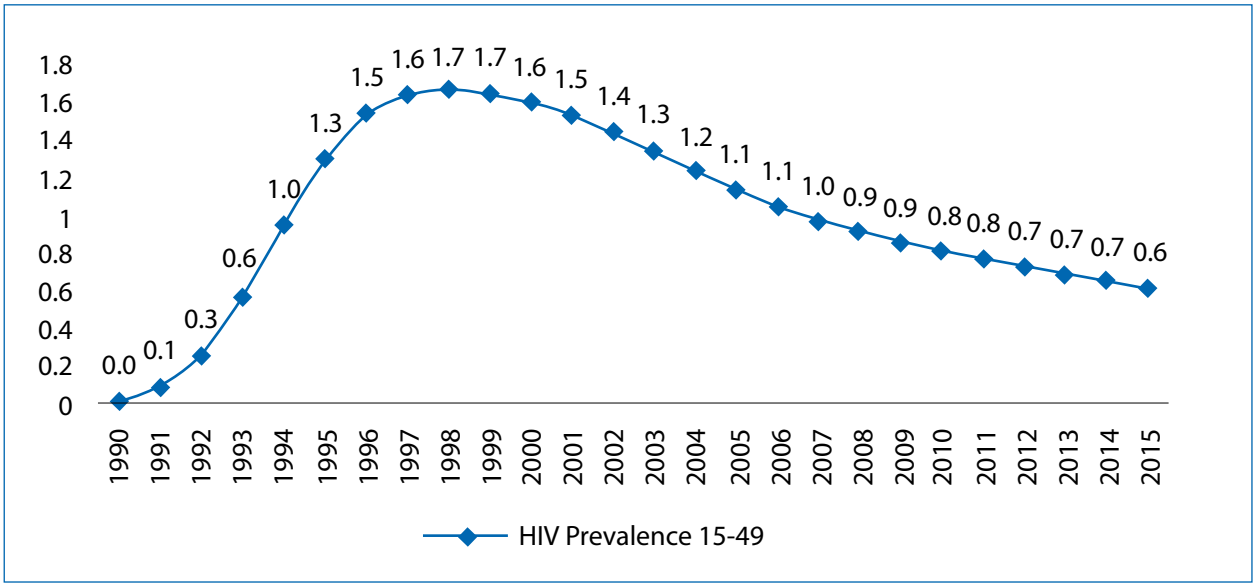
1.4. METHODOLOGY

The review was conducted during November and December 2012. A desk review surveyed information from existing sources concerning HIV, all of the main government social protection schemes in Cambodia, and literature containing examples of HIV-sensitive social protection schemes from other countries. Preliminary findings were shared by email to invite feedback from key stakeholders including NAA, CARD, Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), Ministry of Interior (MoI), Ministry of Health (MoH), Ministry of Economy and Finance (MEF), the Council for the Development of Cambodia, civil society organizations and development partners. Interviews were conducted with representatives of relevant government and non-government institutions to collect information on the main social protection schemes, information on practical experience with their implementation, and recommendations for the future. The findings were disseminated at a national consultative meeting on HIV-sensitive social protection, which provided a valuable opportunity for dialogue between key stakeholders. A full list of participating stakeholders is provided in Appendices 3 and 4; a full list of the literature reviewed is provided in Appendix 5.

2 HIV IN CAMBODIA

HIV prevalence in Cambodia is estimated to have decreased to 0.7 or 0.8% in 2012, from 1.1% in 2006 (NCHADS, 2012). There were an estimated 75,900 people living with HIV in Cambodia in 2010, and this is expected to decline to 70,400 in 2015 (NCHADS, 2012). With more than 80% of Cambodia's population – and more than 90% of the poor – living in rural areas (RCG, 2010), the majority of people living with HIV are also expected to be found in rural areas.[3] However, HIV prevalence is concentrated among key affected populations who usually live in or migrate to urban areas, such as entertainment workers (4.6%)[4], men who have sex with men (MSM) (2.1-2.2%)[5], and people who inject drugs (24.4%)[6] (NCHADS, 2012). This highlights the necessity of social protection mechanisms to reach both the general population and key populations, as well as people living with HIV in both rural and urban areas. ART coverage is high at more than 80%, with 48,362 active ART patients at the end of the third quarter in 2012 (NCHADS, 2012).

FIGURE 1 ESTIMATED PROJECTIONS OF HIV PREVALENCE 1990-2015 (NCHADS, 2012)



3 For projections of HIV prevalence among the general female population (2010-2015) calculations were based on the HIV sentinel survey (HSS) 2010, which was used to estimate the number of Cambodian women of child-bearing age (15-49) who were living with HIV infection in 2010. As the HSS 2010 data were collected from health centres in both rural and provincial towns, HIV prevalence among antenatal care clients in 2010, adjusted for urban/rural with a ratio of (20/80), was used (NCHADS, 2012). Earlier projections (e.g. 1995-2006) presented data disaggregated by urban and rural variables: HIV prevalence was estimated to decline to 1.1% in rural areas and 1.4% in urban areas. Despite a lower prevalence in rural areas, with 80% of the population living rurally, a higher number of people living with HIV would reside in rural areas, compared to among the 20% of the population living in urban areas (NCHADS, 2007).

4 HIV prevalence among female entertainment workers (n=432) who reported having more than 14 male clients per week was 13.9%, while the prevalence among those who reported having 14 clients or less per week (n=3,390) was only 4.1% (NCHADS, 2012).

5 MSM data references from the BROS Khmer study (Liu & Chhorvann, 2010).

6 National Center for HIV/AIDS, 2007, Report of HIV prevalence among drug users 2007.

2.1. SOCIOECONOMIC IMPACT OF HIV AT THE HOUSEHOLD LEVEL IN CAMBODIA

The 2010 socioeconomic impact study revealed serious impacts of HIV on health status, poverty, food security and access to health and education among households affected by HIV (Cercone & Pinder, 2010). In nearly all indicators, HIV-affected households (HIV-HHs) were worse off than non-affected households (NA-HHs). The disproportionate socioeconomic impacts of HIV at the household level provide a strong rationale for social protection mechanisms that are sensitive to the unique needs and circumstances of people living with and affected by HIV.

The study, commissioned by UNDP, was a cross-sectional household survey of 2,623 HIV-affected households and 1,349 control or "non-affected" households, encompassing a total of 17,695 individuals across 12 provinces in Cambodia. Additional statistics are provided by the Stigma Index Survey which interviewed 397 people living with HIV in five provinces, specifically to determine the levels and impacts of stigma and discrimination experienced by affected individuals (CPN+, 2012).

2.2. PROFILE OF HOUSEHOLDS AFFECTED BY HIV

- Women headed
- Unemployed women
- Widowed women
- Less educated
- Do not own home
- Fewer assets

The socioeconomic impact of HIV study in 2010 found noticeable differences between HIV-HH and NA-HH, rural and urban HIV-HH, and between female- and male-headed HIV-HHs (Cercone & Pinder, 2010). HIV-HHs were slightly smaller (4.4 members) than NA-HHs (4.6 members). Heads of households were more likely to be female (53% of HIV-HHs) compared to 35% of NA-HHs. Heads of HIV-HHs were more likely to be not currently married than those of NA-HHs. HIV-HH members were less likely to have achieved at least some secondary education or higher (31% vs. 37% of NA-HH members).

Overall, only 53% of HIV-HH owned their place of residence, compared with 80% of NA-HHs. HIV-HH owned significantly less of every item than NA-HHs (except for mobile phones, where the differences between households were not significant). There were substantial differences between the marital status of the men and women living with HIV, with women more likely to have been widowed (45% females; 8% males), and less likely to be currently married (42% females; 77% males). Men living with HIV had attained a higher level of education than women in the same location (overall, 42% of males had attained at least some secondary education, compared to only 19% of females). Women living with HIV faced higher levels of unemployment than men living with HIV (37% vs. 28%).

2.3. IMPACT OF HIV ON ECONOMIC FACTORS

- Lower income
- Lower paid work
- A reduction in income
- More children working
- More girls working
- Inability to work
- More debt
- Loans from moneylenders
- Loans with higher interest rates
- An unpaid household member providing care
- Female caregivers
- A caregiver who stopped or reduced their income
- Consume less (in rural areas)
- Consume less high-protein food
- Spend more (%) on rent and income
- Spend less (%) on health

HIV-HH reported lower annual per capita income (US $454) on average than NA-HH (US $548), with the primary earner of HIV-HHs more likely to have lower paid employment. While unemployment figures were similar between affected and unaffected households, more children (9.2% of 10-14 year olds) in HIV-HHs were working, especially girls, compared to NA-HHs (7.3%). Rural households turned to child-income earners more often than urban households. There was a significant difference between girls and boys in the workforce, with 10% of girls in HIV-HHs being employed (as opposed to only 5.5% in NA-HHs) compared to the non-significant difference for boys of 9.2% (HIV-HHs) and 7.3% (NA-HHs).

HIV affects the ability of people living with HIV to contribute to household activities and to the workforce. Women living with HIV were more likely to be widowed or unemployed than men living with HIV. Both women and men reported significant drops in income after the diagnosis of HIV; men reported a 54% drop in income, while women reported a 47% drop. In general, 14% of HIV-HH members reported being too sick to perform their regular activities in the previous four weeks, compared to 8% of NA-HHs. Workers in HIV-HHs were more likely to miss a day of work, with 57% of employed household members reporting having missed a day of work in the previous three months, compared to less than 49% of NA-HHs members.

Overall, 34% of people living with HIV who needed care were not receiving it, with the percentage rising to 38% in rural areas. Among those who did receive care, the vast majority (90%) of caregivers were unpaid household members (10% were unpaid individuals coming in from outside the household, while only three households (<0.01%) paid an external individual to provide care). Most caregivers were female (54%).

Significant numbers of caregivers in HIV-HH reported either leaving their regular job or experiencing a reduction in income since taking on care-giving duties. HIV-HHs were more likely to receive government or NGO financial support and less likely to receive revenue from agricultural activities. Overall per capita consumption was similar between affected and non-affected households, but rural HIV-HHs had significantly lower consumption than rural NA-HHs.

Overall, HIV-HHs consumed slightly less than NA-HHs. Spending on food (approximately 59%) and education (approximately 4%) as a proportion of consumption was similar between the different households. HIV-HHs used a higher proportion of consumption on rent and bills (13%) compared to NA-HHs (10%). The only area of consumption where HIV-HHs spent less than NA-HHs was health (8% and

9% respectively) for reasons of greater exemptions for people living with HIV.

Overall, HIV-affected households were found to allocate less of their total food consumption to high protein items such as fish, meat, poultry and eggs. This is particularly true for rural households, where the non-affected households allocated over 13% more to consumption of protein-based foods than HIV-HHs.

