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END PROJECT EVALUATION

CHANGES IN HIV INTEGRATED PREVENTION, CARE AND IMPACT MITIGATION EFFORTS FROM 2009-2011

May 2012

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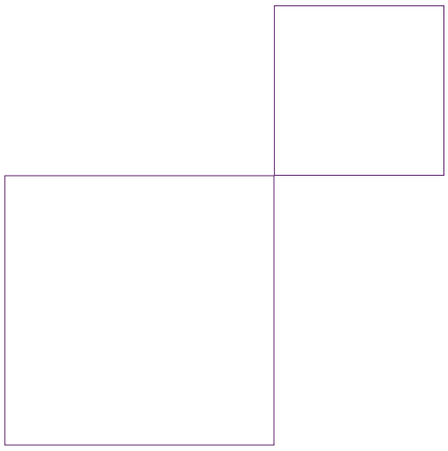

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ART	Antiretroviral Therapy
CCASVA	Cambodian Children Against Starvation and Violence
CPR	Community Poverty Reduction
EC	European Commission
EL	Economic Livelihood
EW	Entertainment worker
FGD	Focus Group Discussion
FP	Family Planning
Freq	Frequency
FW	Factory Worker
HCBC	Home and Community Based Care
ICP	Integrated Care and Prevention
IDI	In Depth Interview
IGA	Income Generation Activities
IP	Implementing Partner
KCN	Kompong Chhnang
KII	Key Informant Interview
KMDC	KHANA, Meanchey Drop in Center
KSP	Kompong Speu
MARPs	Most at Risk Populations
MDG	Millennium Development Goal
MHSS	Men's Health Social Service
MSM	Men who have sex with men
NAPA	National Prosperity Association
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	Non-Governmental Organization
OD	Operational District
OI	Opportunistic Infection
OVC	Orphan and Vulnerable Children
PAO	Provincial AIDS Office
PC	Partners in Compassion
PLHIV	People living with HIV
PMTCT	Prevention from Mother to Child Transmission
PVG	Prey Veng
PWID	People who Injecting Drug
PWUD	People who Use Drug
SHG	Self Help Group
SRH	Sexual and Reproductive Health
SROI	Social Return on Investment
STI	Sexually Transmitted Infection
VCS	Village/Commune Safety
VCT	Voluntary Counseling Testing
WOMEN	Women Organization for Modern Economic
WOSO	Women Service Organization

EXECUTIVE SUMMARY

With funding support from the European Commission, the "Increasing Community Action on HIV/AIDS Prevention Integrated with Care and Impact Mitigation Efforts in Cambodia" project has been implemented since 2007 in Prey Veng, Kampong Chnnang, and Kampong Speu provinces.

The project comprised of two components: HIV Integrated Care and Prevention (ICP) and Focused Prevention (FP). Activities for ICP in the project include community based care and support; facilitation of access to care and treatment; provision of socio-economic support to People Living with HIV (PLHIV), Orphans and Vulnerable Children (OVC) and their families; and reduction of stigma and discrimination that they face. And FP works to improve the positive behavioral changes of risk taking among Most at Risk Population including entertainment workers (EW), men who have sex with men (MSM) and People who use durugs (PWUD).

As the close out of the project is approaching, an end project evaluation was carried out in November 2011 to evaluate the efficiency and effectiveness of the program and measure the impact of the program on the beneficiaries and community as a whole.

The end line survey mainly used a quantitative approach to measure the changes in main project outcome indicators, with an added qualitative approach to complement the quantitative data and try to identify any emerging issues. A total of 1,676 PLHIV, OVC, EW, MSM and (PWUD) were randomly selected for face-to-face interviews using cluster sampling.

Findings from the survey clearly indicated that the project has played a very important role in alleviating the burden of HIV/AIDS among PLHIV and OVC in the targeted provinces. Sustainability of the project is essential for the wellbeing of its current beneficiaries: both direct and indirect beneficiaries. This positive achievement should be maintained, with additional improvements to bridge the remaining gaps for the benefit of those infected and affected by HIV.

Also, KHANA and its partners have properly addressed the needs of the most-at-risk-populations to keep the level of consistent condom use for EW remained high with a significant reduction of recent abortion after the SRH/HIV integration has been in place. However, the level of condom use and other risk behaviors in other MARPs especially among PWUD and people who inject drug (PWID) still raise a concern for the prevention program to actively strengthen the interventions, linkages, systematic referral and follow-up between health sectors and relevant services.

Integrated care and prevention (ICP)

Overall satisfaction with services provided by the ICP component remains high for both PLHIV and OVC. The high satisfaction level implies the relevance, efficiency and effectiveness of the community action on HIV prevention integrated with care and impact mitigation over the project, especially among PLHIV. It was also supported by the Social Return on Investment (SROI) finding, which revealed that for every $1 invested in the ICP activities between

2007 and 2011 about $2 was generated in social, health, and economic related values. This is indicative of a positive return for the community-based response to HIV, and shows that the program works.

The number of PLHIV who reported undergoing Antiretroviral Therapy (ART) remained as high at nearly 90%. About 40% of couples reported were discordant, which points to the importance of treatment as prevention and positive prevention among couples.

Also, there was a significant improvement in the capacity of KHANA's Implementing Partners in all aspects - including organizational, managerial, technical, and promotion of community participation. This improvement could be attributed to the enhancement of the technical support provided by KHANA. The enhanced technical support was initiated in 2010 following an IP baseline assessment that found the need for more regular technical support visits and quarterly monitoring visits.

About 60% of PLHIV reported having received support from the project in the past 6 months to bring economic improvements for their family. The support they received ranged from financial support to technical supports to generate income through fish rearing, chicken rearing or home gardening. More than 80% reported an improved family economic circumstance in comparison with before the Economic Livelihood project inception. Also, a significant decline in reports of debt payment was observed, along with a reduction in demand for financial support for cover health costs and an increased demand for Income Generating Activities (IGA). The findings suggest positive changes in many dimensions of socio-economic status and perceptions among PLHIV reached by community based care and support. Improved health status and increased understanding of self reliance seem to have led to increased demands for IGA. PLHIV whose basic health and socio-economic needs are met through community support want to reduce dependency and achieve sustainable livelihoods.

There was a significant increase in OVC regular access to schooling, especially for girls. The findings highlight positive changes in some aspects of social support and health conditions among OVC. The improvements in socio-economic status are likely due to contributions from the project, as well as increased community and family support.

Focused Prevention (FP)

Consistent condom use among entertainment workers with clients remains high, but still relatively low when with their sweetheart. The program still needs to maintain the high level of condom use with all types of EW partner especially with non-paid partners. However, low level of condom use and other risk behaviors among MSM and PWUD/PWID is still a cause for concern and highlights the need for the program to actively strengthen the interventions and services related to condom and lubricant access, needles and syringe program (NSP) as well as working to improve enabling environment factors.

Between 2009 and 2011 there has been an approximately 50% reduction in recent abortion. This suggests that the Sexual Reproductive Health/ HIV integration strategy implemented by KHANA in 2010 has started to have an impact on women. However, a significant increase in the instances of condom breakage and slippage raises concerns that need to be aggressively addressed, such as unwanted pregnancy, family planning, regular sexually transmitted infections (STI) check up and proper referral for care and treatment.

Reports show that HIV testing among MARPs has significantly increased among all groups, except people who use drugs. HIV testing increase was particularly observed among entertainment workers. This may indicate that the integration of prevention and care for MARPs has eliminated barriers to services delivery and improve linkages and systematic referral between health sectors services, thus improving women's access to these services.

Our main concern was about low proportion of shared needles and syringes among PWID though it was shown that that PWID represented less than 10% of the whole drug user population. Another concern was that although the prevalence of self-reported STI was fairly high, the rate of those seeking proper treatment at public STI clinic was very low. For PWUD/PWID group, there is a need for a more intensive focus to reduce the practice of sharing needles and syringes, while increasing availability of sterile needles/syringes as well as to maintain good collaboration and coordination with local authorities and all relevant government institutions.

i. INTRODUCTION

1. Background

Cambodia has recently been internationally lauded for its successes in slowing the HIV epidemic. By 2010, HIV prevalence had fallen to 0.8% from a peak of over 2% a decade before [1]. Outstanding national leadership and commitment has been recognised through a Millennium Development Goal award in 2010, as Cambodia has reached its Universal Access target for antiretroviral treatment. According to the recent Report of the Commission on AIDS in Asia, Cambodia has reached a 'mature response' stage, whereby the national program enjoys consistent mobilization of resources to achieve a sustainable and comprehensive AIDS response [2].

The epidemic in Cambodia remains concentrated, with high HIV prevalence among most at risk populations including men who have sex with men, transgender persons, entertainment workers and drug users [1, 3, 4]. To prevent a resurgence of the epidemic, programs must be tailored to the needs of these groups, and the stigma discrimination they face in communities and when accessing to health services must be reduced.

2. About KHANA

KHANA is the largest national, non-governmental organization (NGO) providing HIV prevention, care and support services in Cambodia. Initially established in 1996 as a project of the International HIV/AIDS Alliance, KHANA became an NGO in its own right in 1997. It was the first Alliance Linking Organization to receive full endorsement as an accredited member in 2008.

Today, KHANA works in 19 provinces and municipality through a network of 38 implementing partners. These partners are promising community-based organizations, local NGOs working with communities and networks that are committed on HIV/AIDS, health and development issues. We have provided funding to scale up their programs and training to build their skills and strengthen their organizational and financial management. Our partners are our connection to the communities that we serve. They ensure that our program priorities are grounded in the real needs of Cambodia's people.

KHANA's programs are focused on:

- HIV prevention among most at risk populations (MARPs) such as men who have sex with men (MSM), people who use drugs (PWUD), and entertainment workers (EW)
- Integrated care and prevention for people living with HIV (PLHIV) and orphans and vulnerable children (OVC) through home and community based care (HCBC)
- Impact mitigation, such as livelihood support and food security, for PLHIV, OVC and their families
- Policy dialogues, advocacy and networking – bringing the voice of affected communities to both national and international policy forums

3. About the project

Since 2007, KHANA and seven implementing partners have carried out the “Increasing Community Action on HIV/AIDS Prevention Integrated with Care and Impact Mitigation Efforts in Cambodia” project.

The project has focused on an integrated and care prevention as well as focused prevention targeting MARPs, PLHIV and OVC in 7 operational districts and 34 health centres in 3 provinces: Kampong Chhnang, Kampong Speu and Prey Veng.

In implementing the project, KHANA and its partners have taken a holistic approach to address the varied needs of the project’s beneficiaries, both individuals and communities. This includes addressing psycho-social needs, reducing stigma and discrimination, improving economic sustainability, ensuring appropriate nutrition, and reducing barriers impeding access to basic services such as health care and schooling [5].

Through activities in the ICP component, by the end of 2010, 1,059 PLHIV and 2,404 orphans and vulnerable children (OVC) received care and support through Community Based Care and Support. Services provided include primary health care, income generation activities, counseling, welfare and emotional support.

HIV prevention activities in the Focused Prevention component of the project have reached a total of 23,225 people. This includes 753 EW, 1,669 MSM, 595 PWUD/ PWID, 5,767 garment factory workers (FW), 6,062 married couples (discordant and concordant), and 2,962 members of the general population (more emphasis on vulnerable youth and/ or orphans and vulnerable children 11 – 24 years old). A total of 98,285 condoms and lubricants were distributed [5].

Economic Livelihood is the main concern for PLHIV and MARPs where the project was implemented, who require support to improve their livelihood and vocational capacities. Through KHANA and its implementing partners, the HIV affected families received economic livelihood support, which includes small grant and vocational training to improve food security and access to health care, education and employment. A total of 116 HIV affected households, including PLHIV and OVC households, received small scale grants for income generation or saving schemes initiation, which helped to address their most urgent needs.

4. Rationale of the end project evaluation

As the project is coming to a close, the end project evaluation is imperative to evaluate the efficiency and effectiveness of the program; measure changes in the main project outcomes; gauge program impacts on the beneficiaries and community as a whole; and determine to what extent the project objectives have been achieved.

ii. STUDY OBJECTIVES

The overall objective of this end project evaluation is to review and document information relating to the implementation of the Integrated Care and Prevention (ICP) and Focused Prevention (FP) components of the project, and to determine to which extent the project has achieved its intended objectives.

The specific objectives of the evaluation are as follows:

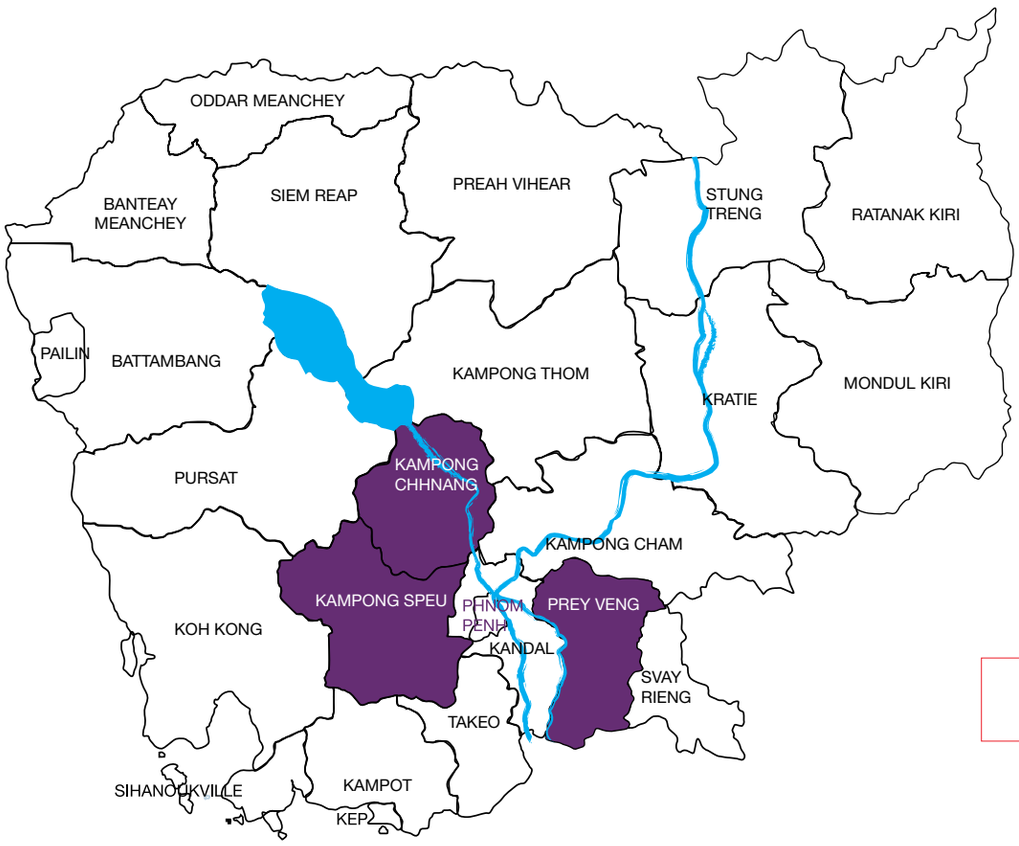
1. To assess changes to the project's main outcome indicators in regards to the integrated care and prevention and socio-economic status of PLHIV and OVC.
2. To determine the level of economic livelihood of PLHIV supported by KHANA and implementing partners by late 2010.
3. To assess the changes in main outcome indicators in regards to the focused prevention among MARPs (i.e. condom use, awareness about HIV/ Sexual Reproductive Health (SRH)).
4. To assess changes in the level of satisfaction towards care and treatment services provided through the ICP component.
5. To analyze the program implementation process, focusing on capacity building and technical support provided by KHANA, and service delivery and field activities carried out by its implementing partners.
6. To provide recommendations for further improvement of the project implementation.

iii. METHODS

First, a quantitative approach was used to identify and determine the magnitude of changes to the main project indicators. Then, an additional qualitative approach was used to explore and obtain a greater insight into issues, challenges and satisfaction towards HIV care services over the course of the project life.

1. Sites and target groups

The evaluation was conducted in the 3 provinces where the project was implemented: Kampong Chhnang, Kampong Speu and Prey Veng, targeting the project beneficiaries: PLHIV, OVC and their families and communities for the ICP component, and MSM, EW, and PWUD/PWID for the FP component.



2. Sample sizes and sampling approach

Two sample comparisons proportion were used to detect 10-15% change in main outcome indicators, such as better health condition, access to care, HCBC referral for PLHIV, regular school attendance for OVC while for the MARPs condom and lubricant use, HIV testing, and drug use risk behavior, were used to calculate the required sample size.

The power of 80% with 95% confidence interval was taken into account when calculating the required sample size. Design effect of 2 was used to compensate the cluster effect. These indicators were based on the project's midterm review targeting PLHIV and OVC as well as the baseline survey targeting MARPs in 2009 [6]. The sample size was calculated by using STATA 11, which estimated the total sample size to be about 1,700.

Two-stage cluster sampling was used to select the required samples. Coordination and administrative support was facilitated by KHANA's partners at the provincial level, to ensure the effectiveness of the data collection. Supported by KHANA's research team, the implementing partners updated the sampling frame of the groups. To ensure effectiveness and feasibility in the planning of data collection, the sample size in each group was proportionally allocated to the size of surveyed groups in each province.

In addition to questionnaires inquiring information about access to care and treatment, community support and satisfaction levels among OVC and PLHIV, the qualitative approach was used to gain optimal insights into the project from different angles: a more thorough assessment of the quality of life of PLHIV, OVC and their families, satisfaction levels as well as the quality of care and support provided to the groups as experienced firsthand by the study population, stakeholders and health providers involved in the project.

The qualitative components included both in-depth interviews and focus group discussions (FGD). While FGD helped in exploring a variety of issues related to quality of life and care, satisfaction levels, and in-depth interviews; it also provided a good opportunity to investigate rigorously each issue of interest, while at the same time allowing the investigator to make sense of the complex behaviors, problems and challenges the groups faced.

In order to gain a comprehensive picture of the project's implementation, eligible participants in this qualitative component consisted of those who had been with the project for at least 2 years. FGDs were conducted among PLHIV and foster families (for OVC) to complement the quantitative findings related to HIV care, support and community involvement relating to the implemented project. In each FGD, 6 to 8 targeted people were invited to participate.

In-depth interviews were conducted among PLHIV, self-support groups, OVC and foster families to gather information related to the quality of care and support which OVC and PLHIV have received. In addition, community people, health staff, project staff and staff at the Provincial AIDS Office (PAO) and Operational District (OD) were also invited to interview with the main purpose of examining the characteristics of the project and collecting lessons learned from the project implementation process. In total, 4 FGD and 8 in-depth interviews were conducted.

Different field guides were developed for OVC, PLHIV and other stakeholders involved. Each guided question included components such as demographic information of the participants, awareness of HIV and AIDS information, experience of stigma and discrimination, type of services received, quality of services received, the process of receiving services, impact of the services on the quality of life of PLHIV and OVC, and how to improve the existing services. All focus group discussions and in-depth interviews were documented and backed up with tape recordings, with the consent from the study participants.

3. Questionnaire development

Five sets of questionnaires were developed separately for the quantitative component. They were similar to the tools used in midterm review with few additional questions to fit the current context of the project. The Khmer questionnaires were then field tested to ensure that the wording and content were culturally appropriate, acceptable and clearly understandable to the study participants. About 2-3 study participants in each group were interviewed face-to-face to assess the content, format, length, language, and appropriateness of the questionnaires. Then, wordings and suggestions from the pre-test were revised and reformatted accordingly.

4. Training the data collection team

The main objective of the training is to make sure that all interviewers and supervisors understood the procedures and adhered to the same standard in order to ensure the quality of the data collected. Therefore, interviewers and supervisors received training before carrying out the data collection. The training covered necessary skills including interview techniques, confidentiality and privacy, as well

as practice of the questionnaires. Study protocol was also presented during the training session to ensure the team members were familiarized.

Data quality control was regularly conducted by rechecking and reviewing the questionnaires after administration to ensure the completeness and consistency of the questionnaire. A regular meeting with the interviewer team was conducted to resolve any issues that arose during the fieldwork and to review progress and communicate any problems or issues during the data collection.

