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Khmer HIV/AIDS NGO Alliance (KHANA)
Integrated Care and Prevention (ICP) Program

End-of-Project Review

August 2006

Supported by
Global Fund Round 1 and PEPFAR/USAID

Ted Nierras (consultant)

KHANA
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Khmer HIV/AIDS NGO Alliance

Contents

This report is made possible by the generous support of the American People through the United States Agency for International Development (USAID). The contents are the responsibility of KHANA and do not necessarily reflect the views of USAID or the United States Government.

Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral treatment
BCC	Behavior change communication
BWAP	Battambang Women's Aids Project
CARAM	Coordination of Action Research on AIDS and Mobility
CBO	Community-based organization
CPN+	Cambodian People Living with HIV/AIDS Network
COC	Continuum of care
DFID	UK Department for International Development
EU	European Union
FAD	Finance and Administration Department
FO	Finance officer
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GF1, GF5,...	Global Fund Round 1, Global Fund Round 5, so on
GF PR	Global Fund Principal Recipient
HIV	Human immunodeficiency virus
HBC	Home-based care
HCT	Home-care team
ICP	Integrated Care and Prevention
IEC	Information, education and communication
KHANA	Khmer HIV/AIDS NGO Alliance
KOSHER	Key of Social Health Educational Road
KT	Kaksekor Thmey
M&E	Monitoring and evaluation
MOU	Memorandum of understanding
NAA	National AIDS Authority
NAS	Nak Akphivath Sahakum
NCHADS	National Center for HIV/AIDS, Dermatology and STIs
NGO	Non-governmental organization
NSP2	Cambodia National Strategic Plan on HIV/AIDS 2006-2010
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHA	Person / people living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PO	Program officer
SCC	Salvation Center Cambodia
SHCH	Sihanouk Hospital Center of Hope
SMT	Senior management team
STI	Sexually-transmitted infection
TB	Tuberculosis
TL	Team leader
TSV	Technical support visit
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Executive Summary

KHANA is one of Cambodia's leading NGOs on HIV/AIDS contributing to the national response with support from USAID, the Global Fund, and other donors. The Integrated Care and Prevention (ICP) Program comprises KHANA's largest single program area. ICP began in the late 1990s as KHANA's home-based care (HBC) program. In recent years, ICP's program delivery has expanded beyond HBC to include:

- facilitating access to care and treatment;
- providing socio-economic support to people living with HIV/AIDS (PLHA), or phans and vulnerable children (OVC), and their families;
- improving capacity of governmental and PLHA partners; and
- reducing stigma and discrimination faced by PLHA/OVC.

Currently, KHANA's ICP team includes 12 full-time staff, managing 61 partner organizations and 67 home care teams (HCTs). The program regularly reaches over 9,000 PLHA and over 12,000 OVC.

With Global Fund Round 1 and USAID fiscal year 2006 financial support to IPC coming to an end in mid/late-2006, KHANA commissioned this end-of-project review. The **overall objective** of the end-of-project review was to provide recommendations for improvement in the IPC program. The **specific objectives** of the review were to assess and comment on:

- **Program performance** : whether the program achieved its own targets,
- **Program management** : how the program organized and used its technical, human, and financial resources in pursuing its objectives, and
- **Program design** : how the program can continue to be relevant and contribute to the national response.

Review recommendations are meant to be used during program implementation with renewed financial support from Global Fund Round 5 and USAID.

In the **performance** section, the findings of the review are mostly positive, and there are only a few recommen-dations for improvement. In the **management** section, the findings of the review, while mainly positive, are mixed; many substantial recommendations for improvement are given. Finally, in the section on **design,** while the findings are mainly positive, they are again mixed; some substantial recommendations for improvement are provided, which in general need wider discussion with the KHANA board and senior management team (SMT). As performance is directly related to management, and design feeds back into performance, the findings and recommendations across the themes tend to reinforce one another. The following are a selection of findings and recommendations:

Performance

Findings

- ICP is valuable. It improves PLHA/OVC quality of life, reduces vulnerability, and mitigates impact. It increases access to care/support, reduces stigma/discrimination, and increases capacity.
- The main needs of PLHA/OVC, particularly those already on ART, are not health-related but instead are socio-economic.
- KHANA has fulfilled the terms of its contract with the ICP donors. Outputs have generally met or exceeded targets; expenditure has been below budget.

Recommendations

- ICP should continue and grow. In planning the future growth of IPC, KHANA should consider the national epidemic and response ahead of its own priorities and capacities; specifically, ICP should expand to follow the national continuum of care (COC) program.

Management

Findings

- Overall, ICP management is effective. However, there is scope for substantial improvement.
- ICP's cost-per-beneficiary is significantly lower than planned. High outputs are due to: expansion of COC and ART access; expansion of ICP services, for example, food aid; and an increase in trust and a reduction in stigma and discrimination. Low expenditure is due mainly to low local NGO partner expenditure.
- KHANA risk management is effective; for example, KHANA has terminated projects with cause, and documented the steps taken in such actions.
- ICP program continuity is secure – Global Fund Round 5 and USAID funds are anticipated – but growth is not assured – new funds from the EU will add some growth but not all that is possible given needs and capacity. In particular, the numbers and needs of OVC are likely to grow very quickly – along with the potential for ICP to increase its impact mitigation work.

Recommendations

- ICP and KHANA's Finance and Administration Department should analyze further why the cost per beneficiary has been significantly lower than planned, and take steps to ensure that this does not happen again in future. Those steps might include: setting higher targets, reducing budgets, or both.
- FAD internal control processes should continue. These include: optimum budget ratios, cost attribution to specific donors, and risk management.
- ICP should anticipate growth in OVC numbers and needs and begin to develop programming, and to fundraise, to meet those needs.

Design

Findings

- Overall, the design of the ICP program is sound. It comprises multiple interventions delivered in an integrated way.
- Because the expressed needs of PLHA/OVC are not health-related but socio-economic, ICP (and KHANA) should determine to what degree, and how, it should change to better meet those needs.
- Because the national epidemic and response are evolving, again, ICP (and KHANA) should determine to what degree, and how, it should change to continue to contribute to the national response.
- ICP uses no IEC/BCC materials of its own.
- PLHA are themselves mobile people.
- There is very little lessons-sharing built into the ICP design.

Recommendations

- KHANA should:
  - further intensify its focused prevention work;
  - change its care work, so that rather than having at its core home-based care, it should have as a primary emphasis community-based support for treatment and care. ICP activities should shift away from providing basic medical and psycho-social support at home and towards conducting treatment education and promoting VCT access, adherence, positive prevention and PMTCT;

- broaden its impact mitigation work, particularly in the areas of increasing PLHA household income and increasing OVC school enrollment.