Accumulating debt was more common among HIV-HHs (65%) than NA-HHs (53%). The primary reason debt was incurred was the same for both households: "household consumption needs". As expected, illness or health needs were given as a major reason by HIV-HHs (21%), and more frequently cited than by NA-HHs (15%). Although NGOs were a primary source of loans for both households, HIV-HHs relied on moneylenders more frequently (26% of loans) than NA-HHs (21% of loans). HIV-HHs were more likely to report paying higher interest rates (5.4% interest rate on average) compared to NA-HHs (4.3% interest rate on average).

The univariate analysis showed a household with at least one person living with HIV was 1.7 times more likely to be below the poverty line than a non-affected household. Overall, the probability of a HIV-HH being below the poverty line was 28%.

2.4. IMPACT OF HIV ON EDUCATION

- Lower attendance rates among girls and older children
- More likely to have missed 10 days or more
- Rural girls most affected

Girls and older children living in HIV-HH reported lower attendance rates than those in NA-HH. Extreme differences were seen between households with older girls (15-17 years of age) in secondary school, particularly in upper secondary school. The net attendance rate for these girls in NA-HHs was almost twice that of those in HIV-HHs (16% compared to 9%). Overall, HIV-HHs were more likely than NA-HHs to state that children were not enrolled for financial reasons (21% vs. 15%), or because the child must contribute to the household income (22% vs. 18%). Whether affected by HIV or not, across all households, girls were more likely than boys to not be attending school for financial reasons, or because they needed to help with chores (23% boys in HIV-HHs vs. 33% girls in HIV-HHs).

Children in HIV-HHs were significantly more likely to have missed more than 10 days of school in the past year than those in NA-HHs (15% vs. 8%). This was especially so for girls, young children and those in rural areas. Girls in HIV-HHs were impacted most, with a 50% increase in the percentage of HIV-HH girls (14%) having been absent 10 days or more than girls in NA-HHs (9%).

Orphans and vulnerable children have equal attendance rates to non-vulnerable children; however orphans and vulnerable children who are girls in rural areas have lower attendance rates (93%) than non-vulnerable rural girls (97%).

The univariate results show that the HIV status of the household is a significant risk factor for a child missing more than 10 school days in the last year. A child living in a HIV-HH was three times more likely to have lost more than ten days than a child from a NA-HH (41.8% vs. 18.8%).

Households that spent more on education per capita also had a higher probability of their children staying in school, most likely showing that spending on education is a proxy for household commitment. Government scholarships were also a significant explanatory factor, and increased the probability of staying in school by nearly 1.5 times.

2.5. IMPACT OF HIV ON HEALTH

- Worse health status
- Poorer households with worse health than wealthier households
- More likely to seek care in the public sector
- More satisfied with access to health services
- Lower charges for health-care services
- More health-care charges exempted
- Prior to diagnosis, sold land and other assets, reduced savings, increased debt
- ART use is high
- Treatment for opportunistic infections is lower in rural areas.

Members of HIV-HHs were reported to be in worse health than those in NA-HHs. Members of poorer households (both HIV-affected and non-affected) were reported to be in worse health than those in wealthier households. People living with HIV used significantly more ambulatory and inpatient health services and were significantly more likely to seek care in the public sector, than members of NA-HHs.

People living with HIV were significantly more satisfied with their access to health services than survey respondents in NA-HHs. Charges for health-care services reported by members of HIV-HHs were significantly lower than those reported by members of NA-HHs, and people living with HIV were more likely to have health-care charges exempted than members of non-affected households.

Prior to diagnosis, people living with HIV reported selling land and other assets, cutting into savings and taking on debt, in order to cover costs associated with prolonged illness.

Men living with HIV in rural areas were less likely to have been diagnosed with HIV through voluntary confidential counselling and testing (VCCT) than women, or than men living in urban areas. Overall, there was no difference between people living with HIV who identified themselves as members of key affected populations, and those who did not, with regard to being diagnosed through VCCT. ART use is high among all people living with HIV. However, use of medications to prevent or treat opportunistic infections is lower for people living with HIV in rural areas.

There was no difference between the proportion of HIV-HHs and NA-HHs who had incurred catastrophic health expenditures.

2.6. IMPACT OF HIV ON FOOD SECURITY

- More hungry
- Eat less food
- More food support
- Variations in food support
- Less food support for non-Khmer

Only small differences exist in the reported number of daily meals between the members of HIV-HHs and NA-HHs. However, members of HIV-HHs were significantly more likely to have been hungry and not eaten due to lack of food, than members of NA-HHs.

HIV-HHs received food support at significantly higher levels than NA-HHs, and a greater percentage of poor HIV-HHs received food support than wealthier households. Large provincial variations were reported in the percentage of HIV-HHs receiving food support. HIV-HHs, where the head of household identified themselves as Khmer, were more likely to have received food support than those with non-Khmer heads of household.

2.7. IMPACT OF HIV ON STIGMA, DISCRIMINATION AND QUALITY OF LIFE

- High internal stigma
- Vulnerable to verbal abuse and threats
- Low discrimination from health-care workers
- Overall lower quality of life

Internal stigma was high, with 16% of people living with HIV reporting suicidal thoughts and 65% reporting low self-esteem. Some 23% of women living with HIV reported having been verbally attacked, and 7% had been physically threatened or attacked, because of their status. People living with HIV reported very low levels of discrimination from health-care workers (less than 1%). In the 2010 Stigma Index Survey, the proportion of people living with HIV who reported discriminatory attitudes from health-care workers on disclosing their HIV status was slightly higher, at 2.9% (CPN+, 2012). Nevertheless, health-care workers were the least likely to discriminate against people living with HIV who participated in the Stigma Index Survey, compared to negative experiences from: adult family members (6.4%), spouses (6.8%), teachers (7.1%), co-workers (10.5%), friends (13.2%) and neighbours (23.2%). Overall, people living with HIV were more likely to report their quality of life as poor or very poor, than respondents in NA-HHs.

2.8. IMPACT OF HIV: SPECIAL CONSIDERATIONS

Further Impacts of HIV

- One-third of households caring for orphans
- Widows had lower per capita incomes
- Children of widows repeated a grade at school
- Widows were less likely to inherit husband's assets
- Low levels of breastfeeding
- Higher recent migration
- More likely to have a member of key affected populations in the household

Over one-third of HIV-HH reported caring for a child orphaned by AIDS. It was estimated there are over 85,000 children made vulnerable by HIV in Cambodia. Widow-headed HIV-HHs had lower per capita incomes, and children within these households were more likely to have repeated a grade at school. Widows in HIV-HHs were less likely to have inherited their late husband's assets than those in NA-HHs.

The percentage of HIV-HHs who had received a home-based care visit in the previous three months differed by provincial location and ethnicity. Very low levels of HIV-positive pregnant women reported breastfeeding their babies.

Significantly more HIV-HHs migrated within the previous five years than NA-HHs.

HIV-HH were significantly more likely to contain members who identified as belonging to a key affected population.

3 HIV-SENSITIVE SOCIAL PROTECTION

Social protection is increasingly recognized as an investment in a country's social, physical, financial and human capital, and an essential component in national economic strengthening. The NSPS defines social protection as:

> ***"Social protection helps people cope with major sources of poverty and vulnerability, while at the same time promoting human development. It consists of a broad set of arrangements and instruments designed to: 1) protect individuals, households and communities against the financial, economic and social consequences of various risks, shocks and impoverishing situations, and 2) bring them out of poverty. Social protection interventions include, at a minimum, social insurance, labour market policies, social safety nets and social welfare services."***

More recently, social protection has been identified as one of the key development synergies, which contribute towards achieving maximum effectiveness of investments as part of a strategic response to HIV and AIDS through the creation of an enabling environment (Schwartländer et al., 2011). This reflects a shift from a service response approach to HIV, to focusing on investment (Miller & Samson, 2012).

Social protection can contribute to HIV prevention, treatment, care and support:

> ***"… [P]olicies or programmes should address people living with HIV and households affected by HIV, for example by ensuring that they have access to services, that policies are inclusive and non-stigmatising, and that the form of social protection helps reduce an individual's chance of becoming infected with HIV (susceptibility) and the likelihood that HIV will have damaging effects on individuals, households and communities (vulnerability)." (Samuels, Blake & Akinrimisi, 2012).***

The evidence base for the positive impact of social protection on HIV prevention, care and treatment is growing. Cash transfers have been shown to contribute to lower HIV prevalence in women, but not in all circumstances. An evaluation of a randomized control trial in Zomba, Malawi, found that recipients of an unconditional monthly cash transfer had lower HIV prevalence than women in the control group, who received no cash transfer, with evidence further supported by changes in self-reported sexual behaviour (Miller & Samson, 2012). A study in rural Tanzania found a significant reduction in sexually transmitted infection prevalence for the treatment group that was eligible for US $20 payments, but no such reduction was found for the group receiving a lesser US $10 payment (Miller & Samson, 2012). El Salvador's Comunidades

Solidarias Rurales cash transfer programme and India's Janani Suraksha Yojana scheme are examples of initiatives that provide incentives for women to deliver their babies in a government or accredited private health facility, and that reduce social and financial barriers of access. This therefore increases the uptake of critical prevention health services, such as prevention of mother-to-child transmission (PMTCT), which in turn contributes to HIV prevention (Miller & Samson, 2012). Links between both conditional and unconditional cash transfer programmes, school attendance, and risk factors in Pakistan, Bangladesh, Mexico and South Africa suggest possible impacts in terms of reduced vulnerability to HIV (Miller & Samson, 2012).

Social transfers and food transfers can play an important role in the nutritional recovery of patients receiving HIV treatment, as well as improving testing and treatment uptake. In a Malawi study, a randomly assigned small monetary incentive (one-tenth of a day's wage) led to a 50% increase in people returning to collect their HIV results, while cash transfers to cover clinic transportation costs in rural Uganda (US $5-8 per month) led to better treatment adherence (Miller & Samson, 2012). Cambodia's own experience of providing cash and other in-kind support to people living with HIV to access ART has helped contribute to its 92% ART coverage.

Households receiving cash transfers are more likely to seek health care for sick children, are more food secure, and are more likely to invest in strategies that strengthen their livelihoods and household economies, which all help households absorb the impacts of AIDS. An important concern is ensuring that people affected by HIV are not discriminated against or excluded from social health protection schemes, such as being excluded from health insurance (Miller & Samson, 2012).

Public works programmes must be carefully designed to be sensitive to the challenges that may accompany HIV, such as medical expenses and the heavy care burden that women may already be bearing. In some cases, programmes must be responsive to labour deficits at the household level (Miller & Samson, 2012).

