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BASELINE DOCUMENTATION

SUSTAINABLE ACTION AGAINST HIV AND AIDS IN COMMUNITIES (SAHACOM)

Research Department on HIV and AIDS, Health and Development

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Heng Sopheab, Tuot Sovannary and Ung Mengieng

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ACRONYMS

AIDS :	Acquired Immunodeficiency Syndrome
ANC :	Antenatal care
ART :	Anti-retroviral Treatment
ARV :	Anti-retroviral Drug
ATS :	Amphetamine Type Stimulants
BSS :	Behavioral Surveillance Survey
CABA :	Children Affected by AIDS
CBO :	Community Based Organizations
CIA :	Children Infected with HIV/AIDS
CoC :	Continuum of Care
CPN+ :	Cambodian People Living with HIV Network
CSO :	Community Support Officer
CSV :	Community Support Volunteer
DMS :	Database Management System
DU :	Drug User
EW :	Entertainment Worker
FGD :	Focus Group Discussion
FP :	Focused Prevention
HC :	Health Center
HCBC :	Home and Community Based Care
HIV :	Human Immunodeficiency Virus
HSS :	HIV Sentinel Surveillance
ICP :	Integrated Care and Prevention
IDU :	Injecting Drug User
IGA :	Income Generation Activity
IPs :	Implementing Partners
M&E :	Monitoring and Evaluation
MARPs :	Most at Risk Populations
MDG :	Millennium Development Goal
MoH :	Ministry of Health
MOU :	Memorandum of Understanding
MRS :	Monitoring and Reporting System
MSM :	Men who have Sex with Men
NAA :	National AIDS Authority
NCHADS :	National Centre for HIV/AIDS, Dermatology, and STDs
NGOs :	Non Government Organization
NSP II	National Strategic Plan for a Comprehensive & Multi-Sectoral Response to HIV/AIDS 2006-2010
OD :	Operational District
OI :	Opportunistic Infection
OVC :	Orphans and Vulnerable Children
PAC :	Provincial AIDS Committee
PAO :	Provincial AIDS Office
PAS :	Provincial AIDS Secretariat
PE :	Peer Educator
PF :	Peer Facilitator
PHD :	Provincial Health Department
PLHIV :	People Living with HIV
PMO :	Program Management Officer
PMR :	Planning and Monitoring Report
PMTCT :	Prevention of Mother-To-Child Transmission
RGC :	Royal Government of Cambodia
SAHACOM :	Sustainable Action against HIV and AIDS in Communities
SHG :	Self-Help Group
SID :	Strategic Information Department
SOP :	Standard Operating Procedure
SPA :	Standard Package Activity
SRH :	Sexual and Reproductive Health
STI :	Sexually Transmitted Infection
TB :	Tuberculosis
TS :	Technical Support
TSV :	Technical Support Visits
UNDP :	United Nation Development Programme
VCCT :	Voluntary Confidential Counseling and Testing
WFP :	World Food Program

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EXECUTIVE SUMMARY

The Sustainable Action against HIV and AIDS in Communities (SAHACOM) program is supported by USAID and runs from 01 October 2009 to 30 September 2014 with a budget of USD 13.4 million. Through this program KHANA will work closely with 26 local NGOs and Community Based Organizations (CBOs) to provide high quality care and support services to over 20,000 PLHIV and OVC, and prevention information and services to at least 8,000 most at risk populations (MARPs). The program works in 9 severely affected provinces and municipalities: Its overall goal is to improve the health and quality of life of people in Cambodia by reducing the impact of HIV/AIDS, especially among MARPs.

This baseline study has been conducted to enable the achievements of the program to be measured and evaluated. The study documents inputs, output, outcome and impacts indicators, and includes quantitative data from relevant publications and the KHANA database management system. It also includes qualitative data collected from focus discussion groups during field visits, consultative meetings and KHANA internal and donor reports.

The study was conducted in late 2010 in gathering quantitative data on HIV prevalence, as well as data on knowledge and related behaviours amongst MARP, PLHIV and OVC. This data provides an overview of the epidemic at the outset of the SAHACOM program. Qualitative data has also been gathered on: focused prevention and integrated care and prevention; social protection and livelihoods; and policy and strategy work at national, provincial and local level. Key findings include:

- IPs have adapted the SAHACOM model during implementation, depending on local context, particularly in relation to the number and ratio of CSV, PE/PF, and SHG members. Barriers to referrals include stigma and discrimination, unprofessional attitudes from health service providers, and costs of transport not adequately covered due to high fuel prices.
- Integration of SRH services is being undertaken by IPs resulting in increased awareness and understanding among MARP, PLHIV and OVC.
- OVC may drop out of school in order to generate income for their households.
- As food support from WFP will end in December 2012, additional livelihoods support is needed to provide secure livelihoods for most needy households

- The Village and Commune Safety Policy affects outreach and other work with people who use drugs.
- Capacity assessments of IPs showed weakness in the areas of partnership, referral systems, coordination, advocacy and HIV/AIDS technical capacity. Some reasons for these weaknesses include staff turnover and lack of appropriate resources to carry out activities in these areas.
- In general, KHANA and its implementing partners have strong collaboration and partnerships with various stakeholders, including government agencies, local authorities, religious groups, health service providers, and strategic partners.
- Working with relevant stakeholders has contributed to a more enabling environment, but development of more supportive and enabling environments among health workers, law implementers, and local authorities should be further strengthened.
- The legal and policy environment and harassment from law enforcement officers still pose challenges for implementation of work with MARPs.
- Overlapping of outreach between USAID supported collaborating agencies needs to be resolved and division of coverage and target group population agreed.
- Changes to the monitoring and reporting system have been challenging for IPs, but will contribute to increased simplicity and user friendliness in the long run.

INTRODUCTION

Cambodia is one of the few countries in the world to achieve the Millennium Development Goal (MDG6) to combat HIV/AIDS, malaria and other diseases, with prevalence falling from 2% in 1998 to 0.9% in 2006. The latest estimates of HIV prevalence by sentinel surveillance were 14% among brothel-based sex workers (2006), 11.8% among indirect sex workers (2003), and 1.1% among pregnant women attending antenatal care clinics [1]. The decline of HIV in Cambodia is due to coordination and collaboration between government and non-government organisations in the fight against HIV. Noteworthy are, for example, the 100% condom use program for brothels and sex work related establishments, and the provision of STI services for most-at-risk populations (MARPs) as well as the general population [2, 3].

KHANA is the largest national, non-governmental organization working in the HIV/AIDS response in Cambodia. KHANA works at community level in 20 provinces and municipalities through 38 NGO implementing partners (IP). KHANA was initially established in 1996 as a project of International HIV/AIDS Alliance, and has operated as a NGO since 1997. It was officially registered as a local NGO in 2000. KHANA programs focus on HIV prevention, particularly among most-at-risk populations (MARPs), including men who have sex with men (MSM); injecting and non-injecting drug users (IDU, DU); and entertainment workers (EW) including brothel-based sex workers, freelance sex workers, karaoke workers, beer promotion women and beer garden women. Married couples and youth are also covered in the prevention program.

Providing care and support to adults and children infected and affected by HIV is an important component of KHANA's programming. The Integrated Care and Prevention (ICP) program is one of KHANA's largest areas of work. It began in 1997 as a home-based care pilot project. The ICP approach has expanded beyond home-based care to include engagement of PLHIV in positive prevention; facilitation of access to treatment and care; provision of socio-economic support to PLHIV, orphaned and vulnerable children (OVC) and their families; and stigma and discrimination reduction activities. KHANA has been a key partner in supporting the delivery of the national Continuum of Care model (CoC), through its Community Based Care (CBC) program for PLHIV. Participation and empowerment of communities and affected people is a key principle of KHANA work. KHANA has supported the development of PLHIV networks in Cambodia through long term partnerships with IPs. KHANA promotes formation of self help groups (SHG) among PLHIV, enabling regular meetings for mutual psychosocial support and sharing information about positive prevention, health care, treatment adherence and livelihoods. Some SHG have also organized saving schemes to improve the livelihoods security of their members.

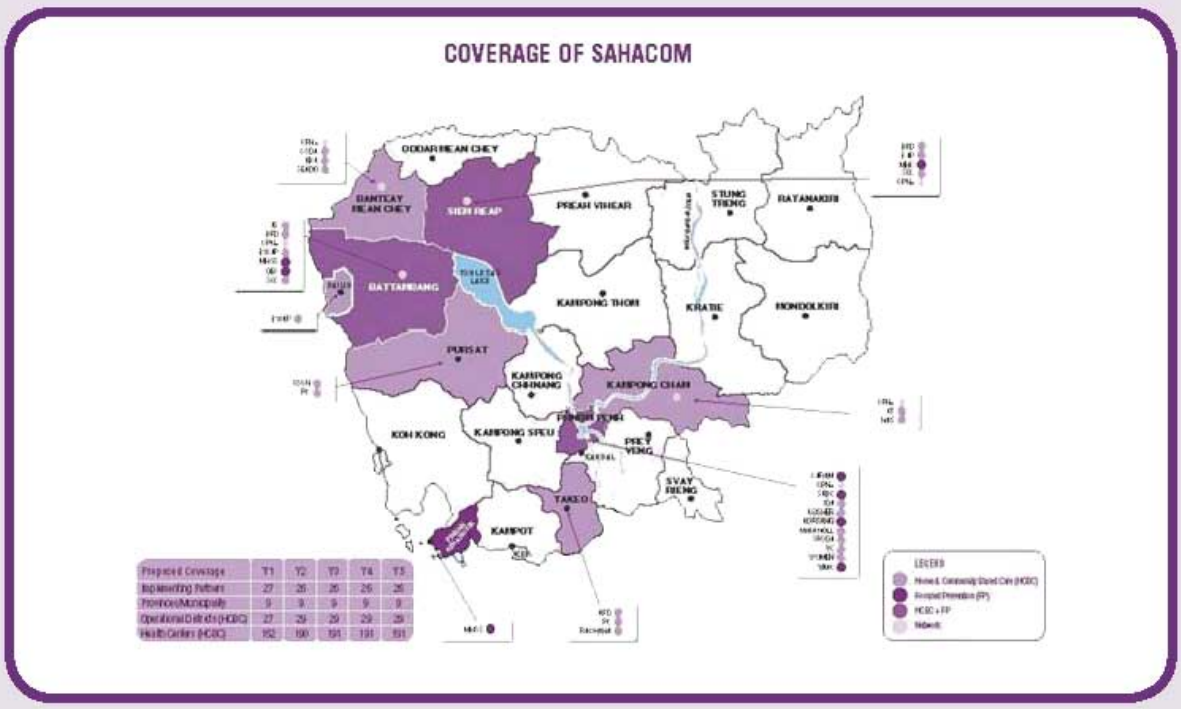
In October 2009, following national and international recognition for its contribution to HIV prevention, care and support. KHANA was granted a major five-year project by USAID: *Sustainable Action against HIV and AIDS in Communities*

(SAHACOM). SAHACOM will work closely with 26 local NGOs and Community Based Organizations (CBOs) to make vital, high quality care and support services available to over 20,000 PLHIV and OVC, and prevention information and services available to at least 8,000 MARPs in 9 severely affected provinces of the country: Siem Reap, Bantey Meanchey, Battambang, Pailin, Pursat, Kampong Cham, Takeo, Sihanouk Ville and Phnom Penh municipality (Figure 1). Its Overall goal is to improve health and quality of life for people in Cambodia by reducing the impact of HIV/AIDS, especially among MARP through three expected results [4]:

1. Improved coverage, quality and sustainability of comprehensive and integrated services for PLHIV (including MARPs) and OVC, which have successfully linked communities with public health and non-health services.
2. Improved uptake of innovative and targeted HIV prevention interventions and services by MARPs, especially by those from currently under-served and neglected groups.
3. Strengthened capacity and leadership of NGOs/CBOs and communities (especially those representing MARPs and PLHIV) leads to their meaningful participation in delivering quality and sustainable HIV prevention and care services within the national response.

To measure achievements of the SAHACOM project effectively it is imperative to carry out baseline documentation. Different levels of project indicators will be documented during the early stage of project implementation. These include: Impact / outcome indicators defined as changes over the project implementation (e.g. decline of HIV prevalence, always using condoms, access to VCCT); output indicators defined as services and activities delivered (e.g. number of staff trained, PLHIV referred to treatment, care and support including ART); and input indicators (e.g. staff, funding, facilities etc.).