- More concretely, ICP should:
  - conduct formative research to review experience to date in impact mitigation and socio-economic approaches, and to design and conduct a pilot program; and also,
  - conduct a review of existing NGO partners' multi-sectoral approaches (where these exist); and document and share lessons from these.
- ICP should conduct a review of PLHA/OVC IEC/BCC needs and IEC/BCC materials currently being used; if needed, ICP should develop new materials. These may be on: treatment education, side effects, adherence, nutrition, hygiene, exercise, positive living, positive prevention, PLHA mobility, and related topics.
- Working with other KHANA units such as the communications officer and the M&E team, ICP should develop:
  - basic promotional materials about its own work (for example, a brochure or a VCD);
  - "lessons learned" reports on various aspects of the ICP program; and
  - lessons-sharing events, such as conferences on various ICP-related topics. These may include: gender and AIDS care, responses to OVC, and OVC and schools.
- ICP should develop and maintain practical international links, primarily with the Alliance but also with other agencies involved in community-based support for care and treatment.

Introduction:
the Changing Face of AIDS in Cambodia

In 2006, Cambodia continues to grapple with serious development challenges: poverty, poor education and employment opportunities, gender inequity, social dislocation, and one of the most severe AIDS epidemics in Asia. In recent years, gains have been made against AIDS: the prevalence of HIV in the general adult population has declined, and the number of people living with HIV/AIDS (PLHA) accessing anti-retroviral treatment (ART) has increased dramatically. Many factors have contributed to these gains: political leadership, sound public health approaches, the meaningful involvement of affected communities, and significant international assistance. However, while prevention efforts show results and access to care increases, the conditions for a resurgent epidemic remain – poverty and inequality are the base on which AIDS thrives. Meanwhile, AIDS to date has created serious negative effects in affected households and communities – impacts which will need continued mitigation into the long-term.

In the past, the Cambodian faces of AIDS were those of a young urban woman working in a brothel, or a sick man in his 30s going home to his village to die. They are still the faces of AIDS now – joined by a young transgender person, a drug-dependent teenager, a rural woman raising her children alone. In addition, increasingly, the face of AIDS in Cambodia is that of a child – receiving ART as well as community-based support for housing, food, and schooling – a child with a future that remains deeply uncertain, but one that does include some glimmers of hope.

Hem Srey Khourchh, 9 years old, living with HIV/AIDS in Kampong Cham province.

This document is the report of the **end-of-project** review of the Khmer HIV/AIDS NGO Alliance's (KHANA) Integrated Care and Prevention (ICP) prgram, supported by the Global Fund against AIDS, Tuberculosis and Malaria Cambodia Round 1, and the US President's Emergency Plan for AIDS Relief (PEPFAR) through the USA gency for International Development (USAID). Conducted in August 2006, the overall objective of the review was to provide recommendations for improvement of KHANA's ICP program, which will receive continued Global Fund and USAID funding through 2007 and beyond. The review examined program performance, program management, and program design. One of the review's main themes is that, as the face of AIDS changes in Cambodia, so too should the design, management and performance of this program.

Background to the Review

Cambodia AIDS situation and response : Cambodia has made many significant gains against AIDS in recent years: Focused prevention efforts among sex workers and their clients, including the 100% condom use program and various outreach and peer education projects, have decreased HIV transmission in sex work situations and contributed to decreasing general adult HIV prevalence. The Ministry of Health's continuum of care (COC) package has by mid-2006 introduced anti-retroviral treatment (ART) to an estimated 16,000 people, about 80% of the estimated number of those in need. The AIDS law, enacted in 2002, signals an ever-more favorable countrywide environment for prevention, care and support, and recognition of the rights of those infected and affected. With this situation, the National Strategic Plan on HIV/AIDS 2006-2010 (the second such national strategy and therefore known as NSP2) has outlined national strategic directions for the response. These include: continued and increased prevention interventions, with additional interventions to reach other vulnerable groups such as men who have sex with other men (MSM) and drug users; continued and increased comprehensive care, treatment and impact mitigation interventions; and an expanded response across all sectors.

KHANA: The Khmer HIV/AIDS NGO Alliance (KHANA) has become one of Cambodia's leading non-governmental organizations (NGOs) on HIV/AIDS. KHANA's mission focuses on reducing people's vulnerability to HIV/AIDS and sexually-transmitted infections (STIs) and the impact of AIDS, by developing effective and sustainable community-level responses, building the capacity of NGOs and community-based organizations (CBOs), and collaborating with government and other stakeholders.KHANA began as the Cambodia country program of the International HIV/AIDS Alliance, which remains KHANA's main international counterpart. KHANA receives support from the Alliance and a range of donors, including the Global Fund and USAID, and in turn provides management, technical and financial support to local NGOs/CBOs throughout Cambodia: in 2005, KHANA supported over 80 NGO/CBO partners to implement over 120 projects. In this way, in its prevention, care and support, advocacy and capacity-building work, KHANA mobilizes civil society and contributes to the broader national response and NSP2.

ICP: The Integrated Care and Prevention (ICP) program comprises KHANA's largest single program area, and the work for which it is best-known. ICP began in the late 1990s as KHANA's Home-Based Care (HBC) program. An evaluation in 2000 of the start-up phase supported by the World Bank, USAID and others, found that the HBC program was "reducing the suffering… and improving the quality of… lives" of PLHA; "increasing understanding… and reducing discrimination against PLHA in the community"; and, "by providing social and economic support,… helping to empower some of the poorest and most disadvantaged." In 2003, KHANA obtained support from Global Fund Round 1 for HBC. A mid-project review in 2005 found that "the main achievement of HBC is (the delivery of) comprehensive services, such as basic home care, access to medical services, psychological support, ART, TB treatment, welfare support, and support for income generation and education." The mid-term review found an increase in PLHA involvement and empowerment, and a decrease in their economic burden and experience of stigma and discrimination. More recently, with the advent and rapid uptake of ART, KHANA has expanded the ICP approach beyond HBC to include:

- Engaging PLHA in positive prevention,
- Facilitating access to treatment and care,
- Providing socio-economic support to PLHA, orphans and vulnerable children (OVC), and their families,
- Improving capacity of governmental and PLHA partners, and
- Reducing stigma and discrimination faced by PLHA/OVC through community education.

Currently, KHANA's ICP team includes 12 full-time staff managing 61 partner organizations and 67 home care teams (HCTs). The program regularly reaches over 9,000 PLHA and over 12,000 OVC. The program's annual cash budget is approximately US$1.5 million; of this, the two largest contributors, accounting for more than 90% of the total, are the Global Fund and USAID.

End-of-Project Review: With Global Fund Round 1 and USAID fiscal year 2006 financial support for ICP coming to an end in mid/late-2006, KHANA commissioned this end-of-project review. The initial terms of reference for the end-of-project review were very broad: the exercise was to have been an evaluation investigating "changes brought about by the project among people living with HIV/AIDS, their families and communities; implementing NGO and governmental partners; KHANA and the broader Cambodian HIV/AIDS and development response." The evaluation was to identify project "inputs, processes, outputs and outcomes" and further, to identify "achievements, problems, constraints and lessons." It was also to "observe broader changes in the evolving Cambodian HIV/AIDS epidemic and response," and taking these into account, to develop recommendations.