Social protection with relevance to people and households affected by HIV can be either HIV focused or HIV mainstreamed.

3.1. HIV-SPECIFIC SOCIAL PROTECTION

HIV-specific social protection mechanisms have already been mentioned. These are any scheme or programme that specifically or exclusively focuses on people living with and/or affected by HIV; for example, free provision of HIV treatment; the small financial incentive provided by the health clinic which encourages people to return for their HIV test result; and the cash transfers for people on ART to facilitate adherence.

In general, the HIV-sensitive approach is preferred over the HIV-specific (HIV-exclusive) approach, from

HIV focused	HIV mainstreamed
HIV-specific social protection: specifically targeting people living with and/or affected by HIV	**HIV-relevant social protection:** designed for the general public, but relevant to people living with and/or affected by HIV as well as key populations **HIV-sensitive social protection:** designed for the general public, but with specific provisions for people living with and/or affected by HIV, as well as key populations at risk of HIV infection

financial sustainability and equity perspectives, as stated in the Five Principles of HIV-Sensitive Social Protection mentioned previously. At the same time, while social protection schemes should target poor and vulnerable people in general, in some circumstances the specific needs of people living with HIV can be addressed. Factors include stigma and discrimination against people living with HIV; confidentiality of HIV status to avoid social sanctions; the stage of the illness; whether people are on ART; and the support structure and/or household in which they find themselves (Samuels, Blake & Akinrimisi, 2012).

3.2. HIV-RELEVANT SOCIAL PROTECTION

HIV-relevant social protection refers to any scheme or mechanism which is designed for the general public, but also happens to have benefits for (some) people living with HIV. An example of HIV-relevant social protection is Lesotho's social pension (Old Age Pension) which was introduced in 2004 when the Lesotho Demographic and Health Survey estimated that the adult prevalence of HIV was 24%. With this high prevalence, one in five children was estimated to have been orphaned as a result of their parents dying of an AIDS-related illness. The death of the middle generation created a high number of intergenerational households consisting of grandparents caring for children. The social pension brought financial relief to people over 60, many of whom were carers. It currently covers 80,000 people or 55% of the over-60 population. The pension is not exclusively for caregivers or exclusively for people affected by HIV. However, by targeting all people aged 60 and over, the pension automatically includes large numbers of older caregivers who look after children affected by HIV. Therefore, it is a universal social protection mechanism which has high relevance to a significant cohort of the population affected by HIV; both the older caregivers and the orphans and vulnerable children in their care. There is an advantage to having eligibility criteria that do not focus exclusively on HIV-affected households, as this may be less stigmatizing than tying the transfer to the HIV status of household members (Schüring, 2011).

3.3. HIV-SENSITIVE SOCIAL PROTECTION

HIV-sensitive social protection refers to general social protection schemes modified with specific provisions to address the unique needs and circumstances of people living with, affected by, or vulnerable to HIV. This can be achieved, for example, by changing the eligibility criteria, introducing mechanisms to protect confidentiality, adding HIV-related benefits, or removing HIV-excluding clauses. There are a number of examples of cash transfers and subsidies in India in which criteria for eligibility was relaxed for people living with HIV (Nadkarni, Goel & Pongurlekar, 2011). In other cases, a different type of eligibility change may open up the scheme to people living with HIV (as well as other people in similar situations). For example, the widow pension in Rajasthan was initially available only to women over the age of 40; many women living with HIV who were widowed before the age of the 40 found they were ineligible. Special provisions were introduced to expand coverage of the widow pension to women living with HIV, who had been widowed at any age.

Similarly, bus concessions in Rajasthan, originally aimed at people with a disability or with cancer, were expanded to include people living with HIV. In another Indian state, the minimum age of eligibility for widow pensions was simply reduced to 18 for all female widows. This allowed women living with HIV, and other women of any age who had been widowed, to access the pension. Another example is Thailand's universal health coverage scheme, considered one of the best models today. It initially

excluded HIV treatment, but later became highly HIV sensitive, with a comprehensive coverage of HIV-related services even beyond treatment, such as methadone maintenance therapy for injecting drug users, who are highly vulnerable to HIV.

An example from Cambodia of adapting a mainstream response to become HIV sensitive is the relaxation of lending criteria in a microfinance institution for people living with HIV. After receiving a petition from a local community member, who explained that his asset liquidation was a direct result of living with HIV, Vision Fund Cambodia adapted its financial services to meet the specific needs of people living with and affected by HIV. HIV-affected households are offered a special interest rate of 2%, compared with the standard rate of 3%, and people living with HIV are not required to provide collateral when applying for loans.

Finally, legal responses can also be HIV sensitive. For example, in 2007, the Supreme Court of Nepal ordered the government to amend all discriminatory laws against sexual minorities and to include the third gender category in relevant government documents[7]. For the first time in its history, the third gender category was included in the national census conducted in 2011.[8]

Similarly, the Supreme Court of Pakistan ordered the government to provide legal recognition of third gender.[9] In both Nepal and Pakistan, the third gender now has its own distinct category in the national identity card, which is necessary for availing entitlements to public services such as health care, legal counseling and voting.[10] Criminalization of same-sex relationships was declared unconstitutional by the High Court of Delhi in India in 2009,[11] and Fiji[12] passed the National Crimes Decree in 2010 that decriminalized sex between men.

While the enforcement of laws is often an issue, these legal advancements can bring recognition, protection and new opportunities to marginalized communities highly vulnerable to HIV. These in turn could trigger social transformation for a more equitable society and lower rates of HIV prevalence. Therefore, these can be termed as transformative HIV-sensitive social protection.

7. UNDP (2011) Efforts to boost 'Third Gender' rights in Nepal.
8. UNDP (2011) Nepal census recognizes third gender for the first time.
9. BBC (2009) Pakistani eunuchs to have distinct gender.
10. Misra, R. (2009) Pakistan Recognises Third Gender and UNDP (2011) Nepal census recognizes third gender for the first time.
11. Das, A. (2009) Gay and Transgender Rights in India: Naz Foundation v. Government of NCT of Delhi.
12. UNAIDS and APCOP (2010) FIJI – MSM Country Snap Shot.

4 INCREASING HIV SENSITIVITY OF SOCIAL PROTECTION

There are two key strategies to increase the HIV sensitivity of social protection mechanisms. The first is to expand entitlements to include people living with HIV and key affected populations, the second is to reduce the barriers to accessing existing benefits for HIV-affected individuals and household members.

4.1. EXPAND BENEFIT ENTITLEMENTS TO PEOPLE LIVING WITH HIV AND KEY AFFECTED POPULATIONS

HIV-affected households may be income poor (rather than asset poor) or near poor, and therefore fall outside the eligibility for some social protection and targeting mechanisms. In particular, Health Equity Funds (HEF) and identification through the Identification of Poor Households Programme (IDPoor) are two major initiatives that have high relevance to households affected by HIV. Expanding eligibility to HEFs to include people living with HIV, or people on ART, would ensure the schemes were HIV sensitive. The addition of this cohort to access the scheme has financial implications, as any expansion of a response does. However, the additional costs may not be prohibitive. Currently, it is not known how many of the estimated 75,000 people living with HIV are also included in the lists of poor households of the IDPoor programme. It is unlikely to be possible to measure the number of people living with HIV who have been identified as IDPoor 1 or 2 through IDPoor data collection. However, a survey of HIV-positive people's inclusion in the lists of poor households of the IDPoor programme, through ART and HIV health facilities, may be feasible. With this data, the cost of inclusion into HEFs and other schemes aimed at the (very) poor, with high relevance to people living with HIV, can be calculated.

Community-based health insurance (CBHI) has the potential to include people living with HIV and working members of key affected populations in urban areas. Entertainment workers and MSM who are employed (including self-employed) may be able to afford health insurance premiums to cover their medical costs. CBHI has already successfully been implemented through health facilities in Cambodia, including urban areas such as Phnom Penh, for some time (Annear, 2007). Expanding existing CBHI in urban areas to key HIV-affected populations working in the informal sector could have significant benefits for entertainment workers, transgender people and MSM. Reaching key affected populations with CBHI may be most effective and appropriate through existing services for key affected populations, and networks such as the Women's Network for Unity (WNU) and Bandanh Chaktomuk (BC).

The example of adapting microfinance for people living with HIV by relaxing lending criteria and providing lower interest rates has been described above. There is also potential for urban microfinance institutions to partner with both networks of people living with HIV, and networks of key affected

populations, to negotiate concessions for members to access loans.

The IDPoor process is highly relevant to poor people living with HIV who qualify for inclusion. The NSPS notes that IDPoor will be the primary targeting methodology for household poverty and geographic targeting across all social protection schemes, while still allowing for the use of complementary methodologies where justified and necessary. Therefore, future iterations of any social protection scheme, such as HEFs (and other schemes that use IDPoor as eligibility criteria) can consider categorical inclusion of special vulnerable groups as defined in the NSPS, which include people living with HIV. (Other special vulnerable groups in the NSPS are ethnic minorities, people living with disabilities or chronic illnesses, homeless people and the elderly, among others).

4.2. REDUCE BARRIERS TO ACCESSING SOCIAL PROTECTION

4.2.1. Reduce and eliminate stigma and discrimination

People living with HIV, their families and key affected populations continue to face stigma and discrimination because of their HIV status and/or because of prejudice against people who may be perceived as deviating from certain social norms. Both discrimination and fear of discrimination act as strong deterrents for people living with HIV and members of key affected populations to access employment and services. Very low levels of stigma and discrimination among health-care workers were reported by people living with HIV, in both the socioeconomic impact study and the Stigma Index Survey, indicating that concerted sensitization within sectors can yield effective results. However, key affected populations, including lesbian, gay, bisexual and transgender (LGBT) people, continue to report discrimination within health-care settings (CCHR, 2012). Many people living with HIV, and particularly key affected populations, continue to experience stigma and discrimination among families, communities, employers, law enforcers and education services. Eliminating stigma and discrimination in all aspects of society will substantially reduce the vulnerability of people living with HIV and key affected populations who are currently deterred from accessing services and employment opportunities, or harassed into excluding themselves.

