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# Executive summary

In response to the increasing need on HIV and AIDS care and treatment to PLHA, and to fill the gap of response in the NSP II 2006-2010 of the NAA and the strategic plan for HIV/AIDS and STD prevention and care in health sector, Cambodia 2008-2010, CARE International in CAMBODIA received part of global fund grant round 4 within amount of 1,799,736.79 USD under grand number CAM-405-G05-H-CARE1, entitled “**CARE Global Fund Round 4 Continuum of Care project**” for 5 years period from 1st September 2005 to 31st August 2010.

**The goal of the project** was to increase the survival rate of people living with HIV/AIDS in Cambodia.

**The objectives of the project** were to increase the number and percentage of people with advance HIV infection receiving ARV treatment; and to increase access to comprehensive HIV care and treatment.

**The interventions of the project were as following: to** improve the quality and accessibility of care for PLHAs, support a national quality control system for laboratory, monitor and support services for HIV/AIDS care, increase accessibility of PLHAs and their families/caregivers to integrated quality community based health care services; reduce stigma and discrimination of children infected and affected by HIV/AIDS, facilitate the access to health care and treatment for children and caregiver infected and affected by HIV; and to provide social and socio-economic support to orphans and vulnerable children, their families and or extended families.

**The project beneficiaries** were HCP, community members, PLHA and OVC.

After 5-year implementation, project was planned to have a final evaluation to observe the project impact and to use its finding to make decision on policy and strategy on HIV and AIDS care and treatment in the future.

1. **The objectives of the evaluation were:** toassess the knowledge and practice of beneficiaries; to assess the accessibility; to assess the quality of HIV and AIDS care and treatment services; to assess household perceptions on the efficiency of interventions and practices; to assess patients’ behavior change and social encouragement for reducing discrimination; and to use the finding to recommend for future interventions.

1. **The** **methods:** there were a mix quantitative (cross-sectional design) and qualitative method (desk review, in-depth interview and FGD), used for this evaluation. Koh Kong and Banteay Meanchey were selected as evaluation sites. PLHA, HCP, counselor, manager and team leader were a survey group. The total sample size required by the HH survey was 327 samples (PLHAs) and 74 samples were required for qualitative survey. The SRS was used for HH survey while convenient and purposive sampling was used for qualitative survey.
2. **The finding and conclusion**

Project was designed and developed based on and aligned to the country priority set in the NSP II (2002-2010) of NAA and “Strategic plan for HIV/AIDS and STD prevention and care in health sector, Cambodia 2008-2010” of MoH.

The project was designed to provide PHD and its networks at the sub-national level for example the OD, OI and ART clinic team, the CoC team to own and to lead the work plan development, the implementation, the coordination, the monitoring etc that sustainability could be ensured after the project ended.

The CARE International did play an appropriate role as international NGO to contribute to the gap set by the government through both technical and financial support to the existing public system.

The project had strong monitoring and evaluation system to capture all data from the project implementation that could be used to generate information for project progress report regularly as required by PR/MoH and GF.

The project did improve the general health status of PLHA (97%) through increasing knowledge on health care and especially on HIV and AIDS health care, accessing to HIV and AIDS health care services and other HIV and AIDS related services and to MMM where they could be encouraged and motivated to share their positive experience. As concrete evidence 92% of respondents felt confident to take care of their HIV and AIDS status and 69% did informed about their CD4 count increased.

The impact on general health status of PLHA was resulted by the quality of the clinician and other health care providers at the HIV and AIDS clinic, the counsellor and the HBC team. This information did show clearly the effectiveness of the continuum of care strategy of MoH.

The project did increase capacity of local staff and community members who were responsible for HIV and AIDS care and treatment through several training from national down to provincial and to on-site level.

The project did change HCP for HIV and AIDS care and treatment to become a professional who could provide qualified education, counselling etc to ensure compliance and adherence.

The project did improve the quality of care and treatment of PLHA to receive clear, appropriate and well understood message on drug compliance and adherence through education and counselling from dispenser**.**

Finally, the project was concluded as a success project due to:

* All activities planned were totally implemented
* All output targeted indicators (25 indicators) were achieved. Out of those achieved targeted indicators, 17 targeted indicators were overachieved (see more in the annex 1)
* All outcome targeted indicators were overachieved.
* As target, 2,942 of people with advanced HIV infection received antiretroviral therapy at CARE-supported sites by the end of the project but as monitoring report, 2,827 PLHA were accessed to ART therefore it achieve 96% of the target. Confirmed by the HH survey, 91% of contacted ART were under active ART.
* As target, 2,585 of active clients at CARE-supported OI/ART service who received OI and/or ART care at the end of reporting period (Non Cumulative-current) but observing from monitoring report, 2,944 of active clients received OI/ART services. Therefore it achieved 13% over the target. Confirmed by the evaluation, all contacted respondents were accessed to OI and/or ART services.
* The impact targeted indicator was achieved while 86% of individual still on ART at 12 months after initiating HAART based on monitoring report. Confirmed by the HH survey, 73% of the respondents were under active ART for more than a year.

1. **The recommendation**

With enough evidence found in this evaluation, the project implementers and the government partners should first adopt these achievements as the lesson-learnt or the best practice that could be used to scale-up to other CoC sites in Cambodia and could be shared at national and international meeting or conference.

Learning from this evaluation, some practical recommendations are highlighted as following to better filling the gap of this project implementation:

* 1. **The knowledge on health and HIV and AIDS care**

Based on finding from this evaluation, majority of PLHA get health knowledge from HCP and community educator, therefore regular refresher training for HCP and community educator should be provided on regular basis to update health information as well as appropriate health service delivery and more time should be allocated for HCP to provide health education or counselling to PLHA.

The VCCT should be scaled up to meet the need of high-risk people who could get as earlier as possible the information on their HIV status. Moreover, VCCT is the entry point of receiving comprehensive knowledge on HIV and AIDS care.

Media production through TV and radio are the most popular and interested by the PLHA therefore to raise health and HIV and AIDS knowledge to PLHA, IEC material production through TV and radio should be adopted.

* 1. **The practice on health and HIV and AIDS care**

Providing support on transportation fee seen as significant impact to increase PLHA accessing to HIV and AIDS care and treatment service while majority of them are poor that could not afford transportation fee.

The free of charge policy on HIV and AIDS care and treatment and the friendly behaviour in welcoming, consulting, counselling etc by HCP are contributing factors in practice to improve people accessing to HIV and AIDS care and treatment services. Therefore the positive behaviour and attitude of HCP should be maintained, improved and sustained. In addition the positive behaviour and attitude of HCP also seen as positive impact on reducing discrimination and stigmatization to PLHA.

In strengthening and improving the ARV compliance and adherence among PLHA, educate and counsel the PLHA themselves, their spouses and their family members were the most interested and popular.

The compliance and adherence on complementary exam (chest X-ray) and lab test (CD4 test, sputum screening) should be improved to meet the SOP and to meet the appointment.

MMM and self-help group should be expanded and sustained because it is very important to encourage and motivate PLHA to live in positive life and to reduce stigmatization and discrimination.

* 1. **The commodity**

PHD, OD, OIs and ART clinic, OIs and ARV pharmacist and dispenser should work closely with the procurement unit of NCHADS to ensure that the supply of all commodities is not out of stock or in close expiry date.

* 1. **The sustainability**

As the project is implemented within the existing public system, improve infrastructure, build public HCP capacity, equip material and system for HIV and AIDS care, and owned by the local health authority, the sustainability in general is not a question but some key activities inside and outside the public system should be considered after the project ended:

* The community activities such as self-help group networking, outreach activity of community educator, the capacity building, community visit or supervision etc
* The ad-hoc supplies to CoC such as OI drug, ARV, medical equipment and materials etc
* The regular refresher training, coordinating meeting etc

Anyway, all of the above concerns are taken over by RACHA in Koh Kong site while NCHADS and CPN+ will be considered to take over in Bnateay Meanchey site.

1. **The best practice**

Due to the finding and lesson learnt gained from the monitoring and evaluation system for this particular project, it provide enough scientific evidenced base to document a best practice that could be use as a standard model for in-country scaling up or other countries in the region or in the world for initiating such important project.

* 1. Project is well designed under sustainable strategy
  + To provide government ownership
  + To align with the national strategy, policy, SOP etc.
  + To support existing public service delivery system.
  + To harmonize with other stakeholders.
  1. The project is well equipped with comprehensive package that fit to local conditions to strengthen HIV and AIDS care and treatment.
  + Improve infrastructure to an acceptable level.
  + Improve medical equipment and material to a standard level based on SOP.
  + Improve human capacity to a professional level based on SOP.
  + Improve operation (management, coordination, supervision, monitoring, and

evaluation) to a well coordinated level.

1. CARE International in Cambodia plays and respects its role as international NGO mandate to fill the gap of public service without creating any parallel or competing system with public system
2. Project is flexible enough to reprogram the activities and to reallocate the funding to fit the change of the local situation as well as the beneficiary informed by the progress report.
3. Project is lead and managed by strong, capable and experience CARE International who could harmonize and coordinate well among development partners involving in project management, implementation, monitoring and evaluation.
4. The capacity building is provided as a package to expose trainee to the theory then practice and finally to share knowledge, skill and experience with continuing support through on-the job training, meeting etc. All trainings are conducted with a standard curriculum.
5. The project is implemented based on the work plan under supervision (with clear checklist) to regular improve the project performance and monitoring (with clear system and data collecting form) to improve the project implementation.
6. The project is designed to have well plan for final evaluation.

# Acknowledgement

# First of all, the evaluation team would like to express our great thank to Care International management team, in particular to Mr. Bill Pennington, the Program Director, and Dr Srey Vantuon, project manager who provided all information needed for the evaluation as well as all the administrative arrangements and supports to the whole process of the evaluation.

# Our special gratitude made to all members of the HIV and AIDS care and treatment team of PHD, OD, OI and ART team for their time to provide important and necessary information to enrich this evaluation report.

# We never forget to appreciate and thank all the participants (PLHA) who were active to provide all reliable and accurate data in the field that could assist our team to generate such data into evaluation information successfully.

# By the way, our appreciation to all evaluation team members who actively designed, collected, edited, cleaned, entered, and analysed data into information under technical support from Dr Hor Bun Leng, technical advisor to this evaluation.

# Finally, the financial support from the GF R4, without its support this evaluation could not be happened to generate invaluable information used for further improvement of the next project, strategy and policy for HIV and AIDS care and treatment in the future.

# Acronym & Abbreviation

# AEM Asian Epidemic Model

# AIDS Acquired Immune-Deficiency Syndrome

# ART Anti-Retro viral Treatment

# ARV Anti-Retro Virus

# CAM Cambodia

# CoC Continuum of Care

# CPN+ Cambodian People living with HIV Network

# DU Drug User

# GF Global Fund

# FGD Focus Group Discussion

# FEFO First expired first out

# HAART Highly Active Anti-Retrovirus Treatment

# HBC Home Based Care

# HC Health Center

# HCP Health Care Provider

# HH Household

# ICRC International Committee for Red Cross

# IEC Information, Education and Communication

# GF Global Fund

# GF R4 Global Fund Round 4

# HIV Human Immuno-deficiency Virus

# LMIS Logistics Monitoring Information System

# M.D Medical Doctor

# M&E Monitoring and Evaluation

# MMM Mundul Mith Chouy Mith (Friend help friend)

# MoH Ministry of Health

# M.Sc Master of Science

# MSM Men have Sex with Men

# NAA National AIDS Authority

# NAP National AIDS Program

# NBTC National Blood Transfusion Center

# NCHADS National Centre for HIV/AIDS, Dermatology and STD

NGO Non-Governmental organization

NIPH National Institute of Public Health

NSP National Strategic Plan

OD Operational District

OI Opportunistic Infection

OVC Orphan Vulnerable Children

PLHA People Living with HIV and AIDS

PMTCT Prevent Mother To Child Transmission

PR Principle Recipient

PSU Primary Sampling Unit

QO Quarterly Order

RACHA Reproductive and Child Health Alliance

SRS Simple Random Sampling

SSF Single Stream Funding.

SOP Standard Operating Procedure

SR Sub-recipient

STD Sexually Transmitted Disease

STI Sexually Transmitted Infection

ToR Term of Reference

TV Television

TWG Technical Working Group

USD US Dollar

VCCT Voluntary Counseling and Confidential Testing

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# I. Introduction

1. **The HIV and AIDS status**

Under the HIV test kit support from ICRC to national blood transfusion center (NBTC) of ministry of health (MoH), the first HIV was officially announced in mid-1991 through screening from the blood donor. In 1993, two years after learning about the HIV, the first AIDS case was officially recorded through a patient diagnosed Calmet hospital in Phnom Penh municipality.

Since then the HIV spread in a form of increasing dramatically trend to reach the epidemic peak in 1998 when the HIV prevalence among general population aged 15-49 years old was 2%. Then the trend of HIV prevalence has been decreased gradually to 7% by 2010 based on the projection using HSS data in 2006 and Asian Epidemic Model (AEM).

**Figure 1: The projection of HIV prevalence among general population aged 15-49 years old from 2006-2012 (If ARV is available)**

Source: NCHADS

1. **The continuum of care for HIV and AIDS**

After the first AIDS was diagnosed in Calmete hospital in 1993 at the general medicine services, the OI care and treatment for PLHA was introduced followed by the opening of the anti-retroviral treatment (ART) service in 1997 in Khmer-Soviet friendship hospital with a rapid scale up then based on the increasing need of the PLHA.

To ensure the comprehensive response to care and treat PLHA and to ensure the compliance and adherence to ART, the first HIV and AIDS triangle care was introduced in Cambodia in 2000 by MoH, highlighting the linkage between institutional care (hospital care), home and community based care and self-help group.

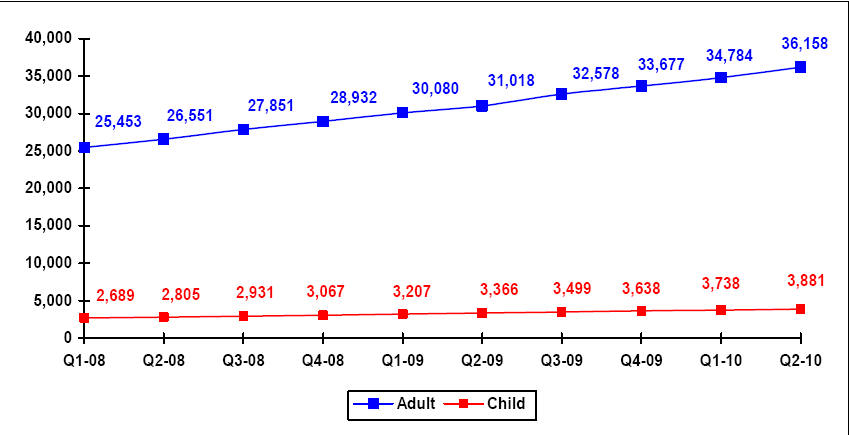
In 2005, the HIV and AIDS triangle care strategy was revised and named as the continuum of care (CoC) focusing on VCCT, hospital care, and home and community care. Under CoC, so far, there were 51 health facilities providing OI care and ART services in 20 provinces supported by the government and NGOs sectors by quarter two in 2010. Out of these 51 sites, 27 do provide care and treatment to children living with HIV/AIDS.

**Figure 2: The trend number of care service and number of PLWHA receiving ARV**

Source: NCHADS

By the end of quarter 2, 2010 there were 40,039 active patients receiving ART. Among these patients 36,158 were adults and 3,881 were children.

**Figure 3: The trend number of adult & children patients receiving ARV from 2007-2009**

Source: NCHADS

Comparing with 35,100 adult living with HIV and AIDS who are in need of ART in 2009, generated by the AEM, the CoC program could achieve up to 100% of the total need.