Figure 1: SAHACOM Coverage

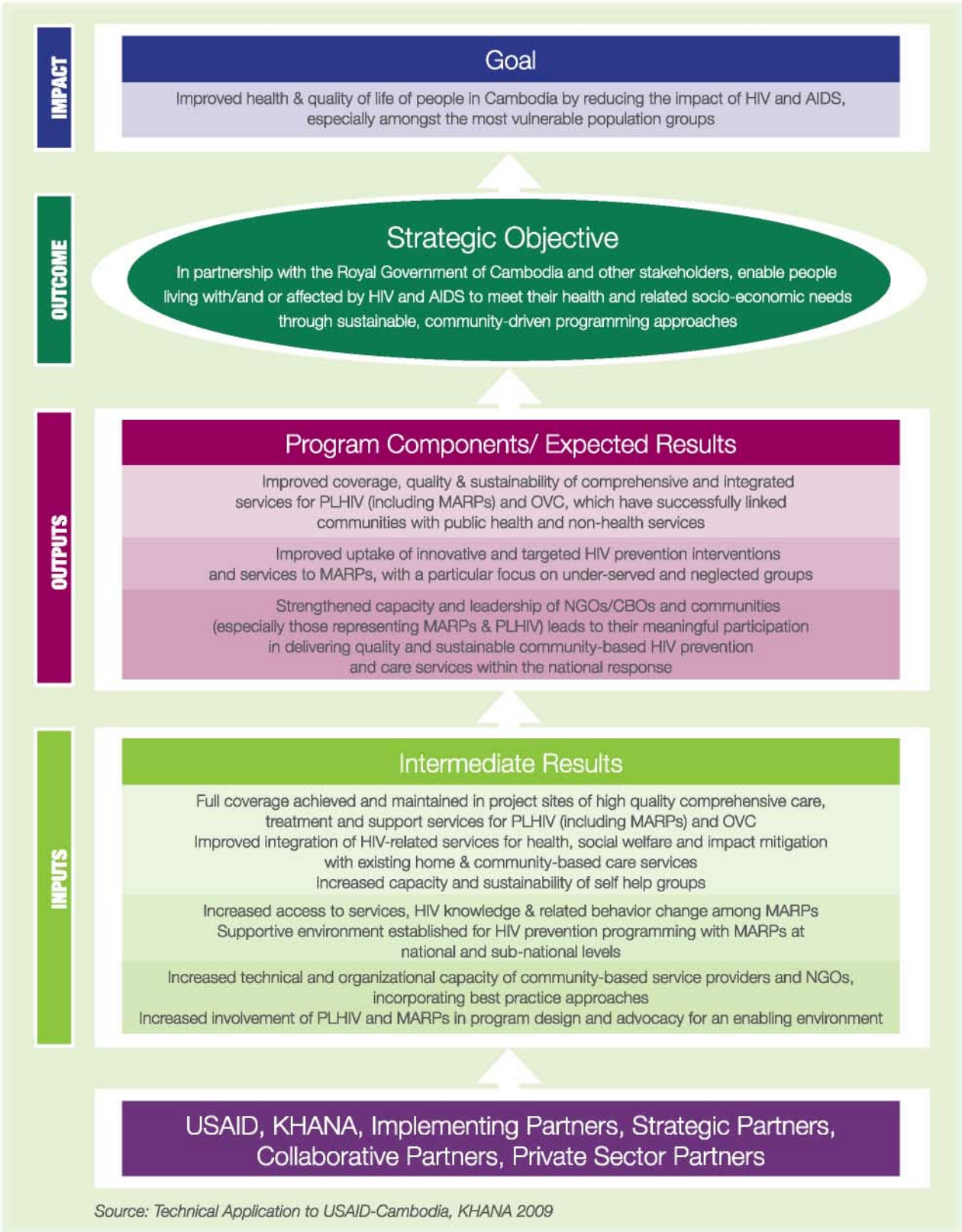


Source: Technical Application to USAID-Cambodia, KHANA 2009

1. SAHACOM Strategy

SAHACOM focuses on programming at the intersection of public health, human rights and development. Working within a public health framework, the program focuses on the needs and rights of beneficiaries and supports them to strengthen capacity to participate actively in their communities. SAHACOM views individuals in their social and economic context, recognizing the significance of gender, poverty and power relations [4]. This approach is reflected in holistic programs that go beyond health issues to impact on individual and community health and wellbeing (Fig 2).

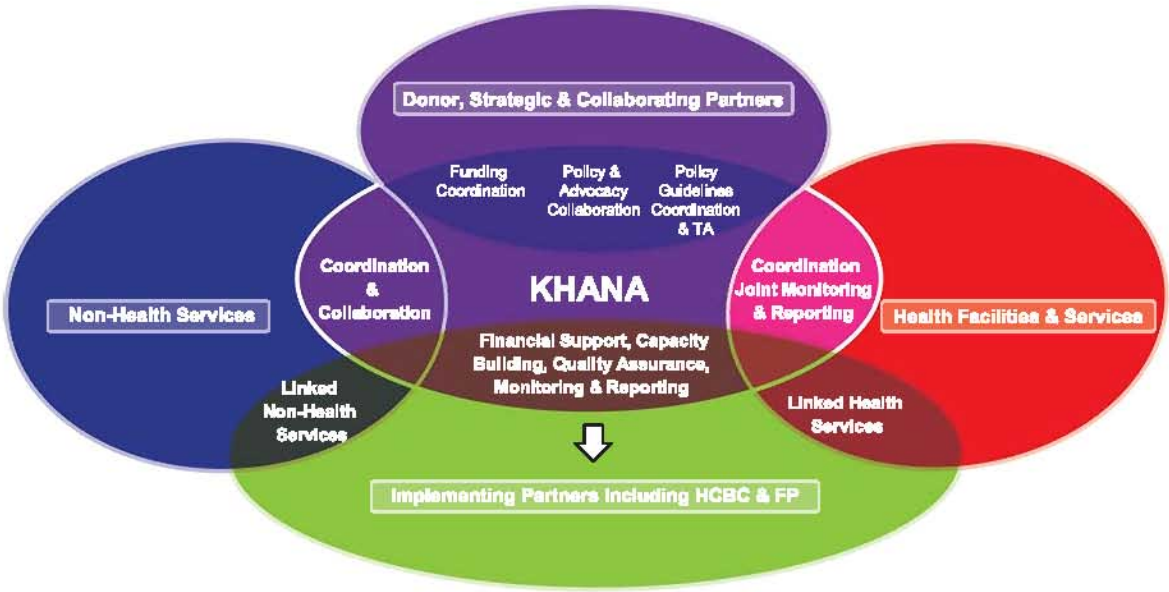
Figure 2: Intervention logic of SAHACOM



Source: Technical Application to USAID-Cambodia, KHANA 2009

Funded by USAID through KHANA, implementing partners and other partners also contribute inputs into the selected target areas to achieve intermediate results. Achieving these intermediate results will contribute significantly to achieving the expected results, strategic objective and overall goal of improving health and quality of life of people in Cambodia by reducing the impact of HIV and AIDS, especially among the most vulnerable population groups [5].

Figure 3: Summary of SAHACOM'S Operational Framework



Source: Technical Application to USAID-Cambodia, KHANA 2009

Figure. 3 shows KHANA's overall technical approach, ie. to work closely with donors, strategic partners, collaborating partners (both government and non-government sectors), health facility-based services, non-health facility-based services and implementing partners.

Working with donors, strategic and collaborating partners

KHANA works with both government and non-government partners at all levels for resource mobilization, funding allocation and coordination. KHANA works to influence the policy environment through participation, collaboration, coordination and engagement with government in national technical working groups and in developing policy guidelines and advocacy tools.

Working with health facility-based services

To make the link between community and health facility services, KHANA works in collaboration with health service agencies both at national and sub-national levels including, national centers, provincial health departments, operational districts and health centers. Collaboration takes place in areas of coordination, joint monitoring and reporting, improving the enabling environment, and increasing and facilitating uptake of community referrals for HIV testing, ART and CD4 counts; sexual and reproductive health services, family planning and maternal and child health services opportunistic infections…

Working with non-health facility-based services

Viewing individuals within socio-economic and development contexts enables KHANA to deliver holistic programs that go beyond simple health issues to have broader impact on individual and community health and wellbeing. This links KHANA to non-health related services. Livelihoods are a central concern for communities, and community-based prevention, care and support

programs are well placed to expand initiatives in this area. KHANA experience in income generation and strengthening livelihoods has made evident the complexities of this work. KHANA partners with VFC, CEDAC and DAI to extend its expertise in this area and to deliver a holistic approach to economic livelihoods, including its Village Savings and Loans (VSL) Scheme.

Working with implementing partners

As shown in the operational framework above, the SAHACOM project works through implementing partners primarily focused on Integrated Care and Prevention (ICP) and Focused Prevention (FP) through the provision of community services by Community Service Volunteers (CSV), Peer Facilitators (PF) and Peer Educators (PE). CSVs are people living with HIV who volunteer to carry out ICP activities such as home-based care and self help group coordination in their communities. Focused Prevention services are provided by PF and PE who are entertainment workers and who also volunteer to work in the community. All volunteers receives a small remuneration in return.

In the SAHACOM project, the ICP and FP model have been significantly modified to reflect the changing context of the HIV/AIDS epidemic in Cambodia, including improved access to ART. The project aims to ensure sustainability at the community level.

NCHADS acknowledges that the national SOP for home and community based care (HCBC) in Cambodia needs to be updated and it is envisaged that this process will be completed during the first two years of the SAHACOM program. Therefore, this new model has the potential to be incorporated into the national SOP and scaled up further. The model has shifted away from reliance on NGO staff to more independent community based care.

Previously, one home care team supported only one health center (HC) catchment area. Currently, teams have been split and now cover two or three times the area. NGO staff coordinates program activities, while community support volunteers (CSV) play a stronger role in providing community-based care and support. This is the context and entry point for the new model under SAHACOM. KHANA and IPs have provided appropriate training and mentoring to CSVs, who are selected on clear criteria which measure their potential to play a leading role in the delivery of quality services.

Under the revised model, ICP service delivery will be led by the community support volunteers (CSVs), who also act as leaders and deputy leaders of PLHIV self-help groups (SHG) and coordinate OVC Support Groups (OVC SG). IPs are supported to recruit CSVs from volunteers working in previous HCBC teams. Under SAHACOM, KHANA will no longer support the HCBC teams in their current form. Instead, resources will be focused on building the capacity of CSVs and SHGs. CSVs will provide basic health care and leverage the well-established referral networks with the public health system at both HC and referral hospital level. CSVs will be the focal points for delivery of community services, and responsible for building SHG involvement and ownership in service delivery and management over the five year period. They will be responsible for ensuring that community services complement the facility-based services of the government's Continuum of Care for PLHIV.

Figure 4: Flow Chart of Focused Prevention Model

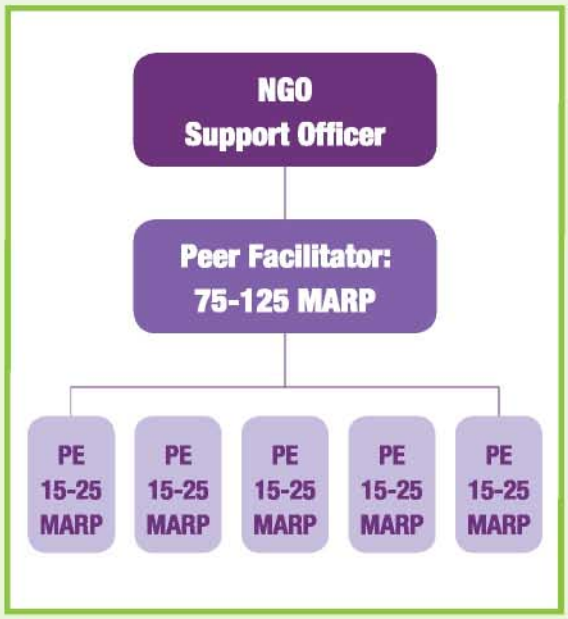
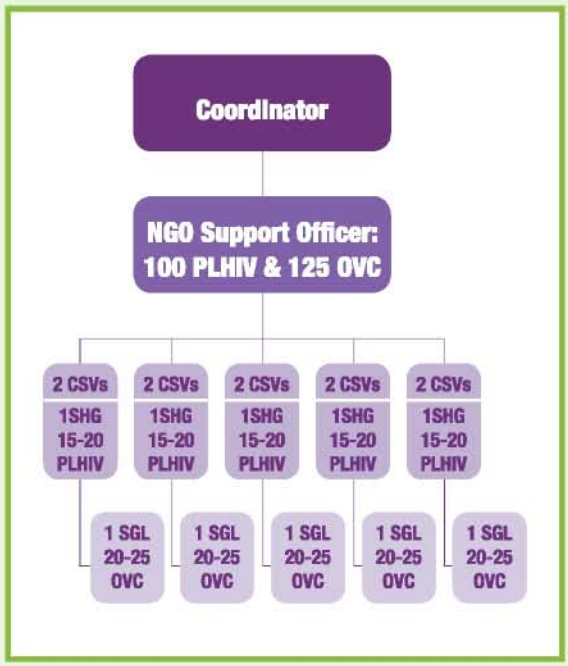


Figure 5: Flow Chart of Integrated Care and Prevention Model



2. SAHACOM Monitoring and Evaluation Framework

The Monitoring & Evaluation (M&E) Plan for SAHACOM builds on KHANA's existing systems and processes. These have been developed and refined to encompass KHANA's contribution to the National Strategic Plan II, and Cambodia's Universal Access targets, as well as to support the implementation of multiple projects funded by different donors, including USAID. The M&E Framework for SAHACOM includes the indicators, targets, data sources and methods for collection which KHANA uses to gather this information. The framework uses relevant PEPFAR and Cambodian Universal Access indicators at output and outcome levels, enabling KHANA to measure SAHACOM implementation and to measure impact of SAHACOM activities at individual and community to national level.

KHANA has solid experience in collecting, consolidating and analyzing program monitoring information from IPs, and reporting to donors. KHANA strives to link program monitoring to strategic information and knowledge sharing, with the ultimate goal of improving quality of programming. To manage these processes for SAHACOM, KHANA draws upon its monitoring and reporting team which is part of the Implementing Partner Program Management Department (IPPM). The Monitoring and the Reporting team is responsible for coordination of all M&E activities and reporting to stakeholders such as USAID and the Royal Government of Cambodia (RGC). The Research Department coordinates operational research activities. Both teams work in collaboration with other agencies.

To capture regular program monitoring and reporting information, KHANA uses its existing database system, the Database Management System (DMS) for planning and monitoring progress. The DMS captures qualitative narrative reports and a range of quantitative indicators. It takes a bottom-up approach to ensure accurate and reliable reporting from IPs at the grassroots level feeding into the KHANA monitoring systems at the national level. The DMS is used to generate the data and information needed for programmatic reviews and external reports. The DMS has already attracted considerable attention from stakeholders [6] for its ability to capture and generate complex information from a wide range of partners. The DMS complements the International HIV/AIDS Alliance's global Monitoring and Reporting System (MRS) which consolidates data and reporting from Alliance linking organizations at the country level to provide global level analysis across the Alliance.

KHANA takes the following approach to monitoring SAHACOM:

- **Review and adaption of organizational M&E guidelines:** To support the Database Management System, KHANA has produced accompanying guidelines. In consultation with USAID and with inputs from IPs and beneficiaries, these will be reviewed, adapted and updated, as appropriate.