4.2.2. Eliminate HIV exclusions in health insurance

Networks of people living with HIV report that some of their members continue to lack health insurance because of HIV-exclusion clauses, presumably because insurers deem people living with HIV as being more likely to make claims. Regardless of whether households affected by HIV do make more, or higher-value, claims against policies, health insurance should not systematically discriminate against them. In addition to adhering to the principle of non-discrimination, health insurance schemes should note that the health-care costs of households affected by HIV are less than those not affected, because of the number of HIV-related costs already covered by other schemes (e.g. free ART, free primary health care for people living with HIV). The socioeconomic impact study found that HIV-affected households spend less per hospital visit than non-HIV-affected households, as many of the costs are already covered by government and donor schemes. Recently in India, the Delhi High Court ordered the government to address the issue of non-coverage of people living with HIV in health and non-health insurance.[13]

13. http://www.hindustantimes.com/India-news/NewDelhi/HIV-AIDS-patients-will-soon-have-health-cover/Article1-1019775.aspx

4.2.3. Complement existing identification systems with self-elective assessments

Likelihood of eligibility for IDPoor classification and HEFs is lower for mobile populations, particularly migrants and homeless people, as they are less likely to be living in households included in the assessment process. Network of people living with HIV highlighted the fact that many of their members, including people who inject drugs, LGBT people, MSM and sex workers, have experienced rejection from their family homes and from their former communities (CCHR, 2012). Their isolation from family and/or the lack of permanent residence for those made homeless makes it more difficult for them to be included in pre- and/or post-identification mechanisms. Household-based assessments are a barrier to HIV-relevant services for both single and mobile people, and could be complemented with self-election for assessment, based on relevant criteria at meeting points for key affected populations. Members of positive networks would be able to apply for schemes via their network offices, and targeted health, and other, service facilities.

4.2.4. Link vocational training, market access and microfinance

The current vocational training options provided at institutions are relatively technically specialized, with minimum education and fee requirements that many people living with HIV and key affected populations cannot meet. In the case of people living with HIV who do have the requisite minimum education, fees could be discounted or scholarships provided to give them access to the training.

Positive networks have found that their members receiving alternative vocational training face barriers in utilizing their skills; they lack business acumen and experience to enter markets, and lack the capital required to start their own business. Combining training in vocational skills, accessing markets and linking initiatives with microfinance loan facilities would reduce barriers to people affected by HIV using their acquired skills to generate income.

5 RECOMMENDATIONS FOR INCREASING HIV SENSITIVITY OF EXISTING SOCIAL PROTECTION SCHEMES

The major social protection schemes in Cambodia are summarized in the following table under the five NSPS objectives. Also listed are possible modifications to make them HIV sensitive and/or sensitive to other vulnerable groups.

5.1. TABLE OF MAJOR SCHEMES BY NSPS OBJECTIVES

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
1: Cover basic needs during crisis and emergencies					
Adults/families affected by emergencies in 200 communes in 50 districts in 7 provinces [14]	Scholarships in cash for Grades 5-6 & 8-9 Free distribution of rice Social cash cards Food-for-work Cash-for-work	Emergency Food Assistance Project	Ministry of Economy and Finance		Public Works Programmes: • Public Works Programmes: • Sensitize Emergency Food Assistance Project officials to the issues of people living with/ affected by HIV • Provide light ("soft") work for people living with HIV, chronic illness and/or disability • In case people living with HIV have no access to "soft" work, they should have access to daily unemployment allowance • "Soft" work should be defined in consultation with National AIDS Authority and networks of people living with HIV • Women living with HIV should be given preferential allocation for work to ensure steady income • People on ART should be given short breaks periodically during the day, if needed, as well as a paid leave entitlement for regular health monitoring and replenishment of medicines • Flexible labour options for members of households affected by HIV, chronic illness and/ or disability

14. http://www.efap.org.kh/page2.php?key1=aboutus

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
1: Cover basic needs during crisis and emergencies					
Adults/families affected by emergencies	Package of emergency food relief	Package of emergency relief to vulnerable people and victims of emergency	Ministry of Social Affairs, Veterans and Youth Rehabilitation		Prioritization of families and individuals affected by HIV Additional nutritional support to households which include people living with HIV
Adults/families affected by emergencies	Emergency assistance - cash and in-kind assistance to communes to support achievement of CMDGs	Commune transfers for emergency assistance	Ministry of Interior		Prioritization of families and individuals affected by HIV Additional nutritional support to households which include people living with HIV Sensitization of commune councils to issues of people affected by HIV and AIDS
2: Reduce poverty and vulnerability of poor mothers and children					
Children in primary schools in 12 provinces	School meals for all children Grades 1-6 Food scholarships (10kg rice) for IDPoor 1, Grades 4-6 Cash scholarships	School Meals Programme	World Food Programme & Ministry of Education		Include children affected by HIV and AIDS as an eligible category Additional nutritional support (iron and protein rich) to children living with HIV
Poor and vulnerable	Cash support to communes for facilitating access of households to sanitation	Community Led Total Sanitation (CLTS)	Ministry of Rural Development		Include households affected by HIV as an eligible category Sensitize commune councils to issues of people affected by HIV and AIDS

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
2: Reduce poverty and vulnerability of poor mothers and children					
Mothers and children	Improving maternal health and newborn care, promotion of key health and nutrition practices	Child Survival	Ministry of Health	• Departmental links and collaboration to promote early ANC registration of pregnant women living with HIV has been implemented through national PMTCT programme. According to Ministry of Health guidelines, all pregnant women who attend ANC will be counselled for HIV testing on a voluntary basis • Health-care workers have been sensitized to the issues of pregnant women living with HIV, and given training on caring for infected pregnant women and lactating mothers	• Focused efforts at increasing awareness among women living with HIV about benefits of Child Survival Programme and how to access the scheme • Involvement of women living with HIV in design and implementation of the scheme

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
2: Reduce poverty and vulnerability of poor mothers and children					
Households with pregnant and lactating women, as well as children less than 2 years old	Monthly food package	Maternal and Child Health and Nutrition Programme	Ministry of Health & World Food Programme		Additional nutritional support (iron and protein rich) to girls and children living with HIV Focused efforts at increasing awareness among women living with HIV and women who are in key affected populations about benefits of MCHN programme and how to access the scheme.
Women with IDPoor classification	Vouchers	Health Vouchers for Reproductive Health Services	Ministry of Health		Include women living with HIV and women of key affected populations as eligible categories Focused efforts at increasing awareness among women living with HIV and women of key affected populations about benefits of Health Vouchers scheme and how to access it
Families of children at high risk of non-attendance	Scholarships in cash (for Grades 4-12)	Education Sector Support Programme: Fast-Track Initiative (Grades 4-6), Cambodia Education Sector Support Project (Grades 7-9), Japan Fund for Poverty Reduction (Grades 7-9), Basic Education and Teacher Training (Grades 7-9), Enhancing Education Quality Project (Grades 10-12), Dormitory (Grades 10-11), various projects (Grades 7-9)	Ministry of Education, Youth and Sport		Include children from households affected by HIV or whose parents are key affected populations in eligibility criteria Children infected or affected by HIV, or whose parents are key affected populations, to be included in the special groups that are supported with school fees, books, uniform, etc. Sensitize school authorities and communities around schools on issues of children affected by HIV. Efforts should be made through the scheme to fight stigma and discrimination against children infected or affected by HIV

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
3: Reduce seasonal unemployment and provide livelihood opportunities					
Self employed	Small-scale credit	National Poverty Reduction Fund	Ministry of Labour and Vocational Training		• Provide focused training and skill building support for initiating income generation activities for people living with HIV, chronic illness or disability, with special consideration for affected physical and health conditions, e.g. by targeting people living with HIV through ART clinics. Ensure locations and timings are accessible, by facilitating short training sessions near the ART clinic on the same day as people collect their ART, so they can easily attend the training • Sensitize Ministry of Labour and Vocational Training and microfinance institution officials to the issues and needs of households affected by HIV • Waive minimum duration for accessing of scheme • Relax collateral requirement for households affected by HIV, especially women-headed households • Offer a discounted interest rate for households affected by HIV and other vulnerabilities

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
3: Reduce seasonal unemployment and provide livelihood opportunities					
Unemployed poor	Public job-finding service	National Employment Agency	Ministry of Labour and Vocational Training		Create links between networks of people living with HIV/key affected populations and job service centres so that networks and organizations can refer members to job services, and job centres can alert networks and organizations to potential employment opportunities Sensitize public job-finding service staff to eliminate stigma and discrimination of people living with or affected by HIV and key affected populations, so that staff can promote non-discrimination among employers Sensitize job service staff to the specific needs and issues affecting people living with HIV and key affected populations so they can better identify potential relevant employment opportunities (e.g. jobs with flexible or shorter working hours, jobs which require less manual or heavy work for people living with HIV or those with care-giving responsibilities).
Unemployed poor	Technical and vocational education and training (TVET) pilot	Technical and vocational education and training programme (TVET)	Ministry of Labour and Vocational Training		Sensitize Ministry of Labour and Vocational Training staff to eliminate stigma and discrimination of people living with or affected by HIV and key affected populations Create links between Ministry of Labour and Vocational Training, networks of people living with HIV and key affected populations to identify opportunities for members to participate in TVET Relax minimum educational attainment requirements for people living with HIV and key affected populations who demonstrate aptitude for specific technical and vocational specializations

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
3: Reduce seasonal unemployment and provide livelihood opportunities					
Families of children who work	Direct intervention and livelihood improvement	Project of Support to the National Plan of Action on the Elimination of the Worst Forms of Child Labour	Ministry of Labour and Vocational Training		Sensitize Ministry of Labour and Vocational Training staff on needs and issues of households affected by HIV (e.g. as per the socioeconomic impact study) to ensure that families affected by HIV whose children are in labour are prioritized to participate in direct interventions
Unemployed poor	Employment in building and maintaining roads, canals, ponds, dams and other productive assets in their communities	Food-for-assets programme and Productive Assets and Livelihoods Support (PALS)	World Food Programme, Ministry of Rural Development, National Committee for Sub-National Democratic Development		See comments on Public Works Programmes in Emergency Food Assistance Project above

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
4: Promote affordable health care for the poor and vulnerable					
Poor and "near poor"	Pre-defined health care benefit package, in exchange for a minimal premium	Community-based health insurance (CBHI)	13 CBHIs run by a variety of local and international NGOs. Under guidelines developed by Ministry of Health		Automatic inclusion of people living with HIV as beneficiaries, irrespective of IDPoor status Sensitize key providers about the need to maintain confidentiality and reduce stigma and discrimination Develop protocols to ensure that the confidentiality of people living with HIV is maintained Include people living with HIV as a special category to access the scheme
Poor patients identified by IDPoor and by post-identification at health facility in 50 Operational Districts	Reimburses health care fees, provides food during hospitalization, and reimburses transportation costs to the hospital if needed. If necessary, provides ambulance from home to hospital or from hospital to Phnom Penh hospital, free of charge. Funeral costs in case the patient dies. HEFs also cover delivery and abortion. Cancer is treated if the facilities are able to treat it	HEF	Ministry of Health and development partners		
Poor and vulnerable	User fee exemptions	Social health protection	Ministry of Health		