Early on in the process, discussions with KHANA senior management, ICP team leaders, the Global Fund Principal Recipient (GF PR), and USAID, simplified the scope of the review, in order to make it more feasible as well as more useful to KHANA, its donors, and other stakeholders. These early discussions clarified that the review was to focus on and assess three specific issues in detail:

- Program performance – whether KHANA achieved its objectives,
- Program management – how it did so, and
- Program design – how the program can continue to be relevant.

In each of these three areas, review recommendations are meant to be used by KHANA during future program implementation with renewed financial support from Global Fund Round 5 and USAID. This end-of-project review was therefore an opportunity for KHANA to take stock of ICP, to determine specific directions for the program's improvement, and to contribute to KHANA's organization-wide strategic development.

Objectives of the Review

Given the above background and discussions on the terms of reference, the **overall objective** of the end-of-project review was to provide recommendations for improvement of KHANA's ICP program. The **specific objectives** of the review were to assess and comment on:

- **Program performance** : whether the program achieved its own targets, as agreed and documented in the Memorandum of Understanding (MOU) with the Global Fund Principal Recipient (GF PR), the workplan, monitoring and evaluation (M&E) plan, budget, procurement plan, and reports to GF PR,
- **Program management** : how the program organized and used its technical, human and financial resources in pursuing its objectives, including: program strategy and structure; human resources system; financial budgeting, control and reporting; grant management and risk management, and
- **Program design** : how the program can continue to be relevant and contribute to the evolving national epidemic and response, as outlined in NSP2 and the priorities of donors such as GF PR, USAID, future and potential supporters, and as expressed by PLHA/OVC and their families and communities.

Review Methods

KHANA contracted Mr. Ted Nierras as an external consultant to lead the review process. An independent consultant in HIV/AIDS based in Laos, Ted Nierras consulted for KHANA in 2005-06, and, from 2003-05, he was the Country Director for the International HIV/AIDS Alliance in China. KHANA's Monitoring and Evaluation team assigned Dr. Em Sovannarith as Mr. Nierras's associate during the process. They worked for two weeks, between 7-18th August 2006.

They conducted the review in a 2-step process. The first step (during the first week, 7-11 August) focused on developing an overview of the entire ICP program and, given the program's size and complexity, and the limited time available for the review, refining the review's objectives and methods. Activities during the first step included:

- Introductory meetings with Dr. Kong Sopheap and Dr. Ly Chansophal, KHANA ICP team leaders (TLs),
- Meetings with a range of external stakeholders, including GF PR, USAID, the National Center for HIV/AIDS, Dermatology and STIs (NCHADS), the National AIDS Authority (NAA), and the Cambodian People Living with HIV/AIDS Network (CPN+),
- A one-day workshop involving six KHANA ICP partners from three provinces, Phnom Penh, Battambang and Kampong Cham,
- Visits to two partners (who were not at the one-day workshop), one in Phnom Penh and another in Takeo, and
- A meeting with Dr. Oum Sopheap, KHANA executive director, to discuss initial impressions and to finalize review objectives and methods.

By the end of the first step, the specific objectives of the review – examining program performance, program management and program design – had been developed.

The second step (during the second week, 14-18 August) focused on assessing the three specific issues of performance, management and design. Activities during the second step included:

- A visit to one more partner (which was at the one-day workshop during the first step), in Kampong Cham,
- Repeated meetings with ICP team leaders (one meeting on each specific issue),
- Further meetings with KHANA: the board chair (who is also the UNAIDS country coordinator), the director of finance and administration, the monitoring and evaluation (M&E) team leader, and one ICP program officer (PO),
- A review of documents in relation to the three specific issues of performance, management and design, and
- A presentation of preliminary findings and recommendations to the KHANA Executive Director, ICP and M&E team leaders, and other staff, with a discussion to wrap up.

By the end of the second step, the main findings and recommendations of the review had been developed and discussed with KHANA.

Limitations: The main challenge facing the review was that, on one hand, KHANA's ICP program is relatively large and complex, while the review consultant and KHANA counterpart had limited capacity and time. There was no feasible way, for example, to obtain data from all 61 ICP partner organizations and 67 home care teams (HCTs), or even indeed to meet with all 12 ICP staff, as on any given day, many of them are visiting partners and HCTs. Instead, before the review, the consultant requested the ICP and M&E teams to organize the one-day workshop and visits held during the first step. The partners and provinces represented in the one-day workshop were purposively selected to give a view of the range of partners and projects. The partners visited during the first step were similarly purposively selected to give a range of programmatic approaches, as well as to be relatively-easily reached from Phnom Penh.

Meetings with stakeholders in Phnom Penh and with KHANA staff were generally conducted in English, but the one-day workshop and discussions during visits were generally held in Khmer. As the review consultant does not have Khmer language, the counterpart generally provided translation (except during the visit to one Phnom Penh partner, which kindly provided translation from one of its own staff). Inevitably, translation limited the depth of discussions and took up what was already limited time. Nonetheless, the time spent with partners and in the community provided the review process a solid grounding in the realities of life with HIV/AIDS in Cambodia today, and a clear view of the many and changing faces of AIDS. In reflection, placing PLHA/OVC at the center of the review's emphasis was an important way to deal with the review's methodological limitations.

Program Structure

In line with KHANA's overall mission, the Integrated Care and Prevention (ICP) program's goals are to "improve the quality of life of PLHA, reduce people's vulnerability, and mitigate the impact on OVC," and its objectives are to "facilitate access to treatment and care for PLHA/OVC, provide socio-economic support to PLHA/OVC, and reduce stigma and discrimination faced by PLHA/OVC."

As KHANA is an intermediary organization the role of the ICP team is to provide management and technical support to partners so that they are able to implement activities to achieve the program's objectives. ICP staff:

- Develop and design annual grants to partners,
- Develop and conduct training so that partners can increase coverage and improve quality,
- Conduct regular technical support visits (TSVs) to partners to provide ongoing one-on-one management and technical support and advice,
- Advocate for the rights of PLHA/OVC and work with partners to develop ways to protect and promote these, and
- Monitor, assess and report on partner implementation.

Every partner is assigned one program officer who is their main point of contact with ICP and who conducts TSVs. The TSVs serve multiple functions: management and technical support as well as program monitoring.

ICP partners manage home care teams (HCTs); some partners manage one, others two, and a few manage multiple teams. In the KHANA system, each HCT is funded by a single grant, so a partner with more than one HCT will have more than one active grant from KHANA at that time. (Some partners split up the resources of a single grant into two or more sub-teams, each of which they call a "HCT"; partners do this for a variety of programmatic and administrative reasons. This review uses the KHANA system where each HCT corresponds to a unique grant). A partner organization receiving funding from multiple donors for a large AIDS program might, for example, have an AIDS program manager, and an AIDS care program coordinator, overseeing many KHANA-supported HCTs, each with its own team leader. A smaller partner, or a smaller program, might instead only have a half-time AIDS coordinator, overseeing, for example, two HCTs.

At its heart, each HCT is a public-private partnership. The team leader and one or more full-time NGO staff work with one part-time health center staff and a few volunteers, many of them PLHA themselves. While managed by a local NGO/CBO, each HCT works out of a public-sector health center and takes on that health center's catchment area (in rural areas, this usually corresponds to a few communes in a single district). The HCT conducts community and house-to-house outreach HIV prevention and AIDS care services. In effect the HCT extends the reach of the health center and at the same time improves the access of PLHA/OVC to care.