**Figure 4: The projection of PLWHA aged more than 15 years old who need ARV by year from 2006-2012**

Source: NCHADS

1. **CARE International**

CARE international Cambodia is an international non-governmental organization (NGO) worked in Cambodia since 1973 to provide food relief, medical and educational assistance till 1975 when Khmer Rouge took power and NGO was not allowed to operate in Cambodia. In 1990, CARE returned back to Cambodia, assisting the United Nations repatriate 370,000 Khmer refugees from camps along the Thai border and providing humanitarian assistance. CARE international Cambodia has been one of the first NGO to start working on HIV prevention as early as 1992 by providing HIV prevention intervention to high-risk group such as sex workers, garment factory, fisherman etc.

For this particular project, CARE International Cambodia received funding from the Global Fund Round 4 under “CARE Global Fund Round 4 Continuum of Care Project” to work in partnership with NCHADS, PHD, OD, OI/ART clinic to increase the survival rate of people living with HIV and AIDS in Cambodia.

Under this project, CARE International Cambodia was responsible to collaborate with partners to provide technical and financial support to expand continuum of care service delivery, to improve quality of HIV and AIDS care and treatment and to reduce discrimination and stigmatization toward PLHA.

II. About the project

In response to the increasing need on HIV and AIDS care and treatment to PLHA, and to fill the gap of response in the NSP II 2006-2010 of the NAA and the strategic plan for HIV/AIDS and STD prevention and care in health sector, Cambodia 2008-2010, the expansion and quality improvement of the continuum of care have been the most need.

Under GF R4 support to Cambodia, CARE International in Cambodia received part of global fund grant round 4 within amount of 1,799,736.79 USD under the grand number CAM-405-G05-H-CARE1, entitled “**CARE Global Fund Round 4 Continuum of Care project**” for 5 years period from 1st September 2005 to 31st August 2010.

1. **The goal and objectives**
   1. **The goal of the project** was to increase the survival rate of people living with HIV/AIDS in Cambodia.
   2. **The objectives of the project** were:

* To increase the number and percentage of people with advance infection receiving ARV treatment; and
* To increase access to comprehensive HIV care.

1. **Key project interventions:**

The interventions of the project were as following:

* Improve the quality and accessibility of care for PLHAs through consolidating and extending health facility based care services in selected areas;
* Support a national quality control system for laboratory, monitoring and support services for HIV/AIDS care, including monitoring through the NIPH-National Laboratory;
* Increase accessibility of PLHAs and their families/caregivers to integrated quality community based health care services;
* Reduce the stigma and the discrimination of children infected and affected by HIV/AIDS by provide psychosocial support to PLHAs;
* Facilitate the access to health care and treatment for children and caregiver infected and affected by HIV;
* Provide social and socio-economic support to orphans and vulnerable children, their families and or extended families;
* Provide support and implement quality management systems into the blood system conduct by implement government partner;
* Contribute to the reduction of blood donors with HIV;
* Create an enabling environment for the prevention of sexual transmission with a focus on couple, pre-marriage, and positive prevention through community base approaches;
* Provide targeted sexual transmitted infected (STI) services for population in high risk situations;
* Provide STI/HIV education through peer education support for populations in high risk situations; and
* Promote the referral to HIV counseling, testing and care for populations in high risk situations.

1. **The project beneficiaries**

* Implementation government partner at provincial and OD and HC level;
* 101 PLHAs counselors and PLHA educators as co-implementation voluntary partners in the project.
* 2.585 PLHA as direct target beneficiaries.

1. **The indicators set for the project were** as following:
   1. **The impact indicators**

* Percentage of individuals who are still on ARV at 12 months after initiating HAART (Non Cumulative %)
  1. **The outcome indicators**
* Number and percentage of people with advance HIV infection receiving ART treatment
* % of PLHA access to comprehensive HIV care.
  1. **The output indicators**
* Number of ODs with at least one site providing ARV among 4 CARE target ODs (Cumulative)
* Number of government facilities providing ARV among 4 CARE target ODs (Cumulative)
* Number of provincial ODs with at least one MMM among 4 CARE target ODs (Cumulative)
* Number of MMM established and operating in four CARE target ODs (Cumulative)
* Number of PLHA attending support group meetings at MMM at CARE-supported facilities (Non Cumulative)
* Percentage of female among all PLHA attending support group meetings at MMM at CARE-supported facilities (Non Cumulative %)
* Number of people with advanced infection newly initiated on antiretroviral therapy at CARE-supported sites during the reporting period (New clients) (Non Cumulative)
* Number of people with advanced infection receiving antiretroviral combination therapy at CARE-supported sites at the end of this reporting period (Current clients) (Non Cumulative-current)
* Number of people with advanced infection who are receiving antiretroviral combination therapy at CARE-supported sites at the end of the reporting period (Cumulative clients)
* Percentage of women among PLHA receiving ARV at CARE supported sites (Non Cumulative)
* Number of clinicians who received clinical mentoring by an experienced HIV physician for at least 2 month (Cumulative)
* Number of nurse counselors trained to provide ARV/ adherence counseling (Cumulative)
* Number of PLHA counselors trained to provide ARV and adherence counseling (Cumulative)
* Number of PLHA trained to provide ARV and adherence education (Cumulative)
* Number of pharmacists trained to support HAART (Cumulative)
* Number of lab technicians trained to support HAART (Cumulative)
* Number of health worker's participation in trainings (including initial and refresher training) (Cumulative)
* Number of PLHA's participation in trainings (including initial and refresher training) (Cumulative)
* Number of provincial ODs with at least one health care service providing cotrimoxazole prophylaxis among three CARE target ODs (Cumulative)
* Number of CARE-supported facilities providing cotrimoxazole prophylaxis (Cumulative)
* Number of PLHA (stage II-IV) receiving cotrimoxazole prophylaxis at CARE-supported facilities (Non Cumulative-current)
* Number of active clients at CARE-supported OI/ART service who not yet started ART at the end of the reporting period (Non Cumulative-current)
* Number of active clients at CARE-supported OI/ART service who receive OI and/or ART care at the end of reporting period (Non Cumulative-current)
* Number of OI and ART consultations in each quarter

III. The methodology

1. **The goals**

To conduct final evaluate of the five-years project “CARE’s Care and Treatment Project at Koh Kong and Banteay Meanchey provinces from 1st September 2005 - 31st August 2010” under financial support from the global fund R4 that its finding could be used to improve strategy, policy and guideline and interventions in the future project.

1. **The objectives**
   1. Assess the knowledge and practice of beneficiaries related to HIV and AIDS care and treatment.
   2. Assess the accessibility to HIV and AIDS care and treatment services by the beneficiaries.
   3. Assess the quality of HIV and AIDS care and treatment services provided to the beneficiaries.
   4. Assess household perceptions on the efficiency of interventions and practices.
   5. Assess patients’ behavior change and social encouragement for reducing discrimination.
   6. Using the finding to recommend for future interventions.

1. **The** **methods**
   1. Design: There were a mix quantitative (cross-sectional design) and qualitative method (desk review and FGD), used for this evaluation.
   2. Site: Two project implementing sites (Koh Kong and Banteay Meanchey) were selected for evaluation. In Koh Kong province, OI/ART clinics in Smach Mean Chey and Sre Ambel districts were selected as site for evaluation while Poi Pet and Mong Kul Borei districts were selected in Banteay Meanchey Province.
   3. Survey group:

* For the HH survey PLHA was a survey group.
* For the qualitative survey there were different survey group
  + For FGD: HCP (clinician and nurse) and counselor
  + For in-depth interview: Manager and team leader of the project at the national and sub-national level.
  1. Sample size:
* For HH survey

GFR4 targeted a total of four operational districts (OD) in Cambodia. A selection of a representative sample of households belonging to the targeted areas proposed, and the beneficiaries of the project determined as the population selected for the HH survey.

Table 1: the distribution of project beneficiaries by sites

|  |  |  |  |
| --- | --- | --- | --- |
| No. | Operational Districts | Beneficiaries (OI and ART) | |
| Number | Percentage (%) |
| 1. | Smach Meanchey | 581 | 19.74 |
| 2. | Srea Ambil | 268 | 9.11 |
| 3. | Bantey Meanchey | 765 | 25.99 |
| 4. | Poi Pet | 1329 | 45.16 |
| Total | | 2,943 | 100% |

Table 2 : The number of sample size required for household survey by sites

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No. | Operational Districts | PSU | # of selected respondents | Percentage (%) |
| 1. | Smach Meanchey | PSU1 | 147 | 44.95 |
| 2. | Srea Ambil |
| 3. | Bantey Mean Chey | PSU2 | 180 | 55.05 |
| 4. | Poy Pet |
| Total | |  | 327 | 100% |

All implementing operational districts in each province were merged into 1 groups (therefore 2 Primary Sampling Unit were created) based on the target provinces (Koh Kong and Banteay Meanchey) for sample size computation. Using a sampling method based on 95% confident level, a 5% of margin of error, and 85% of data distribution, the total sample size required by this evaluation survey was 327 samples (PLHAs), 147 samples from Koh Kong site and 180 samples from Banteay Meanchey. Communes and individuals were selected randomly from the target areas.

* For FGD with stakeholders

3 types of FGDs were conducted in each OD with different types of stakeholders. Therefore the total numbers of FGDs in all target areas were 12 FGDs. Each OD was planned to conduct FGD as following:

* 1 FGD with health care provider: there were 6-8 participants for this FGD with variety of job status, clinician, nurses, and PLHA counselors,
* 1 FGD with PLHA leaders (counselors): There were 6 counselors planned for FGD.
* 1 FGD with beneficiaries (PLHA): there were 6-8 beneficiaries planned for FGD.
* For key informant interviews:

At least one representative from a hospital management team in each OD was selected to be interviewed.

Totally, there were 68 samples participated in the qualitative method divided into:

* 6 project management team
* 17 pharmacists
* 17 dispensers and
* 34 PLHA
  1. Sampling: There were four different methods used to select the samples:
* Site selection: the stratified sampling method was used to select 17 sites out of 41 implementing sites based on the 3 different periods of support (the early project support, the middle project support and the nearly end project support).
* Sample selection
* For sites that had only one person who play double role as pharmacy and dispensary management, he/she had to be selected automatically
* For sites that had both pharmacist and dispenser, they were both selected automatically
* For site that had more than two, the simple random sampling was used
* For PLHA, convenient sampling was used
* For the project management team, the purposive sampling was used.
  1. Instrument: There were several tools used as evaluation instruments:
* The project proposal of GF R4
* The CoC
* The SOP
* The project report
* The unstructured-questionnaire was designed and used for face to face in-depth interview and FGD
* The structured-questionnaire was designed and used for face to face interview survey.
  1. Preparation: There were several activities prepared, the questionnaire development, the data collection plan, the training for interviewer and supervisor, the administrative arrangement for data collection in the field.

**Study Team Structure:**

PCMT team, GF PM and GF PO

Team4

- 1 Field supervisor

- 5 Data collections

Team3

- 1 Field supervisor

- 5 Data collections

Team2

- 1 Field supervisor

- 5 Data collections

Team1

- 1 Field supervisor

- 5 Data collections

The research team members were recruited from the current CARE interns as well as from other CARE project staff voluntarily seconded from other projects.

* 1. Data collection: 20 skillful and experience interviewers and 4 supervisors were recruited to do in-depth interview and FGD.

The female and male interviewers were paired in mixed gender teams of 4. Each team followed the agenda on data collection in the field. The time required for data collection depended on the accessibility of the site itself, the availability of samples that fit the criteria. The actual interview took approximately 45-50 minutes.

The important part of their jobs was to ensure that each interview was informed consent and confidential with no curious onlookers or ‘eavesdroppers’ nearby to disturb the process.

Each day during data collection, the interviewer reviewed the questionnaires carefully. In case that a questionnaire had incomplete or missing data, interviewers had to go back to the respondents to complete the interview before leaving the survey site. Data collection was taken place over a 2 week period. Tape recorder is requested to use during the in-depth interview.

* 1. Data analysis:
* For quantitative data, descriptive analysis was made through frequency distribution.
* For qualitative data, team met to debrief, discuss and transcribe field notes from the interview including tape recorder each afternoon and evening. This was done as soon as possible after the fieldwork so that the data was still fresh and conversation details easily recalled. Summary was compiled for each site before moving to the next site. The team leader was responsible for typing, compiling and analyzing the qualitative data. Analysis was conducted based on a mapping plan for effectively sorting, categorizing and classifying raw data into units of analysis as well as changing information from narrative form into a concrete filing system.

IV. The finding

1. **The participation**

There were totally 357 respondents participated in the survey and it distributed well among both sites in Koh Kong (44.82%) and Banteay Meanchey (55.18%). The observed sample size (357) was achieved about 9% over the proposed sample size (327).

Regarding sex, female respondents (61.62%) were captured more than male (38.38%) but it distributed well among both sites.

Most of female contacted for interview and FGD, they got HIV from their husbands and they learn that they were infected when their husband got sick or when they got sick. Because they were infected they rarely got the job away home.

**Table 3: the distribution of respondents by sex and sites**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **No** | **Site** | **Sex** | | | | | |
| **Male** | | **Female** | | **Total** | |
| **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **01** | **Koh Kog** | **56** | **43.75** | **104** | **47.27** | **160** | **44.82** |
| **02** | **Banteay Meanchey** | **72** | **56.25** | **125** | **52.73** | **197** | **55.18** |
| **Total** | | **128** | **100** | **220** | **100** | **357** | **100** |

1. **The general information**
   1. **The age**

In majority, the respondents were in more than 35-50 years old group (56%) and followed by more than 25-35 years old group (31%). Anyway, the survey also captured small proportion of age group less than and equal 25 years old (2%) and more than 50 years old (11%). Anyway, there was a notice that the age category was well distribution among both sites.

**Table 4: the age distribution among respondents by sites**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No** | **Site** | **Age** | | | | |
| **≤ 25** | **>25-35** | **>35-50** | **>50** | **Total** |
| **01** | **Koh Kog** | **2%** | **33%** | **57%** | **9%** | **100%** |
| **02** | **Banteay Meanchey** | **2%** | **30%** | **55%** | **13** | **100%** |
| **Total** | | **2%** | **31%** | **56%** | **11%** | **100%** |

* 1. **The marital status**

Most of respondents captured in this survey were married (96%) with small proportion of single status (4%). For more detail information, 27% and 3% of the total samples were divorced and separated respectively.

**Table 5: the marital status distribution among the respondents by sites**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No** | **Site** | **Marital status** | | | | |
| **Single** | **Married** | **Divorced** | **Separated** | **Total** |
| **01** | **Koh Kog** | **5%** | **59%** | **33%** | **3%** | **100%** |
| **02** | **Banteay Meanchey** | **3%** | **53%** | **40%** | **4%** | **100%** |
| **Total** | | **4%** | **56%** | **27%** | **3%** | **100%** |

* 1. **The family members**

When asking about the size of family members, in average there are five members with the minimum size of ????? and maximum size of ?????. Further asking about the dependency of their family members, in average there was two with the minimum size of ????? and maximum size of ?????.

* 1. **The children**

When asking about the size of children in the family, in average there are two children with the minimum size of ????? and maximum size of ?????.

* 1. **The education**

For general education, about 60% of the respondents were at primary level with decreasing proportion to reach higher level; 10% at junior secondary level; 4% at senior secondary level and only 1% at university.

Information gained from in-depth interview and FGD, female respondents were less likely to get access to education and the most they could reach the primary level.