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
5: Improve social protection for specific poor and vulnerable groups					
HIV/AIDS infected and affected people, and orphans and vulnerable children (selected individuals in 10 provinces)	For children: cash and in-kind transfers, cash for transport to and from pagoda for psychosocial support provided by monks, cash for transport for children living with HIV to collect ART For adults: cash and in-kind transfers, cash for transport to collect ART, cash for transport to and from pagoda for psychosocial support provided by monks and self-help group meetings	Buddhist Leadership Initiative (BLI)	Ministry of Cult and Religion	Yes - exclusive scheme for people living with HIV	Expand to all 24 provinces Further include people with chronic illness and/ or disability
Elderly	Elderly persons' association support and services	Old People's Associations	Ministry of Social Affairs, Veterans and Youth Rehabilitation		For people living with HIV who would like to join Older People's Associations,[15] relax minimum age of 60, at which people are considered "elderly"
Homeless	Social networks in communes/ sangkats; reception and management of homeless people in state-managed shelters; temporary shelter, vocational training and reintegration of homeless people into communities	Care services for homeless	Ministry of Social Affairs, Veterans and Youth Rehabilitation		Staff and other residents of short-stay homes need to be sensitized about issues regarding confidentiality, care and support to ensure stigma-free environment Wider awareness about the scheme and the services that are offered is needed among people living with HIV and key affected populations Introduce treatment support for residents living with HIV for OI, and link to ART centre

15 The 2004 Survey of Elderly included "a representative survey of persons aged 60 and over" (Knodel, Kim, Zimmer & Puch, 2005)

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
5: Improve social protection for specific poor and vulnerable groups					
Orphans	Residential care and food	Orphanage funding	Ministry of Social Affairs, Veterans and Youth Rehabilitation, Departments of Social Affairs, Veterans and Youth Rehabilitation, NGOs		Sensitize staff regarding issues of confidentiality and eliminating stigma and discrimination, and ensure that they are able to provide a stigma-free environment through sensitizing all resident children Ensure that staff are trained in treatment literacy and counselling skills for issues specifically related to children living with HIV, such as managing disclosure of own status, health issues including nutrition, co-infections, opportunistic infections, and sexual relationships including safe sex Ensure additional nutritional support for children living with HIV Ensure treatment access for OI and ART for children living with HIV, and link to ART centre
Child victims of trafficking, sexual exploitation and abuse; children in conflict with the law; and drug-addicted children	Allowance, alternative care, residential care Services: Reception centre for victims of trafficking; provide education, health care and vocational training to female victims of human trafficking; provide repatriation support to victims of human trafficking; drop-in centre for victims of human trafficking	Child welfare, rescue and rehabilitation, and reintegration services	Ministry of Social Affairs, Veterans and Youth Rehabilitation		
Patients with malaria, HIV, TB or children (for vaccination)	Provision of free medicine, free vaccinations for children	Global Fund	Ministry of Health	Yes - people living with HIV are included to access the services as specified in the scheme	
People living with HIV, TB and other vulnerable children	25 kg/month rice ration for households (temporary income transfer)	Food Assistance Programme	Ministry of Health, Ministry of Social Affairs, Veterans and Youth, NGOs	Yes - people living with HIV are included to access the services as specified in the scheme	
People living with HIV/AIDS	Food assistance	Family benefits for agricultural / plantation workers	Ministry of Health, Ministry of Social Affairs, Veterans and Youth Rehabilitation	Yes - exclusive scheme for people living with HIV	

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
5: Improve social protection for specific poor and vulnerable groups					
People with disabilities	Physical rehabilitation centres/community-based rehabilitation services		Ministry of Social Affairs, Veterans and Youth Rehabilitation		Sensitize Ministry of Social Affairs, Veterans and Youth Rehabilitation to the specific vulnerabilities of people with disabilities (including children) to sexual violence to prevent sexual abuse and violence, and to meet the needs of people with disabilities who have been subjected to sexual violence. This includes the need to facilitate access to VCT and ART, as appropriate
Landless, homeless, affected by emergency, demobilized soldiers, families of deceased soldiers	Social land concessions	Housing for poor & vulnerable	Ministry of Social Affairs, Veterans and Youth Rehabilitation		Landless farmers living with/affected by HIV and women living with HIV, or who are widowed, to be prioritized for social land concessions
Formal sector (contributory schemes)					
Private sector employees of firms with more than eight employees (except domestic workers)	(i) Employment injury coverage:[16] Temporary cash for the period of temporary disability on the second day after the accident at a rate of 70% of the daily contributory average wage, for a maximum of 180 days. In serious cases, allowance for the care taker is 50% of the temporary cash amount. In case of permanent disablement,	NSSF: Health Insurance (planned)	Ministry of Labour and Vocational Training, Ministry of Social Affairs, Veterans and Youth Rehabilitation		Age relaxations for people living with HIV to access the schemes Include HIV infection as a life-threatening condition Sensitization of key providers about the need to maintain confidentiality and develop protocols to ensure that the confidentiality of people living with HIV is maintained Extend period of benefits for orphaned children affected by HIV and AIDS

16 http://www.nssf.gov.kh/

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
Formal sector (contributory schemes)					
	lifetime pension based on the loss of earning capacity. If the loss of earnings is less than 20%, the employee will be awarded a lump-sum payment instead of a pension. If the injury results in death, the dependants of the employee, including legal spouse, natural, adopted or step-children, and parents, will obtain survivors' benefit. The parents receive the benefit for lifetime, while the benefit is allocated to the spouse until death or remarriage, and to the children until the age of 18 (or 21 if they continue their tertiary education), or until marriage. Disabled children receive lifetime benefits as long as they remain mentally or physically disabled. A funeral allowance of 1,000,000 Riel is also provided; (ii) Health insurance; and (iii) Pension coverage.				

Target group	Entitlement	Name of scheme	Implementing agency	Modification	
				Done (Details)	Suggestions
Formal sector (contributory schemes)					
Civil servants	Sickness cash benefit; Work-injury benefits; Maternity benefits (90 days full salary); Retirement benefits; Invalidity benefits; Death benefits; Spouse allowance; Child allowance	NSSFc	Ministry of Economy and Finance, Ministry of Social Affairs, Veterans and Youth Rehabilitation		
Veterans	Sickness cash benefit; Work-injury benefit; Maternity benefit; Retirement benefit; Invalidity benefit; Death benefit; Marriage allowance	NSSFv	Ministry of Social Affairs, Veterans and Youth Rehabilitation		

5.2. SOCIAL PROTECTION SCHEMES/ MECHANISMS AND THEIR RELEVANCE TO PEOPLE AFFECTED BY HIV

In many cases social protection schemes have relevance to people living with HIV particularly if they are poor. However many schemes do not have geographical universal coverage while others would possibly be of benefit but people living with or affected by HIV face barriers to accessing them. Some of these barriers are specific to people affected by HIV such as HIV-related stigma and discrimination, while barriers such as being unable to do heavy manual work (e.g. as part of a public works programme) may affect people living with HIV and people with chronic illnesses, disability or people who are older. Some barriers to people living with or affected by HIV further highlight challenges to wider community members. For example, a parent widowed because of HIV may not be able to take part in a public works programme because of childcare responsibilities: other single parents and those widowed for other reasons may similarly face these barriers.

Key social protection schemes selected from the above table (plus the IDPoor targeting mechanism) are described in more detail in this section. Their relevance to people affected by HIV is discussed as are the specific challenges to individuals and households affected by HIV in relation to their access to the schemes and the schemes' effectiveness for them. The descriptions note whether schemes have been adapted to meet the needs of people living with and or affected by HIV, and makes suggestions for how schemes can be adapted or changed to increase people's access and the schemes effectiveness.

5.2.1. Free primary health care and ART for people living with HIV

(HIV specific)

The main social protection scheme for people living with HIV is free primary health care and ART. ART is funded by external donors, including the Global Fund, and Cambodia has achieved extensive coverage of most people living with HIV who need treatment. Primary health care for people living with HIV is mandated to be provided free of charge by the Law on Prevention and Control of HIV/AIDS (RCG, 2002). High ART coverage among the adult population is calculated to have averted 21,497 labour force deaths and reduced Gross Domestic Product (GDP) losses by over US $100 million per year for the period 2003-2009 (Cercone & Pinder, 2010).

Free primary health care for people living with HIV is more complex as it is not necessarily defined as a minimum package of services, so patients may receive uneven service provision. Additionally, the provision of free services to people living with HIV was not necessarily supported by funding sources, meaning that health facilities were expected to provide services free of charge and absorb the costs in their budgets. In practice, this often led to unofficial charges for services. Funding, including salary top-ups for a limited time, was introduced as part of the Health Sector Wide Approach (SWAp) to help reduce unofficial demands for payments.

Despite these sectoral challenges, some of which affect all areas of public health provision (not only those related to HIV), health services for people living with HIV exist and have been extended to include cash transfers, travel costs and reimbursements, food for patients and carers, and other benefits which reduce the costs associated with accessing ART and other health services. The socioeconomic impact study found that people

living with HIV were more likely to have health-care charges exempted than members of non-affected households, and there was no difference between the proportion of HIV-HHs and NA-HHs who had incurred catastrophic health expenditures in the past 12 months (Cercone & Pinder, 2010).

Relevance to people and households affected by HIV

- Exclusive for people living with HIV and highly relevant because most people living with HIV will access ART and primary health care.

Issues and challenges of people and households affected by HIV

- Without a defined minimum package, services are accessed unevenly by people living with HIV depending on where they live and which facility they visit.
- Unofficial demands for payment continue to impact on the health-seeking behaviours of people, particularly those who are poor.
- The associated costs of accessing primary health care and ART services remain problematic for poor people living with HIV if additional cash or reimbursement benefits are not also provided.
- The vertical nature of the health system makes effective referrals across departments or services challenging, for example between Sexually Transmitted Infections (STI) and Voluntary Counselling and Testing (VCT) services, and between HIV, primary care, PMTCT and non-communicable disease services.
- The costs of services that are highly relevant to people living with HIV are not always exempted from fees, for example, PAP smears[17] to test for cervical cancer in women living with HIV.

Recommendations

- Define a minimum package of primary health care for people living with HIV to ensure consistency of service provision.
- People living with HIV should automatically qualify for a Health Equity Card regardless of whether they meet IDPoor criteria or not.
- Increase cooperation and referrals between departments and services, and sensitize health-care workers to promote referrals to services for preventative and non-communicable diseases (for example PAP smears for women living with HIV.