- **Conduct field monitoring:** The Implementing Partner Program Management Department, through its three regional teams, undertakes Technical Support and monitoring visits on a quarterly basis to each IP. The M+R team will undertake follow-up visits and review existing field visit forms and templates, adapting them as appropriate, to increase levels of reporting on success stories, reported behavior change and achievement of program results. This data will in turn feed into strategic information (SI) activities.
- **Implement and strengthen qualitative program monitoring:** The DMS is linked to the participatory 'review and re-planning' process in which KHANA meets with IPs annually to review progress, discuss achievements and challenges in program implementation, and plan ahead. Program beneficiaries, community support volunteers, peer educators, peer facilitators and IP staff participate in these meetings. KHANA conducts quarterly program meetings with partners, key personnel and program staff to review progress against targets. During TS field visits, KHANA staff review, develop and strengthen existing tools to better capture basic qualitative data on attitude, behavior and practice, especially among MARP beneficiaries. This information is linked to SI activities. KHANA also works with IPs and outreach workers in the use of participatory evaluation methodologies, such as Most Significant Change methodology.
- **Assuring quality and accuracy of information:** IPs use one standard reporting format in order to ensure consistency and comparability of data, to facilitate data quality assurance and minimize data errors. KHANA has a rigorous internal system for quality assurance, with reports viewed by the assigned Program Management Officer (PMO), then by the Regional Team Leader, the IPPM Director, and finally by the M+R team. Reviews will monitor IP performance against KHANA Standard Package of Activities (SPA) to ensure activities reach required quality standards. For SAHACOM, KHANA will review and harmonize its standards against those in the MoH/NCHADS SOP. As a member of the International HIV/AIDS Alliance, KHANA will also incorporate the Alliance quality standards for community-based HIV programming. The Alliance standards are based on evidence and expertise from community level HIV programming globally.
- **Submit regular reporting:** KHANA provides programmatic and financial progress reports to USAID on a semi-annual, annual and end-of-program basis. These reports present a comprehensive overview of programmatic and organizational performance for the reporting period with annexes detailing grants, performance indicators, and beneficiary coverage and case studies within USAID formats. The DMS will additionally be used to generate reports on program coverage data to feed into national-level M&E.
- **Strengthen collaboration and networking with other agencies in M&E:** KHANA continues to actively contribute to the National M&E Technical Working Group under the NAA. It also works with other agencies, including UNAIDS, to contribute to efforts to roll out harmonized processes for national M&E tools, indicators and systems development and to share and develop M&E and research methods.
- **Provide TA on monitoring systems, data use (quantitative/qualitative) and program planning:** Particular emphasis will be placed on strengthening IP capacity to analyze program data and apply this to improve program planning. IP needs for technical support on M&E will be identified during TS field visits, using a capacity assessment tool, adapted from the Alliance's *NGO Capacity Assessment Toolkit* [7]. Periodic training workshops on participatory evaluation methodologies (such as Most Significant Change) will be held for IP and other stakeholders, including program beneficiaries from PLHIV and MARP groups. These workshops will form the basis for greater involvement of community beneficiaries in program planning and evaluation.
- **Linking program monitoring to strategic information and knowledge sharing:** The Strategic Information (SI) and knowledge sharing activities proposed for this program will be linked to KHANA monitoring systems.

OBJECTIVES

The objective of this baseline documentation is six-fold.

1. To establish baseline data for prevention as well as behavioral indicators for focused prevention with MARPs.
2. To establish baseline indicators for care and support related to integrated care and prevention (ICP) among PLHIV, OVC and affected families.
3. To explore the challenges and issues of project implementation in relation to FP with MARP and ICP for PHIV and OVC, livelihoods and collaboration and coordination with local authorities and law enforcement agencies.
4. To assess organizational capacity of SAHACOM implementing partners.
5. To review the strengths and challenges of the new SAHACOM model (FP & ICP).
6. To make recommendations for further improvement of the SAHACOM project.

METHODS

This baseline information is mainly based on desk review, field visits and consultative meetings. The desk review included review of existing surveys and study reports, project reports, planning and monitoring reports and reports from technical support visits (TSVs) conducted in 2009 and early in semester 1 of 2010. Field visits were necessary to verify and corroborate the collected information to ensure data accuracy and completeness. Finally at least 4-5 consultative meetings were held with KHANA Management Consultative Team and technical staff (M&E and IPPM staff) in order to get more inputs and clarifications to ensure key relevant issues related to the goals of SAHACOM project were covered.

Table 1 illustrates the different levels of indicators that can be tracked by surveys and studies (impact and outcome indicators), and program and project based data (inputs and output). In addition, others indicators in the 'M&E and Reporting Guidelines of KHANA Implementing Partners and Donors', tracked by the database information system were reviewed.

Table 1: Selected Indicators from M&E Framework in SAHACOM

Indicators	Data sources
Impact Indicators: Long term effect of the project and program, measured by population based surveys and studies (biological and socio-behavioral)	
HIV prevalence among ANC aged 15-24 years	NCHADS HSS.
% of PLHIV on ART	NCHADS reporting system
Quality of life for PLHIV	UNDP Socio-economic study
Outcome indicators: Short term effect due to the program, measured by the baseline and follow-up surveys, behavioral surveillance survey	
% of MARP reporting the consistent use of condoms (i.e. EW, MSM, DU, IDU)	BSS, baseline, mid-term and end of program evaluations
% of adults and children with advanced HIV infection receiving ART	Database and baseline, mid-term and end of program evaluations
% MARP that have received HIV testing	NCHADS BSS, KHANA baseline, end of program evaluations
Output indicators: Immediate effect, services and activities delievered to target groups, measured mostly by supervision and quarterly reports, program data	
Number of households with OVC that receive a minimum package of support	Routine quarterly reports from the Data Management System (DMS)
Current school attendance among orphans and among non-orphans aged 10-14	Routine quarterly reports from DMS
Number of people newly initiating antiretroviral therapy during the reporting period	Routine quarterly reports from DMS
Number of HIV-infected clients attending HIV care and treatment receiving TB treatment	Routine quarterly reports from DMS
Number of people receiving family planning and SRH counseling	Routine quarterly reports from DMS

1. Desk Review

A desk review was carried out by the research team covering review of relevant surveys, studies, reports and projects documents, and data from the database management system.

A Review of surveys and studies including:

- Mid-term review of the Integrated Care and Prevention (ICP) project regarding PLHIV and OVC (January 2010)
- Baseline survey on HIV knowledge, attitudes, practices and related risk behaviors among MARPs (January 2010)
- Socio-economic impact of HIV/AIDS epidemic at the household level in Cambodia (Sanigest International and UNDP-Cambodia, June 2010) (Draft report)
- Measuring Impact: Condom use among high risk urban men (PSI 2009)
- Behavioral surveillance survey (BSS 2010, NCHADS on-going data collection July 2010)
- PLHIV Stigma Index study (CPN+ and KHANA, August 2010)

B Review of program and project reports including:

- KHANA semi-annual donor report to USAID (October 2009 to March 2010)
- KHANA Planning and Monitoring Reports (PMR): budget, group, performance, coverage)
- KHANA financial reports 2009-2010
- M&E framework of SAHACOM project (KHANA 2009)
- KHANA Annual Reports 2009 and 2010

C Additional data analysis and data sources

- KHANA program monitoring database (DMS)
- Data from the socio-economic impact of HIV/AIDS epidemic at the household level in Cambodia (Sanigest International and UNDP-Cambodia, June 2010)
- HIV Surveillance Survey-NCHADS, 2006
- Mith Samlanh and Korsang Routine Survey Survey-2004
- Introduction, Administration, Scoring and Generic Version of the Assessment, WHO 1998

- Behavior Surveillance Survey, NCAHDS, 2010
- Cambodia STI Surveillance Survey, NCAHDS, 2005

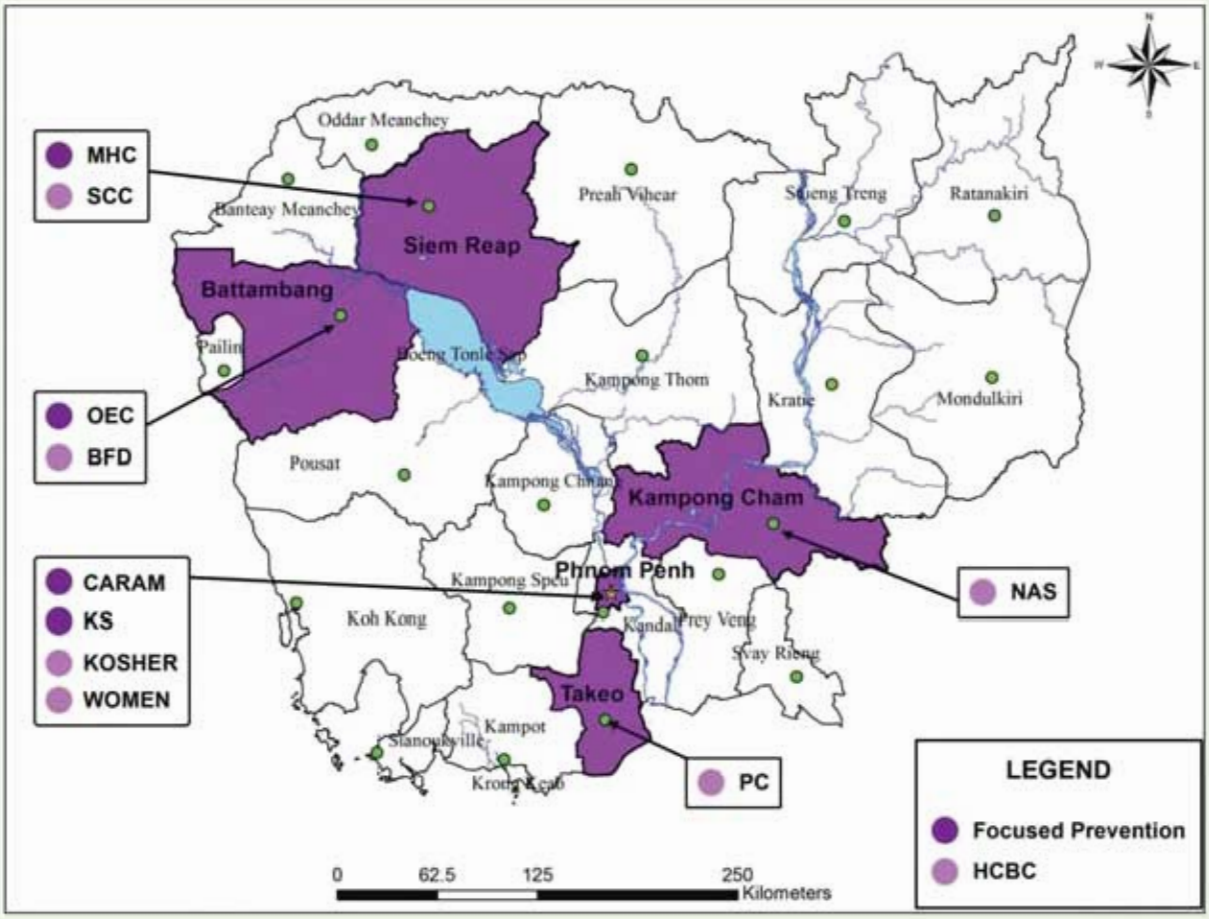
2. Field Visits

The research team conducted field visits to 10 implementing partners in 4 provinces and 1 municipality including Battambang, Siem Reap, Kampong Cham, Takeo and Phnom Penh between 06 and 21 December 2010 (see Figure 6). A total of 91 persons, including Executive Directors (ED), Program Coordinators (PC), CSO, OVC Team leaders, CSV, PE and PF, participated in focus group discussions (FGD) during field visits. The FGDs were arranged with each of the 10 selected partners and each focus group included 8-10 parsons. A FGD tool was developed and used during the visits (see annex 3).

The purpose of the field visits were the following:

- To update information related to focused prevention (FP) and integrated care and prevention (ICP) including coverage, MARP population size and data quality.
- To verify operational procedures and tools used (e.g. the SOP or adapted SOP for program implementation).
- To identify challenges and barriers in implementation and emerging issues.
- To interview key informants and IP management teams and observe delivery of services with the ICP and FP teams.
- To gather feedback and comments from IP and beneficiaries around program implementation.

Figure 6: Provinces/Municipality Covered During Field Visits



3. Consultative Meetings

In order to support the review process and report writing, various consultative meetings were carried out. The first was conducted within the KHANA Strategic Information Department (previous name before the Monitoring and Reporting team and Research Department were separated) to get primary feedback and comments on methods, timeline, and team composition. The second meeting was conducted to get technical inputs from the Program Management Department (previous name for Implementing Partner Program Management Department before M&R and grant management teams were added) and Technical Support and Best Practice Department. After these consultative meetings a finalized protocol was developed. A third consultative meeting was held to review the first draft report to gather additional inputs, comments, and suggestions with the Program Management, Technical Support and Best Practice Departments. A final draft report was sent to Senior Management Team (SMT) for gain final inputs.

RESULTS

1. Quantitative Baseline

1.1 Input Indicators:

These indicators include project staff, funding and facilities. These indicators are measured through supervision, financial reports and monthly or quarterly program reports. Number of staff and amount of funding are shown in Tables 2, 3, and 4. There were close to 250 project staff including both full time and part time staff. These IP staff, community volunteers and peer facilitators included PLHIV to increase effectiveness of program implementation. Sixteen staff and 464 volunteers were HIV positive.

Table 2: Resource Staff at Implementing Partner Level under SAHACOM Project

	Female	Male	Total
Number of Full-time staff	77	111	188
Number of Part-time staff	29	26	55
Total number of staff both part-time and full-time	**106**	**137**	**243**
Number of staff infected with HIV	8	8	16
Number of Team Volunteers /Peer Facilitators (PF)	253	290	543
Number of Village Volunteers /Peer Educators (PE)	319	283	602
Total Number of Volunteers and PF/PE	**572**	**573**	**1145**
Number of Volunteer/Peer Educator infected with HIV	209	255	464

Source: KHANA PMR Oct-Dec 2010

Criteria for providing grants to partners

KHANA provides grants to ICP partners based on the number of self help group (SHG) and number of support groups (SG) reached. A self help group should be composed of 15-20 PLHIV and 20-25 children for an OVC support group. Therefore, KHANA calculates partner grants based on the total number of SHG and SG, with approximately $1,150 per SHG and $750 per SG being allocated. Likewise, for focused prevention with MARPs, the number of beneficiaries is calculated in order to determine the grant amount. The amount also varies according to geographical areas; coverage of 100-150 people will be allocated a budget amount of $15,000 for urban/provincial town areas (as beneficiaries are located in closer proximity to each other) and approximately $18,000 for a rural/ isolated area (as beneficiaries are located further apart from one another).

Table 3 illustrates the budget and allocation per partner during the last year of the previous three year project funded by USAID PEPFAR (before SAHACOM). In that year, KHANA work covered 10 provinces and municipalities. Twenty six IPs received grants, with the total value being USD $1,798,886.81. Table 4 shows the budget and allocation per partner for grants in the financial year Oct 09 – Sept 10, with a total budget of USD $1,345,546. The grant amount between the years is roughly a bit different, the focus under SAHACOM is more on the long term partners of KHANA rather than providing one off or short term grants.