**Table 6: the distribution of educational status among the respondents by sites**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No** | **Site** | **Marital status** | | | | |
| **None** | **1-6** | **7-9** | **9-12** | **>12** |
| **01** | **Koh Kog** | **34%** | **57%** | **6%** | **4%** | **0%** |
| **02** | **Banteay Meanchey** | **21%** | **60%** | **13%** | **5%** | **1%** |
| **Total** | | **27%** | **58%** | **10%** | **4%** | **1%** |

* 1. **The family’s job**

**Table 7: the distribution of family job status among the respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Family’s job status | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Labor seller | 23% | 55% | 41% |
| 02 | Rice farmer | 11 % | 35 % | 24 % |
| 03 | Vegetable farmer | 12 % | 4 % | 8 % |
| 04 | Seller | 20 % | 20 % | 20 % |
| 05 | Moto-taxi driver | 20 % | 17 % | 18 % |
| 06 | Civil servant | 5 % | 9 % | 7 % |
| 07 | Fishery | 4 % | 7 % | 6 % |
| 08 | Construction worker | 22 % | 5 % | 12 % |
| 09 | Animal raising | 31 % | 10 % | 19 % |
| 10 | House wife | 6 % | 15 % | 11 % |
| 11 | Private company/NGOs | 2% | 3% | 3% |
| 12 | Others | 12 % | 5 % | 8 % |

There were varieties of professional and non-professional job carried by respondents ‘families. The highest proportion was labor seller (41%), followed by rice farmer (24%), small bussiness seller (20%), animal raiser (19%), moto-taxi driver (18%), construction worker (12%), and house wife (11%). The finding clearly informed us that they had in fact not only one job.

* 1. **The respondent’s job**

There were also varieties of professional and non-professional job carried by respondents. The highest proportion was labor seller (28%), animal raising (20%), followed by rice farmer (18%) and seller (13%), In general, nearly all of them were non professional.

**Table 8: the distribution of job status among the respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Respondent’s job status | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Labor seller | 17% | 37% | 28% |
| 02 | Rice farmer | 11 % | 24 % | 18 % |
| 03 | Vegetable farmer | 11 % | 3 % | 6 % |
| 04 | Seller | 13 % | 14 % | 13 % |
| 05 | Moto-taxi driver | 6 % | 8 % | 7 % |
| 06 | Civil servant | 3 % | 4 % | 4 % |
| 07 | Fishery | 3 % | 4 % | 3 % |
| 08 | Construction worker | 10 % | 2 % | 5 % |
| 09 | Animal raising | 29 % | 13 % | 20 % |
| 10 | House wife | 6 % | 8 % | 7 % |
| 11 | Private company/NGO | 2% | 2% | 2% |
| 11 | Others | 13 % | 4 % | 8 % |

* 1. **The family property and accessibility**

The findings showed clearly the proportion of family who could access to service as family need. For instance, 58% of them could access to mobile phone connection, 46% to electricity, 14% to cooking gas, 37% to TV, 17 to radio etc.

Regarding the property, 58% of them owned mobile phone, 37% owned bicycle, 25% owned motorcycle, etc. By the way, there were other properties such as boat, DVD player, generator, battery etc

**Table 9: the distribution of family property and accessibility by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Family property and accessibility | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Electricity | 47 % | 45 % | 46 % |
| 02 | Mattress | 15 % | 7 % | 10 % |
| 03 | Gas cooker | 14 % | 15 % | 14 % |
| 04 | Wooden chair | 13 % | 8 % | 10 % |
| 05 | Plastic chair | 12 % | 22 % | 18 % |
| 06 | Bed | 55 % | 52 % | 53 % |
| 07 | Table | 33 % | 19 % | 25 % |
| 08 | Electric fan | 20 % | 20 % | 20 % |
| 09 | Radio | 18 % | 16 % | 17 % |
| 10 | Black and white TV | 9 % | 8 % | 8 % |
| 11 | Colour TV | 38 % | 36 % | 37 % |
| 12 | Mobile phone | 49 % | 66 % | 58 % |
| 13 | Other phone | 2 % | 2 % | 2 % |
| 14 | Sewing machine | 1 % | 8 % | 5 % |
| 15 | Wall clock | 19 % | 23 % | 21 % |
| 16 | Bicycle | 26 % | 45 % | 37 % |
| 17 | Motorcycle | 20 % | 30 % | 25 % |
| 18 | Plowing machine |  | 3 % | 2 % |
| 19 | Water pump machine | 1 % | 5 % | 3 % |
| 20 | Others | 16 % | 34 % | 26 % |

* 1. **The length accessing to OI and ART**

Based on table 10, about 60% of the respondents have accessed to OI and ART services for more than 1 to 5 years. About 18% has just accessed to service less than a year and the same proportion seen among respondents (17%) who have accessed to services more than five year to seven years. Anyway, there is small proportion of respondents (5%) who have accessed to services more than seven years.

In average, respondents have been 4 years accessing to OI and ART services with 2 years as standard deviation. The minimum year was 0 and 15 years was maximum.

**Table 10: the distribution of length accessing to OI and ART by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Length (year) accessing to OI and ART service | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | ≤1 | 20 % | 17 % | 18 % |
| 02 | >1-3 | 28 % | 32 % | 30 % |
| 03 | >3-5 | 31 % | 30 % | 30 % |
| 04 | >5-7 | 18 % | 16 % | 17 % |
| 05 | >7-9 | 1 % | 2 % | 2 % |
| 06 | >9-11 | 2 % | 2 % | 2 % |
| 07 | >11 |  | 1 % | 1 % |
|  | Total | 100% | 100% | 100% |

* 1. **The active ART**

The information on active ART among respondents gained from this survey shown that almost all of them are under active ART.

In average, respondents have been 3 years under active ART services with 2 years as standard deviation. The minimum year under active ART was 0 and 11 years was maximum.

**Table 11: the proportion of respondents who were under active ART by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | The active ART | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Yes | 89 % | 92 % | 91 % |
| 02 | No | 11 % | 8 % | 9 % |
| Total | | 100% | 100 % | 100 % |

* 1. **The length under active ART**

The finding on the length of being under active ART, 26% of them under or equal one year, 30% are more than one to three years, 32% are more than three to five years, 11% are more than five to seven years and there is small proportion (1%) who are more than seven years.

**Table 12: the distribution of length under active ART among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Length (year) under ART | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | ≤1 | 24 % | 27 % | 26 % |
| 02 | >1-3 | 27 % | 31 % | 30 % |
| 03 | >3-5 | 39 % | 27 % | 32 % |
| 04 | >5-7 | 9 % | 12 % | 11 % |
| 05 | >7-9 | 1 % | 1 % | 1 % |
| 06 | >9-11 |  | 1 % | 0 % |
| 07 | >11 |  | 1 % | 0 % |
|  | Total | 100% | 100% | 100% |

* 1. **The ART choices**

For further detail understanding on the ART choices among respondents under active ART, 32% of them said they are under first choice, 13% under second choice and 2% under third choice. Anyway, there was high proportion of respondents (53%) who did not know their ART choice.

**Table 13: the distribution of ART choices among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | ART choices | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | 1st choice | 50 % | 19 % | 32 % |
| 02 | 2nd choice | 18 % | 8 % | 13 % |
| 03 | 3rd choice | 4 % | 0% | 2 % |
| 04 | Don’t know | 28 % | 73 % | 53 % |
| Total | | 100% | 100% | 100% |

🖝 We never known that what ART choice we got, it depended on the prescription made by clinician and we never heard about it from HCP.

🖝 Information from key informant confirmed that most of PLHA (>90%) are under the first choice of ART.

1. **The knowledge and practice on HIV and AIDS care**

In assessing knowledge and practice on HIV and AIDS care among respondents several questions with multiple choices and yes/no answer was used as following:

**3.1. The knowledge on health care meaning**

When asking about the meaning of health care, 67% of them selecting answer as improving health, protecting disease (37%), being away from disease (25%), caring about health (7%), and curing disease (4%).

**Table 14: the distribution of knowledge on the meaning of prevention among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Meaning of prevention** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Protect disease | 43 % | 32 % | 37 % |
| 02 | Cure disease | 6 % | 2 % | 4 % |
| 03 | Avoid disease | 23 % | 26 % | 25 % |
| 04 | Improve health | 60 % | 73 % | 67 % |
| 05 | Live healthier and long life | 4% | 5% | 4% |
| 06 | Care about health (hygiene and sanitation | 2 % | 12 % | 7 % |

**3.2. The knowledge on how important of prevention and treatment**

In majority, respondents (81%) strongly recognized that prevention was more important than treatment.

🖝 For me in our situation now, I think that both were important because it was hard for us to prevent the disease.

**Table 15: the distribution of knowledge on how important of prevention and treatment among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Important of prevention and treatment** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Prevention | 73 % | 88 % | 81 % |
| 02 | Treatment | 27 % | 12 % | 19 % |
| Total | | 100% | 100% | 100% |

**3.3. The knowledge on OI meaning**

Answering to question on OI meaning, 59% of respondents selected as disease of weaken immune, disease screened before ART (21%), disease of PLHA (6%) and disease included with ART (1%). In addition, there were other meanings expressed by the respondents as diarrhea, skin, TB diseases etc.

**Table 16: the distribution of knowledge on OI meaning among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Meaning of OI** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Disease screened before ART | 22 % | 20 % | 21 % |
| 02 | Disease included with ART | 2 % | 1 % | 1 % |
| 03 | Disease of PLHA | 9 % | 4 % | 6 % |
| 04 | Disease of weaken immune | 59 % | 59 % | 59 % |
| 05 | Don’t know | 11 % | 8 % | 9 % |
| 06 | Other | 8% | 25% | 18% |

**3.4. The knowledge on ART meaning**

Answering to ART meaning, 62% of them said that ART was to delay PLHA’s life followed by reducing HIV replication (34%), killing HIV virus inside PLHA’s body (9%), curing AIDS (7%), keeping PLHA as healthy person (7%), and protect OIs (3%).

🖝 We strongly believed that ART was the only mean to delay our lives from AIDS. We could survive as long as we could get ART.

**Table 17: the distribution of knowledge on ART meaning among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Meaning of ART** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Delay PLHA’s life | 64 % | 61 % | 62 % |
| 02 | Kill HIV virus inside PLHA’s body | 13 % | 5 % | 9 % |
| 03 | Cure AIDS | 8 % | 7 % | 7 % |
| 04 | Reduce HIV replication | 31 % | 36 % | 34 % |
| 05 | Keep PLHA as healthy person | 1% | 11% | 7% |
| 06 | Protect OIs | 3% | 2% | 3% |
| 07 | Don’t know | 4 % | 6 % | 5 % |

**3.5. The requirement of self-health care**

The information in table 18 clearly shown that all respondents (100%) strongly agreed on self-health care as a requirement during OI and ARV treatment.

**Table 18: the distribution of knowledge on requirement of self-health care by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Requirement of self-health care | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Yes | 100 % | 100 % | 100 % |
| 02 | No | 0 % | 0 % | 0 % |
| 03 | Don’t know | 0% | 0% | 0% |
| Total | | 100% | 100% | 100% |

**3.6. The reason of self-health care**

To gain further in-depth understanding on the important reasons of self health care, 69% of them said they required self-health care to live longer, to increase quality of life (41%), to prevent OIs (32%) and to prevent transmission to other (4%).

**Table 19: the distribution of knowledge on reason of self-health care among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Reason of self-health care** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Prevent OIs | 28 % | 35 % | 32 % |
| 02 | Increase quality of life | 41 % | 41 % | 41 % |
| 03 | Live longer | 64 % | 72 % | 69 % |
| 04 | Prevent HIV transmission to other | 5 % | 4 % | 4 % |

**3.7. The first advice on health care need**

Based on the finding from the survey in table 20, 69% of them said the first person to get advice on health care need was health care provider followed by village educator (12%), MMM (6%), family members (6%) and counselor (4%).

**Table 20: the distribution of person provide first advice on health care need among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **First person to get advice on health care need** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Family members | 5 % | 6 % | 6 % |
| 02 | Friends |  | 1 % | 0 % |
| 03 | Health care provider | 68 % | 70 % | 69 % |
| 04 | Counselor | 4 % | 4 % | 4 % |
| 05 | Village educator | 16 % | 9 % | 12 % |
| 06 | MMM | 3 % | 8 % | 6 % |
| 07 | Other | 4 % | 3 % | 3 % |

**🖝** I were confident with the HCP on giving me advice on health care because they were correctly trained and they were specialized on health care and treatment but family members and community neighbor were also important.

**3.8. The exercise**

For information on practicing exercise, about half of the respondents (45%) did it frequently, 17% practice it sometime, 5% practice it rarely and 33% rarely practiced it.

**Table 21: the distribution of practicing exercise among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Exercise** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Frequently (everyday or 4-5times/week) | 49 % | 42 % | 45 % |
| 02 | Sometime (2-3 times/week) | 14 % | 20 % | 17 % |
| 03 | Rarely (1time/week) | 7 % | 2 % | 5 % |
| 04 | Never | 30 % | 36 % | 33 % |
|  | Total | 100% | 100% | 100% |

**3.9. The ART reminder**

When asking about the person who plays a role as ART reminder to ensure ART adherence and compliance, majority of them (68%) trust themselves as the best ART reminders, followed by family members beside spouse (53%), spouse (40%), alarm clock or radio or TV (9%) and other (6%).

🖝 I always trusted myself in ART compliance and adherence and I used some means to keep me reminded such as alarm clock and my family members.

**Table 22: the distribution of ART reminder among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **ART reminder** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Spouse | 45 % | 37 % | 40 % |
| 02 | Family members | 54 % | 53 % | 53 % |
| 03 | Alarm clock | 32 % | 21 % | 26 % |
| 04 | By myself | 54 % | 79 % | 68 % |
| 05 | Home care team | 1 % | 1 % | 1 % |
| 06 | Other | 6 % | 6 % | 6 % |

**3.10. The home practice for self-health care**

Further in-depth on the practice of self-health care, the survey found approximately the same proportion distributed across some key activities such as taking care of body hygiene (64%), taking regular medicine (55%), taking enough rest (53%), practicing exercise (41%), avoiding harmful food and drink (25%), eating hygiene and nutrient food (17%) and doing home work (9%).

🖝 Since I were under ARV treatment, I quit all my bad practice behavior such as tobacco, alcohol etc. Importantly, I noticed that my health got a lot of improvement.

**Table 23: the distribution of home practice for self-health care among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Home practice for self-health care** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Exercise | 56 % | 28 % | 41 % |
| 02 | Take regular medicine | 61 % | 50 % | 55 % |
| 03 | Take care of body hygiene | 56 % | 71 % | 64 % |
| 04 | Take enough rest | 53 % | 53 % | 53 % |
| 05 | Avoid harmful food and drink | 18 % | 29 % | 24 % |
| 06 | Eat hygiene and nutrient food | 14% | 20% | 17% |
| 07 | Do home work | 4% | 12% | 9% |

1. **The accessibility to HIV and AIDS care and treatment**

**4.1. The knowledge on HIV and AIDS care and treatment services**

The VCCT is a good place to get information on HIV and AIDS care services while 27% of the respondents reported learning HIV and AIDS care through VCCT staff, followed by self-knowledge (14%), home care team (12%), villager (11%), village health volunteer (10%) etc.

🖝 In fact we never know exactly the HIV and AIDS care treatment services even we hear about it through TV, radio, community members etc because we were not interested and we were not expected to face with such disease. Anyway, we learn about these services when our spouse got sick and when we got sick that we needed to go to clinic in general or informed by the community member on HIV and AIDS care and treatment services.