5.2.2. Buddhist Leadership Initiative

(HIV specific)

The Buddhist Leadership Initiative mobilizes monks in 10 provinces to provide cash and in-kind transfers and psychosocial support for adults living with HIV and for orphans and vulnerable children. It includes cash for transport to access ART, and facilitates awareness sessions and self-help groups, some of which have active microfinance mechanisms.

Relevance to people and households affected by HIV

- HIV-specific social protection
- Exclusive for people living with HIV and highly relevant because the programme reduces stigma and discrimination and provides practical support in the form of cash and in-kind transfers. The programme also helps people living with HIV access their treatment, by offering practical and emotional support.

17 Papanicolaou screening test used to detect potentially pre-cancerous and cancerous processes

Issues and challenges of people and households affected by HIV

- The limited capacity for the initiative to include all people living with HIV in its catchment area means that participation is restricted to a small number of people and children affected by HIV.
- Some community members object to its HIV-specific targeting, particularly those living with other chronic illnesses such as diabetes, who perceive the initiative as unfairly prioritizing HIV-affected households over others with health-related vulnerabilities.
- The HIV-specific targeting can inadvertently cause the disclosure of the HIV status of beneficiaries, particularly during home visits.

Recommendations

- Expand the programme to all 24 provinces.
- Further include people with chronic illness and/or disability.

5.2.3. Targeting mechanism: Identification of Poor Households

(HIV relevant)

The main targeting mechanism is the IDPoor programme, introduced in 2006. It is based on an assessment of asset level and proxy indicators of a household's poverty. There are additional non-scoring questions which identify whether there are any special issues affecting a household which are highly relevant to those affected by HIV. For example, the questionnaire asks whether the household has lost income, had a shortage of food, sold assets or borrowed money, and whether this was because of chronic illness or disability preventing work (MoP, 2008). It asks whether children missed school in the last month, whether the head of household is divorced or widowed (with three or more children), and whether the household is child-headed (no members aged 18 years or older). Any household which answers "yes" to any of these non-scoring questions will automatically be considered for inclusion in the list of poor households by the village representative group. The village representative group then decides as a group (based on the score, the special household situation and their observations) whether or not to include the household in the draft list of poor households that will be presented to and validated by the community. IDPoor has been implemented in nearly all rural areas, and the list of qualifying households will be updated every three years.

Relevance to people living with HIV and HIV-affected households

- As already discussed, from the evidence generated in the socioeconomic impact of HIV study, loss of income, death of a family member, selling assets, and children missing school are more likely to be characteristic of households affected by HIV than those which are not. With the majority of Cambodia's population and the majority of the poor living in rural areas, the IDPoor targeting mechanism should capture poor households (as defined by the scheme) affected by HIV, and therefore facilitate their access to essential services.

Issues and challenges of people and households affected by HIV

- The programme's current focus on rural areas means that poor households and individuals affected by HIV in urban areas are not yet included. A process to identify poor households in urban areas will be piloted in 2013.

- Income levels per se are not part of the assessment. While proxy indicators and non-scoring questions give the opportunity to identify households that are vulnerable, as they include questions around income-generating activity and borrowing, HIV-affected households that are income-poor rather than asset-poor (in which the main income earner has recently lost their employment or ability to work) may find that they still do not qualify for inclusion.
- The programme is designed to identify the very poor; so those who are near poor and may be at risk of becoming very poor in the near future due to a major health or unemployment shock, are unlikely to be included in the classification.
- People who identify as key affected populations or marginalized groups are more likely to reside in urban areas where the identification scheme is yet to be implemented.
- Key affected populations who are employed, and therefore have incomes, would not qualify for inclusion in IDPoor.
- Many key affected populations, whether employed or not, will also be unlikely to be included in IDPoor classification, as they do not live in family homes (e.g. entertainment workers who live in their place of work, people who use injecting drugs who live transiently, and MSM who have been rejected by their families). In some cases, a person who is a member of a key affected population may maintain good relationships with their family living in a rural area, in which case there is a possibility that they will be included in the list of household members. However, many people who are key affected populations (as already mentioned) and are also LGBT are more likely to have been ostracized from their family homes as a result of their lifestyles. In these cases, rejected family members are unlikely to be included in the household member list of a family that is classified as IDPoor.
- With the IDPoor assessment taking place every three years, some households and individuals who qualify between assessments have a long wait to be included in the list; except in the case of accessing HEFs, where post-identification can take place. Post-identification is a different identification mechanism developed by MoH.
- Decisions for inclusion are made at community level, and some people living with HIV who have not been included may not have sufficient agency to challenge decisions. To make their case they would likely be required to disclose their HIV status, which some may prefer to keep confidential. Key affected populations including LGBT people may find themselves discriminated against, and have few or no avenues for recourse.
- To preserve people's privacy, the IDPoor programme does not ask households or individuals to disclose HIV status, and nor should it. However, this does mean that it is not possible through the IDPoor programme to assess how many people living with HIV and/or households affected by HIV are included in IDPoor. There may be other ways of surveying people, for example at the point of ART delivery, to assess the numbers of people living with HIV who have qualified for IDPoor.

In discussions with people living with HIV in rural areas, individuals have expressed a lack of understanding of the IDPoor programme and some attributed their exclusion to their existing participation in one or more other social protection mechanisms, meaning they believed the external support they received meant they did not

qualify in one of the IDPoor categories (Kaybryn, forthcoming). Similarly, people living with HIV and who have qualified as IDPoor have reported exclusion from commune-level resources; they also attributed this to being in receipt of a cash transfer or other service. There is no verifiable evidence as the actual reasons for these individuals being excluded from IDPoor classification or other resources have not been thoroughly researched. But it does raise the issue that there is a possibility that some people living with HIV are being excluded from IDPoor identification because of the perception by local decision makers that they already receive sufficient external support. In the current context of Cambodia's social protection response, very few schemes are permanent; they are more likely to be time-limited and/or geographically limited programmes. So the fact that someone is in receipt of a cash transfer or food assistance might be more usefully interpreted as an indicator of their vulnerability rather than their resilience, depending on the specific details of the external support.

Adaptations related to HIV

The IDPoor programme has not been developed specifically for the context of HIV. However, notably, at least two urban HIV treatment centres are being used as entry points to identify households that qualify as poor by implementing a post-identification mechanism. Anecdotally, some health providers estimate that 80% of the people they make the decision to assess (not 80% of all clients) can be categorized as poor.

Recommendations

- Automatically give people living with HIV access to the subsequent benefits of being categorized as IDPoor, irrespective of poverty status.
- Sensitize key providers about the need to maintain confidentiality.
- Develop protocols to ensure that the confidentiality of people living with HIV is maintained.

5.2.4. Health Equity Funds

(HIV relevant)

HEFs are financing schemes which help poor people get better access to government health services. The funds pay for services that poor people access at facilities as part of a defined minimum package to ensure consistency (MoH, 2012). The package includes transport costs, food allowances for carers and some other costs, for example, funeral costs. People pre-identified as poor through IDPoor are eligible to access the schemes. A poverty assessment can be done at the health facility for people who are not already in receipt of an Equity Card issued by the IDPoor programme.

Relevance to HIV-affected households

HEFs are highly relevant to poor people living with HIV and poor households affected by HIV, who can access both HIV-related and non-HIV-related services and treatments. ART is already provided free of charge to people living with HIV, as is primary health care (see the section on HIV-specific schemes above). However, in practice 'primary health care' could be limited to little more than a consultation, as there is no pre-defined minimum package for people living with HIV, and treatments for opportunistic infections are not always freely available to patients, according to feedback from networks of people living with HIV. Under the HEF, poor households affected by HIV can access all primary health care for free, as well as specialized services (with referrals from their local health provider). Furthermore, the eligibility for HEFs is portable and a household member can access any services supported by a HEF, regardless of whether they are in their usual place of residence or not.

Issues and challenges for people and households affected by HIV

- Many of the challenges of the IDPoor classification relate to accessing services through HEFs. Vulnerability is not always synonymous with extreme poverty; so people living with HIV who are not already very poor will not be included in the IDPoor scheme, and therefore will not receive an Equity Card. There is the possibility of being post-identified at a health facility, which increases the chances of poor members of households affected by HIV accessing HEFs. But, as with the IDPoor programme, the assessment is based on assets rather than income levels. Those people living with HIV who are near poor and who have not depleted their assets, but have lost their employment or ability to work, may still not qualify.
- At a practical service level, although people living with HIV reported very little discrimination by health workers in the Stigma Index Survey, anecdotal evidence suggests that out-of-pocket patients (who pay cash on the day) are prioritized for services over people with IDPoor-issued Equity Cards. For people who are sick, including people living with HIV, waiting a long time at a health facility can be a serious strain on their health, and for those who are not seriously ill, long waits take more time away from income earning opportunities.
- While stigma related to living with HIV may have declined significantly, key affected populations such as entertainment workers, MSM, people who use injecting drugs and marginalized LGBT people may continue to face stigma related to their behaviours and/or sexual orientations.

Recommendations

- Automatic inclusion of people living with HIV as beneficiaries irrespective of IDPoor status.
- Sensitize key providers about the need to maintain confidentiality.
- Develop protocols to ensure that the confidentiality of people living with HIV is maintained.
- Include people living with HIV as a special category to access the scheme.

5.2.5. Community-based health insurance (CBHI)

(HIV relevant)

CBHI is a subsidized voluntary contributory insurance scheme which allows those who can afford it to pay a small amount to insure against health expenditures in accessing government health services. There is usually a sliding scale of payments commensurate with a sliding scale of benefits that the insurance cover will provide.

Relevance to HIV-affected households

CBHI is highly relevant to households affected by HIV, whether or not they have qualified for IDPoor classification and whether or not HEFs are available in their area. For the near poor who have an income, the insurance acts as a highly subsidized pre-payment for health services. The minimum cover period is usually three months; cover for longer periods is further discounted and payments are staggered so that the whole amount is not required immediately. In some schemes any children under the age of two in the household of the adult who purchases a premium are automatically covered for the same period.

Issues and challenges of people and households affected by HIV

- Affordability remains the biggest challenge for the near poor who have assets and so do not qualify for the IDPoor programme or post-identification at health facilities, but who have experienced a drop in income, or are unemployed.
- The schemes are largely implemented in rural areas, making them inaccessible to key affected populations who live in urban areas.

Recommendations

- Automatic inclusion of people living with HIV as beneficiaries irrespective of IDPoor status.
- Sensitize key providers about the need to maintain confidentiality.
- Develop protocols to ensure that the confidentiality of people living with HIV is maintained.
- Include people living with HIV as a special category to access the scheme.