Table 3: Budget for Implementing Partners, Oct 08- Sep 09

No	Partners	Funding (USD)	Main Activity	Geography
1	AFD	40,693.00	ICP*	Takeo & Kampot
2	BFD	102,719.00	ICP	Battambang & Siem Reap
3	BWAP	34,985.00	ICP	Battambang
4	CARAM	74,861.00	FP**	Phnom Penh
5	CPN+	45,295.00	NW***	Phnom Penh & Kandal
6	CSCN	20,155.00	ICP	Pursat
7	CSDA	23,091.00	ICP	Banteay Meanchey
8	HACC	44,000.00	NW	Phnom Penh
9	IDA	70,832.00	ICP	Phnom Penh
10	KBA	60,616.00	ICP & FP	Banteay Meanchey
11	KDFO	20,000.00	FP	Phnom Penh
12	KOSHER	87,711.00	ICP	Phnom Penh
13	KS	109,467.00	FP	Phnom Penh
14	KT	61,651.00	ICP	Kampong Cham
15	KWWA	25,582.00	ICP	Kratie
16	Maryknoll	424,682.00	ICP	Phnom Penh
17	MHC	56,454.00	FP	Siem Reap
18	NAS	70,807.00	ICP	Kampong Cham
19	OEC	22,007.00	FP	Battambang
20	PC	173,863.00	ICP	Takeo & Pursat
21	SCC	45,776.00	ICP	Siem Reap
22	SEADO	38,776.00	ICP	Banteay Meanchey
23	SFODA	27,514.81	ICP & FP	Phnom Penh
24	VC	16,469.00	ICP	Phnom Penh
25	WMC	34,983.00	FP through Media	Phnom Penh
26	WOMEN	65,897.00	ICP	Phnom Penh
26 Implementing Partners (IPs)		**$1,798,886.81**	**18 ICP, 8 FP, and 2 NW**	**9 Provinces and 1 Municipality**

** ICP = Integrated Care & Prevention*

*** FP = Focused Prevention*

**** NW = Network*

Source: Annual Program Report to USAID/Cambodia, Oct 2008 to Sep 2009

Table 4: Budget for Implementing Partners, Oct 09- Sept 10

No	Partners	Funding (USD)	Main Activity	Geographic Area
1	AS	20,463	HCBC*	Battambang
2	BFD	90,461	HCBC	Battambang
3	BSDA	37,930	HCBC	Kampong Cham
4	BWAP	36,047	HCBC	Pailin
5	CARAM	49,997	FP**	Phnom Penh
6	CPN+	73,227	SP***	Phnom Penh
7	CSCN	50,505	HCBC	Pursat
8	CSDA	44,833	HCBC	Banteay Meanchey
9	HACC	40,104	SP	Phnom Penh
10	IDA	55,338	HCBC	Phnom Penh
11	KBA	31,936	HCBC	Banteay Meanchey
12	KORSANG	97,056	FP	Phnom Penh
13	KOSHER	71,188	HCBC	Phnom Penh
14	KT	41,312	HCBC	Kampong Cham
15	MHC	54,660	FP	Siem Reap
16	MODE	20,183	HCBC	Siem Reap
17	NAS	56,822	HCBC	Kampong Cham
18	OEC	22,459	FP	Battambang
19	PC	185,460	HCBC	Pursat & Takeo
20	RACHANA	23,740	HCBC	Takeo
21	SCC	46,014	HCBC	Siem Reap
22	SEADO	32,501	HCBC	Banteay Meanchey
23	SIT	20,001	FP	Phnom Penh
24	VC	29,920	HCBC	Phnom Penh
25	WMC	36,786	FP through Media	Phnom Penh
26	WOMEN	76,603	HCBC	Phnom Penh
26 partners		**1,345,546**	**18 HCBC, 6 FP, and 2 SP**	**7 provinces and 1 municipality**

Source: KHANA's Semi-Annual Progress Report to USAID/Cambodia, Oct 2009 to March 2010

** HCBC = Home and Community Based Care*

*** FP = Focused Prevention*

**** SP= Strategic Partner*

Table 5: SAHACOM 2010 Budget by Category at KHANA Level

Category	Amount (In USD)
Medicine and Pharmaceutical Products	253
Exchange Visit	2,792
Professional Fees	9,700
International Travel	18,521
Living Supports to Client/Target Population	22,221
Field Trip	29,090
Equipment	47,606
Consultants	75,581
Office Running Costs	87,368
Workshops	89,153
Publications	93,163
Meeting & Events	121,625
Sub-agreements	142,524
Personnel & fringe	421,300
Grant to Partner	1,455,451
Total	**2,616,348**

Source: Supporting Community Action for HIV and AIDS in Cambodia, Annual report 2010

Based on the USAID fiscal year, the first year of SAHACOM sub agreements to implementing partners ran from Oct 2009 to Sept 2010. For the 26 implementing and strategic partners involved in the program, KHANA signed agreements for a total amount of USD $1,345,546. The grant amounts provided to IPs varies from year to year. The total grant amount provided to partners during the KHANA fiscal year Jan–Dec 2010 was USD $1,455,451. The difference between the two amounts is due to the increased amount during quarter one (Oct-Dec 2010) in year two (USAID fiscal year).

In each of the quarters some of the IPs were affected by delayed disbursements which resulted in some planned activities not being completed. In addition, some program budget constraints have been major barriers to project implementation including the amount of budget allocated for running costs, technical support (for strategic and operational plan development), and for organizational development. As highlighted at the 2010 Regional Partners meeting there was no budget for international travel included [6].

1.2 Output Indicators

Output indicators cover services and activities delivered to target groups, measured through program monitoring and supervision, and regular program reports. Key indicators are shown in Table 6.

Table 6: Output Indicators of KHANA Program

Code		Indicators	Oct-Dec 2009		
KHANA	USAID		F	M	Total
Focused Prevention					
K01	H2.3D	Number of service providers/Community Support Volunteers (CSV) trained in HIV prevention (including FP, PE)	83	74	**157**
K1104	P7.1D	Number of PLHIV reached through HIV prevention activities	1,123	705	**1,828**
K1101	P8.1D	Number of OVC or/and youth from 11-24 reached through HIV prevention activities including life skills (=A&B)	1,033	882	**1,915**
K1102	P8.1D	Number of individuals reached through stigma and discrimination session	668	359	**1,027**
K1103	P8.1D	Number of Married Couples reached through HIV prevention activities	870	332	**1,202**
K1111	P8.1D	Number of People reached through HIV/AIDS and Drug prevention activities	2,076	1,041	**3,117**
K12	P8.1D	Number of general population reached through community events			**12,308**
K1105	P8.3D	Number of MSM reached through HIV prevention activities		828	**828**
K1107	P8.3D	Number of Female Entertainment Workers reached through HIV prevention activities	682		**682**
K1110	P8.3D	Number of IDU reached through HIV/AIDS and Drug prevention activities	129	660	**789**
Home and Community Based Care					
K18	C1.1D	Number of PLHIV family members received care and support (Include PLHIV)	9,043	8,184	**17,227**
K27U	C1.1D	Numbers of OVC members received care and support	4,384	3,967	**8,351**
K19	C2.1D	Number of PLHIV received ART through support of HCBC	2,544	1,809	**4,353**
K30	C2.1D	Number of infected children received ARV through HCBC	122	134	**256**
K20	C2.4D	Number of HIV-infected clients attending HIV care / treatment services that are receiving treatment for TB disease (DOTS)	36	34	**70**
K23	H2.3D	Number of NGO staff/CSV trained in providing HCBC	63	60	**123**
K24	H2.3D	Number of care givers as family member trained in providing home based care	198	134	**332**
K36	H2.3D	Number of NGO staff and volunteers trained in caring for OVC	15	15	**30**
K37	H2.3D	Number of service providers / caretakers trained in caring for OVC	124	56	**180**

Source: KHANA's Partner Monitoring Reports (PMR) Dec, 2009.

All the above output indicators are non-cumulative indicators. The data provided is for only one particular quarter, and is not cumulated with the previous quarter or year. See the detailed explanation of the indicators in annex 1.

Table 7: Output Indicators in SAHACOM's Monitoring and Evaluation Framework

SAHACOM's Monitoring and Evaluation Framework	2009	KHANA Code
Number of OVC served by OVC programs	6756	K28
Current school attendance among orphans and among non-orphans aged <18	959	K34
Number of households with OVC that receive minimum package of support	105	K35
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	70	K20
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	133	K04
Number of newly initiating antiretroviral therapy during the reporting period	231	New (K19+K30)
Number of individuals who ever recieved antiretroviral therapy by the end of the reporting period	4378	OLD (K19+K30)
Number of individuals receiving antiretroviral therapy at the end of the reporting period	4609	K19+K30
Number of HIV-infected clients attending HIV care, treatment receiving TB treatment	6877	K16+K29

Source: KHANA's Partner Monitoring Report (PMR) Dec, 2009.

Since a number of indicators used in USAID semester and annual reports are not originally in the SAHACOM's M&E framework, selected indicators from the M&E framework are shown in Table 7 above. See the detailed explanation of the indicators in Annex 2.

1.3 Outcome and Impact Indicators

Outcome indicators were defined as short term effects of the program measured by the baseline and follow-up surveys, as well behavioral surveys as part of the national surveillance system. As shown in Table 8, indicators are related to HIV testing at VCCT in the past 12 months and consistent condom use among MARPs.

Impact indicators were defined as the long term effect of the project or program, measured by population based surveys and studies conducted by the national HIV/AIDS program. The typical impact indicators are change in HIV prevalence trends and decline of HIV incidence. As illustrated in Table 8, all HIV prevalence data are based on NCHADS data which was collected from 2005 to 2007. Data on the quality of life of PLHIV was based on the UNDP socio-demographic study of PLHIV in Cambodia in 2010. [7]

Table 8: Outcome and Impact Indicators

No	Indicators	Baseline	Sources
	Outcome Indicator		
	Focused Prevention		
1	% of MSM reporting the correct and consistent condom use (with sweetheart in the past month)	26.9%	The Baseline Survey
2	% of ESW reporting the correct and consistent condom use (with sweetheart in the past three months)	61.7%	The Baseline Survey
3	% of DU reporting the correct and consistent condom use (with regular partner in the pass 12 months)	28.3%	The Baseline Survey
4	% of IDU reporting the correct and consistent condom use (with regular partner in the past year)	30.3%	NCHADS, 2007
5	% of MSM that have received VCCT in the last 12 months	58.3%	The Baseline Survey
6	% of ESW that have received VCCT in the last 12 months	68.1%	The Baseline Survey
7	% of DU that have received VCCT in the last 12 months	60.8%	The Baseline Survey
8	% of IDU that have received VCCT in the last 12 months	52.0%	NCHADS, 2007
	Home and Community Based Care		
9	% of PLHIV adult received ART*	60.3%	KHANA, 2009
10	% of PLHIV adult received ART**	69.0%	KHANA, 2009
11	% of CIA received ART*	62.5%	KHANA, 2009
12	% of CIA received ART**	59.4%	KHANA, 2009
	Impact Indicator		
	Focused Prevention		
1	HIV prevalence among adult population (15-49years)	0.7%	NCHADS,2007
2	HIV prevalence among MSM	5.0%	NCHADS,2005
3	HIV prevalence among ESW	14.0%	NCHADS,2006
4	HIV prevalence among DU	1.1%	NCHADS, 2007
5	HIV prevalence among IDU	24.4%	NCHADS, 2007
	Home and Community Based Care		
6	**Quality of live of PLHIV**		
6.1	Rated their life as good among adult PLHIV (in the last four weeks)	35.4%	UNDP, 2010
6.2	Health satifaction among adult PLHIV (in the last four weeks)	52.4%	UNDP, 2010
6.3	Feeling safe in daily life	33.6%	UNDP, 2010
6.4	Enough money to meet the need	2.8%	UNDP, 2010
6.5	Satisfaction with the HCBC service	83.0%	KHANA, 2010
6.6	Satisfy with ability to perform daily living	48.5%	UNDP, 2010
6.7	Satisfy with capacity for work	49.7%	UNDP, 2010
6.8	Satisfy with access to health	87.8%	UNDP, 2010

** Under KHANA's coverage by December 2009.*

*** Under SAHACOM project from Oct-Dec 2009.*

1.3.1 Prevention

Most of the outcome and impact indicators were based on previous national surveys . In these surveys HIV prevalence among MSM was > 5% nationally and 8.7% in urban areas [8]. MSM who reported correct and consistent condom use in the past month is 26.9 % with current sweethearts, 80% with paid sex, 66.6% with women, 60% with male sweethearts, 75% when buy sex from men, 69.3% when selling sex to men, 55% when inserting penis in partner's anus in the past, and 63.5% when having receptive sex in the past 12 months. 58.3% of MSM, both short and long hair, had received VCCT in the past 12 months [9].

HIV prevalence among entertainment sex workers (ESW) was 14% [10]. 89.2% ESW reported correct and consistent condom use with clients in the past month, and 61.7% with sweethearts in the past three months. 68.1% of ESW had received VCT test in the past 12 months [9].

HIV prevalence among Drug Users (DU) and Injecting Drug Users (IDU) is 1.1% and 24.4% respectively [11]. 28.3% of DU reported correct and consistent condom use with their regular partner, 85.3% when paying for sex (for male DU only), 96.4% with their clients for DU who are also EW, and 81.3% with casual partners. 60.8% of DU had received VCCT testing in the past 12 months. 30.3% of IDU reported always using condoms when having sex with regular partners in the past year, 61.7% with non regular partners in the past year, and 69.3% with paid sex in the past year. 52% IDU in IDU Rehabilitation Center and 54% of IDU in the community had received VCCT services respectively [12].

1.3.2 Care and support

The main indicators used for ICP are about the quality of life of PLHIV based on respondents "perceived" quality of life [13] . However, the indicators aim to reflect multiple dimensions of quality of life including health, living conditions and financial stability. Questions asked included whether they had been satisfied with their health, were able to concentrate well, and able to perform tasks related to daily living. 35.4% of adult PLHIV rated their life as good, 33.6% felt safe in their daily lives, and 2.8% reported having enough money to meet their needs. 52.4% reported being satisfied or very satisfied with their health in the past four weeks. 48.5% and 49.7% were satisfied with their ability to perform tasks related to daily living and with work capacity, respectively [7]. The midterm review of ICP regarding PLHIV and OVC conducted by KHANA in 2010 found that 83% were satisfied with the ICP program [14]. In KHANA programmes in December 2009, the percentage of PLHIV adults who received ART was 66.5% (male: 67.9% vs. female: 65.4%). The percentage of children infected with HIV/AIDS (CIA) who received ART is 64.1% (boys: 62.8% vs. girls: 65.3%). For SAHACOM specifically, in December 2009, 69% of PLHIV adults received ART (male: 69.1% vs. female: 69%) and 59.4% CIA received ART (boys: 59.6% vs. girls: 59.2%) [15]

2. Qualitative Baseline

Qualitative methods were used in order to better understand the challenges and issues of project implementation in relation to the new models for prevention interventions with MARPs, and care and support for PLHIV and OVC, as well as community involvement. FGDs were employed to collect qualitative data on these areas. Data was grouped and categorized according to these themes.