5. Data collection

Quantitative data was mainly collected by trained interviewers who have had experience in collecting data under close supervision. Informed consent, confidentiality, as well as privacy of the subjects, were strictly ensured. PLHIV and OVC were interviewed at their convenience either at their houses, pagoda, Self Help Group (SHG) leader's house or any other agreed meeting points. At no point during the data collection were any refusals observed in any of the groups. Coordination and administration were arranged by KHANA in collaboration with its implementing partners. KHANA Research Team Leader was the focal person who coordinated the study. Participants were interviewed face-to-face after informed consent had been obtained. The estimated time for each interview was about 20-30 minutes, including the obtaining of informed consent.

Qualitative data collection was conducted by trained qualitative research team members. A field guide was used to ensure the flow and completeness of information from both FGD and in-depth interviews. All FGD and in-depth interviews were documented with notes and recordings.

6. Data entry and analysis

Quantitative data were coded and entered into a computerized database using EpiData version 3 (Odense, Denmark). Double data entry was performed to minimize entry errors. The data were analyzed using STATA 11. Descriptive statistics were performed for all variables to determine mean, median, range and frequency. As some of the questions were structured in a way that allowed respondents to give multiple answers; the data did not sum up to 100%.

Three dimensions of different sets of variable related to satisfaction level (home-and community based care and self help group, health education and social support provided by KHANA and implementing partners, as well as HIV care and treatment services) were generated based on the summation of different sets of satisfaction variables. Each dimension comprised of about 7-10 questions relating to level of satisfaction, with the score ranging from 1 (unsatisfied) to 10 (highly satisfied).

Complementary qualitative data were first transcribed in Khmer. Then, content analysis was performed by the research team to identify emerging issues, and themes to support the quantitative findings.

7. Ethical considerations

The study protocol was submitted and approved by the National Ethics Committee for Health Research at the Ministry of Health. Anonymity of all study participants was guaranteed. No records were made of the names of study participants. All collected questionnaires and field notes are kept at the Research Department under the responsibility of the Research Team Leader.

Privacy and confidentiality were protected during the interview sessions. The participation in this study was voluntary: the PLHIV and OVC (foster families) had the right to refuse to participate in the study and to stop the interview at any time. Some tokens such as school materials, crackers, condoms and other commodities were provided to respondents after the interview.

iv. RESULTS OF THE END-LINE SURVEY

The end-line survey was conducted in November 2011. Samples collected were summarized in Table 1. Findings from the Integrated Care and Prevention component are presented first, followed by the Focused Prevention component.

Table 1: Samples collected from each provinc

Group / Province	Kampong Chhnang	Kampong Speu	Prey Veng	Total
PLHIV	124	77	157	**358**
OVC	65	120	131	**316**
MSM	137	72	176	**385**
PWUD/PWID	108	103	86	**297**
EW	NA	56	264	**320**
Total	434	428	814	**1676**

A. Integrated care and prevention component

1. People living with HIV (PLHIV)

1.1. Demographic characteristics of PLHIV

The ages of PLHIV in the sample group ranged from 21 to 67 years old, with an average age of 41 years old. More than 65% of the samples were women. Education level was approximately 4 years, and one fifth had no schooling at all. More than half of the PLHIV samples were married and currently living together with a spouse, while another 40% were divorced or widowed. 1.1% reported to be MSM (4/358). Close to 30% of the OVC sample group reported to be living within the PLHIV households. Less than 10% of PLHIV were migrant workers (Table 2).

Table 2: Socio-demographic Characteristics of PLHIV

Variables	PLHIV (n= 358)	
	Freq	%
Age of the participants, mean (median), years	41 (40)	
Sex of the participants		
Male	119	33.2
Female	239	**66.8**
Education level, mean (median)	3.7 (3)	
Marital status		
Married and live together	189	**52.8**
Divorced, widow(er)	149	41.6
Married but live away	14	3.9
Not married	6	1.7
Relationship between spouses ≥ 5 years, n = 205	172	83.9
Number of people living in family	5 (4)	
OVC living within PLHIV households, n = 355	101	**28.5**
PLHIV who were migrant workers	24	**6.7**

1.2. Socio-economic condition of PLHIV

Table 3 shows the main indicators related to the socio-economic condition of PLHIV. For the majority of the PLHIV sample group, the family's main source of income was reported to be gained through self-employment (58.7%), followed by farming, selling labor and others. More than one half of PLHIV sampled were reported to be the principal breadwinner of the family. Only about one fourth of the respondents' spouses were identified as the main breadwinner. The average weekly income was found to be about $19, ranging from less than $1 to $225. 37% reported that the income they earned is enough for their families. Many still reported having to sell different household assets or items, in order to buy food and clothes (53.9%) and medical care (26.3%). Close to 80% reported ever having to borrow money or rice from others.

Table 3: Socio-demographic condition of PLHIV

Variables	PLHIV (n= 358)	
	Freq	%
Main souces of income in the family		
Self employed	210	58.7
Farming	142	39.7
Selling labor	134	34.6
Monthly salary	82	22.9
Charity from NGOs or individual	42	11.7
Main bread winner in the family		
Myself	**190**	**53.1**
Spouse	94	26.3
Children	46	12.8
Sibling and relatives	28	7.8
Report of enough weekly family income	135	37.7
Weekly family income, mean (median), $	18.8 (13.0)	
Weekly family income should be enough mean, (median) $, n = 224	25.0 (18.3)	
Ever sold different assets in the past year		
Bufallo, cow or pig	145	**40.5**
Chicken and duck	162	45.3
Motobike and bicyle	9	2.5
TV, radio, mobile phone	16	4.4
Farm, ricefield and house	19	5.3
Ever borrowed money or rice from others	**280**	**78.2**
Expense money from sold assests last year		

Food and clothes	**193**	**53.9**
Medical care	**94**	**26.3**
Support children to school	41	11.5
Transportation	26	7.3
Paying debt	10	2.8
Other	112	31.3
Urgent need for the family		
Money	**189**	**52.8**
Food	140	39.1

1.3. Economic livelihood support for PLHIV and their families

A set of questionnaires was used to collect information about economic livelihood support for PLHIV and their families in this end project survey. Close to 60% reported that they had received support from the project to improve their family's economic condition in the past 6 months (Table 4). The types of support received include financial support (40.8%), different technical supports (29.9%), and seed (3.6%). Of those who had received financial support, about 78% received from $40 to $120.

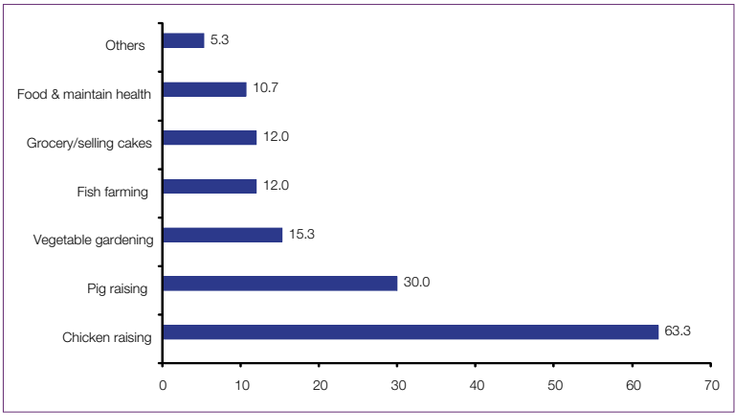
Most of the support was received for less than 6 months, consistent with the KHANA Economic Livelihoods (EL) project, which was also part of the ICP component and was first implemented in April 2011 to support about 800 PLHIV households. More than 80% of the samples reported that there had been an improvement in their family economic condition since the commencement of the EL project. Additionally, the PLHIV reported that the extra income from the economic livelihood support was used to increase food intake for their families, medical care, running a small business, school expenses for children, and other expenses (Table 4).

Table 4: Economic likelihood supports to PLHIV and families by KHANA/IP

Variables	PLHIV (n= 358)	
	Freq	%
Support to increase family economics in past 6 months	205	57.3
Types of support from KHANA/IP in the past 6 months		
Money	**146**	**40.8**
Technique	107	29.9
Seeds	13	3.6
Amount of financial support for increasing family economics, n = 150		
< 41$	32	21.3
42-120$	**114**	**76.0**
> 120$	4	2.7
Duration since you get the financial support, n = 150		
< 6 months	144	96.0
7- 12 months	3	2.0
> 12 months	3	2.0
Supports help family economics comparing with before no support		
Weekly family income, mean (median), $	18.8 (13.0)	
Weekly family income should be enough		
mean, (median) $, n = 224	25.0 (18.3)	
Ever sold different assets in the past year		
Better	**127**	**84.7**
The same	22	14.7
Worse than	1	0.6
Earning incomes from the support are used for, n = 150		
Increase more food for family (3 times/day)	**97**	**64.7**
Additional investment on business	**79**	**52.5**
Medical care	**78**	**52.0**
Expense to children for schools	**65**	**43.3**
Buying vegetable seeds (i.e. cucumber, egg plan)	50	33.3
House repairing (>50$)	18	12.0
Improving well or toilet	14	9.3

As indicated by Figure 1 below, PLHIV used the financial support for family income generation activities, which include raising chicken or pigs, fish rearing operating a small business such as selling groceries or cakes, vegetable gardening, and other forms of income generating activities.

Figure 1: The use of financial supports to generate family income in different forms



** Note: (n = 150)*

1.4. Health condition, HIV/AIDS status and Antiretroviral Therapy (ART)

Overall, 68.7% of PLHIV self-rated their health as good in general. Only 10% of the PLHIV reported knowing their HIV status for less than 2 years, most have been aware of their HIV positive status for several years.

More than 95% of their spouses knew their HIV status. About 60% of their spouses are also HIV positive, meaning that the remaining 40% are discordant couples. According to the program monitoring report (Personal communication, M&R Unit, KHANA), no new infections were observed among discordant couples under ART in 2011, showing that the treatment as prevention approach worked.

Public hospitals or Voluntary Counseling and Testing (VCT) clinics were the most commonly reported places to confirm HIV status. Nearly 90% of the PLHIV reported receiving ART for an average of 44 months, of which 16% received ART in the past 6 months. PLHIV were referred to health service facilities providing ART and Opportunistic Infections (OI) treatment mostly by the home and community based care team (33.2%) and health service providers (31.6%). More than 90% of PLHIV are members of a self help group (Table 5).

Although the majority of respondents reported understanding that ART can significantly improve their health condition, 18% still have misunderstood that ART could prevent Sexually Transmitted Infections (STI).

Table 5: HIV/AIDS status, health condition and ART

Variables	PLHIV (n= 358)	
	Freq	%
Report good health of PLHIV in the past 6 months	**246**	**68.7**
Report knowing HIV status < 2 years	39	10.9
Spouses or partners are also positive	**213**	**59.6**
Spouses or partners know your HIV/AIDS status	**349**	**97.5**
Places where HIV status was confirmed	351	98.0
Public hospital	254	71.0
VCT included NGO VCT	94	26.3
Received counselling for the last HIV test	**351**	**98.0**
Currently taking antoretroviral drug (ARV)	321	89.7
Duration of taking ARV, mean (median), months, n = 324	44.0 (40.5)	
Persons or services refer you to the OI/ART services		
Home based care team	**119**	**33.2**
Health workers	113	31.6
Relatives and friends	57	15.9
VCT staff	40	11.2
Self help group	25	7.0
TB staff	4	1.1
Currently a member of self support group	334	93.3
Understanding about antiretroviral therapy (ART)		
ART prevent you from additional infection	89	24.9
ART make you as healthy as before infected	294	82.1
Using ART, no need to use condom when having sex	**19**	**5.3**
ART prevent from sexually transmitted infections	65	18.2
Report descreased discrimination against PLHIV		
families comparing with the last 12 months	282	78.8

1.5. Concerns of PLHIV and community supports

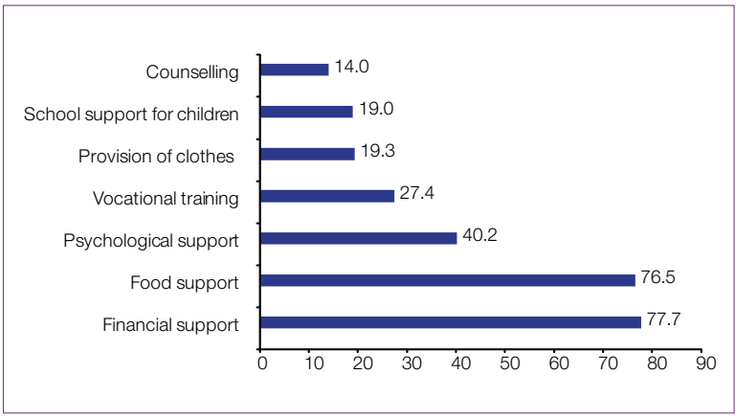
The main concern reported by PLHIV was their financial capacity to pay for medical care and food (Table 6). In the past 6 months, KHANA and partners have been the main source of support for PLHIV and their families (98%), followed by relatives and other NGOs. Only 1 PLHIV received social welfare support from the village. Types of support that they needed from KHANA and partners include support for income generating activities (IGA) (72.9%), financial support (47.2%), vocational training, psychological support and others. Food support (85.5%) and financial support (78.5%) were the two most useful types of support for daily living.

Table 6: Community support and the concerns of PLHIV

Variables	PLHIV (n= 358)	
	Freq	%
The biggest concerns related to illness of PLHIV		
Money for health care	**230**	**64.3**
Money for buying food	**153**	**53.9**
Money supporting children to school	139	38.8
Take care of sick children	34	9.5
Types of support most needs of from KHANA/IP		
Income generation support	261	**72.9**
Financial support	**169**	**47.2**
Support child education	63	17.6
Vocational training	56	**15.6**
Psychological support	41	**11.5**
Others	190	**53.1**
Source of help support for PLHIV & families in the past 6 months		
KHANA and partners	351	**98.0**
Relatives	54	15.1
Other NGOs	54	**15.1**
Neighbor	16	**4.5**
Village leader and social welfare	1	**0.3**
Months receiving supports from KHANA/IP, mean (median)	**34.5 (36.0)**	
Types of support most useful for daily living for PLHIV and families		
Food support	306	**85.5**
Financial support	281	**78.5**
Psychological support	76	21.3
Training on IGA	84	23.5
Clothes support	58	16.2
Support for children's school	49	13.7
Support transportation and school fee	27	7.5
Counselling	24	6.7
Discussion on child health and education	17	4.8
Find jobs	2	0.6
Friends/relatives share meals with at home	334	93.3
Friends and relatives visited PLHIV	345	96.4
Level of discrimination compared to the last year		
Less than	319	89.1
The same	20	5.6
More than	15	4.2

Figure 2 shows the types of support that PLHIV and families received in the past 6 months. As shown, more than 75% received financial support (for transportation fee) to visit health providers and to get OI/ARV and food support (i.e. rice, cooking oil, canned fish and iodized salt). Other types of support received include psychological support, vocational training, provision of clothes, schooling support for children, and counseling.

Figure 2: Support that PLHIV and families received in the past 6 months.



2. Orphans and vulnerable children (OVC)

2.1. Demographic and schooling conditions

The age range of the OVC sample was reported to be from 3 to 17 years old, with the average age being 12 years old. Boys represented about 45% of the OVC. About 70% of them were in primary school; with only 10 out of 316 OVC in high school. 96% of OVC reported that they were currently in school. However, about one fourth reported that they had suspended attending school at some time over the past 6 months in order to earn income for their families. There was no difference found between boys and girls. KHANA and its implementing partners are the main source (99%) of additional schooling supports, such as school uniforms and materials (Table 7). 16.5% (50/303) reported some difficulties in school; because the OVC had parents or siblings who were either sick or had passed away due to HIV/ AIDS related illnesses, they had been neglected by their teachers.

Table 7: Schooling conditions and support for OVC

Variables	OVC (n = 316)	
	Freq	%
Age of the participants, mean (median)	**12.3 (12)**	
Sex of the participants		
Boy	**145**	**45.9**
Girl	**171**	**54.1**
Educational level, mean (median)	5.1 (5)	
Grade year in school, n = 309		
Primary school (Grade 1- 6)	218	70.6
Lower secondary (Grade 7- 9)	**81**	**26.2**
Higher secondary (Grade 10-12)	10	3.2
Report enough stationaries for schooling, n = 304	207	68.1
Currently reported in school	304	96.2
Ever suspended school to earn income in past 6 months, n = 304	**78**	**25.7**
Received additional support for school in past 6 months	291	92.1
Source of additional supports for school, n = 291		
KHANA/IPs	289	99.3
Charity	9	3.1
School	8	2.8
Local social worker	3	1.0
Having friends either in school or in village	309	97.8

2.2. Living and family conditions

More than 45% of OVC reported that they live with parents, and over 30% live with grandparents. Almost 50% reported feeling happy about living in the households, only less than 20% reported feeling unhappy. Overall, OVC reported that their parents or guardians have a positive attitude towards them.

Table 8: Living and family conditions

Variables	OVC (n = 316)	
	Freq	%
OVC living with		
Parents	147	46.5
Grand parents	**107**	**33.9**
Aunt and uncle	**49**	**15.5**
Siblings	11	3.5
Feeling living with this household*, n = 250		
Happy	118	47.2
Normal	**88**	**35.2**
Unhappy	44	17.6
Able to discussion trouble with parents &guardian, n = 250	176	70.4
Parents or guardians' general attitude toward OVC, n = 250		
Pay more attention than other children	**223**	**89.2**
Blame or scold	20	8.0
Unequal support comparing to the other children in families	5	2.0

2.3. Health conditions and nutritional issues

Over 75% of OVC reported getting sick in the past 6 months, 60% (148/241) experienced serious illness that limited their ability to participate in daily activities such as school or work. Less than 10% of OVC reported feelings of depression, despair or hopelessness in the past month.

Only about 84% respondents reported having enough food to eat in the past 6 months, meaning that 16% (52/316) had an insufficient supply of food. Due to lack of food in the past 12 months, about 40% OVC families reduced their meal times to only two times per day; only 57.6% had 3 meals per day.

Table 9: Health condition and nutrition

Variables	OVC (n = 316)	
	Freq	%
Ever have had sick in the last 6 months	241	76.3
Ever have illness that prevented from working or studying in the last 6	148	61.4
Feel depressed, despair or hopeless in the last month		
Never	177	56.0
Sometime	108	34.2
Frequently	24	7.6
Report enough food to eat in the last 6 months	264	**83.5**
Reduce times of daily meals due to lack of food in last year	124	**39.2**
Report number of meal per day		
3 times	182	57.6
2 times	134	**42.4**
Thought on availability of food compared to other children in the village		
Same	124	39.2
Less than others	185	58.5
More than others	7	2.3

2.4. Support from the community and NGOs

The community (i.e. neighbors, self-support groups, villagers) plays an important role in providing the first line of support for families and children affected by HIV. However, as previously explained, most of the support was from NGOs. For instance, 99% of additional schooling support was from KHANA and its implementing partners. The support that the children received after their parents' death include clothes and other materials (94%), food such as rice, noodles, canned fish (85%), psychological support (78.7%), school support (76.3%) and others (Table 10). Food support (81.7%) and clothes (74.4%) are the two types of support considered most helpful for daily life. Psychological support was perceived to be the least required type of support.

Table 10: Community and NGO support and OVC needs

Variables	OVC (n = 316)	
	Freq	%
Support from NGO and other people since parent died or got sick		
Clothes and other materials	297	**94.0**
Food supports (rice, noodles, canned fish)	267	**84.8**
Psychological supports (visits, encouragment)	248	**78.7**
Support for schooling	241	76.3
Financial supports	213	67.8
Types of support which would be helpful for OVC family in daily needs		
Food supports-rice, noodles, canned fish	258	**81.7**
Provide clothes and other materials	235	**74.4**
Financial supports	144	45.6
Support for schooling	87	27.5
Psychological supports (visits, encouragment)	25	7.9
Visit from HCBC in the last 6 months, n = 302	281	93.1
Two most urgent needs of OVC		
School uniform and study material	217	68.7
Food	203	64.2
Thought on stigma & discrimation in the community in the last year, n = 310		
Sharply decreased	94	30.3
Decreased some	141	45.5
Not decreased	64	20.6
Increased	11	3.6

B. Focused prevention component

1. Entertainment workers

1.1 Socio-demographic characteristics

Karaoke workers and beer promotion women represented the two highest proportions of the EW sampled with 55% and 38.4% respectively. The mean age of the women was 24 years old, with the range from 17 to 39 years old. Women aged 24 or under accounted for 65% of the sample. Over 90% of the sample women were either not married or divorced.

