KHANA
UNITED FOR A STRONGER COMMUNITY

KHANA SEMI-ANNUAL MINI REPORT

PREPARING FOR THE NEW CHAPTER

AUGUST 2014 | CAMBODIA

Information used in this report is based on the content of KHANA's Semi-Annual Implementing Partners Meeting and SAHACOM Closeout Meeting that took place on the 10th of July, 2014, at Sokha Hotel and Resort, Siem Reap, Cambodia.

CONTENTS

JANUARY – JUNE 2014: THE SNAPSHOT

People living with HIV (PLHIV) reportedly on ART under KHANA's coverage

89%

Most-at-risk populations (MARP) in Cambodia reached by KHANA and its Implementing Partners (48,300 individuals)

80%

Eligible PLHIV receiving ART, while 89% staying on ART under KHANA coverage

99%

Of 29,296 MARPs tested HIV-positive via finger prick testing

0.45%

New cases identified (219 out of 16,934 PLHIV)

1.3%

0.23%

Pregnant women tested HIV-positive

0.21%

Of 1,867 sero-discordant couples having sero-conversion

100%

Pregnant women receiving Option B+ and exposed infants tested HIV-negative

1.7%

Tuberculosis (TB) patients tested HIV-positive in 2013

0.15%

AIDS-related mortality rate, down from 0.36% in 2013

INTERPRETING THE MODEST RISE IN NEW CASE DETECTION

The first half of 2014 has played witness to a number of modest statistical increases in various program areas under KHANA. For example, newly identified HIV cases under the Community-Based Prevention, Care and Support program (CBPCS) stand at 219 (out of 16,934 PLHIV). In addition, of all the 29,296 people considered most-at-risk who took the finger prick test since this new innovation was first introduced, 131 (0.45%) tested HIV-positive in January-June 2014. In the same period, based on data from Korsang and Mondul Meanchey, 3 out of 134 people who inject drugs (PWID) tested HIV-positive. 5 out of 2,169 pregnant women (0.23%) also tested positive for HIV, but all of them have received Option B+, and all of the exposed infants were born HIV-free.

While the data could be considered as contributing to the positive momentum in the fight against HIV/AIDS, the low rate of new case detection could also mean that the mechanisms used in identifying new cases and reaching new MARPs could still have loopholes, particularly when it comes to reaching key populations who either are hidden or exhibit overlapping risk behaviors. For comparative purposes, from October 2013 to June 2014, 155 out of 2,310 individuals who came to Chhouk Sar – a Flagship Project's Center of Excellence (CoE) – tested HIV-positive. At 6.71%, this rate of new HIV cases is considerably higher than that of KHANA's as a whole. Several contributing factors to this could be: (1) Chhouk Sar is located within a MARP hotspot zone; (2) it has a comprehensive service package, from HTC to ART; (3) it offers a safe, confidential, and friendly environment to its clients; and (4) as a CoE, it has piloted and implemented various new innovations aimed at more effective and efficient HIV/AIDS programming.

It is imperative then that KHANA and its IPs will need to evaluate their key performance indicators more thoroughly, in addition to a critical assessment of the design and implementation of its various programs and innovations. This will certainly ensure higher efficacy and cost-effectiveness of the programs and better inform KHANA and its IPs of their next steps in integrated HIV/AIDS programming in line with a new and more innovative HIV response.

KHANA AND IMPLEMENTING PARTNERS PREPARE FOR THE EVOLVING FUNDING CONTEXT

Participants discussing the lessons learned and challenges in Integration Management and setting new priorities as part of a reprogramming effort at the Semi-Annual IP and SAHACOM Closeout Meetings on July 10th, 2014, in Siem Reap, Cambodia

An ongoing theme at the 2014 Semi-Annual IP and SAHACOM Closeout Meetings dealt with the preparation KHANA and its IPs would need to undertake in the immediate future in light of the recent changes in the funding environment. The focus was on lessons learned and challenges that KHANA and IPs had experienced so far, in the hope that such information could become beneficial for all involved in regards to future program priorities.