**Table 24: the distribution of knowledge on HIV and AIDS care and treatment services among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Knowledge on HIV and AIDS care and treatment services** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Myself | 13 % | 16 % | 14 % |
| 02 | VCCT staff | 24 % | 29 % | 27 % |
| 03 | Home care team | 16 % | 9 % | 12 % |
| 04 | Village health volunteer | 17 % | 4 % | 10 % |
| 05 | Villager | 14 % | 8 % | 11 % |
| 06 | Spouse/other relative | 3% | 7% | 5% |
| 07 | Peer educator/MMM | 0% | 13% | 7% |
| 08 | PLHA | 1% | 3% | 2% |
| 09 | HCP | 6% | 6% | 6% |
| 10 | NGO staff | 6% | 5% | 5% |
| 11 | Other | 0 % | 1 % | 1 % |

**4.2. The benefit of using HIV and AIDS care and treatment services**

**Table 25: the distribution of benefit of using HIV and AIDS care and treatment services among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Benefit of using HIV and AIDS care and treatment services** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | HIV test | 28 % | 14 % | 20 % |
| 02 | CD4 test | 58 % | 61 % | 60 % |
| 03 | Lab test | 9 % | 13 % | 11 % |
| 04 | ART | 70 % | 88 % | 80 % |
| 05 | OIs screening | 23 % | 11 % | 16 % |
| 06 | OIs treatment | 69 % | 86 % | 78 % |
| 07 | MMM | 9 % | 7 % | 8 % |
| 08 | Materials & transportation fee | 8% | 26% | 18% |
| 09 | Counseling & health promotion | 12% | 9% | 10% |
| 08 | Other | 0 % | 2 % | 1 % |

The key benefit received from the HIV and AIDS care services were ART (80%), OIs treatment (78%), CD4 testing (60%), HIV testing (20%), OIs screening (16%), other lab testing (11%), MMM (8%) etc.

🖝 For us the HIV and AIDS treatment service was our lives without these services we thought we all died long time ago. To come to HIV and AIDS care services, it mean that we got everything that we needed to take care of our health for example health care and treatment especially ART, motivation and encouragement through education and counseling, and social support through food and transportation.

**4.3. The mean to get HIV and AIDS information**

From the table 26, TV (40%) was the most popular source for HIV and AIDS and other health information, followed by clinic health care provider (33%), radio (27%), village educator (26%), village member (24%), and counselor and VCCT staff (16%). Printing material such as leaflet (6%) and family members (4%) was not a popular source of information.

**Table 26: the distribution of mean to get HIV and AIDS information by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Mean to get HIV and AIDS information** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Home care team | 13 % | 9 % | 10 % |
| 02 | Counselor | 19 % | 13 % | 16 % |
| 03 | VCCT staff | 24 % | 8 % | 15 % |
| 04 | Clinic provider | 24 % | 40 % | 33 % |
| 05 | Leaflet | 1 % | 11 % | 6 % |
| 06 | TV | 25 % | 52 % | 40 % |
| 07 | Radio | 19 % | 33 % | 27 % |
| 08 | Village educator | 24 % | 28 % | 26 % |
| 09 | Village member | 20 % | 27 % | 24 % |
| 10 | Family members | 5 % | 3 % | 4 % |
| 11 | MMM meeting | 5% | 15% | 11% |
| 12 | Visit health center | 2% | 3% | 3% |
| 11 | Others | 4 % | 5 % | 5 % |

🖝 We liked TV and radio, we did not like printing materials such as leaflet, poster, booklet etc because we were illiteracy and generally we did not like to read.

**4.4. The mean during serious illness condition**

Regarding the means used during serious illness condition, 60% of the respondents said they went to HC with relative support, 22% phoned to village counselor, 18% asked somebody to phone to counselor or village educator, 8% phone directly to counselor etc.

**Table 27: the distribution of means used during serious illness condition by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Mean used during serious illness condition** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Go to HC supported by relative | 57% | 62% | 60% |
| 02 | Phone to counselor | 7 % | 9 % | 8 % |
| 03 | Phone to village educator | 13 % | 30 % | 22 % |
| 04 | Ask somebody to phone to counselor or village educator | 24 % | 13 % | 18 % |
| 05 | Contact MMM | 0% | 5% | 3% |
| 06 | Others | 3 % | 4 % | 3 % |

**4.5. The frequency of using health care services**

In general all contacted samples used health care services for HIV and AIDS care and treatment frequently, 75% of them used it bimonthly, 15% was on monthly basis and 10% was in every three months.

**Table 28: the frequency distribution of using health care services by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Frequency of using health care services** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Monthly | 21 % | 9 % | 15 % |
| 02 | Bimonthly | 78 % | 74 % | 75 % |
| 03 | Every 3 months | 1 % | 17 % | 10 % |
| 04 | Every 4-6 months | 0 % |  | 0 % |
|  | Total | 100% | 100% | 100% |

**4.6. The means of transportation to health care services**

For information on transportation means to HIV and AIDS care services, 62% of respondents used moto-taxi, 19% used their own motorcycle, 11% used bicycle, 10% used taxi, 8% walked and 1% used speed boat particularly in Koh Kong site.

**🖝** We usually shared our transportation fee if we lived nearby. In general we got support from NGO.

**Table 29: the distribution of transportation means to health care services among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Means of transportation to health care services** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Moto-taxi | 65% | 61% | 62% |
| 02 | Walk | 14 % | 4 % | 8 % |
| 03 | Bicycle | 12 % | 10 % | 11 % |
| 04 | Motorcycle | 16 % | 21 % | 19 % |
| 05 | Friend’s motorcycle | 3 % | 2 % | 2 % |
| 06 | Taxi | 7 % | 13 % | 10 % |
| 07 | Boat | 2 % |  | 1 % |
| 08 | Speed boat | 1 % |  | 1 % |
| 09 | Other | 2 % | 1 % | 1 % |

**4.7. The length of time to health care services**

In majority, 83% of the respondents spent less than one hour or at most one hour to travel to HIV and AIDS care services while the rest (17%) spent more than one hour.

**Table 30: the distribution of length of time to health care services by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Length of time to health care services** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | ≤1 | 81 % | 84 % | 83 % |
| 02 | >1 | 19 % | 16 % | 17 % |
|  | Total | 100% | 100% | 100% |

**4.8. The frequency of chest X-ray**

The information learn from the survey on the frequency of chest X-ray, it was high proportion of respondents (66%) who did chest X-ray in non-regular basis, 24% of them never had chest X-ray comparing to very small proportion of respondents (10%) who had ever access to chest X-ray on regular basis.

**Table 31: the frequency distribution of chest X-ray among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Frequency of chest X-ray** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Once in 3 months | 4 % | 1 % | 2 % |
| 02 | Once in 6 months | 4 % | 5 % | 4 % |
| 03 | Once in 12 months | 4 % | 2 % | 3 % |
| 04 | Once in 24 months | 1 % |  | 1 % |
| 05 | Not regular | 61% | 70% | 66% |
| 06 | Never | 26 % | 23 % | 24 % |

**4.9. The X-ray by appointment**

In further understanding on the compliance of chest X-ray by appointment, most of the respondents (95%) completely or almost followed the appointment except 5% of respondents who never followed the chest X-ray appointment.

**Table 32: the frequency distribution of chest X-ray by appointment among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Chest X-ray by appointment** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Completely follow the appointment | 77 % | 93 % | 86 % |
| 02 | Almost follow the appointment | 19 % | 1 % | 9 % |
| 03 | Never follow the appointment | 4 % | 6 % | 5 % |

**4.10. The frequency of CD4 testing**

Looking at frequency of CD4 testing about 80% of the respondents had it in every six month, 10% had it in every three month while only small proportion (1%) said they never had CD4 test.

**Table 33: the frequency distribution of CD4 testing among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **The frequency of CD4 testing** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Once in 3 months | 8 % | 11 % | 10 % |
| 02 | Once in 6 months | 73 % | 83 % | 79 % |
| 03 | Once in 12 months | 3 % | 0 % | 1 % |
| 04 | Never | 2 % |  | 1 % |
| 05 | Other | 14 % | 6 % | 9 % |
|  | Total | 100% | 100% | 100% |

**4.11. The CD4 testing by appointment**

In further understanding on the compliance of CD4 testing by appointment, most of the respondents (98%) completely or almost followed the appointment except small proportions of respondents (2%) who never followed the CD4 testing by appointment.

**Table 34: the distribution of CD4 testing by appointment among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **The CD4 testing by appointment** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Completely follow the appointment | 79 % | 96 % | 89 % |
| 02 | Almost follow the appointment | 17 % | 3 % | 9 % |
| 03 | Never follow the appointment | 4 % | 1 % | 2 % |

**4.12. The frequency of sputum screening**

**Table 35: the frequency distribution of sputum screening among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **The frequency of sputum screening** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Once in 3 months | 5 % | 8 % | 6 % |
| 02 | Once in 6 months | 1 % | 8 % | 5 % |
| 03 | Once in 12 months | 1 % | 4 % | 3 % |
| 04 | Never | 31 % | 6 % | 17 % |
| 05 | On irregular basis | 62 % | 75 % | 69 % |

Learning from the survey finding on the sputum testing, there was high proportion of respondents (69%) who had sputum screening on irregular basis, 17% who never had sputum screening comparing and other (14%) had sputum screening on irregular basis.

**4.13. The sputum screening by appointment**

For further investigation on compliance, the sputum screening by appointment was asked. As result most of the respondents (95%) completely or almost followed the appointment except small proportions of respondents (5%) who never follow the sputum screening by appointment.

**Table 36: the distribution of sputum testing by appointment among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **The Sputum testing by appointment** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Completely follow the appointment | 75 % | 96 % | 88 % |
| 02 | Almost follow the appointment | 15 % | 2 % | 7 % |
| 03 | Never follow the appointment | 10 % | 2 % | 5 % |
|  | Total | 100% | 100% | 100% |

1. **The quality of HIV and AIDS care and treatment services**
   1. **The expenditure on HIV and AIDS care and treatment services**

When asking about the expenditure on all HIV and AIDS care services, all of the respondents reported no a single riel spent from their pockets.

🖝 It was consistent with the information gained from the key informant and FGD among PLHA, all of them felt very happy that they could get free of charge from the HIV and AIDS care services.

* 1. **The quality level of health care provider**

When asking them about the quality level of health care in general among health care providers through their own assessment and perception nearly all of them (97%) rate very good or at least good. There was only 3% who did not satisfy yet.

🖝 From the FGD and key informant, all of them shown satisfactory on the performance quality by HCP but at an acceptable level.

**Table 37: the distribution of quality level of health care provider by respondents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Quality level of health care provider** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Very good | 38 % | 30 % | 33 % |
| 02 | Good | 60 % | 67 % | 64 % |
| 03 | Not good | 2 % | 3 % | 3 % |
|  | Total | 100% | 100% | 100% |

* 1. **The quality level of clinician**

Using the same question for quality level of consultation among clinicians nearly all of them (97%) rated very good or at least good. There was only 3% who did not satisfy yet.

**Table 38: the distribution of quality level of health care provider by respondents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Quality level of clinician** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Very good | 36 % | 35 % | 35 % |
| 02 | Good | 62 % | 61 % | 62 % |
| 03 | Not good | 2 % | 4 % | 3 % |
|  | Total | 100% | 100% | 100% |

* 1. **The behaviour of clinician**

**Table 39: the distribution of quality level of clinician behaviour**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Quality level of clinician behaviour** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Be satisfied | 96 % | 95 % | 96 % |
| 02 | Be less satisfied | 4 % | 5 % | 4 % |
|  | Total | 100% | 100 % | 100 % |

Going to specific topic on the quality of clinician behaviour, nearly all of them (96%) were satisfied and there was only 4% who expressed less satisfaction.

* 1. **The quality level of drug explanation**

When asking about the quality of clarity on drug explanation made by health care provider almost all of them (97%) said they got clear enough or at least it was acceptable while 3% of them expressed less satisfaction.

**Table 40: the distribution of quality level of drug explanation**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Quality level of drug explanation** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Be clear enough | 94 % | 100 % | 97 % |
| 02 | Be less clear enough | 6 % |  | 3 % |
|  | Total | 100% | 100 % | 100 % |

🖝 We found a little bit difficult during the first ART to capture all the meaning explained by the HCP but after few months exposing to ART we understood well.

* 1. **The sources of additional drug explanation**

**Table 41: the distribution of source for additional drug explanation**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Source of additional drug explanation** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | MMM | 11 % | 21 % | 17 % |
| 02 | Drug dispenser | 29 % | 22 % | 25 % |
| 03 | Drug counselor | 32 % | 48 % | 41 % |
| 04 | Home care team | 17 % | 13 % | 15 % |
| 05 | Relatives/PLHA | 13% | 18% | 16% |
| 06 | Others | 3% | 3 % | 3 % |

In case that they were not clear enough on drug use explained by HCP, a question was asked “who did they ask for further explanation?” As result, 41% of them went to drug counselor, 25% to drug dispenser, 17% to MMM, 16% to relative/PLHA and 15% to home care team for additional explanation.

* 1. **The perception on drug quality**

To assess their perceptions on drug quality, a question was asked “Every time you get drug from the clinic, do you think that the drug quality was acceptable?”. In response, all of them (100%) strongly believed that drug that they received from the clinic was at acceptable quality.

**Table 42: the distribution of perception on drug quality among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Perception on drug quality** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Yes | 100 % | 99 % | 100 % |
| 02 | No | 0% | 0% | 0% |
|  | Total | 100% | 100 % | 100 % |

* 1. **The knowledge on drug quality**

To learn more about their perception on drug quality, their knowledge on drug quality was assessed. As result, about half of them (50%) rely on HCP, 45% recognized on feeling better after drug use and only 4% of them used expired date.

🖝 We had any knowledge on drug quality. We totally relied on the HCP. We strongly believed that all drugs from public clinic were qualified.

**Table 43: the distribution of knowledge on drug quality among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Knowledge on drug quality** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Expired date | 2 % | 6 % | 4 % |
| 02 | Rely on HCP | 56 % | 46 % | 50 % |
| 03 | Better after use | 46 % | 45 % | 45 % |
| 04 | Don’t know | 4% | 13% | 9% |
| 04 | Other | 1 % | 3 % | 2 % |

* 1. **The mean of complaint**

In case that they were not satisfied with the HIV and AIDS services provided by the health care provider, 34% said they did nothing, 18% said they reported to peer educator, 16% reported to HCP, 16% reported to village educator, 11% wrote a letter and put in the mail box and 3% reported to counsellor.

🖝 So far we never made any complaint about HIV and AIDS care and treatment service because we understood about the burden and the difficulty of HCP who had small number to serve many PLHA.

🖝 We as HCP understood well about making our client unhappy because sometime they had to wait for a long time to get services, they had limited time to ask question, they had limited time to get education or counselling but we had no choice because of the number of HCP and the number of client were not proportionate.

**Table 44: the distribution of means to make complaint among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Means used to make complaint** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Report to HCP | 22 % | 13 % | 17 % |
| 02 | Report to counselor | 4 % | 2 % | 3 % |
| 03 | Report to village educator | 15 % | 16 % | 16 % |
| 04 | Report to peer educator | 8 % | 27 % | 18 % |
| 05 | Write a letter to put in the mail box | 13 % | 10 % | 11 % |
| 06 | Do nothing | 38 % | 32 % | 34 % |
| 07 | Report to NGO | 4% | 9% | 7% |
| 08 | Don’t know | 1% | 2% | 2% |
| 09 | Other | 3 % | 6 % | 4 % |

1. **The community motivation**

**6.1. The MMM participation**

To participate in the MMM, about 50% of the interviewees reported to joint MMM monthly while 35% of them jointed MMM sometime.

🖝 We like MMM very much because MMM always encouraged and motivated us to be stronger, healthier, and hope. In addition, we could get more social and psychological support and plenty of time to ask questions.

**Table 45: the distribution of MMM participation among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **MMM participation** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Never | 4 % | 12 % | 8 % |
| 02 | Sometime | 43 % | 28 % | 35 % |
| 03 | every month | 47 % | 52 % | 50 % |
| 04 | Others | 7 % | 8 % | 7 % |

**6.2. The importance degree of MMM**

Nearly all of them said that MMM were very important for them and they were very interested to participate in MMM.

**Table 46: the distribution of important degree of MMM among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Important degree of MMM** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Be very important | 58 % | 72 % | 65 % |
| 02 | Be important | 40 % | 28 % | 33 % |
| 03 | Be not important | 2 % | 1 % | 1 % |

**6.3. The important recipes of MMM**

When asking about the important recipes of participating in the MMM, they highlighted as being not alone (42%), having opportunity to receive and share experience (50%), receiving updated information, receiving problem-solving on care and treatment (61%) and receiving food and transportation support (36%). In addition, they said MMM could increase encouragement, feeling more brave, happier and more positive lives.