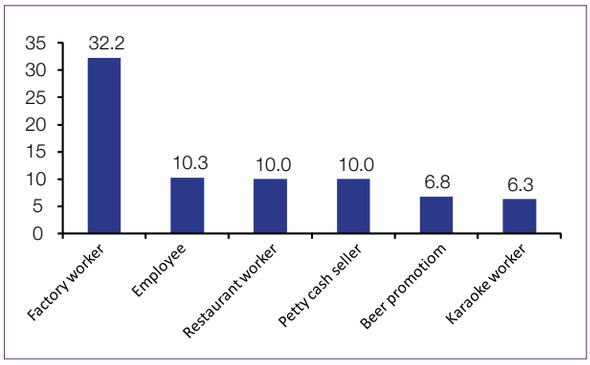
On average, the entertainment workers had received about 4 years of primary education (grade 1-6), while 18% had no schooling at all. Their average monthly income is about US$140 per month. About 94% reported living in their place of work with the establishment owners. 55 % reported that they had been working in this field/ career for the past 6 months or less, and have lived in this province for one year or less.

Table 11: Socio-demographic characteristics

Variables	EW (n = 229)	
	Freq	%
Age, mean (median)	23.5 (23)	
Range	17-39	
Marital status		
Not married	175	**54.7**
Divorced	125	**39.1**
Married but living separtely	11	3.4
Married and live together	9	2.8
Duration of schooling, mean (median)	4.4 (5)	
Range	0-11	
Monthly income, mean (median), USD	141 (110)	
Range	24-917	
Currently living with		
Establisment owners	299	**93.7**
Relatives/parents/spouse/friends	13	4.1
Other women in rented rooms	7	2.2
Duration of working in the current place, months, mean (median)	8 (3)	
Duration of working in this job, months, mean (median)	12 (6)	
Duration of living in this province, months, mean (median)	92 (12)	

Most of the entertainment workers reported working as garment factory workers 12 months before their current jobs (Figure 3).

Figure 3: Percentage of previous jobs of EW 12 months ago

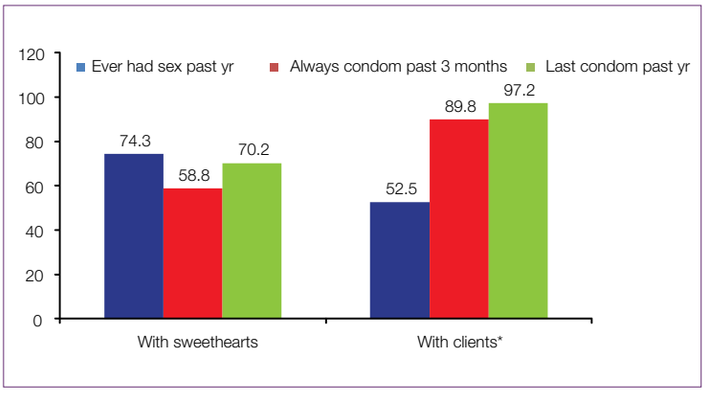


1.2 Sexual behavior and condom use

19% of entertainment workers reported that they have never experienced sexual intercourse. One half of the EW interviewed said that their first experience of sexual intercourse had been with their spouses, 32% with sweetheart, and less than one fifth (17%) with their clients. About 2% reported that they were raped the first time they had sex. 74% of those with sweethearts reported having sex with their partners in the past year. Consistent condom use with sweethearts in the past 3 months was reported at less than 60%. The most common reason for low condom use with sweetheart was likely the element of trust present in a long-term relationship.

More than 50% of EW reported having sex with their clients in the past year, and consistent condom use in the past month was reported to be 89.8%. 3% (7/230) reported having had experiences in which clients refused to use condoms (i.e. offering extra money, threatening verbally or with a gun, or being under the influence of alcohol or drugs). Many EW experienced condom breakage or slippage at least one time in the past 3 months (22.3%). Figure 4 illustrates the pattern of sexual behavior and condom use with different partners either sweetheart or clients.

Figure 4: Reported sexual encounters with different partners and consistency of condom use



** Always condom use with clients specified in the past month; denominators were different from question to question.*

1.3 Health seeking behavior and HIV education

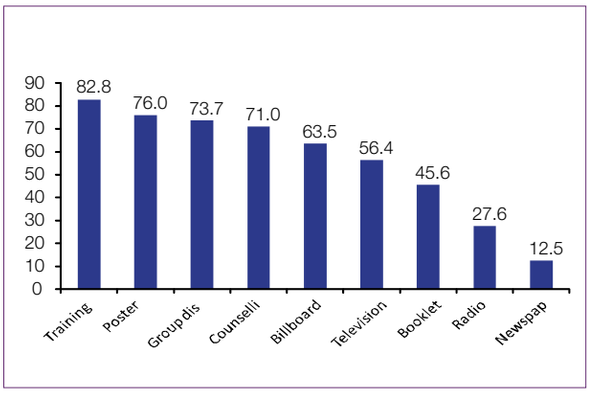
80% of EW reported that they had sought STI treatment and health check-ups at either public or NGOs clinics in the past 3 months. About 68% kept to the appointment time arranged by the clinics. Overall, about 27% reported at least one STI symptom (i.e. genital ulcer, genital swelling, and abnormal vaginal discharge). This is described in more detail in Table 12. The first place EW reported seeking STI treatment from was public clinic (50%), followed by NGO clinic, pharmacies, and private clinic. It was also reported that outreach and peer educators are the main advisors for EW when seeking STI treatment (67%).

Table 12: Self-reported STI symptoms and health seeking behavior

Variables	EW (n = 320)	
	Freq	%
Ever sought health and STI check-up at public clinics		
or NGO clinics	**256**	**80.0**
One time	59	18.4
Twice	63	19.7
Three times	134	41.9
Kept to the appointment time	220	68.7
STI symptoms in the past year	88	**27.5**
Genital ulcer or genital blister	14	4.4
Genital swelling	23	7.2
Vaginal discharge	76	23.7
First place to seek treatment from experiencing STI symptoms, n = 88		
Buying medicine at pharmacies	10	11.4
Visit private clinic	8	9.1
Public clinic	44	**50.0**
NGO clinic	19	**21.6**
Source of advise for last STI treatment, n = 82		
Herself	13	15.9
Friend	4	4.9
Outreach and peer educator	55	**67.1**
Owner, pimp	6	7.2

More than 92% (296/320) reported that they had received HIV related information within the past 3 months, most of which was received via HIV campaign or training, poster, group discussion and counseling (Figure 5). Most of the information received was passed on by peer educators and NGO staff (97.2%), followed by VCT staff (30.7%), public STI clinic staff (30.7%) and private STI clinic staff (17.7%).

Figure 5: Source of HIV information EW received in past 3 months



1.4 Sexual and reproductive health issues

Improving the sexual and reproductive health (SRH) for women at reproductive age is one of the main tasks of the Ministry of Health (MoH) to achieve Millennium Development Goal (MDG) 5. KHANA's 5-years Strategic Plan 2011-2015 clearly states the importance of integrating SRH into HIV programs, either directly or through referrals [7] to ensure the synergy between the two, which can play a meaningful role in program and service delivery.

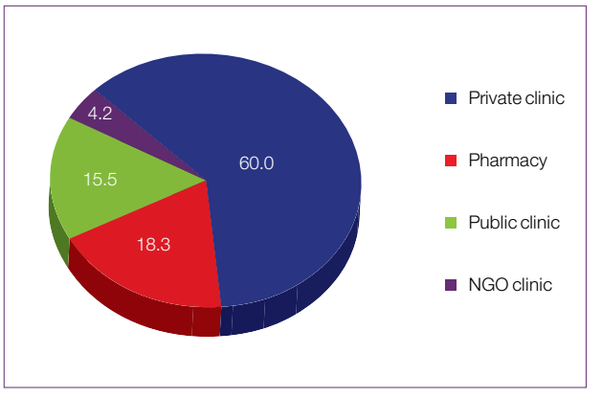
89% of EW reported to have received information about SRH and family planning. Among those who are sexually active, more than 25% of EW reported to have used contraceptive methods before, of which more than 65% had used condoms (Table 13). Still, 11% (28/259) reported becoming pregnant while they were working as EW. Of those, 27% experienced abortion at least once in the past 6 months.

Table 13: Sexual and reproductive health issues

Variables	EW (n = 320)	
	Freq	%
Ever received information about SRH, family planning in past 3 months	286	**89.4**
Ever used diffrent types of contraceptive method, n = 259	72	**27.8**
Condom	**173**	**66.8**
Pill	7	2.7
IUD	6	2.3
Withdrawal	3	1.2
Injection	2	0.8
Number of pregnancy, mean (median)	1.1 (1)	
Report of pregnancy when being as EW, n = 259	28	10.8
Ever reported of abortion	70	27.0
Number of abortion until now among reported abortion, n = 70		
1 abortion	46	65.7
≥ 2 abortions	24	34.3
Duration of last abortion ≤ 6 months	19	**27.1**
Report of abortion at least once while working as EW, n = 259	24	**9.3**

Figure 6 illustrates the places where women working as EW reported having sought their last abortion. It shows that a high proportion of the abortions took place in private clinics. Additional work may be needed to increase awareness on safe abortion (in a proper clinic with skilled health providers) and condom use as dual protection against unwanted pregnancy as well as HIV and STI transmission.

Figure 6: Places EW seek last abortion service from (%)



1.5 Types of support received, HIV testing and awareness of available HIV services

In the past 6 months, EW received different types of support that included transportation fee for accessing health services (64.7%), commodity support (i.e. medicine, toothpaste, soft drink, towel) (35.3%), psychological support (29.1%) and others.

Close to two third of EW reported being tested for HIV in the past year, of which 93% reported HIV testing in the past 6 months. More than 85% had tested either at public hospitals or VCT clinics (either owned by the government or NGO). 90% were aware of the availability of ART service, 77% reported knowing about HIV care services, and about 90% believed that they could access services when needed.

2. Men who have sex with men

2.1 Socio-demographic profile

The mean age of respondents was 23 years old (median = 21), ranging from 15 to 55 years old. 86% of them were not married and currently live with their parents (61%).

The respondents reported their occupation as students (28.8%), farmer (17.7%), self employed (petty cash vendor) (16.1%), military/police (8.3%) and hair dresser (7.5%). 67% reported that they perceived themselves as men, 22.3% as women, and 11% as both men and women.

2.2 Sexual behaviors and condom use

Over 37% of MSM reported having paid sex with women in the past month. Of those, 93.2% used condom consistently. About 15% of the group reported selling sex to women in the last month, with over 79% consistent condom use. 8.7% reported paying men for sex in the last month, with 73.7% reported consistent condom use. 44% sold sex to men with 76.5% consistent condom use. 63% of MSM reported using lubricant, either for insertive or receptive sex.

Table 14: Sexual behaviors and condom use

Variables	MSM (n=385)	
	Freq	%
Report having sweetheart (SH)	183	47.5
Report having sex with sweetheart (n=183)	81	44.3
Always used condom with sweetheart in last month (n=80)	51	**63.8**
Report **paid sex** with **women** in past month (n=197)	73	37.1
Always condom use with paid sex with women last month (n=73)	68	**93.2**
Report of **selling sex to women** in last month (n=197)	29	14.7
Condom use when selling sex to women last month (n=29)	23	**79.3**
Had sex with male Sweethart in last month, those had sex (n=206)	159	77.2
Always used condom with male Sweethart in past month (n=148)	108	**73.0**
Report of **paying men for sex** in the last month (n=241)	21	8.7
Always used condom with paying sex in the last month (n=19)	14	73.7
Report of **selling sex to men** in last month (n=241)	107	44.4
Always condom use when selling sex to men last month (n=102)	78	**76.5**
Ever insertion anal sex in the last month (n=241)	124	51.5
Always used condom with insertion anal sex last month (n=121)	96	**79.3**
Always used lubricant with insertion anal sex last month (n=122)	78	63.9
Ever receptive sex last month (n=241)	133	55.2
Always used condom with receptive sex last month (n=134)	102	**76.1**
Always used lubricant with receptive sex last month (n=133)	84	63.2

2.3 HIV/AIDS knowledge, stigma and discrimination

Over 68% of respondents had been tested for HIV and were aware of the test result. Of those, 78.5% had been tested in the last 6 months. Overall, MSM reported high levels of knowledge on HIV transmission and prevention (>99%). However, less than 50% knew about HIV transmission from mother to child and from blood transfusion. More than 80% of MSM reported that their neighbors have a positive attitude towards HIV infected people; neighbors were willing to visit, share meals together, and were also willing to keep the HIV status of a family member a secret.

Table 15: Reports of perception related to risk and discrimination

Variables	MSM (n=385)	
	Freq	%
Thought on risk of HIV infection compared to other people (n=378)		
Much higher	108	28.6
Higher	115	**30.4**
Similar risk	27	7.1
Lower risk	128	**33.9**
Neighbors are not afraid to visit HIV infected family member	340	**88.3**
Neighbors are not afraid to have meals with HIV infected family member	307	**80.4**
Willing to keep HIV status as secret of member	173	44.9
Discrimination thought to PLHIV compared with last year (n=383)		
Increase	27	7.1
Decrease	336	**87.7**
Same	20	5.2
Thought on discrimination toward MSM compared to the last year (n=376)		
Increase	76	29.2
Decrease	250	**66.5**
Same	50	13.3

2.4 Community support, access to health care, and networking

MSM respondents reported receiving psychological support (49.4%) and counseling support (38.4%) within the last 6 months. 60% said that they had received HIV information within the last 3 months via peer outreach provided by KHANA implementing partners. 7% of MSM reported having an STI within the past year (i.e. genital ulcer, discharge). Of those, 37% sought treatment at an STI clinic. 22.2% treated themselves or bought medicine from pharmacies.

On average, one MSM respondent knew about other 16 MSMs (median = 27) in his network. They usually socialize or meet their partners at concerts and community gatherings (17%), at home (16%) or at parties (13%).

3. People who use drugs

Implementing partners worked with people who use drugs, community youth and local service providers to provide services for PWUD/PWID. The services provided include drop in center, harm reduction program, drug detoxification, recreation, vocational training and social welfare support.

This section highlights the socio-demographic profile of drug users, their characteristics, sexual behavior and condom use, knowledge about HIV, health-seeking behavior, and community support.

3.1 Socio-demographic and drug use experience

The average age of drug user respondents was 22.2 years old, with most members of the group being under 25 years of age. 77% were unmarried. And about 67% reported that they are living with their parents. The average duration of drug use was 34.9 months. 8.2% of drug user respondents were reported to be injecting drug users. The average duration of injecting drug use was 11.5 months. 73.7% reported that they could buy sterile needles and syringes at the drug stores and pharmacies or from friends (31.6%). Only 15.8% reported accessing the drop in center of local NGOs though needles and syringes were provided free of charge. 15.6% reported to have stayed at rehabilitation center at least once.

Table 16: Socio demographic profile and experience using drug

Variables	PWUD (n = 297)	
	Freq	%
Mean age, (median)	22.2 (21)	
Age < 25 years	235	**79.1**
Sex of respondent		
Male	289	**97.3**
Female	8	**2.7**
Duration of schooling, mean (median)	8.9 (9)	
Duration of drug use, in months, mean (median)	34.9 (13)	
Report ever injecting drug (n=243)	20	**8.2**
Injecting drug in months, mean (median), n=20	11.5 (4)	
Report sharing needle and syringe (n=20)	8	**40.0**
Frequent use the needle and syringe (n=7)	2	10.0
Report cleaning needle and syringe when shared (n=7)		
Sometime	1	**14.3**
Never clean	4	57.1
Place to access needles and syringes (n=19)		
harmacies	14	**73.7**
Friends	6	31.6
NGO drop in center	3	**15.8**
Ever stayed in a rehabilitation center (n=243)	38	15.6

3.2 Sexual behaviors and condom use

Age at first sexual intercourse was as reported to be as early as 15 years old (median = 18). About 71% of respondents reported that they had been sexually active in the past year. Among those who had sexual intercourse, 41.3% reported having had sex after taking drugs. More than 86% believed that their drug use increased their sexual desire.

52% always used a condom with regular sexual partners, and more than 83% always used a condom with paid sexual partners, most of whom were entertainment workers (52.9%). 90% of them reported that they had acquired their condoms at pharmacies. Only 22.2% accessed condoms provided by NGO community peer workers and outreach.

Table 17: Sexual behaviors and condom use

Variables	PWUD (n = 297)	
	Freq	%
Age of first sexual intercourse, in year, mean (median)	14.9 (18)	
Ever having sex in the last year	210	**70.7**
Having sex after using drug use in the last year (n=210)	87	**41.3**
Drug use increases sexual desire (n=88)	76	**86.4**
Number of paid sex partners in the last month, mean (median)	3.3 (3)	
Always use condom with paid sexual partner (n=118)	98	**83.1**
Type of paid sexual partners (n=210)		
Entertainment workers	111	**52.9**
Brothel based sex workers	45	21.3
Street sex workers	17	**8.1**
Sweetheart or girlfriend	7	3.3
Always use condom with occasional sexual partners* (n=156)	129	**82.7**
Place to access condom		
Pharmacy	268	**90.2**
Entertainment establishment	115	38.7
Staff from NGO	66	**22.2**
Health center	82	27.6

**Occasional drug users are defined as those using drugs 2 times or less per week in the past month.*

3.3 HIV and AIDS knowledge

More than 99% of respondents reported being aware that HIV could be transmitted through using shared needles and syringes. 80% received information on HIV prevention and drug use from NGO staff, and more than half heard about this information from mass media. Out of 47.5% drug users who had been tested for HIV, 97% were aware of their test results. In the survey, two questions were asked about their awareness of the availability of OI/ART services. 69% knew that OI/ART services were available at public health facilities, and 67% believed that they could access the services when needed.

Table 18: HIV knowledge, testing and education and information

Variables	PWUD (n = 297)	
	Freq	%
Aware that HIV can be transmitted through needles and syringes	292	99.3
Ever received information and education about HIV and drug		
NGO staff	238	**80.1**
TV or Radio	151	**50.8**
Ever been tested for HIV	141	**47.5**
Know the result of HIV test (n=141)	137	**97.2**
Duration of last HIV test in months, mean (median)	6.7 (3)	
Awareness about the availability of OI/ART services	204	**68.9**
Believe that access to service is available	199	67.0

3.4 Support from the community and health seeking behavior on STI

The main type of support received by the respondents in the past 6 months was psychological support (56%) and counseling (40%). Over 47% of this support was provided by KHANA and its implementing partners. Approximately 9% of respondents reported signs and symptoms of STI in the last year.

The number of respondents seeking treatment for STI is still relatively low. Private clinics and traditional healers are the main places that respondents seek treatment from. This raises a concern for the program that needs to actively strengthen the packages of harm reduction interventions, linkages, systematic referral and follow-up between health sectors and relevant services, in line with the recommendation of the national Continuum of Prevention Care and Treatment (CoPTC) (in draft).

Table 19: Support from the community and health seeking behavior on STI

Variables	PWUD (n = 297)	
	Freq	%
Received any kinds of support in the last 6 months		
Psychological support	166	**55.9**
Referral fee	50	16.8
Social welfare	67	22.6
Counseling	120	**40.4**
Sources of support in the last 6 months		
KHANA and IP	140	**47.1**
Family	50	**16.8**
Report of STI symptoms in the past year	27	**9.1**
Accessed treatment from when having last STI symptoms (n = 27)		
Private clinic	8	**29.6**
Public clinic	4	14.8
Traditional healer	8	**29.6**
No treatment	4	14.8

3.5 Recognition of the village and commune safety policies

25% of PWUD/PWID had never heard about the "Village and commune safety policy". This policy was first implemented since 2010 with the aim to fight against five social issues in communities: drug, human trafficking, gangster, domestic violence and gambling. This policy involves all local authorities: police, military police, military at all levels, as well as the communities-to make sure that their communities are clean from these mentioned above.

15% had experienced being arrested by police. More than half of those arrested reported that they had been arrested once; 15-20% had been arrested 2-3 times; while 4.5% had been arrested more than 3 times. 70% of those who were ever arrested reported that they been put in jail. Only 30% were sent to rehabilitation centers. Though 67% of drug users believed that the implementation of the policy had reduced the number of PWUD in their community, in fact, it has resulted in drug users becoming more hidden, more mobile, and consequently, harder to reach.