The qualitative data reflects the three main components under KHANA focused programs:

- Focused prevention with most at risk populations such as drug users, MSM and entertainment workers; and integrated care and prevention for PLHA and OVC including a comprehensive package including basic medical care, psychological support, access to education, prevention education, and access to medical services including referrals to ART, Happy Happy programs for OVC, and positive prevention support.
- Food support from the World Food Program (WFP), and livelihood support with most at risk populations and PLHIV. These activities including income-generation and vocational training opportunities.
- KHANA and IP work on policy dialogue and networking through collaboration and coordination including with local and national authorities.

2.1 HIV Focused Prevention (FP) and Integrated Care and Prevention (ICP)

Five areas are covered under this section: coverage and target population; monitoring and reporting systems; referral and follow up; social welfare and food support to PLHIV and OVC; and sexual and reproductive health.

2.1.1 Coverage and target population

Six implementing partners work on focused prevention activities including work with the media. These include CARAM, KORSANG, MHC, OEC, SIT and WMC working in three coverage areas: Siem Reap, Battambang and Phnom Penh.

MHC works with MSM in Siem Reap, while CARAM and SIT work on HIV prevention among EW in Phnom Penh. OEC and KORSANG have been working on drug related HIV prevention focusing on injecting drug users and ATS users in Battambang and Phnom Penh, respectively. The activities include outreach, peer education, care and support and operation of drop-in centers. Through peer education, these implementing partners update drug users on information relevant to HIV and drug use, related illnesses, drug use reduction and related risk behaviors, including unsafe sex practices. At the same time, PF and PE also provide counseling and testing services and conduct home visits to beneficiaries to follow up their health status and offer referrals for medical or other social services. 18 implementing partners work on Integrated Care and Prevention among PLHIV and OVC as detailed below:

Name	Abbreviation	Province
Cambodian Socio-Economic Development and Democracy Association	CSDA	Banteay Meanchey
Khmer Buddhist Association	KBA	Banteay Meanchey
Social Environment Agricultural Development Organization	SEADO	Banteay Meanchey
Buddhism For Development	BFD	Battambang
Aphivat Strey Organization	AS	Battambang
Buddhism and Society Development Association	BSDA	Kampong Cham
Kasekor Thmet	KT	Kampong Cham
Nak Akphiwat Sahakum	NAS	Kampong Cham
Battambang Women's AIDS Project	BWAP	Pailin
Indradevi Association	IDA	Phnom Penh
Social Health Educational Road	KOSHER	Phnom Penh
Vithey Chivit Organization	VC	Phnom Penh
Women Organization for Modern Economy and Nursing	WOMEN	Phnom Penh
Cambodian Save Children Network	CSCN	Pursat
Partners in Compassion	PC	Pursat & Takeo
RACHANA	RACHANA	Takeo
Minority Organization for Development of Economy	MODE	Siem Reap
Salvation Center Cambodia	SCC	Siem Reap

Source: KHANA, 2009

Overlapping target groups is still a big challenge

A major challenge of program coverage is overlapping target coverage among USAID funded projects through FHI, KHANA, and PSI. A field assessment was conducted by a joint USAID and relevant NGO team on this issue [16]. Some findings are highlighted below:

- It appears the delivery of messages to the same target group could be better coordinated and efficient. For example, in Battambang, MHC has been providing AB messages to MSM on one day and C messages to MSM on another separate visit. This appears to have been done for administrative and programmatic convenience.
- The PHD and PAO appear to have a coordinating role in the province of Battambang and Siem Reap to facilitate coordination between organizations.
- USAID could facilitate communication between partners at the provincial level as this is not happening fully effectively. One example is the lack of communication between MHC and Marie Stopes International Cambodia in relation to perceived target overlaps in Battambang and Siem Reap.
- Often one person could be considered under multiple MARPS categories. It is not clear how partners account for this overlap between DU, EW and MSM.
- The USAID partners should coordinate conversations between sub-partners in the field, whether or not they have USG funding, to deliver a more efficient response.

As suggested by USAID, it is recommended that KHANA, PSI, and FHI need to coordinate in order to minimize overlapping activities, and to coordinate on overhead and training costs, and calendar plans in order to maximise efficiency and effectiveness. Joint technical support and monitoring visits either with FHI or PSI need to be set up on a quarterly basis.

Division of coverage and target group population

The Provincial Health Department (PHD) plays an important role when it comes to coordination in dividing target areas for both focused prevention and integrated care and prevention. Under the management of the Provincial AIDS Office (PAO), overlap of target areas could be minimised. The PHD could call for meetings regarding overlap concerns and seek consensus on division of targets and coverage. KHANA and its IP aim to stay ahead by conducting mapping assessments for initial new projects or coverage scale up. This initial assessment not only identifies available geographic coverage but also assesses the needs of the target group.

'Before setting up the program, we did a mapping to get an idea of where the potential target groups are and if there are any other NGOs working in that particular geographical area. With PHD's coordination, we could avoid potential coverage overlap' (Community Support Officer-FGD)

2.1.2 M&E and reporting system

Required donor indicators

Receiving funding from multiple donors, KHANA must comply with various reporting requirements. KHANA reports to each donor including USAID, GFATM, EC and AusAID on a quarterly or semi-annual basis including indicator data and narrative text. The various donor indicators contribute to a list of KHANA indicators which harmonizes all donor indicators in one database management system. To facilitate use of this system KHANA has developed a number of tools including M&E guidelines, data collection tools, monitoring systems and database management system. These details can be found in the KHANA Monitoring, Evaluation and Reporting Guidelines [17].

Capacity and workload of IP staff and contribution of KHANA staff

The KHANA reporting system is comprehensive for capturing output indicators at IP level, however many IPs still challenges using the system [18]. These challenges include: the workload for IPs related to multiple funding sources and different M&E requirements; limited staff capacity; limited computer capacity (i.e. old computers with low version software); time required for using Excel templates; and availability of internet for email connection. It is crucial to look at the role of the program management officer (PMO) and database management officer (DBMO), which is critically important to regularly support the implementing partner in collection of reliable and accurate data. A further challenge with the M&E and reporting system is that in the new SAHACOM model, part of the role of peer facilitators and CSVs is to help fill in the data collection form and send to this to program

support officers for data quality assurance and consolidation. Further capacity building is needed to strengthen skills in data entry and analysis to prevent poor data collection and entry.

'The database is too big in size thus it's running quite slow especially in low capacity computer.' (M&E Officer-FGD)

'We have no big problems with the reporting system, only some errors found from PF but we mentored them. It was hard at the first but later on we will be able to do it better on our own' (ESW program-FGD)

To strenthen the capacity of IP staff, KHANA focuses on provision of regular training on M&E and reporting. However, only a few relevant IP staff, usually from management level, are able to participate in KHANA M&E trainings due to limited budget allocation for M&E training. Besides these trainings, the KHANA team, including PMOs and the M&E team, periodically conduct direct orientation and coaching to M&E focal persons in IPs during technical support visits or upon request.

'Only one or two staff could participate in the trainings. We, the rest of the staff, wish to participate in the next training but...' (Community Support Officer-FGD)

Complexity of the M&E and reporting system

KHANA experienced many revisions of the monitoring and reporting system due to donor requirements. This required KHANA and IP time and effort to revise the database management system (DMS). Revisions were also made to the system to reduce errors, improve data entry processes and make it more user-friendly. Many implementing partners find the new DMS data entry process very time consuming. In addition, the many forms they are required to fill out, and revisions to those forms, also require IP time and effort [19]. Training on the forms is required to familiarize users on their use. Despite frequent revisions, many IP staff in the focus group discussions revealed they aim to overcome these challenges.

'...KHANA reporting system has changed so many times. We are too old and we are not that smart. Luckily, we have our assistant that can help to enter the data every month...' (Drug use program-FGD)

'The forms have changed quite often. An updated form was introduced right after CSV and CSO had been trained on how to use the previous version. Most of the CSVs are not highly educated and are not very flexible to the new forms. I believe that both KHANA and donors well understood about the matter. If the forms are more users friendly, that would be great. '(Program Coordinator and Community Support Volunteer-FGD)

Simplicity of the system

Many simplifications have been made to achieve a simple uniform reporting format. These include revision of the DMS to reduce errors and improve data entry processes so that they are more user-friendly. Increased simplicity of the system allows data from peer outreach workers or CSVs to be sent through to KHANA for analysis, consolidation and generation of data for donor reports and requirements, as well as to feed into national reports, policies and national strategic plans.

'The reporting system so far is easy to use and acceptable. The updated system is even easier (M&E Officer-FGD)

'I have been working as Program Coordinator at the end of 2009. I find KHANA's M&E system fairly easy. Until 2011 the system is even clearer and better. KHANA needs precise data from each partner.' (Program Coordinator-FGD)

Reporting flow and frequency of the report

Generally, the PF/PE and CSVs collect data and fill out the data collection form to report to the NGO support officer/program coordinator. This person then reviews and consolidates the data and sends it to the KHANA Program Management Officer (PMO). The PMO checks the data and gets back to the IP M&E focal person for further queries. The program management team, including team leader and monitoring and reporting team, also reviews, checks and corrects the data. Due to the numerous steps in report development and the complexity of indicators (Figure 7), it is estimated that it takes about 3 weeks for submitting the consolidated reports from the field to KHANA. Delays and late report submission from IPs are common.

Figure 7: M & E Reporting Date and Flow External to Internal

Source: Monitoring, Evaluation & Reporting Guidelines, 2009

2.1.3 Referral and follow up (STI, SRH, VCCT, OI/ARV and PMTCT)

Referral as part of HIV prevention

Referral of target groups to relevant health services is a core part of KHANA work through close coordination with health-based facilities following the national guidelines. To facilitate MARPs' accessibility to health services, especially DU, ESW and MSM, arranged appointment schedules were made with health facilities, particularly STI clinics and VCCT services. PF and PE contact MARPs through outreach, as well as education at drop-in centers run by KHANA and IPs. PF and PE provide counseling and follow up on access to health services with health service providers. Regarding referrals, PE and PF issued standard referral slips to MARPs attached to health facilities. With this support, MARPs were able to check and follow up their health status regularly. The number of referrals varied according to implementing partners. The referral cost included in the program is an average of USD $3 for transportation. For special referral cases costs are provided up to USD $10 for additional testing including TB, PMTCT and CD4 where cases are HIV positive. PE and PF mostly referred cases for STI and VCCT. It is still challenging to refer cases where long distance travel is needed as the cost is not affordable. PE and PF often decide to refer to health facilities close to their catchment areas or places well known to the PE and PF.

A challenge reported during focus group discussions with drug outreach workers was a concern about referrals for drug users. Drug users were still unwilling and felt stigmatized and discriminated to access to VCCT services although the health facilities were collaborating with the IP. Outreach workers could offer encouragement and advice to drug users to access testing services but not force them to test without their consent.

'We have referral cards, health facility contacts…we referred them but it is not easy. It is hard to approach them even after we gave them the information about the benefit of taking blood test…' (Drug use program-FGD)

'We advise and explain to them [beneficiaries] to be brave to get HIV test. If they did not agree we will not refer them or they can seek for service by themselves' (MSM outreach workers-FGD)

Implementing partners had referral and follow up systems in place. In the case of beneficiaries engaging in unsafe behaviours, they were referred to VCCT every three months and referrals for STI testing were provided on a monthly basis.

'For the referral, we tested for HIV very three months if we suspected to have unsafe sexual relations. In case we have safer sex, we will have blood test in every six months. We have checked for STI once a month if we are quite risky of sexual relation…' (MSM-FGD)

Referral as part of care and treatment

Referral and follow up have been provided for PLHIV through CSVs. Working closely with the CoC and OD, CSVs and IP staff referred PLHIV to health services including OI/ARV, CD4 count, TB, and PMTCT. Referral to treatment is one of the core functions provided by CSVs. Referrals are based on appointments noted on referral cards. They can also go to the OI/ARV site by themselves and can claim for transportation from the CSV afterward. In order to be sure that they actually went to get services as referred, NGO staff maintain contact with health center staff and SHG members. Even though IPs have a strong referral system, CSVs and program managers reported challenges including the fact that PLHIV are highly mobile for work. Additionally, some PLHIV did not keep to scheduled appointment dates. This makes referral and follow-up challenging for CSVs. The time allocated for medical check-ups has also been reported as not fairly allocated as people who pay a fee are served first before those who cannot afford to pay.

'We have to wait for so long even if we have the card. If we pay some amount of money we will be served right away; otherwise, we have to wait until after those who paid had been served.' (CSV-FGD)

The attitude of the health providers can also be a barrier preventing PLHIV from seeking health services. Not all PLHIV know their specific

needs for medical treatment and so support from health service providers is indispensable. However, it was reported that the attitude and approach of the health service providers are sometimes not professional.

'The way health service providers talk to us is very rude. They are really in a bad mood. Sometimes they don't even answer our questions. When we, for example, asked about CD4 count for children [number of CD4 vs. the percentage], they said it's our technique and you don't have to understand.' (Community Support Volunteer-FGD)

'If you don't have enough money, don't be sick. USD10 is not enough. This is what the services provider told me. I was so upset and wanted to fight back but unfortunately I was so weak from diarrhea. I went to borrow money from the monk to provide USD30. After I got the money they gave me intravenous therapy.' (Community Support Volunteer-FGD)

2.1.4 Social welfare and food support to PLHIV and OVC

Food support as a basic need for HIV affected families

Based on KHANA selection criteria, the most in need PLHIV and OVC were provided social welfare such as food support, clothes, household items and educational support. In addition, food support from the WFP is also important for PLHIV and OVC families. We continue to work with WFP to provide food support for HIV affected families. This is to improve health and to alleviate the economic burden in the family.

'Eligible OVC have been receiving school materials and uniform, and food support [30kg of rice, 1 kg of cooking oil, and 0.5 kg of salt] from the World Food Program.' (OVC Leader-FGD)

There was concern about food shortages because each IP had scaled up their reach year by year, but the amount of food support available remained the same or even less, resulting in .no guarantee of food support to all PLHIV. Phase in (get the food support) or phase out (no longer get the food support) for both PLHIV and OVC households is based on the selection criteria developed by WFP and development partners. Food support has also acted as a catalyst for PLHIV to disclose their status and access support from CBC. WFP support will end in December 2012.