**Table 47: the distribution of important recipes of MMM among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Important recipes of MMM** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Be not alone | 62 % | 25 % | 42 % |
| 02 | Receive and sharing experience | 54 % | 46 % | 50 % |
| 03 | Receive updated information | 63 % | 60 % | 61 % |
| 04 | Receive problem-solving on care and treatment | 45 % | 74 % | 61 % |
| 05 | Receive food and transportation support | 54 % | 20 % | 36 % |
| 06 | Other | 5 % | 14 % | 10 % |

**6.4. The unimportant recipes of MMM**

To understand more on the negative few on the unimportant recipes of MMM, a group of respondents who reported never go to the MMM meeting and who said that the MMM was not important were asked additional question to get detail recipes. In fact, they all felt important but it was not their priority due to their priority jobs to earn their family living. Some interviewees said they wanted to go to MMM in general but they want to keep their HIV status confidential, they still felt shy, and they had no time enough.

**6.5. The contact person at the clinic**

**Table 48: the distribution of contact person at the clinic among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Contact person at the clinic** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Register | 86 % | 94 % | 90 % |
| 02 | Counselor | 58 % | 88 % | 75 % |
| 03 | Clinician | 88 % | 93 % | 91 % |
| 04 | Dispenser | 93 % | 97 % | 95 % |
| 05 | Lab technician | 13 % | 12 % | 13 % |
| 06 | Meet NGO | 1% | 10% | 6% |
| 06 | Meet MMM | 1 % | 8 % | 5 % |

Regarding information on contact person at the clinic, nearly all of them (90%) met with register, 91% met clinician, 95% met dispenser, 75% met with counsellor and not many of them said they met NGO (6%) to get transportation support and 5% met MMM.

**6.6. The welcome behaviour**

**6.6.1. By HCP**

Learning about the quality of HCP on client welcoming, 81% of samples informed that they accepted the welcome behaviour of the HCP when they met them at the clinic while 19% of them said they received welcome from HCP but it was not in a well acceptable welcome behaviour.

🖝 They were not friendly all the time and we understood that because they work hard. Anyway, their behaviours were acceptable.

**Table 49: the distribution of welcome behaviour by HCP by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Welcome behaviour** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Yes | 86 % | 77 % | 81 % |
| 02 | Not really | 14 % | 23 % | 19 % |
| 03 | Not at all |  | 1 % | 0 % |
|  | Total | 100% | 100% | 100% |

**6.6.2. By counsellor**

**Table 50: the distribution of welcome behaviour by counsellor by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Welcome behaviour** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Yes | 91 % | 87 % | 89 % |
| 02 | Not really | 9 % | 13 % | 11 % |
| 03 | Not at all | 0% | 0% | 0% |
|  | Total | 100% | 100% | 100% |

For quality of counsellor on client welcoming, 89% of respondents accepted the welcome behaviour while 11% of them said it was not in a well acceptable welcome behaviour.

**6.7. The opportunity for questions**

In order to improve the quality of compliance and adherence to HIV and AIDS care and treatment exceptionally on ART, the HCP should take time to explain clearly and in detail to patient on drug use, drug reaction, drug effect etc, along with enough time for patient to ask questions.

**6.7.1. Clinician**

Regarding time and opportunity to ask questions freely from clinician, 97% of the interviewees said they had opportunity and time enough to ask questions freely (87%) and to ask some questions (10%). Anyway, there was small proportion (1%) claiming as difficulty and seen in Banteay Meanchey.

**Table 51: the distribution of opportunity for questions from clinician by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Opportunity for questions** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Ask freely | 91 % | 84 % | 87 % |
| 02 | Ask only some questions | 9 % | 11 % | 10 % |
| 03 | Not at all |  | 2 % | 1 % |
| 04 | Don't know |  | 4 % | 2 % |
|  | Total | 100% | 100% | 100% |

**6.7.2. From dispenser**

It shown approximately the same with clinician while 95% of the interviewees said they had opportunity and enough time to ask questions freely (83%) and to ask some questions (12%) with small proportion (1%) claiming as difficulty and seeing in both sites.

**Table 52: the distribution of opportunity for questions from dispenser by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Opportunity for questions** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Ask freely | 85 % | 82 % | 83 % |
| 02 | Ask only some questions | 12 % | 12 % | 12 % |
| 03 | Not at all | 1 % | 1 % | 1 % |
| 04 | Don't know | 3 % | 5 % | 4 % |
|  | Total | 100% | 100% | 100% |

**6.7.3. From counsellor**

As the same as clinician and dispenser, 97% of them said they had opportunity and enough time to ask questions freely (92%) and to ask some questions (5%) from counselor with small proportion (1%) claiming as difficulty and seen in both sites.

**Table 53: the distribution of opportunity for questions from counsellor among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Opportunity for questions** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Ask freely | 90 % | 94 % | 92 % |
| 02 | Ask only some questions | 8 % | 3 % | 5 % |
| 03 | Not at all | 1 % | 1 % | 1 % |
| 04 | Don't know | 1 % | 2 % | 2 % |
|  | Total | 100% | 100% | 100% |

**6.7.4. At MMM**

During the MMM participation, 94% of them said they had opportunity and enough time to ask questions freely (92%) and to ask some questions (2%) from HCP and their peers with zero proportion claiming as difficulty.

**Table 54: the distribution of opportunity for questions at MMM by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Opportunity for questions** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Ask freely | 95 % | 90 % | 92 % |
| 02 | Ask only some questions | 3 % | 1 % | 2 % |
| 03 | Not at all | 0% | 0% | 0% |
| 04 | Don't know | 2 % | 9 % | 6 % |
|  | Total | 100% | 100% | 100% |

🖝 In comparing to all contacted person at the clinic for HIV and AIDS care and treatment, MMM was a good place to enjoy questions and answers because there were many people that we could ask for. It was really a limit with clinician, dispenser and counselor.

**6.12. The visit of neighbours**

For relation as neighbor and culture, they always pay patient’s home visit to show concern, encouragement and support. For this particular subject 85% of the samples said that they received neighbor visit frequently (43%), sometime (32%) and rarely (10%).

🖝 We felt that the picture of discrimination was no longer seen in our community while the picture of stigmatization could exist. We lived as normal people so far, we could enjoy social event as others and we received home visit from neighbor time to time especially when we got serious sick.

**Table 55: the frequency distribution of neighbor visit among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Neighbor visit** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Frequently | 40 % | 47 % | 43 % |
| 02 | Sometime | 32 % | 31 % | 32 % |
| 03 | Rarely | 11 % | 10 % | 10 % |
| 04 | Never | 17 % | 12 % | 15 % |
| Total | | 100% | 100% | 100% |

**6.13. The community group**

Totally, about 40% of the respondents participated in the self-help group. There was also a notice that PLHA in Banteay Meanchey had higher proportion (61%) than Koh Kong (16%) in participating in self-help group.

**Table 56: the distribution of types of community group by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Type of community group** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Self-help group | 16 % | 61 % | 40 % |
| 02 | Others | 84 % | 39 % | 60 % |
| Total | | 100 % | 100 % | 100 % |

**6.14. The children educational opportunity**

Based on the finding, 71.52% of respondents had opportunity to send their children to school with approximate the same proportion distribution in Koh Kong (71.23%) and Banteay Meanchey (71.75%).

**Table 57: the distribution of educational opportunity among respondents’ children by sites**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **No** | **Opportunity** | **Sites** | | | | **Total** | |
| **Koh Kong** | | **Banteay Meanchey** | |
| **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **01** | **Yes** | **104** | **71.23%** | **127** | **71.75%** | **231** | **71.52%** |
| **02** | **No** | **42** | **28.77%** | **50** | **28.25%** | **92** | **28.48%** |
| **Total** | | **146** | **100%** | **177** | **100%** | **323** | **100%** |

**6.15. The discrimination against children**

Looking at the discrimination picture, particularly to children affected by HIV and AIDS, about 70% of the interviewees said that their children never had or met any form of discrimination while other said they met frequently (10%), sometime (10%) and rarely (11%).

**Table 58: the distribution of discrimination against children among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Discrimination against children** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Frequently | 12 % | 9 % | 10 % |
| 02 | Sometime | 6 % | 13 % | 10 % |
| 03 | Rarely | 13 % | 9 % | 11 % |
| 04 | Never | 69 % | 69 % | 69 % |
| Total | | 100 % | 100 % | 100 % |

🖝 Even there was still a discrimination picture to our children in school but we thought that it was normal when they had quarrel but the big problem for us, was the support to get our children school

**6.16. The change**

To measure the change among respondents who benefited by the project implementation, 92% of respondents felt confident to take care of their HIV and AIDS status, even there were few of them (8%) felt noting change during the 5-year project implementation.

**Table 59: the distribution of change among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Change** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | I have strong confidence | 14 % | 31 % | 23 % |
| 02 | I am confident | 78 % | 61 % | 69 % |
| 03 | I have nothing change | 8 % | 8 % | 8 % |
| Total | | 100 % | 100 % | 100 % |

🖝 We strongly evaluated that the project did make a huge positive change to our lives as PLHA, without this project, we did not know how we could cope with our own disease and our own health. The project did improve us knowledge on HIV and AIDS, improve us access to HIV and AIDS care services, improve us hope to psychological and social support. We would suggest having this project continued and sustained.

1. **The knowledge and perception on project effectiveness**

**7.1. The clinician**

When asking about how important of HIV and AIDS clinician for their lives as PLHA that needed continuum of care and treatment and how contribution to the project effectiveness. All of respondents did say that their lives were totally relied on the HIV and AIDS clinician.

**Table 60: the distribution of knowledge and perception on project effectiveness by clinician contribution among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Clinician contribution** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Very important | 76 % | 88 % | 83 % |
| 02 | Important | 24 % | 12 % | 17 % |
| 03 | Normal | 0% | 0% | 0% |
| Total | | 100 % | 100 % | 100 % |

**7.2. The counsellor**

Refer to how important of HIV and AIDS counsellor; all of them had the same feeling as important as clinician.

**Table 61: the distribution of knowledge and perception on project effectiveness by counsellor contribution among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **Counsellor contribution** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Very important | 71 % | 84 % | 78 % |
| 02 | Important | 29 % | 16 % | 22 % |
| 03 | Normal | 0% | 0% | 0% |
| Total | | 100 % | 100 % | 100 % |

**7.3. The HBC team**

The same knowledge was found about the important of HBC team as the most need of PLHA and as part of the continuum of care components and it did contribution to the project effectiveness. As result, 95% of the respondents agreed to have HBC team as important component.

**Table 62: the distribution of knowledge and perception on project effectiveness by HBC team contribution among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **HBC team contribution** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Very important | 60 % | 72 % | 67 % |
| 02 | Important | 34 % | 23 % | 28 % |
| 03 | Normal | 6 % | 5 % | 5 % |
| Total | | 100 % | 100 % | 100 % |

**7.4. The CD4**

There was a notice that most of the PLHA (69%) covered by the project did have their CD4 count increased, 6% had their CD4 count decreased, small proportion had their CD4 count stabilized and about 22% did not know or remember their CD4 status.

🖝 From the monitoring report more than 80% of the active ART patients did have their CD4 count increased after 3 months of treatment with increasing trend.

**Table 63: the distribution of CD4 status among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **CD4 status** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Increase | 63 % | 73 % | 69 % |
| 02 | Decrease | 4 % | 8 % | 6 % |
| 03 | Stable | 1 % | 5 % | 3 % |
| 04 | Don't know | 14 % | 3 % | 8 % |
| 05 | Not remember | 19 % | 11 % | 14 % |
| Total | | 100 % | 100 % | 100 % |

**7.5. The general health status**

To response to the question asking them to compare their general health status before and after receiving the HIV and AIDS care services under this project support, nearly all of them 97% agreed that there was much improvement of their general health status. Anyway, there was small percentage (5%) claimed no improvement or even waste than before.

**Table 64: the distribution of general health status among respondents by sites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | **General health status** | Sites | | Total |
| Koh Kong | Banteay Meanchey |
| 01 | Much improvement | 39 % | 57 % | 49 % |
| 02 | Improvement | 60 % | 38 % | 48 % |
| 03 | Stable | 1 % | 3 % | 2 % |
| 04 | Waste than before |  | 3 % | 2 % |
| Total | | 100 % | 100 % | 100 % |

V. The conclusions

* + - 1. **The overall conclusion**

Project was designed and developed based on and aligned to the country priority set in the strategy II of the national strategic plan for comprehensive and multi-sectoral response to HIV and AIDS (2006-2010) that clearly stated that “Increased coverage of effective interventions for care and support and additional interventions developed” of the NAA and “Strategic plan for HIV/AIDS and STD prevention and care in health sector, Cambodia 2008-2010” of MoH that clearly stated in the second top priority “to solve burden of HIV and AIDS care and treatment in weak health system” and the specific strategy number one as “to provide health service delivery”.

The project was designed to provide PHD and its networks at the sub-national level for example the OD, OI and ART clinic team, the CoC team to own and to lead the work plan development, the implementation, the coordination, the monitoring etc that sustainability could be ensured after the project ended.

🖝 This project did surely showed to fill the gap of HIV and AIDS care and treatment services to get better function to meet the SOP and owned by the local authority (director and manager).

The CARE International Cambodia did play an appropriate role as NGO to contribute to the gap set by the government through providing both technical and financial support to the need of the existing public system.

🖝 CARE International did play an active role to provide effective technical and financial support meet the need at the local level with more flexibility. With this project we notice our service would be upgraded into a well acceptable standard and as evidence the number of clients kept increased (director and manger).

The project had strong monitoring and evaluation system to capture all data from the project implementation that could be used to generate information for project progress report regularly as required by PR/MoH and GF.

🖝 We never had such strong monitoring system before but CARE International project move us up to another level of quality improvement based on computerized data management system with ability to generate regular progress report (director and manger).

The project did improve the general health status of PLHA (97%) through increasing knowledge on health care and especially on HIV and AIDS care and treatment, accessing to HIV and AIDS health care services and other HIV and AIDS related services and to MMM where they could be encouraged and motivated to be a team to share their positive experience. As concrete evidence 92% of respondents felt confident to take care of their HIV and AIDS status and 69% did informed about their CD4 count increased.

The impact to the general health status of PLHA was contributed by the quality of the clinician and other health care providers at the HIV and AIDS clinic, the counsellor and the HBC team. This information did show clearly about the effectiveness of the continuum of care strategy of MoH.

The project did increase capacity of local staff and community member who was responsible for HIV and AIDS care and treatment through several training from national down to provincial and to on-sit training and to ensure the ARV availability for patients.

The project did change HCP for HIV and AIDS care and treatment to become a professional who could provide education, counselling etc to ensure compliance and adherence.

The project did improve the quality of care and treatment of PLHA to receive clear, appropriate and well understood message on drug compliance and adherence through education and counselling from dispenser**.**

🖝 In fact, we totally support the change and it really the big change of health status among PLHA in term of better accessing to HIV and AIDS care service and to better improvement of their quality of lives through increasing trend of CD4 count etc. Indeed, these changes were the impact of the better change of the infrastructure of HIV and AIDS care service, the improvement of capacity of HCP, the well functioning of medical equipment and drug supplies etc resulted from the project (director and manger).

Finally, the project was concluded as a success project due to:

* All activities planned were totally implemented
* All output targeted indicators (25 indicators) were achieved. Out of those achieved targeted indicators 17 targeted indicators were overachieved (see more in the annex 1)
* All outcome targeted indicators were achieved.

As target, 2,942 of people with advanced HIV infection received antiretroviral therapy at CARE-supported sites by the end of the project. But as monitoring report, 2,827 PLHA were accessed to ART therefore it achieve 96% of the target. Confirmed by the HH survey, 91% of contacted samples were under active ART.