In addition HCTs provide for PLHA/OVC:

- Community education events for prevention, community support for care, and reduction of stigma and discrimination
- Regular home visits
- Positive prevention education
- Basic medical treatment
- Basic psychological support
- Referral to health services for VCT, OI treatment including TB, ART including CD4 monitoring
- Support for shelter, income-generation, welfare, schooling and funerals
- Food and nutrition support

- Support for setting up self-help groups
- Facilitation of foster care
- OVC "happy happy" days (kids' fun days in local communities)

To complement the work of local partner NGOs/CBOs, and to maintain a favorable environment for community-based care and support, ICP also provides direct assistance both to PLHA organizations and to governmental agencies at the provincial level. ICP supports 12 provincial CPN+ networks. These provincial networks conduct annual advocacy activities and quarterly coordination meetings among PLHA in the province. More than 300 PLHA self-help groups receive organizational support through ICP's work with CPN+. In this way ICP supports a significant portion, perhaps even a majority, of PLHA self-help groups in the country. In addition ICP supports 10 provincial home care networks. A coordinator, a staff person at the provincial AIDS office, convenes quarterly coordination meetings among HCTs in the province, and serves as a liaison to the health department at the provincial level. In the future, these home care networks will be absorbed in the provincial continuum of care (COC) structure, with the network coordinators becoming provincial COC coordinators.

Monitoring and reporting: ICP program officers (POs) spend most of their effort on grant management, that is, monitoring and providing feedback and support to partners during TSVs, and afterwards reporting on progress up through the KHANA system and eventually to donors. Partners forward quarterly reports to their PO. Each PO, who generally manages around five partners, checks these before passing them onto to one of the ICP team leaders (TLs), who clear them before passing them onto the monitoring and evaluation (M&E) team. The dedicated M&E team is new – because of an increase in donor funding, reporting requirements, and partners, KHANA established the team in 2005. Specific M&E team staff process partner reports in specific ways. In particular, all reports are entered into the Alliance reporting system, a computerized database which links plans and reports, fills in pre-determined indicators and reporting formats, and is used by KHANA and other Alliance partners worldwide to report to all donors – the Global Fund, USAID, and others. In addition, M&E staff "pull" from the database reports for each specific donor, including the Global Fund, according to their indicators of interest, funded programming and outputs. Global Fund Round 1 support to ICP had the following indicators of interest:

- Number of home care teams (HCTs)
- Number of provincial positive networks
- Number of provincial home care networks
- Number of PLHA reached
- Number of OVC reached
- Number of referrals to health services

Reports to donors are cleared by the senior management team (SMT) and copied to the board. The M&E team conducts M&E training for all KHANA partners, including ICP partners; the latest training was conducted in early 2006.

Financial management and reporting: KHANA's finance and administration department (FAD) is the key support structure for all program teams, including ICP. Until recently, senior FAD staff were able to share oversight responsibilities for most financial management functions – corporate budgets, partner budgets, control, accounting and reporting. Again, with an increase in the volume of work, the FAD structure is becoming increasingly specialized: there is now a team leader for corporate accounts and another for partner support, and in the future, there will be one for donor reporting. Preparation of proposal and annual budgets involves relevant program and FAD teams. Within these budgets, preparation and approval of partner budgets (i.e., KHANA's onward grants) involves the relevant program team and the partner support team within FAD. One important future step in financial management is that KHANA will make clear that program team leaders, including ICP, will budget-hold. FAD plans to begin producing regular management accounts so that team leaders will be able to manage their budgets more closely and more accurately. Reports will be drawn up by the new donor reporting team within FAD working with the relevant program team. FAD also provides training for KHANA partners, including periodic TSVs to partners, and each partner is assigned one finance officer (FO) who is their main point of contact with FAD.

A Program Story :
a Future for my Daughter

(Ms.) Suorn Phearith is a community volunteer with a home care team (HCT) in Stung Meanchey district in Phnom Penh, managed by the local NGO WOMEN. She tells her story: "My husband and I are from Kampot province. When we moved to Phnom Penh he had a job as a driver, and we lived in our own house. In 1999, he fell sick with AIDS. We sold our house, moved back to Kampot, and slowly went through our savings as he became more and more sick. Within a year he died. In 2000, I decided to move back here to Phnom Penh with my daughter. We didn't have any money to live here, but there was no good schooling in the village and I couldn't imagine a good future for her there."

"At first we rented living space under a house – we couldn't rent the house, just the space under a house, just a space to live. I also rented a sewing machine and worked – I worked very hard. Soon enough I met the HCT from WOMEN, and they helped us with some food, basic medicines, school fees, and some money for the business. I kept working a lot, sewing. Now with money from sewing I'm renting this house. I want more capital to expand the business, and what I really want is to see my daughter finish high school – she's got 4 more years. She's also studying English and computers too."

Suorn Phearith became a HCT volunteer herself in 2003. Despite the few life opportunities she has had, and the devastating experience of AIDS, she exhibits self-confidence, resourcefulness, and a sound understanding of business administration: "I can sew quite well, and I'm a good designer, and I can teach others too – there's a market for all this. WOMEN bought me a sewing machine but this way it's too slow, I can only work on one thing at a time. I need more capital – to get raw materials in bulk, to rent more machines, to teach people, produce more. It's not worth it to produce such a small amount each day – this business needs cash flow."

Suorn Phearith reflects, "Before all this we had enough money. AIDS pushed us into poverty. But then HCT and ART transformed my life. I'm in much better health and I have hope for my daughter's future. That's the most important thing."

Suorn Phearith, her daughter, HCT leader, a neighborhood boy, and some of her products, in front of her house.

Overview of
Findings and Recommendations

In the **performance** section of the review, the findings are mostly positive, and there is only one general recommendation for improvement. In the **management section**, the findings of the review, while mostly positive, are mixed; many substantial recommendations for improvement are given. Finally, in the section on **design**, while the findings are mainly positive, they are again mixed; some substantial recommendations for improvement are provided, which in general need wider discussion in the KHANA board and senior management team (SMT). As performance is directly related to management, and design feeds back into performance, the findings and recommendations across these three specific issue areas tend to reinforce one another.

◻ Performance

Findings

♦ **For PLHA/OVC :**

1. The ICP program reaches PLHA/OVC with a valuable package of home and community-based care, support, prevention and capacity-building services. For PLHA/OVC reached ICP improves quality of life, reduces vulnerability to HIV/AIDS, and mitigates the impact of HIV/AIDS. ICP increases PLHA/OVC's access to the continuum of AIDS care, including VCT, ART, and OI treatment; increases socio-economic, psycho-scial and political support; reduces stigma and discrimination; and increases capacity and visibility of self-help groups and networks.

   Over 9,000 PLHA and over 12,000 OVC are currently being reached with this package of services. While it was not possible for the review to collect more than a few anecdotal stories of PLHA/OVC receiving services, such as that of Ms. Suon Phirit in the section above, the review did examine the program's management and monitoring system, and it is reasonable to assume that the great majority of PLHA/OVC reached do obtain valuable assistance from ICP.