School attendance support to OVC

It was the role of CSVs, through home visits, to encourage OVC and their families to access education services. Beside support for school materials, the partners also collaborate with the schools to support OVC. School access should be free, but in some instances children have to pay daily money to the teachers. In these cases, the NGO staff will contact those teachers and request that these informal fees be dropped. Implementing partners also provide many of the children with basic school needs including school uniforms and materials.

'We have been advising children to go to school. After we talked to the teachers about charging money in order to go to school, those kids go to school without paying any money.'

'We do not support the school as a whole, but rather provide school uniform and material for both infected and affected OVC.' (OVC Leader-FGD)

OVC dropping out of school

The drop out of OVC from school due to HIV-related stigma and discrimination has been reduced. The main reason for school drop-out is the need for income to support the family. When OVC turn a certain age they sometimes drop out of school to search for jobs. This occurs especially for those whose household are very poor.

'As OVC get older (16-17 years old), they tend to drop out in search for job [labor job] to fulfill their day-to-day needs. They don't have enough to eat and have to feed elderly [grandparents].' (OVC Leader-FGD)

2.1.5 Support to sexual and reproductive health and family planning services

Increased understanding on SRH and family planning

The integration of SRH into HIV programs has started in 2010 through empowering

communities to better understand family planning through community awareness activities and events; integration with positive prevention education among PLHIV; and dissemination of other key SRH and family planning messages. KHANA has adapted the government's Linked Response model to promote the integration of SRH and HIV responses. KHANA and IPs collaborated with health facilities including public and NGO facilities who are working on provision of sexual and reproductive health services for referrals and treatment. Condoms were a common method used among target populations for safer sex and prevention of unwanted pregnancy (dual protection).

'…they increase condom use during the sexual relation comparing to before when they rarely used them. Now they always use, and are not willing to have sex if no condom' (MSM outreach workers-FGD)

'…STI and vaginal discharge including gonorrhea can be transmitted through sexual intercourse so condoms can help them the most...' (Entertainment worker-FGD)

USAID family planning and HIV/AIDS statutory and policy requirements

KHANA and IP programs complied with the statutory and policy requirements of USAID in relation to family planning and HIV. The integration of sexual and reproductive health into HIV programs has been taking place at both KHANA and partner level. KHANA and IP programs increased access to infected and affected populations who might find accessing HIV services difficult. Those programs include sexual and reproductive health and rights, family planning, PMTCT, and unwanted pregnancy. The approach advocates that PLHIV can make their own choices regarding their bodies. IPs and CSVs have no right to force positive women's reproductive choices but can provide advice or consultation, including PMTCT.

'Although they are HIV positive, it's totally up to them to have a baby. No one is going to forbid them as long as they are seeking PMTCT services to make sure that the baby is not infected. You are infected and if your child is infected who is going to take care of you when you become very ill?' (Community Support Volunteer-FGD)

'The majority of them came to discuss with us when they want to have children. We made them take CD4 test. Then we decide if they are healthy enough to have a baby.' (Community Support Officer-FGD)

'I have been advising pregnant women on HIV testing, HIV knowledge, and PMTCT (Community Support Officer-FGD)

Education sessions on health related Issues needed

Specific trainings, including SRH and basic health care, are needed to provide PLHIV and MARPs with enough knowledge to make decisions around SRH and basic health options. Group discussions with community support volunteers showed PLHIV received education sessions on sexual and reproductive health, ARV adherence and regular medical treatment and check-ups. Positive prevention was also included in the education sessions.

'Through education session, PLHIV have been educated on basic health care, referrals to health check-ups and so on…' (Community Support Volunteer-FGD)

2.2 Livelihood Improvement through Vocational Training and Income Generation Activities

Vocational training to improve access to employment

Vocational training is provided targeted to specific jobs. The vocational training provided depends on availability of project budget. Vocational education programs have been targeted to address the employment problems of high-risk populations. Many most at risk persons lack even the most basic academic skills, not to mention the higher education required to secure a well paying job. MARPs require programs that can help develop good communication and social skills, creative thinking, teamwork and responsibility for their own learning and advancement. Vocational programs are provided by KHANA and its implementing and other strategic partners, including government agencies. This vocational training includes occupational training such hair dressing and small grants for running businesses. Sometimes NGO staff can refer beneficiaries for jobs after training, but it is not always the case.

'They cannot be independent even after they received training so we can just refer them to find a job…' (Entertainment workers-FGD)

'The participant, trained on hair dressing and face make up but they don't have enough money to invest so they cannot do so' (MSM outreach workers-FGD)

Income generation activities

In addition to care and support for PLHIV and OVC, Income Generating Activities (IGA) were provided to those in extreme need, along with small business skills training to generate income for their household. Within the 2009 fiscal year of the SAHACOM grants to HIV affected families for IGA was no longer supported. Prior to 2009, under the USAID project, families were provided with between 140,000 and 160,000 Riel (about USD 35-40) to contribute to small businesses such as livestock raising, vegetable planting and grocery selling. The KHANA program management team continues to monitor the grants under IGA activities supported to date. Both successes and failures have been reported. Failure is often due to a number of factors including: limited agricultural skills/knowledge; lack of other proper skills trainings; sole dependence on the IGA budget for survival; the amount of IGA is too little; and diseases affecting livestock.

'$40 is barely enough to make the cage for chicken not to mention buying chicken. It is too little to create a grocery shop as well.' (Community Support Volunteer-FGD)

'Those households who are too poor to earn a living would spend that $40 for their immediate need rather than running small business. How could they possibly buy food for chickens or pigs, for example, when their stomach is rumbling? They will have to feed themselves first.' (Program Coordinator-FGD)

As illustrated in the Household Economic Livelihood Survey report 2010, beneficiaries were highly dependent on aid handouts, limiting motivation to engage in self-driven productive activities [20]. Assistance to beneficiaries included direct aid for health, food, and businesses start up, while a very small percentage of this assistance focused on developing behaviors or skills that would allow households to stabilize and reduce vulnerability by their own resources and means [20].

'The failure rate is about 70% simply because they do not know how to do it [small business and agricultural work] properly.' (Community Support Volunteer-FGD)

Poultry raising could be the most profitable of many other small businesses. A lot of people want to plant vegetables, but the problem is that there is not a sufficient amount of water for irrigation, and some families do not have farm land. They don't have money to buy water for irrigation or to rent a piece of land for planting.

As indicated in the conceptual framework, introducing a livelihood support program as one of the main program components of SAHACOM, aims to support poor affected families by promoting access to microfinance, income generation and business skills in a sustainable way [4]. This is achieved by developing economic self confidence, self respect, self esteem, and encouraging active agriculture and productive behavior [20].

2.3 Collaboration and Coordination with Local Authorities and Law Enforcement Agencies to Establish a Supporting Environment

Collaboration and coordination

In general, KHANA and its implementing partners had strong collaboration and partnerships with various stakeholders, including government agencies, local authorities, religious groups, health service providers, and strategic partners. This was achieved through different channels such as technical working group meetings and provincial meetings. Even though good collaboration has been built up, there are still challenges for program implementation depending on the operating area. Sometimes collaboration and coordination were affected by misunderstandings between outreach workers and law enforcement officers. There is a need to strengthen the level of communication across the relevant sectors, especially with local authorities.

'Since we have no wider cooperation, it is hard to work with drug users; it is linked to the drug law with opposite approaches…' (Drug outreach workers-FGD)

Regular involvement of these stakeholders was crucially important through formal or informal meetings. The main purpose was to update on progress and identify approaches for improving conditions for the target group, including

identifying emerging issues and challenges. For example, project implementation in relation to drug use does not stand alone; we need to cooperate with local authorities to enable program implementation and be aware of the impacts of the village/commune safety policy of the Ministry of Interior (គោលនយោបាយភូមិ ឃុំ/សង្កាត់មានសុវត្ថិភាព) which came into effect since 2010. This directive aims to clean communities of gangsters and gambling, drug users, production and distribution of illicit drugs, domestic violence, human trafficking, rape and theft and crime. A main focus of the policy is to eliminate drug use, and so implementation of this policy affects programs working with drug users. It has become increasingly difficult to reach the target group through peer outreach activities, including provision of NSP. Group discussions with drug users reveal that when outreach workers left, after provision of clean injecting equipment, the authorities came and arrested a number of drug users.

'…They [the authorities] required us to cooperate with them, we cannot work alone because the authority want to have a good [village and commune] profile as having no drug users in their community. Therefore, when we do outreach for HIV prevention, the clients denied being drug user…' (Drug program staff FGD)

'The implementation of the safety village-commune affects our peer outreach activity…' (Drug program-FGD)

'After we [outreach workers] left the community, they [the authorities] came in so they [drug users] were afraid of disclosure' (drug outreach workers-FGD)

Communication and coordination mechanisms should be in place

It is challenging to work across different agencies, including local authorities, entertainment establishments, police and health sector workers. It takes time for collaboration and trust to be built. Support and follow up with these agencies is necessary for program implementation. Therefore, regular meetings to strengthen coordination and collaboration mechanisms are crucial.

'… To meet with the establishment owners we waited up to a month, we cannot coordinate well like this. So, we have to continue to follow up based on their promise and commitment…' (Entertainment outreach workers-FGD)

'They [the authorities] tend to be late if the meeting occurs in the morning. Some of them stay in the meeting only less than an hour. They are quite busy with their other works.' (Program Coordinator-FGD)

Carrying condoms equated to seeking or selling sex

During group discussions, MSM reported being forced to surrender condoms to the police when they walked in public parks at night with MSM friends. Carrying condoms is used to imply MSM could be having or selling sex with their partners or clients. The police thought that by confiscating condoms MSM will go home early, but this is not always the case. Confiscation of condoms puts MSM at greater risk for HIV and STI transmission; some MSM will continue to have sexual relations without condoms.

'They [the police] think that if we carry condoms we will continue to have sexual partners. They [the police] wanted us to get back home that's why condoms have been taken out from us. They did not know on our way home whether we met with sexual partners by chance and that is the problem' (MSM peer workers-FGD)

Signed MoUs will help to strengthen levels of coordination and collaboration

In order to make collaboration and coordination across the institutions easier, Memorandums of Understanding (MOU) are signed, which serve to clarify relationships and alleviate challenges of collaboration between the relevant agencies. The MoU aims to help avoid issues of overlap, misunderstandings and lack of collaboration, but only a limited number of KHANA's partners have signed MoUs with the Provincial Health Department (PHD). SCC, PC, WOMEN, and KOSHER are in the process of signing MoUs. However, almost half of the reviewed partners do not have MoU with the PHD. This can lead to difficulties and misunderstandings in coordination and collaboration.

'There is communication difficulty regarding the MoU. But I heard that HACC is going to coordinate with the local NGOs as MoU members to help solve the problem.' (Program Coordinator-FGD)

Rights, law and policy implementation

KHANA uses a rights-based approach when working to reduce stigma and discrimination against PLHIV, most at risk populations and other vulnerable groups. KHANA works to decrease discrimination against people when accessing

services. KHANA endeavors to protect the human rights of communities affected by HIV. Entertainment workers in particular face issues with sexual, physical and verbal violations from their clients. However, rather than approaching the police they say nothing to avoid losing their jobs. Local NGOs can support them with legal assistance, but are often requested by the victim not to make the violations public because they are afraid of their losing job.

'If they sued they will lost their job, so they kept quiet and go back to work...' (Entertainment workers-FGD)

After the endorsement of the law on Prevention and Control of HIV/AIDS in Cambodia (AIDS Law) in 2002, communities affected by HIV, including PLHIV, seem to have been aware of PLHIV rights and issues of confidentiality. PLHIV themselves know and understand better their own rights as people living with HIV; more than 80% had heard of the AIDS law and among those 68% had read or discussed the content of the law [21]. Even though the proportion of PLHIV aware of the AIDS law was high, it was a gap in program implementation.

'PLHIV rights including freedom from stigma and discrimination, and the right to have access to treatment, care and support have been better recognized. Unlike four or five years ago, the level of stigma and discrimination is decreasing. It's really low.' [Community Support Volunteer-FGD]

'Even if the AIDS law has been introduced and applied into workplace, there are still gaps at the implementing level. They [a company] said they won't employ those who are HIV positive. They require all the potential applicants to get tested for HIV. Isn't it a violation of the law?' (Program Coordinator-FGD)

Laws around drug use are a big concern for people who use drugs. As drug use is illegal, the police can arrest users at any time. KHANA and its IPs aim to address the health needs of people who use drugs rather than criminalize them. Peer outreach workers reported that sometimes, after arresting drug users, the police will refer them to drug rehabilitation centers, but on other occasions they physically assault them and demand money from them.

'When they [the police] met young drug users, they arrested them and sent them to drug rehabilitation centers or beat them or asked them [drug users] for money...' (Drug outreach workers-FGD)

Working on creating enabling environments led to improved law implementation and increased coordination and collaboration

The formation of supportive environments for target populations around HIV prevention activities for most at risk groups increased the ability of members of these groups to control their health outcomes. Working with relevant stakeholders including health workers, law implementers, and local authorities helped improve access to essential services and readiness of MARP groups to make changes for improving their health. This also reduced stigma and discrimination against MARPs. KHANA and IPs have credibility and strong partnerships with government agencies at the national level, which can help to represent the voices and concerns of ESW, MSM and IDU through technical working groups. Support for prevention programming for MARPs is affected by the changing nature of the commercial sex industry and difficulties with enforcement of the Law on Prevention of Sexual Exploitation and Human Trafficking. The latter is contradictory to implementation of the government's 100% condom use policy. To open discussions around these issues, KHANA worked with NAA in collaboration with Provincial AIDS Committee/ Secretariat (PAC/PAS) to conduct sensitization workshops on strengthening support for entertainment establishment workers through the 'MARP Community Partnership Initiative'. Support was sought for collaborative working between various players including government agencies, communities, civil society representatives, development partners, entertainment venue/establishment owners, entertainment workers and MSM. A total of four events were conducted in selected locations in 2010 including Phnom Penh, Siem Reap, Battambang and Bantey Meanchey. The aim of the events were to discuss with stakeholders the steps required o help create an enabling environment for MARPs to access HIV interventions including prevention services, STI check- ups, HIV treatment and socio-economic support.