Table 20: Awareness about village and commune safety policy

Variables	PWUD (n = 297)	
	Freq	%
Ever heard of village and commune safety (VCS) policy (n=297)	222	**74.8**
Ever been arrested during implementation of VCS policy (n=295)	44	**14.9**
Frequency of arrest (n=44)		
Once	26	**59.1**
Twice	9	20.5
Three times	7	15.9
More than three times arrest	2	4.5
Place of transfer after having arrested (n=43)		
Rehabilitation	9	20.9
Prison	34	**79.1**
Change to the number of drug user after VCS (n=297)		
Decreased	199	**67.0**
Same	13	4.4
Increased	11	3.7

V. CHANGES OVER THE PROJECT IMPLEMENTATION: 2009-2011

Data from the midterm and end-line surveys were combined together with matched variables. Both surveys used a cluster sampling with take-all approach, and the same data collection tools. Chi-square test was used to detect changes in key outcome indicators in all dataset. No baseline or midterm data for PWUD/PWID was available for comparison, due to sporadic program implementation for this target group in these provinces in 2008-2009. Therefore, the research team decided not to collect PWUD/PWID data during the midterm review of this project.

Because the questionnaires were designed with multiple choices, some indicators and figures did not sum up to 100%. There are also variations on denominators across the tables.

Table 21: Sample size by group and by year

Group	2009	2011	Total
PLHIV	193	358	551
OVC	194	316	510
EW	229	320	549
MSM	260	385	645
PWUD / PWID*	-	297	297

**Data was not collected in 2009*

A. Changes in Integrated Care and Prevention

Changes in key outcome indicators related to PLHIV and OVC include socio-economic and health conditions as well as community support. Satisfaction level toward services provided in the ICP component was also highlighted.

1. People living with HIV

1.1 Changes in work and income

PLHIV reported significant improvements in living conditions. There was a significant increase in self-employment and monthly salary as the main sources for generating income for PLHIV's family. This might be linked to their improved health condition that allows them to return to work, either self-employed or working for others. PLHIV reported significant decrease (65% reduction) in borrowing money or rice from others in the past year (91.2% in 2009 vs. 78.2% in 2011. Adequate weekly income for the families also increased, from 9.3% in 2009 to more than 37% in 2011 ($p < 0.001$) or about 6 times higher in 2011 than 2009. Though people still sold assets to pay for expenses and debt, the proportion of assets sold for paying debt has declined significantly (17% vs. 2.8%, $p < 0.001$). Reports of selling farmland have decreased from about 17% in 2009 to 5% in 2011 ($p < 0.001$). A reduction in the asset selling patterns and debt could indicate a return to better living conditions and improving health conditions. Qualitative findings confirm these findings, as indicated in the quotes below.

Table 22: Changes in work and economic condition of PLHIV

Variables	2009 (N = 193) 2011		2011 (N = 358)		P value
	N	%	N	%	
Main sources of income in the family					
Self employed	83	**43.0**	210	**58.7**	< 0.001
Farming	86	44.6	142	39.7	0.26
Selling labor	55	28.5	124	34.6	0.14
Monthly salary	20	**10.4**	82	**22.9**	< 0.001
Charity from NGOs or individual	42	21.7	42	11.7	0.02
Report adequate weekly income for the families	18	**9.3**	135	**37.7**	< 0.001
Ever sold different assets in the past year					
Bufallo or cow	14	22.6	26	21.7	0.88
Pig	42	59.2	43	39.5	0.01
Chicken and duck	77	51.0	162	56.3	0.29
Motobike or bicyle	12	**6.2**	9	**2.5**	0.03
Farming land	21	**17.1**	10	**5.1**	< 0.001
Ever borrow money or rice from others in past year	176	**91.2**	280	**78.2**	< 0.001
Expense money from sold assets in last year					
Food and cloth	123	**63.7**	193	**53.9**	0.03
Medical care	68	**35.2**	94	**26.3**	0.03
Support children to school	22	11.4	41	11.5	0.98
Transportation	23	11.9	26	7.3	0.07
Paying debt	33	**17.0**	10	**2.8**	< 0.001

"I feel much better than before, looking back to our much worse health condition at that time, now our living condition is much better" (FGD-KCN)

"I feel it was harder before when I worked for a garment factory, but now after receiving support from NAPA [KHANA implementing partner], I have got the support for referral [cost for transportation]. I stopped working [as a factory worker]. NAPA gave me US$ 120 to run a small business that is now in good progress". (FGD-KSP)

1.2 Improved health condition and ART

Significant changes were observed, including an increase in the number of people accessing public hospitals and VCT clinics to confirm their HIV status. This is in part due to the increasing availability of public services and the requirement for PLHIV to have their status confirmed by health workers before being eligible for OI/ART.

There is a decrease in referrals provided by HCBC and SHG for PLHIV to access OI/ART services from 2009 (47%) to 2011 (33%), p< 0.001). Further analysis shows the lower proportion was observed in Kampong Chnnang (26.6%), while Kampong Speu, 37.7% and Prey Veng, 36.3%. However, as shown in Table 23, health staff and VCT staff are becoming increasingly involved in providing referrals to OI/ ART services.

There are a number of explanations for this change. Firstly, preparation for the project's phase out, along with a reduction of the fieldwork budget might have resulted in deceleration of fieldwork and consequently affected the home and community based care response during that time. The revision of OI/ART guidelines to increase the eligibility of PLHIV with CD4 ≤ 300 cells per mm3, and the improvement of Health Systems Strengthening (HSS) under The Global Fund Round 9 grant might also have contributed to the improvement of referral from health facilities, including VCT services.

Table 23: Changes in health condition and referral to ART services

Variables	2009 (N = 193)		2011 (N = 358)		P value
	N	%	N	%	
Patient reported good health compared with last 6 months	118	61.1	228	63.7	0.55
Places where HIV status was confirmed					
Public hospital	114	**59.1**	254	**71.0**	0.02
VCT including (NGO VCT)	67	34.7	94	26.3	
Received counselling for the last HIV test	189	97.9	351	98.0	0.92
Currently taking antoretroviral drug (ARV)	161	**83.4**	321	**89.7**	**0.03**
Persons or services who refer you to the OI/ART services					
Home based care team	91	**47.2**	119	**33.2**	< 0.001
Self help group	20	**10.4**	25	**6.9**	
Relatives and friends	41	21.2	57	15.9	
Health workers	36	**18.7**	117	**32.7**	
VCT staff	5	**2.6**	40	**11.2**	
Currently a member of self support group	164	85.0	334	93.3	0.004

"My health is quite good now. I have medicine, food, counseling, enough sleep, good spirit, exercise and do not have heavy work [collecting green grass for cow]" (FGD-KCN)

"Now it is quite different from the last two years [2009], [now] we take care of our health, adhere to ART, and our CD4 count increased" (FGD-KSP)

[How has your health changed]: "It [my health] changed a lot. My health was worse before but now I can do a lot of jobs, my CD4 count increased. It is 519 cells per mm3 now" (IDI-33 years old)

Improved understanding about ART is illustrated in Table 24. Misunderstanding about ART has decreased significantly from 2009 to 2011. In 2009, about 45% thought that ART can prevent STI, while in 2011 only 18% PLHIV have this misunderstanding. A monitoring report prepared by an independent consultant in September 2011 shows higher levels of awareness and understanding of their own needs among PLHIV. It also stated that PLHIV were in a much better position to exercise their rights and that there had been a noticeable enhancement of self esteem [8].

Table 24: Understanding about antiretroviral treatment (ART)

Variables	2009 (N = 193)		2011 (N = 358)		P value
	N	%	N	%	
ART prevents you from additional infection	143	**74.1**	89	**24.9**	< 0.001
ART makes you as healthy as before infected	157	81.4	294	82.1	0.82
Using ART, no need to use condom when having sex	14	**7.3**	19	**5.3**	0.35
ART prevents you from sexually transmitted infections	86	**44.6**	65	**18.2**	< 0.001

[Can ART prevent STI transmission?] "Not at all, unless we use condom when having sex" (IDI, PVG)

"Due to my complete adherence to ART and regular health visit, my CD4 count increased from 300 to 799" (IDI, KSP)

1.3 Changes in community support

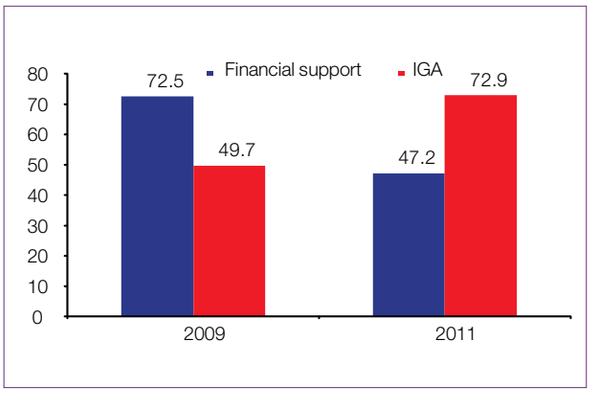
PLHIV are still concerned about having enough money for their health care and food. In 2009, 92.7% of respondents reported that they had received food support (i.e. rice, cooking oil, canned fish and iodized salt) within the previous six months; this figure had dropped to 76.5% in 2011 (p< 0.001). These figures are in line with the phase-in and phase out strategy of the World Food Program (WFP) support which will come to a complete halt in 2012. In July 2011, the KHANA Implementing Partner Program Management held a workshop to discuss the exit strategy, taking into account the concerns related to the end of WFP support and the phasing out of this project. The exit strategy includes seeking other funding opportunities such as a village saving loan with technical support from KHANA, and the opportunity for welfare support by being integrated with the community decentralization plan (EC workshop phase-out plan for IP, July 2011). On the other hand, it has been found that psychological support increased significantly from 22.8% to 40.2% (p< 0.001) over the project life.

Table 25: Community support and needs of PLHIV

Variables	2009 (N = 193)		2011 (N = 358)		P value
	N	%	N	%	
The biggest concerns related to your illness					
Money for health care	103	**53.4**	230	**64.3**	**0.01**
Money for buying food	111	57.5	193	**53.9**	**0.41**
Money supporting children to school	56	29.0	139	38.8	0.02
Take care of sick children	17	8.8	34	9.5	0.79
Supports PLHIV & families received in the past 6 months					
Financial support	141	73.1	278	77.7	0.22
Food support (rice, cooking oil, canned fish, salt)	179	**92.7**	274	**76.5**	< 0.001
Psychological support	44	**22.8**	144	**40.2**	< 0.001
Provision of clothes	25	12.9	69	19.3	0.06
School support for children	7	**3.6**	68	19.0	< 0.001
Counselling	35	18.1	50	14.0	0.19
Useful supports for PLHIV's families' daily lives					
Psychological support	33	17.2	76	21.3	0.25
Financial support	155	80.7	281	78.5	0.53
Food support	178	**92.2**	306	**85.5**	0.01
Support children for school	12	6.3	49	13.7	0.008
Cloth support	24	12.5	58	16.2	0.24
Counselling	17	8.9	24	6.7	0.36
Training on IGA	19	**9.9**	84	**23.5**	< 0.001
Support transportation and school fee	5	2.6	27	7.5	0.02
Think friends/relatives dare to have meal with you in the house	172	89.1	334	93.3	
Friends and relatives visited PLHIV	179	92.8	345	96.4	

Figure 7 shows that there has been a significant decline in provision of financial support from KHANA and implementing partners, and a significant increase in the demand for Income Generating Activities (IGA). PLHIV and their families also reported on the usefulness of the IGA training, suggesting that increased capacity for self-reliance may lead to increased demands for IGA. PLHIV whose basic health and socio-economic needs are met through community support usually wants to reduce their dependency and maintain sustainable livelihoods.

Figure 7: Shift patterns of PLHIV need about financial and IGA support



****There is a highly significant difference between 2009 and 2011 with p <0.001*

2. Orphan and vulnerable children

2.1 Schooling, health condition and support for OVC

Within the period of 2009-2011, there was a significant increase in regular access to schooling for OVC (83.5% vs. 96.2%, p< 0.001). The level of change over this period was larger for girls (77.8% vs. 95.9%, p< 0.001) than it was for boys (87.5% vs. 96.6%, p< 0.006) and has resulted in the 2011 level of OVC access to schooling to be almost the same for girls as it is for boys. In addition, there have also been improvements reported in the physical health of OVC. The number of OVC respondents reported ever being sick declined significantly from 43.3% in 2009 to 23.7% in 2011 (p< 0.001).

Reports of reductions in the number of daily meals due to lack of food decreased from 53.1% to 39.2% (p = 0.002). Reports of periods of inadequate food supply during the preceding year also dropped from 36.1% to 16.5%. The findings highlight positive changes in some aspects of social support and health condition among OVC. Socio-economic status as measured by secure access to food also improved significantly. These improvements are likely due to contributions from KHANA program as well as increased community and family support.

Table 26: Schooling, health condition and support for OVC

Variables	2009 (N = 194)		2011 (N = 316)		P value
	N	%	N	%	
Report enough stationaries for schooling	53	**32.5**	207	**68.1**	< 0.001
Currently reporting in school	162	**83.5**	304	**96.2**	< 0.001
Ever been suspended from school to earn income in the past 6 months	48	32.0	78	28.3	0.41
Received additional supports for schooling in the past 6 months	132	**68.0**	291	**92.1**	< 0.001
Source of additional supports for schooling from					
KHANA/IPs	126	95.5	289	99.3	0.007
Charity	8	6.1	9	3.1	0.15
School	4	3.0	8	2.8	0.87
Difficulty in school because teacher did not pay attention due to parents or sibling died or were sick of HIV	47	**28.8**	51	**16.7**	< 0.001
Ever got sick in the past 6 months	84	**43.3**	75	**23.7**	< 0.001
Have enough food to eat in the past 6 months	**150**	**77.3**	264	**83.5**	0.08
Reducing time of daily meal due to lack of food in past 12 months	103	**53.1**	124	**39.2**	0.002
Ever had meal interuption in the past 12 months	70	**36.1**	52	**16.5**	< 0.001

"The WOSO [KHANA implementing partner] provided counseling support, advice, health care, food support [rice, salt and oil], dishes, mosquito net, blanket, schooling materials, clothes, involved Happy Happy Program. I am almost 100% happy with these supports." (OVC, 16 years old, KSP)

"I feel good this year [2011]. My three grandchildren received bicycles, books, pens, school bags… all things. They [NGO staff] reminded us to take our medicine correctly and consistently, encouraged us, and gave us hope" (FGD-Caregiver, KCN).

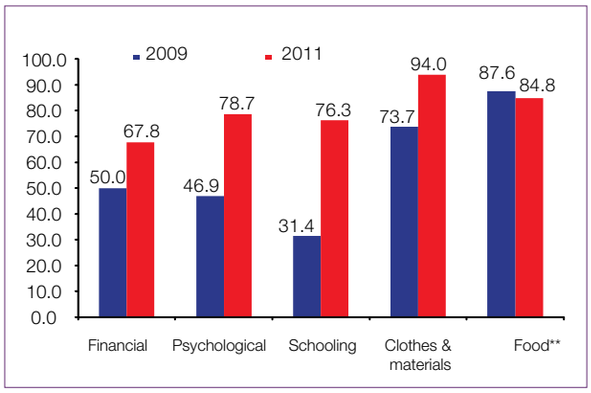
[How is your daily meal?]

"Before, we were short [of food] almost every day. We only had two times meal per day, but now with the support of the organization [PC, a KHANA implementing partner], my grandchild can eat three times per day" (FGD-Caregiver-KCN)

2.2 Community support and the needs of OVC

Between 2009 and 2011, significant increases were reported in the level of community support to OVC. Most notably, the percentage of OVC reportedly receiving psychological and schooling support increased by 32% and 45% points respectively. This is shown in more detail in Figure 8.

Figure 8: Different community supports for OVC



***All of the numbers show significant difference between 2009 and 2011 with p value < 0.001, except for food support.*

OVC still reported that support in the form of clothing and relevant materials (59.8% vs. 74.4%, p = 0.001) were highly useful to them. School uniforms and materials were among urgent needs for OVC (57.2% vs. 68.7%, p = 0.009). High demand for such support suggests the need to maintain access to regular schooling. These improvements in support received are likely due to contributions from KHANA program as well as increased community and family support.

[What did you get from the organization [KHANA's IP]?]

"Schooling materials, blanket, mosquito net, mat, hot container, cooler. They [NGO staff] also visited us every month or two. They have to travel by boat to reach us, which is hard.

[How has this support maintained your needs and how has your life changed?]

"It has released about 80-90% of our burden. Today I live better; I have rice and I get an incentive of US$15 per month". [OVC group leader]' (IDI, 12 years old-KCN).

"PC [KHANA's implementing partner] supports us by providing mat, mosquito net, cooler, hot container, plate, rice pot, schooling materials, spoons, books, pens, shoes" (FGD-caregivers-KCN)

[How do you feel about their living condition?]

"As far as I know, before joining the project, their living conditions were not so good, nor were their health. Some people even passed away because of poor health and economic conditions [no food and medicine], but now with the support of the organization [KHANA's implementing partner] they are much better in terms of health, economy, IGA and schooling. Before, they did not go to school because of sickness or economic hardship. [What do the children do if they don't go to school?]

"The parents sent them to earn money by harvesting, washing clothes, or fishing. Now they look better [get fat] and have enough food to eat (KII-Program Coordinator-KCN)

[Do you think the project meets their needs?]

"I think, most of the needs are met, due to the change in their way of living. We supply about 80% of what they need. Not only us as an organization, but the local authority also provided them support [to repair their house, we provided the roof and the local authority added pillars, planks and nails]' (KII- program coordinator-KCN)

B. Changes in satisfaction towards program implemented for PLHIV and OVC

Three main dimensions were used to compare satisfaction levels between the midterm and end line evaluations: home and community based care and self help groups, HIV related information, education and social support provided by KHANA, and the HIV/AIDS care and treatment services.

The satisfaction level related to the home and community based care services and self-help groups was determined through 11 questions for PLHIV and 8 questions for OVC. The satisfaction level, with regards to the provision of information, education and social support by KHANA, was determined through 7 questions for PLHIV and OVC. Finally, the level of satisfaction towards HIV/AIDS care and treatment was determined through 8 questions. All variables in each component of satisfaction level were combined to generate overall scores so that overall satisfaction in each component could be reflected.

The scores from the questions were then categorized into 3 levels of low, medium and high based on the first, second and last 30 percentile. The detail of the scoring information was placed in Appendix 1.

Overall, the levels of satisfaction remained as high in the end-line evaluation as they were during the mid-term review. Significant increase is reported in the level of satisfaction towards home and community based care and self-help groups, HIV care and treatment services for PLHIV, and OI/ ART services (from 78% in 2009 to 96% in 2011). Reports of improved health and living conditions, as well as reduction of death rates among PLHIV, support these findings of high satisfaction levels. [8]

The high satisfaction levels in different components of the program intervention areas suggest relevance, efficiency and effectiveness of the community action on HIV prevention, integrated with care and impact mitigation over the project.

Table 27: Satisfaction level by component of program implementation for PLHIV

Variables	2009 (N = 193)	2011 (N = 358)	P value
	N (%)	N (%)	
Satisfaction with the home & community based care and SHG			
Low (score ≤ 44)	2 (1.0)	2 (0.5)	**0.02**
Medium (score 45-69)	16 (8.4)	11 (3.1)	
High (score ≥ 70)	**174 (90.6)**	**345 (96.4)**	
Satisfaction with health education and social supports			
Low (score ≤ 28)	4 (2.1)	12 (3.4)	0.12
Medium (score 29-45)	14 (7.3)	44 (12.2)	
High (score ≥ 46)	**175 (93.7)**	**302 (84.4)**	
Satisfaction with HIV/AIDS care and treatment services			
Low (score ≤ 32)	30 (15.5)	0 (0.0)	**< 0.001**
Medium (score 33- 50)	0 (0.0)	5 (1.4)	
High (score ≥ 51)	**163 (84.5)**	**353 (98.6)**	

[Are you satisfied with the home and community based care and self help group?]