2. Many PLHA/OVC reached are poor; their main expressed needs are socio-economic. Particularly where PLHA/OVC are already receiving ART, PLHA/OVC say that their needs are: income, employment, shelter and education. ICP is not designed to meet all the expressed needs of PLHA/OVC; instead its objective is to offer better overall AIDS care, and in doing so provides a limited range of income, food, shelter, education and health care support.

   This dynamic illustrates what is in a way the central design dilemma facing ICP: To what degree should ICP continue to pursue its own HIV/AIDS objectives, and to what degree should it change to meet better on one hand the expressed needs of PLHA/OVC, and the other hand the priorities of the national response? As Dr. Ly Chansophal, one of the ICP team leaders, said on the very first day of the review process: "Our support for PLHA/OVC is in no way able to match all their needs. Our most difficult challenge is to determine how much to support PLHA/OVC to overcome poverty-related vulnerabilities to HIV/AIDS."

   ICP already includes, through an innovative relationship with the World Food Programme, food and nutrition support for some PLHA/OVC. Food aid is designed to be integrated into a broader household welfare and development package. On its own food aid may be ineffective, or even encourage dependency; but as part of an overall household and community development package, which may

include skills training, support for agricultural and handicraft production, and other inputs to increase household survival and self-sufficiency, it does have a role to play.

Nonetheless, the question remains of how KHANA should prioritize and deliver socio-economic interventions to improve quality of life of PLHA/OVC. Clearly ART by itself is not the complete solution: As the Sihanouk Hospital Center of Hope (Phnom Penh) HCT recounted, "One of our patients was a moto driver. He was always working to earn for his family and, even if he was on ART, going hungry himself– every day till the day he died."

ICP partners and HCTs have realized that, with the introduction of ART, many PLHA/OVC are no longer ill and do not need home-based care. Now that ART has added "years to life," ICP must find ways to add "life to years." Partners in Compassion (Takeo) said, "Now that they (PLHA/OVC) have their lives back, they need a life" – PLHA/OVC need education, skills for employment, incomes, and hopes for the future, as in the story of Ms. Suon Phirit in the section above.

♦ **For local NGO partners:**

3 ICP effectively mobilizes and supports local NGOs and other partners. Over 60 partners are involved in ICP. All local NGO partners met during the review (at the 1-day workshop and during visits) had a very high opinion of KHANA technical support. There is clear evidence that ICP staff focus on supporting local NGOs, particularly through TSVs, and this support is appreciated. CPN+ had particularly positive views of ICP and KHANA.

♦ **For the health care system:**

4 ICP is auxiliary to the health system. Even in urban areas health services have little or no outreach capacity; ICP increases the health system's access to communities and patients, improves their adherence to ART and OI treatment, and improves the functioning of COC. During the one-day workshop held as part of the review, one of the participants said that ICP and the home-based care program is "part of the dam that keeps away the next Cambodia HIV epidemic tidal wave. To keep the wave away we need to keep the dam functioning well."

5 However, there are many more patients on ART (reached by COC) than reached by ICP. While ICP regularly reaches over 9,000 PLHA and over 12,000 OVC, the national COC system has reached an estimated 16,000 people with ART. In some places, COC functions without an ICP presence.

♦ **For the Global Fund and the broader national response:**

6 Financial support from GF1 has enabled KHANA to more than double its coverage of PLHA/OVC with integrated care and prevention services. At the end of 2002, before GF1 support to ICP began, KHANA's cumulative reach was 3,262 PLHA and 3,860 OVC. By mid-2006, those newly-reached with only GF1 support (that is, excluding those newly-reached with USAID and other donor support) were 4,860 PLHA and 6,927 OVC. The majority of newly-reached PLHA/OVC are afterwards then regularly reached by the program (but, not surprisingly, some PLHA/OVC move away, die or are otherwise lost to the program). Another way of looking at this – to be discussed again in the review section on management – is that KHANA has been able to absorb, manage, and utilize GF1 resources successfully to double its existing ICP program.

7 In managing and delivering ICP, KHANA contributes to NSP2 priorities. The program contributes specifically to Strategy 2, "increased coverage of effective interventions for comprehensive care and support…" As in Findings 2 and 5 above, and as will be discussed again in the review section on design, the question for the future is, to what degree should the program change to better fulfill the priorities of the national response? In the care and support area changes may include, for example, greater emphases on positive prevention, coverage and quality of VCT, ART education and adherence, and greater TB case finding and

treatment - all aspects of care and support that go beyond home-based care. And there is even greater potential growth in the impact mitigation area – income, shelter, employment, education and other socio-economic support for PLHA/OVC.

8 KHANA has fulfilled the terms of its MOU with GF PR. Output achievements have generally met or exceeded targets; expenditure has been below budget. Working with and in consultation with GF PR, KHANA has developed and periodically revised the documentation governing the grant – workplan, M&E plan, budget, procurement plan. KHANA has provided bi-annual reports detailing progress of the grant. As explained above, KHANA has instituted and periodically upgraded structures and systems that enable it to manage its grant – the ICP team itself, a dedicated M&E team, and FAD. KHANA's M&E system and the indicators used to monitor and report on this grant are sound.

Recommendations

1 The ICP program should continue and grow. ICP is valuable; the unmet needs of PLHA/OVC in care and support are large; and KHANA is able to manage ICP and to work effectively with local NGO partners, the health care system, GF PR, and the broader national response. ICP clearly contributes to the care and support response, and therefore, KHANA and its donors should plan to increase the scope, coverage and delivery of ICP. Future growth in ICP should be based primarily on the national epidemic and response. It should only secondarily be based on KHANA's existing capacity – the location and capacity of its local NGO partners, and the capacity of its own ICP staff. More specifically (and in relation to Finding 5) ICP should expand to cover all the areas covered by COC. The goal here should be universal access to ICP services as a contribution to COC and the national response. If needed, KHANA should find or develop new local NGO partners, hire and train new staff, and raise new funds to move towards such a situation.

◻ Management

Findings

♦ **Overall:**

1 The ICP program's structure, staff, and partners constitute a system that is sufficient to manage GF 1 resources to deliver intended objectives (echoing Performance Findings 3, 4, 6, 7 and 8 above). As a whole KHANA is able to provide technical delivery, program monitoring and reporting, and financial management and reporting to a satisfactory level. However, there is substantial scope for the ICP team to build its capacity further, in order to manage more resources and to deliver greater results. Such growth would need to be in cooperation with the M&E team and the FAD.

♦ **On the ICP team:**

2 The ICP team does not yet have a team strategic plan that fits within the overall KHANA organizational strategic plan. The articulation of ICP's team goals and objectives do not clearly fit within those of KHANA overall–some of these statements of intention repeat the overall KHANA strategy. Without a team strategy ICP finds itself simply managing in order to fulfill obligations to donors such as the Global Fund. In order to grow strategically, as well as contribute to KHANA's overall strategic development, the team will need to develop even a brief team strategy.