Even though we aim to create an enabling environment to support work with entertainment workers, the law on Suppression of Sexual Exploitation and Human Trafficking needs to be adapted to be more beneficial for HIV programming among entertainment workers. One of the major challenges for prevention work was the closure of many brothels, karaoke, bars and massage parlors in 2008 after the law was released. Cracking down on these venues, as part of an effort to combat human trafficking resulted in

significant difficulties for working on HIV prevention among entertainment workers. Many of the women from the brothels had to work in entertainment venues, massage parlors, or become free lance sex workers in order to avoid being caught. Therefore, reaching those who are most at risk became harder than before. Some establishment owners were afraid of their establishments being closed down, so prevented outreach workers from visiting for fear the police may see outreach work as an indication that sex work was taking place. Some establishment owners dare not sell condoms on site for fear they would be accused of encouraging sex work and being involved in human trafficking.

3. Organizational Capacity Baseline

Strengthening capacity and leadership of NGOs, CBOs and communities is the one of the main expected results of SAHACOM to ensure program efficiency and effectiveness as well as increase the long-term sustainability of the community response to HIV[4] . A series of NGO capacity assessments were conducted with the 37 implementing partners. The objective was to develop a baseline measure of partner capacity and pin-point general strengths and gaps to feed into a tailored capacity building plan for each of the implementing partners.

The NGO capacity assessment tool developed by the International HIV/AIDS Alliance was adapted for use in the local context [22] . The tool consists of 13 indicators divided into four categories:

1. Partnerships, referral systems, coordination, communication and advocacy
2. HIV and AIDS technical capacity
3. Organizational strengths
4. Promotion of participation of PLHIV and other affected communities

Participatory self assessments were conducted through group discussions to reach consensus on assessment scores. In order to triangulate and validate the information provided, the assessment team reviewed the completeness and accuracy of the information through relevant support documents and field reviews with affected communities. 22 of 24 KHANA implementing partners under SAHACOM-USAID were assessed. Women's Media Center was not included as the assessment period overlapped with its internal review. BSDA was also not included since this NGO registered as an implementing partner after the assessment took place.

The overall average score was divided into five categories ranging from poor to very good. The scores below are poor (below 2.0), moderate poor (2.0 – 2.9), some capacity (3.0 – 3.9), good (4.0 – 4.9), and very good (5.0) (for further details see annex 4).

Table 9: Number of Implementing Partners and Overall Score Performance

Score	# of NGO	%
Poor	0	0
Moderate poor	3	14
Some capacity	11	50
Good	8	36
Very good	0	0
Total	**22**	**100**

As shown in Table 9, 8 IP (36%) scored from 4-4.9 indicating good capacity, which shows that they met most of the criteria of the assessment. 50% (11 IP) have some capacity, which indicates that these organizations met some of the criteria, while 14% of them met only a few criteria. Analyzing the selected 13 indicators in more detail, we found that IPs were weak in areas of partnership; referral systems; coordination and advocacy (effective targeted communication and advocacy work, research, consultation and analysis); and HIV/AIDS technical capacity (experience, knowledge and skill including access to technical resources and knowledge). The majority of staff in these organisations were not trained in conducting effective advocacy and research, including the development of a communication and advocacy strategy. In addition, the technical capacity of the staff and the ability of the organization to access technical resources were also weak. This was measured by in staff that retained HIV skills and knowledge for at least 2 years. Some key staff are experts in HIV only. In addition not all IPs had resource centers available, and insufficient budgets to enable internet access.

Adding the categories 'moderate poor' and 'some capacity' together represents almost two-thirds of all IPs in the assessment. It was recommended to those implementing partners prioritise strengthening technical capacity in areas such as: communication and advocacy work; research, consultation and analysis,

knowledge and skills in HIV; and access to technical resource and knowledge in technical support plans. However, it is recommended that the technical support team look at the detailed individual capacity assessment report to support preparation of the plans [23] .

Table 10: Average Score by Indicators

N.O	Indicators	Average
1.1	Awareness and working relationships with other organizations	3.8
1.2	Referrals	4.0
1.3	Effective, targeted communication and advocacy work	3.1
1.4	Research, consultation and analysis as a foundation for advocacy work	3.0
2.1	Experience, knowledge and skills	3.4
2.2	Access to technical resources and knowledge	3.2
3.1	Governance, strategy and structure	3.5
3.2	Human resources and administration	3.5
3.3	Program management	3.8
3.4	M&E	3.7
3.5	Financial management and sustainability	3.7
4.1	Level and range of involvement of key populations (PLHIV, MSM, SW, DU) and other affected communities	3.6
4.2	Efforts made to promote involvement of people living with HIV/AIDS and other affected communities	3.9

The technical support plan has been developed as the road map for gap identification in capacity building at implementing partner level. KHANA conducted an orientation workshop, which is part of capacity building to implementing partners, to ensure the delivery of HIV related services in an effective and efficient manner. The development of the technical support plan of each implementing partner under SAHACOM has been led by the IPPM department. The plans will be implemented through technical support from 2011-2012 with focus on individual IP capacity gaps [24].

4- SAHACOM Model in Practice

The SAHACOM model aims to decentralize responsibility and increase community involvement to achieve more sustainable ways of receiving quality services. Previously care and support was delivered through a home care team leader and team volunteer. Under the new model the program is delivered through a Community Support Office (CSO) and Community Support Volunteer (CSV). Some of the people working under the previous structure have become CSVs. As CSVs they lead self help group meetings, provide one on one support and counselling, provide referrals, prepare activity work plans and advance budget for activity implementation. They can be members of the Commune Council for Women and Children and conduct other advocacy activities with local authorities.

Implementation of the community-based care model

The implementation of the SAHACOM model has not been strictly followed by all implementing partners and implementation of the model varies from one partner to another. Some CSOs support less than 5 CSVs and some more than 5, depending on the geographic characteristics of the area. CSO managing scattered or wide coverage areas take responsible for fewer CSVs. Some self-help groups have either very few or very many PLHIV members which does not follow the proposed model. The SAHACOM model proposes that there should be one CSV and one CSV assistant. The CSV should lead a PLHIV SHG and CSV assistant should lead an OVC support group. In reality, having two positions was applied only in the first year of the project. In the second year the model was changed to only one CSV due to limited budget allocation for CSVs which led to staff drop out,. The same incentive rate of USD $30 per month for CSV incentives was expected

across all implementing partners including USD $20 for allowance, USD $5 for transportation and another USD $5 for communication. In reality, each implementing partner decided on an amount based on IP location and budget. Some implementing partners had budget for only one CSV (USD $20-$30 per month). Therefore, some CSVs had more responsibility than before including being in charge of PLHIV SHGs and OVC Support Groups.

Some CSV support] About15 to 20 PLHIV, but some CSV can reach 30 PLHIV' (Management team-FGD)

'I am responsible for three groups of two OVC support groups and one PLHIV self help group with a total of 31 OVC and 14 PLHIV' (CSV-FGD).

'Because of widespread communes and villages, the clients in my commune are very many, so we have two members [CSV] supporting 43 PLHIV and 70 OVC (CSV-FGD)

Implementation of the focused prevention (FP) model

The review found some challenges regarding implementation of the new FP model. Particularly within partners working with drug users, there were challenges for PE/PF in moving from site to site if they didn't know the drug user networks.

'...I understood the feeling of drug user who doesn't care about the other so the PF from one different side cannot go in to the other' (Drug outreach worker-FGD)

Some program managers did not stick closely to the model but adapted it based on their practical situation. If they followed the model completely they would not be able to work effectively in their context. During implementation of the program it became clear that one PF can take responsible for only 2 PE instead of 5 as outlined in the proposed model, so this amount was reduced by many partners.

'They [PF] took responsible only 2 PE' (Drug program-FGD)

'KHANA suggested one PF take responsibility for 5 PE. I strongly debated we cannot work like that because one PE is responsible for 20-25 drug users. It is just too much... (Drug program-FGD)

'Each PE is responsible for 10-20 EW; they [PE] manage the SHG members. If we give them more SHG to support, they cannot afford enough time and resources' (Entertainment program-FGD)

'We reached 645 MSM in HIV prevention activities with the support of 17 PF and 53 PE in five administrative districts' (MSM program-FGD)

It is common practice for IPs to adapt the model proposed by KHANA through SAHACOM. The main reasons include budget allocation, entertainment establishment, location and the number of entertainment workers or MSM. These factors influenced the management decisions in terms of allocation of PF or PE. Adaptation is easier for entertainment worker and MSM programs compared to drug user programs. The PE or PF working with EW or MSM can move from one site to another without difficulty.

'...We cannot adapt to the new SOP because of budget allocation. If we manage based on the SOP, the number of PF and PE are not the same as today so we have to be flexible according to the available budget' (entertainment worker program-FGD)

'Actually, PF gets USD 30 incentive and PE gets no incentive, unfortunately. But they [PE] will get support with travel cost during meetings' (Drug user program-FGD)

'They are working hard; it is good that they could be supported with the monthly incentive of USD 30 including the travel cost for both PE and PF during meetings' (Entertainment worker program-FGD)

The new model requires strong management and increased responsibility for CSVs and PFs. The CSV or PE who have part-time jobs are not able to join the program full time. Often they have little knowledge of management, planning and reporting and many CSVs are also illiterate. They have a small low allowance but increased role and responsibility, and often felt discouraged and de-motivated in their job.

CONCLUSION AND RECOMMENDATION

The findings from this documentation will serve as baseline information for the full five-year project implementation period. Establishing key quantitative and qualitative information is vitally important to measure implementation of the prevention, care and support program and to serve as a benchmark for midterm and end of project evaluations.

Input, output, outcome and Impact Indicators

Input indicators measure funding, resources, staff, and facilities through supervision, monthly or quarterly financial accounts reports, and reports on the number of staff, computers and budget allocation. Output indicators measure specific activities through routine progress monitoring, for example measuring the number of PLHIV and OVC who received care and support through CBC and/or the number of MARP who received HIV prevention services. KHANA has changed several output indicators and the ways of recording which has led to variations on reported numbers reached. It was clear that the revision of indicators and the methods for data recording was needed to help with cleaning of data, strengthening the collecting system and making data more robust. This may make it hard to understand. It is recommended KHANA make data calculation and methods of recording data consistent over time and minimize complexity in the system.

Outcome and impact indicators measure short term and long term effects. These indicators record for example, change of behavior and attitudes, STI and HIV trends, quality of life and social and economic impacts. For KHANA indicators (inputs and output) it may not be possible to measure program progress using outcome and impact by collecting regular data in the way we do for monitoring progress. KHANA should undertake a review and survey with each IP, as well as EW clients and other relevant agencies at the field level. The M&E system will aim to measure the positive change in behavior and quality of life resulting from the interventions. In addition, it is recommended that KHANA should document those relevant indicators based on the existing available data.

HIV focused prevention, care and support interventions

Coverage: One of the ongoing challenges for coverage is overlapping of targets and areas among USAID-funded projects implemented by KHANA, FHI and PSI. MSM is the main concern, as the collaborating agencies are reaching the same target populations and areas although with different messages. We recommend the relevant agencies, with involvement of the PAO, seek consensus and clear division on coverage including development of monitoring mechanisms to minimize double counting. Coordination meetings should be held on a quarterly basis. Additional leadership from the USAID office in Cambodia would also contribute to achieving a successful outcome in this area.

M&E and reporting: KHANA has revised the monitoring and reporting package several times including revisions to data collection tools, the database system, and reporting and M&E formats. This places a strain on IP staff especially for IPs with high

rates of staff turnover or limited facilities and human resource capacity. The revisions aim to reduce errors, improve the data entry process and make the process more user-friendly. Many implementing partners found the revised database system helpful. Simplification of the system is one outcome, but to ensure the M&E processes run effectively and properly, we need to further strengthen the capacity of IP focal point staff including backup staff in case of staff turnover. Computers with appropriate capacity are required along with training, coaching, monitoring, and supervision that responds to IP needs,

Referrals and follow up: Low allocation of costs for transportation does not match current high fuel prices. Beneficiaries would prefer to be referred to easy–to-reach nearby health centers/clinics, regardless of the quality of the services provided, rather than to commute to more distant services. Transportation costs should be allocated based on current fuel prices. Referral of drug users to VCCT services should be encouraged and accompanied with appropriate consent from the drug users. Implementing partners refer MARP to VCCT in cases of suspected unsafe sexual practices with their partners. We recommend there is no need to wait for suspected unsafe sexual practices, but rather MARPs should be referred to get basic health services including SRH on a regular basis every 6 months. One of the challenges regarding referrals for PLHIV to OI/ARV is movement of PLHIV from place to place related to migration for work. Another concern is PLHIV not keeping to their scheduled medical appointment times. It is recommended CSVs and CSOs should increase their follow up visits with PLHIV and work with service providers to track movement of PLHIV.

It was reported that USD$3 doe transportation costs was not always adequate. Implementing partners indicated USD $5 per referral would more adequately cover transport costs. Another barrier is the time required to attend medical checkups as it is claimed that service providers serve paying patients first and keep the non-paying PLHIV waiting for long periods. This issue should be negotiated with the service provider, so that they attend to clients on a first come first served basis. Unprofessional attitudes from service providers also distract PLHIV from attending services. Professionalism of service providers and efforts to cater to the needs vulnerable people such as PLHIV should be promoted.

Improved livelihoods through vocational training, IGA, and welfare and food support

A number of vocational trainings were provided to MARPs by KHANA and other agencies. However, the level of investment was limited due to low budget allocation. It is recommended that KHANA and IPs should increase investment or collaborate with other agencies to support MARPs to access employment opportunities in a sustainable way.

Providing money alone is not enough to successfully and sustainably support income generation. Along with IGA, beneficiaries have a need for small business and agricultural skills training to lead to more sustainable outcomes.

The findings also showed a lot of people want to plant vegetables as a source of income, but are restricted by insufficient amount of water for irrigation or ownership of farmland. The beneficiaries were not able to buy water for irrigation or rent a piece of land for planting. KHANA and IPs should seek support from other agencies or the government around the creation of community irrigation systems or construction of wells.

Food support from WFP will end in December 2012 leaving a big challenge for HIV-affected households who are currently supported and who struggle with access to food commodities and lack of businesses and production. KHANA should scale up support through livelihood activities and provide opportunities for skills training in areas such as animal husbandry and fish farming. KHANA should explore possibilities to mobilize replacement support from other sources so that food support may continue for households with the most need until secure livelihoods support has been provided for them. This additional budget could be allocated for emergency food support to those in most need.

OVC who drop out of school show a need for income to support their family. When OVCs are old enough to earn income they drop out of school to search for such income opportunities, often around the age of 16-17 years old. KHANA and IPs should mentor the family and school staff to find a way for the OVCs to continue in their studies, for example by seeking part time work around school hours to supplement their study and family needs.