A number of key outcomes from the discussions clearly warrant additional consideration in relations to the streamlining of future programming. There has been strong collaboration between IPs and private businesses, local government, and local health centers. Such an alliance will prove critical to the sustainability of KHANA and IPs' implementation of integrated HIV programming, especially at the community level. IPs have also made it clear that, in addition to family support, immediate, regular and close follow-up by community support volunteers (CSVs) and outreach workers (OWs) have contributed to high ART retention and adherence. However, there is still a unified

call for more capacity building and better task delegation for both CSVs and OWs.

Providing a safe environment for MARPs (PWID in particular) to receive HTC and following up on clients who are on mobility have been identified as two major ongoing struggles that IPs are dealing with. This could possibly imply that both KHANA and its IPs need to prioritize activities that directly contribute to services for these particularly individuals as well as PLHIV. In addition, while roles and responsibilities for management personnel and members of the Boards of Directors have been better defined, and cash management mechanisms has also improved, human resource management at IP level is still not running smoothly, and the need for additional funding and staff to cope with increasing workload still persists. This places even more constraints on the sustainability of the IPs and their program implementation in the context of the new Global Fund's funding model.

The takeaway message from all the discussions is that both KHANA and IPs need to be ready with some level of restructuring to accommodate the new funding model. This includes more streamlined priorities, with chief focus on maintaining community-based specialists, diversifying funding sources, and minimizing workforce and expenses while maintaining optimal program impacts.

SAHACOM CLOSEOUT

Program title : Sustainable Action Against HIV and AIDS in the Community (SAHACOM)
Donor : United States Agency for International Development (USAID)
Implementing Partner : KHANA
Duration : October 2009 – September 2014
Geographical Focus : Phnom Penh and 8 high-burden HIV provinces
Total cost : $13.4 million

The SAHACOM Project aims to achieve improved health and quality of life of people in Cambodia by reducing the impact of HIV and AIDS, especially among the most vulnerable population groups. Throughout its 5-year cycle, the project has garnered tremendous accomplishments. It has contributed significantly to the national response for community- and home-based care (CHBC) and provided valuable support and technical assistance in livelihood enhancement, focused prevention, and gender inclusiveness.

The preliminary findings from the USAID's end-of-project evaluation of SAHACOM are clearly evident of the project's successful implementation. SAHACOM has been effective in helping the Royal Government of Cambodia attain coverage for PLHIV and orphan and vulnerable children and linking PLHIV to various health support services. Furthermore, the success of self-help groups (SHG) and CSVs, with sustained collaboration with local authorities and communities, has led to reduced AIDS-related stigma and discrimination at the village level. The village saving and loan (VSL) scheme has proven beneficial as a self-empowerment model and a potentially sustainable mechanism in supporting a secure livelihood for PLHIV. What is equally noteworthy is that specialist IPs are found to be more successful in reaching key populations with HTC, as compared to facility-based services and non-specialist IPs. Finally, SAHACOM has done a great job with its capacity building programs to further strengthen SHG and OWs in delivering quality services to the target populations.

The USAID assessment is quick to point out a number of key elements that need to be considered for the future directions of KHANA and IPs. To begin with, KHANA and IPs should transition to a community-based case management approach for those most in need. Additionally, it is suggested there be a shift of focus towards urban areas where the rate of key populations could potentially be higher. Collaboration with IPs will need to be streamlined by prioritizing high-performance specialist IPs. Last but not least, to further enhance efficiency and cost-effectiveness, KHANA and its IPs will also need to reassess their work plans and costs related to outreach activities, incentives, and human resource management.
Apart from these findings, at the Semi-Annual Meetings, all SAHACOM IPs were briefed on the next plan of action regarding the closeout of the project. The detailed step-by-step process aimed at helping the IPs achieve a smooth program transition by late September to meet the closeout deadline.

WHAT'S NEXT

The second half of 2014 will see a few major plans put into action. One among which is the prioritization of activities for KHANA and its IPs for the remainder of 2014 and the following fiscal year. This will also involve the decision on if contractual agreements with a number of IPs should be extended in light of the Global Fund's new funding model. In addition, KHANA will start preparing the Year 3 work plan for its USAID-funded Flagship Project with its Consortium Partners, expected to begin in October. Finally, KHANA will undergo a critical internal assessment of its organizational structure and performance to accommodate the evolving funding context more effectively and efficiently.