3 The ICP team structure, and the division of labor among the team's two team leaders and 10 project officers, has evolved more because of historical background than because of strategic direction. TLs and POs each have a mix of responsibilities, some of them thematic, and some geographic. For example, a PO might manage one provincial home care network, one provincial positive network in a different province, and two local NGO partners in yet another province, far away from the others.

3.A In relation to this, ICP TLs have some direct PO responsibilities. Each TL, besides taking responsibility for team management, also manage some partners directly.

4 ICP POs have particular skill sets that have not been formally assessed or articulated. For example, some POs have more experience in working with government, others are NGO managers, and still others have more experience in working with PLHA groups.

5 There is gender balance in the team. There is one openly HIV-positive ICP staff member.

♦ **On the M&E team:**

6 The M&E team receive data from ICP (and other program teams), process them, and pass them onto SMT and donors for management and reporting purposes. Currently M&E staff have little or no field role. There is scope for increased value-added from the M&E team; for example, in conducting research studies and generating periodic or thematic program lessons learned reports, i.e., increasing the overall knowledge base for policy and program development.

♦ **On financial management:**

7 KHANA SMT intend to make clear that TLs are budget holders – to state this clearly in the financial procedures manual, to produce regular management accounts for team leaders to track their budget implementation, and to train and support TLs in this role.

8 The ICP program's cost per beneficiary is lower than planned (another way of saying this is that the output-to-expenditure ratio is higher than planned – this finding echoes Performance Finding 8 above but provides more detail). Almost all output targets have been exceeded, and yet the budget has been under-spent.

Output targets v. achievements (GF1 only)	Target	Achievement
Home care teams	32	34
Provincial home care networks	12	12
Provincial positive networks	8	7
PLHA reached	2875	4860
OVC reached	4171	6927
Referrals to health services	2800	12,309

According to KHANA reports to GF PR, there are several reasons for high output achievement: the expansion of COC, i.e., PLHA/OVC's greater access to ARV acting as an incentive to access ICP; the expansion of the ICP package itself, specifically the inclusion of food aid, again acting as an incentive for PLHA/OVC to access ICP; and an increase in trust and a decrease in stigma and discrimination in the community. The main reason for low expenditure, on the other hand, has been low local NGO partner expenditure. Budget lines for KHANA expenses (salaries, technical support visits) have been spent satisfactorily. The entire program has been subject to some disbursement delay, but while this would have affected expenditure in relation to time, it should not have affected expenditure in relation to outputs. Therefore, either the output targets were set too low, or the budget was set too high (or both).

It is important to view this finding in perspective. According to KHANA, many other Cambodia GF recipients and sub-recipients have underspent their budgets – these have to do with understandable difficulties in scale-up and performance. There are many worse situations: where a recipient is simply unable to use the financial resources to deliver a program, for example, or where they use up the entire budget but deliver only a fraction of the planned outputs. The situation in this program – the high output-to-expenditure ratio – does not harm the intended beneficiaries in the same way. Nonetheless, more balanced management at KHANA would mean more effective use of resources, and greater benefits both to beneficiaries as well as to stakeholders such as donors.

9 FAD controls ICP's budget ratios (across the GF budget categories). At both KHANA and local partner NGO levels, these ratios (percentage of budget on salaries, operations, training, equipment, administration, and so on) are kept to predetermined reasonable levels.

10 There is no co-mingling of funds. Every project is attributable to a single donor. KHANA common costs such as salaries are pro-rated to donors.

♦ **On risk management:**

11 In using GF1 resources KHANA has demonstrated effective management of program risks. In late 2005, KHANA requested GF PR for a re-alignment of the program budget because the cost per beneficiary was significantly lower than planned; this was approved. Two onward grants have been terminated for cause, one with a local partner NGO and the other with a provincial home care network. In both cases, grant management irregularities were found during routine monitoring and reporting, and referred up to SMT for deliberation, consultation with GF PR, and action. Steps taken were documented throughout.

♦ **On program continuity:**

12 Anticipated renewed funding from GF5 and USAID will allow a continuation of programming from GF1 and USAID at the same scope (i.e., with no significant expansion). Anticipated new funding from the EU will enable a small expansion. Potential future funding from GF6 is likely to allow an expansion of PLHA but not likely OVC programming (dependant on global and country-level decisions on GF6). But OVC numbers and needs are likely to grow much more than PLHA numbers and needs. Management of the funding "pipeline" is of course a broader strategy and design issue.

Recommendations

♦ **For the ICP team:**

1 ICP TLs, in coordination with KHANA SMT, should begin to discuss the development of a team strategic plan within the KHANA strategic plan. When the existing KHANA strategic plan is revised and renewed (in the next year or two), ICP should then develop a team strategic plan that fits within it (it is better to wait until the KHANA strategic plan is renewed to then develop an ICP team strategic plan; nonetheless discussions in this direction should begin). A strategic plan articulates an overall direction that is broader than simply the implementation of a project or a set of projects.

2 The ICP team structure and the division of labor among its staff should be rationalized. One way to do this is for POs to be assigned roles and responsibilities according to geographical area, i.e., one PO for a few contiguous provinces. Another way is to develop a thematic division of labor, i.e., 1-2 POs for all home care networks, 1-2 POs for positive networks, 1-2 POs focused on OVC, 1-2 POs on gender and AIDS, and so on; the team would then use a matrix organizational chart. All positions should have, as a minimum, clear job descriptions, annual performance reviews and improvement plans, and training opportunities to meet identified improvement needs. The ICP team should conduct a capacity assessment of current staff and determine overlaps and gaps.

2.A ICP TLs should not carry PO responsibilities. They should go on TSVs anyway but leave day-to-day partner management to POs. At the end of each quarter, TLs, in coordination with POs, should determine which partners have the most important and urgent needs, and go with POs on TSVs to those partners the following quarter. In this way, TLs should backstop, strengthen and support POs facing challenging situations with partners.

3 The ICP team should develop specialized expertise in-house (this recommendation follows from 2 above). At a minimum, there should be POs for: GIPA (which should be an openly-HIV-positive staff member), VC, gender, BCC, food aid (on the assumption that this will continue to be an ICP component). This will allow

POs to develop specialist skills, access as well as deliver higher-quality technical support, and facilitate more practical lessons sharing.

4 In hiring new staff the ICP team should maintain or improve the existing gender balance. It should also prioritize hiring appropriately-qualified openly HIV-positive candidates, (KHANA should consider applying this recommendation as an organization-wide policy.)

♦ **For the M&E team:**

5 The M&E team should continue its program support role, that is, to provide technical backstopping so that the ICP team (and other teams) fulfill the responsibility of ensuring adequate monitoring and reporting. M&E staff should have some field role, negotiated with the ICP team (and other teams). More importantly, in order to grow, the M&E team should develop its own strategy, funding and program portfolio over and above its program support role. This would include, for example, conducting research studies and generating periodic or thematic program lessons learned reports.