Sexual and reproductive health and family planning

Integration of sexual and reproductive health and family planning into the HIV program had been taking place at KHANA and IP level. KHANA and IPs ensure compliance with USAID family planning and HIV/AIDS statutory and policy requirements. Family planning counseling is provided to PLHIV so that they are informed of their options by IP staff or CSV leaders. CSVs and CSOs need to build strong referral

networks to provide PLHIV with access to relevant health services. IP and CSV would benefit from policy training in relation to SRH which could be conducted by KHANA program management officers.

Strengthening levels of collaboration and coordination

A lot of challenges were faced around implementation of HIV prevention among most at risk populations. These include in particular conducting peer outreach activities for provision of clean needle and syringe programs. Outreach workers highlighted cases of law enforcement officials following them while doing outreach in the community. This led drug users to be reluctant to disclose their situation to outreach workers, for fear of harassment by law enforcement officials. Providing clean needle and syringe programs to drug users aims to reduce harm from HIV, HVB, HVC transmission. Our interventions operate in conjunction with referrals for treatment and education programs to reduce drug use. However, law enforcement strategies aim to arrest drug users and remove them from the community in line with the village and commune safety policy. Sensitisation on harm reduction approaches for key stakeholders, especially the local authorities and police officers, should be carried out through formal or informal meetings Another purpose for coordination meetings would be to update local authorities on progress and challenges and to identify better mechanisms for improving the conditions of the target group, including for health related issues. IAn MoU could help to minimize misunderstandings and increase coordination and collaboration. It is recommended all IPs should sign an MOU with relevant government agencies and local authorities regarding implementation of their project interventions.

Entertainment workers report experiencing both physical and verbal harassment from clients, however there is a culture of silence due to fear of losing their jobs. Strengthening legal assistance and emergency support contacts for EW, along with opportunities for vocational training to decrease dependency on their job as EW is recommended.

To better support HIV affected populations, formation of supportive environments among health workers, law implementers and local authorities should be strengthened. This will help MARP to have increased control over their health outcomes and increase access to services, support health seeking behaviours, and reduce stigma and discrimination. In the case of emerging hot issues, KHANA and IPs should be ready to react quickly to bring attention to the issue. KHANA should bring the voices and concerns from beneficiaries, particularly PLHIV, OVC, ESW, MSM and IDU to policy and decision makers through technical working group meetings.

Strengthening organizational capacity

The majority of IPs are weak in areas of partnership, referral systems, coordination, advocacy, and HIV/AIDS technical capacity (with an average score in the survey of less than 3.5). One of the issues is that the majority of staff in these areas were not trained in conducting effective advocacy and research including the development of the communication and advocacy strategies. It is recommended that existing technical support plans should be implemented to address this. Technical capacity in HIV knowledge and skills of the community staff should also be addressed. Training opportunities should be given to relevant staff who could in turn train their peers.. Budget allocation for center resources, including access to the internet, should be increased. Published tools, reports and guidelines should be distributed not only to each IPs and distributed amongst staff, i.e. not just available at the IP headquarter office.

Implementing the SAHACOM model on focused prevention and CBC

The review showed that none of the IPs was strictly following the proposed SAHACOM model. This deviation is as a result of budget availability in terms of the number of PF/PE CSVs. In order to make sure the model runs smoothly and effectively we should reconsider the budget allocation for PF/PE/CSVs.. In addition, CSVs and PEs have low capacity in terms of management, planning and reporting skills and capacity strengthening in these areas should be prioritized.

Further recommendations

A mid-term review of the program should be conducted which aims to monitor outcomes of project implementation; and review organizational capacity and the models. Technical support visits by program management officers should be documented to gathering information on progress and lessons learnt. The key findings of the baseline information should be integrated into program monitoring, especially for the new fiscal year of SAHACOM. One good outcome is the SAHACOM model has been recognized by various donors and national and international agencies. It is recommended that conducting a detailed review through operational research will help to improve the project so it can serve as a best practice model locally and internationally.

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ANNEX 1: OUTPUT INDICATOR OF KHANA PROGRAM

The number of PLHIV reached through HIV prevention activities (K1104) covers those reached through focused, direct or targeted prevention activities—peer education activities, life skills education and/or participatory prevention activities, implemented through interpersonal group and group communication strategies. This is linked with PEPFAR indicator P7.1D: Number of people living with HIV reached with a minimum package of Prevention with PLHIV (PwP) interventions.

Minimum Package of Positive Prevention In order to count under this indicator (P7.1D), PLHIV must, **in their last visit,** have received (in a clinic/facility-based or community/ home-based program) the following interventions that constitute the minimum package of Positive Prevention:

- Assessment of sexual activity and provision of condoms and risk reduction counseling
- Assessment of partner status and provision of partner testing or referral for partner testing
- Assessment for STIs and provision of or referral for STI treatment and partner treatment
- Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services
- Assessment of adherence and (if indicated) support or referral for adherence counseling
- Assessment of need and refer or enroll PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc. (Output indicators: Baseline [4]

1,828 PLHIV, 61% of which were female, were reached through positive prevention activities in December 2009.

The number of OVC and/or youth aged 11-24 reached through prevention activities, including life skills (K1101), and number of people reached through HIV/AIDS and drug prevention activities (K1111), measures those reached through focused, direct or targeted prevention activities. These activities include life skills and are implemented through interpersonal and group communication strategies among the general population in the community. This is different from individuals reached through IEC activities or through mass channels.

The number of people reached with stigma related sessions (K1102) counts those who have been exposed to, or attended sessions focused on reducing stigma and discrimination towards people living with, or associated with HIV&AIDS. The number of married couples reached through HIV/AIDS prevention activities (K1103) measures

peer counseling sessions for married couples provided by a trained peer counselor and group discussions about HIV prevention or condom use. These sessions reach both men and women, but not necessarily together. Sometimes wives and husbands attend the sessions separately. In cases where they attended together, we counted this as 2 (1 male and 1 female).

The number of the general population reached through community events (K12) measures the number of people who attended community campaigns, including education through parades, art performances and/or other ceremonies. The above indicators link with PEPFAR indicators for the number of targeted population reached with individual and/or small group level prevention interventions that are based on evidence and/or meet the minimum standards required (P8.1D). P8.1D is under prevention sub area 8: Sexual and other behavioral risk prevention.

The number of MSM (K1105), female entertainment workers (K1107), and IDU (K1110) reached through HIV prevention activities measures the number within each group who were reached through focused, direct or targeted prevention activities, including peer education activities, life skills education and/or participatory prevention implemented through interpersonal and group communication strategies. These indicators are linked with the PEPFAR indicator on number of MARPs reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards (P8.3D).

The number of PLHIV family members (including PLHIV) (K18), and OVC members (K27U) who received care and support counts people reached with home based care visits, counseling, education, and medical care. People provided with financial support, legal services, support for schooling, access to shelter or other medical or social services are also counted under these indicators. They are linked with the PEPFAR indicator on number of eligible adults and children provided with a minimum of one care service (C1.1D).

The number of PLHIV (K19) and infected children (CIA) (K30) who received ART through facilitation and support of home care teams measures the number of HIV positive children and adults who received antiretroviral therapy (ART) through facilitation and support of home care teams within the reporting period. ART for the purpose of preventing mother-to-child transmission (PMTCT) is not included in this indicator. These indicators are linked with the PEPFAR indicator on number of HIV positive adults and children receiving a minimum of one clinical service (C2.1D). The number of HIV infected clients attending HIV care/treatment services who are receiving treatment for TB disease (DOTS) (K20) counts the number of HIV positive individuals who received DOTS through a delivery mechanism supported by IPs during the reporting period. It is linked with the number of HIV positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment (C2.4D). The total number of HIV positive patients who received DOTS is 70 (50 % female) from Oct-Dec 2009.

The numbers of service providers trained in HIV prevention (K01); NGO staff/community support volunteers (CSV) trained in providing CBC (K23) and caring for OVC (K36); care givers (family members) trained in providing home based care (K24); and service providers/caretakers trained in caring for OVC (K37) are linked with the PEPFAR indicator on number of health care workers who successfully completed an in-service training program (H2.3D).

K01 measures the number of people trained in HIV prevention strategies for direct activity implementation with the community. Service providers could be peer educators, outreach workers, community based workers or health workers, and this training could be for peer outreach activities, participatory prevention, interactive sexuality and life skills education, or counseling to support community-based prevention work. The training could be for behavior change communication (BCC) or behavior change intervention (BCI). The training provided could also provide skills for interpersonal or small group communication.

K23, K24, &K36 count training and support to individuals to be trained in providing external support, counseling, legal services, companionship, financial support, care, support for schooling, medical care and other medical or social services. K37 measures the number of service providers or caretakers trained in caring for Orphans and Vulnerable Children (OVC). The support is both direct (carrying out training) and indirect (providing financial or technical support).

ANNEX 2: OUTPUT INDICATOR IN SAHACOM'S MONITORING AND EVALUATION FRAMEWORK

The number of Orphans and Vulnerable Children (OVC) receiving care and support through a CBC team (K28) is a cumulative indicator—adding the number of newly reached people with the number reached in the previous reporting period. It measures the number of OVC or Children Affected by AIDS (CABA) who received care and support including regular visits by a home care team member enabling children to attend school, increasing their access to health care, provision of food aid, psychosocial and recreational activities. This indicator includes orphans and other vulnerable children who received assistance directly from KHANA IPs. Approximately 6700 OVC were provided with care and support in 2009.

The number of OVC supported to attend school is a cumulative (K34) indicator. It measures the number of OVC who are in need of support and who have obtained support to attend school in the community, and are served by the reporting organization. OVC or CABA includes children identified as most vulnerable within an HIV/AIDS affected community according to locally defined criteria, regardless of the specific cause of their vulnerability. The total number of OVC supported to attend school by Dec 2009 was 959.

The number of PLHIV self help groups and OVC support groups established are cumulative indicators (K21, K31). They measure the number of self help and self support groups which contain PLHIV and OVC who received support from community support volunteers. The total number of PLHIV self help group and OVC support groups respectively established was 650 and 666 by December 2009.

The number of PLHIV and infected children receiving Anti-Retroviral Treatment (ART) through a CBC team are cumulative indicators (K19+K30). These indicators are linked with PEPFAR indicator C2.1D: number of HIV-positive adults and children receiving a minimum of one clinical service. They measure the number of HIV-infected individuals (both adult and children) who received ART through a delivery mechanism supported by IPs during the reporting period. ART for the purpose of preventing mother-to-child transmission (PMTCT) is not included in this indicator. The total number of PLHIV and infected children receiving ART is 8,575 and 1,185, respectively.

The number of people living with HIV (PLHIV) receiving care and support through a CBC team is a cumulative indicator (K16). This indicator measures the number of PLHIV receiving external support including counseling, medical care, help with household work, companionship, financial support, legal services, care and support for schooling, access or refer to shelter or other medical and social services through home based care teams. In 2009, 16,271 PLHIV received such support.

ANNEX 3:
FIELD GUIDE AND TOOLS

Focused prevention

The following areas were explored through open questions to Program Coordinators, Team Leaders, PE, PF, and other relevant staff.

1. **External and internal challenges for program implementation:**
   - **a.** Collaboration and coordination, supporting environment, law implementation, drug issues
   - **b.** Specific target population (MSM, I/DU and ESW)
   - **c.** Emerging issues M&E Framework, reporting forms, DBMS, staff capacity, workload

   Observation of the services delivered:
   - **d.** Implementing partners level-home visit, supervision, outreach program, training, PE/PF
   - **e.** Incentives for PE/PF
   - **f.** Service delivery provision for beneficiaries, needs and levels of satisfaction

2. **Is there any suggestion or comment you wish to make in order to improve project implementation? Is there any suggestion or comment you wish to address to KHANA directly? Do you have any suggestions for local authorities, government agencies…**

3. **Is there anything else you wish to add?**

Integrated Care and Prevention

The following areas were explored through open questions addressed to Program Coordinators, Team Leaders, CSO, CSV, CSVA, and other relevant staff.

1. **External challenges and internal challenges for program implementation**
   - **a.** Collaboration and coordination, supporting environment, law implementation, drug issues
   - **b.** Specific target population (PLHIV and OVC)
   - **c.** Emerging issues …
   - **d.** M&E Framework, reporting forms, DBMS, staff capacity, workload…

   Observation of services delivered:
   - **a.** Implementing partners , supervision, outreach program, training, CSO/CSV
   - **b.** Referrals, follow up, OI/ARV adherence, food support,
   - **c.** School attendance, school follow up, school materials, community and teacher support, food support… (OVC)
   - **d.** Sexual and Reproductive Health (SRH) for PLHIV including PMTCT…
   - **e.** Service delivery for beneficiaries (PLHIV, OVC and their family), needs and levels of satisfaction.

2. **Is there any suggestion or comment you wish to make in order to improve project implementation? Is there any suggestion or comment you wish to address to KHANA directly? Do you have any suggestions for local authorities, government agencies**

3. **Is there anything else you wish to add?**

ANNEX 4: NUMBER OF IMPLEMENTING PARTNERS AND OVERALL SCORE PERFORMANCE

No	IPs	Overall Performance
1	KOSHER	2.2
2	VC	2.7
3	KS	2.9
4	SIT	3.0
5	IDA	3.1
6	KT	3.1
7	CSCN	3.2
8	CSDA	3.2
9	RACHANA	3.3
10	KBA	3.5
11	MHC	3.5
12	AS	3.6
13	OEC	3.7
14	NAS	3.8
15	MODE	4.0
16	SCC	4.0
17	PC	4.1
18	SEADO	4.1
19	CARAM	4.2
20	BWAP	4.2
21	BFD	4.4
22	WOMEN	4.4

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Design by [illegible]: info@[illegible]cambodia.com

KHANA

33 Street 71, Sangkat Tonle Bassac,
Khan Chamkar Mon, Phnom Penh, Cambodia
Telephone: 023 211 505 | Fax: 023 214 049
Website: **www.khana.org.kh**

Khana is a linking organisation of the global partnership
International HIV/AIDS Alliance
Supporting community action on AIDS in developing countries

The International HIV/AIDS Alliance (Alliance Secretariat)
Preece House, 91-101 Davigdor Road, Hove, BN3 1RE, UK
Tel: +44 (0) 1273 718900 | Fax: +44 (0) 1273 718901
Email: **mail@aidsalliance.org** | **www.aidsalliance.org**