**Table 65: the achievement of advanced HIV infection person received ART at project site**

|  |  |  |  |
| --- | --- | --- | --- |
| Indicator | Targeted value | Observed value | Achievement |
| # of people with advanced HIV infection received antiretroviral therapy at CARE-supported sites by the end of the project | 2,942 | 2,827 | 96% |

As target, 2,585 of active clients at CARE-supported OI/ART service received OI and/or ART care at the end of reporting period (Non Cumulative-current). But as monitoring report, 2,944 of active clients received OI/ART services. Therefore it achieved 13% over the target. Confirmed by the evaluation, all contacted respondents were accessed to OI and/or ART services.

**Table 66: the achievement of active HIV client received OI/ART at project site**

|  |  |  |  |
| --- | --- | --- | --- |
| Indicator | Targeted value | Observed value | Achievement |
| # of active clients at CARE-supported OI/ART service received OI and/or ART care at the end of reporting period (Non Cumulative-current) | 2,585 | 2,944 | 113% |

* The impact targeted indicator was achieved while 86% of individual still on ART at 12 months after initiating HAART based on monitoring report. Confirmed by the HH survey, 73% of the respondents were under active ART for more than a year.

* + - 1. **Specific conclusion**
* The participation rate by the selected samples were high (more than 90%) with 9% overachieved the proposed sample size in HH survey.
* The female sample was 1.5 times more than male samples. It was due to female PLHA was not mobile as male PLHA.
* The HH survey did well capture the adult population at reproductive age group (more than 25 to 50 years old).
* Nearly all of the HH respondents were married (96%)
* The average size of family members was 5 while the average size of dependent family members was 2. For the size of children, in average, there were 2.
* Only about half of them (58%) could access to 1-6 years education with decreasing proportion to higher educational level. Unfortunately, 27% of them were illiteracy.
* For job to get main income, both family of the respondents and the PLHA themselves carried unprofessional job using labour force and as farmer (48% and 18% respectively)
* Not many of them accessed to communication (mobile phone “58%”, TV “37%”), electricity (46%), gas cooker (14%) etc as well as owning property (TV “37%”, bicycle “37%”, motorcycle “25%”, ploughing machine “2%”,).
* The length accessing to OI and ART services was four years in average with 2 years of SD.
* About 91% of the respondents were under active ART with an average length of 3 years and SD of 2 years.
* Among PLHA who known their ART choice, most of them under 1st ART choice. Anyway, about half of the samples did not know their ART choices.
* Regarding health knowledge in general, there were high proportion of interviewers select right answers:
  + 66% said that health care mean to improve health
  + 81% recognized that prevention was more important than treatment
  + 57% believed that OI was a disease of weaken immune system
  + 31% thought that ART was to reduce HIV replication and
  + 100% confirmed that they required self-health care to improve health and to increases their quality of life
* Regarding health care practice:
  + PLHA strongly believed in HCP while majority of them (69%) selected HCP as the first person to get advice on health.
  + 67% of them did practice exercise but in different frequency
  + Self-reminder (68%) shown as best option for ART compliance and adherence due to individual living with HIV and AIDS followed by spouse (40%) and family member (53%).
  + For home practice as self-health care, there were variety of activities but the most predominantly were taking care of body hygiene (64%), taking enough rest (53%), taking regular medicine (55%) and doing exercise (41%).
  + When they got serious ill they claimed that they (60%) went to HC with relative support.
  + All contacted interviewers used health care services frequently, but 75% of them used it bimonthly.
  + Moto-taxi (62%) was the most popular transportation mean used by the PLHA to HC services followed by their own motorcycle (19%) and bicycle (11%).
  + Majority of them (about 80%) complied strictly the chest X-ray screening, the CD4 testing, the sputum screening etc as appointed by the HCP.
* PLHA in general had better access to HIV and AIDS care and treatment:
  + The media such as TV and radio were the most popular sources to be interested by the respondents (40%) followed by HCP (33%) and village member (26%). The printing material was not a popular source of information at all.
  + Beside the self-awareness (68%) on HIV and AIDS care and treatment services, VCCT was an entry point to get information on HIV and AIDS continuum of care services.
  + There were a lot of benefit gained from accessing to HIV and AIDS care services more than the HIV and AIDS care and treatment but the social and psychological support.
  + It was not a big concern regarding a difficulty to access to HC services while most of them (83%) spent less than one hour to go to get HIV and AIDS care and treatment services.
* MMM was still interested by the PLHA to have opportunity to encourage and motivate self-confidence to improve and share their knowledge, skill and experience on HIV and AIDS care and to live positively through competent problem-solving.
* The quality of HIV and AIDS care and treatment service were notice as at high and acceptable satisfactory level.
  + No PLHA spent any riels for their HIV and AIDS care and treatment service
  + Nearly all of them (97%) rated as very good or good on the quality of health care provider in general based on their perception.
  + The same rate (97%) was rated clinician and 96% of them fully satisfied with the clinician behaviour.
  + On the quality of drug explanation, nearly all of them (97%) got clear enough or at acceptable level and drug counsellor (41%) and drug dispenser (25%) were popular for additional explanation on ARV use.
  + All of the respondents believed that all medicine received at the clinic was quality and half of them believed in HCP.

* Community was well motivated and interested by the PLHA. Nearly all of them (98%) felt that MMM was important opportunity that they could feel alone, received and shared experience, received updated information and received food and transportation support. Therefore, the majority of them (85%) had participated in MMM on monthly basis or sometime. In addition, about half of them did participate in other community support group such as self-help group.
* The behaviour of HCP was positively improved
  + The HCP and counsellor did show an acceptable quality of welcome behaviours while more than 80% of respondents claimed that they accept their welcome behaviour.
  + More than 90% of the PLHA claimed that they had enough time and chance to ask questions freely or at least some questions from clinician, dispenser, counsellor and MMM members.
* The picture of discrimination found that it existed from this evaluation but it was not at the serious concern while 85% of PLHA had neighbour visit frequently, sometime or rarely and 69% of the interviewees never had any discrimination act to their children. More importantly, 71.52% of the respondents had their children in school.
* The individual PLHA (92%) agreed that the project did make them confident enough to live positively with HIV with hope on HIV and AIDS care and treatment. All of them strongly accepted that the HIV and AIDS clinician, the counsellor, the HBC team were the most importance contributing to the quality of their live on HIV and AIDS care and treatment.
* Due to the effective care and treatment, about 70% of them recognized their CD4 increased and their general health status did improve a lot comparing to the status before accessing to HIV and AIDS care and treatment.

VI. The recommendation

With enough evidence found in this evaluation, the project implementers and the government partners should first adopt these achievements as the lesson-learnt or the best practice that could be used to scale-up to other CoC sites in Cambodia and could be shared at national and international meeting or conference.

Based on the new guideline on CD4 counts used as eligible criteria for ART that changed from 250 to 350/mm3, the number of PLHA who are in the need of ART will be increased therefore the need for expansion the effective and quality of HIV and AIDS care and treatment are still the top priority for Cambodia. Therefore the lesson-learnt and the best practice developed from this project should be used to answer to the future response to the increasing need of PLHA.

Learning from this evaluation, some practical recommendations are highlighted as following to better filling the gap of this project implementation:

**The knowledge on health and HIV and AIDS care**

Based on finding from this evaluation, majority of PLHA get health knowledge from HCP and community educator, therefore regular refresher training for HCP and community educator should be provided to update health information as well as appropriate health service delivery and more time should be allocated for HCP to provide health education or counselling to PLHA. PLHAs have appropriate knowledge on health and HIV and AIDS in general but they still need more explanation and clarification on some specific health and HIV and AIDS knowledge for example more than half of them said ART is to delay their lives, to cure AIDS, to kill HIV virus inside PLHA’s body etc. Another example, most of them had limited knowledge on drug quality.

The VCCT should be scaled up to meet the need of high-risk people who could get as earlier as possible the knowledge on their HIV status and the entry point of receiving comprehensive knowledge on HIV and AIDS care.

Media production through TV and radio are the most popular and interested by the PLHA therefore to raise health and HIV and AIDS knowledge to PLHA, therefore, IEC material production through TV and radio should be adopted.

**The practice on health and HIV and AIDS care**

Providing transportation fee support seen as significant support to increase PLHA accessing to HIV and AIDS care and treatment service while majority of them are poor that could not afford the transportation fee.

The free of charge policy on HIV and AIDS care and treatment and the friendly behaviour in welcoming, consulting, counselling etc by HCP are contributing factors in practice to improve people accessing to HIV and AIDS care and treatment services. Therefore the positive behaviour and attitude of HCP should be improved, maintained and sustained. In addition, the positive behaviour and attitude of HCP also see as positive impact on reducing discrimination and stigmatization to PLHA.

In strengthening and improving the compliance and adherence on taking ARV among the PLHA, educate and counsel the PLHA themselves, their spouses and their family members are the most interested and effective support.

The compliance and adherence on complementary exam (chest X-ray) and lab test (CD4 testing, sputum screening) should be improved to meet the SOP and to meet the appointment.

MMM and self-help group should be expanded and sustained because it is very important to encourage and motivate PLHA to live in positive life and to reduce stigmatization and discrimination.

**The commodity**

PHD, OD, OIs and ART clinic, OIs and ARV pharmacist and dispenser should work closely with the procurement unit of NCHADS and MoH to ensure that the supply of all commodities is not out of stock or in close expiry date.

**The sustainability**

As the project is implemented within the existing public system, build public HCP capacity, equipped material and system for HIV and AIDS care and treatment, the sustainability in general is not a question but some key activities inside and outside the public system should be considered:

* The community activities such as self-help group networking, outreach activity of community educator, the capacity building, community visit or supervision etc
* The ad-hoc support to CoC such as OIs, ARV, medical equipment and materials etc
* The regular refresher training

🖝 As director of the HIV and AIDS care clinic, I felt that after CARE project ended the HIV and AIDS care and treatment service is still going on but some activities is going to be ended or implemented in an irregular basis due to financial support. As public services we rely on the support from the network for example from MoH to NCHADS to PHD to OD to RH and to HC but the support usually never meet the demand, the supplies sometime are not on time therefore these problems will be happened again after Care project ended.

Anyway, all of the above concerns are taking over by RACHA in Koh Kong site while NCHADS and CPN+ will be considered to fill the gap in Bnateay Meanchey site.

VII. The lesson-learnt

Base on the evaluation, the lesson-learnt could be drawn as following:

**The limitation**

1. The supplied equipment and material sometime could not well operate due to irregular supply of electricity, water etc. In addition there is no plan for maintenance or replacement of broken equipment and material.
2. Some OIs and ARV drug is supplied close to expiry date and occasionally out of stock.
3. Due to workload plus no incentive or motivation plan, the task performance does not follow exactly the SOP or training guide.
4. The human resource always keeps moving in and out that would increase spending resource on capacity building.
5. Computer and software program on project monitoring is available but in limited use in generating information for local use.
6. There are two monitoring system for HIV and AIDS care and treatment running in parallel in each site.

**The strength**

1. The project is ownership by government entity who responsible for OIs and AIDS care and treatment (NCHADS, PHD, OD, CoC team).
2. The project is aligned with the national strategic plan of the NAA and MoH.
3. The project is harmonized among the stakeholders on HIV and AIDS care and treatment.
4. The project did transform the HIV and AIDs care and treatment service delivery into a standard based on SOP.
5. The project builds local HCP to be professional on HIV and AIDS care and treatment.
6. The project builds community members to improve HIV and AIDS care and treatment and to reduce stigmatization.
7. The project improves quality of HIV and AIDS care and treatment to PLHA to reach a satisfactory level.
8. The project is supervised regularly to track the activities performance and to provide on the job training to improve project performance

**The limitation**

1. The local people rarely get back the project report.
2. The field monitoring officer plays an active role to collect data and send to the CARE central office where data is analyzed and report is written while the local agency could not yet be able to analyze and write the report by themselves yet.
3. The national report prepared by the national program is rarely shared to get feedback from the network.
4. The project has no baseline information to compare with the final evaluation

**The strength**

1. The project is more flexible that fund could be allocated or activity could be reprogramed to meet the real situation.
2. The project is well and regular monitor through existing CoC computerized monitoring system with several data collecting form developed and progress report written.
3. The project is well designed on final evaluation to see the project outcome and impact that could be used to inform future policy and strategy on HIV and AIDS care and treatment.
4. The project does improve linkage of all CoC components.
5. The project does achieve all the implementation of planned activities.
6. The project does achieve all project indicator targets (output, outcome and impact).

VIII. The best practice

Due to the finding and lesson learnt gained from the monitoring and evaluation system for this particular project, it provide enough scientific evidenced base to document a best practice that could be use as a standard model for in-country scaling up or other countries in the region or in the world for initiating such important project.

**1.** Project is well designed under sustainable strategy

* + To provide government ownership
  + To align with the national strategy, policy, SOP etc.
  + To support existing public service delivery system.
  + To harmonize with other stakeholders.

1. The project is well equipped with comprehensive package that fit to local conditions to strengthen HIV and AIDS care and treatment.
   * Improve infrastructure to an acceptable level.
   * Improve medical equipment and material to a standard level based on SOP.
   * Improve human capacity to a professional level based on SOP.
   * Improve operation (management, coordination, supervision, monitoring, and evaluation) to a well coordinated level.
2. CARE International in Cambodia plays and respects its role as international NGO mandate to fill the gap of public service without creating any parallel or competing system with public system
3. Project is flexible enough to reprogram the activities and to reallocate the funding to fit the change of the local situation as well as the beneficiary informed by the progress report.
4. Project is lead and managed by strong, capable and experience CARE International who could harmonize and coordinate well among development partners involving in project management, implementation, monitoring and evaluation.
5. The capacity building is provided as a package to expose trainee to the theory then practice and finally to share knowledge, skill and experience with continuing support through on-the job training, meeting etc. All trainings are conducted with a standard curriculum.
6. The project is implemented based on the work plan under supervision (with clear checklist) to regular improve the project performance and monitoring (with clear system and data collecting form) to improve the project implementation.
7. The project is designed to have well plan for final evaluation.

References

1. The CoC frame work, NCHADS, MoH, April 2003.
2. National Guidelines for the Selection of People Living with HIV/AIDS for Antiretroviral Therapy, NCHADS, MoH, July 2003
3. National guidelines for the use of ART in adults and adolescents, NCHADS, MoH, December 2003
4. SOP for implementing community home-based care activities in Cambodia, April 2006
5. SOP for implementing MMM activities in Cambodia, NCHADS, MoH, April 2006
6. SOP expanding the CoC-satellite sites, NCHADS, MoH, January 2006
7. The WHO web-site
8. The UNAIDS web-site
9. The NAA web-site
10. The NCHADS web-site
11. The CARE International web-site, [www.acted.org](http://www.acted.org) and www.psfci.org
12. The national strategic plan for comprehensive and multi-sectoral response to HIV and AIDS

II 2006-2010, NAA.

1. Strategic plan for HIV/AIDS and STD prevention and care in health sector, Cambodia 2008-

2010, MoH.

1. HIV drug resistance surveillance – Early warning indicator 2008-2009, NCHADS December

2009.