"I am more than 100% satisfied due to many reasons; I was alone before but now I have help and have made progress with the support of the group. We visited each other and remind each other about our health appointments' (IDI-KSP)

"Satisfied, they [the NGO staff] visit us, encourage us and care about us" (IDI-PVG)

"100% satisfied. We can use it [money support for IGA] to buy hens and a cage. We can eat the produce and sell some of it to supplement our other needs. Also, we gained more skills and knowledge to improve production" (FGD-KCN)

[Are you happy with your current health status and your work?]

"Yes, we are about 80% happy, because for work we can do though we can't compare to ordinary people (not infected by HIV)".

[How about support for health service?]

"About 90% happy, they (the health service providers) welcome me most of the time" (IDI-PVG)

Table 28: Satisfaction level by component of program implementation for OVC

Variables	2009 (N = 194) N (%)	2011 (N = 316) N (%)	P value
Satisfaction with the home &community based care and self support group			
Low (score < 32)	11 (5.7%)	9 (2.8%)	0.27
Medium (score 32-55)	34 (17.6%)	59 (18.7%)	
High (score ≥ 56)	148 (76.7%)	248 (75.5%)	
Satisfaction with support for education, referral, school, food and social welfare provided by KHANA / IP			
Low (score <28)	8 (4.2%)	12 (3.8%)	0.37
Medium (score 28-48)	43 (22.3%)	88 (27.8%)	
High (score ≥ 49)	142 (73.5%)	216 (65.4%)	
Satisfaction with support and OI/ARV treatment services*			
Low (score <32)	1 (4.4%)	0 (0.0%)	0.16
Medium (score 32-55)	4 (17.4%)	1 (4.0%)	
High (score ≥ 56)	**18 (78.2%)**	**24 (96%)**	

"I am about 90% satisfied. I can benefit from this [involvement with self support group]. As orphans, we have to be strong". (IDI-OVC 12 year olds-KCN)

[How satisfied are you with the education and social support?]

"I am 100% satisfied, because I can study and I can find a job in the future - no knowledge, no job. The food support has helped relieve about 90-100% of my burden; I can live properly" (IDI 12 years old-KCN)

"The organization supports all of us to go to school, gives us encouragement and advice. We have fun. I am satisfied" (IDI, 16-year old-KSP)

[How satisfied are you with the vocational skill training?]

"I am totally satisfied. I wanted to learn animal feeding technique and would like to have more training' (FGD-caregiver-KCN)

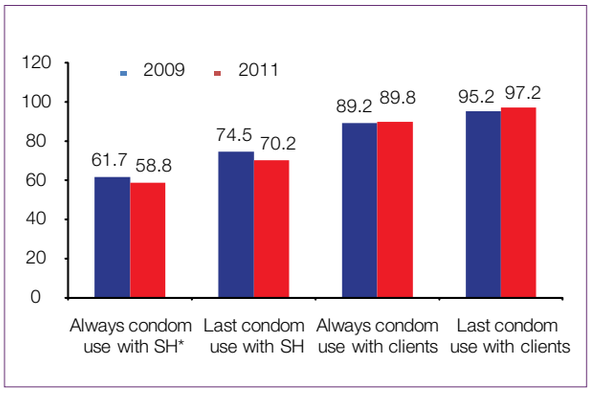
C. Changes in Focused Prevention

1. Entertainment workers

1.1 Condom use among entertainment workers

Reports of consistent condom use with clients remain higher than consistent condom use with sweethearts (60%). One interesting finding was the significant increase of reported condom breakage and slippage. Respondents reported at least one instance of condom breakage or slippage in the past 3 months (from 12.6% to 22.3% (p = 0.06)). This raises a concern about unwanted pregnancy among women. A research report in Cambodia and Laos showed that there was an association between experiences of condom breakage and recent abortion [9]. Therefore, educational campaign about condom use with lubricant should be intensively promoted to reduce instances of condom breakage, in addition to Population Service International (PSI) marketing, even though accessibility to condoms was reported to have increased from 91% (2009) to 95.9% (2011) (p = 0.02).

Figure 9: Comparison of condom use with sweetheart and with client 2009-2011



*Note: *SH: sweetheart. Always condom use with SH means the respondent always used condoms in the last 3 months. "Always condom use with clients" means that the respondent always used condoms in the last one month when having sex with a client. "Last condom use" refers to condom use within the past year.*

1.2 Self-reported STI, abortion, and sexual reproductive health education and information

Self-reported STI symptoms in the past year declined significantly from 38% in 2009 to 27.5% in 2011 (p = 0.009). Outreach and peer educators have continued to play a significant role in advising EW to seek treatment at proper STI clinics; reported at about 67% in midterm and end line evaluations.

More than one fifth of EW reported to have had abortion. The number of those reporting 2 or more abortions decreased from 41% to 34% (p =0.40). There was about a 50% reduction in abortions reported to have taken place within the past 6 months in 2011, in comparison with 2009 (27% vs. 47.5%, p =0.02). The finding was supported by the increased number of women referred to STI services and family planning programs [10]. This might suggest that the SRH/HIV integration strategy that has been implemented since 2010 by KHANA has started to have an impact. This is in line with KHANA's new strategic plan for 2011-2015 that aims to strengthen community understanding about SRH, with an emphasis on increasing knowledge and awareness on prevention of unwanted pregnancy [7].

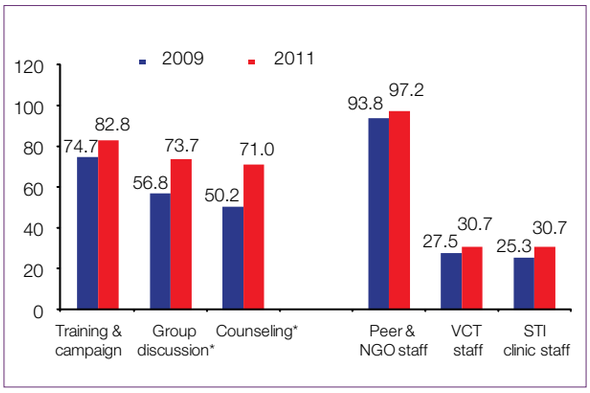
Table 29: Self-reported STI, abortion and education and information

Variables	2009 (N = 229)		2011 (n = 320)		P value
	N	%	N	%	
STI symptoms in the past year	87	**38.0**	88	**27.5**	**0.009**
First place to seek treatment when having symptoms	***n = 87***		***n = 88***		
Buying medicine at pharmacies	5	**6.0**	10	11.4	
Visit private clinic	5	6.0	8	9.1	
Public clinic	45	51.7	44	50.0	0.70
NGO clinic	30	34.5	19	21.6	0.06
Ever reported of abortion	63	27.5	70	21.9	0.12
Number of abortion until now among reported abortion	***n = 63***		***n = 70***		
One abortion	37	58.7	46	65.7	0.40
≥ 2 abortions	26	41.3	24	34.3	
Duration of last abortion ≤ 6 months	29	**47.5**	19	**27.1**	0.02

In terms of access to HIV information and education, mass media (including TV and radio) continues to play a major role in disseminating HIV related information. However, MARPs have not been targeted specifically through media campaigns. This might be a result of the "Commune and Safety Policy" that was mandated by the government in 2009.

As illustrated in Figure 10, there is a significant increase in community involvement in HIV trainings and campaigns, group discussions, and counseling services. Figure 10 also shows that peer outreach workers continue to play an important role in providing information and education related to HIV/ SRH prevention and service referrals for entertainment workers.

Figure 10: Direct source of HIV related information and education for EW



**Statistically significant difference between 2009 and 2011 with p < 0.001*

1.3. Changes in HIV test and awareness about HIV care services

Reports of HIV testing among EW remained high at more than 70%. The percentage of EW reported to have undergone HIV testing within the past 6 months has increased significantly from about 71% in 2009 to 93.5% in 2011 (p < 0.001). This may indicate that the integration of prevention and care for MARPs has been successful in eliminating barriers and increasing access to service delivery by establishing linkages and systematic referral between health sectors services [11]. This is also reflected in the high percentage of HIV testing at public health facilities and VCT, which was reported to be 87% in 2011. A significant increase was also observed on the entertainment workers' awareness of public HIV care services.

Table 30: Changes in HIV testing and awareness about HIV care services among EW

Variables	2009 (N = 229)		2011 (n = 320)		P value
	N	%	N	%	
Ever had HIV test in the past year	156	68.1	232	72.5	0.26
Duration of last HIV test ≤ 6 months	112	**70.9**	216	**93.5**	< 0.001
Places of last HIV test among those tested in past 12 months					
Public hospital, and VCT including NGO VCT	132	**82.5**	202	**87.1**	0.26
Private lab or clinic	18	11.3	23	9.9	
Others	10	6.2	7	3.0	
Receiving last HIV test result among those tested	145	**90.5**	215	**92.7**	0.46
Receiving counseling for last HIV test	142	88.8	213	91.8	0.30
Awareness about the availability of ART service	208	**90.8**	290	**90.6**	0.69
Knowledge of HIV/AIDS care service among those who knew	***n = 184***		***n = 248***		
OI/ART clinic or service	134	**72.8**	223	**89.9**	< 0.001
NGO clinic	75	**40.7**	49	**19.8**	< 0.001
Friend help friend center (MMM)	22	9.6	4	1.6	
Home and community based care	38	16.6	14	5.7	
Can access services when needed	214	93.5	287	89.7	0.12

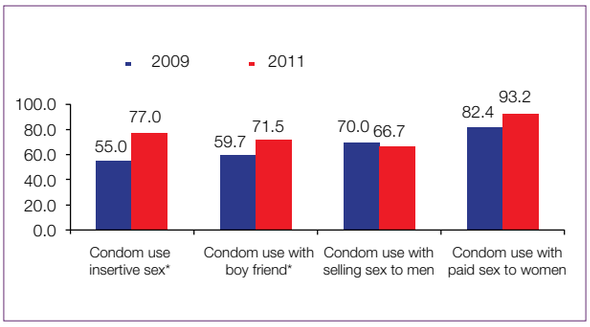
2. Men who have sex with men

2.1 Changes in condom use and risk behavior

In general, there is an increase in the percentage of consistent condom use among MSM. From 2009 to 2011, consistent condom use for insertive sex increased by 22% points from 2009 to 2011. Significant increase was observed for lubricant use in insertive sex (from 30.0% in 2009 to 61.0% in 2011 (p<0.01)) and consistent condom and lubricant use for receptive sex (from 36.5% in 2009 to 61.3% in 2011).

Consistent condom use with boyfriends was increased by 12% (59.7% in 2009 to 71.5% in 2011). Similarly, the percentage of MSM who reported consistent condom use when engaging in paid sex with women also increased (82.4% in 2009 compared to 93.2% in 2011). The only decrease observed was for consistent condom use when selling sex to men, from 70% in 2009 to 66.7% in 2011.

Figure 11: Changes in condom use among MSM in the past month



**Statistically significant at p<0.05; **statistically significant at p<0.01.*

2.2 Health seeking behavior and HIV testing among MSM

Less than 10% of MSM interviewed reported having an STI in the last year. However, the rate is significantly higher in 2011 (7.0%) than in 2009 (2.7%), with p = 0.02. This might suggest higher risk behavior among this group that requires more attention. Also, among the MSM who reported having had an STI, the proportion of those seeking treatment at a public STI clinic or NGO declined between 2009 and 2011. However, during the same period, the percentage of those seeking treatment from a pharmacy increased by about 8%. Therefore, the program staff should carefully revisit the intervention package and reinforce the linkages and referral system with the STI clinics to increase regular check-ups among MSM.

There was no significant difference between 2009 and 2011 in relation to those who were ever tested for HIV. However, an increase is observed in the proportion of MSM reported to have had an HIV test in the past 6 months, from 74.8% in 2009 to 77.0% in 2011 (Table 31).

Table 31: STI treatment, HIV test and discrimination towards MSM (%)

Variables	2009 (N = 259)		2011 (N = 385)		P value
	N	%	N	%	
Reported STI in the last year	7	2.7	27	7.0	
First place to seek treatment from when having STI symptoms	***n = 7***		***n = 27***		0.02
STI clinic	4	57.1	10	37.0	
Pharmacy	1	14.3	6	22.2	0.60
NGO	1	14.3	3	11.1	
Duration of ever HIV test in the last year	***n = 151***		***n = 270***		
<6 months	113	74.8	208	77.0	
6-12 months	20	13.3	26	9.6	0.41
13-24 months	7	4.6	19	7.0	
>24 months	10	6.6	12	4.4	
Thoughts on discrimination against MSM compared to the last year					
More than	48	18.8	76	20.0	
Less than	160	62.5	250	65.5	0.06
Same	48	18.8	50	14.0	

D. Changes in capacities of the implementing partners

Findings from capacity assessment conducted to the seven implementing partners (CCASVA, CPR, WOSO, NAPA, MHSS, WOMEN, and PC) during the mid-term review in 2009 were used as a baseline to evaluate changes to their capacity at the end of the project. Alliance adapted tool on capacity assessment was used for both the baseline and the end line assessment to ensure comparability. The tool contained 4 capacities divided into 13 indicators.

Aside from using the questionnaires, the assessment team also interviewed key staff members of KHANA's implementing partners. To confirm the reliability of information collected from the interview, the team randomly selected supporting documents for review. 5 different categories were established, ranging from poor to very good: poor <2, moderate 2-2.9, have some capacity: 3- 3.9, good: 4- 4.9, and very good ≥ 5. The findings are summarized in Table 32.

Table 32: Changes in scoring category for the 4 main capacities (%)

Scoring category	Capacity 1		Capacity 2		Capacity 3		Capacity 4	
	2009	2011	2009	2011	2009	2011	2009	2011
Moderate	14.0	0.0	14.0	0.0	0.0	0.0	29.0	0.0
Some capacity	29.0	29.0	43.0	29.0	14.0	14.0	14.0	0.0
Good	57.0	71.0	43.0	57.0	86.0	86.0	57.0	86.0
Very good	0.0	0.0	0.0	14.0	0.0	0.0	0.0	14.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

***This capacity assessment was conducted to 7 implementing partners*

Capacity 1: Partnerships, referral systems, coordination, and advocacy

Assessment of Capacity 1 reviewed the working relationship between the evaluated organizations and relevant government institutions and organizations from national to sub-national level, referral mechanism, and evidence based advocacy activities.

All implementing partners scored higher than moderate for Capacity 1. 71% of were rated as 'good' in 2011 compared to 57% in 2009. This change is the result of the development of a close working relationship, connection, and effective communication between the implementing partners and the sub-national level, including the provincial health department, technical working groups, provincial AIDS office, and the organizations operating in their coverage area. Another strong aspect within this capacity was the referral mechanism from community to health facility based services. Each implementing partner regularly verified its referral system through coordination meetings with the service providers, and monthly meetings with the field project team and the community outreach workers.

Capacity 2: HIV/AIDS Technical Capacity

The assessment of this capacity mainly evaluated the experiences, knowledge, and skills of the IP's staff and management team on HIV/AIDS and other health priorities, and their capability to access information needed to improve their knowledge and skills to effectively implement the project.

Compared to the findings from 2009, all 7 implementing partners have improved in this area: 71% achieved a score of either 'good' or 'very good' in HIV and AIDS technical capacity. This outcome highlights the improvement and continuous learning of the required knowledge and skills by the IP's staff. During group discussion, the front line staff and office team demonstrated a good understanding and response to the criteria of HIV related and other health issues such as sexual reproductive health, STI, positive prevention messages, standard packages of activities, and Prevention of Mother to Child Transmission (PMTCT). This has been achieved primarily through external and internal trainings provided by KHANA, NCHADS, Provincial AIDS Office, and other institutions. Improvements in internet access and the setting up of a library with up-to-date information also contributed to the change. Despite this improvement, it is observed that the culture of learning and sharing at the organizational level, and the regular subscription to local newsletter or articles was not yet in place. This needs to be seriously considered for further action.

Capacity 3: Organizational Strength

Organizational strength was focused on 5 indicators related to the function of the governing board, the well-updated strategic plan, the organizational structure, human resource management, program and finance management, Monitoring & Evaluation, and sustainability.

The organizational capacity of all implementing partners remained unchanged between 2009 and 2011; all implementing partners have shown strong capacity over the last three years of the project. As seen, 86% of all implementing partners maintained their rating as 'good' in this capacity. Most of them have maintained their board function properly and have a strong human resource management capacity. The crucial, required policies (i.e. personnel policy) were in place. The majority of implementing partners have developed and updated their strategic plan. There are a few improvements needed in the program management aspect, mainly in relations to the record of the official signed work plan, M&E plan, and other important signed documents.

Capacity 4: Promotion of participation of people living with HIV and other affected communities

Two indicators were used to assess this capacity: to what extent the target beneficiaries and the affected communities have been involved in the project and how much the implementing partners have empowered and encouraged their participation at all stages of the project(s).

Table 32 clearly shows that a significant change occurred from 2009 to 2011. No IP were graded below 4 (Good score). All implementing partners moved from "moderate" and "have some capacity" in 2009 to "good" (86%) and very good (14%) in 2011. The employment policy encourages the affected community and target beneficiaries to apply for any position at the organization. All IP employed members of their target groups in permanent positions, such as officer, assistant, or supervisor.

The current model has also empowered community ownership and full participation in the project. This has been achieved through the work and roles of the community support volunteers and peer outreach workers in community education sessions, self help group meetings, facilitation of referral support, psychosocial support, and regular home visits to follow up on the health of the self help group members. The capacity building plan and on-going support for them was also incorporated in the annual work plan to increase their knowledge and skills on HIV/AIDS, other health and non-health related work. Additionally, the project evaluation gathered inputs, comments, suggestions, and feedback from PLHIV, OVC, and MARPs. Special leave for staff members who are PLHIV or MARPs to receive treatment/medical follow up was clearly stated in the office policy. However, only few implementing partners created advisory groups that consisted of representatives from key affected populations to provide recommendations on project design and planning. There's also a lack of involvement of key affected populations at the decision-making level, both on the board and in management.

In conclusion, findings from the assessment carried out as part of the end line project evaluation showed a significant improvement in the capacity of implementing partners in all aspects. This may be due, in part to the improvement of KHANA technical support plan introduced in 2010, following the IP baseline assessment that addressed the need for more regular technical support visits and quarterly monitoring visits.

Despite these positive outcomes, there were several criteria which should be further addressed. One of them is the effort to improve advocacy and research activities. Some advocacy works have already been implemented at the community level, but they are not sufficient to promote the existing work. Learning and sharing sessions within the organization should take place to encourage a culture of knowledge sharing and management among the staff. Subscription to health newsletters and journals should also be put in the organizational plan.

Under capacities 3 and 4, the next technical support should aim at strengthening the development of organizational strategic plan, document keeping, formation of advisory groups that consist of key affected populations, and increasing the participation of beneficiaries in the organization's decision-making processes.

vi. CONCLUSIONS AND RECOMMENDATIONS

Over the course of the project, KHANA and its implementing partners have properly addressed the needs of the project's beneficiaries. It is clearly shown that the project played a very important role in alleviating the burden of HIV/AIDS among PLHIV and OVC in the targeted provinces. Sustainability of the ICP is essential for the wellbeing of current ICP beneficiaries: both direct and indirect; infected and affected people; and OVC. This positive achievement should be maintained with additional improvements to bridge the remaining gaps for the benefit of those infected and affected people.

People living with HIV

- Close to 60% of PLHIV reported being supported by the project to improve family economy in the past 6 months, ranging from financial support to technical supports (i.e. fish rearing, home gardening). More than 80% of respondents reported an improvement in their family's economic situation, in comparison with before the initiation of KHANA's Economic Livelihood project. This is also observed in the significant decrease in borrowing money or rice and the significant increase of a sufficient weekly family income.
- There was a significant decline reported in the number of beneficiaries that need to pay debts and a reduction in demand for financial support to cover health costs. Furthermore, there was a reported increase in the demands for IGA. Findings suggest positive changes in many dimensions of socio-economic status and perceptions among PLHIV reached by community based care and support. Improved health status and increased understanding of self reliance seem to have led to increased demands for IGA. PLHIV whose basic health and socio-economic needs were met through community support tend to want to reduce their dependency and achieve sustainable livelihoods. This economic livelihood project should be expanded to meet the increased demand of the beneficiaries which could contribute to the sustainability after the project end.
- PLHIV reported to be under ART remain as high as nearly 90%. 40% of reported couples are discordant, which indicate the importance of treatment as prevention and positive prevention among couples. Significant positive changes were observed in terms of the respondents' understanding of ART.
- A significant decline was reported in services provided by HCBC team and self help group activities, while an increase was observed among health service providers (i.e. health center and VCT staff). The increased involvement of health service providers in supporting HIV integrated care and prevention is encouraging. A study in an Africa setting suggested that HIV funding may strengthen the health system and may contribute to the improvement of integrated services [12].