SEMESTER HIGHLIGHTS IN PICTURES

(1) – (3): Semi-Annual IP and SAHACOM Closeout Meetings | **(4) – (5):** KHANA's Board Retreat and Meeting | **(6):** Asia Action Harm Reduction Program's participation in Por Sen Chey's quarterly meeting | **(7):** Visit of NAA's Dr. Tieng Phalla to KLLC | **(8) – (9):** USAID's SAHACOM Closeout Evaluation

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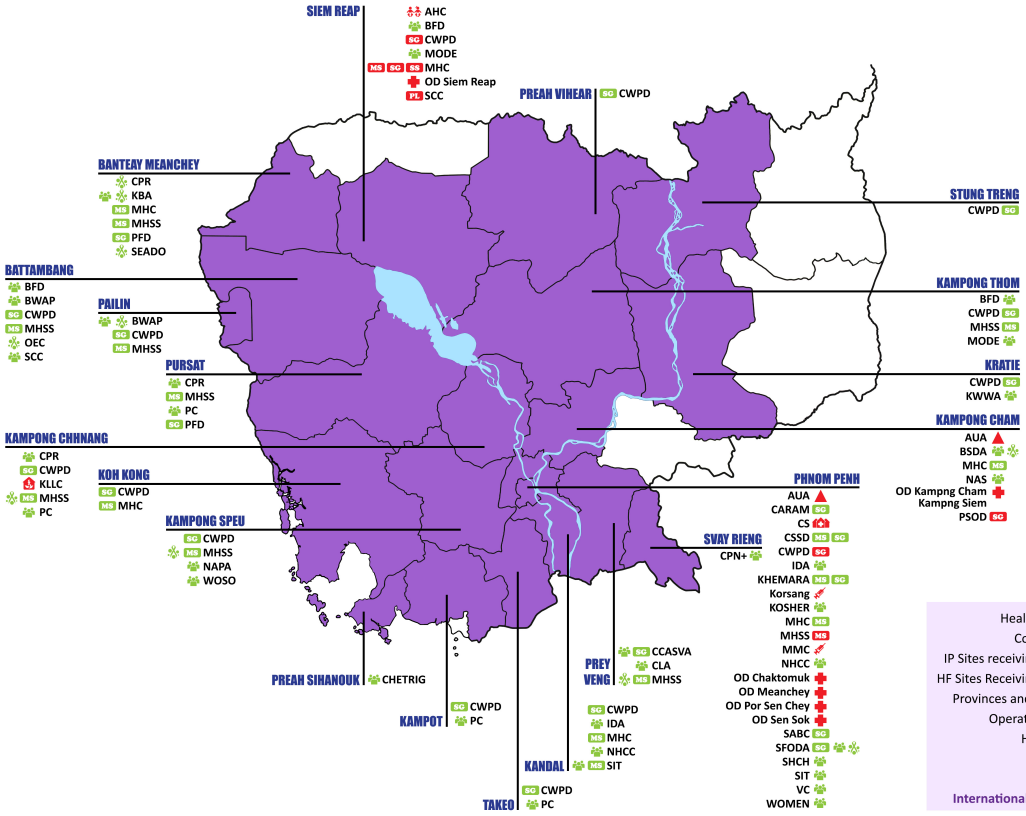
KHANA COVERAGE 2014



Health Facility CoE:	6
Community CoE:	13
IP Sites receiving Flagship TA:	33
HF Sites Receiving Flagship TA:	15
Provinces and Municipality:	20
Operational Districts:	55
Health Centers:	380
Strategic Partners:	
CPN+	
International HIV/AIDS Alliance	

Center of Excellence (CoE)	
Implementing Partner (IP)	
Community-Based Health Facility (HF) for MARPs	
Community- and Health Facility-Based Coordination for PLHIV	
Flagship-Supported Health Facility Site	
Harm Reduction	
Livelihood	
Pediatric Health Facility	
CBPCS	
HIV Prevention for PWUD	
MStyle	MS
PLHIV	PL
SMARTGirl	SG
Srey Sros	SS