1. Disease specific country coordination proposal for the globbal fund to fight AIDS, TB and Malaria 4th round-2004, HIV/AIDS component: Continuum of Care
2. Global fund round 4 phase 1 and phase 2 final proposal on “CARE GFATM Round 4” 2005, 2007.
3. Grant final report on the project “CARE Global Fund Round 4 Continuum of Care project”, December 2010.
4. The progress report on the project “CARE Global Fund Round 4 Continuum of Care project”, 2006, 2007, 2008, 2009 and 2010.
5. The progress quarterly report, NCHADS, 2010

Annexes

**Annex 1: The project achievement on output and outcome indicator target**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator Description** | **Intended result** | **Actual result** | **Reasons for deviation and any other comments** |
| 1.1. Number of ODs with at least one site providing ARV among 4 CARE target ODs (Cumulative) | 4 | 4 | Fully achieved Koh Kong Province = 2 OI/ART clinics (Smach Meanchey and Sre Ambel) Ban Teay Meanchey province = 2 OI/ART clinics ( Mong Kul Borey and Poi Pet) |
| 1.2. Number of government facilities providing ARV among 4 CARE target ODs (Cumulative) | 5 | 6 | Koh Kong Province = 2 OI/ART clinics (Smach Meanchey and Sre Ambel) Ban Teay Meanchey province = 4 OI/ART clinics (Mong Kul Borey and Poi Pet, Serey Sophoan and Thmar Pouk) |
| 1.3. Number of provincial ODs with at least one MMM among 4 CARE target ODs (Cumulative) | 4 | 4 | Fully achieved Koh Kong Province = 2 OI/ART clinics (Smach Meanchey and Sre Ambel) Ban Teay Meanchey province = 2 OI/ART clinics ( Mong Kul Borey and Poi Pet) |
| 1.4. Number of MMM established and operating in 4 CARE target ODs (Cumulative) | 5 | 6 | Fully Achieved: Koh Kong Province = 2 OI/ART clinics (Smach Meanchey and Sre Ambel) Ban Teay Meanchey province = 4 OI/ART clinics (Mong Kul Borey and Poi Pet, Serey Sophoan and Thmar Pouk) |
| 1.5. Number of PLHA attending support group meetings at MMM at CARE-supported facilities (Non Cumulative) | 16320 | 19691 | In Q 20 (KK = 416 (SA = 146, SMC =270), BMC = 499 (MBR = 202, PP =297), Total Q20 = 915. ( last semi = 18776) total in cumulative in this reporting period is 19691 Again 20% overachieved for same reason as previous semi-annual report - MMM team members, PLHA counselors and PLHA educators collaborated with health staff to update meeting agenda in response to PLHAs priorities. Also, the support for transportation increased slightly and this is another factor that encouraged greater participation. |
| 1.6. % of female among all PLHA attending support group meetings at MMM at CARE-supported facilities (Non Cumulative %) | 55% | 60% | In Q 20 (KK F 241: 416 , BMC F: 304:499 ) Grand total: 915 F: 545. Rate = 60% Males are frequently involved in business or migrant labor within the border area thereby reducing their participation, whereas women are more likely to be home providing care and seeking for support for their families. |
| 1.7. Number of people with advanced infection newly initiated on antiretroviral therapy at CARE-supported sites during the reporting period (New clients) (Non Cumulative). | 1080 | 1361 | 26% over achieved in Q 20 85 ( SMC = 19, SA = 7, MBR = 16, P Pet= 43) last semi = 1276, total in this semi-annual is 1361 Reason for this over achievement because the increasing of eligible ARV base on CD4 counting from 250 to 350 in national protocol revise, it cause over achieved than expected, however ARV is also could maintain in cover the amount of increasing by all clinics too. |
| 1.8. Number of people with advanced infection receiving antiretroviral combination therapy at CARE-supported sites at the end of this reporting period (Current clients) (Non Cumulative-current) | 1862 | 2152 | 15% over achieved in this reporting period (MBR= 614, PPet = 886, SMC = 467, SA = 185 ) Total in this reporting period is 2152 Reason for this over achievement because of the very well collaboration among clinic staff counselor and educators with home care team as well as VCCT to admire patient than expected. |
| 1.9. Number of people with advanced infection who ever receiving antiretroviral combination therapy at CARE-supported sites at the end of this reporting period (Cumulative clients) | 2942 | 2827 | Achieved by 96% In Q 20= 2827 (MBR = 841, PP = 1084, SMC = 704, SA =198). Reflects good self help care and OI adherence as a result of good counseling and health education by PLHA counselors |
| 1.10. % of women among PLHA receiving ART at CARE supported sites (Non Cumulative) | 51% | 55% | In Q20: SMC = 926/ F470, SA 362/F203, total KK 1288/673, MBR = 1227/F634, PP 1761/F1025, total BMC 2988/F 1859 Grand total 4276/F2332 = 55% |
| 1.11. % or Individuals still on ART at 12 months after initiating HAART (Non Cumulative.%) | 86% | 86% | In Q20: KK SMC ( Die =1 Lost = 10 Transfer out = 0 , SA Die = 1 Lost = 0 Transfer out = 0) BMC ( Die = 1 Lost = 0 Transfer out = 0 , PPet= Die = 1 Lost = 0 Transfer out = 0) |
| 1.12. Number of clinicians who received clinical mentoring by an experienced HIV physician at least 2 month (Cumulative). | 22 | 23 | This target was met in the last reporting period. NO clinicians have been trained during this reporting period. |
| 1.13. Number of nurse counselors trained to provide ART/ adherence counseling (Cumulative) | 22 | 34 | This target was met in the last reporting period. NO nurse counselors have been trained during this reporting period. |
| 1.14. Number of PLHA counselors trained to provide ART & adherence counseling (Cumulative) | 27 | 154 | PLHAs have been supported to attend " PMTCT and TB/AIDS" training at Kampong Som in Q20 ( KK = 23 BMC = 13 , total = 36 ) Last semi is 118, total in this reporting period is 154 PLHAs under CARE project have two role of responsibility both counseling as well as educating, While we provide training to our PLHAs volunteers we count both educator and counselors, otherwise our topic in training always include both education and counseling skill. Anyhow due to this indicator is achieved since in early of phase II, reason for low estimation, while budget are still flexibility those are contributed to cumulative data become more than expected |
| 1.15. Number of PLHA trained to provide ART & adherence education (Cumulative) | 71 | 117 | PLHAs have been supported to attend " PMTCT and TB/AIDS" training at Kampong Som in Q20. Last semi is 81, total in this reporting period is 117 PLHAs under CARE project have two role of responsibility both counseling as well as educating, While we provide training to our PLHAs volunteers we count both educator and counselors, Moreover our topic in training are include both education and counseling also. Same reason due to low estimation as this indicator is fully achieved since last semi and while budget are still flexibility those are to contribute to cumulative become more than expectation too. |
| 1.16. Number of pharmacists trained to support HAART (Cumulative) | 8 | 10 | NO pharmacists have been trained during this reporting period. |
| 1.17. Number of lab technicians trained to support HAART (Cumulative) | 8 | 7 | NO Lab technicians have been trained during this reporting period. |
| 1.18. Number of health worker's participation in trainings (including initial and refresher training) (Cumulative) | 44 | 55 | NO Lab health workers have been trained during this reporting period. |
| 1.19. Number of PLHA's participation in trainings (including initial and refresher training) (Cumulative) | 122 | 142 | PLHAs have been supported to attend " PMTCT and TB/AIDS" training at Kampong Som in Q20 ( KK = 23 BMC = 13 , total = 36 ) Last semi is 106, total in this reporting period is 142 |
| 2.1. Number of provincial ODs with at least one health care service providing cotrimoxazole prophylaxis among 3 CARE target ODs (Cumulative) | 4 | 5 | Koh Kong Province = 2 OI/ART clinics (Smach Meanchey and Sre Ambel) Ban Teay Meanchey province = 3 OI/ART clinics ( Mong Kul Borey, Poi Pet and Serey Sophoan) |
| 2.2. Number of CARE-supported facilities providing cotrimoxazole prophylaxis (Cumulative) | 4 | 4 | Fully achieved Koh Kong Province = 2 OI/ART clinics (Smach Meanchey and Sre Ambel) Ban Teay Meanchey province = 2 OI/ART clinics ( Mong Kul Borey and Poi Pet) |
| 2.3. Number of PLHA (stage II-IV) receiving cotrimoxazole prophylaxis at CARE-supported facilities (Non Cumulative-current) | 1762 | 3792 | In Q 20: Koh Kong Province = (SMC 748, SA 296 ) Ban Teay Meanchey province = 556, ( MBR 865, Poi Pet 1883 ) total = 3692 Significantly over achieved for the same reason as previous report - that Poi Pet could not separate contrimoxazole treatment from prophylaxis. |
| 2.4. Number of active clients at CARE-supported OI/ART service who not yet started ART at the end of the reporting period (Non Cumulative-current) | 966 | 792 | Achieved only 82% reason initiate OI are admit in late stage. In Q 20: MBR= 151, PP 443= , SMC = 114 , SA = 84, total = 792. (Last semi is 778) This reflects good counseling, education and self help care by PLHAs |
| 2.5. Number of active clients at CARE-supported OI/ART service who receive OI and/or ART care at the end of reporting period (Non Cumulative-current) | 2585 | 2944 | Over achieved by 13% due high adherence. Q20: MBR= 765, PP 1329 =, SMC = 581, SA = 269 , total = 2944 |
| 2.6 Number of OI and ART consultations in each quarter | 69831 | 2848 | The provinces of BMC and KK are situated at borders, and the majority of affected and infected people in these provinces are migrant workers. Clients require more time between appointments as they travel for work. Appointments are therefore usually every 2 to 3 months. However some clients require access to services more than once per month because of their health status . Most of patients whose appointments are only every 2 to 3 months are in stable health In Q20: MBR=635, PP =1558, SMC =430, SA =225, total = 2848. |

**Annex 2: Questionnaire for household interview**

Dear Sir and Madame, I am ...........................member of the evaluation team that requested by Care under the GFATM R4 project that was implemented by Care in collaboration with NCHADS/OD/CoC team, to do a project evaluation. Due to all of you as our project beneficiary of this project you are all selected to be a key informant of this project evaluation. The objective of our interview is to learn from you in detail about your knowledge, support you get so far related to your health especially on OIs and ART care and treatment as well as your thought and recommendation to the future. We need about 45 minutes of your time to do this interview. Meanwhile, we encourage you to provide us all accurate information to this evaluation that we could use to improve this type of project in the future. We ensure you that all your information kept confidential. Do you agree to participate in this interview?

|  |
| --- |
| Date of interview: ................................... Interviewer name:............................Code of:.................. Questionnaire.................. |
| Location: Village: .......................... Commune: ............................. District: .................................. |
| OD name: Smach Mean Chey—1, Srea Ambel—2, Mongkol Borei—3, Ou Chrov—4 |
| Interviewee name: ......................Gender:.............................Age:................................ID#............... |

1. **General Information**

|  |  |
| --- | --- |
| 1.1 | What is your marital status?  Single --1 Married--2 Divorced –3 Separated—4 Widow or widower—5 Other—9……… |
| 1.3 | How many members in your family? Total:……..person Dependent:……..person |
| 1.4 | How many children do you have? Total:………..person Dependent:……..person |
| 1.5 | What is your education level?  Non—1 Grade 1-7—2 Grade 7-9—3 Grade 10-12—4 Over grade 12—5 |
| 1.6 | What are your family’s main jobs?  🞎 Rice paddy farmer 🞎 Cash crop farmer 🞎 Seller (small scale)  🞎 Construction worker 🞎 Motorcycle taxi driver 🞎 Civil servant 🞎 Fishery  🞎 House wife 🞎Animal feeding 🞎Other……………………………………….. |
| 1.7 | What are your main jobs?  🞎 Rice paddy farmer 🞎 Cash crop farmer 🞎 Seller (small scale)  🞎 Construction worker 🞎 Motorcycle taxi driver 🞎 Civil servant 🞎 Fishery  🞎 House wife 🞎Animal feeding 🞎Other……………………………………….. |
| 1.8 | Materials in your family?  🞎 Electricity 🞎 Mattress🞎 Gas Cooker 🞎 Wooden chair 🞎 Plastic chair  🞎 Bed 🞎 Table 🞎 Electric fan 🞎Radio/Cassette player 🞎 Black &white TV  🞎 Color TV 🞎 Mobile phone🞎Other phones 🞎 Sewing machine 🞎 Hanging clock  🞎 Bicycle 🞎 Motor cycle 🞎 Machine driven cart 🞎Water Pump Machine 🞎 Other……… |
| 1.10 | How long have you been accessing OI/ART services? Total:..........year At targeted clinic….…..year |
| 1.11 | Are you using ARV drug to against HIV/Aids? Yes—1 No—2 |
| 1.12 | If yes, how many years have you been accessing this kind of drug? Total:………year At targeted clinic….…..year |
| 1.13 | What line of ARV regimen you got?  1st line regimen—1 2nd line regimen—2 3rd line regimen and over—3 Don’t know—4 |

1. **Knowledge and practice for HIV related health care**

|  |  |
| --- | --- |
| 2.1 | What is health prevention mean to you?  🞎 To protect disease 🞎 To cure disease 🞎 To avoid sickness 🞎 To stay in healthy  🞎 Other…………………………………………………………………………………… |
| 2.2 | Among health prevention and treatment which one sounds important to you?  Prevention—1 Treatment—2 |
| 2.3 | What is OI mean to you?  🞎 It is an opportunity disease to be checked before ART  🞎 It is an opportunity disease to be combined with ART  🞎 It is an opportunity disease that happens to PLHA  🞎 It is an opportunity disease to that happens to PLHA while immune is weaken  🞎 Other…………………………………………………………………………………… |
| 2.4 | What is ART mean to you?   * It is a treatment to provide to PLHA to delay their lives * It is the treatment to provide to PLHA to kill HIV virus in our body * It is treatment to cure PLHA * It is a treatment to provide to PLHA to reduce HIV multiplication in human body   🞎 Others…………………………………….…………………………………….……. |
| 2.5 | Do you need self-health care while you are on either OI treatment and/or ART?  Need—1 No need—2 Don’t know—3 |
| 2.6 | Why do you need self-health care while you are on either OI treatment and/or ART?  🞎 To prevent opportunistic infection  🞎 To improve the quality of life  🞎 To stay in healthy  🞎 Others…………………………………….…………………………………….……. |
| 2.7 | When you got health problem, who do you usually go first for advice?  Family members—1 Close friend—2 Clinic staff—3 Counselor—4  Village educator—5 Peer educator--6 Other…………………………………….…… |
| 2.8 | How often do you practice exercise?  🞎 Often (every day or 4-5 days/week)—1 Occasionally (1-2 times/week )—2 Rarely (1 time /month)—3 Never—4 |
| 2.9 | Do you have someone to remind you on taking drug at home?  🞎 My husband or wife 🞎 My children 🞎 My alarm clock  🞎 By myself 🞎 Home care giver 🞎 Other…………………………………………… |
| 2.10 | What activities you do at home in taking care of yourself?  🞎 Exercising 🞎 Taking drug on time 🞎 Self hygiene 🞎 Household hygiene and sanitation  🞎 Taking enough sleep 🞎 Avoid food and drink that harmful for health 🞎 Other……… |