Orphans and vulnerable children

- There was a significant increase in OVC's regular access to schooling. The level of change is notably larger for girls. The findings highlight positive changes in some aspects of social support and health conditions among OVC.
- There is a reported increase of sufficient food for daily meals, as well as a significant increase of community support to OVC, along with psychological and schooling support. These improvements in socio-economic status are likely due to contributions from this project, as well as increased community and family support.

Satisfaction levels reported by PLHIV and OVC

- Overall satisfaction with services provided through the ICP component remains high for both PLHIV and OVC. Positive changes were observed among PLHIV, while the satisfaction levels among OVC have remained stable.
- The high satisfaction levels in different components of the program intervention areas suggest the relevance, efficiency and effectiveness of the community action on HIV prevention integrated with care and impact mitigation over the project. This was also supported by the SROI finding which revealed that for every $1 invested in the ICP between 2007 and 2011; about $2 was generated in social, health, and economic related values. This is indicative of a positive return for the community based response to HIV and shows that the program works.

Entertainment workers

- Consistent condom use with clients remained high, but consistent condom use with sweethearts was reported to be relatively low. The program should emphasize and maintain high level of condom use with all types of partners by ensuring the availability of condoms. Innovative model should be explored to improve the consistent condom use with sweethearts.
- The significant increase of condom breakage and slippage raises a concern about unwanted pregnancy among women. Therefore, in addition to existing HIV prevention message, educational campaign about condom and lubricant use should be intensified in an effort to reduce condom breakage.
- 50% reported reduction in abortion between 2009 and 2011 might suggest that the SRH/HIV integration strategy which KHANA has implemented since 2010 has started to have an impact. However, we should be cautious about this reduction, and aggressive intervention should continue to promote regular STI check up and proper referral for treatment, family planning, and prevention of unwanted pregnancy.
- Reports of HIV testing among entertainment workers remained high at more than 70%. The percentage of entertainment workers reported to have been tested for HIV within the past 6 months has increased significantly from 71% in 2009 to 94% in 2011. This may indicate that the integration of prevention and care for MARPs has been successful in eliminating barriers and increasing access to service delivery by establishing linkages and systematic referral between health sectors services.

Men who have sex with men

- Consistent condom use when selling sex to men remained relatively low. However, the percentage of MSM who reported always using condoms with boyfriend significantly increased from 59% in 2009 to 71% in 2011, while condom use when paying for sex with women increased from 82% to 93%.

- Either as receptive or insertive partners, lubricant use increased significantly from 30% in 2009 to 61% in 2011. Both higher consistent condom use and lubricant use should be maintained and strengthened to reach about 90% or more within the MSM group - either when paying for sex or selling sex, both receptive and insertive sex.

- Though a relatively small proportion of MSM reported having had STI in the last year, the observed report in 2011 (7.0%) was significantly higher than in 2009 (2.7%). The decline in reported access of public STI clinics and NGO clinics among MSM seeking treatment for STI raises a concern of a higher risk behavior among this group that would more attention. Therefore, program staff should carefully revisit the intervention package and ensure the effectiveness of links and referral with STI clinics to increase regular check-ups among MSM.

- The percentage of respondents who reported HIV testing within the past 6 months remains high at about 77% (2011) comparing to 75% in 2009.

People who use drugs

- 79% of PWUD/PWID respondents were 24 years old or under. 97% of them were male. 8.2% of drug users reported injecting drugs. 40% of injecting drug users (8/20) reported sharing needles and syringes during their last injection, although a high proportion of them reported that they were aware of the risks related to sharing needles and syringes, having received the information from the program staff. Programs should focus on intensively reducing the practice of sharing needles and syringes, increasing cleaning practices, and ensuring availability of sterile needles/ syringes for all drug users, particularly those who inject drugs.

- 86% reported that taking drugs has to some extent, had an effect on increasing their sexual desire. Though consistent condom use was reported to be high with paid partners (83%), increasing social concerns such as violence, rape, and other criminal activities should not be overlooked.

- Less than 50% of PUD tested for HIV and 9% reported STI symptom in the past year, while those seeking proper treatment at public STI clinic was very low. This highlights the need for the program to actively strengthen the linkages, systematic referral and follow-up between health sectors and relevant services according to the recommendation of the national CoPCT *(in draft)*.

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APPENDIX 1: SATISFACTION LEVEL

Satisfaction for PLHIV

Satisfaction with home and community based care (HCBC) and self-help group

Variables	2009 (N = 193)	2011 (N = 358)
	Mean (Median)	Mean (Median)
Satisfaction with HCBC service	9.5 (10)	9.4 (10)
Information and education related to HCBC service	9.5 (10)	9.3 (10)
OI treatment and care related to HCBC	9.2 (10)	9.2 (10)
Referral services including OI and HIV testing	9.5 (10)	9.5 (10)
Counseling and psychological supports	9.5 (10)	9.5 (10)
Competency of the HCBC	9.5 (10)	9.5 (10)
Friendliness and good relationship of the team	9.7 (10)	9.6 (10)
HIV/AIDS self help group	9.6 (10)	9.4 (10)
Importance of the self help group in sharing experience and psychological coping strategies	9.5 (10)	9.4 (10)
Importance of the self help group in helping each others	9.6 (10)	9.4 (10)
Receiving regular service and drug compliance	9.7 (10)	9.7 (10)
Overall satisfaction with the HCBC and self help group	**83.0 (87)**	**100.7 (106)**
Categories of the overall satisfaction level*		
Low (score ≤ 44)	2 (1.0%)	2 (0.5%)
Medium (score 45-69)	16 (8.4)	11 (3.1)
High (score ≥ 70)	**174 (90.6%)**	**345 (96.4%)**

** Chi-square test with significant level, p = 0.02*

Satisfaction with HIV/AIDS related health, education, referral, social welfare

Variables	2009 (N = 193)	2011 (N = 358)
	Mean (Median)	Mean (Median)
HIV related education sessions organized by KHANA/IP	9.6 (10)	9.7(10)
Vocational training skills for income generation for family	9.3 (10)	9.5 (10)
Financial support for transportation to access to the service and testing	9.6 (10)	9.7(10)
Commodity support (rice, cooking oil, salt) for patients and families	9.8 (10)	9.7 (10)
OVC arrangement for care and support from the foster families	9.5 (10)	9.5 (10)
OVC arrangement for schooling and school materials for children	9.7 (10)	9.6 (10)
Social support and welfare	9.5 (10)	9.5 (10)
Overall satisfaction with health education provided by KHANA/IP	55.5 (59)	57.4 (60)
Categories of the overall satisfaction scores*		
Low (score ≤ 28)	4 (2.1%)	12 (3.4%)
Medium (score 29-45)	14 (7.3%)	44 (12.2%)
High (score ≥ 46)	**175 (90.7%)**	**302 (84.4%)**

** Chi-square test with significant level, p = 0.12*

Satisfaction with HIV/AIDS related care and treatment services

Variables	2009 (N = 193)	2011 (N = 358)
	Mean (Median)	Mean (Median)
Current treatment and care service you are using	9.5 (10)	9.8 (10)
Competency of medical professional in the health facilities	9.8 (10)	9.6 (10)
Friendliness and attention from health professional and staff	9.5 (10)	9.5 (10)
Proper location and cleanliness of the health facilities	9.3 (10)	9.2 (10)
Proper working hours of the health facilities	9.2 (10)	9.0 (10)
Waiting time for the service at the health facilities	8.7 (10)	8.6 (9)
Confidence in your confidentiality related to HIV/AIDS status	9.2 (10)	9.3 (10)
Easiness in getting necessary information if you need	9.4 (10)	9.5 (10)
Overall satisfaction with HIV/AIDS care and treatment services	72.8 (85)	73.4 (77)
Categories of the overall satisfaction scores*		
Low (score ≤ 32)	30 (15.5%)	0 (0.0%)
Medium (score 33- 50)	0 (0.0%)	5 (1.4%)
High (score ≥ 51)	**163 (84.5%)**	**353 (98.6%)**

** Chi-square test with significant level, p < 0.001*

Satisfaction for OVC

Satisfaction with home and community based care (HCBC) and self support group

Variables	2009 (N = 194)	2011 (N = 316)
	Mean (Median)	Mean (Median)
Satisfaction with home and community based care service	9.4 (10)	9.1 (10)
Information and education related to home based care service	9.0 (10)	8.9 (10)
OI treatment and care related to home based care	8.9 (10)	8.8 (9)
Referral services including OI and HIV testing	9.4 (10)	8.9 (10)
Counseling and psychological supports	9.1 (10)	9.0 (10)
Competency of the home based care team	9.3 (10)	8.9 (10)
Friendliness and good relationship of the team	9.4 (10)	9.1 (10)
Satisfaction toward self support group	9.0 (10)	8.9 (10)
Importance of the self-support group in sharing experience	*9.1 (10)*	*9.0 (10)*
Importance of the self-support group in helping each others	*9.0 (10)*	*9.2 (10)*
Receiving regular self-support group on drug compliance	*9.1 (10)*	*9.0 (10)*
Overall satisfaction with HCBC and self support group	**66.1 (70)**	**65.6 (69)**
Categories of the overall satisfaction level		
Low (score <32)	11 (5.7%)	9 (2.8%)
Medium (score 32-55)	34 (17.6%)	59 (18.7%)
High (score ≥ 56)	148 (76.7%)	248 (78.5%)

** Based on 8 combined satisfaction questions*

Satisfaction toward the support to education, referral, school, food and social welfare provided by KHANA and IPs

Variables	2009 (N = 194)	2011 (N = 316)
	Mean (Median)	Mean (Median)
HIV related education sessions organized by KHANA/IP	9.3 (10)	9.3 (10)
Vocational training skills for income generation for family	9.2 (10)	8.8 (10)
Financial support for transportation to access to the service	9.3 (10)	9.2 (10)
Commodity support (rice, cooking oil, salt) for patients and families	9.7 (10)	9.6 (10)
OVC arrangement for care and support from the foster families	9.1 (10)	9.2 (10)
OVC arrangement for schooling and school materials	9.4 (10)	9.5 (10)
Satisfaction towards social welfare supports	9.5 (10)	9.4 (10)
Overall satisfaction with supports to health, referral and social welfare	**56.0 (60)**	**53.0 (56)**
Categories of the overall satisfaction scores		
Low (score <28)	8 (4.2%)	12 (3.8%)
Medium (score 28-48)	43 (22.3%)	88 (27.8%)
High (score ≥49)	142 (73.5%)	216 (65.4%)

** Based on 7 combined questions*

Satisfaction towards support and OI/ARV treatment services

Variables	2009 (N = 194)	2011 (N = 316)
	Mean (Median)	Mean (Median)
Current OI/ART treatment and care service	9.4 (10)	9.3 (10)
Competency of medical professional in the health facilities	9.0 (10)	9.5 (10)
Friendliness and attention from health professional and staff	8.6 (10)	9.4 (10)
Proper location and cleanliness of the health facilities	8.6 (10)	9.2 (10)
Proper working hours of the health facilities	8.4 (10)	8.8 (9.0)
Waiting time for the service at the health facilities	7.8 (9.0)	8.2 (9.0)
Confidentiality kept by health providers related to HIV/AIDS status	8.8 (10)	9.6 (10)
Easiness in getting necessary HIV information if required	8.9 (10)	9.3 (10)
Overall satisfaction with HIV/AIDS care and treatment services*	**69.5 (76)**	**72.5 (74)**
Categories of the overall satisfaction scores		
Low (score <32)	1 (4.4%)	0 (0.0%)
Medium (score 32-55)	4 (17.4%)	1 (4.0%)
High (score ≥ 56)	**18 (78.2%)**	**24 (96%)**
Total score was based on 8 combined questions		

**Only 23 OVC in 2009 and 25 OVC in 2011 reported using OI/ART care and treatment*

APPENDIX 2: QUESTIONNAIRES

FOR PLHIV

Questionnaire number ☐☐☐☐☐☐

[Introduction: The following is to be read by the interviewer to the respondent]

My name…..……from KHANA, is conducting an impact survey of the program implementation under EC funding support. We would like to learn more about PLHIV in term of their daily live, health status, and the support from the communities. The result from the interview will help us to evaluate what we have been done for the last five years. We would like to request your cooperation for about 45 minutes to ask you questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important.

Note: to be interviewed the PLHIV who aged more then 15

Do you agree to be interviewed? 1. Yes 2. No

Signature of interviewer as a proof of receiving verbal consent from participant

……Date……..……..……

Did the interviewee abandon the interview?

1. Yes (precise question number…….)
2. No

Supervisor's name……..Date……..

Data Entry Clerk 1 …… Date: .....

Data Entry Clerk 2 …… Date: .....

Provincial code: 1. Kampong Speu 2. Prey Veng 3. Kampong Chhnang

Part 1: Socio-demographic profile

1. Sex of respondent
    1. Male
    2. Female
2. Age of respondent……years
3. Educational years……years
4. Marital status
    1. Married
    2. Single
    3. Divorce, widow/widower
    4. Married but live separately
    5. Not married but live with together
5. Duration of relationship
    1. Less than 1 year
    2. 1 - 4 years
    3. 5 - 9 years
    4. 10 - 14 years
    5. More than 15 years
6. Are you a sub target group

	Yes	No	No answer
1. MSM/TG/Lesbian	1	2	88
2. Entertainment Worker	1	2	88
3. Drug User	1	2	88
4. Migrant	1	2	88

7. How many people living with the household?
    1. Age from 0 -14 ..... people
    2. Age from 15 – 19..... people
    3. Age from 20 – 24..... people
    4. Age from 25 – 29..... people
    5. Age from 30 – 39..... people
    6. Age from 40 – 49..... people
    7. More than 50..... people
8. How many infected OVC living with?……..people (under 18 year of age)

Part 2: Job, income and economic livelihood support

9. How many people living in your house?…….people (with same kitchen at least living together for 3 months)
10. What are the main sources of income of your family? (more than one answer allowed)
    1. Salary
    2. Selling labor
    3. Help from relative
    4. Help from neighbor
    5. Donation from charity
    6. Farming
    7. Own earning
    8. Other…..
11. Who is the main breadwinner?
    yself
    2. Spouse
    3. Relative
    4. Children
    5. Other…..
12. What is average family income per week?.....Riel
13. Does your income enough for your family?
    1. Yes (Skip to Q15)
    2. No
    3. Don't know
14. How much income did you consider enough for your family?.....Riel/week
15. Last year, have you ever sold such the things listed below?

		Don't have	Yes	No
1.	Buffalo or cow	0	1	2
2.	Pig	0	1	2
3.	Chicken or duck	0	1	2
4.	Bicycle	0	1	2
5.	Motorbike	0	1	2
6.	Radio	0	1	2
7.	Television	0	1	2
8.	Cart	0	1	2
9.	Fridge	0	1	2
10.	Sewing machine/Boat machine	0	1	2
11.	Mobile phone	0	1	2
12.	Farming land	0	1	2
13.	Field land	0	1	2
14.	House	0	1	2
15.	Other…….……	0	1	2

16. Last year, have you ever borrowed money or rice from other?
    1. Yes
    2. No
17. Last year, what did you do to the money from selling the above items? (More than one answer allowed)
    0. Never borrow or sell anything
    1. Food and clothes
    2. Medical care
    3. Support children to school
    4. Travel
    5. Religious ceremony
    6. Pay loan
    7. Other…….……

18. What is your main need in your family today?
    1. Food
    2. Clothes, housing material (mosquito net, blanket, mat…)
    3. Support children to school
    4. Health care and treatment
    5. Money
    6. House repair
    7. Other…….....……
19. Did you receive any support from KHANA in the last 6 months?
    1. Yes
    2. No
    3. Didn't know
20. What are kinds of support that you received in the last 6 months?
    0. Nothing
    1. Money
    2. Technique
    3. Seeds
    4. All above
    5. Social welfare
    6. Don't know
21. How much do you get money for income generation activities?
    0. Nothing
    1. Less than 41 USD
    2. 42 – 120 USD
    3. More than 120 USD
22. When did you get it?
    0. Nothing
    1. Less than 6 months ago
    2. 7 – 12 months ago
    3. More than 12 months ago
    4. Don't know
23. What are the purposes of using money? (More than one answer allowed)
    0. Nothing
    1. Pig/cow/buffalo raising
    2. Chicken/duck raising
    3. Fish raising
    4. Food stuff
    5. Vegetable/rice field growing
    6. Other…..
24. How much this support help your family if compare to the time without support?
    0. Nothing
    1. Worse than before
    2. No change
    3. Better than before
    4. Don't know

25. Profit from the support used for

		Yes	No	Don't know
1.	House repair	1	2	88
2.	Improve WC	1	2	88
3.	Bought seeds	1	2	88
4.	Invest on business	1	2	88
5.	More meal to eat (3 times/day)	1	2	88
6.	Seek for treatment	1	2	88
7.	More expense for kid to school	1	2	88
8.	Not above support	1	2	88

Part 3: ART and health status

26. How is your health status in the last 6 months?
    1. Excellent
    2. Good
    3. Fair
    4. Worse
27. How long did you know your HIV status?
    1. Less than 2 years
    2. 2 – 4 years
    3. 5 – 9 years
    4. 10 – 14 years
    5. More than 15 years
28. Did your partner HIV positive?
    1. Yes
    2. No
29. Did your family or partner know your HIV status?
    1. Yes
    2. No
30. Where did you get HIV test?
    1. Private clinic
    2. Government hospital
    3. VCCT
    4. NGOs' testing center
    5. Other…….
31. Last testing, did you get counseling?
    1. Yes
    2. No
32. Currently are you on ART?
    1. Yes
    2. No
33. How long are you on ART?.....months
34. Who refer you to OI/ART service?
    1. Self help group member
    2. Community based care and support
    3. VCCT staff
    4. Relative
    5. Friend
    6. Health center staff
    7. TB program staff
    8. Other…….

35. Are you currently member of SHG?
    1. Yes
    2. No
    3. Don't know about SHG

36. Are you agree with the below statement for ART?

	Agree	Disagree
1. Prevent to transmit HIV to sexual partner	1	2
2. Make your health as good as before infected	1	2
3. Sex without condom	1	2
4. Preventing STI to sexual partner	1	2

37. Compare to the last 6 months, what is your current health status?

    1. Excellent
    2. More better
    3. Fair
    4. I seem like not serious sick anymore
    5. My health seem not better as whom I know
    6. Not fine
    7. I think now I am healthy
    8. Other…..

38. Compare to the last 12 months, what do you think regarding to discrimination toward your family from others?
    1. Strongly decrease
    2. A bit more decrease
    3. Neutral
    4. No more change
    5. More increase
    6. Don't know

Part 4: Concerning issue and community support

39. What are your main concerns related to your health status? (More than one answer allowed)
    1. Support for child to school
    2. Food
    3. Health care
    4. House
    5. Take care of sick children
    6. Other…..

40. What did KHANA support you and your family? (More than one answer allowed)
    1. Referral cost
    2. Psychological support
    3. Support IGA
    4. Child education
    5. Create support group
    6. Vocational training
    7. Other…..