5.2.6. Emergency assistance, education scholarships, school meals programmes, health vouchers, maternal and child health

(HIV relevant)

A number of initiatives are aimed at very poor households, and as many households affected by HIV can be categorized as poor, these programmes are likely to be highly relevant to them. Emergency assistance can be provided in the form of food, cash, education scholarships and work programmes. The Education Sector Support Programme includes scholarships for families of children at high risk of non-attendance. The School Meals Programme is a transfer (conditional on attending school) that includes a daily food ration of rice (115g), oil (5g), beans (15g), salt (93g) and fish (15g) for children. Take-home rice rations are provided to some children, as are cash transfers. Health vouchers for reproductive health services are targeted at women of reproductive age, as well as women who are in households included in the IDPoor list of poor households.

Relevance to HIV-affected households

- Health vouchers for reproductive health services could contribute to increasing access for households affected by HIV. The 2010 Stigma Index Survey found that 7.6% of people living with HIV reported being denied family planning services, and 8.4% reported being denied sexual and reproductive health services in the preceding 12 months, because of their HIV status.
- The socioeconomic impact study identified the school dropout rate, particularly among girls, as a major consequence for HIV-affected households.
- Households affected by HIV often remove children from school to save costs otherwise spent on education, and in order for children to work. HIV-affected households also have reduced food security compared to non-affected households. School feeding programmes provide an incentive to families to send their children to school, as well as meeting the nutritional needs of children.
- Children living with HIV may require more nutrient energy intake than non-affected children (up to 10%), especially when they are affected by an opportunistic infection (up to 30%). Overall though, the most important factor in their diet is that it is balanced (Willumsen, 2012) which the school feeding programme aims to provide.

- Assets (food and cash) for work schemes are relevant to people and households affected by HIV if they are without employment.

Issues and challenges of people and households affected by HIV

- Some schemes are universal, so all children in schools are included in meals programmes, but education scholarships (cash and food) are targeted at IDPoor 1 households, so all the challenges noted above for households affected by HIV in relation to IDPoor apply; namely that children of people living with HIV who have not been identified as poor by the IDPoor programme cannot access scholarships.
- Coverage of most schemes is geographically targeted, making them irrelevant through non-accessibility by people affected by HIV in areas not covered.
- Food rations contribute to a balanced diet, but general programmes do not necessarily meet the specific additional nutritional needs of some children who are living with HIV or with opportunistic infections.
- Works programmes may not be feasible for HIV-affected households, if people living with HIV have less energy to perform manual work, or sustained and consecutive work days. Similarly, members of households affected by HIV may have caring duties (of either people living with HIV or of children) which prevent them from committing to long work days or long periods of work.

Recommendations

Emergency assistance	Education scholarships	School meals programmes	Health vouchers, maternal and child health
Prioritization of families and individuals affected by HIV Additional nutritional support to households which include people living with HIV Sensitization of commune councils to issues of people affected by HIV and AIDS **Public Works Programme:** Sensitize Emergency Food Assistance Project (EFAP) officials to the issues of people living with/affected by HIV Provide light ("soft") work for people living with HIV, chronic illness and/or disability In case people living with HIV have no access to "soft" work they should have access to daily unemployment allowance Soft work should be defined in consultation with NAA and networks of people living with HIV Women living with HIV should be given preferential allocation for work to ensure steady income People on ART should be given short breaks periodically during the day, if needed. Flexible labour options for members of households affected by HIV, chronic illness and/or disability	Include children from households affected by HIV or whose parents are key affected populations in eligibility criteria Children infected or affected by HIV or whose parents are key affected populations to be included in the special groups that are supported with school fees, books, uniforms, etc. Sensitize school authorities as well as communities around the school on issues of children affected by HIV. Efforts should be made through the scheme to fight stigma and discrimination against children infected or affected by HIV	Include children affected by HIV and AIDS as an eligible category Additional nutritional support (iron and protein rich) to children living with HIV	Focused efforts at increasing awareness among women living with HIV about programmes and how to access them Departmental links and collaboration to promote early ANC registration of pregnant women living with HIV. Early registration during pregnancy will ensure HIV testing and reduce the risk of vertical transmission Involvement of women living with HIV in the design and implementation of the scheme Sensitize health-care workers to the issues of pregnant women living with HIV, and provide training on caring for infected pregnant women and lactating mothers Additional nutritional support (iron and protein rich) to girls and children living with HIV Include women living with HIV and women who are also key affected populations as eligible categories

5.2.7. Microfinance

(HIV relevant)

Small-scale credit is provided to people who are self-employed through the National Poverty Reduction Fund, the Special Fund of Samdech Prime Minister, microfinance institutions and many NGO livelihood programmes.

Relevance to HIV-affected households

- Credit is highly relevant to households affected by HIV, which are more likely to have lost employment and therefore need to become self-employed, with the support of a small amount of capital.
- Affordable loans are highly relevant to HIV-affected households which are more likely to use higher interest credit from informal money lenders, causing them to increase their debt exponentially if they cannot afford to make repayments on time.
- Microfinance is highly relevant to households affected by HIV which cannot access bank credit windows having sold their land, which is usually a collateral requirement for formal lending institutions.

Issues and challenges of people and households affected by HIV

- People living with HIV and members of households affected by HIV may not have the human capital to make a return on financial capital, and are more likely to acquire debt for consumption. This means that their loan requests are likely to be turned down by microfinance lenders, and they may not fully understand the reasons.
- Microfinance mechanisms often still require a minimum level of assets for collateral against which to borrow, which households affected by HIV cannot meet if they have sold their land and other property.
- The geographical coverage of many microfinance initiatives is often limited and therefore not always available for households affected by HIV.

Recommendations

- Improve access to credit facilities for self-employed people living with/affected by HIV and for people who are key affected populations, ensuring confidentiality and no stigmatization.
- Focused training and skill building support for initiating income generation activities for people living with HIV, chronic illness or disability, with special consideration for physical and other health conditions.
- Sensitize MoLVT and microfinance institution officials to the issues and needs of households affected by HIV.
- Waive minimum duration for accessing the scheme.
- Relax collateral requirement for households affected by HIV, especially women-headed households.

Adaptations related to HIV

- Some microfinance institutions have introduced concessions specifically for households affected by HIV, such as waiving the collateral requirements or lowering the interest rate for loans to them.

5.2.8. Technical and vocational education and training programme

(HIV relevant)

Public, private and NGO TVET institutions provide training in a range of specializations, including agriculture (irrigation techniques, etc.), mechanical engineering, business management and information technology. The National Technical Training Institute provides training in civil engineering, electrical engineering, electronics, architecture and information technology.

Relevance to HIV-affected households

The skills and technical training provided through TVET have the potential to increase the income earning abilities of HIV-affected households, as long as they meet the minimum criteria to apply and can afford the course fees.

Issues and challenges of people and households affected by HIV

- The fees for courses would likely make the programmes out of reach for households affected by HIV, particularly in rural areas.
- Even where scholarships are available, the majority of members of households affected by HIV living in rural areas have lower educational achievements and may not have the minimum education requirements to undertake advanced or specialist skills training.

Recommendations

- Preference given to men and women affected by HIV and AIDS.
- Waive minimum education attainment criteria for people living with or affected by HIV and AIDS.

5.2.9. Formal sector contributory social security

(HIV relevant)

A fairly comprehensive set of employment related benefits is provided through the National Social Security Fund (NSSF) for formal sector workers, the National Social Security Fund for Veterans (NSSFv) and the National Social Security Fund for civil servants (NSSFc). Pension, work injury compensation, sickness benefit, severance pay, maternity leave, death benefits and other cash transfers are provided to members of the funds who have met the minimum eligibility criteria.

Relevance to HIV-affected households

For formal sector workers living with HIV, the NSSF, NSSFv and NSSFc provide benefits (with no HIV exclusion clauses) to workers and their family members, making it highly relevant to them.

Issues and challenges of people and households affected by HIV

- A minority of workers are formally employed and therefore only a small number of people living with HIV are likely to be eligible for formal sector contributory social security schemes.

Recommendations

- Age relaxation for people living with HIV to access the schemes.
- Include HIV infection as a life-threatening condition.
- Sensitization of key providers about the need to maintain confidentiality and develop protocols to ensure that the confidentiality of people living with HIV is maintained.
- Extend period of benefits for orphaned children affected by HIV and AIDS.

5.2.10. The Maternal and Child Health and Nutrition programme

(HIV sensitive)

The Maternal and Child Health and Nutrition programme is an example of a wider initiative that includes a specific provision for households affected by HIV, making it HIV sensitive. It provides daily food rations containing 77% of a child's energy (and most micronutrient) requirements, and at least one-third of these requirements for pregnant and lactating women. The specific component for people living with HIV, and orphans and vulnerable children, consists of food assistance of 25kg of rice monthly to households, as part of a package of home-based care services. The food ration acts as a temporary income transfer to stabilize household food intake during times of crisis, to prevent harmful coping mechanisms and to protect productive assets (WFP Cambodia, 2010).

Relevance to HIV-affected households

- Nutrition programmes are highly relevant to HIV-affected households given that they are frequently more food insecure than non-affected households. By receiving adequate nutrition as part of the home-based care package, households reduce the number of school days missed, take out fewer loans, increase dietary diversity, are more likely to participate in livelihood training, and experience reduced stigma (WFP Cambodia, 2006).

Issues and challenges of people and households affected by HIV

- The main challenge for people and households living with HIV is that the programme is due to finish at the end of 2012; a phase-out planned since 2010 in close consultation with MoH and NGOs. While food transfers under this programme will cease, in many cases other NGO income-generating/livelihood-support activities will continue. Other WFP-supported programmes (school meals, cash and food scholarships, productive assets and livelihood support, and the maternal and child health and nutrition programme) are HIV sensitive and inclusive of adults and children living with HIV, and orphans and vulnerable children. In addition, WFP will focus efforts on developing a sustainable system for nutritional support (nutrition assessment, education and counselling) to ART clients in care and treatment, as part of a standard package of national care and treatment services. Institutionalization of HIV and nutrition in the public health system (ART centres) was identified as a gap by NCHADS.

Recommendations

- Additional nutritional support (iron and protein rich) to girls and children living with HIV.
- Focused efforts at increasing awareness among women living with HIV and women who are key affected populations about benefits of MCHN programme and how to access the scheme.
- Monitor the impact of the program closure on HIV-affected households

6 RECOMMENDATIONS FOR NEXT STEPS

The NSPS and the Five Principles of HIV-Sensitive Social Protection offer an important policy space and impetus for social protection implementers to ensure responses are sensitive to the unique needs and circumstances of people living with, affected by, and vulnerable to HIV. The December 2012 launch of the Monitoring Framework for the NSPS provides further impetus for collecting data relevant to the impact of social protection for people affected by HIV. HIV-sensitive social protection will help Cambodia meet all five NSPS objectives.