♦ **On financial management:**

6 KHANA program team leaders (this review focused on ICP and M&E teams) should assume steadily-increasing responsibility for generating income for their teams, i.e., developing and maintaining donor relations, developing and submitting funding concepts and proposals, and developing other partnerships (for example, sponsorships) that may generate cash or in kind support. They should then budget-hold as already planned by KHANA SMT.

7 ICP and FAD should further analyze why in this project the cost per beneficiary has been lower than planned (or, put another way, why the output-to-expenditure ratio has been higher than planned). In the future, team leaders' budget-holding should reduce this problem (Management Finding 7 and Recommendation 6 above). However if the problem has to do with inaccurate planning, then either targets should be raised or the budget should be reduced. If the problem has to do with insufficient local partner NGO absorptive capacity, steps should be identified to increase this.

8 FAD should continue to control budget ratios. As TLs begin to budget-hold, they should assume steadily-increasing responsibility for ensuring reasonable ratios in both budgets and actual expenditures (doing this is a consequence of increasing financial resource mobilization, Recommendation 6 above).

9 FAD should continue to maintain the system by which all costs can be attributed to specific donors.

♦ **On risk management:**

10 KHANA should continue to manage risk. TLs should ensure that all POs understand terminations with cause as examples of good management practice. It is vital that the system by which implementation difficulties are identified and addressed remains in place.

♦ **On future program growth:**

11 ICP should anticipate future growth in OVC numbers and needs, and begin developing potential funding submissions to other donors. KHANA SMT and ICP TLs should engage new donors such as DFID, and approach the private sector and private foundations to support future OVC work.

Design

Findings

♦ **Overall:**

1. The ICP program design is sound. ICP features multiple components (described in the section Program Structure above) delivered in an integrated way at the community and household level.

   As described in the sections above on Performance and Management, the main expressed needs of PLHA/OVC are socio-economic (increased household income, food, shelter, schooling, i.e., related to poverty rather than HIV status). ICP on the other hand is essentially a community health outreach program. From this perspective the main design question for ICP is: within KHANA's mandate, to what degree, and how, should ICP change in order to meet the main expressed needs of PLHA/OVC?

   At the same time, the main normative (i.e., expert-led) priorities in HIV/AIDS are universal access to prevention, care, treatment and support. From this perspective, the main design question for ICP is: to what degree and how ICP should change in order to support universal access goals. For example, how can HCTs further increase VCT and ART coverage, uptake and adherence?

♦**On program content:**

2. ICP does not produce or provide IEC/BCC materials for use by HCTs (they use materials produced by other agencies or other KHANA programs.

3. PLHA are themselves a mobile population. PLHA move for a variety of reasons: after becoming ill, to get closer to families; to get closer to treatment opportunities; and, with ART and becoming healthy, to find better employment and income opportunities. As an outreach program (and like any outreach program) ICP finds the mobility of its target population a challenge.

♦**On lessons sharing:**

4. ICP and M&E teams are almost completely focused on implementation and regular program monitoring and reporting. There is little leftover capacity or effort to reflect, identify lessons, share these within KHANA and with a broader national and international stakeholder audience. Engagements to influence the policy and programming environment are left to the interest and availability of TLs or individuals in SMT. And yet ICP is a tremendous untapped resource of knowledge on PLHA/OVC and their home and community life.

Recommendations

♦ **On overall approach:**

1. As prevention starts to show results, and care access continues to improve, KHANA should intensify its focused prevention work with key populations – sex workers and clients, men who have sex with other men (MSM), and drug users, including injecting drug users (IDUs). The ICP program should change the focus of its care work – so that it will no longer have at its core HBC, but instead community-based treatment education, VCT access, PMTCT, and adherence education and counseling. Rather than home visits for palliative care, HCTs should be conducting activities such as regular workshops to increase communities' awareness of and support for treatment, VCT "outreach and information days," and treatment education sessions for PLHA/OVC and their families. Most critically, KHANA, through ICP, should significantly broaden its impact mitigation work – two of the most basic interventions should be increasing household incomes and increasing school enrollment in families affected by AIDS. Rather than having OVC-focused impact mitigation as an adjunct of PLHA-focused HBC, impact mitigation work should be broader and reach many more OVC through increased investment in improving household incomes and school enrollment. These changes will require re-orientation at multiple levels – strategy, program management, and human resource make-up and management.

2 ICP should conduct (or commission) formative research to review experience to date in HIV/AIDS impact mitigation, i.e., reducing poverty-related vulnerabilities to HIV/AIDS, to assess KHANA/ICP's readiness to test new interventions, and to design a small program of support, for initial implementation in, for example, two provinces only. KHANA (and donors) should acknowledge that KHANA itself will need to build expertise in this area. However, some of KHANA's local NGO partners already do have expertise, and should new approaches prove valuable, KHANA has the capacity for immediate scale-up, to generate large results rapidly.

3 ICP should conduct a review of any multi-sectoral approaches that already exist, particularly where a local NGO partner adds donor funds other than KHANA to meet broader expressed needs of PLHA/OVC. These approaches should be documented and shared within KHANA and with its own donors. Should ICP develop one PO as a specialist on multi-sectoral approaches this should be their project and it should be resourced.

♦ **On program content:**

4 ICP should conduct a review of IEC/BCC needs of PLHA/OVC reached, and of existing IEC/BCC materials used by partners. Some IEC/BCC needs would include: treatment education, side effects, adherence, nutrition, hygiene, exercise, positive living, and positive prevention. Should existing materials not be sufficient to meet these needs, ICP should, in cooperation with HCT partners, develop a range of suitable materials. Should ICP develop one PO as a specialist on care and support IEC/BCC this should be their project; it should be resourced. IEC/BCC materials produced should acknowledge and address the reality of mobility in the lives of PLHA.

♦ **On lessons sharing:**

5 ICP should work with the newly-recruited KHANA corporate communications officer to develop corporate materials about ICP, its supporters, beneficiaries, and impacts. These could include, for example, a brochure and a promotional VCD. ICP and the communications officer could work with other agencies, such as national and international media outlets to develop stories on ICP's work. ICP should resource this work. ICP and the communications officer should seek technical assistance and possible funding support from the Alliance's communications unit.

6 ICP should work with the M&E team to develop program lessons learned materials about ICP. This could, for example, be a series of reports generated every six months. The regular monitoring report to GF PR could be the basis of these reports, but their audience will not be a donor but instead a broader national and international professional audience interested in AIDS home and community-based care in Cambodia. Each report could focus on a geographical area within Cambodia or a thematic topic within ICP, for instance, gender, OVC, socio-economic approaches, and so on. ICP should resource this work, which in effect would be a "buy-in" of technical support from the M&E team. Should the M&E team wish to conduct more in-depth studies they should raise resources to support those.

7 More ambitiously, ICP should lead all of KHANA in organizing nationwide lessons-sharing events in community support for treatment and care. For example, in cooperation with NCHADS, NAA, CPN+ and other national stakeholders, KHANA could organize a conference on the role of communities in treatment and care. KHANA could also organize sub-conferences on say, gender and AIDS care, or OVC care and support, or OVC and schools. ICP would need to raise resources, and recruit appropriate staff, to organize such events.