41. In the last 6 months, what support did you get? (More than one answer allowed)
    0. Nothing
    1. Psychological support
    2. Money/social welfare
    3. Food support
    4. School support for child
    5. Help to find job
    6. Provide clothes
    7. Take care of children
    8. Counseling
    9. Vocational training
    10. Other…….....
42. In the last 6 months, who did support your family? (More than one answer allowed)
    1. Relative
    2. Family
    3. Neighbor
    4. Village chief
    5. Social worker
    6. KHANA/IP
    7. NGOs or other institution
    8. Other…….....
43. How long did you get support from KHANA/IP?.....months (0 if no support)
44. What support do you think you need for you and your family? (More than one answer allowed)
    1. Psychological support
    2. Fund/social welfare supports
    3. Food support
    4. Support child to school
    5. Find job
    6. Clothes
    7. Take care of children
    8. Counseling
    9. Training on income generation
    10. Discuss on child health and education
    11. Support for transportation/health and school
    12. Other…….....
45. Do you think your friend and neighbor can eat meal with you?
    1. Yes
    2. No
    3. Don't know
46. In the last 6 months, did your friend and neighbor visit you?
    1. Yes
    2. No
    3. Don't know
47. What do you think about discrimination compare with the last year?
    1. More than before
    2. Less than before
    3. No change
    4. Don't know

Part 5: Satisfactory on care and treatment service

(Please evaluate in the services by giving the score from 1 to 10, meanwhile 1 is worse, 10 is excellent, and 0 means never received any services)

5.1 Home Based Care and Self Support group

1. Satisfactory toward HBC service for PLHIV
   0 1 2 3 4 5 6 7 8 9 10
2. Satisfactory toward Info given by HBC
   0 1 2 3 4 5 6 7 8 9 10

3 Satisfactory toward OI care by HBC
0 1 2 3 4 5 6 7 8 9 10

4 Satisfactory toward referral transportation to health services
0 1 2 3 4 5 6 7 8 9 10

5 Satisfactory toward counseling and psychological support
0 1 2 3 4 5 6 7 8 9 10

6 Satisfactory toward capacity of HBC on providing service
0 1 2 3 4 5 6 7 8 9 10

7 Satisfactory toward communication of HBC
0 1 2 3 4 5 6 7 8 9 10

8 Satisfactory toward self help group initiation
0 1 2 3 4 5 6 7 8 9 10

8.1 Important of self help group on experience sharing and psychological support
0 1 2 3 4 5 6 7 8 9 10

8.2 Important of self help group on emergency support
0 1 2 3 4 5 6 7 8 9 10

8.3 Important of self help group on Improving adherence
0 1 2 3 4 5 6 7 8 9 10

5.2 Education, food and health support from KHANA/IP

9 Satisfactory toward HIV education provide by NGO
0 1 2 3 4 5 6 7 8 9 10

10 Satisfactory toward training on IGA
0 1 2 3 4 5 6 7 8 9 10

11 Satisfactory toward referral cost support to health services
0 1 2 3 4 5 6 7 8 9 10

12 Satisfactory toward food support (rice, salt and oil)
0 1 2 3 4 5 6 7 8 9 10

13 Satisfactory toward support to get foster parents
0 1 2 3 4 5 6 7 8 9 10

14 Satisfactory toward support for children go to school
0 1 2 3 4 5 6 7 8 9 10

15 Satisfactory toward social welfare
0 1 2 3 4 5 6 7 8 9 10

5.3 Satisfactory on HIV health and treatment service

16 Satisfactory toward OI and ART services
0 1 2 3 4 5 6 7 8 9 10

17 Satisfactory toward doctor at service
0 1 2 3 4 5 6 7 8 9 10

18 Satisfactory toward communication of the service provider
0 1 2 3 4 5 6 7 8 9 10

19 Accessible and cleanliness of the service center
0 1 2 3 4 5 6 7 8 9 10

20 Satisfactory toward working time at OI/ART service
0 1 2 3 4 5 6 7 8 9 10

21 Satisfactory toward waiting time
0 1 2 3 4 5 6 7 8 9 10

22 Satisfactory toward confidentiality keeping of service provider
0 1 2 3 4 5 6 7 8 9 10

23 Satisfactory toward Access for HIV information
0 1 2 3 4 5 6 7 8 9 10

FOR OVC

Questionnaire number ☐☐☐☐☐☐

[Introduction: The following is to be read by the interviewer to the respondent]

My name…….....……from KHANA, is conducting an impact survey of the program implementation under EC funding support. We would like to learn more about OVC in term of their study, daily live, health status, and the support from the communities. The result from the interview will help us to evaluate what we have been done for the last five years. We would like to request your cooperation for about 45 minutes to ask you questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important.

Note:

1. If OVC's age is between 11-17, should interview him/her
2. If OVC's age is less than 11, should interview his/her caregiver

Do you agree to be interviewed? 1. Yes 2. No

Signature of interviewer as a proof of receiving verbal consent from participant

……Date……..……..……

Did the interviewee abandon the interview?

1. Yes (precise question number……)
2. No

Supervisor's name……..…..Date……..

Data Entry Clerk 1 …… Date: .....

Data Entry Clerk 2 …… Date: .....

Provincial code: 1. Kampong Speu 2. Prey Veng 3. Kampong Chhnang

Part 1: Socio demographic characteristic

1. Sex of respondent
    1. Male
    2. Female
2. Age of respondent……years
3. Currently are you studying?
    1. Yes
    2. No
    3. No answer
4. Education grade…….....…..... (0 if Never entered school)
5. Do you have enough stationary for your study?
    0. Not study
    1. Yes
    2. No
6. Why haven't you studied now? (more than one answer allowed)
    0. Studying
    1. Vacation
    2. Parents die or sick
    3. Don't like school or drop out of school
    4. No money
    5. Help house work
    6. Take care of sick family members

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7. Work for money
8. Sick
9. No support (family and caregiver)
10. School far from home
11. Too young for school
12. Other……
13. Don't know

7. How many year have you been in school?.....years
8. In the last 6 months, have you ever suspended school for work to feed family?
    0. Not study
    1. Yes
    2. No
    3. Ever suspended, but not for earn money
9. In the last 6 months, have you ever got any external support for school?
    1. Yes
    2. No
10. If yes what are the sources? (more than one answer allowed)
    0. No support
    1. KHANA/IP
    2. Support from school
    3. Donation
    4. NGO……
    5. Local social worker
11. Do you have any problem with your study because you didn't get attention from teacher compare to other student due to you have family affected by HIV?
    0. Not study
    1. Yes
    2. No
    3. Don't have family affected by HIV
12. Do you have friend in class or village?
    1. Yes
    2. No

Part 2: Living and family condition

13. Who is your guardian?
    1. Parent
    2. Aunt/uncle
    3. Grandparent
    4. Relative
    5. Older sister/brother
    6. Step-parent
    7. Adopted parent
    8. Myself
    9. Orphan center staff
    10. Don't know
    11. Others……
14. How do you feel when living in the family? (Skip this question when asking caregiver)
    1. Very happy
    2. Happy
    3. Simple
    4. Unhappy
    5. No answer

15. If you feel worried do you discuss with your guardian? (Skip this question when asking caregiver)
    1. No
    2. Yes
    3. Not sure
    4. No guardian
16. What is your guardian attitude toward you? (Skip this question when asking caregiver)
    1. Don't pay attention, leave lonely
    2. Scold
    3. Physical abuse
    4. Provide not enough food
    5. Need to work in order to live in family
    6. Not get along with other children in family
    7. Not allow to go to school
    8. Taking your property
    9. Force you to work
    10. Pay attention to you more than others
    11. Don't know
    12. Other…….....……

Part 3: Psychological and nutritional supports

17. In the last 6 months, have you ever got sick?
    1. No
    2. Yes
    3. No answer
18. In the last 6 months, have you ever got very sick which cannot work or go to school?
    0. Never got sick
    1. No
    2. Yes
    3. No answer
19. In the last 6 months, how long did you get sick?.....days
20. In the last 1 month, have you ever had feeling like despair, depressed or sad?
    1. Never had this feeling
    2. Rarely
    3. Frequently
    4. Very often
    5. Always
    6. Don't know
21. Have you ever thought want to hurt yourself because you feel despair?
    1. No
    2. Yes
    3. No answer
    4. Don't know
22. How often did you think like this?
    0. Never
    1. Only one time
    2. Less than 1 time per month
    3. 1 or 2 times per month
    4. 1 time per week
    5. All most everyday
    6. Everyday
    7. No answer

23. How many time did you have meal per day?.....times
    1. Breakfast
    2. Lunch
    3. Dinner
    4. No answer
24. In the last 6 months, did you have enough food to eat?
    1. Yes
    2. No
25. Why hadn't enough food to eat?
    0. Have enough food to eat
    1. Don't have money
    2. Have more children
    3. No one prepare food for
    4. No wood/charcoal/gas to cook
    5. Don't know
    6. No answer
    7. Other……
26. In the last 12 months, did your family reduce number of meal times because of not enough food?
    1. Yes
    2. No
    3. Don't know
27. In the last 12 months, have you and your family ever starved?
    1. Yes
    2. No
    3. Don't know
28. Do you think that your house have food as others?
    1. The same
    2. More than others
    3. Less than others
    4. Don't know

Part 4: Community and NGO supports

29. What kind of support did you get when your parents pass away or get sick?

	Yes	No	Don't know
1. Psychological support	1	0	88
2. Financial support	1	0	88
3. Food support	1	0	88
4. Support for school	1	0	88
5. Help to find job	1	0	88
6. Provide cloth and other equipment	1	0	88
7. Help to take care of other small children	1	0	88
8. Drug and counseling	1	0	88
9. Don't know	1	0	88
10. Other……	1	0	88

30. Who providing support to you and your family? (more than one answer allowed)
    1. Family member
    2. Step parents
    3. Foster parents
    4. Other community member
    5. KHANA/IP
    6. Other NGO
    7. Social worker
    8. Don't know

31. What kind of support do you think that is useful for you? (Skip this question when asking caregiver)
    1. Psychological support
    2. Financial support
    3. Food support
    4. Support other children for school
    5. Support for job finding
    6. Cloth and other material support
    7. Help to take care of other children
    8. Counseling
    9. Don't know
    10. Other…….
32. In the last 6 months, has Home Based Care ever visited you?
    1. Yes
    2. No
    3. Don't know
33. In the last 6 months, what information did HBC provide to you and your family? (more than one answer allowed)
    1. HIV and AIDS information
    2. Drug and its bad impact
    3. Psychological support to overcome difficulty and sickness
    4. Provide place to get services and own right
    5. Food and some medical drug support
    6. Educate on health and hygiene
    7. Other…….
34. Select two of your most needs (read and circle)
    1. Food
    2. Cloth
    3. School uniform and study material
    4. Medical care
    5. Other…….
35. What is the level of discrimination toward you and your family or others in village compare to the last 1 year?
    1. Decrease sharply
    2. More decrease
    3. No more decrease
    4. More increase
    5. Don't know

Part 5: Satisfactory on care and treatment services

(Please evaluate in the services by giving the score from 1 to 10, meanwhile 1 is worse, 10 is excellent, and 0 means never received any services)

5.1 HBC and self support group

1. Satisfactory toward HBC service for OVC
   0 1 2 3 4 5 6 7 8 9 10
2. Satisfactory toward info given by HBC
   0 1 2 3 4 5 6 7 8 9 10
3 Satisfactory toward OI care by HBC
   0 1 2 3 4 5 6 7 8 9 10
4 Satisfactory toward transportation (referral) to health services
   0 1 2 3 4 5 6 7 8 9 10
5 Satisfactory toward counseling and psychological support
   0 1 2 3 4 5 6 7 8 9 10
6 Satisfactory toward capacity of HBC on providing service
   0 1 2 3 4 5 6 7 8 9 10
7 Satisfactory toward communication, friendliness, of HBC
   0 1 2 3 4 5 6 7 8 9 10
8 Satisfactory toward self support group initiation
   0 1 2 3 4 5 6 7 8 9 10

8.1 Important of self support group one experience sharing and psychological support
0 1 2 3 4 5 6 7 8 9 10

8.2 Important of self Support group on emergency support
0 1 2 3 4 5 6 7 8 9 10

8.3 Important of self support group on improving adherence
0 1 2 3 4 5 6 7 8 9 10

5.2 Education, food and health supports from KHAN/IP

9 Satisfactory toward HIV education provide by NGO
   0 1 2 3 4 5 6 7 8 9 10
10 Satisfactory toward training on IGA
   0 1 2 3 4 5 6 7 8 9 10
11 Satisfactory toward transportation support to health service
   0 1 2 3 4 5 6 7 8 9 10
12 Satisfactory toward food support (rice, salt and oil)
   0 1 2 3 4 5 6 7 8 9 10
13 Satisfactory toward support on diary and future plan
   0 1 2 3 4 5 6 7 8 9 10
14 Satisfactory toward school support and study material
   0 1 2 3 4 5 6 7 8 9 10
15 Satisfaction toward social welfare support
   0 1 2 3 4 5 6 7 8 9 10

5.3 Satisfactory on HIV health and treatment services

16 Satisfactory toward OI and ART service
   0 1 2 3 4 5 6 7 8 9 10
17 Satisfactory toward health provider at health facility services
   0 1 2 3 4 5 6 7 8 9 10
18 Satisfactory toward communication, friendliness of the service provider
   0 1 2 3 4 5 6 7 8 9 10
19 Accessible and cleanliness of the health facility services
   0 1 2 3 4 5 6 7 8 9 10
20 Satisfactory toward working time at OI ART facility services
   0 1 2 3 4 5 6 7 8 9 10
21 Satisfactory toward waiting time at health facility
   0 1 2 3 4 5 6 7 8 9 10
22 Satisfactory toward confidentiality keeping of service provider
   0 1 2 3 4 5 6 7 8 9 10
23 Satisfactory toward access for HIV and AIDS information
   0 1 2 3 4 5 6 7 8 9 10

FOR ENTERTAINMENT WORKER

Questionnaire number ☐☐☐☐☐☐

[Introduction: The following is to be read by the interviewer to the respondent]

My name…….....……from KHANA, is conducting an impact survey of the program implementation under EU funding support. We would like to learn more about EW in term of the result of HIV program, their risk, and stigma and discrimination. The result from the interview will help us to evaluate what we have been done for the last five years. We would like to request your cooperation for about 30 minutes to ask you questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important.

Note: to be interviewed the EW who age between 15-49

Do you agree to be interviewed? 1. Yes 2. No

Signature of interviewer as a proof of receiving verbal consent from participant

……Date……..……..……

Did the interviewee abandon the interview?

1. Yes (precise question number…….)
2. No

Supervisor's name……..…..Date……..

Data Entry Clerk 1 …… Date: .....

Data Entry Clerk 2 …… Date: .....

Province: 1. Kampong Speu 2. Prey Veng

Target group: 1. Massage 2. Karaoke 3. Beer Promoter 4. Beer Garden

Part 1: Socio demographic characteristic

1. Age of respondent…….years
2. Marital status
    1. Married and live with together
    2. Unmarried
    3. Divorce/Widower
    4. Married but live separately
    5. Unmarried but live with partner
3. Age of first married……...years (0 if unmarried)
4. Duration of school education……years
5. Average monthly income per month…….riel (including salary and other income)
6. Currently living with
    1. Parents
    2. Relative
    3. Spouse
    4. Friend
    5. Other female in rent house
    6. Alone
    7. Other……

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7. Duration in month of working here..... .months (1. If 1 month or less than 1 month)
8. Duration in month in this career..... months (1. If 1 month or less than 1 month)
9. Duration in year of living in this province ..... months (1. If 1 month or less than 1 month)

Part 2: Sexual and condom use behavior

10. Have you ever had sweetheart in the last 1 year?
    1. Yes
    2. No
11. Have you ever had sex with sweetheart in last 1 year?
    0. Don't have sweetheart
    1. Yes
    2. No
12. How often have you used condom with current sweetheart in the last 3 months?
    0. Don't have sweetheart
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    5. Never had sex with sweetheart
13. Did you use condom for last sex with current sweetheart?
    0. Don't have sweetheart
    1. Yes
    2. No
    3. Never had sex with sweetheart
14. Reason for not using condom with sweetheart
    1. Trust him/have long relationship
    2. Love sweetheart
    3. No condom at that time
    4. Use condom can reduce feeling desire
    5. Sweetheart doesn't want to use condom
    6. Other…….……
    7. Don't know
15. Age at first sex…….years (0. If never had sex)
16. First sex with
    0. Never had sex
    1. Husband
    2. Sweetheart
    3. Client
    4. Other…….……
17. Have you ever had sex with client in the last year?
    1. Yes
    2. No
18. Did you use condom for last sex with client?
    0. Never had sex with client/never had sex
    1. Yes
    2. No
19. How often you used condom with client in the last month?
    0. Never had sex with client
    1. Always
    2. Frequently
    3. Rarely
    4. Never used

20. Have you ever experienced in condom broken or fail off with client in the last 3 month?
    0. Never had sex
    1. 1 times
    2. More than 1 time
    3. Never broke or fail
    4. Never used condom
    5. Don't know
21. Would you be able or convenience to find condom when required?
    1. Yes
    2. No
    8. Don't know
22. Number of men sexual partner in the last year……..
23. Number of men sexual partner in the last month……..
24. Number of men sexual partner in the last week……
25. Have you ever met clients to not using condom in the last month

	Yes	No	No answer
1. Get extra money	1	2	9
2. Weapon threaten	1	2	9
3. Verbal threaten	1	2	9
4. Drunken	1	2	9
5. Heavy drug use	1	2	9
6. Never	1	2	9

Part 3: Health seeking, treatment and HIV and AIDS education

26. How often have you gone to seek for STD in the last three months?
    1. 1 time
    2. 2 times
    3. More than 3 times
    4. Never
    5. Don't remember
    6. No answer
27. Have you ever respected to the appointment time?
    0. Don't have appointment
    1. Yes
    2. No
28. Have you ever experienced in the following symptom?

	Yes	No	DK	No answer
1. Gentile ulcer	1	2	8	9
2. Gentile swollen	1	2	8	9
3. Discharged with bad smell	1	2	8	9

29. If you were experienced with above symptom, where were your first treatment? (More than one answer allowed)
    0. No experience
    1. Bought drug from store
    2. Private clinic
    3. Public clinic
    4. NGO clinic
    5. Traditional healer
    6. No treatment
    7. Other ……

30. Who mentor you to have last STD treatment?
    0. Never gone to seek STD
    1. By myself
    2. Friend
    3. Peer educator/NGO's staff
    4. Entertainment owners
    5. Other……
31. Have you ever received education on SRH and birth spacing in the last 3 months?
    1. Yes
    2. No
32. What method have you used for birth spacing?
    0. Not use at all
    1. Implant/IUD
    2. Pill
    3. Condom
    4. Spermicidal
    5. Injection
    6. Calendar
    7. Withdrawal
    8. Abortion
    9. Others……
33. Total number of pregnant .....times
34. Number of pregnant from being work as EW.....times
35. Number of children alive.....children
36. Number of abortion.....times
37. How long of last abortion ..... months
38. Number of abortion work as EW .....times
    (0 Never aborted, 98 don't remember, 99 no answer)
39. Where were you sake for last abortion?
    0. Never aborted
    1. Private clinic
    2. Health center pubic hospital
    3. NGO clinic
    4. TBA
    5. Bought medicine from pharmacy
    6. Others……
40. Have you ever received information about HIV education in the last 3 months?
    1. Yes
    2. No
41. What method in receiving information about HIV education in the last 3 months?

	Yes	No
0. Not ever received	1	2
1. TV	1	2
2. Radio	1	2
3. Newspaper	1	2
4. Billboard	1	2
5. Poster	1	2
6. Booklet	1	2
7. Training or AIDS campaign	1	2
8. Focused Group Discussion	1	2
9. Counseling	1	2
10. Other……	1	2

42. Have you received any information about AIDS Education from other agencies?

	Yes	No
0. Not ever received	1	2
1. Staff of STD clinic	1	2
2. Peer educator	1	2
3. VCCT	1	2
4. Doctor or staff of private clinic	1	2
5. Other……..	1	2

43. What have you received support last three months?
    1. Psychological support
    2. Referral fee
    3. Food support
    4. School for kids
    5. Job
    6. Clothes
    7. Vocational training
    8. Others…….

44. Have you ever done HIV blood testing in last one year?
    1. Yes
    2. No

45. Duration of last HIV blood testing ..... months

46. Place of last HIV blood testing
    0. Never done HIV test
    1. Private clinic
    2. Public hospital
    3. VCCT
    4. NCHADS
    5. Other…….