1. **Accessibility to HIV health care services**

|  |  |
| --- | --- |
| 3.1 | How do you know the first time the OIs or ART clinic?  Myself—1 VCCT staff—2 HBC staff—3 Village volunteer—4 People in the village—5 Other—99…………………………………………….……………………………… |
| 3.2 | What benefit have you got so far from access to your clinic each time?  🞎 HIV test 🞎 CD4 test 🞎 Lab test 🞎 Receiving ART 🞎 OI care 🞎 OI drug  🞎 Peer educator 🞎 Other………………………………………………….……………. |
| 3.3 | How do you get HIV and AIDS and other health information so far?  🞎 HBC staff 🞎 Counselor 🞎 VCCT staff 🞎 Clinical staff 🞎 Printing material (leaflet, poster, booklet) 🞎 TV 🞎 Radio 🞎 Village educator 🞎 People in the village 🞎 Family members Other……………………………………………………………… |
| 3.4 | While you are so sick at home, how do you do?  🞎 Call to counselors  🞎 Call to educator  🞎 Tell some one to call counselor or educator  🞎 Other……………………………………………………………………… |
| 3.5 | How often you go to the clinic?  1 time/month—1 1 time in 2 months—2 1 time in 3 months  1 time in 4-6 months—4 1 time in over than 6 months—5 |
| 3.6 | How do you go to the clinic?  🞎 Walking 🞎 Bicycle 🞎 Motorbike 🞎 Friend’s motorbike 🞎 Taxi 🞎 Boat  🞎 Speed boat 🞎 Other……………………………………………………………… |
| 3.7 | How long do you spend to reach clinic?........................Minute |
| 3.8 | How often do you take X-ray?  Every 3 months—1 Every 6 months—2 Every 12 months—3  Every 24 months—4 Other—99………………………………………………….. |
| 3.9 | Do you take X-ray on time as dated by the doctor? (On time scheduled and punctual)  Totally on time—1 Mostly on time—2 Less on time—3 Not on time—4 |
| 3.10 | How often do you have blood test for checking the present of CD4?  Every 3 months—1 Every 6 months—2 Every 12 months—3  Every 24 months—4 Other—99………………………………………………….. |
| 3.11 | Have you got blood test for checking the present of CD4 as dated by the doctor? (On time scheduled and punctual)  Totally on time—1 Mostly on time—2 Less on time—3 Not on time—4 |
| 3.12 | How often do you take phlegm test for checking the present of TB?  Every 3 months—1 Every 6 months—2 Every 12 months—3  Every 24 months—4 Other—99………………………………………………….. |
| 3.13 | Have you got phlegm test for checking the present of TB as dated by the doctor? (On time scheduled and punctual)  Totally on time—1 Mostly on time—2 Less on time—3 Not on time—4 |

1. **Perception on the quality of providing HIV health care services**

|  |  |
| --- | --- |
| 4.1 | How much do you pay in average each time for a consultation or treatment service? (Please state 0 if not pay)………….riels |
| 4.2 | When you are **sent to the clinic**, how satisfy do the clinicians take care of you?  Very good—1 Good—2 Not so good—3 Not good—4 |
| 4.3 | How do you evaluate your clinician listens to you during consultation?  Very good—1 Good—2 Not so good—3 Not good—4 |
| 4.4 | Do you satisfy with attitude or behavior of the clinician?  Yes—1 So so —2 No—3 |
| 4.5 | Do you get clear information on drug administration each time while you back home?  Yes—1 So so —2 No—3 Other—99…………………………………………… |
| 4.6 | In case you do not get clear information, who do you usually go to for more explanation?  🞎 MMM 🞎 Drug dispenser 🞎 Drug Counselors 🞎 HBC team  🞎 Other……………………………………………………………………………… |
| 4.7 | Do you think the drugs that you received are in acceptable quality?  Yes—1 No—2 Don’t know—3 |
| 4.8 | How do you know that you get a quality drug?  🞎 I read the expired date 🞎 I believe in health care provider 🞎 I don’t know  🞎 Other………………………………………………………………………………. |
| 4.9 | In case you are not feeling well and want to make complain, how will you do?  🞎 Meet with the clinician and report him/her  🞎 Meet your counselor and report him/her  🞎 Meet Village Health Educator and report  🞎 Meet Peer Educator and report  🞎 Write the letter then place into the letter box  🞎 Do nothing  🞎 Other……………………………………………………………………………….. |

1. **Social Encouragement Activities**

|  |  |
| --- | --- |
| 5.1 | How often have you attended MMM meeting?  Never—1 Sometime (every 2 or 3 month or as when I want)—2  Every month—3 Others--99……………………………………………………… |
| 5.2 | How importance to you on attending with MMM’s meeting?  Very important—1 Important—2 Not really—3 Not important—4 |
| 5.3 | If important, why?  🞎 Don’t feel alone 🞎 Sharing experiences from other  🞎 Updated information from counselor or medical staff  🞎 Getting more solutions related to HIV and AIDS care and support  🞎 Getting food and transportation allowance  🞎 Other…………………………………………………………..………… |
| 5.4 | If not important, why? …………………………….………………………… |
| 5.5 | Each time you go to clinic, what are the clinicians you need to meet?  🞎 Registration 🞎 Counselor 🞎 Consultation staff 🞎 Drug provider 🞎 Other clinicians for taking test 🞎 Meet other clinicians……………………………………………….. |
| 5.6 | Do you think clinic staffs give you warm welcome each time you get to clinic?  Good welcome—1 Less welcome—2 Not welcome—3 |
| 5.7 | Do you think clinic consolation staff gives you warm welcome each time you get to clinic?  Good welcome—1 Less welcome—2 Not welcome—3 |
| 5.8 | Do you think you can ask free questions while you are with consultation staff?  Yes—1 Not really—2 Not at all—3 Don’t know—4 |
| 5.9 | Do you think you can ask free questions while you are with drug dispenser?  Yes—1 Not really—2 Not at all—3 Don’t know—4 |
| 5.10 | Do you think you can ask freely question while you with drug counselor?  Yes—1 Not really—2 Not at all—3 Don’t know—4 |
| 5.11 | Do you think you can ask freely for your question while you are at MMM?  Yes—1 Not really—2 Not at all—3 Don’t know—4 |
| 5.12 | How often your neighbor and other persons in your village used to visit you?  Often—1 Not often—2 Rarely—3 Never—4 |
| 5.13 | Have you been involved in the group in your village?  Self Health Group—1 Other groups……………………………………………. |
| 5.14 | Do your children go to school? **(No need to ask if they don’t have children)** Yes—1 No—2 |
| 5.15 | If no, why?........................................................................................................... |
| 5.16 | Do your children ever tell you that someone discriminate and stigmatize to them?  Often/usually—1 Not often—2 Rarely—3 Never—4 |
| 5.17 | How do you think after participating the project and what changes you received?  Much braver than before—1 Braver than before—2 Same as before/shy/not brave—3 |

1. **Perceptions on efficiencies from the impact of intervention and practice**

|  |  |
| --- | --- |
| 6.1 | How is the clinician important for your life?  Very important –1 Important—2 Normal—3 |
| 6.2 | How is the counselor important for your life?  Very important –1 Important—2 Normal —3 |
| 6.3 | How is the Home Base Care team important for your life? Very important –1 Important—2 Normal —3 |
| 6.4 | How is your CD4 status increase or decreas ? (Ask them to estimate)   * At the beginning of treatment :........................................don’t know/not remember--1 * Currently:........................................................................ don’t know/not remember—2 |
| 6.5 | Do you think that your health condition is getting improved after receiving care and treatment?  Much improved—1 Improved—2 Same as before—3 Worse than before—4 |
| 6.6 | What problems you face in accessing services from clinic?  🞎 Lack of mean for transportation 🞎 Clinicians are busy 🞎 Spend time to wait  🞎 No problem 🞎 Other………………………………………………………………. |
| 6.7 | Example that you are required to pay for services or you will not supported on transportation and treatment/receiving service from clinic, are you willing to continue your health care at clinic?  Must go to receive health care services from clinic—1 Maybe yes—2 Not to continue—3 |
| 6.8 | Why? ……………………………………………………….……………………………. |
| 6.9 | SIien you got HIV, is there any negative impact for your jobs? Yes—1 No—2 |
| 6.10 | If yes, how is the impact?  ……………………………………………………….………………………………….  ……………………………………………………….…………………………………. |

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***Thanks!***

**Annex 3**

**Questionnaires for in-depth interview with key informance with hospital director or manager**

Date of the interview: ........................................................................................................

OD name: Smach Mean Chey—1, Srea Ambel—2, Mongkol Borei—3, Ou Chrov—4

Name of the interviewer: .......................................................................................................

Name of interviewee: .................... Sex: ........ Age:.......... Role: ...........................................

Dear Sir and Madame, I am ...........................member of the evaluation team that requested by Care under the GFATM R4 project that was implemented by Care in collaboration with NCHADS/OD/CoC team, to do a project evaluation. Due to your active role and responsibility involving in this project you are selected to be a key informant of this project evaluation. The objective of our interview is to learn from you in detail about the project implementation, progress, achievement, and effectiveness as well as your thought and recommendation to the next project. We need about 1 hour of your time to do this interview. Anyway, we encourage you to provide us all accurate information to this evaluation that we could use to improve this type of project in the future. We ensure you that all your information kept confidential. Do you agree to participate in this interview?

1. Could you brief us a little bit about the project “??????????” ?
2. What kind of support that you hospital/OD received from this project?
3. What do you see as progress, achievement and effectiveness of the project?
4. In general how do you satisfy with the support from Care (technically and financially to the project especially to your province?
5. What is the limitation of the project
6. The project is ended by August 2010, as the director of hospital what do you thing about the sustainability of this project?
7. Could you provide us what do you think as lesson learn from this project?
8. If the project is sustained, what is your recommendation for improvement?

**Annex 4****: Unstructured Questionnaire for FGD among Health Care provider**

Date of the FGD conduction: .....................................................

OD name: Smach Mean Chey—1, Srea Ambel—2, Mongkol Borei—3, Ou Chrov—4

Target Group: Health Care staff—1 PLHA Counselor—2

Name of the facilitation: 1 : ...................................................... 2 : ............................................

Name of participant :

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Name | Sex | Age | Role |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |
| 7 |  |  |  |  |
| 8 |  |  |  |  |

Introduction:

Dear Sir and Madame, I am ...........................member of the evaluation team that requested by Care under the GFATM R4 project that was implemented by Care in collaboration with NCHADS/OD/CoC team, to do a project evaluation. Due to your active role and responsibility involving in this project you are selected to be a key informant of this project evaluation. The objective of our FGD is to learn from you in detail about the project implementation, progress, achievement, and effectiveness as well as your thought and recommendation to the next project. We need about 1 hour of your time to do this FGD. Anyway, we encourage you to provide us all accurate information to this evaluation that we could use to improve this type of project in the future. We ensure you that all your information kept confidential. Do you agree to participate in this FGD?

1. Do you know about the project”???????????????” which is been implemented by CARE? Could you please describe briefly about this project?

....................................................................................................................................................

....................................................................................................................................................

**2.** What are the differences you have seen comparing before and after the project implementation?

....................................................................................................................................................

....................................................................................................................................................

**3**. What have you seen as the strengths and weaknesses or the limitations of this project?

- Input (human and materials)

- Relationship (project staff, clinician and community)

- Collaboration in implementing the project activities?

- Announcement activities

- Providing services

- Receiving services

- Sustainability

....................................................................................................................................................

.........................................................................................................................................................

**4.** According to you, what is the best practice from this project for nationwide implementation? (Please specify the reasons)

- Input (human and materials)

- Relationship (project staff, clinician and community)

- Collaboration in implementing the project activities?

- Announcement activities

- Providing services

- Receiving services

- Sustainability

- Other

....................................................................................................................................................

.........................................................................................................................................................

**5**.This project is ended by August 2010. Therefore, what are the impacts to the supports which you received on your work so far from this project?

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....................................................................................................................................................

**6.** What are your recommends on this project?

....................................................................................................................................................

....................................................................................................................................................

**Annex 5: Unstructured Questionnaire for in-depth interview among PLHA**

Date of the interview: .............................................................................................

OD name: Smach Mean Chey—1, Srea Ambel—2, Mongkol Borei—3, Ou Chrov—4

Name of the interviewer: ..........................................................................................

Name of interviewee: ............................. Sex:....................... Age:..........................

Dear Sir and Madame, I am ...........................member of the evaluation team that requested by Care under the GFATM R4 project “ Project name” that was implemented by Care in collaboration with NCHADS/OD/CoC team, to do a project evaluation. Due to all of you as our project beneficiary of this project you are all selected to be a key informant of this project evaluation. The objective of our interview is to learn from you in detail about your knowledge, support you get so far related to your health especially on OIs and ART care and treatment as well as your thought and recommendation to the future. We need about 1 hour of your time to do this interview. Anyway, we encourage you to provide us all accurate information to this evaluation that we could use to improve this type of project in the future. We ensure you that all your information kept confidential. Do you agree to participate in this interview?

Note:

....................................................................................................................................................

....................................................................................................................................................

1. How do you know that you live with HIV?

....................................................................................................................................................

....................................................................................................................................................

1. How do you get the first HIV test?

....................................................................................................................................................

....................................................................................................................................................

3. How long did it take to take first care and treatment after learning about HIV status?

....................................................................................................................................................

....................................................................................................................................................

4. How do you learn the first time the OIs and ART services?

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5. How long (month-year) have you been under ART treatment?

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6. Do you regularly come to have ART?

* Monthly or else?
* Irregularly
* No ARV drug (Shortage)
* Why you have to adhere to ART regularly

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7. How much do you spend each time you come for consultation and ART drug?

- Transportation cost, HCP cost and food cost

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8. In what level are you in ARV management?

* 1. What is ARV?

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* 1. Why do you need ARV?

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* 1. When do you need ARV?

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* 1. How do you store ARV?

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* 1. How do you take ARV?

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* 1. What consequence of misuse of ARV?

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* 1. Why you have to use it for the whole life?

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* 1. What is the side effect of ARV?

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9. So far what do you get from

1. Physician

2. Dispenser

3. Drug counselor

4. MMM

5. Self-help group

6. HBC

* HBC
* Listen to you attentively
* Opportunity for question
* Provide clear information
* Provide support in responding to the need
* Explaining on OIs and ART, ARV administration, eating food, ARV side effect
* Etc

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10. All supports you get so far what are the good points and limitations?

10.1. Physician

10.2. Dispenser

10.3. Drug counselor

10.4. MMM

10.5. Self-help group

10.6. HBC

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11. How do you satisfy with the supports so far?

11.1. Physician

11.2. Dispenser

11.3. Drug counselor

11.4. MMM

11.5. Self-help group

11.6. HBC

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12. What are your recommends to improve care and treatment in the future?

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**Annex 6:** Resources person for End-line Survey on Global Fund Round 4 project

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| --- | --- | --- | --- | --- | --- |
| Group | Location | Resource Name | Gender | Role | Contact Phone |
| 1 | Smach Meanchey | SETH Sopheap | M | Team Leader | 012 734 808 |
| 1 | Smach Meanchey | Moth Chan Sotheara | F | Data Collector | 011 502 825 |
| 1 | Smach Meanchey | Neak Samneang | F | Data Collector |  |
| 1 | Smach Meanchey | Chan You Dinan | M | Data Collector | 0975 831 667 |
| 1 | Smach Meanchey | Sek Dara | M | Data Collector | 017 362 439 |
| 1 | Smach Meanchey | Neak Nem | M | Field support | 077 221 108 |
| 2 | Srer Ambel | Chan Youdina | M | Team Leader |  |
| 2 | Srer Ambel | Phorn Sovannara | M | Interviewer | 092 803 050 |
| 2 | Srer Ambel | Sary Both | M | Interviewer | 016 434 148 |
| 2 | Srer Ambel | Prak Sovanpiseth | M | Interviewer | 016 613 322 |
| 3 | Mongkol Borey | SRENG Bora | M | Team Leader |  |
| 3 | Mongkol Borey | Kao Sotheara | F | Interviewer | 011 674 502 |
| 3 | Mongkol Borey | Chhuoy Socheat | F | Interviewer | 012 881 461 |
| 3 | Mongkol Borey | Phum Srey Leak | F | Interviewer | 015 504 620 |
| 3 | Mongkol Borey | Svay Saren | M | Interviewer | 077 566 978 |
| 3 | Mongkol Borey | Sorng Kosal | M | Interviewer | 077 423 623 |
| 3 | Mongkol Borey | Chum Yaneth | M | Interviewer | 016 327 345 |
| 4 | Poy Pet | THOL Daneth | F | Team Leader |  |
| 4 | Poy Pet | Kong Salun | F | Interviewer | 012 697 276 |
| 4 | Poy Pet | Chet Chenda | F | Interviewer | 077 227 849 |
| 4 | Poy Pet | Sorn Sothyrak | M | Interviewer | 092 782 243 |
| 4 | Poy Pet | Bun Trey | M | Interviewer | 0976 343 676 |
| 4 | Poy Pet | Then Sokveng | M | Interviewer | 012 895 215 |
| 4 | Poy Pet | Neak Nem | M | Interviewer | 077 221 108 |