8 ICP should develop and maintain practical international links in home- and community-based care. Having POs specialize in particular areas will facilitate this, as, for example, the OVC specialists will have much to discuss with their international OVC specialist counterparts. The Alliance, for example, has learned many lessons about community mobilization for treatment and care and OVC support; KHANA could both learn from as well as contribute to this knowledge. Organizing conferences will also increase these ties for practical support and visibility.

Conclusion:
No "Business as Usual"

KHANA is widely recognized in the Cambodian, and indeed the international, AIDS response as a successful organization – it has displayed innovation, developed capacity where none before existed, delivered scale-up of programming, and secured sustainability as a local institution with enduring international links. The Integrated Care and Prevention (ICP) program too has displayed the same characteristics as its host organization – indeed, for many years and until now, the home-based care (HBC) program has been routinely described as an "outstanding" practice. One of the themes of this review, however, is that KHANA and ICP should not rest on achievements to date.

ICP has become a large and complex program. In contrast this review process was fairly limited in scope and conducted over a very limited amount of time. In light of this the review process focused down on 3 specific issues – program performance, program management, and program design – and even then could not examine all possible instances and examples to develop evidence in support of its findings and recommendations. Nonetheless, from 3 different issues or angles of approach the findings and recommendations do reinforce one another, and emphasize the need for change within ICP: In the era of reduced prevalence and greater ART access it is time to set aside HBC, and to put in its place intensified focused prevention, continued community support for treatment and care, and a major expansion of impact mitigation work. In moving forward ICP has the opportunity not only to be ever more relevant to the Cambodian AIDS epidemic and the national response, but also to take the rest of KHANA with it, in pursuit of KHANA's ongoing organizational strategic development. It is true that, the larger the program, the harder it is to change direction – but in the case of ICP and KHANA change is not only worthwhile, it is essential.

In leaving aside "business as usual" and developing its new direction for the future, ICP would do well to keep its focus on the lived experience of PLHA/OVC in Cambodia, to keep looking at the Cambodian faces of AIDS. As they change ICP will be able to harness the strength to change too – to make real a time when PLHA/OVC do not die or suffer from AIDS, but claim their rights and opportunities, carry out their roles and responsibilities, participate in and contribute to a better Cambodia.

Annex 1

Review Schedule

Date	Time	Activity	People Met	Documents Consulted
Sun 6 Aug		Arrival of review consultant		
Mon 7 Aug	Am	Introductory meetings	Dr. Kong Sopheap and Dr. Ly Chansophal / ICP TLs	ICP Powerpoint presentation, NSP2, UNAIDS Country profile, HSS 2003 & 2002 reports, ICP Mid-term review, HBC Evaluation
	Pm	Donor meetings	Dr. Sok Bunna / USAID, Dr. Or Vandine / GF PR, Ms. Inga Olesky / GF PR M&E adviser	
Tues 8 Aug	Am	Stakeholder meetings	Dr. Ly Penh Sun / NCHADS, Dr. Teng Kunthy / NAA	
	Pm	Stakeholder meetings	Mr. Heng Sokrithy / CPN+	
Weds 9 Aug	Am	Field visit to WOMEN (Phnom Penh)	WOMEN staff, volunteers, PLHA/OVC in community	
	Pm	Preparation for workshop		
Thurs 10 Aug		Workshop		
	Lunch	Briefing meeting	Dr. Oum Sopheap / KHANA ED	
Fri 11 Aug	Am	Analysis & finalization of step 2 (2nd week) of review		

	Pm	Field visit to Partners in Compassion (Takeo)	Partners staff, volunteers, PLHA/OVC in community	
Sun 13 Aug	Pm	Travel to Kampong Cham		
Mon 14 Aug	Am	Field visit to NAS (Kg Cham)	NAS staff, volunteers, PLHA/OVC in community	
	Pm	Travel back to Phnom Penh		
Tues 15 Aug	Am	Meetings on Performance	ICP TLs, Dr. Leng Kuoy, M&E TL	MOU with GF PR, Workplan, M&E plan, Budget, Procurement plan, KHANA M&E system (Powerpoint presentation), KHANA M&E coverage data (Excel file), KHANA reports to GF PR, KHANA file of correspondence with GF PR
	Pm	Analysis		
Weds 16 Aug	Am	Meetings on Management	ICP TLs, Ms. Hor Many / ICP PO, Ms. Pen Monorom / FAD director	KHANA organogram, ICP job descriptions, KHANA confidential file on grants terminated
	Pm	Analysis		
Thurs 17 Aug	Am	Meetings on Design	ICP TLs, Dr. Aye Thwin / World Food Programme consultant	KHANA “Integrating HIV/AIDS into Community Development” report
	Pm	Analysis		
Fri 18 Aug	Am	Meeting on Design	Mr. Tony Lisle, Board chair (and UNAIDS country coordinator)	
	Pm	Debrief		
Sat 19 Aug		Review consutant departure		

Annex 2

Workshop with Selected Partners

10 August 2006

❖ Agenda

The overall objective of the end-of-project review is to provide recommendations for improvements to ICP (which will in future receive continued support from GF 5 and USAID/PEPFAR). The specific objectives of the review are still under development but they are likely to include investigation of the ICP program's:

- Performance – according to the GF1 workplan, budget, M&E plan, procurement plan, achievements v. targets, and contextual issues,
- Management – use of program, human, financial and administrative resources to achieve objectives; match between program outputs and expenditure; M&E; experience & lessons sharing; financial management; and
- Design – relevance to the epidemic / response; fit within NSP2 & COC; components of & integrated delivery of ICP; moving beyond just HBC to address care & treatment, but also moving beyond HBC as a component of health programming to contribute to broader development & impact mitigation programming; continued & strengthened support to PLWHA/GIPA.

The objective of this workshop is to provide observations and recommendations for the review team to consider (as it goes into more detailed investigation in the later part of the evaluation). Participants are a selection of 6 KHANA ICP partners from 3 provinces. During the overview workshop the participants will be asked to provide their inputs through a series of small group exercises. As a result of the workshop the review team will obtain an overview of the program and decide on a greater focus for later detailed investigation. Hopefully, the participants will also obtain a better understanding of their own and other teams' achievements, challenges and lessons.

❖ Participants

PNH:	KOSHER, SHCH	Team leaders	: 8	Women	: 11
BTM:	SCC, BWAP	Team members	: 10	Men	: 13
KCH:	NAS, KT	PLWHA	: 6		
	4 people / partner NGO				

❖ Schedule

Am

8	Welcome, introductions, workshop agenda
8.30	6 small groups (by partner NGO): discussion on performance
9	3 partner NGO presentations, questions and answers
10	Break
10.15	3 partner NGO presentations, Q&A
11	Break
11.15	3 small groups (by province): discussion on top 3 challenges
12	Break

Pm

2	3 small group presentations on top 3 challenges, Q&A
3	Break
3.15	3 small groups (team leaders, team members, PLWHA): recommendations
	3 small group presentations on recommendations, Q&A
4	Break
4.15	6 small groups (by partner NGO): reflection on lessons
4.30	Adjournment

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