Furthermore, HIV-sensitive social protection can pave the way for demonstrating and advocating the importance of making general social protection schemes sensitive to the specific needs of other special vulnerable groups as defined in the NSPS, such as ethnic minorities and persons with disabilities (PwD). Similar assessment studies can be initiated to pursue this aim, for example, 'PwD-sensitive' social protection. Evaluations or reviews of key social protection pilots and policies can be used as an opportunity to assess their relevance and sensitivity to all of the NSPS special vulnerable groups. Such social protection efforts, with the pronounced emphasis on the most vulnerable and excluded, could contribute to inclusive national development that is founded on the principles of human rights, equity and dignity.

The following recommendations focus on short-term actions needed to engage all stakeholders fully in a national dialogue on HIV-sensitive social protection (and social protection sensitive to other special vulnerable groups in some cases), and build the evidence base needed to inform policy and programme decisions.

6.1. GOVERNMENT MINISTRIES AND POLICY MAKERS

1

Create a space for dialogue on HIV-sensitive social protection at the levels of TWGs, including the HIV Impact and Mitigation TWG and the Social Protection Interim TWG.

2

Consider a joint meeting between the two groups and key stakeholders, such as representatives of people living with HIV and key affected populations, to reflect on this review and identify further opportunities for increasing HIV sensitivity of social protection throughout Phase 1 of the NSPS.

3

Use every opportunity in NSPS Phase 1 (2011-2015) in relation to the development of policy (and design and implementation of programmes and monitoring/evaluation), to consider the HIV sensitivity of social protection responses and targeting mechanisms, and adjust them or develop a strategy to adjust them as appropriate.

4

Consider how these opportunities can increase the sensitivity of social protection to other special vulnerable groups.

5

Use existing evidence on access and barriers to social protection by people affected by HIV to inform decision making, consult networks of people living with HIV and key affected populations, and support the implementation of further research to increase the evidence base to inform decision making.

6.2. NETWORKS OF PEOPLE LIVING WITH HIV AND KEY AFFECTED POPULATIONS

1

Conduct a utilization study to assess levels of, and barriers to, access to social protection by people living with HIV, households affected by HIV, key affected populations and marginalized groups, to build the evidence base for policy and programme design and implementation processes.

2

Build organizational and membership capacity in, and knowledge of, social protection responses and targeting mechanisms to increase the effectiveness of networks' engagement in national dialogue.

3

Explore the potential with key government and development partners for establishing a mechanism for networks of people living with HIV and key affected populations to monitor levels of, and barriers to, access to social protection, in order to record and understand changes in levels of access through time-series data and evidence.

6.3. DEVELOPMENT PARTNERS

1

Support national dialogue with government and community stakeholders by providing technical resources and guidance.

2

Use the significant involvement in the implementation of social protection programmes and pilots as opportunities to review their sensitivity to the NSPS special vulnerable groups.

3

Support networks of people living with HIV and key affected populations to design and implement a utilization study to review access to social protection by people affected by HIV, by providing financial and technical resources.

4

Support the development of tools to analyze the HIV sensitivity of social protection and other resources, such as checklists, costing tools and examples of appropriate changes, to increase the HIV sensitivity of social protection responses.

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APPENDIX 1: OPPORTUNITIES TO REVIEW HIV SENSITIVITY OF SOCIAL PROTECTION MECHANISMS

Throughout Phase 1 (2011-2015) of the NSPS, there are numerous opportunities to review and consider adaptations to existing social protection schemes, including a number of pilots taking place. Evaluation processes also offer an important opportunity to collect data relevant to understanding levels of access to social protection by people living with HIV and households affected by HIV.

The following list is not exhaustive and is expected to be expanded as key stakeholders contribute information about their relevant processes taking place between now and 2015.

Urban poor identification pilot (2013) and roll out (2014)	MoP-IDPoor programme
Private sector social health insurance (2013)	NSSF
Micro Enterprise Pilot Voucher Skills Training Programme (part of STVET) pilot (2013)	Ministry of Labour and Vocational Training (MoLVT)
Private sector pensions (2015)	NSSF
Development of BHS Monitoring and Evaluation Database (2013)	URC
Monitoring and evaluations of HEFs (2013-2015)	MoH, AFH, URC, BTC etc.
Maternal and Child Health and Nutrition (cash transfer) pilot (2013)	MoH, UNICEF, WB, CARD
Single window service (information on how to access social protection) pilot (2013)	ILO
Evaluations of the 2011 flood response	No specific agencies have been identified yet who have undertaken or plan to undertake post-response M&E
Expansion of scholarship programme and school feeding programmes	MoEYS, WFP
Evaluation of WFP food assistance programme for people living with HIV	WFP, NGO partners (KHANA)
Development of integrated national public works programme to address (seasonal) rural unemployment	
Monitoring and reviews of existing assets-for-work programmes	MEF, MRD, WFP
Piloting of Productive Assets and Livelihoods Support Programme (PALS)	WFP, MRD, NCDD
Expansion of CBHI (TBC)	MoH
Development of long-term strategy to increase social protection for poor, elderly, disabled (e.g. through cash transfers or social pensions)	MoSVY
Targeted food distribution to specific vulnerable groups (TBC)	MoH
Development of social welfare services, including child welfare and youth rehabilitation, welfare and rehabilitation for people with disabilities, homeless, welfare for elderly and veterans	MoSVY
Utilization study to assess access to social protection by people living with HIV and key affected populations (A recommendation of this review)	UNDP, networks of people living with HIV and key affected populations
Strengthening Economic Livelihood Opportunities for Low-Income and HIV Positive Women (SECLO) Poverty Baseline Report completed, end-line survey being developed, project evaluation in December 2012/January 2013	CHEC

APPENDIX 2: KEY INFORMANT INTERVIEW PARTICIPANTS

INTERVIEWS TOOK PLACE WITH THE FOLLOWING STAKEHOLDERS

	Name	Organization
1.	Heng Chheang Kim	ART Users Association (AUA)
2.	Brett Ballard (Dr)	Australian Government Overseas Aid Program (AusAID) Cambodia
3.	Prempret Suos	Australian Government Overseas Aid Program (AusAID) Cambodia
4.	Ya Sethadavith	Bandanh Chaktomak (BC)
5.	Sao Sopheap	Bandanh Chaktomak (BC)
6.	Sorn Sothearidd h	Cambodian People Living with HIV/AIDS Network (CPN+)
7.	Prum Dalish	Cambodian Community of Women Living with HIV/AIDS (CCW)
8.	H.E. Ngy Chanphal	Council for Agricultural and Rural Development (CARD)
9.	Anja Papenfuss	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) Cambodia
10.	Malika Ok	International Labour Organization (ILO) Cambodia
11.	Choub Chamreun	KHANA
12.	Phoeuk Taing	KORSANG
13.	H.E. Dr Teng Kunthy	National AIDS Authority (NAA)
14.	H.E. Dr Mean Chhi Vun	National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS)
15.	Usha Mishra	United Nations Children's Fund (UNICEF) Cambodia
16.	Penny Campbell	United Nations Children's Fund (UNICEF) Cambodia
17.	Tapley Jordanwood	University Research Co., LLC (URC)
18.	Vanny Peng	World Bank
19.	Francesca de Ceglie	World Food Programme (WFP) Cambodia
20.	Suntakna Meng Chhum (Dr)	World Food Programme (WFP) Cambodia
21.	Dany Eng	World Health Organization (WHO) Cambodia
22.	Masami Fujita (Dr)	World Health Organization (WHO) Cambodia

APPENDIX 3: NATIONAL CONSULTATIVE MEETING PARTICIPANTS

1.	Heng Chheang Kim	Coordinator	ART Users Association (AUA)
2.	Sao Sopheap	National Coordinator	Bandanh Chaktomak (BC)
3.	Ya Sethadavith	Coordinator	
4.	Eat Sopheak	Senior Trainer	Cambodia Business Coalition on AIDS (CBCA)
5.	Juliette Rousselot	Consultant	Cambodian Center for Human Rights (CCHR)
6.	Sorn Sothearidh	Coordinator	Cambodian People Living with HIV Network (CPN+)
7.	Kasem Kolnary (Dr)	Director	Cambodian HIV/AIDS Education and Care (CHEC)
8.	Piroska Bisits Bullen	Technical Advisor	
9.	Say Ung (Dr)	CARD-SPCU Deputy Director	Council for Agricultural and Rural Development – Social Protection Coordination Unit (CARD-SPCU)
10.	Kong Chanthy	CARD-SPCU Officer	
11.	Heng Sarith	Communication Officer	
12.	Aum Leakhena	Communication Officer	
13.	Meng Danin	M&E Assistant	
14.	Tim Vora	Executive Director	HIV/AIDS Coordinating Committee (HACC)
15.	Sok Kunthy	Freelance Interpreter	
16.	Dr Ly Chansophal (Dr)	Training Coordinator	KHANA
17.	Ouk Theara	Reporter	KKN
18.	Phoeuk Taing	Executive Director	KORSANG
19.	Chea Sokny	Deputy Director	MoLVT
20.	H.E. Dr Teng Kunthy	Secretary General	National AIDS Authority (NAA)
21.	Ros Seilavath (Dr)	Deputy Secretary General	
22.	Voeung Yanath (Dr)	Deputy Director	
23.	Phorng Chanthorn	MARP Assistant	
24.	Saneth Vathna	Director	National Institute of Social Affairs (NISA)
25.	Khlang Pichet	Programme Coordinator	National Orphans and Vulnerable Children Task Force (NOVCTF)
26.	Sum Sophorn (Dr)	Deputy Director	National Social Security Fund (NSSF)
27.	Kith Morady	Programme Manager	Save the Children
28.	Marie-Odile Emond	Country Coordinator	UNAIDS Cambodia
29.	Sok Chanchhorvy	Governance Team Leader	UNDP Cambodia
30.	Bou Amara	Programme Analyst	
31.	Jo Kaybryn	Social Protection Consultant	
32.	Marisa Foraci	Social Protection Focal Point	
33.	Tep Kuntheara	Programme Analyst	
34.	Phy Phat	Programme Associate	
35.	Mak Sodaline	Programme Accounts	
36.	Leang Sopheak	Governance Team Intern	
37.	Nur Yunus	Governance Team Intern	
38.	Vanny Peng	Social Protection Consultant	World Bank
39.	Suntakna Meng Chhum (Dr)	Programme Officer	World Food Programme (WFP)

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Pasteur Street, Boeung Keng Kang
P. O. Box 877, Phnom Penh, Cambodia
Tel : (855) 23 216 167 or 214 371
Fax : (855) 23 216 257 or 721 042
E-mail : registry.kh@undp.org
Website: www.kh.undp.org