47. Did you receive HIV test result (we don't want to know you result)?
    0. Never done HIV test
    1. Yes
    2. No

48. Did you receive counseling for lasting result?
    0. Never done HIV test
    1. Yes
    2. No

49. Do you have relative or friends infected or killed by HIV?
    1. Relative
    2. Friend
    3. No
    4. Relative and friend

50. Will you take care your family member who infected by HIV?
    1. Yes
    2. No

51. Will you buy food or goods from HIV infected family?
    1. Yes
    2. No

52. Will you allow PLHIV in teaching in school?
    1. Yes
    2. No

53. Will you keep secret if family member infected by HIV?
    1. Yes
    2. No

54. Have you ever worked in the following area?

	Yes	No
1. Night club dancer	1	2
2. Masseuse	1	2
3. Beer girl	1	2
4. Karaoke girl	1	2
5. Waitress in beer garden	1	2
6. Restaurant	1	2
7. Factory worker	1	2
8. Other……..	1	2

55. Do you aware about ARV services?
    1. Yes
    2. No
    9. No answer

56. Where do services available for HIV/AIDS infected?
    0. Not know
    1. MMM
    2. HBC
    3. OI/ART Services
    4. Pagoda
    5. NGO Clinic
    6. Other……..……

57. Do you believe in receiving ARV when it required?
    1. Yes
    2. No
    3. Don’t know

58. Have you ever experienced in using drug?
    1. Yes
    2. No

FOR MSM

Questionnaire number ☐☐☐☐☐☐

[Introduction: The following is to be read by the interviewer to the respondent]

My name…….....……from KHANA, is conducting an impact survey of the program implementation under EC funding support. We would like to learn more about MSM in term of the result of HIV/AIDS program, their risk, and stigma and discrimination. The result from the interview will help us to evaluate what we have been done for the last five years. We would like to request your cooperation for about 30 minutes to ask you questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important.

Note: to be interviewed the MSM who aged more than 15

Do you agree to be interviewed? 1. Yes 2. No

Signature of interviewer as a proof of receiving verbal consent from participant

…….Date……..……..……

Did the interviewee abandon the interview?

1. Yes (precise question number…….)
2. No

Supervisor's name……..…..Date……..

Data Entry Clerk 1 …… Date: .....

Data Entry Clerk 2 …… Date: .....

Provincial code: 1. Kampong Speu 2. Prey Veng 3. Kampong Chhnang

Part 1: Socio demographic characteristic

1. Age of respondent……years
2. Marital status
    1. Married and live with partner
    2. Married but live separately with partner
    3. Divorce
    4. Widow
    5. Single
    6. Unmarried but live with partner
3. Duration live in this province……..years
    0. Don't live in this province
    37. More than 3 years
    38. Lived in this province since I was born
    98. No answer
    99. Don't know
4. Currently living with
    1. Wife/sexual partner
    2. Parents
    3. Relative
    4. Friend
    5. Colleague
    6. Alone
    7. Other……
    98. No answer

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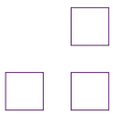
5. Duration of education……..years
    1. Never studied
    2. No answer
    99. Don't know
6. Age of first sex……..years
    0. Never had sex
    98. No answer
    99. Don't know
7. Personal thinking on their own gender identity?
    1. Male
    2. Female
    3. Both of male and female
    99. Don't know
8. Major of occupation?
    0. Unemployment
    1. Student
    2. University student
    3. Motor/taxi diver
    4. Policeman
    5. Soldier
    6. Government officer
    7. Farmer
    8. Worker
    9. Entrepreneur
    10. Private company staff
    11. NGO staff
    12. Sex worker
    13. Hair maker
    14. Other……

Part 2: Sexual behaviors

9. Number of women sex partner in the last 12 months……women
    0. Never had sex with woman
    96. Cannot count
    98. No answer
    99. Don't know
10. Number of men sex partner in the last 1 month……men
    0. Never had sex with man
    96. Cannot count
    98. No answer
    99. Don't know
11. Number of men sex buyer in the last 1 week……..men
    0. Never had sex with man
    98. No answer
    99. Don't know
12. Have you had sex with girlfriend in the last 1 month?
    0. Don't have girlfriend
    1. Yes
    2. No
    98. No answer

13. How often have you used condom with girlfriend in the last 1 month?
    0. Don't have girlfriend
    1. Never had sex with girlfriend
    2. Always
    3. Frequently
    4. Rarely
    5. Never used
    98. No answer
14. Have you ever had sex with women commercial sex worker in the last 1 month?
    1. Yes
    2. No
    98. No answer
    99. Don't know
15. How often have you used condom with women commercial sex worker in the last 1 month?
    0. Never had sex with commercial sex worker
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    98. No answer
16. Have you sold sex to women in the last 1 month?
    1. Yes
    2. No
    98. No answer
17. How often have you used condom with women sex buyer in the last 1 month?
    0. Never had sex with women sex buyer
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    98. No answer
18. Have you ever had sex with boyfriend in the last 1 month?
    0. Don't have boyfriend
    1. Yes
    2. No
    98. No answer
19. How often have you used condom with boyfriend in the last 1 month?
    0. Don't have boyfriend
    1. Never had anal sex with boyfriend
    2. Always
    3. Frequently
    4. Rarely
    5. Never used
    98. No answer
    99. Don't know
20. Have you ever paid to men for sex service in the last 1 month?
    1. Yes
    2. No
    98. No answer
21. How often have you used condom for anal sex with men sex seller in the last 1 month?
    0. Never had sex with men sex seller
    1. Ever had sex with men sex seller but not for anal sex
    2. Always
    3. Frequently
    4. Rarely
    5. Never used
    98. No answer
    99. Don't know

22. Have you ever received money from sex service to men in the last 1 month?
    1. Yes
    2. No
    98. No answer
23. How often have you used condom with anal sex men client in the last 1 month?
    0. Never had sex with anal sex men client
    1. Ever had sex with men client but not anal sex
    2. Always
    3. Frequently
    4. Rarely
    5. Never used
    98. No answer
24. Have you ever had insertive anal sex in the last 1 month?
    1. Yes
    2. No
    98. No answer
25. How often have you used condom for insertive anal sex in the last 1 month?
    0. Never had insertive anal sex
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    98. No answer
26. How often have you used lubricant for insertive anal sex in the last 1 month?
    0. Never had insert anal sex
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    98. No answer
27. Have you ever been receptive sex in the last 1 month?
    1. Yes
    2. No
    98. No answer
28. How often have you used condom for receptive sex in the last 1 month?
    0. Never had sex for receptive sex
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    98. No answer
    99. Don't know
29. How often have you used lubricant for receptive sex in the last 1 month?
    0. Never had sex for receptive sex
    1. Always
    2. Frequently
    3. Rarely
    4. Never used
    98. No answer
    99. Don't know



Part 3: Knowledge of HIV/AIDS and sigma and discrimination

30. How do you have potential in HIV transmission comparing to normal people?
    1. Highest
    2. More higher
    3. The same
    4. Lower
    98. No answer
    99. Don't know
31. When did you receive your last HIV test?
    0. Never done HIV test
    1. Ever done HIV test but didn't receive the result
    2. Less than 6 months ago
    3. 7 – 12 months ago
    4. 13 – 24 months ago
    5. More than 2 years ago
    98. Don't know
32. Currently, does HIV is curable?
    1. Yes
    2. No
    99. Don't know
33. What are the routes of HIV transmission? (more than one answer allowed)
    1. Have sex
    2. Shared not clean needle and syringe
    3. Mother to child transmission
    4. Blood transfusion
    5. Mosquitoes bit
    6. Living with PLHIV
    7. Other…….
    99. Don't know
34. Just looking the appearance can you identify whether they have HIV or not?
    1. Yes
    2. No
    99. Don't know
35. What are the ways to protect HIV transmission? (more than one answer allowed)
    1. Always use condom
    2. Abstinence
    3. Single partner
    4. Antibiotic before have sex
    5. Cleaning gentile after have sex
    6. Well check on appearance of sex partner
    7. Not use shared syringe and needle
    8. Others…….
36. If your family member infected, will friends or neighbor visit your family?
    1. Yes
    2. No
    99. Don't know
37. If your family member infected, will people in village have meal with your family?
    1. Yes
    2. No
    99. Don't know
38. If your family member infected, will you keep it secret to other people?
    1. Yes
    2. No
    99. Don't know

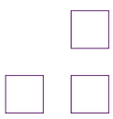
39. From your point of view to discrimination to HIV infected people, has it been changed?
    1. More increase
    2. More decrease
    3. No change
    99. Don't know
40. From your point of view to discrimination to MSM, has it been changed?
    1. More increase
    2. More decrease
    3. No change
    4. Never discriminated
    99. Don't know

Part 4: Looking for treatment and education

41. What kinds of support have you received in the last 6 months? (more than one answer allowed)
    1. Psychological
    2. Referral fee
    3. Welfare/food
    4. School
    5. Job
    6. Counseling
    7. Vocational training
    8. Others…….....……
    88. Nothings
42. Whom have you received education session on HIV and AIDS in the last 3 months? (more than one answer allowed)
    0. Nothings
    1. STD clinic
    2. KHANA/IP (peers)
    3. VCCT
    4. Private clinic
    5. Others…….....……
43. Have you had STD sympathies in the last 12 months?

	Yes	No
1. Gentile Ulcer	1	2
2. Gentile swollen	1	2
3. Discharge	1	2

44. Level of STD pain in the last 12 months
    0. Never had STD
    1. Serious
    2. Not much serious
    3. A little bit pain
    4. Not pain
    98. No answer
    99. Don't know
45. Where did you get for the last STD treatment?
    0. Never had STD
    1. Public hospital/STD clinic
    2. Private clinic
    3. Traditional healer
    4. Pharmacy
    5. NGO clinic
    6. Others…….....……
    98. No answer
    99. Don't know



46. After got treatment, is it cured by above mentioned?
    0. Never had STD
    1. Yes
    2. No
    98. No answer
    99. Don't know
47. Number of day of stop sex after STD
    0. Never had STD
    1. Never stop sex
    2. 1 – 3 days
    3. 4 – 10 days
    4. Until finished treatment
    5. Until it is cured
    98. No answer
    99. Don't know

Part 5: Network and location for MSM

48. Number of MSM you know at this place……..MSM (have relation in the last 6 months)
    98. No answer
    99. Don't know
49. Among MSM whom you know, please estimate of their age as following range
    1. Under 15 .....
    2. 15-19 .....
    3. 20-29 .....
    4. 30-39 .....
    5. Above 40 .....
    98. No answer
    99. Don't know
50. Frequently to meet them at the following place in the last 6 month?
    (Note: 1. Very often, 2. frequently, 3. rarely, 4. Never)
    1. Park .....
    2. Riverside .....
    3. Road .....
    4. Night club .....
    5. Café shop .....
    6. Pagoda .....
    7. Restaurant .....
    8. Theater .....
    9. Market .....
    10. Near barracks .....
    11. Massage club .....
    12. Swimming pool or sauna ..……..
    13. Internet shop .....
    14. Telephone point .....
    15. Residence .....
    16. Concert .....
    17. Dancing in a party .....……..
51. Have you ever used drug in the last 12 months?
    1. Yes
    2. No

FOR PWUD/PWID

Questionnaire number ☐☐☐☐☐☐

[Introduction: The following is to be read by the interviewer to the respondent]

My name…….....…from KHANA, is conducting an impact survey of the program implementation under EC funding support. We would like to learn more about PWUD / PWID in term of the result of HIV/AIDS program, their risk, and stigma and discrimination. The result from the interview will help us to evaluate what we have been done for the last five years.
We would like to request your cooperation for about 30 minutes to ask you questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important.

Note: to be interviewed the PWUD / PWID who aged more then 15

Do you agree to be interviewed? 1. Yes 2. No

Signature of interviewer as a proof of receiving verbal consent from participant

…….Date……..……..……

Did the interviewee abandon the interview?

1. Yes (precise question number…….)
2. No

Supervisor's name……..…..Date……..

Data Entry Clerk 1 …… Date: .....

Data Entry Clerk 2 …… Date: .....

Province: 1. Kampong Speu 2. Prey Veng 3. Kampong Chhnang

Part 1: Socio demographic characteristic

1. Sex
    1. Male
    2. Female
    3. MSM/TG
2. Age of Respondent……years
3. Marital status
    1. Married
    2. Single
    3. Divorce/Widow/Widower
    4. Married but live separately
    5. Unmarried but live with together
4. Currently in school?
    1. Yes
    2. No
5. Higher year of education…….years
6. Duration live in the studied province……..months
7. Place of living
    1. Along the street
    2. Live with parents
    3. Own house
    4. Organization's center
    5. Relative
    6. Other……

Part 2: Drug use situation

8. Duration of using drug……..……..months (defined as a person who have used illicit drug in any route of administration in the past 12 months)
   99. If never used (Skip to part4)
   88. Don't know
9. Have you ever injected drug?
   1. Yes
   2. No (Skip to Q11)
10. Duration of inject drug……..……..months
    (0 if less than 1 month)
11. Type of drug used last month

	Non-injected			Injected		
	Yes	No	D/K	Yes	No	D/K
1. Heroin	1	2	8	1	2	8
2. Yama	1	2	8	1	2	8
3. Ectasy	1	2	8	1	2	8
4. Amphetamin	1	2	8	1	2	8
5. Valium Diazepam	1	2	8	1	2	8
6. Glue	1	2	8	1	2	8
7. Marijuana	1	2	8	1	2	8
8. Other……	1	2	8	1	2	8

12. Have you ever used to stay in rehabilitation center?
    1. Yes
    2. No (Skip to part 3)
13. How frequency of sent to rehabilitation center?
    1. 1 time
    2. 2 times
    3. 3 times
    4. More than 3 times
14. Last time sent to rehabilitation center?
    1. 2007
    2. 2008
    3. 2009
    4. 2010
    5. 2011

Part 3: Sharing needle and syringe (For PWID only, if not please skip to part 4)

15. In the last infected, have you ever shared needle and syringe with the other?
    1. Yes
    2. No
    88. Don't know
16. How often have you used to share needle and syringe in the last month?
    1. Always
    2. Frequently
    3. Rarely
    4. Never share
    88. Don't know
17. How often have you cleaned needle and syringe in the last month?
    1. Always
    2. Frequently
    3. Rarely
    4. Never clean
    5. Use new one
    88. Don't know

18. If it is cleaned, how was your clean?
    0. Without clean
    1. New needle and syringe
    2. Used cool water
    3. Used hot water
    4. Boil
    5. Used soap
    6. Used alcohol
    7. Used other method…….……

19. Place of accessing new needle and syringe

	Yes	No
1. Drug store	1	2
2. Health service facility	1	2
3. Family or relative	1	2
4. Sexual partner	1	2
5. Friend	1	2
6. Other injecting drug user	1	2
7. Drug seller	1	2
8. NSP	1	2
9. NGO drop in center	1	2
10. Other…….……..	1	2

20. How often have you shared needle and syringe used by other people in the last month?
    1. Always
    2. Frequently
    3. Rarely
    4. Never shared
    88. Don't know

21. How often have you shared clean material with other people in the last month?
    1. Always
    2. Frequently
    3. Rarely
    4. Never shared
    88. Don't know

Part 4: Sexual behaviors and sexual partner

22. Currently married or living with partner
    1. Married and live with partner
    2. Married but live with another partner
    3. Married but live alone
    4. Unmarried but live with partner
    5. Unmarried and live alone

23. Age at first sex…….....years old

    (0 if never have sex)

24. Have you ever have sex in the last one year?
    1. Yes
    2. No

25. Have you ever have sex with men in the last one year? (for men drug user only)
    1. Yes
    2. No
    0. Never have sex

26. Have you ever have sex after using drug last one year?
    1. Yes
    2. No
    0. Never have sex

27. Did drug increase your sexual desire?
    1. Yes
    2. No
    0. Never have sex
    88. Don't know
28. Have you ever use condom with regular sex partner in the last sex?
    1. Yes
    2. No
    3. Don't have regular sex partner
    0. Never have sex
29. How often do you use condom with regular sex partner in the last one year?
    1. Always
    2. Frequently
    3. Rarely
    4. Never use
    5. Don't have regular sex partner
    0. Never have sex
30. Number of commercial sex partner that you have had sex with in the last 1 month …….....….people
    0. Never have sex
    1. Never have sex with commercial sex partner
31. Did you use condom with commercial sex partner for the last sex?
    1. Yes
    2. No
    3. Never have sex with commercial sex partner
    0. Never have sex
32. How often have you used condom with commercial sex partner in the last one year?
    1. Always
    2. Frequently
    3. Rarely
    4. Never use
    5. Never have sex with commercial sex partner
    0. Never have sex
33. Type of commercial sex partner
    1. Brothel
    2. Street sex partner
    3. Entertainment workers
    4. Never seek for paid sex partner
    5. Others…….....……
    0. Never have sex
34. Number of paid sex (selling sex to others) or drug last month…….....……..person
    0. Never have sex
    1. Don't have paid sex
35. Did you use condom with paid sex?
    1. Yes
    2. No
    3. Don't have paid sex
    0. Never have sex
36. How often have you used condom with occasional sexual partner in the last year?
    1. Always
    2. Frequently
    3. Rarely
    4. Never use
    5. Don't have occasional partner
    0. Never have sex

37. Where or with whom you can get condom (provider or place)? (More than one answer allowed)
    1. Pharmacy/drug store
    2. Health center/hospital
    3. Bar/guest house/hotel
    4. NGO's staff
    5. Friends
    6. Other……
    88. Don't know

Part 5: STD, support and treatment

38. Have you ever have the following symptom in the last one year?

	Yes	No
1. Discharge and bad smell	1	2
2. Genital Ulcer	1	2
3. Vaginal discharge	1	2

39. Where were you gone for your last STD treatment? (more than one answer allowed)
    0. No STD symptom
    1. Drug store
    2. Private clinic
    3. Public or STD clinic
    4. NGO clinic
    5. Traditional Healer
    6. No treatment
    7. Other……

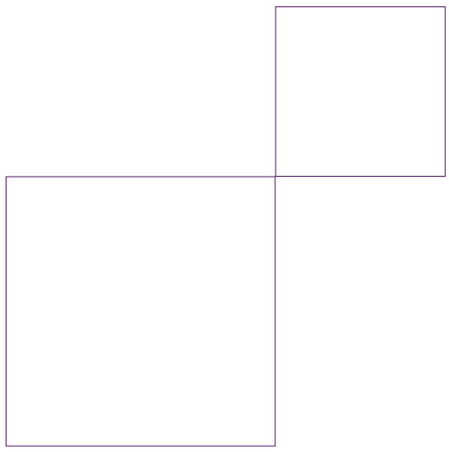
Part 6: Knowledge and information related to HIV

40. Have you be able to ensure proper use condom when have sex?
    1. Yes
    2. No
    88. Don't know
41. Have you known HIV can transmit via needle and sharing ?
    1. Yes
    2. No
    88. Don't know
42. With whom have you ever received information about HIV and drug use?
    1. NGO Staff
    2. TV or Radio
    3. Staff in rehab
    4. Family
    5. Never received any information
    6. Other……
43. Have you known about VCCT?
    1. Yes
    2. No
44. Have you ever do HIV test?
    1. Yes
    2. No
45. Have you received HIV test result?
    1. Yes
    2. No
    0. Never did HIV test
    9. No answer

46. How long have you did HIV test for the last test?.....month
    (0 if never did HIV test)
    47. Have you been aware about OI/ART facility?
    1. Yes
    2. No
48. Do you believe on receiving ARV when required?
    1. Yes
    2. No
    88. Don't know
49. Have you received education session including support in the last six months?
    1. Yes
    2. No
    88. Don't know
50. What support that you received last six months? (more than one answer allowed)
    1. Psychological
    2. Referral fee
    3. Welfare
    4. School support
    5. Job opportunity
    6. Clothes
    7. Child care
    8. Counseling
    9. Vocational training
    10. Others……
51. Who support you in the last six months? (more than one answer allowed)
    1. Relatives
    2. Family
    3. Neighbor
    4. Village chief
    5. Social work
    6. KHANA/IP
    7. Others NGO
    8. Others……
52. How long have you got support from KHANA/IPs?.....months
    0. Never got support
    1. Less than 1 month
    99. Don't remember

Part 7: Village commune safety policy

53. Have you ever heard of village commune safety policy?
    1. Yes
    2. No
    88. Don't know
54. Have you ever arrested during the policy implementation?
    1. Never arrested
    2. Yes
    3. No
    88. Don't know
55. How often have you been arrested?
    0. Never arrested
    1. 1 times
    2. 2 times
    3. 3 times
    4. More than 3 times
56. Where were you transferred to?
    0. Never arrested
    1. Rehabilitation center
    2. Treatment service in community
    3. Refer to receive health service
    4. Prison/police station
    5. Other……
57. How these policies make change number of drug users?
    1. Decrease sharply
    2. More decrease
    3. No change
    4. More increase
    5. Increase sharply
    88. Don't know



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KHANA IMPLEMENTING PARTNERS

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

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